

## **PRODUCT MONOGRAPH**

**Pr AA-MEDROXY**

**Medroxyprogesterone Acetate Tablets USP**

**2.5 mg, 5 mg, 10 mg and 100 mg**

**PROGESTIN**

AA PHARMA INC.  
1165 Creditstone Road, Unit #1  
Vaughan, Ontario  
L4K 4N7  
[www.aapharma.ca/en/](http://www.aapharma.ca/en/)

Date of Preparation:  
June 20, 2024

**Control No.: 286901**

**Table of Contents**

**PART I: HEALTH PROFESSIONAL INFORMATION..... 3**

SUMMARY PRODUCT INFORMATION ..... 3

INDICATIONS AND CLINICAL USE ..... 3

CONTRAINDICATIONS ..... 4

WARNINGS AND PRECAUTIONS ..... 4

ADVERSE REACTIONS ..... 12

DRUG INTERACTIONS ..... 15

DOSAGE AND ADMINISTRATION ..... 16

OVERDOSAGE..... 18

ACTION AND CLINICAL PHARMACOLOGY ..... 19

STORAGE AND STABILITY ..... 22

DOSAGE FORMS, COMPOSITION AND PACKAGING ..... 22

**PART II: SCIENTIFIC INFORMATION ..... 23**

PHARMACEUTICAL INFORMATION ..... 23

CLINICAL TRIALS ..... 23

DETAILED PHARMACOLOGY ..... 26

TOXICOLOGY ..... 27

REFERENCES..... 29

**PART III: CONSUMER INFORMATION..... 34**

## PrAA-MEDROXY

Medroxyprogesterone Acetate Tablets USP

2.5 mg, 5 mg, 10 mg and 100 mg

### PART I: HEALTH PROFESSIONAL INFORMATION

#### SUMMARY PRODUCT INFORMATION

Route of Administration	Dosage Form / Strength	All Nonmedicinal Ingredients
Oral	Tablets / 2.5 mg, 5 mg, 10 mg and 100 mg	Colloidal silicon dioxide, croscarmellose sodium, D&C yellow #10 (2.5 mg tablet), FD&C blue #2 (5 mg tablet), FD&C yellow #6 (2.5 mg tablet), lactose monohydrate, magnesium stearate, microcrystalline cellulose, and sodium lauryl sulfate

#### INDICATIONS AND CLINICAL USE

AA-MEDROXY (medroxyprogesterone acetate) is indicated for:

- Hormonal replacement therapy, to oppose the effects of estrogen on the endometrium and significantly reduce the risk of hyperplasia and carcinoma;
- Functional menstrual disorders due to hormonal imbalance in non-pregnant women, in the absence of organic pathology;
- Adjunctive and/or palliative treatment of recurrent and/or metastatic endometrial carcinoma;
- Adjunctive and/or palliative treatment of hormonally-dependent, recurrent metastatic breast cancer in post-menopausal women.

For indications not including breast cancer, AA-MEDROXY should be prescribed only to women with intact uteri.

**Pediatrics (<16 years of age):** AA-MEDROXY is not intended for pediatric use and no clinical data has been collected in children.

## CONTRAINDICATIONS

Estrogen and Estrogen/Progestin combinations are contraindicated in patients with any of the following disorders:

- Patients who are hypersensitive to this drug or to any ingredient in the formulation or component of the container. For a complete listing, see the **DOSAGE FORMS, COMPOSITION AND PACKAGING** section of the product monograph.
- Liver dysfunction or disease as long as liver function tests have failed to return to normal;
- Known or suspected estrogen-dependent or progestin-dependent malignant neoplasia (e.g., endometrial cancer), unless AA-MEDROXY is being used as a treatment for endometrial or breast cancer, as outlined in the **INDICATIONS AND CLINICAL USE** section;
- Known, suspected, or past history of breast cancer, unless AA-MEDROXY is being used as a treatment for breast cancer in postmenopausal women, as outlined in the **INDICATIONS AND CLINICAL USE** section;
- Undiagnosed abnormal genital bleeding;
- Known or suspected pregnancy;
- Active or past history of arterial thromboembolic disease (e.g. stroke, myocardial infarction, coronary heart disease);
- Active or past history of confirmed venous thromboembolism (such as deep vein thrombosis or pulmonary embolism) or active thrombophlebitis;
- Partial or complete loss of vision due to ophthalmic vascular disease.

## WARNINGS AND PRECAUTIONS

### Serious Warnings and Precautions

The Women's Health Initiative (WHI) trial examined the health benefits and risks of oral combined *estrogen plus progestin* therapy (n=16,608) and oral *estrogen-alone* therapy (n=10,739) in postmenopausal women aged 50 to 79 years.<sup>17,47,57</sup>

The *estrogen plus progestin* arm of the WHI trial (mean age 63.3 years) indicated an increased risk of *myocardial infarction* (MI), *stroke*, *invasive breast cancer*, *pulmonary emboli* and *deep vein thrombosis* in postmenopausal women receiving treatment with combined conjugated equine estrogens (CEE, 0.625 mg/day) and medroxyprogesterone acetate (MPA, 2.5 mg/day) for 5.2 years compared to those receiving placebo.<sup>57</sup>

The *estrogen-alone* arm of the WHI trial (mean age 63.6 years) indicated an increased risk of *stroke* and *deep vein thrombosis* in hysterectomized women treated with CEE-alone (0.625 mg/day) for 6.8 years compared to those receiving placebo.<sup>47</sup>

Therefore, the following should be given serious consideration at the time of prescribing:

- Estrogens with or without progestins **should not** be prescribed for primary or secondary prevention of cardiovascular diseases.

- Estrogens with or without progestins should be prescribed at the **lowest effective** dose for the approved indication.
- Estrogens with or without progestins should be prescribed for **the shortest period** possible for the approved indication.

## **General**

Some information presented in the Warnings and Precautions section is provided in light of the fact that a progestin medication is often prescribed concomitantly with an estrogen medication. Information in this section pertaining to combined estrogen-progestin therapy may therefore not apply to progestin-only therapy. Physician discretion is advised.

When AA-MEDROXY is used for adjunctive and/or palliative treatment of recurrent and/or metastatic endometrial or hormonally-dependent, recurrent metastatic carcinoma of the breast in post-menopausal women, the risks outlined in this **WARNINGS AND PRECAUTIONS** section (including cardiovascular disorders and breast and ovarian cancer), should be weighed against the potential benefits of this treatment to the patient.

## **Carcinogenesis and Mutagenesis**

### ***Breast cancer***

Available epidemiological data indicate that the use of combined *estrogen plus progestin* by postmenopausal women is associated with an increased risk of invasive breast cancer. In the *estrogen plus progestin* arm of the WHI trial, among 10,000 women over a one-year period, there were:

- 8 more cases of invasive breast cancer (38 on combined HRT versus 30 on placebo).<sup>57</sup>

The WHI study also reported that the invasive breast cancers diagnosed in the estrogen plus progestin group were similar in histology but were larger (mean [SD], 1.7 cm [1.1] vs 1.5 cm [0.9], respectively; P=0.04) and were at a more advanced stage compared with those diagnosed in the placebo group. The percentage of women with abnormal mammograms (recommendations for short-interval follow-up, a suspicious abnormality, or highly suggestive of malignancy) was significantly higher in the estrogen plus progestin group versus the placebo group. This difference appeared at year one and persisted in each year thereafter.<sup>17</sup>

In the estrogen-alone arm of the WHI trial, there was no statistically significant difference in the rate of invasive breast cancer in hysterectomized women treated with conjugated equine estrogens versus women treated with placebo.<sup>47</sup>

It is recommended that estrogens with or without progestins not be given to women with existing breast cancer or those with a previous history of the disease (see **CONTRAINDICATIONS**). There is a need for caution in prescribing estrogens with or without progestins for women with known risk factors associated with the development of breast cancer, such as strong family history of breast cancer (first degree relative) or who present a breast condition with an increased risk (abnormal mammograms and/or atypical hyperplasia at breast biopsy). Other known risk factors for

the development of breast cancer such as nulliparity, obesity, early menarche, late age at first full term pregnancy and at menopause should also be evaluated.

It is recommended that women undergo a mammography prior to the start of HRT treatment and at regular intervals during treatment, as deemed appropriate by the treating physician and according to the perceived risks for each patient.

The overall benefits and possible risks of hormone replacement therapy should be fully considered and discussed with patients. It is important that the modest increased risk of being diagnosed with breast cancer after 4 years of treatment with combined estrogen plus progestin HRT (as reported in the results of the WHI trial) be discussed with the patient and weighed against its known benefits.

*Instructions for regular self-examination of the breasts should be included in this counselling.*

### **Endometrial hyperplasia & endometrial carcinoma**

The incidence of estrogen-associated endometrial hyperplasia was assessed in 2 large, long-term, randomized clinical trials. The first study demonstrated that combining conjugated estrogens with medroxyprogesterone acetate or micronized progesterone protected the endometrium from hyperplastic changes associated with estrogen-only therapy. In the second study, the endometrial hyperplasia incidence was significantly lower in women treated with conjugated estrogen and medroxyprogesterone acetate ( $P < 0.001$ ) than in women treated with conjugated estrogen alone (see **CLINICAL TRIALS**).

### ***Ovarian cancer***

Some recent epidemiologic studies have found that the use of postmenopausal hormone replacement therapy (*estrogen alone* and *estrogen plus progestin* therapies) in particular for five or more years has been associated with an increased risk of ovarian cancer.

### **Cardiovascular**

The results of the Heart and Estrogen/progestin Replacement Studies (HERS and HERS II) and the Women's Health Initiative (WHI) trial indicate that the use of *estrogen plus progestin* is associated with an increased risk of coronary heart disease (CHD) in postmenopausal women.<sup>26,31,57</sup> The results of the WHI trial indicate that the use of *estrogen-alone* and *estrogen plus progestin* is associated with an increased risk of stroke in postmenopausal women.<sup>47,57</sup>

### ***WHI trial findings***

In the combined *estrogen plus progestin* arm of the WHI trial, among 10,000 women over a one-year period, there were:

- 8 more cases of stroke (29 on combined HRT versus 21 on placebo)
- 7 more cases of CHD (37 on combined HRT versus 30 on placebo).<sup>57</sup>

In the *estrogen-alone* arm of the WHI trial of women with prior hysterectomy, among 10,000 women over a one-year period, there were/was:

- 12 more cases of stroke (44 on *estrogen-alone* therapy versus 32 on placebo)
- No statistically significant difference in the rate of CHD.<sup>47</sup>

### ***HERS and HERS II findings***

In the Heart and Estrogen/progestin Replacement Study (HERS) of postmenopausal women with documented heart disease (n=2763, average age 66.7 years), a randomized placebo-controlled clinical trial of secondary prevention of coronary heart disease (CHD), treatment with 0.625 mg/day oral conjugated equine estrogen (CEE) plus 2.5 mg oral medroxyprogesterone acetate (MPA) demonstrated no cardiovascular benefit. Specifically, during an average follow-up of 4.1 years, treatment with CEE 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 hormone treated group than in the placebo group in year 1, but not during the subsequent years.<sup>31</sup>

From the original HERS trial, 2321 women consented to participate in an open label extension of HERS known as HERS II. Average follow-up in HERS II was an additional 2.7 years, for a total of 6.8 years overall. After 6.8 years, hormone therapy did not reduce the risk of cardiovascular events in women with CHD.<sup>26</sup>

### ***Blood pressure***

Women using hormone replacement therapy sometimes experience increased blood pressure. Blood pressure should be monitored with HRT use. Elevation of blood pressure in previously normotensive or hypertensive patients should be investigated and HRT may have to be discontinued.

## **Endocrine and Metabolism**

### ***Adrenocortical function***

Clinical suppression of adrenocortical function has not been observed at low dose levels. However, the high doses of AA-MEDROXY used in the treatment of certain cancers may, in some cases, produce Cushingoid symptoms (e.g., "moon" facies, fluid retention, glucose intolerance, and blood pressure elevation).

### ***Glucose and lipid metabolism***

A worsening of glucose tolerance and lipid metabolism have been observed in a significant percentage of peri-and post-menopausal patients. Therefore, diabetic patients or those with a predisposition to diabetes should be observed closely to detect any alterations in carbohydrate or lipid metabolism, especially in triglyceride blood levels.

Women with familial hypertriglyceridemia need special surveillance. Lipid-lowering measures are recommended additionally, before treatment is started.

### ***Heme metabolism***

Women with porphyria need special surveillance.

## **Other Conditions**

AA-MEDROXY contains lactose. In patients with rare hereditary galactose intolerance, lactase deficiency or glucose-galactose malabsorption, the severity of the condition should be taken into careful consideration before prescribing AA-MEDROXY. The patients should be closely monitored.

### ***Calcium and phosphorus metabolism***

Because the prolonged use of estrogens with or without progestins influences the metabolism of calcium and phosphorus, estrogens with or without progestins should be used with caution in patients with metabolic and malignant bone diseases associated with hypercalcemia and in patients with renal insufficiency.

### ***Decrease in bone mineral density***

There are no available studies on the effects of orally administered medroxyprogesterone acetate (MPA) as a single agent, on bone mineral density (BMD).

However, it may be suspected that for specific medical conditions, when MPA is administered over a prolonged period of time at a dose that is high enough to suppress endogenous estrogen production (e.g. pre-menopausal women), it could result in a decrease in bone mineral density (BMD). In these circumstances, adequate calcium and vitamin D intake should be considered.

### ***Hypothyroidism***

Patients who require thyroid hormone replacement therapy and who are also taking estrogen should have their thyroid function monitored regularly to assure that thyroid hormone levels remain in an acceptable range (see **Drug-Laboratory Test Interactions**).

## **Genitourinary**

### ***Vaginal bleeding***

Abnormal vaginal bleeding, due to its prolongation, irregularity or heaviness, occurring during therapy should prompt appropriate diagnostic measures to rule out the possibility of uterine malignancy and the treatment should be re-evaluated.

### ***Uterine leiomyomata***

Pre-existing uterine leiomyomata may increase in size during estrogen use. Growth, pain or tenderness of uterine leiomyomata requires discontinuation of medication and appropriate investigation.

### ***Endometriosis***

Symptoms and physical findings associated with a previous diagnosis of endometriosis may reappear or become aggravated with estrogen use.



## ***Menstrual Bleeding Patterns***

Patients should be advised of the menstrual bleeding patterns expected with the sequential regimen (see **DOSAGE AND ADMINISTRATION**).

Upon sequential administration of medroxyprogesterone acetate tablet to women with adequate levels of estrogen (endogenous or exogenous), withdrawal bleeding usually occurs within 7 days after stopping medroxyprogesterone acetate tablet. Bleeding that occurs during medroxyprogesterone acetate tablet administration period indicates a need for a longer duration, or a higher dose of medroxyprogesterone acetate tablet.

## **Hematologic**

### ***Venous thromboembolism***

Available epidemiological data indicate that use of estrogen with or without progestin by postmenopausal women is associated with an increased risk of developing venous thromboembolism (VTE).

In the *estrogen plus progestin* arm of the WHI trial, among 10,000 women on combined HRT over a one-year period, there were 18 more cases of venous thromboembolism, including 8 more cases of pulmonary embolism.<sup>57</sup>

In the estrogen-alone arm of the WHI trial, among 10,000 women on estrogen therapy over a one-year period, there were 7 more cases of venous thromboembolism, although there was no statistically significant difference in the rate of pulmonary embolism.<sup>47</sup>

Generally recognized risk factors for VTE include a personal history, a family history (the occurrence of VTE in a direct relative at a relatively early age may indicate genetic predisposition) and severe obesity (body mass index > 30 kg/m<sup>2</sup>) and systemic lupus erythematosus. The risk of VTE also increases with age and smoking.

The risk of VTE may be temporarily increased with prolonged immobilization, major surgery or trauma. In women on HRT, attention should be given to prophylactic measures to prevent VTE following surgery. Also, patients with varicose veins should be closely supervised. The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, hormone therapy should be discontinued immediately, given the risks of long-term disability or fatality.

If feasible, estrogens with or without progestins should be discontinued at least 4 weeks before major surgery which may be associated with an increased risk of thromboembolism, or during periods of prolonged immobilization.

## **Hepatic/Biliary/Pancreatic**

### ***Gallbladder diseases***

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

## ***Jaundice***

Caution is advised in patients with a history of liver and/or biliary disorders. If cholestatic jaundice develops during treatment, the treatment should be discontinued and appropriate investigations carried out.

## ***Liver function tests***

Liver function tests should be done periodically in subjects who are suspected of having hepatic disease. For information on endocrine and liver function tests, see section under **Monitoring and Laboratory Tests.**

## **Immune**

### ***Anaphylactic/Anaphylactoid reactions***

Anaphylactic and anaphylactoid reactions have occasionally been reported in patients treated with medroxyprogesterone acetate tablet.

## **Neurologic**

### ***Cerebrovascular insufficiency***

Patients who develop visual disturbances (including sudden partial or complete loss of vision or sudden onset of proptosis, diplopia), classical migraine, transient aphasia, paralysis, or loss of consciousness should discontinue medication.

Patients with a previous history of classical migraine and who develop a recurrence or worsening of migraine symptoms should be reevaluated.

## ***Dementia***

Available epidemiological data indicate that the use of combined *estrogen plus progestin* in women age 65 and over may increase the risk of developing probable dementia.

The Women's Health Initiative Memory Study (WHIMS), a clinical substudy of the WHI, was designed to assess whether postmenopausal hormone replacement therapy (oral *estrogen plus progestin* or oral *estrogen-alone*) reduces the risk of dementia in women aged 65 and over (age range 65-79 years) and free of dementia at baseline.<sup>43, 44</sup>

In the *estrogen plus progestin* arm of the WHIMS (n=4532), women with intact uteri were treated with daily 0.625 mg conjugated equine estrogens (CEE) plus 2.5 mg medroxyprogesterone acetate (MPA) or placebo for an average of 4.05 years. The results, when extrapolated to 10,000 women treated over a one-year period showed:

- 23 more cases of probable dementia (45 on combined HRT versus 22 on placebo).<sup>43</sup>

In the *estrogen-alone* arm of the WHIMS (n=2947), women with prior hysterectomy were treated with daily 0.625 mg CEE or placebo for an average of 5.21 years. The results, when extrapolated to 10,000 women treated over a one-year period showed:

- 12 more cases of probable dementia (37 on estrogen-alone versus 25 on placebo), although this difference did not reach statistical significance.<sup>44</sup>

When data from the *estrogen plus progestin* arm of the WHIMS and the *estrogen alone* arm of the WHIMS were combined, as per the original WHIMS protocol, in 10,000 women over a one-year period, there were:

- 18 more cases of probable dementia (41 on *estrogen plus progestin* or *estrogen-alone* versus 23 on placebo).<sup>44</sup>

In addition, conjugated equine estrogens and medroxyprogesterone acetate (CEE/MPA) therapy did not prevent mild cognitive impairment (MCI) in post-menopausal women 65 years of age or older. Use of hormone therapy to prevent dementia or MCI in women 65 years or older is not recommended.<sup>43, 44</sup>

### ***Epilepsy***

Particular caution is indicated in women with epilepsy, as estrogens with or without progestins may cause an exacerbation of this condition.

### **Psychiatric**

#### ***Depression***

Patients who have a history of mental depression should be carefully monitored while receiving therapy with AA-MEDROXY. Some patients may complain of premenstrual like depression while on AA-MEDROXY.

### **Renal**

#### ***Fluid retention***

Estrogens with or without progestins may cause fluid retention. Therefore, particular caution is indicated in cardiac or renal dysfunction or asthma. If, in any of the above-mentioned conditions, a worsening of the underlying disease is diagnosed or suspected during treatment, the benefits and risks of treatment should be reassessed based on the individual case.

### **Sexual Function/Reproduction**

#### ***Menopause***

The age of the patient constitutes no absolute limiting factor although treatment with progestins may mask the onset of the climacteric.

### **Special Populations**

**Pregnant Women:** Usage in pregnancy is not recommended. Progestational agents are also not recommended as a diagnostic test for pregnancy. If the patient is exposed to AA-MEDROXY (medroxyprogesterone acetate) during pregnancy or if she becomes pregnant while taking the drug, she should be apprised of the potential risk to the fetus.

**Nursing Women:** Detectable amounts of progestin have been identified in the milk of mothers receiving the drug. Infants exposed to medroxyprogesterone via breast milk have been studied for developmental and behavioral effects through puberty. No adverse effects have been noted.

**Pediatrics (< 16 years of age):** AA-MEDROXY is not intended for pediatric use and no clinical data has been collected in children.

**Geriatrics (> 65 years of age):** Of the total number of subjects in the estrogen plus progestin substudy of the Women's Health Initiative (WHI), 21.5 percent (n = 3,576) were 70 to 79 years old at baseline.

No significant differences in relative risks of stroke and invasive breast cancer were observed between subjects 70 years and over compared to younger subjects. However, there was a higher relative risk of stroke and invasive breast cancer in women 75 and over compared to younger subjects.

### **Monitoring and Laboratory Tests**

Before AA-MEDROXY is administered, the patient should have a complete physical examination including a blood pressure determination. Breasts and pelvic organs should be appropriately examined and a Papanicolaou smear should be performed. Endometrial biopsy should be done only when indicated. Baseline tests should include mammography, measurements of blood glucose, calcium, triglycerides and cholesterol, and liver function tests.

The first follow-up examination should be done within 3-6 months after initiation of treatment to assess response to treatment. Thereafter, examinations should be made at intervals at least once a year. Appropriate investigations should be arranged at regular intervals as determined by the physician.

*The importance of regular self-examination of the breasts should be discussed with the patient.*

## **ADVERSE REACTIONS**

### **Adverse Drug Reaction Overview**

See **WARNINGS AND PRECAUTIONS** regarding potential induction of malignant neoplasms and adverse effects similar to those of oral contraceptives.

#### ***Overview of Adverse Drug Reactions with Medroxyprogesterone Acetate Use:***

The following adverse reactions have been reported with the use of medroxyprogesterone acetate:

Breast - tenderness, galactorrhea;

Reproductive System - breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, changes in cervical erosion and cervical secretions;

Central Nervous System - headache, nervousness, dizziness, depression, insomnia, somnolence, fatigue, premenstrual syndrome-like symptoms;

Thromboembolic phenomena - including thrombophlebitis and pulmonary embolism;

Skin and Mucous Membranes - sensitivity reactions ranging from pruritus, urticaria, angioneurotic edema to generalized rash and anaphylaxis; acne, alopecia, hirsutism;

Gastrointestinal - abdominal discomfort, nausea, bloating;

Miscellaneous - pyrexia, increase in weight, peripheral edema, "moon" facies.

***Overview of Adverse Drug Reactions with estrogen/progestin combination use:***

The following adverse reactions have been reported with estrogen/progestin combination in general:

**Blood and lymphatic systems disorders**

Altered coagulation tests (see **WARNINGS AND PRECAUTIONS, Drug-Laboratory Tests Interactions**)

**Cardiac disorders**

Palpitations; increase in blood pressure (see **WARNINGS AND PRECAUTIONS**); coronary thrombosis.

**Endocrine disorders**

Increased blood sugar levels; decreased glucose tolerance.

**Eye disorders**

Neuro-ocular lesions (e.g., retinal thrombosis, optic neuritis); visual disturbances; steepening of the corneal curvature; intolerance to contact lenses.

**Gastrointestinal disorders**

Nausea; vomiting; abdominal discomfort (cramps, pressure, pain); bloating.

**General disorders and administration site conditions**

Fatigue; changes in appetite; changes in body weight; change in libido.

**Hepatobiliary disorders**

Gallbladder disorder; asymptomatic impaired liver function; cholestatic jaundice.

**Musculoskeletal and connective tissue disorders**

Musculoskeletal pain including leg pain not related to thromboembolic disease (usually transient, lasting 3-6 weeks) may occur.

**Nervous system disorders**

Aggravation of migraine episodes; headaches; dizziness; neuritis.

## **Psychiatric disorders**

Mental depression; nervousness; irritability.

## **Renal and urinary disorders**

Cystitis; dysuria; sodium retention; edema.

## **Reproductive system and breast disorders**

Breakthrough bleeding; spotting; change in menstrual flow; dysmenorrhea; vaginal itching/discharge; dyspareunia; endometrial hyperplasia; pre-menstrual-like syndrome; reactivation of endometriosis; changes in cervical erosion and amount of cervical secretion; breast swelling and tenderness.

## **Skin and subcutaneous tissue disorders**

Chloasma or melasma; which may persist when drug is discontinued; erythema multiform; erythema nodosum; haemorrhagic eruption; loss of scalp hair; hirsutism and acne.

## **Vascular disorders**

Isolated cases of: thrombophlebitis; thromboembolic disorders.

## **Post-Market Adverse Drug Reactions**

Adverse events reported during worldwide post-marketing experience, regardless of causality and frequency, are listed below. It should be noted that the nature of post-marketing surveillance makes it difficult to determine if a reported event was actually caused by medroxyprogesterone acetate tablet.

**Musculoskeletal and connective tissue disorders:** muscle spasms

**Nervous system disorders:** cerebral infarction

**Pregnancy, puerperium and perinatal conditions:** abortion spontaneous

**Respiratory, thoracic and mediastinal disorders:** dyspnea

**Vascular disorders:** hemorrhage

The following post-market ADRs have been observed with medroxyprogesterone acetate indicated for oncology:

**Cardiac disorders:** myocardial infarction, congestive heart failure

**Eye disorders:** diabetic cataract

**Gastrointestinal disorders:** constipation, diarrhea, dry mouth

**Investigations:** elevation of white blood cells and platelet counts

**Nervous system disorders:** loss of concentration, adrenergic-like effects (e.g., fine-hand tremors, sweating, cramps in calves in night)

**Psychiatric disorders:** euphoria

**Renal and urinary system disorders:** glycosuria

If adverse symptoms persist, the prescription of the HRT should be re-considered.

## **DRUG INTERACTIONS**

### **Overview**

Preparations inducing liver enzymes (e.g., barbiturates, hydantoins, carbamazepine, meprobamates, phenylbutazone or rifampicin) may interfere with the activity of orally administered progestins.

### **Drug-Drug Interactions**

Concomitant administration of aminoglutethimide with medroxyprogesterone acetate (MPA) may significantly reduce the bioavailability of MPA.

Medroxyprogesterone acetate (MPA) is metabolized in-vitro primarily by hydroxylation via the CYP3A4.<sup>59,60</sup> Specific drug-drug interaction studies evaluating the clinical effects with CYP3A4 inducers or inhibitors on MPA have not been conducted and therefore the clinical effects of CYP3A4 inducers or inhibitors are unknown.

### **Drug-Food Interactions**

Administration with food increases the bioavailability of MPA. A 10 mg dose of oral MPA taken immediately before or after a meal, increased average MPA,  $C_{max}$  (51 and 77%, respectively) and average AUC (18 and 33%, respectively). The half-life of MPA was not changed with food. MPA can be taken with or without food.

### **Drug-Herb Interactions**

It was found that some herbal products (eg, St. John's wort) which are available as over-the-counter (OTC) products might interfere with steroid metabolism, and therefore, alter the efficacy and safety of estrogen/progestin products.

Physicians and other health care providers should be made aware of other non-prescription products concomitantly used by the patient, including herbal and natural products, obtained from the widely spread Health Stores.

### **Drug-Laboratory Test Interactions**

The results of certain endocrine and liver function tests may be affected by estrogen/progestin-containing products:

- increased sulfobromophthalein retention;
- increased prothrombin time and partial thromboplastin time; increased levels of fibrinogen and fibrinogen activity; increased coagulation factors VII, VIII, IX, X; increased norepinephrine-induced platelet aggregability; decreased antithrombin III;

- increased thyroxine-binding globulin (TBG), leading to increased circulating total thyroid hormone (T<sub>4</sub>) as measured by column or radioimmunoassay; T<sub>3</sub> resin uptake is decreased, reflecting the elevated TBG; free T<sub>4</sub> concentration is unaltered;
- other binding proteins may be elevated in serum ie, corticosteroid binding globulin (CBG), sex-hormone binding globulin (SHBG), leading to increased circulating corticosteroids and sex steroids, respectively; free or biologically active hormone concentrations are unchanged;
- impaired glucose tolerance;
- reduced serum folate concentration;
- increased serum triglycerides and phospholipids concentration.

The following laboratory tests may be affected by the use of AA-MEDROXY.

- (a) Gonadotropin levels;
- (b) Plasma progesterone levels;
- (c) Urinary pregnanediol levels;
- (d) Plasma testosterone levels (in the male);
- (e) Plasma estrogen levels (in the female);
- (f) Plasma cortisol levels;
- (g) Glucose tolerance test;

The results of the above laboratory tests should not be considered reliable unless therapy has been discontinued for 2 to 4 weeks. The pathologist should be informed that the patient is receiving HRT therapy when relevant specimens are submitted.

## DOSAGE AND ADMINISTRATION

### Dosing Considerations

When estrogen is prescribed for a postmenopausal woman with a uterus, a progestin should also be initiated to reduce the risk of endometrial cancer. A woman without a uterus does not need progestin. Use of estrogen, alone or in combination with a progestin, should be with the lowest effective dose and for the shortest duration consistent with treatment goals and risks for the individual woman. Patients should be re-evaluated periodically as clinically appropriate (for example, 3-month to 6-month intervals) to determine if treatment is still necessary (see **WARNINGS AND PRECAUTIONS**). For women with intact uteri, adequate diagnostic measures, such as endometrial sampling, when indicated, should be undertaken to rule out malignancy in cases of undiagnosed persistent or recurring abnormal vaginal bleeding. Patients should be started at the lowest dose. The lowest effective dose of medroxyprogesterone acetate has not been determined.

### Recommended Dose and Dosage Adjustment

#### 1. Hormone Replacement Therapy:

##### a) Progestin Challenge Test:

The progestin challenge test may be considered for amenorrheic women with intact uteri. AA-MEDROXY (medroxyprogesterone acetate) 10 mg daily should be administered for 10 days.



A negative test is identified by the absence of withdrawal bleeding, and implies the absence of endometrial stimulation due to insufficient estrogen secretion.

A positive test is indicated by the presence of withdrawal bleeding which occurs within 7 days after stopping AA-MEDROXY treatment. Withdrawal bleeding implies the presence of sufficient endogenous estrogen to stimulate the endometrium.

b) Sequential Therapy

Days of the Month																															
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Sequential Estrogen - 25 days																															
										Start	AA-MEDROXY Tablets 5 - 10 mg/day																				
Continuous Estrogen - everyday																															
AA-MEDROXY Tablets 5 - 10 mg/day										Stop																					

In women with intact uteri receiving estrogen replacement therapy, AA-MEDROXY tablets may be given in a dosage of 5 - 10 mg daily for 12 - 14 days. The recommended starting dose for AA-MEDROXY should be 10 mg/day, administered for 12 - 14 days. A dose of 5 mg/day AA-MEDROXY for 12 - 14 days may be appropriate for some women.

**Note:** The lowest dose of AA-MEDROXY required to protect the endometrium from estrogenic-hyperstimulation should be used. A good indicator is the lowest dose of AA-MEDROXY that will consistently result in withdrawal bleeding within 7 days after stopping AA-MEDROXY treatment. Bleeding that occurs during the AA-MEDROXY treatment indicates a need for a longer duration, or higher dose of AA-MEDROXY.

2. Functional Menstrual Disorders

a) Secondary Amenorrhea:

After ruling out pregnancy, AA-MEDROXY may be administered in doses ranging from 5 – 10 mg daily depending upon the degree of progestational effect desired. The dose should be given daily for 12 - 14 days every month.

Note: In patients with poorly developed endometria, conventional estrogen therapy should be given in conjunction with AA-MEDROXY.

b) Dysfunctional Uterine Bleeding:

In dysfunctional uterine bleeding, AA-MEDROXY may be given in doses ranging from 5 – 10 mg/day, for 10 - 14 days, beginning on the assumed or calculated 12 - 16<sup>th</sup> day of the cycle. This regimen should be repeated for 2 subsequent cycles or longer if necessary.

When bleeding is due to a deficiency of both ovarian hormones, as indicated by a poorly developed proliferative endometrium, conventional estrogen therapy should be given in conjunction with AA-MEDROXY. If bleeding is controlled satisfactorily, at least two subsequent cycles of treatment should be given.

If dysfunctional uterine bleeding is not controlled by hormone therapy, appropriate diagnostic measures should be undertaken to rule out uterine pathology.

3. Endometrial Cancer:

200 - 400 mg/day is the usual dose. It is suggested that if neither subjective nor objective improvement is noted within 2 to 3 months, therapy should be discontinued. Where improvement is noted and the disease process appears to be stabilized, it may be possible to maintain this improvement with a 200 mg/day dose.

4. Breast Cancer:

The recommended dose is 400 mg daily, given in divided doses. The patient should be continued on therapy as long as she is responding to treatment. Although doses of up to 2400 mg daily have been reported, controlled studies using 800 mg daily did not demonstrate any appreciable increase in response rates compared to the 400 mg daily dose.

AA-MEDROXY is not recommended as primary therapy, but as adjunctive and palliative treatment in advanced, inoperable cases including those with recurrent metastatic disease.

**Note:** Response to hormonal therapy for endometrial or breast cancer may not be evident until 8 to 10 weeks of therapy. Rapid progression of disease at any time during therapy should result in termination of treatment with AA-MEDROXY.

### Missed Dose

If a dose of this medication has been missed, it should be taken as soon as possible. However, if it is almost time for the next dose, skip the missed dose and go back to the regular dosing schedule. Do not double doses.

### Administration

AA-MEDROXY (medroxyprogesterone acetate) is administered orally.

## **OVERDOSAGE**

### **Symptoms of overdose**

Progestin (e.g., norethindrone acetate) overdose has been characterized by depressed mood, tiredness, acne and hirsutism.

In female patients, overdose may result in a period of amenorrhea of a variable length and may be followed by irregular menses for several cycles.

No cases of overdose in male patients have been reported. However, such overdose, if it were to occur, would not likely result in any particular symptomatology.

### **Treatment of overdose**

There is no known therapy for overdose of medroxyprogesterone. Doses as high as 1000 mg for the therapy of endometrial carcinoma have been used without adverse effect.

For management of a suspected drug overdose, contact your regional poison control centre.

## **ACTION AND CLINICAL PHARMACOLOGY**

### **Mechanism of Action**

Medroxyprogesterone acetate is an orally-active progestational steroid (progestin) derived from a synthetic source and devoid of androgenic and estrogenic activity.

### **Pharmacodynamics**

#### Osteoporosis/osteopenia

Presently there are no conclusive data concerning the mechanism of action of progestins on bone.

Clinically, research to date has shown women treated with medroxyprogesterone acetate to prevent estrogenic hyperstimulation of the endometrium do not lose protection against osteoporosis.

#### Urogenital symptoms

Medroxyprogesterone acetate, when administered to women with adequate levels of estrogen (endogenous or exogenous), transforms a proliferative endometrium into a secretory endometrium. Withdrawal bleeding is anticipated within 7 days after stopping medroxyprogesterone acetate.

Microscopically, the secretory change is associated with glycoprotein-rich stromal cells which surround the glands and vessels and assist them in maintaining their integrity during hormonal withdrawal. The result is an orderly regression and remodelling, and preservation of the functional layer of the endometrium.

Medroxyprogesterone acetate decreases both cytoplasmic and nuclear estrogen receptors in endometrial cells. In addition, medroxyprogesterone acetate induces estradiol dehydrogenase (E<sub>2</sub>DH) activity, the enzyme mechanism by which endometrial cells metabolize and excrete estrogens.

Oral medroxyprogesterone acetate also produces typical progestational changes in the cervical mucous (inhibits ferning) and increases the intermediate cell count in the maturation index of the vaginal epithelium.

#### Metabolism

In studies which examined metabolic changes, a decrease in glucose tolerance has been associated with progestins, including medroxyprogesterone acetate.

Medroxyprogesterone acetate shows small or undetectable effects on lipoproteins when used at therapeutic dosages. Furthermore, research demonstrates that the use of medroxyprogesterone acetate with estrogen in hormone replacement therapy maintains the estrogenic effects on lipid profile.

#### Hemostatic factors

There is no conclusive evidence that medroxyprogesterone acetate produces adverse coagulation changes in women receiving the progestin alone, or as part of a sequential regimen with estrogen.

### Endocrine

Medroxyprogesterone acetate in appropriate doses, suppresses the secretion of pituitary gonadotropins which in turn, prevents follicular maturation, producing anovulation in the premenopausal woman.

The anti-cancer activity of medroxyprogesterone acetate at pharmacologic doses may be dependent upon its effect on the hypothalamic/pituitary/gonadal axis, estrogen receptors and the metabolism of steroids at the tissue level.

Like progesterone, medroxyprogesterone acetate is thermogenic. At the very high dosage levels used in the treatment of certain cancers (500 mg/day or more), corticoid-like activity may be manifest.

Medroxyprogesterone acetate in appropriate doses suppresses the Leydig cell function in the male (i.e., suppresses endogenous testosterone production).

### Pharmacokinetics

In a randomized, cross-over study using 22 healthy male volunteers, the pharmacokinetics of medroxyprogesterone acetate 2.5 mg and medroxyprogesterone acetate 10 mg tablets was studied following 10 mg single oral doses in the following regimens:

- (A) four medroxyprogesterone acetate 2.5 mg tablets or
- (B) one medroxyprogesterone acetate 10 mg tablet as a single dose during a fasting period which began 9 hours before and lasted until 4 hours after the dose. Treatment phases were separated by a 14-day washout period. Blood samples were collected prior to and at the following times after drug administration: 0.5, 1.0, 2.0, 3.0, 4.0, 6.0, 8.0, 10.0, 12.0, 16.0, 24.0, 36.0, 72.0, 96.0, and 120.0 hours. The resulting serum samples were analyzed for medroxyprogesterone using a radioimmunoassay procedure.

Relevant bioavailability parameters are included in Table 1:

**Table 1: Pharmacokinetic Parameters of Medroxyprogesterone Acetate Following Oral Administration**

Medroxyprogesterone acetate Dose (mg)	T <sub>max</sub> (hr)	C <sub>max</sub> (ng/mL)	AUC (ng/hr/mL)
2.5 mg (4 tablets)	1.68	22.10	390.66 – 466.62
10 mg (1 tablet)	1.91	19.26	399.95 – 471.96

Dose = single oral dose

T<sub>max</sub> = time to reach peak serum concentration

C<sub>max</sub> = peak serum concentration

AUC = area under the curve

The pharmacokinetics of medroxyprogesterone acetate 100 mg tablets was assessed in a clinical study using 16 healthy, male volunteers. A single dose of medroxyprogesterone acetate 100 mg was administered orally to subjects who fasted overnight and for 2 hours after the dose was administered. Blood samples were collected prior to, and at the following times, after drug administration: 0.5, 1.0, 2.0, 3.0, 4.0, 6.0, 8.0, 10.0, 12.0, 26.0, 32.0, 50.0, 74.0, 98.0, and 170.0 hours. Serum samples were analyzed for medroxyprogesterone using a radioimmunoassay procedure.

Relevant bioavailability parameters are included in Table 2.

**Table 2: Pharmacokinetic Parameters of Medroxyprogesterone Acetate Following Oral Administration**

Medroxyprogesterone acetate Dose (mg)	T <sub>max</sub> (hr)	C <sub>max</sub> (ng/mL)	AUC (ng/hr/mL)
100 mg	4.1	35.2	974.2

Dose = single oral dose

T<sub>max</sub> = time to reach peak serum concentration

C<sub>max</sub> = peak serum concentration

AUC = area under the curve

**Absorption:** Medroxyprogesterone acetate is rapidly absorbed from the gastrointestinal tract, and maximum concentrations are obtained between 2 to 4 hours after oral administration.

**Distribution:** MPA is approximately 90% protein bound, primarily to albumin; no MPA binding occurs with sex hormone binding globulin.

**Metabolism:** Medroxyprogesterone acetate is metabolized in the liver to several progestin metabolites. The major drug-related material found in circulation following oral administration has been characterized as both free and glucuronide-conjugated metabolites of medroxyprogesterone acetate.

**Excretion:** Medroxyprogesterone acetate has an apparent half-life of about 30 hours and is primarily eliminated via fecal excretion, to which biliary secretion may contribute. Approximately 44% of an oral dose is eliminated through urinary excretion in the form of metabolites.

The only metabolite of medroxyprogesterone acetate that has been isolated and unequivocally identified is 6 $\alpha$ -methyl-6 $\beta$ , 17 $\alpha$ ,21-trihydroxy-4-pregnene-3,20-dione-17-acetate, and appears to be the primary urinary metabolite. This metabolite accounts for approximately 8% of an oral dose, and is found to be excreted as a glucuronide conjugate.

### **Special Populations and Conditions**

**Hepatic Insufficiency:** No clinical studies have evaluated the effect of hepatic disease on the pharmacokinetics of Medroxyprogesterone acetate. However, MPA is almost exclusively eliminated by hepatic metabolism and steroid hormones may be poorly metabolized in patients with severe liver insufficiency, (see **CONTRAINDICATIONS**).

## **Progestin Pharmacology**

Medroxyprogesterone acetate significantly reduces the risk of endometrial hyperplasia in women with intact uteri. See **Pharmacodynamics** for specific information on the pharmacology of medroxyprogesterone acetate.

## **STORAGE AND STABILITY**

Store at room temperature 15°C - 30°C. Keep in a safe place out of the reach of children

## **DOSAGE FORMS, COMPOSITION AND PACKAGING**

### **Composition**

In addition to medroxyprogesterone acetate, each tablet contains the following non-medicinal ingredients: colloidal silicon dioxide, croscarmellose sodium, lactose monohydrate, magnesium stearate, microcrystalline cellulose, and sodium lauryl sulfate. The 2.5 mg tablet also contains the colouring agents D&C yellow #10 and FD&C yellow #6. The 5 mg tablet also contains the colouring agent FD&C blue #2.

### **Availability**

**AA-MEDROXY 2.5 mg:** each pink orange, round, biconvex tablet scored and engraved "MED" over "2.5" on one side and "APO" on the other side, contains 2.5 mg medroxyprogesterone acetate. Available in bottles of 100 and 500.

**AA-MEDROXY 5 mg:** each blue, round, biconvex tablet scored and engraved "MED" over "5" on one side and "APO" on the other side, contains 5 mg medroxyprogesterone acetate. Available in bottles of 100 and 500.

**AA-MEDROXY 10 mg:** each white, round, biconvex tablet engraved "APO" on one side, "MED" over score "10" on the other side, contains 10 mg medroxyprogesterone acetate. Available in bottles of 100 and 500.

**AA-MEDROXY 100 mg:** each white, round, flat-faced, bevelled edge tablet engraved "APO" on one side, scored and engraved "MED" over "100" on the other side, contains 100 mg medroxyprogesterone acetate. Available in bottles of 100 and 500.

## PART II: SCIENTIFIC INFORMATION

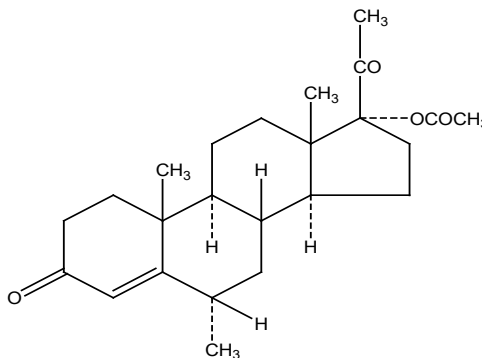
### PHARMACEUTICAL INFORMATION

#### Drug Substance

Proper Name: Medroxyprogesterone acetate

Chemical Names: 1) Pregn-4-ene-3,20-dione,17-(acetyloxy)-6-methyl-,(6 $\alpha$ )-;  
2) 17-Hydroxy-6 $\alpha$ -methylpregn-4-ene-3,20-dione acetate

Structural Formula:



Molecular Formula: C<sub>24</sub>H<sub>34</sub>O<sub>4</sub>

Molecular Weight: 386.53 g/mol

Physicochemical properties: Medroxyprogesterone acetate is a white to off-white, odourless crystalline powder, stable in air, melting between 200° and 210°C. It is freely soluble in chloroform, soluble in acetone and dioxane, sparingly soluble in ethanol and methanol, slightly soluble in ether and insoluble in water.

### CLINICAL TRIALS

#### Comparative Bioavailability

Three comparative bioavailability studies were performed using healthy human volunteers. The rate and extent of absorption of medroxyprogesterone was measured and compared following oral administration of the following: 1) 8 x 2.5 mg of AA-MEDROXY Tablets or Provera<sup>®</sup> Tablets, and 2) 1 x 100 mg of AA-MEDROXY Tablets or Provera<sup>®</sup> Tablets (under fasted and fed conditions). The results from measured data are summarized as follows:

<b>2.5 mg Tablets Fasting Study: Summary Table of the Comparative Bioavailability Data Medroxyprogesterone (Dose: 8 x 2.5 mg) From Measured Data</b>			
<b>Parameter</b>	<b>Geometric Mean Arithmetic Mean (CV%)</b>		<b>Ratio of Geometric Means (%)** (CI)</b>
	<b>AA-MEDROXY 2.5 mg Tablets</b>	<b>Provera<sup>®†</sup> 2.5 mg Tablets</b>	
AUC <sub>T</sub> (pg·hr/ML)	8913.2 11030.5 (70.6)	9926.1 11868.5 (67.5)	89.8 (80.4 – 101.3)
AUC <sub>I</sub> (pg·hr/ML)	10020.0 12431.5 (69.9)	11046.3 13414.4 (69.4)	90.7 (83.1 – 103.9)
C <sub>max</sub> (pg/ML)	1693.48 2045.14 (60.6)	1895.51 2267.95 (63.4)	89.3
T <sub>max</sub> (hr)*	2.49 (53.1)	2.28 (49.8)	--
t <sub>1/2</sub> (hr)*	10.97 (62.2)	11.61 (59.3)	--

\*Arithmetic means (CV%); \*\*Based on the least squares estimate.

† Provera<sup>®</sup> was manufactured by Pharmacia & Upjohn Inc. (Now manufactured by Pfizer Canada Inc.), and was purchased in Canada.

<b>100 mg Tablets Fasting Study: Summary Table of the Comparative Bioavailability Data Medroxyprogesterone (Dose: 1 x 100 mg) From Measured Data</b>			
<b>Parameter</b>	<b>Geometric Mean Arithmetic Mean (CV%)</b>		<b>Ratio of Geometric Means (%)** (CI)</b>
	<b>AA-MEDROXY 100 mg Tablets</b>	<b>Provera<sup>®†</sup> 100 mg Tablets</b>	
AUC <sub>T</sub> (pg·hr/ML)	17036.3 21385.1 (60.5)	16462.1 21936.6 (69.8)	103.5 (89.8 – 119.3)
AUC <sub>I</sub> (pg·hr/ML)	19027.6 23739.8 (59.1)	20275.6 26730.6 (64.0)	93.8 (88.5 – 113.0)
C <sub>max</sub> (pg/ML)	1636.69 1960.17 (58.1)	1683.09 2131.41 (75.5)	97.2
T <sub>max</sub> (hr)*	4.04 (42.2)	4.10 (47.5)	--
t <sub>1/2</sub> (hr)*	20.4 (44.0)	20.7 (40.9)	--

\*Arithmetic means (CV%); \*\*Based on the least squares estimate.

† Provera<sup>®</sup> was manufactured by Pharmacia & Upjohn Inc. (Now manufactured by Pfizer Canada Inc.), and was purchased in Canada.



<b>100 mg Tablets Fed Study: Summary Table of the Comparative Bioavailability Data Medroxyprogesterone (Dose: 1 x 100 mg) From Measured Data</b>			
<b>Parameter</b>	<b>Geometric Mean Arithmetic Mean (CV%)</b>		<b>Ratio of Geometric Means (%)** (CI)</b>
	<b>AA-MEDROXY 100 mg Tablets</b>	<b>Provera®† 100 mg Tablets</b>	
AUC <sub>0-72</sub> (pg·hr/mL)	68901 76652 (53)	71621 79754 (51)	96.2 (89.3 - 103.6%)
AUC <sub>1</sub> (pg·hr/mL)	74591 83401 (55)	77263 86176 (51)	96.5 (89.8 - 103.8%)
C <sub>max</sub> (pg/mL)	10816 12115 (52)	10838 12559 (58)	99.8 (89.5 - 111.3%)
T <sub>max</sub> (hr)*	3.10 (38)	3.54 (31)	--
t <sub>1/2</sub> (hr)*	27.3 (25)	27.1 (19)	--

\*Arithmetic means (CV%); \*\*Based on the least squares estimate.

† Provera® was manufactured by Pharmacia & Upjohn Inc. (Now manufactured by Pfizer Canada Inc.), and was purchased in Canada.

Medroxyprogesterone acetate has an apparent half-life of about 30 hours.

### Study demographics and trial design

The following studies discussed are based on published literature.

#### Hormonal Replacement Therapy:

The incidence of estrogen-associated endometrial hyperplasia was assessed in 2 large, long-term, randomized clinical trials. A 3-year multicentre, double-blind, placebo-controlled study of 596 nonhysterectomized, postmenopausal women between the ages of 45 and 64 years at study entry were randomized to receive placebo, conjugated estrogen only, conjugated estrogen plus medroxyprogesterone acetate, or conjugated estrogen plus micronized progesterone. Participants administered with 1 of the 3 estrogen-progestin regimens had similar rates of hyperplasia as those given placebo (P=0.16). Combining conjugated estrogen with medroxyprogesterone acetate or micronized progesterone protected the endometrium from hyperplastic changes associated with estrogen-only therapy.

In a second study, 1724 postmenopausal women between the ages of 45 and 65 years were enrolled in a 1-year prospective, multicentre, double-blind, randomized study. All 1385 patients with valid biopsy data received conjugated estrogen 0.625 mg every day of a 28-day cycle, and were randomized to receive medroxyprogesterone acetate 2.5 mg or 5 mg daily, or 5 mg or 10 mg for 14 days per 28-day cycle, or conjugated estrogen only. The endometrial hyperplasia incidence was significantly lower in women treated with conjugated estrogen and medroxyprogesterone acetate (P<0.001) than in women treated with conjugated estrogen alone.

**Functional Menstrual Disorders:**

A prospective, randomized, double-blind study in 77 premenopausal women compared the effectiveness of either medroxyprogesterone acetate or dydrogesterone treatment in inducing withdrawal bleeding in these women with secondary amenorrhea. Of the 48 women qualified for the study, 22 patients received a daily dose of 10 mg medroxyprogesterone acetate and 26 patients received a daily dose of 20 mg dydrogesterone over a 5-day treatment course. Withdrawal bleeding occurred in 21 of the 22 (95%) women taking medroxyprogesterone acetate and in 24 of the 26 (92%) women taking dydrogesterone. Mastalgia was the only side effect reported for both treatments.

**Treatment of Endometrial Carcinoma:**

A randomized trial was conducted in 299 women with advanced or recurrent endometrial carcinoma to assess the importance of prognostic factors and to determine whether a higher dose of medroxyprogesterone acetate would yield a higher response rate. Patients were randomized to receive either 200 mg or 1000 mg of medroxyprogesterone acetate per day orally, and were followed until unacceptable toxicity intervened or their disease progressed. Among patients receiving the low-dose regimen, there was an overall response rate of 25%, whereas this rate was 15% in the group of patients receiving the high-dose regimen. The use of medroxyprogesterone acetate 200 mg/day orally is a reasonable initial approach to the treatment of advanced or recurrent endometrial carcinoma.

**Treatment of Metastatic Breast Cancer in Post-Menopausal Women:**

The effective treatment of metastatic breast cancer with medroxyprogesterone acetate in postmenopausal women was demonstrated in 2 controlled trials. In the first study, 39 postmenopausal women with metastatic breast carcinoma were treated with either 400 mg/day or 800 mg/day medroxyprogesterone acetate. The results showed an objective remission rate of 44% (17 patients). Median remission duration was 8 months. No apparent difference in response between the 2 dose levels was observed. The most common side effects were increased appetite (66%) and weight gain (97%).

In a second study, 47 postmenopausal women with evaluable breast cancer were treated with medroxyprogesterone acetate at daily dose levels of 400 mg. Twenty-five (53%) patients responded to this treatment with duration of remission from 5 to 26 months, with a median of 10 months and a mean of 12+ months. The most common side effect was weight gain (36%).

**DETAILED PHARMACOLOGY**

Medroxyprogesterone acetate induces responses in laboratory animals comparable to those caused by progesterone. It is more potent than progesterone. Medroxyprogesterone acetate induces glandular development in the endometrium, maintains pregnancy, delays parturition, inhibits ovulation and suppresses estrous cycles. It is devoid of androgenic and estrogenic activity. In selected animal tests, medroxyprogesterone acetate has some adrenal corticoid-like activity; in dogs, it increases serum growth hormone levels.

## TOXICOLOGY

### ANIMAL STUDIES

Acute Toxicity: The oral LD<sub>50</sub> of medroxyprogesterone acetate was found to be greater than 10,000 mg/kg in the mouse. The intraperitoneal LD<sub>50</sub> in the mouse was 6985 mg/kg.

Sub-acute and Chronic Toxicology: Medroxyprogesterone acetate administered orally to rats and mice (334 mg/kg/day) and dogs (167 mg/kg/day) for 30 days was found to be non-toxic.

Medroxyprogesterone acetate was administered orally to dogs and rats at 3, 10 and 30 mg/kg/day for 6 months. The drug was considered to be non-toxic at these levels but with anticipated hormonal effects at the higher doses.

Carcinogenicity: Long-term toxicology studies in the monkey, dog, and rat with parenteral medroxyprogesterone acetate have disclosed:

1. No uterine or breast abnormalities were revealed in the rat after 2 years.
2. Beagle dogs receiving 75 mg/kg and 3 mg/kg every 90 days, for 7 years, developed mammary nodules, as did some of the control animals. The nodules appearing in the control animals were intermittent in nature, whereas the nodules in the drug treated animals were larger, persistent, and more numerous. In addition, 2 high-dose animals developed breast malignancies.

The Food and Drug Administration (United States), the Committee on Safety of Medicines (United Kingdom), and 3 International panels of experts have concluded that the Beagle bitch is not an appropriate model for mammary carcinogenicity testing of progesterone derivatives such as medroxyprogesterone acetate.

Because of differences between the Beagle bitch and the human female with regard to sensitivity and metabolism of progestins, positive carcinogenicity studies in the Beagle bitch can no longer be considered indicative of a significant hazard to women.

3. No uterine malignancies were found in monkeys receiving placebo, 3 mg/kg, or 30 mg/kg every 90 days for 10 years. However, 2 monkeys receiving 150 mg/kg every 90 days for 10 years developed endometrial carcinoma. One was treated for 111 months and the other for 125 months of the 130-month study. The lesions were remarkably similar in cell morphology to epithelial plaques which occur in monkeys but not in humans. Electron microscopic studies confirmed that the neoplasms were malignant, epithelial (not mesenchymal), and thus of a type not stimulated by progestins in women. Therefore, it was concluded that the occurrence of these lesions, regardless of the cause, does not indicate medroxyprogesterone acetate is carcinogenic in women.

In the same study, mammary nodules were found in three of the monkeys in the 30 mg/kg group. The lesions showed no signs of malignancy.

Because these lesions were both non-progressive and non-invasive, and because many lesions of this type are known to appear and then regress, it was concluded that the occurrence of this non-malignant mammary lesion in 3 treated monkeys poses no potential risk of breast cancer in women.

Mutagenicity: In the Salmonella/Microsome test (Ames test), DNA damage/alkaline elution assay, and micronucleus test, medroxyprogesterone acetate showed no mutagenic properties.

Reproduction and Teratology: Animal studies have not demonstrated any impairment of fertility in first or second generation studies.

In rats, medroxyprogesterone acetate may have some effect on genital systems, but standard teratologic techniques have shown no effects on non-genital systems.

Medroxyprogesterone acetate produced cleft palates in rabbits, but has been attributed to that particular species' sensitivity to the drug's glucocorticoid activity.

Medroxyprogesterone acetate given orally at 1, 10, and 50 mg/kg/day in pregnant Beagle bitches produced clitoral hypertrophy in the female pups of the high-dose animals. No abnormalities were noted in any of the male pups.

The relevance of any of these findings with respect to humans has not been established.

## REFERENCES

1. Adachi JD, Anderson C, Murray TM, Prior JC. The Canadian consensus conference on the use of progestins in the menopause II. Effect of progestins on bone. *J SOGC* 1991; 13(1): 47-50.
2. Amadori D, Ravaioli R, Ridolfi R, et al. Oral high dose medroxyprogesterone: A study in 21 patients. *Chemioter Oncol* 1979; 3:219-23.
3. American College of Obstetricians and Gynecologists (ACOG) Technical Bulletin #72 Osteoporosis, Washington D.C.: ACOG, October 1983
4. American College of Obstetricians and Gynecologists (ACOG) Technical Bulletin #93 Estrogen Replacement Therapy, Washington D.C.: ACOG, April 1986
5. Astedt B. Fibrinolytic activity of veins during treatment with medroxyprogesterone acetate. *Acta Obstet Gynecol Scand* 1972; 283-86.
6. Astedt B. On fibrinolysis A. In pregnancy, labour, puerperium and during treatment with sex steroids B. In human ontogenesis and in human organ culture. *Acta Obstet Gynecol Scand* 1972; 51(suppl.18): 1-45.
7. Astedt B, Jeppsson S, Pandolfi M. Fibrinolytic activity of veins during use of depot medroxyprogesterone acetate as a contraceptive. *Fertil Steril* 1972; 23(7): 489-92.
8. Ausili-Cefaro GP, Cellini N, Ciarniello V, Trodella L. Preliminary results on MAP (medroxyprogesterone acetate) employment orally administered in the advanced mammary carcinoma. *Acta Med Rom* 1979; 17(4):351-6.
9. Back DJ, Breckenridge AM, Crawford F, MacIver M, Orme ML, Park BK, et al. The effect of rifampicin on norethisterone pharmacokinetics. *Europ J Clin Pharmacol* 1979; 15(3): 193-7.
10. Barrett-Connor E, Wingard DL, Criqui MH. Postmenopausal estrogen use and heart disease risk factors in the 1980s: Rancho Bernado, Calif, Revisited. *JAMA* 1989; 261(14): 2095-2100.
11. Battino S, Ben-Ami M, Geslevich Y, Weiner E, Shalev E, et al. Factors associated with withdrawal bleeding after administration of oral dydrogesterone or medroxyprogesterone acetate in women with secondary amenorrhea. *Gynecol Obstet Invest* 1996; 42(2):113-116.
12. Bernardo-Strada MR, Imperato E, Aspesi G, Pavesi L, Robustelli Della Cuna G. Oral high dose of medroxyprogesterone acetate (MPA) in the treatment of advanced breast and endometrial carcinoma. *Minerva Med* 1980; 71(44): 3241-6.
13. Bewtra C, Kable WT, Gallagher JC. Endometrial histology and bleeding patterns in menopausal women treated with estrogen and continuous or cyclic progestin. *J Reprod Med* 1988; 33(2): 205-8.
14. Bonte J, Drochmans A, Ide P. Cytologic evaluation of exclusive medroxyprogesterone acetate treatment for vaginal recurrence of endometrial adenocarcinoma. *Acta Cytol* 1970; 14(5): 353-6.

15. Brema F, Queirolo MA, Canobbio L, Bruzzi P, Puntoni R, Campora E, et al. Hematologic parameters during treatment with high-dose medroxyprogesterone acetate. *Tumori* 1981; 67(2): 125-8.
16. Canobbio L, Brema F, Massa T, Chiarlone R, Boccardo F, Merlano M. Toxic effects and therapeutic activity of orally administered high dose medroxyprogesterone acetate in metastatic breast cancer. *Chemioter Oncol* 1979; 3:214-8.
17. Chlebowski RT, Hendrix SL, Langer RD, Stefanick ML, Glass M, Lane D, et al. The Women's Health Initiative randomized trial. Influence of estrogen plus progestin on breast cancer and mammography in healthy postmenopausal women. *JAMA* 2003; 289(24): 3243-53.
18. Council Report: Estrogen Replacement in the Menopause. *JAMA* 1983; 249(3): 359-61.
19. Davila E, Thompson TT, Riordan D, Vogel CL. High dose oral medroxy-progesterone acetate (HDO-MPA) for advanced breast cancer (BC). *Proc Am Soc Clin Oncol (ASCO)* 1982; 1:76 (abstract).
20. FDA Advisory Committee: Estrogen replacement therapy should include a progestin to reduce risk of endometrial cancer advisory committee says; FDA to consider combo NDAs. *FDC Reports* 1991:11.
21. Ferenczy A, Gelfand MM, Nisker JA, Spence JE. The Canadian consensus conference on the use of progestins in the menopause I. Progestins and the endometrium. *J SOGC* 1991; 13(1): 36-42.
22. Gambrell RD Jr, Massey FM, Castaneda TA, Ugenas AJ, Ricci CA, Wright JM. Use of the progestogen challenge test to reduce the risk of endometrial cancer. *Obstet Gynecol* 1980; 55(6): 732-38.
23. Gambrell RD Jr, Teran AZ. Changes in lipids and lipoproteins with long-term estrogen deficiency and hormone replacement therapy. *Am J Obstet Gynecol* 1991; 165(2): 307-17.
24. Glenn EM, Richardson SL, Bowman BJ. Biologic activity of 6-alpha-methyl compounds corresponding to progesterone, 17 alpha-hydroxyprogesterone acetate and compound S. *Metabolism* 1959; 8(3):307-17.
25. Gold JJ, Borushek S, Lash S. The use of 6-alpha-methyl 17-acetoxy-progesterone in specific menstrual disturbances. In: Barnes AC, eds. *Symposium: Progesterone*. Augusta, Michigan: Brook Lodge Press 1961; 187-200.
26. Grady S, Herrington D, Bittner V, Blumenthal R, Davidson M, Hlatky M, et al for the HERS Research Group. Cardiovascular disease outcomes during 6.8 years of hormone therapy. Heart and Estrogen/progestin replacement study follow-up (HERS II). *JAMA* 2002; 288(1): 49-57.
27. Hamblen EC, Ellington RN, Wilbanks GD, Grenshaw MC, Williamson RM, Johnson HW. The use of 6- $\alpha$ -methyl '17-  $\alpha$  -acetoxyprogesterone in functional disorders of uterine bleeding and eugonadotropuric amenorrhea. In: Barnes AC, eds. *Symposium: Progesterone*. Augusta, Michigan: Brook Lodge Press 1961: 201-17.

28. Hellman L, Yoshida K, Zumoff B, Levin J, Kream J, Fukushima DK. The effect of medroxyprogesterone acetate on the pituitary-adrenal axis. *J Clin Endocrinol Metab* 1976; 42(5): 912-17.
29. Hormone Replacement Therapy: Highlights from the Sixth International Congress on the Menopause. Bangkok, Thailand. Hormone Replacement Therapy 1990: 1-8.
30. Hortobagyi GN, Buzdar AU, Frye D, Yap HY, Hug V, Pinnamaneni, et al. Oral medroxyprogesterone acetate in the treatment of metastatic breast cancer. *Breast Cancer Res Treat* 1985; 5(3): 321-6.
31. Hulley S, Grady D, Bush T, Furberg C, Harrington D, Riggs B, et al for the Heart and Estrogen/progestin Replacement Study (HERS) Research Group. Randomized trial of estrogen plus progestin for secondary prevention of coronary heart disease in postmenopausal women. *JAMA* 1998; 280(7): 605-613.
32. Kistner RW, Griffiths CT. Use of progestational agents in the management of metastatic carcinoma of the endometrium. *Clin Obstet Gynecol* 1968; 11(2): 439-56.
33. Lemay A, Wolfe BMJ, Scott JZ, Graves GR. The Canadian consensus conference on the use of progestins in the menopause III. Effects of hormone replacement therapy in the menopause on lipids, lipoproteins and coronary heart disease. *J SOGC* 1991; 13(5): 14-20.
34. Looker AC. Dietary Supplement Use in Women: Current Status and Future Directions. *J Nutr* 2003; 133(6): 1957S-2013S.
35. Luporini G, Beretta G, Tabladon D, Tedeschi L, Rossi A. Comparison between oral medroxyprogesterone acetate (MPA) and tamoxifen (TMX) in advanced breast carcinoma. *Proc Am Assoc Cancer Res* 1981; 22:434.[Abstract].
36. Moller KA, Andersen AP. Peroral administration of medroxyprogesterone acetate (MPA) in advanced cancer of the breast. A preliminary report. *Acta Obstet Gynecol Scand Suppl* 1981; Suppl.101: 47-8.
37. Murray TM. The importance of estrogen in osteoporosis prevention official position of the Osteoporosis Society of Canada. *Bulletin for Physicians* 1988; 1:7-11.
38. Nachtigall LE, Nachtigall RH, Nachtigall RD, Beckman EM. Estrogen replacement therapy II: A prospective study in the relationship to carcinoma and cardiovascular and metabolic problems. *Obstet Gynecol* 1979; 54(1): 74-9.
39. Nemoto T, Patel J, Rosner D, Dao TL, et al. Oral medroxyprogesterone in the treatment of metastatic breast cancer. *J Surg Oncol* 1986; 32(4):211-3.
40. Padwick ML, Pryse-Davies J, Whitehead MI. A simple method for determining the optimal dosage of progestin in postmenopausal women receiving estrogens. *N Engl J Med* 1986; 315(157):930-34.
41. Pannuti F, Burrioni P, Fruet F, Piana E, Strocchi E, Di Marco AR, et al. Anabolizing and anti-pain effect of the short-term treatment with medroxyprogesterone acetate (MAP) at high oral doses in oncology. *Panminerva Med* 1980; 22(3): 149-56.

42. Rossouw JE, Prentice RL, Manson JE, Wu L, Barard D, Barnabei VM, et al. Postmenopausal Hormone Therapy and Risk of Cardiovascular Disease by Age and Years Since Menopause. *JAMA* 2007; 297(13): 1465-1477.
43. Shumaker SA, Legault C, Rapp SR, Thal L, Wallace RB, Ockene JK, et al. Estrogen plus progestin and the incidence of dementia and mild cognitive impairment in postmenopausal women. *JAMA* 2003; 289(20): 2651-2662.
44. Shumaker SA, Legault C, Kuller L, Rapp SR, Thal L, Lane DS, et al. Conjugated Equine Estrogens and Incidence of Probable Dementia and Mild Cognitive Impairment in Postmenopausal Women. Women's Health Initiative Memory Study. *JAMA*. 2004; 291(24):2947-2958.
45. Silfverstolpe G, Gustafson A, Samsioe G, Svanborg A. Lipid metabolic studies in oophorectomized women: effects on serum lipids and lipoproteins of three synthetic progestogens. *Maturitas* 1992; 4: 103-111.
46. Swenerton KD, Fugère P, Miller AB, MacLusky N. The Canadian consensus conference on the use of progestins in the menopause IV. Menopausal progestins and breast cancer. *J SOGC* 1991; 13(5): 21-5.
47. The Women's Health Initiative Steering Committee. Effects of conjugated equine estrogen in postmenopausal women with hysterectomy. The Women's Health Initiative randomized controlled trial. *JAMA*. 2004; 291(14):1701-1712.
48. Tominaga T. Oral high dose medroxyprogesterone acetate (MAP) in treatment of advanced breast cancer. Proceeding from the 12th International Congress of Chemotherapy, 1981, July 19-24 Florence, Italy.
49. Thigpen JT, Brady MF, Alvarez RD, Adelson MD, Homesley HD, Manetta A, et al. Oral medroxyprogesterone acetate in the treatment of advanced or recurrent endometrial carcinoma: a dose-response study by the gynecologic oncology group. *J Clin Oncol* 1999; 17(6):1736-44.
50. Tseng L. Steroid specificity in the stimulation of human endometrial estradiol dehydrogenase. *Endocrinology* 1978; 102(5): 1398-1403.
51. Tseng L, Gurpide E. Induction of human endometrial estradiol dehydrogenase by progestins. *Endocrinology* 1975; 97(4): 825-33.
52. Van Deijk WA, Blijham GH, Mellink WA, Meulenberg PM. Influence of aminoglutethimide on plasma levels of medroxyprogesterone acetate: Its correlation with serum cortisol. *Cancer Treat Rep* 1985; 69(1): 85-90.
53. Walter L, Ehrhart H, Schuster H, Leonhardt A. Initiation and results of medroxyprogesterone acetate (MPA) therapy in metastatic breast cancer. *Bayer Internist* 1981; 3:21-3.
54. Weinstein L. Efficacy of a continuous estrogen-progestin regimen in the menopausal patient. *Obstet Gynecol* 1987; 69(6): 929-32.
55. Woodruff JD, Pickar JH. Incidence of endometrial hyperplasia in postmenopausal women taking conjugated estrogens (Premarin) with medroxyprogesterone acetate or conjugated



- estrogens alone. The Menopause Study Group. *Am J Obstet Gynecol* 1994; 170(5 Pt 1) :1213-23.
56. Writing Group for the PEPI Trial. Effects of hormone replacement therapy on endometrial histology in postmenopausal women. The Postmenopausal Estrogen/Progestin Interventions (PEPI) Trial. *JAMA* 1996; 275:370-75.
57. Writing Group for the Women's Health Initiative Investigators. Risks and benefits of estrogen plus progestin in healthy postmenopausal women. Principal results from the Women's Health Initiative Randomized Controlled Trial. *JAMA* 2002; 288 (3): 321-333.
58. Yancy MK, Stone IK, Hannan CJ, Friedl KE, Plymate SR, Wright JR. Serum lipids and lipoproteins in continuous or cyclic medroxyprogesterone acetate treatment in postmenopausal women treated with conjugated estrogens. *Fertil Steril* 1990; 54(5):778-82.
59. Kobayashi K, Mimura N, Fujii H, et al. Role of human cytochrome P450 3A4 in metabolism of medroxyprogesterone acetate. *Clin Cancer Res* 2000; 6(8):3297-303.
60. Zhang JW, Liu Y, Zhao JY, et al. Metabolic profiling and cytochrome P450 reaction phenotyping of medroxyprogesterone acetate. *Drug Metab Dispos* 2008; 36(11):2292-8.
61. Provera<sup>®</sup> Product Monograph. Pfizer Canada Inc. Control# 176877 September 29, 2014.

**PART III: CONSUMER INFORMATION**

**PrAA-MEDROXY  
Medroxyprogesterone Acetate Tablets USP**

**This leaflet is part III of a three-part “Product Monograph” published when AA-MEDROXY was approved for sale in Canada and is designed specifically for Consumers. This leaflet is a summary and will not tell you everything about AA-MEDROXY. Contact your doctor or pharmacist if you have any questions about the drug.**

**ABOUT THIS MEDICATION**

**What the medication is used for:**

- Hormonal Replacement Therapy for Menopause – AA-MEDROXY is used for women with intact uteri who are also receiving estrogen therapy.
- To Treat Menstrual Disorders due to Hormonal Imbalance - In non-pregnant women, AA-MEDROXY helps to balance the effect of estrogen.
- To Treat Cancer:
  - To treat and relieve symptoms associated with endometrial cancer.
  - To treat and relieve symptoms of breast cancer in postmenopausal women.

AA-MEDROXY should be used only under the supervision of a doctor, with regular follow-up at least once a year to identify the side effects associated with its use. Your first follow-up visit should be within 3 to 6 months of starting treatment. Your visit may include a blood pressure check, a breast exam, a Pap smear and pelvic exam. You should have a mammogram before starting treatment and at regular intervals as recommended by your doctor. Your doctor may recommend some blood tests.

Progestin, when used with estrogen therapy, have important benefits but also some risks. You should carefully discuss the risks and benefits of hormone replacement therapy (HRT) with your doctor. If you use progestin with estrogen therapy, check with your doctor to be sure you are using the lowest possible dose that works, and that you don't use them longer than necessary. How long you need to use HRT will depend on the reason for use. You should regularly talk with your doctor about whether you still need treatment with HRT.

If you have any questions about this medication or your condition, please ask your doctor or pharmacist.

**What it does:**

AA-MEDROXY (medroxyprogesterone acetate) is a hormone replacement therapy (HRT) that contains a manufactured progesterone hormone, progestin that is similar to the progesterone produced by a woman's ovaries.

When given with an appropriate dose of estrogen hormone, AA-MEDROXY significantly reduces the risk of developing endometrial hyperplasia (overgrowth of the uterus lining) and the risk of cancer of the uterus. Seven (7) days after stopping AA-MEDROXY treatment, you should have withdrawal bleeding. If bleeding occurs during the AA-MEDROXY treatment, talk to your doctor, as the dose may need to be modified.

Progesterone therapy regulates bleeding patterns. When given to non-pregnant women to treat menstrual disorders, the endometrium (inner lining of the uterus) does not grow as much and bleeding decreases. This is because AA-MEDROXY helps to balance the effect of estrogen. You will know that AA-MEDROXY is effective if it induces a period (any bleeding more than light spotting) within 2 weeks after AA-MEDROXY is given. This bleeding will usually occur 2-7 days after the AA-MEDROXY is finished.

For Oncology: When used to treat cancer, AA-MEDROXY is thought to work two-ways: it decreases hormone release and it prevents the cancer cells from multiplying by balancing out high levels of estrogen. The response to hormonal therapy for endometrial or breast cancer may not be evident until 8 to 10 weeks of therapy.

**When it should not be used:**

You should not take AA-MEDROXY if you have any of the following conditions:

- In the presence of liver disease;
- If you have had or have cancer of the breast or uterus, unless AA-MEDROXY is being used to treat and relieve the symptoms associated with these cancers;
- If you have abnormal vaginal bleeding;
- If you are pregnant;
- If you have had or have any blood circulation problems, such as blood clots, stroke, blindness or migraine headaches;
- If you have had a stroke or heart attack;
- If you have had an unusual allergic response to progestin or to any of the ingredients in the tablet.

## IMPORTANT: PLEASE READ

Do not take AA-MEDROXY for conditions for which it was not prescribed. Do not give AA-MEDROXY to other people, even if they have the same symptoms you have. It may harm them.

### **What the medicinal ingredient is:**

Medroxyprogesterone acetate

### **What the nonmedicinal ingredients are:**

AA-MEDROXY Tablets contain the following inactive ingredients: colloidal silicon dioxide, croscarmellose sodium, lactose monohydrate, magnesium stearate, microcrystalline cellulose and sodium lauryl sulfate.

The 2.5 mg tablet also contains the colouring agents D&C yellow #10 and FD&C yellow #6. The 5 mg tablet also contains the colouring agent FD&C blue #2.

### **What dosage forms it comes in:**

AA-MEDROXY Tablets are available in 2.5 mg, 5 mg, 10 mg and 100 mg strengths.

## WARNINGS AND PRECAUTIONS

### **Serious Warnings and Precautions**

The Women's Health Initiative (WHI) trial is a large clinical study that assessed the benefits and risks of oral combined *estrogen plus progestin* therapy and oral *estrogen-alone* therapy compared with placebo (a pill with no active ingredients) in postmenopausal women.

The WHI trial indicated an increased risk of myocardial infarction (heart attack), stroke, breast cancer, pulmonary emboli (blood clots in the lungs) and deep vein thrombosis (blood clots in the large veins) in postmenopausal women taking oral combined *estrogen plus progestin*.

The WHI trial indicated an increased risk of stroke and deep vein thrombosis in postmenopausal women with prior hysterectomy (surgical removal of the uterus) taking oral *estrogen-alone*.

Therefore, you should highly consider the following:

- There is an increased risk of developing invasive breast cancer, heart attack, stroke and blood clots in both lungs and large veins with the use of estrogen plus progestin therapy.
- There is an increased risk of stroke and blood clots in the large veins with the use of estrogen-

alone therapy.

- Estrogens with or without progestins should not be used for the prevention of heart disease or stroke.
- Estrogens with or without progestins should be used at **the lowest effective dose** and for **the shortest period of time** possible. Regular medical follow-up is advised.

### ***Breast Cancer***

The results of the WHI trial indicated an increased risk of breast cancer in post-menopausal women taking combined estrogen plus progestin compared to women taking placebo. The results of the WHI trial indicated no difference in the risk of breast cancer in postmenopausal women with prior hysterectomy taking estrogen-alone compared to women taking placebo.

Estrogens with or without progestins should not be taken by women who have a personal history of breast cancer.

In addition, women with a family history of breast cancer or women with a history of breast lumps, breast biopsies or abnormal mammograms (breast x-rays) should consult with their doctor before starting HRT.

Women should have a mammogram before starting HRT and at regular intervals during treatment as recommended by their doctor. Regular breast examinations by a doctor and regular breast self-examinations are recommended for all women. You should review technique for breast self-examination with your doctor.

### ***Overgrowth of the lining of the uterus and cancer of the uterus***

The use of *estrogen-alone* therapy by post menopausal women who still have a uterus increases the risk of developing endometrial hyperplasia (overgrowth of the lining of the uterus), which increases the risk of endometrial cancer (cancer of the lining of the uterus).

The purpose of adding a progestin medication to estrogen therapy is to reduce the risk of endometrial hyperplasia.

You should discuss progestin therapy and risk factors for endometrial hyperplasia and endometrial carcinoma with your doctor. You should also report any unexpected or unusual vaginal bleeding to your doctor.

If you have had your uterus removed, you are not at risk of developing endometrial hyperplasia or endometrial carcinoma. Progestin therapy is therefore not generally required in women who have had a hysterectomy.

### ***Ovarian Cancer***

In some studies, the use of estrogen-alone and estrogen plus progestin therapies for 5 or more years has been associated with an increased risk of ovarian cancer.

### ***Heart Disease and Stroke***

The results of the WHI trial indicated an increased risk of stroke and coronary heart disease in post-menopausal women taking combined estrogen plus progestin compared to women taking placebo.

The results of the WHI trial indicated an increased risk of stroke, but no difference in the risk of coronary heart disease in post-menopausal women with prior hysterectomy taking estrogen alone compared to women taking placebo.

### ***Abnormal Blood Clotting***

The results of the WHI trial indicated an increased risk of blood clots in the lungs and large veins in post-menopausal women taking combined *estrogen plus progestin* compared to women taking placebo.

The results of the WHI trial indicated an increased risk of blood clots in the large veins, but no difference in the risk of blood clots in the lungs in post-menopausal women with prior hysterectomy taking *estrogen-alone* compared to women taking placebo.

The risk of blood clots also increases with age, if you or a family member has had blood clots, if you smoke or if you are severely overweight. The risk of blood clots is also temporarily increased if you are immobilized for long periods of time and following major surgery. You should discuss risk factors for blood clots with your doctor since blood clots can be life threatening or cause serious disability.

### ***Gallbladder Disease***

The use of estrogens by postmenopausal women has been associated with an increased risk of gallbladder disease requiring surgery.

### ***Dementia***

The Women's Health Initiative Memory Study (WHIMS) was a substudy of the WHI trial and indicated an increased risk of dementia (loss of memory

and intellectual function) in postmenopausal women age 65 and over taking oral combined *estrogen plus progestin* compared to women taking placebo.

The WHIMS indicated no difference in the risk of dementia in post-menopausal women age 65 and over with prior hysterectomy taking oral *estrogen-alone* compared to women taking placebo.

### **BEFORE you use AA-MEDROXY talk to your doctor or pharmacist if:**

- have a history of allergy or intolerance to any medications or other substances
- have a personal history of breast disease (including breast lumps) and/or breast biopsies, or a family history of breast cancer
- have experienced any unusual or undiagnosed vaginal bleeding
- have a history of uterine fibroids or endometriosis
- have a history of liver disease, jaundice (yellowing of the eyes and/or skin) or itching related to estrogen use or during pregnancy
- have a history of migraine headache
- have a history of high blood pressure
- have a personal or family history of blood clots, or a personal history of heart disease or stroke
- have a history of kidney disease, asthma or epilepsy (seizures)
- have a history of bone disease (this includes certain metabolic conditions or cancers that can affect blood levels of calcium and phosphorus)
- have been diagnosed with diabetes
- have been diagnosed with porphyria (a disease of blood pigment)
- have a history of high cholesterol or high triglycerides
- are pregnant or may be pregnant
- have had a hysterectomy (surgical removal of the uterus)
- smoke

### **INTERACTIONS WITH THIS MEDICATION**

Tell your doctor or pharmacist if you are taking any other medications, including prescription medications, over-the-counter medications, vitamins or herbal products.

Drugs that may interact with AA-MEDROXY include:

- Preparations inducing liver enzymes (eg. barbiturates, hydantoin, carbamazepine, meprobamate, phenylbutazone or rifampin);
- Aminoglutethimide;

## IMPORTANT: PLEASE READ

- Some herbal (e.g., St. John's wort) and natural products which are bought without a prescription.

### PROPER USE OF THIS MEDICATION

AA-MEDROXY should be taken by mouth.

AA-MEDROXY can be taken with or without food.

#### Usual dose:

#### 1. Hormonal Replacement Therapy for Menopause

The recommended dose for women is 5 to 10 mg daily for 12 to 14 days.

#### 2. Functional Menstrual Disorders due to Hormonal Imbalance

- Secondary amenorrhea (absence of menstrual period): After ruling out pregnancy, AA-MEDROXY, may be administered in doses ranging from 5 to 10 mg daily for 12 to 14 days every month.
- Dysfunctional uterine bleeding: AA-MEDROXY may be given in doses ranging from 5 to 10 mg daily for 10 to 14 days, beginning on the 12th to 16th day of the cycle. This regimen should be repeated for 2 subsequent cycles or longer if necessary.

#### 3. Endometrial Cancer

The recommended dose is 200 to 400 mg daily.

#### 4. Breast Cancer

The recommended dose is 400 mg daily, given in divided doses.

It is important that you take AA-MEDROXY regularly at the same time each day.

#### Overdose:

*Symptoms:* Overdosage may result in a period of amenorrhea (absence or cessation of menstrual period) and may be followed by irregular menses for several cycles.

If you think you have taken too much AA-MEDROXY, contact your healthcare professional, hospital emergency department or regional Poison Control Centre immediately, even if there are no symptoms.

#### Missed Dose:

Do not take a double dose to make up for a forgotten tablet. If you miss a dose, take it as soon as you can if it is within 12 hours of the missed dose. If it is over 12 hours since your missed dose, skip the missed dose

and go back to your usual dosing times.

### SIDE EFFECTS AND WHAT TO DO ABOUT THEM

The following side effects have been reported with the use of medroxyprogesterone acetate:

- Breast tenderness;
- Breast milk secretion;
- Breakthrough bleeding;
- Spotting (minor vaginal bleeding);
- Irregular menstrual periods;
- Amenorrhea (absence of menstrual periods);
- Vaginal secretions;
- Headaches;
- Nervousness;
- Dizziness;
- Insomnia, sleepiness, fatigue;
- Premenstrual syndrome-like symptoms;
- Itching, hives, skin rash;
- Acne;
- Hair loss, hair growth;
- Abdominal discomfort; nausea; bloating;
- Fever;
- Increase in weight;
- Swelling;
- Moon shaped face.

If you experience any of these side effects, contact your doctor or pharmacist.

The side effects listed in the table below have been observed with estrogen/progestin combination in general, but not necessarily with AA-MEDROXY.

### SERIOUS SIDE EFFECTS AND WHAT TO DO ABOUT THEM

Frequency	Symptom/ possible side effect	Talk with your healthcare professional		Stop taking the drug and get immediate medical help
		Only if severe	In all cases	
Not known	Persistent sad mood			✓
	Abdominal pain, nausea or vomiting		✓	

## IMPORTANT: PLEASE READ

Frequency	Symptom/ possible side effect	Talk with your healthcare professional		Stop taking the drug and get immediate medical help
		Only if severe	In all cases	
	Pain or swelling in the leg/inflamed vein			✓
	Breast lump		✓	
	Sharp pain in the chest, coughing blood or sudden shortness of breath			✓
	Sudden severe headache or worsening of headache, vomiting, dizziness, fainting, disturbance of vision or speech or weakness or numbness in an arm or leg			✓
	Sudden partial or complete loss of vision			✓
	Unexpected vaginal bleeding		✓	
	Yellowing of the skin or eyes (jaundice)			✓
	Crushing chest pain or chest heaviness			✓

*This is not a complete list of side effects. For any unexpected effects while taking AA-MEDROXY, contact your doctor or pharmacist.*

### HOW TO STORE IT

AA-MEDROXY should be stored at room temperature (15°C to 30°C). Keep out of the reach of children.

### Reporting Side Effects

You can report any suspected side effects associated with the use of health products to Health Canada by:

- Visiting the Web page on Adverse Reaction Reporting (<https://www.canada.ca/en/health-canada/services/drugs-health-products/medeffect-canada.html>) for information on how to report online, by mail or by fax; or
- Calling toll-free at 1-866-234-2345.

*NOTE: Contact your health professional if you need information about how to manage your side effects. The Canada Vigilance Program does not provide medical advice.*

### MORE INFORMATION

If you want more information about AA-MEDROXY:

- Talk to your healthcare professional
- Find the full product monograph that is prepared for healthcare professionals and includes this Consumer Information by visiting the Health Canada website: (<https://www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/drug-product-database.html>); the manufacturer's website (<https://www.aapharma.ca/en/>), or by calling 1-877-998-9097.

This leaflet was prepared by AA Pharma Inc., 1165 Creditstone Road Unit #1, Vaughan, Ontario, L4K 4N7.

Date of Revision: June 20, 2024