

PART VI: Summary of the risk management plan

The content of this part is the same for all invented names of drospirenone 4 mg film-coated tablets.

Summary of risk management plan for Drosind (drospirenone)

This is a summary of the RMP for Drosind. The RMP details important risks for Drosind, how these risks can be minimised, and how more information will be obtained about Drosind, risks and uncertainties (missing information).

I. The medicine and what it is used for

Drosind is indicated for oral contraception. It contains drospirenone as the active substance and it is given orally.

II. Risks associated with the medicine and activities to minimise or further characterise the risks

Important risks of drospirenone, together with measures to minimise such risks are outlined below.

Measures to minimise the risks identified for medicinal products can be:

- Specific information, such as warnings, precautions, and advice on correct use, in the package leaflet and SmPC addressed to patients and healthcare professionals;
- Important advice on the medicine's packaging;
- The authorised pack size — the amount of medicine in a pack is chosen so to ensure that the medicine is used correctly;
- The medicine's legal status — the way a medicine is supplied to the patient (e.g. with or without prescription) can help to minimise its risks.

Together, these measures constitute routine risk minimisation measures.

If important information that may affect the safe use of Drosind is not yet available, it is listed under 'missing information' below.

II.A List of important risks and missing information

Important risks of Drosind are risks that need special risk minimisation activities to further investigate or minimise the risk, so that the medicinal product can be safely administered. Important risks can be regarded as identified or potential. Identified risks are concerns for which there is sufficient proof of a link with the use of Drosind. Potential risks are concerns for which an association with the use of this medicine is possible based on available data, but this association has not been established yet and needs further evaluation. Missing information refers to information on the safety of the medicinal product that is currently missing and needs to be collected (e.g. on the long-term use of the medicine).

List of important risks and missing information	
Important Identified Risks	• Hyperkalemia
Important Potential Risks	• Venous Thromboembolism • Bone fracture/Decrease in bone mineral density • Disturbances of liver function • Benign and malignant liver tumours • Ectopic pregnancy • Breast cancer
Missing Information	• Not applicable

II.B Summary of important risks

Important identified risk: Hyperkalemia	
Evidence for linking the risk to the medicine	Findings from non-clinical trials; few case reports of hyperkalemia from clinical trials.
Risk factors and risk groups	<i>Impaired renal function</i> , concomitant treatments (diuretics, other drugs associated with hyperkalemia as cyclosporine).
Risk minimisation measures	Routine risk minimisation measures: SmPC section 4.3, 4.4 and 4.8 PIL section 3 Additional risk minimisation measures: Not applicable.

Important potential risk: Venous Thromboembolism	
Evidence for linking the risk to the medicine	Suspicion of an association with the medicinal product of interest but this association has not been confirmed.
Risk factors and risk groups	History of VTE, Prolonged immobilisation
Risk minimisation measures	Routine risk minimisation measures: SmPC section 4.3 and 4.4 PIL section 2 Additional risk minimisation measures: Not applicable.

Additional pharmacovigilance activities	Additional pharmacovigilance activities: PASS study: LF111-402 See section II.C of this summary for an overview of the post-authorisation development plan.
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Important potential risk: Bone fracture/Decrease in bone mineral density	
Evidence for linking the risk to the medicine	Suspicion of an association with the medicinal product of interest but this association has not been confirmed.
Risk factors and risk groups	Menopause is associated with an increased risk of decrease in BMD. Adolescence is a critical period of bone accretion. It is unknown if the use of contraceptives during adolescence and early adulthood could reduce peak bone mass and increase the risk for fracture in later life.
Risk minimisation measures	Routine risk minimisation measures: SmPC section 4.4 PIL section 2 Additional risk minimisation measures: Not applicable.

Important potential risk: Disturbances of liver function	
Evidence for linking the risk to the medicine	Suspicion of an association with the medicinal product of interest but this association has not been confirmed.
Risk factors and risk groups	Subjects with pre-existing severe liver disease.
Risk minimisation measures	Routine risk minimisation measures: SmPC section 4.3, 4.4 and 4.8 PIL section 2 Additional risk minimisation measures: Not applicable.

Important potential risk: Benign and malignant liver tumours	
Evidence for linking the risk to the medicine	Suspicion of an association with the medicinal product of interest but this association has not been confirmed.

Risk factors and risk groups	Unknown.
Risk minimisation measures	Routine risk minimisation measures: SmPC section 4.4 and 4.8 PIL section 2 Additional risk minimisation measures: Not applicable.

Important potential risk: Ectopic pregnancy	
Evidence for linking the risk to the medicine	Suspicion of an association with the medicinal product of interest but this association has not been confirmed.
Risk factors and risk groups	History of previous ectopic pregnancy, pelvic inflammatory disease, Chlamydia trachomatis infection, smoking, tubal surgery, induced conception cycle, and endometriosis [Rana 2013] Contraceptive methods lead to an overall lower risk of pregnancy and therefore to an overall lower risk of ectopic pregnancy. However, among cases of contraceptive failure, women at increased risk of ectopic pregnancy compared with pregnant controls included those using POPs, progestin-only implants, or IUDs and those with a history of tubal ligation. [Furlong 2002].
Risk minimisation measures	Routine risk minimisation measures: SmPC section 4.4 PIL section 2 Additional risk minimisation measures: Not applicable.

Important potential risk: Breast cancer	
Evidence for linking the risk to the medicine	Suspicion of an association with the medicinal product of interest but this association has not been confirmed.
Risk factors and risk groups	Advancing age is the biggest risk factor for breast cancer. Reproductive factors that increase exposure to endogenous estrogen, such as early menarche and late menopause, increase risk, as does the use of combination estrogen-progesterone hormones after menopause. Nulliparity and alcohol consumption also are associated with increased risk.

	Women with a family history or personal history of invasive breast cancer, ductal carcinoma <i>in situ</i> or lobular carcinoma <i>in situ</i> , or a history of breast biopsies that show benign proliferative disease have an increased risk of breast cancer. Exposure to ionizing radiation, especially during puberty or young adulthood, and the inheritance of detrimental genetic mutations increase breast cancer risk. [National Cancer Institute: PDQ® Breast Cancer Prevention. Bethesda, MD, 2015]
Risk minimisation measures	Routine risk minimisation measures: SmPC section 4.3 and 4.4 PIL section 2 Additional risk minimisation measures: Not applicable.

Important missing information: Not applicable

II.C Post-authorisation development plan

II.C.1 Studies which are conditions of the marketing authorisation

There are no studies, which are conditions of the marketing authorisation.

II.C.2 Other studies in post-authorisation development plan

PASS Study: LF111-402

Purpose of the study:

The estimated risk of VTE in healthy COC users is 6–12/10,000 women per year compared with non-users (2/10,000 women per year). This increased risk has led to the development of low-dose COC containing ethinylestradiol (EE) (10–25 µg) or oestradiol (E2), or to oral contraceptives containing no oestrogen at all [EMA, Combined hormonal contraceptives 2013].

The risk of VTE events are perceived to be associated with EE and the use of POPs are consequently assumed to have a lower cardiovascular risk. A low risk of VTE was confirmed in the clinical study program for drospirenone (Slinda®), in which no report of VTE occurred after evaluation of use in more than 20.000 cycles [Palacios 2020]

The rationale and objective for the current study is to collect additional observational data and estimate the risk of VTE for the new marketed POP (Slinda®), in comparison with other marketed POPs and COCs of different compositions.

The safety concern addressed with this study is the potential risk of VTE.

Primary objective:

- Incidence rate (IR) of VTE in women on Slinda® in different age groups.

Secondary objectives:

- IR for VTE in women on comparative study treatments in different age groups.
- IR for VTE for all study treatments (without age stratification).
- Relative risk (RR) between women on Slinda® and non-users of hormonal contraception.
- RR between women on Slinda® and women on comparative study treatments.

Explorative objectives:

Descriptive analysis of underlying risk factors (previous thrombosis, smoking, BMI, family disposition, education, predisposing disease)

