

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use CLIMARA PRO safely and effectively. See full prescribing information for CLIMARA PRO.

Climara Pro® (estradiol/levonorgestrel transdermal system)
Initial U.S. Approval: 1975

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

See full prescribing information for complete boxed warning.

Estrogen Plus Progestin Therapy

- Estrogen plus progestin therapy should not be used for the prevention of cardiovascular disease or dementia (5.1, 5.3)
- The Women's Health Initiative (WHI) estrogen plus progestin substudy reported increased risks of stroke, deep vein thrombosis (DVT), pulmonary embolism (PE), and myocardial infarction (MI) (5.1)
- The WHI estrogen plus progestin substudy reported increased risks of invasive breast cancer (5.2)
- The WHI Memory Study (WHIMS) estrogen plus progestin ancillary study of WHI reported an increased risk of probable dementia in postmenopausal women 65 years of age and older (5.3)

Estrogen-Alone Therapy

- There is an increased risk of endometrial cancer in a woman with a uterus who uses unopposed estrogens (5.2)
- Estrogen-alone therapy should not be used for the prevention of cardiovascular disease or dementia (5.1, 5.3)
- The WHI estrogen-alone substudy reported increased risks of stroke and DVT (5.1)
- The WHIMS estrogen-alone ancillary study of WHI reported an increased risk of probable dementia in postmenopausal women 65 years of age and older (5.3)

RECENT MAJOR CHANGES

Warnings and Precautions, Malignant Neoplasms (5.2) 11/2017

INDICATIONS AND USAGE

Climara Pro is an estrogen plus progestin indicated in a woman with a uterus for:

- Treatment of Moderate to Severe Vasomotor Symptoms due to Menopause (1.1)
- Prevention of Postmenopausal Osteoporosis (1.2)

DOSAGE AND ADMINISTRATION

- Apply Climara Pro once-weekly to the lower abdomen (2.3)

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

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- Transdermal system 0.045 mg/day estradiol and 0.015 mg/day levonorgestrel (3)

CONTRAINDICATIONS

- Undiagnosed abnormal genital bleeding (4)
- Known, suspected, or history of breast cancer (4, 5.2)
- Known or suspected estrogen-dependent neoplasia (4, 5.2)
- Active DVT, PE or a history of these conditions (4, 5.1)
- Active arterial thromboembolic disease (for example, stroke and MI), or a history of these conditions (4, 5.1)
- Known anaphylactic reaction or angioedema with Climara Pro (4)
- Known liver impairment or disease (4, 5.10)
- Known protein C, protein S, or antithrombin deficiency, or other known thrombophilic disorders (4)
- Known or suspected pregnancy (4, 8.1)

WARNINGS AND PRECAUTIONS

- Estrogens increase the risk of gallbladder disease (5.4)
- Discontinue estrogens if severe hypercalcemia, loss of vision, severe hypertriglyceridemia or cholestatic jaundice occurs (5.5, 5.6, 5.9, 5.10)
- Monitor thyroid function in women on thyroid hormone replacement therapy (5.11, 5.18)

ADVERSE REACTIONS

- In a prospective, randomized, placebo-controlled, double-blind study, the most common adverse reactions ≥ 5 percent are: application site reaction, vaginal bleeding, breast pain, upper respiratory infection, back pain, depression, pain, headache and flu syndrome. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Bayer HealthCare Pharmaceuticals Inc. at 1-888-84-BAYER (1-888-842-2937) or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch

DRUG INTERACTIONS

- Inducers and/or inhibitors of CYP3A4 may affect estrogen drug metabolism (7.1)
- Hydroxylation of levonorgestrel may interact with inhibitors of CYP3A, CYP2E and CYP2C and decrease the therapeutic effects (7.1)

USE IN SPECIFIC POPULATIONS

- Nursing Mothers: Estrogen administration to nursing women has been shown to decrease the quantity and quality of breast milk (8.3)
- Geriatric Use: An increased risk of probable dementia in women over 65 years of age was reported in the WHIMS ancillary studies of the WHI (5.3, 8.5, 14.6)

See 17 for PATIENT COUNSELING INFORMATION and FDA-approved patient labeling

Revised: 11/2017

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FULL PRESCRIBING INFORMATION

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

Estrogen Plus Progestin Therapy

Cardiovascular Disorders and Probable Dementia

Estrogen plus progestin therapy should not be used for the prevention of cardiovascular disease or dementia [see Warnings and Precautions (5.1, 5.3), and Clinical Studies (14.5, 14.6)].

The Women's Health Initiative (WHI) estrogen plus progestin substudy reported an increased risk of deep vein thrombosis (DVT), pulmonary embolism (PE), stroke and myocardial infarction (MI) in postmenopausal women (50 to 79 years of age) during 5.6 years of treatment with daily oral conjugated estrogens (CE) [0.625 mg] combined with medroxyprogesterone acetate (MPA) [2.5 mg], relative to placebo [see Warnings and Precautions (5.1), and Clinical Studies (14.5)].

The WHI Memory Study (WHIMS) estrogen plus progestin ancillary study of WHI reported an increased risk of developing probable dementia in postmenopausal women 65 years of age or older during 4 years of treatment with daily CE (0.625 mg) combined with MPA (2.5 mg), relative to placebo. It is unknown whether this finding applies to younger postmenopausal women [see Warnings and Precautions (5.3), Use in Specific Populations (8.5), and Clinical Studies (14.6)].

Breast Cancer

The WHI estrogen plus progestin substudy demonstrated an increased risk of invasive breast cancer [see Warnings and Precautions (5.2), and Clinical Studies (14.5)].

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

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

Estrogen-Alone Therapy

Endometrial Cancer

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

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Precautions (5.2)].

Cardiovascular Disorders and Probable Dementia

Estrogen-alone therapy should not be used for the prevention of cardiovascular disease or dementia [see Warnings and Precautions (5.1, 5.3), and Clinical Studies (14.5, 14.6)].

The WHI estrogen-alone substudy reported increased risks of stroke and DVT in postmenopausal women (50 to 79 years of age) during 7.1 years of treatment with daily oral CE (0.625 mg)-alone, relative to placebo [see Warnings and Precautions (5.1), and Clinical Studies (14.5)].

The WHIMS estrogen-alone ancillary study of WHI reported an increased risk of developing probable dementia in postmenopausal women 65 years of age or older during 5.2 years of treatment with daily CE (0.625 mg)-alone, relative to placebo. It is unknown whether this finding applies to younger postmenopausal women [see Warnings and Precautions (5.3), Use in Specific Populations (8.5), and Clinical Studies (14.6)].

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

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

1 INDICATIONS AND USAGE

1.1 Treatment of Moderate to Severe Vasomotor Symptoms due to Menopause

1.2 Prevention of Postmenopausal Osteoporosis

Limitation of Use

When prescribing solely for the prevention of postmenopausal osteoporosis, therapy should only be considered for women at significant risk of osteoporosis and non-estrogen medication should be carefully considered.

2 DOSAGE AND ADMINISTRATION

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 women. Postmenopausal women should be re-evaluated periodically as clinically appropriate to determine if treatment is still necessary.

One Climara Pro transdermal system is available for use.

Initiation of Therapy

Women not currently using continuous estrogen-alone therapy or estrogen plus progestin therapy may start therapy with Climara Pro at any time. However, women currently using continuous estrogen-alone therapy or estrogen plus progestin therapy should complete the current cycle of therapy before initiating Climara Pro therapy. Women often experience withdrawal bleeding at the completion of the cycle. The first day of this bleeding would be an appropriate time to begin Climara Pro therapy.

2.1 Treatment of Moderate to Severe Vasomotor Symptoms due to Menopause

Climara Pro 0.045 mg per day/0.015 mg per day applied to the skin once weekly. Therapy should be started at the lowest effective dose and the shortest duration consistent with the treatment goals. Attempts to discontinue the medication should be made at 3 to 6 month intervals.

2.2 Prevention of Postmenopausal Osteoporosis

Climara Pro 0.045 mg per day/0.015 mg per day applied to the skin once weekly.

2.3 Application of the Transdermal System

Site Selection

- The adhesive side of Climara Pro should be placed on a smooth (fold free), clean, dry area of the skin on the lower abdomen or the upper quadrant of the buttock.
- Climara Pro should not be applied to or near the breasts.
- The area selected should not be oily (which can impair adherence of the system), damaged, or irritated.
- The waistline should be avoided, since tight clothing may rub Climara Pro off or modify drug delivery.
- Application to areas where sitting would dislodge Climara Pro should also be avoided.
- The sites of application must be rotated, with an interval of at least 1-week allowed between applications to the same site.

Application

- Climara Pro should be applied immediately after opening the pouch and removing the protective lining.
- Climara Pro should be pressed firmly in place with the fingers for at least 10 seconds, making sure there is good contact, especially around the edges.
- If the system lifts, apply pressure to maintain adhesion.
- In the event that a system should fall off, the same system may be reapplied to another area of the lower abdomen. If the system cannot be reapplied, a new system may be applied, in which case, the original treatment schedule should be continued.
- Only one system should be worn at any one time during 7-day dosing interval.
- Once in place, the transdermal system should not be exposed to the sun for prolonged periods of time.
- Swimming, bathing, or using a sauna while using Climara Pro has not been studied, and these activities may decrease the adhesion of the system and the delivery of the estrogen and progestin.

2.4 Removal of the Transdermal System

- Removal of Climara Pro should be done carefully and slowly to avoid irritation of the skin.
- Should any adhesive remain on the skin after removal of the system, allow the area to dry for 15 minutes.
- Then gently rubbing the area with an oil-based cream or lotion should remove the adhesive residue.
- Used patches still contain some active hormones. Each patch should be carefully folded in half so that it sticks to itself before throwing it away.

3 DOSAGE FORMS AND STRENGTHS

Climara Pro (estradiol/levonorgestrel transdermal system) 0.045 mg/day estradiol and 0.015 mg/day levonorgestrel – each 22 cm² system contains 4.4 mg of estradiol and 1.39 mg of levonorgestrel.

4 CONTRAINDICATIONS

Climara Pro is contraindicated in women with any of the following conditions:

- Undiagnosed abnormal genital bleeding
- Known, suspected, or history of breast cancer
- Known or suspected estrogen-dependent neoplasia
- Active DVT, PE or a history of these conditions
- Active arterial thromboembolic disease (for example, stroke and MI), or a history of these conditions
- Known anaphylactic reaction or angioedema with Climara Pro
- Known liver impairment or disease

- Known protein C, protein S, or antithrombin deficiency, or other known thrombophilic disorders
- Known or suspected pregnancy

5 WARNINGS AND PRECAUTIONS

5.1 Cardiovascular Disorders

An increased risk of PE, DVT, stroke and MI has been reported with estrogen plus progestin therapy. An increased risk of stroke and DVT has been reported with estrogen-alone therapy. Should any of these occur or be suspected, estrogen with or without progestin therapy should be discontinued immediately.

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

Stroke

In the WHI estrogen plus progestin substudy, a statistically significant increased risk of stroke was reported in women 50 to 79 years of age receiving daily CE (0.625 mg) plus MPA (2.5 mg) compared to women in the same age group receiving placebo (33 versus 25 per 10,000 women-years) [see *Clinical Studies (14.5)*]. The increase in risk was demonstrated after the first year and persisted.¹ Should a stroke occur or be suspected, estrogen plus progestin therapy should be discontinued.

In the WHI estrogen-alone substudy, a statistically significant increased risk of stroke was reported in women 50 to 79 years of age receiving daily CE (0.625 mg)-alone compared to women in the same age group receiving placebo (45 versus 33 per 10,000 women-years). The increase in risk was demonstrated in year 1 and persisted [see *Clinical Studies (14.5)*]. Should a stroke occur or be suspected, estrogen-alone therapy should be discontinued immediately.

Subgroup analyses of women 50 to 59 years of age suggest no increased risk of stroke for those women receiving CE (0.625 mg)-alone versus those receiving placebo (18 versus 21 per 10,000 women-years).¹

Coronary Heart Disease

In the WHI estrogen plus progestin substudy, there was a statistically non-significant increased risk of coronary heart disease (CHD) events (defined as nonfatal MI, silent MI, or CHD death) reported in women receiving daily CE (0.625 mg) plus MPA (2.5 mg) compared to women receiving placebo (41 versus 34 per 10,000 women-years).¹ An increase in relative risk was demonstrated in year 1, and a trend toward decreasing relative risk was reported in years 2 through 5 [see *Clinical Studies (14.5)*].

In the WHI estrogen-alone substudy, no overall effect on CHD events was reported in women receiving estrogen-alone compared to placebo² [see *Clinical Studies (14.5)*].

Subgroup analyses of women 50 to 59 years of age suggest a statistically non-significant reduction in CHD events (CE [0.625 mg]-alone compared to placebo) in women with less than 10 years since menopause (8 versus 16 per 10,000 women-years).¹

In postmenopausal women with documented heart disease (n = 2,763), average 66.7 years of age, in a controlled clinical trial of secondary prevention of cardiovascular disease (Heart and Estrogen/Progestin Replacement Study [HERS]), treatment with daily CE (0.625 mg) plus MPA (2.5 mg) demonstrated no cardiovascular benefit. During an average follow-up of 4.1 years, treatment with CE plus MPA did not reduce the overall rate of CHD events in postmenopausal women with established coronary heart disease. There were more CHD events in the CE plus MPA-treated group than in the placebo group in year 1, but not during the subsequent years. A total of 2,321 women from the original HERS trial agreed to participate in an open label extension of HERS, HERS II. Average follow-up in HERS II was an additional 2.7 years, for a total of 6.8 years overall. Rates of CHD events were comparable among women in the CE plus MPA group and the placebo group in HERS, HERS II, and overall.

Venous Thromboembolism

In the WHI estrogen plus progestin substudy, a statistically significant 2-fold greater rate of VTE (DVT and PE) was reported in women receiving daily CE (0.625 mg) plus MPA (2.5 mg) compared to women receiving placebo (35 versus 17 per 10,000 women-years). Statistically significant increases in risk for both DVT (26 versus 13 per 10,000 women-years) and PE (18 versus 8 per 10,000 women-years) were also demonstrated. The increase in VTE risk was demonstrated

during the first year and persisted³ [see *Clinical Studies (14.5)*]. Should a VTE occur or be suspected, estrogen plus progestin therapy should be discontinued immediately.

In the WHI estrogen-alone substudy, the risk of VTE was increased for women receiving daily CE (0.625 mg)-alone compared to placebo (30 versus 22 per 10,000 women-years), although only the increased risk of DVT reached statistical significance (23 versus 15 per 10,000 women-years). The increase in VTE risk was demonstrated during the first 2 years⁴ [see *Clinical Studies (14.5)*]. Should a VTE occur or be suspected, estrogen-alone therapy should be discontinued immediately.

If feasible, estrogens should be discontinued at least 4 to 6 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization.

5.2 Malignant Neoplasms

Breast Cancer

The most important randomized clinical trial providing information about breast cancer in estrogen plus progestin users is the WHI substudy of daily CE (0.625 mg) plus MPA (2.5 mg).

After a mean follow-up of 5.6 years, the estrogen plus progestin substudy reported an increased risk of invasive breast cancer in women who took daily CE plus MPA. In this substudy, prior use of estrogen-alone or estrogen plus progestin therapy was reported by 26 percent of the women. The relative risk of invasive breast cancer was 1.24, and the absolute risk was 41 versus 33 cases per 10,000 women-years, for CE plus MPA compared with placebo [see *Clinical Studies (14.5)*]. Among women who reported prior use of hormone therapy, the relative risk of invasive breast cancer was 1.86, and the absolute risk was 46 versus 25 cases per 10,000 women-years, for CE plus MPA compared with placebo. Among women who reported no prior use of hormone therapy, the relative risk of invasive breast cancer was 1.09, and the absolute risk was 40 versus 36 cases per 10,000 women-years for CE plus MPA compared with placebo. In the same substudy, invasive breast cancers were larger, were more likely to be node positive, and were diagnosed at a more advanced stage in the CE (0.625 mg) plus MPA (2.5 mg) group compared with the placebo group. Metastatic disease was rare with no apparent difference between the two groups. Other prognostic factors such as histologic subtype, grade and hormone receptor status did not differ between the groups⁵ [see *Clinical Studies (14.5)*].

The most important randomized clinical trial providing information about breast cancer in estrogen-alone users is the WHI substudy of daily CE (0.625 mg)-alone. In the WHI estrogen-alone substudy, after an average follow-up of 7.1 years, daily CE-alone was not associated with an increased risk of invasive breast cancer [relative risk (RR) 0.80]⁶ [see *Clinical Studies (14.5)*].

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

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

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

Endometrial Cancer

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

Clinical surveillance of all women using estrogen-alone or estrogen plus progestin therapy is important. Adequate diagnostic measures, including directed or random endometrial sampling when indicated, should be undertaken to rule out

malignancy in postmenopausal women with undiagnosed persistent or recurring abnormal genital bleeding. There is no evidence that the use of natural estrogens results in a different endometrial risk profile than synthetic estrogens of equivalent estrogen dose. Adding a progestin to estrogen therapy in postmenopausal women has been shown to reduce the risk of endometrial hyperplasia, which may be a precursor to endometrial cancer.

Ovarian Cancer

The WHI estrogen plus progestin substudy reported a statistically non-significant increased risk of ovarian cancer. After an average follow-up of 5.6 years, the relative risk for ovarian cancer for CE plus MPA versus placebo was 1.58 (95 percent CI, 0.77-3.24). The absolute risk for CE plus MPA versus placebo was 4 versus 3 cases per 10,000 women-years.⁷ A meta-analysis of 17 prospective and 35 retrospective epidemiology studies found that women who used hormonal therapy for menopausal symptoms had an increased risk for ovarian cancer. The primary analysis, using case-control comparisons, included 12,110 cancer cases from the 17 prospective studies. The relative risks associated with current use of hormonal therapy was 1.41 (95% confidence interval [CI] 1.32 to 1.50); there was no difference in the risk estimates by duration of the exposure (less than 5 years [median of 3 years] vs. greater than 5 years [median of 10 years] of use before the cancer diagnosis). The relative risk associated with combined current and recent use (discontinued use within 5 years before cancer diagnosis) was 1.37 (95% CI 1.27 to 1.48), and the elevated risk was significant for both estrogen-alone and estrogen plus progestin products. The exact duration of hormone therapy use associated with an increased risk of ovarian cancer, however, is unknown.

5.3 Probable Dementia

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

After an average follow-up of 4 years, 40 women in the CE plus MPA group and 21 women in the placebo group were diagnosed with probable dementia. The relative risk of probable dementia for CE plus MPA versus placebo was 2.05 (95 percent CI, 1.21-3.48). The absolute risk of probable dementia for CE plus MPA versus placebo was 45 versus 22 cases per 10,000 women-years⁸ [see *Use in Specific Populations (8.5), and Clinical Studies (14.6)*].

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

After an average follow-up of 5.2 years, 28 women in the estrogen-alone group and 19 women in the placebo group were diagnosed with probable dementia. The relative risk of probable dementia for CE-alone versus placebo was 1.49 (95 percent CI, 0.83-2.66). The absolute risk of probable dementia for CE-alone versus placebo was 37 versus 25 cases per 10,000 women-years⁸ [see *Use in Specific Populations (8.5), and Clinical Studies (14.6)*].

When data from the two populations in the WHIMS estrogen-alone and estrogen plus progestin ancillary studies were pooled as planned in the WHIMS protocol, the reported overall relative risk for probable dementia was 1.76 (95 percent CI, 1.19-2.60). Since both ancillary studies were conducted in women 65 to 79 years of age, it is unknown whether these findings apply to younger postmenopausal women⁸ [see *Use in Specific Populations (8.5), and Clinical Studies (14.6)*].

5.4 Gallbladder Disease

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

5.5 Hypercalcemia

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

5.6 Visual Abnormalities

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

5.7 Addition of a Progestin When a Woman Has Not Had a Hysterectomy

Studies of the addition of a progestin for 10 or more days of a cycle of estrogen administration, or daily with estrogen in a continuous regimen, have reported a lowered incidence of endometrial hyperplasia than would be induced by estrogen treatment alone. Endometrial hyperplasia may be a precursor to endometrial cancer.

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

5.8 Elevated Blood Pressure

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

5.9 Hypertriglyceridemia

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

5.10 Hepatic Impairment and/or Past History of Cholestatic Jaundice

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

5.11 Hypothyroidism

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

5.12 Fluid Retention

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

5.13 Hypocalcemia

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

5.14 Exacerbation of Endometriosis

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

5.15 Hereditary Angioedema

Exogenous estrogens may exacerbate symptoms of angioedema in women with hereditary angioedema.

5.16 Exacerbation of Other Conditions

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

5.17 Laboratory Tests

Serum follicle stimulating hormone (FSH) and estradiol levels have not been shown to be useful in the management of moderate to severe vasomotor symptoms.

5.18 Drug-Laboratory Test Interactions

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

Increased TBG levels leading to increased circulating total thyroid hormone, as measured by protein-bound iodine (PBI), T₄ levels (by column or by radioimmunoassay) or T₃ levels by radioimmunoassay. T₃ resin uptake is decreased, reflecting

the elevated TBG. Free T₄ and free T₃ concentrations are unaltered. Women on thyroid replacement therapy may require higher doses of thyroid hormone.

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

Increased plasma high-density lipoprotein (HDL) and HDL₂ cholesterol subfraction concentrations, reduced low-density lipoprotein (LDL) cholesterol concentration, and in oral formulations increased triglycerides levels.

Impaired glucose tolerance.

6 ADVERSE REACTIONS

The following serious adverse reactions are discussed elsewhere in the labeling:

- Cardiovascular Disorders [see Boxed Warning, Warnings and Precautions (5.1)]
- Malignant Neoplasms [see Boxed Warning, Warnings and Precautions (5.2)]

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

The data described below is from a one-year, prospective, multicenter, double blind, double dummy, randomized, controlled trial investigating the effect of three different dosage combinations of E2/LNG versus E2 alone on the development of endometrial hyperplasia. All women were postmenopausal, had a serum estradiol level of less than 20 pg/mL, and the sample included both symptomatic and asymptomatic women. The data below includes all adverse reactions reported at a frequency of >3% in the E2/LNG 0.045 / 0.015 group (the approved dosage for Climara Pro, N=212) and the E2 alone group (N=204).

Table 1: All Treatment Emergent Reactions Regardless of Relationship Reported at a Frequency of >3% with Climara Pro in the 1-year Endometrial Hyperplasia Study

Body System Adverse Reaction	Climara Pro 0.045 / 0.015 N ^a = 212	E ₂ N = 204
Body as a Whole		
Abdominal pain	9 (4.2)	11 (5.4)
Accidental injury	7 (3.3)	6 (2.9)
Back pain	13 (6.1)	12 (5.9)
Flu syndrome	10 (4.7)	13 (6.4)
Infection	7 (3.3)	10 (4.9)
Pain	11 (5.2)	13 (6.4)
Cardiovascular System		
Hypertension	7 (3.3)	9 (4.4)
Digestive System		
Flatulence	8 (3.8)	11 (5.4)
Metabolic and Nutritional		
Edema	8 (3.8)	5 (2.5)
Weight gain	6 (2.8)	10 (4.9)
Musculoskeletal System		
Arthralgia	9 (4.2)	10 (4.9)
Nervous System		
Depression	12 (5.7)	7 (3.4)
Headache	11 (5.2)	14 (6.9)

Respiratory System		
Bronchitis	9 (4.2)	7 (3.4)
Sinusitis	8 (3.8)	12 (5.9)
Upper respiratory infection	28 (13.2)	26 (12.7)
Skin and Appendages		
Application site reaction	86 (40.6)	69 (33.8)
Breast pain	40 (18.9)	20 (9.8)
Rash	5 (2.4)	10 (4.9)
Urogenital System		
Urinary Tract Infection	7 (3.3)	8 (3.9)
Vaginal Bleeding	78 (36.8)	44 (21.6)
Vaginitis	4 (1.9)	6 (2.9)

a) N = total number of subjects in a treatment group; n = number of subjects with event.

Irritation potential of Climara Pro was assessed in a 3-week irritation study. The study compared the irritation of a Climara Pro placebo patch (22 cm²) to a placebo (25 cm²). Visual assessments of irritation were made on Day 7 of each wear period, approximately 30 minutes after patch removal using a 7-point scale (0 = no evidence of irritation; 1 = minimal erythema, barely perceptible; 2 = definite erythema, readily visible, or minimal edema, or minimal papular response; 3–7 = erythema and papules, edema, vesicles, strong extensive reaction).

The mean irritation scores were 0.13 (week 1), 0.12 (week 2), and 0.06 (week 3) for the Climara Pro placebo. The mean scores for the Climara placebo were 0.2 (week 1), 0.26 (week 2), 0.12 (week 3). There were no irritation scores greater than 2 at any timepoint in any subject.

In controlled clinical trials, withdrawals due to application site reactions occurred in 6 (2.1 percent) of subjects in the 12-week symptom study and in 71 (8.5 percent) of subjects in the 1-year endometrial protection study.

6.2 Postmarketing Experience

The following adverse reactions have been identified during post-approval use of the Climara Pro transdermal system. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

Genitourinary System

Changes in bleeding patterns

Gastrointestinal

Abdominal distension,* abdominal pain,* nausea

Skin

Alopecia, night sweats, pruritus,* Rash,* hot flush*

Central Nervous System

Dizziness, headache, insomnia

Miscellaneous

Application site reaction,* weight increased, anaphylactic reaction

* Combined two or more similar ARs

7 DRUG INTERACTIONS

7.1 Metabolic Interactions

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

Hydroxylation of levonorgestrel is a conversion step, which is mediated by cytochrome P450 enzymes. Based on *in-vitro* and *in-vivo* studies, it can be assumed that CYP3A, CYP2E and CYP2C are involved in the metabolism of levonorgestrel. Likewise, inducers or inhibitors of these enzymes may either, respectively, decrease the therapeutic effects or result in side effects.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Climara Pro should not be used during pregnancy [*see Contraindications (4)*]. There appears to be little or no increased risk of birth defects in children born to women who have used estrogens and progestins as oral contraceptives inadvertently during early pregnancy.

8.3 Nursing Mothers

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

8.4 Pediatric Use

Climara Pro is not indicated in children. Clinical studies have not been conducted in the pediatric populations.

8.5 Geriatric Use

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

The Women's Health Initiative Studies

In the WHI estrogen plus progestin substudy (daily CE [0.625 mg] plus MPA [2.5 mg] versus placebo), there was a higher relative risk of nonfatal stroke and invasive breast cancer in women greater than 65 years of age [*see Clinical Studies (14.5)*].

In the WHI estrogen-alone substudy (daily CE [0.625 mg]-alone versus placebo), there was a higher relative risk of stroke in women greater than 65 years of age [*see Clinical Studies (14.5)*].

The Women's Health Initiative Memory Study

In the WHIMS ancillary studies of postmenopausal women 65 to 79 years of age, there was an increased risk of developing probable dementia in women receiving estrogen plus progestin or estrogen-alone when compared to placebo [*see Warnings and Precautions (5.3), and Clinical Studies (14.6)*].

Since both ancillary studies were conducted in women 65 to 79 years of age, it is unknown whether these findings apply to younger postmenopausal women⁸ (*see Warnings and Precautions (5.3), and Clinical Studies (14.6)*).

8.6 Renal Impairment

In postmenopausal women with end stage renal disease (ESRD) receiving maintenance hemodialysis, total estradiol serum levels are higher than in normal subjects at baseline and following oral doses of estradiol. Therefore, conventional transdermal estradiol doses used in individuals with normal renal function may be excessive for postmenopausal women with ESRD receiving maintenance hemodialysis.

8.7 Hepatic Impairment

Estrogens may be poorly metabolized in patients with impaired liver function and should be administered with caution.

10 OVERDOSAGE

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

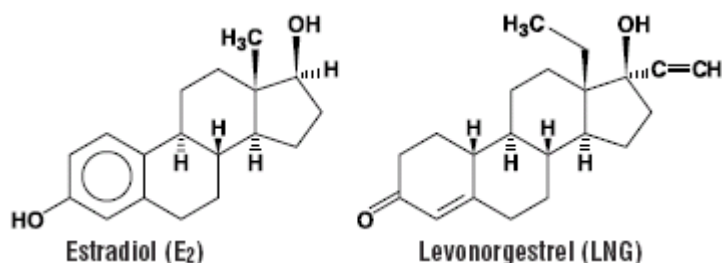
11 DESCRIPTION

Climara Pro (estradiol/levonorgestrel transdermal system) is an adhesive-based matrix transdermal patch designed to release both estradiol and levonorgestrel, a progestational agent, continuously upon application to intact skin. The 22 cm² Climara Pro system contains 4.4 mg estradiol and 1.39 mg levonorgestrel and provides a nominal delivery rate (mg per day) of 0.045 estradiol and 0.015 levonorgestrel.

Estradiol USP has a molecular weight of 272.39 and the molecular formula is C₁₈H₂₄O₂.

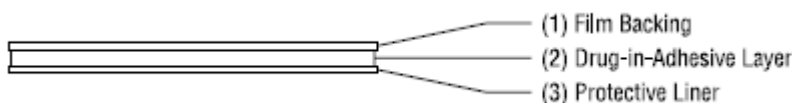
Levonorgestrel USP has a molecular weight of 312.4 and a molecular formula of C₂₁H₂₈O₂.

The structural formulas for estradiol and levonorgestrel are:



The Climara Pro transdermal system comprises 3 layers. Proceeding from the visible surface towards the surface attached to the skin, these layers are:

1. A translucent polyethylene backing film.
2. An acrylate adhesive matrix containing estradiol and levonorgestrel.
3. A protective liner of either siliconized or fluoropolymer coated polyester film. The protective liner is attached to the adhesive surface and must be removed before the system can be used.



The active components of the transdermal system are estradiol and levonorgestrel. The remaining components of the transdermal system (acrylate copolymer adhesive and polyvinylpyrrolidone/vinyl acetate copolymer) are pharmacologically inactive.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism Of Action

Endogenous estrogens are largely responsible for the development and maintenance of the female reproductive system and secondary sexual characteristics. Although circulating estrogens exist in a dynamic equilibrium of metabolic interconversions, estradiol is the principal intracellular human estrogen and is substantially more potent than its metabolites, estrone and estriol, at the receptor level.

The primary source of estrogen in normally cycling adult women is the ovarian follicle, which secretes 70 to 500 mcg of estradiol daily, depending on the phase of the menstrual cycle. After menopause, most endogenous estrogen is produced by conversion of androstenedione, which is secreted by the adrenal cortex, to estrone in the peripheral tissues. Thus, estrone and the sulfate conjugated form, estrone sulfate, are the most abundant circulating estrogens in postmenopausal women.

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

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

Levonorgestrel inhibits gonadotropin production resulting in retardation of follicular growth and inhibition of ovulation.

Studies to assess the potency of progestins using estrogen-primed postmenopausal endometrial biochemistry and morphologic features have shown that levonorgestrel counteracts the proliferative effects of estrogens on the endometrium.

12.2 Pharmacodynamics

There are no pharmacodynamic data for Climara Pro.

12.3 Pharmacokinetics

Absorption

Transdermal administration of Climara Pro produces mean maximum estradiol concentrations in serum in about 2 to 2.5 days. Estradiol concentrations equivalent to the normal ranges observed at the early follicular phase in premenopausal women are achieved within 12–24 hours after the first application.

In one study, steady state estradiol concentrations in serum were measured during week 4 in 44 healthy, postmenopausal women during four consecutive Climara Pro applications of two formulations (0.045 mg estradiol/0.03 mg levonorgestrel and 0.045 mg estradiol/0.015 mg levonorgestrel) to the abdomen (each dose was applied for four 7-day periods). Both formulations were bioequivalent in terms of estradiol and estrone C_{max} and AUC parameters. A summary of Climara Pro single and multiple applications estradiol, estrone and levonorgestrel pharmacokinetic parameters is shown in Table 2.

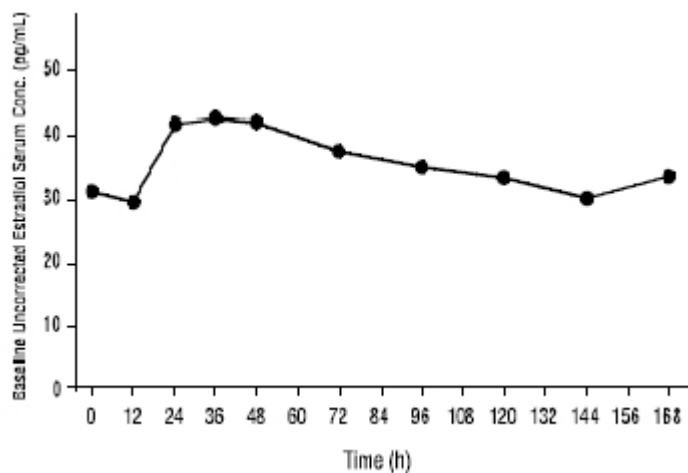
Table 2: Summary of Mean Pharmacokinetic Parameters

Summary of Mean (\pm SD) Pharmacokinetic Parameters Following a Single Application of Climara Pro in 24 Healthy Postmenopausal Women				
Parameter	Units	Estradiol	Estrone	Levonorgestrel
Single application Week 1 Data				
C_{ave}	Pg/mL	37.7 ± 10.4	41 ± 15	136 ± 52.7
C_{max}	Pg/mL	54.3 ± 18.9	43.9 ± 14.9	138 ± 51.8
T_{max}	Hours	42	84	90
C_{min}	Pg/mL	27.2 ± 7.66	32.6 ± 14.3	110 ± 41.7
AUC	Pg.h/mL	6340 ± 1740	6890 ± 2520	22900 ± 8860
Summary of Mean (\pm SD) Pharmacokinetic Parameters (Week 4) Following Four Consecutive Weekly Applications of Climara Pro in 44 Healthy Postmenopausal Women				
Multiple application Week 4 Data				
C_{ave}	Pg/mL	35.7 ± 11.4	45.5 ± 62.6	166 ± 97.8
C_{max}	Pg/mL	50.7 ± 28.6	81.6 ± 252	194 ± 111
T_{max}	Hours	36	48	48
C_{min}	Pg/mL	33.8 ± 28.7	72.5 ± 253	153 ± 69.6
AUC	Pg.h/mL	6002 ± 1919	7642 ± 10518	27948 ± 16426

All mean parameters are arithmetic means except T_{max} which is expressed as the median.

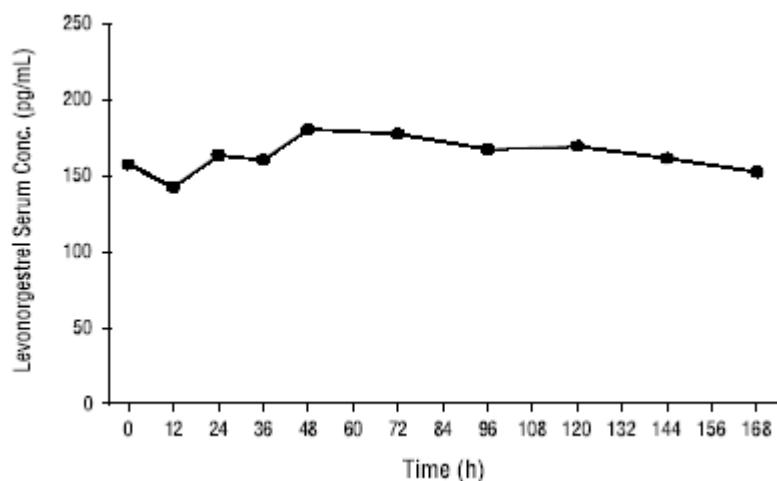
At steady state, Climara Pro maintains during the application period an average serum estradiol concentration of 35.7 pg/mL as depicted in Figure 1.

Figure 1: Mean Estradiol Concentration Profile (Week 4) Following Four Consecutive Weekly Applications of Climara Pro



Following the application of the Climara Pro transdermal system, levonorgestrel concentrations are maximum in about 2.5 days. At steady state, Climara Pro maintains during the application period an average serum levonorgestrel concentration of 166 pg/mL as depicted in Figure 2. The mean levonorgestrel pharmacokinetic parameters of Climara Pro are summarized in Table 2.

Figure 2: Mean Levonorgestrel Concentration Profile (Week 4) Following Four Consecutive Weekly Applications of Climara Pro



Distribution

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

Levonorgestrel in serum is bound to both SHBG and albumin. Following four consecutive weekly applications of Climara Pro mean (\pm SD) SHBG concentrations declined from a predose value of 47.5 (25.8) to 41.2 (22.4) nmol/L at week 4.

Metabolism

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

The most important metabolic pathway for levonorgestrel occurs in the reduction of the Δ^4 - and the 3-oxo-group as well as hydroxylations at positions 2α , 1β , and 16β , followed by conjugation. Most of the metabolites that circulate in the

blood are sulfates of 3 α , 5 β -tetrahydro-levonorgestrel, while excretion occurs predominantly in the form of glucuronides. Some of the parent levonorgestrel also circulates as the 17 β -sulfate. *In-vitro* studies on the biotransformation of levonorgestrel in human skin did not indicate any significant metabolism of levonorgestrel during skin penetration.

Excretion

Estradiol, estrone, and estriol are excreted in the urine along with glucuronide and sulfate conjugates. Following patch removal, serum estradiol concentrations decline with a mean (\pm SD) terminal half-life of 3 \pm 0.67 hours.

Levonorgestrel and its metabolites are primarily excreted in the urine. Mean (\pm SD) terminal half-life for levonorgestrel was determined to be 28 \pm 6.4 hours.

Adhesion

A study of the adhesion potential of Climara Pro was conducted in 104 healthy women of 45–75 years of age. Each woman applied a placebo patch, containing only the Climara Pro adhesive without active ingredient, to the upper outer abdominal areas weekly for three weeks. The adhesion assessment was done visually on Days 2, 4, 5, 6 and 7 of each of the three weeks using a four-point scale. The mean scores ranked in the highest category possible on the 0 to 4 scale demonstrating clinically acceptable adhesion performance.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment Of Fertility

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

14 CLINICAL STUDIES

14.1 Effects on Vasomotor Symptoms

The efficacy of 0.045 mg estradiol/0.03 mg levonorgestrel administered weekly versus placebo in the relief of moderate to severe vasomotor symptoms in postmenopausal women was studied in one 12-week clinical trial (n=183, average age 52.1 \pm 4.93, 82 percent Caucasian). The 0.045 mg estradiol/0.03 mg levonorgestrel dosage strength was shown to be statistically better than placebo at weeks 4 and 12 for relief of both the number and severity of moderate to severe hot flushes. See Tables 3 and 4. Climara Pro and the 0.045 mg estradiol/0.03 mg levonorgestrel dosage strength are bioequivalent in terms of estradiol delivery [*See Clinical Pharmacology (12.3)*].

Table 3: Summary of Mean Daily Number of Moderate to Severe Hot Flushes-ITT^a

		Baseline ^b	Week 4	Week 8	Week 12
Placebo	n ^c	88	82	73	69
	Mean (SD) ^d	10.8 (5.803)	6.13 (4.311)	5.35 (4.095)	5.59 (4.93)
	Mean Change from baseline (SD)	NA	-4.23 (4.374)	-4.8 (4.448)	-4.55 (5.407)
0.045/.03	n ^c	92	88	80	73
	Mean (SD) ^d	10.13 (3.945)	2.69 (4.455)	1.22 (2.804)	1.06 (3.187)
	Mean Change from baseline (SD) ^d	NA	-7.4 (4.715)	-8.68 (4.146)	-8.82 (4.336)
p-Value ^e		NA	<0.001 ^f	NA	<0.001 ^f

a) ITT = Intent-to-Treat population

b) A subject was included at baseline only if the subject had a post-baseline mean score. The post-baseline mean score required 3 days in one week.

c) n = Number of subjects in a treatment group in a cycle; number of subjects varied from cycle to cycle due to missing data

d) SD = standard deviation

e) p-value for comparison to placebo, adjusted by the method of Bonferroni

f) p < 0.025

Table 4: Summary of Mean Severity of Moderate to Severe Hot Flashes-ITT^a

		Baseline ^b	Week 4 (day 7)	Week 8 (day 7)	Week 12 (day 7)
Placebo	n ^c	89	76	68	57
	Mean (SD) ^d	2.42 (0.282)	1.99 (0.875)	1.93 (0.955)	1.8 (1.034)
	Mean Change from baseline (SD) ^d	NA	-0.4 (0.865)	-0.48 (0.922)	-0.57 (1.044)
0.045/.03	n ^c	92	83	72	55
	Mean (SD) ^d	2.48 (0.295)	1.1 (1.191)	0.82 (1.226)	0.44 (0.96)
	Mean Change from baseline (SD) ^d	NA	-1.4 (1.164)	-1.67 (1.245)	-2.06 (1.005)
p-value ^e		NA	<0.001 ^f	NA	<0.001 ^f

a) ITT= Intent-to-Treat population

b) A subject was included at baseline only if the subject had at least 1 post-baseline value.

c) n= Number of subjects in a treatment group in a cycle; number of subjects varied from cycle to cycle due to missing data

d) SD= standard deviation Severity scores are: 1 = Mild, 2 = Moderate, 3 = Severe. Mean severity of hot flashes by day is [(2X number of moderate hot flashes) + (3X number of severe hot flashes)] / total number of moderate to severe hot flashes on that day. If no moderate to severe hot flush was indicated, the mean severity was 0.

e) p-value for comparison to placebo, adjusted by the method of Bonferroni

f) p < 0.025

14.2 Effects on the Endometrium

In a 1-year clinical trial of 412 postmenopausal women (with intact uteri) treated with a continuous regimen of Climara Pro or with an continuous estradiol-only transdermal system, results of evaluable endometrial biopsies show that no hyperplasia was seen with Climara Pro. Table 5 below summarizes these results (Intent-to-Treat populations).

Table 5: Incidence of Endometrial Hyperplasia during Continuous Combined Treatment with Climara Pro, ITT^f

	Climara Pro E ₂ 0.045 mg / LNG 0.015 mg	Estradiol E ₂ 0.045 mg
	n ^a = 210	n ^a = 202
No. of Patients with Biopsies at >6 months ^b	124	139
No. of Patients with Biopsies at 1 year ^c	102	110
No. (%) of Patients with Hyperplasia ^d	0 (0%) ^e	19 (17.3%)
95% Confidence Interval	0-3.55%	9.75–24.79%

a) n = number of intent-to-treat subjects.

b) Defined as at least 180 days of treatment.

c) Defined as ≥ 323 days of treatment.

d) Includes hyperplasia occurring at any time after initiation of treatment as a proportion of patients with biopsies at 1 year.

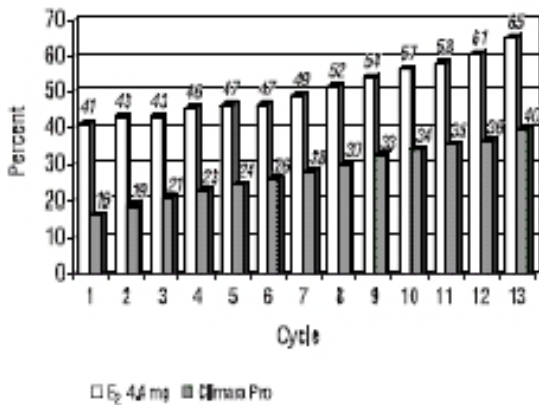
e) p < 0.0167 p-value for comparison to unopposed estradiol dose using the Fisher Exact test. P-values were adjusted by the method of Bonferroni.

f) ITT = Intent-to-Treat population.

14.3 Effects on Uterine Bleeding or Spotting

The effects of Climara Pro on uterine bleeding or spotting, as recorded using an interactive voice response system, were evaluated in one 12-month clinical trial. Results are shown in Figure 3.

Figure 3: Cumulative Proportion of Subjects at Each Cycle with No Bleeding/Spotting Through the End of Cycle 13 Last Observation Carried Forward



- Percent based upon the number of subjects with data
- Last non-missing cycle carried forward through cycle 13
- Bleeding associated with endometrial biopsies not included

14.4 Effects on Bone Mineral Density

The effects on bone mineral density (BMD) were studied in a randomized, double-blind, placebo-controlled clinical trial of transdermal systems (patches) containing only estradiol (E2). The patients were postmenopausal women with hysterectomies, 40–83 years of age (mean=51.4 years), and 77.3 percent Caucasian. Patients received calcium supplements if they appeared deficient on a questionnaire. Vitamin D supplements were not given.

A total of 154 patients were randomized in a 2:2:3 ratio to weekly application of 22 cm² patches containing 2.2 mg E2, 4.4 mg E2, or placebo, for 728 days of continuous treatment (26 28-day cycles). Only the results for the estradiol dose in Climara Pro (4.4 mg E2) and for placebo are presented.

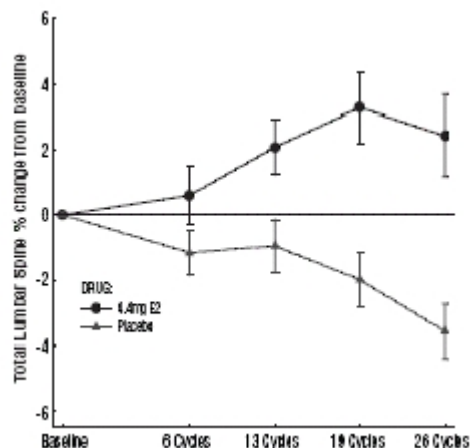
Statistically significant increases in the primary efficacy variable, BMD of the lumbar spine (A-P view, L2-L4), were seen for 4.4 mg E2 compared to placebo (see Table 5 and Figure 4). BMD was also measured at the hip (total, non-dominant side) and radius (midshaft, non-dominant side) with statistically significant treatment effects only observed for the hip (see Table 6).

Table 6: Mean Bone Mineral Density (Standard Deviation)^a

	4.4 mg E₂^b	Placebo
Total Lumbar Spine	n=36	n=46
Baseline (g/cm ²)	1.1 (0.2)	1.1 (0.2)
% Change from baseline LOCF	+1.7% (4.4)	-2.9% (3.8)
P-value compared to placebo	<0.0001	
Total Hip	n=36	n=48
Baseline (g/cm ²)	0.97 (0.1)	0.94 (0.1)
% Change from baseline LOCF	+1.3% (4.2)	-0.9% (5.2)
P-value compared to placebo	0.05	

- a) Intent-to-treat population with on-treatment efficacy data
b) E2=estradiol; LOCF= Last Observation Carried Forward

Figure 4: Percent Change From Baseline in Bone Mineral Density (g/cm²) of Lumbar Spine (A-P View, L2–L4) by Treatment Group and Cycle (Mean ± SE)*



* Data in the figure is for 21 patients on 4.4 mg E2 and 27 placebo patients who completed the study; approximately 44 percent of randomized patients.

14.5 Women's Health Initiative Studies

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

WHI Estrogen Plus Progestin Substudy

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

For those outcomes included in the WHI "global index" that reached statistical significance after 5.6 years of follow-up, the absolute excess risks per 10,000 women-years in the group treated with CE plus MPA were 7 more CHD events, 8 more strokes, 10 more PEs, and 8 more invasive breast cancers, while the absolute risk reductions per 10,000 women-years were 6 fewer colorectal cancers and 5 fewer hip fractures.

Results of the CE plus MPA substudy, which included 16,608 women (average 63 years of age, range 50 to 79; 83.9 percent White, 6.8 percent Black, 5.4 percent Hispanic, 3.9 percent Other) are presented in Table 7. These results reflect centrally adjudicated data after an average follow-up of 5.6 years.

Table 7: Relative and Absolute Risk Seen in the Estrogen Plus Progestin Substudy of WHI at an Average of 5.6 Years^{a, b}

Event	Relative Risk CE/MPA vs. Placebo (95% nCI ^c)	CE/MPA n = 8,506	Placebo n = 8,102
		Absolute Risk per 10,000 Women-Years	
CHD events	1.23 (0.99-1.53)	41	34
<i>Non-fatal MI</i>	1.28 (1.00-1.63)	31	25
<i>CHD death</i>	1.10 (0.70-1.75)	8	8
All strokes	1.31 (1.03-1.68)	33	25
<i>Ischemic stroke</i>	1.44 (1.09-1.90)	26	18

Deep vein thrombosis ^d	1.95 (1.43-2.67)	26	13
Pulmonary embolism	2.13 (1.45-3.11)	18	8
Invasive breast cancer ^e	1.24 (1.01-1.54)	41	33
Colorectal cancer	0.61 (0.42-0.87)	10	16
Endometrial cancer ^d	0.81 (0.48-1.36)	6	7
Cervical cancer ^d	1.44 (0.47-4.42)	2	1
Hip fracture ^c	0.67 (0.47-0.96)	11	16
Vertebral fractures ^d	0.65 (0.46-0.92)	11	17
Lower arm/wrist fractures ^d	0.71 (0.59-0.85)	44	62
Total fractures ^d	0.76 (0.69-0.83)	152	199
Overall Mortality ^f	1.00 (0.83-1.19)	52	52
Global Index ^g	1.13 (1.02-1.25)	184	165

- a) Adapted from numerous WHI publications. WHI publications can be viewed at www.nhlbi.nih.gov/whi.
- b) Results are based on centrally adjudicated data.
- c) Nominal confidence intervals unadjusted for multiple looks and multiple comparisons
- d) Not included in "global index".
- e) Includes metastatic and non-metastatic breast cancer, with the exception of in situ breast cancer.
- f) All deaths, except from breast or colorectal cancer, definite or probable CHD, PE or cerebrovascular disease.
- g) A subset of the events was combined in a "global index", defined as the earliest occurrence of CHD events, invasive breast cancer, stroke, pulmonary embolism, colorectal cancer, hip fracture, or death due to other causes.

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

WHI Estrogen-Alone Substudy

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

Results of the estrogen-alone substudy, which included 10,739 women (average age of 63 years, range 50 to 79; 75.3 percent White, 15.1 percent Black, 6.1 percent Hispanic, 3.6 percent Other), after an average follow-up of 7.1 years are presented in Table 8.

Table 8. Relative and Absolute Risk Seen in the Estrogen-Alone Substudy of WHI^a

Event	Relative Risk CE vs. Placebo (95% nCI ^b)	CE n = 5,310	Placebo n = 5,429
		Absolute Risk per 10,000 Women-Years	
CHD events ^c	0.95 (0.78-1.16)	54	57
Non-fatal MI ^c	0.91 (0.73-1.14)	40	43
CHD death ^c	1.01 (0.71-1.43)	16	16
All strokes ^c	1.33 (1.05-1.68)	45	33
Ischemic stroke ^c	1.55 (1.19-2.01)	38	25
Deep vein thrombosis ^{c, d}	1.47 (1.06-2.06)	23	15
Pulmonary embolism ^c	1.37 (0.90-2.07)	14	10
Invasive breast cancer ^c	0.80 (0.62-1.04)	28	34
Colorectal cancer ^c	1.08 (0.75-1.55)	17	16
Hip fracture ^c	0.65 (0.45-0.94)	12	19
Vertebral fractures ^{c, d}	0.64 (0.44-0.93)	11	18
Lower arm/wrist fractures ^{c, d}	0.58 (0.47-0.72)	35	59

Total fractures ^{c,d}	0.71 (0.64-0.80)	144	197
Death due to other causes ^{e,f}	1.08 (0.88-1.32)	53	50
Overall Mortality ^{c,d}	1.04 (0.88-1.22)	79	75
Global Index ^g	1.02 (0.92-1.13)	206	201

- a) Adapted from numerous WHI publications. WHI publications can be viewed at www.nhlbi.nih.gov/whi.
- b) Nominal confidence intervals unadjusted for multiple looks and multiple comparisons.
- c) Results are based on centrally adjudicated data for an average follow-up of 7.1 years.
- d) Not included in "global index".
- e) Results are based on an average follow-up of 6.8 years.
- f) All deaths, except from breast or colorectal cancer, definite/probable CHD, PE or cerebrovascular disease.
- g) A subset of the events was combined in a "global index", defined as the earliest occurrence of CHD events, invasive breast cancer, stroke, pulmonary embolism, colorectal cancer, hip fracture, or death due to other causes.

For those outcomes included in the WHI "global index" that reached statistical significance, the absolute excess risk per 10,000 women-years in the group treated with CE- alone was 12 more strokes, while the absolute risk reduction per 10,000 women-years was 7 fewer hip fractures.⁹ The absolute excess risk of events included in the "global index" was a non-significant 5 events per 10,000 women-years. There was no difference between the groups in terms of all-cause mortality.

No overall difference for primary CHD events (nonfatal MI, silent MI and CHD death) and invasive breast cancer incidence in women receiving CE-alone compared with placebo was reported in final centrally adjudicated results from the estrogen-alone substudy, after an average follow-up of 7.1 years.

Centrally adjudicated results for stroke events from the estrogen-alone substudy, after an average follow-up of 7.1 years, reported no significant difference in distribution of stroke subtype or severity, including fatal strokes, in women receiving CE-alone compared to placebo. Estrogen-alone increased the risk for ischemic stroke, and this excess risk was present in all subgroups of women examined.¹⁰

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

14.6 Women's Health Initiative Memory Study

The WHIMS estrogen plus progestin ancillary study of WHI enrolled 4,532 predominantly healthy postmenopausal women 65 to 79 years of age (47 percent were 65 to 69 years of age, 35 percent were 70 to 74 years of age, and 18 percent were 75 years of age and older) to evaluate the effects of daily CE (0.625 mg) plus MPA (2.5 mg) on the incidence of probable dementia (primary outcome) compared to placebo.

After an average follow-up of 4 years, the relative risk of probable dementia for CE plus MPA versus placebo was 2.05 (95 percent CI, 1.21-3.48). The absolute risk of probable dementia for CE plus MPA was 45 versus 22 cases per 10,000 women-years. Probable dementia as defined in this study included Alzheimer's disease (AD), vascular dementia (VaD) and mixed type (having features of both AD and VaD). The most common classification of probable dementia in the treatment group and the placebo group was AD. Since the ancillary study was conducted in women 65 to 79 years of age, it is unknown whether these findings apply to younger postmenopausal women [*see Warnings and Precautions (5.3), and Use in Specific Populations (8.5)*].

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

After an average follow-up of 5.2 years, the relative risk of probable dementia for CE-alone versus placebo was 1.49 (95 percent CI, 0.83-2.66). The absolute risk of probable dementia for CE-alone versus placebo was 37 versus 25 cases per 10,000 women-years. Probable dementia as defined in this study included Alzheimer's disease (AD), vascular dementia (VaD) and mixed type (having features of both AD and VaD). The most common classification of probable dementia in the treatment group and the placebo groups was AD. Since the ancillary study was conducted in women 65 to 79 years of age, it is unknown whether these findings apply to younger postmenopausal women [*see Warnings and Precautions (5.3), and Use in Specific Populations (8.5)*].

When data from the two populations were pooled as planned in the WHIMS protocol, the reported overall relative risk for probable dementia was 1.76 (95 percent CI, 1.19-2.60). Differences between groups became apparent in the first year of treatment. It is unknown whether these findings apply to younger postmenopausal women [see *Warnings and Precautions* (5.3), and *Use in Specific Populations* (8.5)].

15 REFERENCES

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10. Hendrix SL, et al. Effects of Conjugated Equine Estrogen on Stroke in the Women's Health Initiative. *Circulation*. 2006;113:2425-2434.

16 HOW SUPPLIED/STORAGE AND HANDLING

16.1 How Supplied

Individual Carton of 4 systems

Climara Pro (estradiol/levonorgestrel transdermal system) 0.045 mg/day estradiol and 0.015 mg/day levonorgestrel – each 22 cm² system contains 4.4 mg of estradiol and 1.39 mg of levonorgestrel. NDC 50419-491-04

16.2 Storage and Handling

Store at 20°C to 25°C (68°F to 77°F); excursions permitted to 15°C to 30°C (59°F to 86°F) [see USP controlled Room Temperature].

Do not store unpouched. Apply immediately upon removal from the protective pouch.

Used transdermal systems still contain active hormones. To discard, fold the sticky side of the transdermal system together, place it in a sturdy child-proof container, and place this container in the trash. Used transdermal systems should not be flushed in the toilet.

17 PATIENT COUNSELING INFORMATION

See FDA-approved patient labeling (Patient Information and Instructions for Use)

Abnormal Vaginal Bleeding

Inform postmenopausal women of the importance of reporting abnormal vaginal bleeding to their healthcare provider as soon as possible [*see Warning and Precautions (5.2)*].

Possible Serious Adverse Reactions with Estrogen Plus Progestin Therapy

Inform postmenopausal women of possible serious adverse reactions of estrogen plus progestin therapy including Cardiovascular Disorders, Malignant Neoplasms, and Probable Dementia [*see Warning and Precautions (5.1, 5.2, 5.3)*].

Possible Less Serious but Common Adverse Reactions with Estrogen plus Progestin Therapy

Inform postmenopausal women of possible less serious but common adverse reactions of estrogen plus progestin therapy such as headache, breast pain and tenderness, nausea and vomiting.

Patient Information

Climara Pro (Klī-mār-uh prō)

(estradiol/levonorgestrel transdermal system)

Read this Patient Information before you start using Climara Pro and each time you get a refill. There may be new information. This information does not take the place of talking to your healthcare provider about your menopausal symptoms or your treatment.

What is the most important information I should know about Climara Pro (combinations of estrogen and a progestin)?

- Do not use estrogens with progestins to prevent heart disease, heart attacks, strokes, or dementia (declines of brain function).
- Using estrogens with progestins may increase your chances of getting heart attacks, strokes, breast cancer, or blood clots.
- Using estrogens with progestins may increase your chance of getting dementia, based on a study of women 65 years of age or older.
- Do not use estrogen-alone to prevent heart disease, heart attacks, strokes or dementia.
- Using estrogen-alone may increase your chance of getting cancer of the uterus (womb).
- Using estrogen-alone may increase your chances of getting strokes or blood clots.
- Using estrogen-alone may increase your chance of getting dementia, based on a study of women 65 years of age or older.
- You and your healthcare provider should talk regularly about whether you still need treatment with Climara Pro.

What is Climara Pro?

Climara Pro is a prescription medicine patch (Transdermal System) that contains two kinds of hormones, an estrogen and a progestin.

What is Climara Pro used for?

Climara Pro is used after menopause to:

- **Reduce moderate to severe hot flashes**

Estrogens are hormones made by a woman's ovaries. The ovaries normally stop making estrogens when a woman is between 45 and 55 years old. This drop in body estrogen levels causes the "change of life" or menopause (the end of monthly menstrual periods). Sometimes, both ovaries are removed during an operation before natural menopause takes place. The sudden drop in estrogen levels causes "surgical menopause."

When the estrogen levels begin dropping, some women get very uncomfortable symptoms, such as feelings of warmth in the face, neck, and chest, or sudden strong feelings of heat and sweating ("hot flashes" or "hot flushes"). In some women, the symptoms are mild, and they will not need to take estrogens. In other women, symptoms can be more severe. You and your healthcare provider should talk regularly about whether or not you still need treatment with Climara Pro.

- **Help reduce your chances of getting osteoporosis (thin weak bones)**

If you use Climara Pro only to prevent osteoporosis due to menopause, talk with your healthcare provider about whether a different treatment or medicine without estrogens might be better for you. You and your healthcare provider should talk regularly about whether you still need treatment with Climara Pro.

Who should not use Climara Pro?

- **Do not use Climara Pro if you have had your uterus (womb) removed (hysterectomy).**

Climara Pro contains a progestin to decrease the chance of getting cancer of the uterus. If you do not have a uterus, you do not need a progestin and you should not use Climara Pro.

- **Do not start using Climara Pro if you:**

- **have unusual vaginal bleeding**

Vaginal bleeding after menopause may be a warning sign of cancer of the uterus (womb). Your healthcare provider should check any unusual vaginal bleeding to find out the cause.

- **currently have or have had certain cancers**

Estrogens may increase the chance of getting certain types of cancers, including cancer of the breast or uterus. If you have or have had cancer, talk with your healthcare provider about whether you should use Climara Pro.

- **had a stroke or heart attack**

- **currently have or have had blood clots**

- **currently have or have had liver problems**

- **have been diagnosed with a bleeding disorder**

- **are allergic to Climara Pro or any of its ingredients**

See the list of ingredients in Climara Pro at the end of this leaflet.

- **think you may be pregnant**

Climara Pro is not for pregnant women. If you think you may be pregnant, you should have a pregnancy test and know the results. Do not use Climara Pro if the test is positive and talk to your healthcare provider.

What should I tell my healthcare provider before I use Climara Pro?

- **Before you use Climara Pro, tell your healthcare provider if you:**

- **have any unusual vaginal bleeding**

Vaginal bleeding after menopause may be a warning sign of cancer of the uterus (womb). Your healthcare provider should check any unusual vaginal bleeding to find out the cause.

- **have any other medical conditions**

Your healthcare provider may need to check you more carefully if you have certain conditions, such as asthma (wheezing), epilepsy (seizures), diabetes, migraine, endometriosis, lupus, angioedema (swelling of face and tongue), or problems with your heart, liver, thyroid, kidneys, or have high calcium levels in your blood.

- **are going to have surgery or will be on bed rest**

Your healthcare provider will let you know if you need to stop using Climara Pro.

- **are breastfeeding**

The hormones in Climara Pro can pass into your breast milk.

Tell your healthcare provider about all the medicines you take, including prescription and nonprescription medicines, vitamins, and herbal supplements. Some medicines may affect how Climara Pro works. Climara Pro may also affect how your other medicines work. Keep a list of your medicines and show it to your healthcare provider and pharmacist when you get a new medicine.

How should I use Climara Pro?

For detailed instructions, see the step-by-step instructions for using Climara Pro at the end of this Patient Information.

- Use Climara Pro exactly as your healthcare provider tells you to use it.
- Climara Pro is for skin use only.
- Change your Climara Pro patch 1 time each week or every 7 days.
- Apply your Climara Pro patch to a clean, dry area on your lower abdomen or buttocks. This area must be clean, dry, and free of powder, oil or lotion for your patch to stick to your skin.
- Apply your Climara Pro patch to a different area of your abdomen or your buttocks each time. Do not use the same application site 2 times in the same week.
- Do not apply Climara Pro to your breasts.
- If you forget to apply a new Climara Pro, you should apply a new patch as soon as possible.
- You and your healthcare provider should talk regularly (every 3 to 6 months) about the dose you are using and whether you still need treatment with Climara Pro.

How do I change Climara Pro?

- When changing Climara Pro, peel off the used patch slowly from the skin.
- After removal of Climara Pro, people usually have either no adhesive residue or light adhesive residue. If any adhesive residue remains on your skin after removing the patch, allow the area to dry for 15 minutes. Then, gently rub the area with an oil-based cream or lotion to remove the adhesive from your skin.
- Keep in mind, **the new patch must be applied to a different skin area of your lower abdomen or buttocks**. This area must be clean, dry, and free of powder, oil or lotion. The same site should not be used again for at least 1 week after removal of the patch.

What are the possible side effects of Climara Pro?

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

Serious, but less common side effects include:

- heart attack
- stroke
- blood clots
- dementia
- breast cancer
- cancer of the lining of the uterus (womb)
- cancer of the ovary
- high blood pressure
- high blood sugar

- gallbladder disease
- liver problems
- changes in your thyroid hormone levels
- enlargement of benign tumors of the uterus (“fibroids”)

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

- new breast lumps
- unusual vaginal bleeding
- changes in vision or speech
- sudden new severe headaches
- severe pains in your chest or legs with or without shortness of breath, weakness and fatigue

Less serious, but common side effects include:

- headache
- breast pain
- irregular vaginal bleeding or spotting
- stomach or abdominal cramps, bloating
- nausea and vomiting
- hair loss
- fluid retention
- vaginal yeast infection
- redness or irritation at the patch placement site

These are not all the possible side effects of Climara Pro. For more information, ask your healthcare provider or pharmacist. Tell your healthcare provider if you have any side effects that bother you or does not go away.

You may report side effects to Bayer Healthcare Pharmaceuticals at 1-888-842-2937 or to FDA at 1-800-FDA-1088.

What can I do to lower my chances of a serious side effect with Climara Pro?

- Talk with your healthcare provider regularly about whether you should continue using Climara Pro.
- See your healthcare provider right away if you get vaginal bleeding while using Climara Pro.
- Have a pelvic exam, breast exam and mammogram (breast X-ray) every year unless your healthcare provider tells you something else.
- If members of your family have had breast cancer or if you have ever had breast lumps or an abnormal mammogram, you may need to have breast exams more often.
- If you have high blood pressure, high cholesterol (fat in the blood), diabetes, are overweight, or if you use tobacco, you may have higher chances for getting heart disease. Ask your healthcare provider for ways to lower your chances of getting heart disease.

How should I store and throw away used Climara Pro?

- Store at room temperature between 68°F to 77°F (20°C to 25°C).

- Do not store Climara Pro patches outside of their pouches. Apply immediately after removal from the protective pouch.
- Used patches still contain estrogen. To throw away the patch, fold the sticky side of the patch together, place it in a sturdy child-proof container, and place this container in the trash. Used patches should not be flushed in the toilet.

KEEP CLIMARA PRO and all medicines out of the reach of children.

General information about the safe and effective use of Climara Pro.

Medicines are sometimes prescribed for conditions that are not mentioned in patient information leaflets. Do not use Climara Pro for conditions for which it was not prescribed. Do not give Climara Pro to other people, even if they have the same symptoms you have. It may harm them.

This leaflet summarizes the most important information about Climara Pro. If you would like more information, talk with your healthcare provider or pharmacist. You can ask for information about Climara Pro that is written for health professionals.

For more information, go to www.climara-us.com or call Bayer HealthCare Pharmaceuticals Inc. at 1-888-842-2937.

What are the ingredients in Climara Pro?

Active ingredient: estradiol and levonorgestrel

Inactive ingredient: acrylate copolymer adhesive, and polyvinylpyrrolidone/vinyl acetate copolymer.

Instructions for Use

Climara Pro (Klī-mâr-uh prō)
(estradiol transdermal system)

Read this Patient Information before you start using Climara Pro and each time you get a refill. There may be new information. This information does not take the place of talking to your healthcare provider about your menopausal symptoms or your treatment.

You will need the following supplies: See Figure A

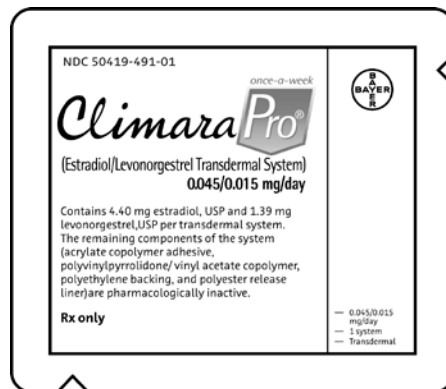


Figure A

Step 1: Pick the days you will change your Climara Pro.

- You will need to change your patch 1 time each week or every 7 days.

Step 2. Remove the Climara Pro patch from the pouch.

- Remove patch from its protective pouch by tearing at the notch (do not use scissors). **See Figure B**

- Do not remove your patch from the protective pouch until you are ready to apply it.

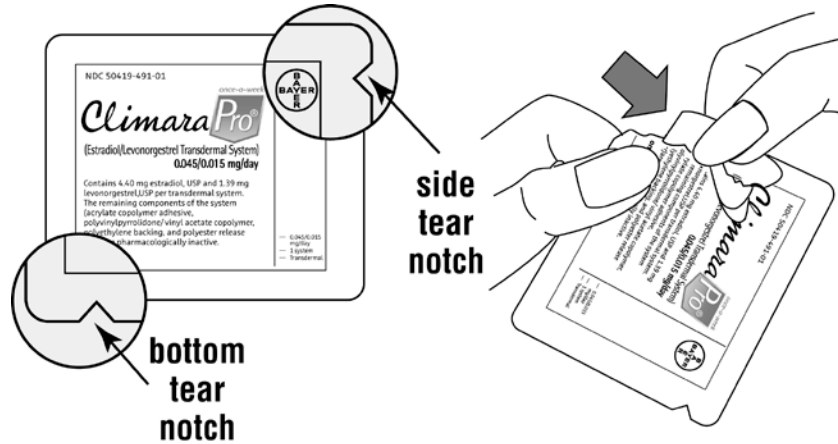


Figure B

Step 3. Remove the adhesive liner. See Figure C

- You will see that Climara Pro is an oval shaped clear patch that is attached to a thick, hard-plastic adhesive liner and covered by a clear, plastic film. **See Figure C**
- To apply your patch you must first remove the protective, clear plastic film that is attached to the clear thicker plastic backing. **See Figure D**
- There is a silver foil-sticker attached to the inside of the pouch. Do not remove the silver foil sticker from the pouch. **See Figure E**

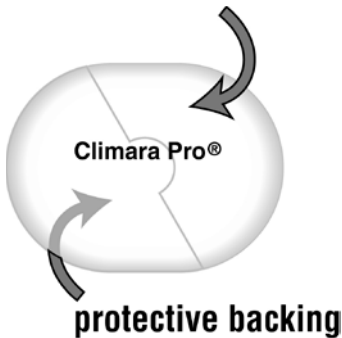


Figure C

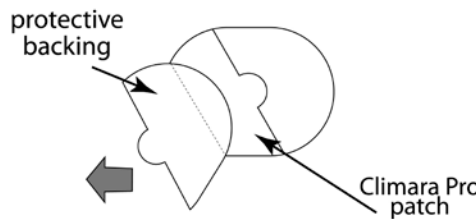


Figure D

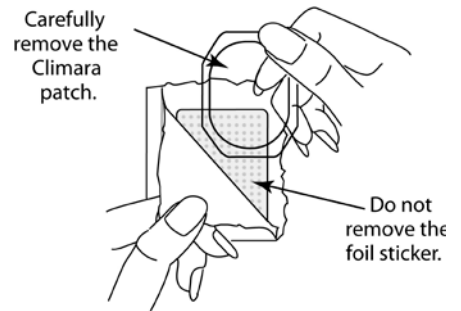


Figure E

Step 4. Placing the patch on your skin.

- Apply the sticky side of the patch to one of the areas of skin shown below. **See Figure F and Figure G**
- **Avoid** touching the sticky side of the patch with your fingers.

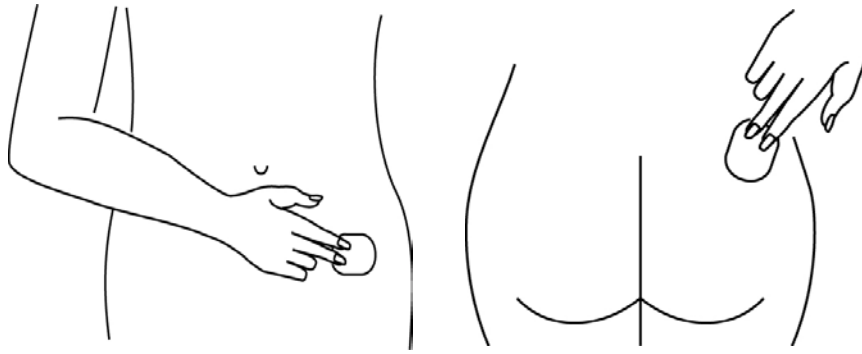


Figure F

Figure G

Note:

- Avoid the waistline, since clothing and belts may cause the patch to be rubbed off.
- Do not apply Climara Pro to your breasts.
- Only apply Climara Pro to skin that is clean, dry, and free of any powder, oil, or lotion.
- You should not apply the patch to injured, burned, or irritated skin, or areas with skin conditions (such as birth marks, tattoos, or that is very hairy).

Step 5. Press the patch firmly onto your skin.

- Press the patch firmly in place with your fingers for at least 10 seconds
- Rub the edges of the patch to make sure that it will stick to your skin. **See Figure H**



Figure H

Note:

- Contact with water while you are swimming, using a sauna, bathing, or showering may cause the patch to fall off.
- If your patch falls off reapply it. If you cannot reapply the patch, apply a new patch to another area (**See Figures F and G**) and continue to follow your original application schedule.
- If you stop using your Climara Pro or forget to apply a new patch as scheduled, you may have spotting, or bleeding, and your symptoms may come back.

Step 6: Throwing away your used patch.

- When it is time to change your patch, remove the old patch before you apply a new patch.

- To throw away the patch, fold the sticky side of the patch together, place it in a sturdy child-proof container, and place this container in the trash. Used patches should not be flushed in the toilet.

This Patient Information and Instructions for Use have been approved by the U.S Food and Drug Administration.

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