

## HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use FLUVIRIN® (Influenza Virus Vaccine) safely and effectively. See full prescribing information for FLUVIRIN®.

**FLUVIRIN® (Influenza Virus Vaccine)**  
**Suspension for Intramuscular Injection**  
**2016-2017 Formula**  
**Initial US Approval: 1988**

### INDICATIONS AND USAGE

- FLUVIRIN® is an inactivated influenza virus vaccine indicated for active immunization of persons 4 years of age and older against influenza disease caused by influenza virus subtypes A and type B contained in the vaccine (1).
- FLUVIRIN® is not indicated for children less than 4 years of age because there is evidence of diminished immune response in this age group (8.4).

### DOSAGE AND ADMINISTRATION

- For intramuscular use only.

Age	Dose	Schedule
4 years through 8 years	One or two doses <sup>a</sup> , 0.5 mL each	If 2 doses, administer at least 1 month apart
9 years and older	One dose, 0.5 mL	-

<sup>a</sup> 1 or 2 doses depends on vaccination history as per Advisory Committee on Immunization Practices annual recommendations on prevention and control of influenza with vaccines.

"-" indicates information is not applicable

### DOSAGE FORMS AND STRENGTHS

FLUVIRIN®, a sterile suspension for intramuscular injection, is supplied in two presentations:

- 0.5 mL single-dose prefilled syringe (3, 11)
- 5.0 mL multi-dose vial containing 10 doses (each dose is 0.5 mL) (3,11)

### CONTRAINDICATIONS

- History of severe allergic reactions (e.g., anaphylaxis) to egg proteins, or any component of FLUVIRIN®, or life-threatening reactions to previous influenza vaccinations. (4.1, 11)

### WARNINGS AND PRECAUTIONS

- If Guillain-Barré syndrome has occurred within 6 weeks of receipt of prior influenza vaccine, the decision to give FLUVIRIN® should be based on careful consideration of the potential benefits and risks. (5.1)
- Immunocompromised persons may have a reduced immune response to FLUVIRIN®. (5.2)
- The tip caps of the FLUVIRIN® prefilled syringes may contain natural rubber latex which may cause allergic reactions in latex sensitive individuals.

### ADVERSE REACTIONS

The most frequently reported adverse reactions are mild hypersensitivity reactions (such as rash), local reactions at the injection site, and influenza-like symptoms. (6)

To report SUSPECTED ADVERSE REACTIONS contact Seqirus at 1-855-358-8966 or VAERS at 1-800-822-7967 and [www.vaers.hhs.gov](http://www.vaers.hhs.gov).

### DRUG INTERACTIONS

- Do not mix with any other vaccine in the same syringe or vial. (7.1)
- Immunosuppressive therapies may reduce immune response to FLUVIRIN®. (7.2)

### USE IN SPECIFIC POPULATIONS

- Safety and effectiveness of FLUVIRIN® have not been established in pregnant women, nursing mothers or children less than 4 years of age. (8.1, 8.3, 8.4)
- Antibody responses were lower in the geriatric population than in younger subjects. (8.5)

See 17 for PATIENT COUNSELING INFORMATION.

Revised: 03/2016

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\* Sections or subsections omitted from the full prescribing information are not listed.

## FULL PRESCRIBING INFORMATION

### 1 INDICATIONS AND USAGE

FLUVIRIN<sup>®</sup> is an inactivated influenza virus vaccine indicated for immunization of persons 4 years of age and older against influenza virus disease caused by influenza virus subtypes A and type B contained in the vaccine [see DOSAGE FORMS AND STRENGTHS (3)].

FLUVIRIN<sup>®</sup> is not indicated for children less than 4 years of age because there is evidence of diminished immune response in this age group.

### 2 DOSAGE AND ADMINISTRATION

#### 2.1 Preparation for Administration

Shake the syringe vigorously before administering the vaccine and shake the multidose vial preparation each time before withdrawing a dose of vaccine. Inspect FLUVIRIN<sup>®</sup> syringes and multidose vials visually for particulate matter and/or discoloration prior to administration [see DESCRIPTION (11)]. If either of these conditions exists, the vaccine should not be administered. Between uses, return the multidose vial to the recommended storage conditions between 2° and 8°C (36° and 46°F). **Do not freeze.** Discard if the vaccine has been frozen.

A separate sterile syringe and needle must be used for each injection to prevent transmission of infectious agents from one person to another. Needles should be disposed of properly and not recapped.

**It is recommended that small syringes (0.5 mL or 1 mL) should be used to minimize any product loss.**

**For intramuscular use only.**

#### 2.2 Recommended Dose and Schedule

The dose and schedule for Fluvirin is presented in Table 1.

**TABLE 1**

**Fluvirin Dose and Schedule**

Age	Dose	Schedule
4 years through 8 years	One or two doses <sup>a</sup> , 0.5 mL each	If 2 doses, administer at least 1 month apart
9 years and older	One dose, 0.5 mL	-

<sup>a</sup> 1 or 2 doses depends on vaccination history as per Advisory Committee on Immunization Practices annual recommendations on prevention and control of influenza with vaccines.

"-" indicates information is not applicable

In children, the needle size may range from 7/8 to 1¼ inches, depending on the size of the child's deltoid muscle, and should be of sufficient length to penetrate the muscle tissue. The anterolateral thigh can be used, but the needle should be longer, usually 1 inch.

In adults, a needle of ≥1 inch is preferred because needles <1 inch might be of insufficient length to penetrate muscle tissue in certain adults. The preferred site for intramuscular injection is the deltoid muscle of the upper arm. The vaccine should not be injected in the gluteal region or areas where there may be a major nerve trunk.

### 3 DOSAGE FORMS AND STRENGTHS

FLUVIRIN<sup>®</sup>, a sterile suspension for intramuscular injection, is supplied in two presentations:

- 0.5 mL single-dose prefilled syringe
- 5.0 mL multi-dose vial containing 10 doses (each dose is 0.5 mL)

### 4 CONTRAINDICATIONS

#### 4.1 Hypersensitivity

Do not administer FLUVIRIN<sup>®</sup> to anyone with known history of severe allergic reactions (e.g., anaphylaxis) to egg proteins (eggs or egg products), or to any component of FLUVIRIN<sup>®</sup>, or who has had a life-threatening reaction to previous influenza vaccinations.

### 5 WARNINGS AND PRECAUTIONS

#### 5.1 GUILLAIN-BARRÉ SYNDROME

If Guillain-Barré syndrome has occurred within 6 weeks of receipt of prior influenza vaccine, the decision to give FLUVIRIN<sup>®</sup> should be based on careful consideration of the potential benefits and risks.

#### 5.2 Altered Immunocompetence

If FLUVIRIN<sup>®</sup> is administered to immunocompromised persons, including individuals receiving immunosuppressive therapy, the expected immune response may not be obtained.

#### 5.3 Preventing and Managing Allergic Reactions

Prior to administration of any dose of FLUVIRIN<sup>®</sup>, the healthcare provider should review the patient's prior immunization history for possible adverse events, to determine the existence of any contraindication to immunization with FLUVIRIN<sup>®</sup> and to allow an assessment of benefits and risks. Appropriate medical treatment and supervision must be available to manage possible anaphylactic reactions following administration of the vaccine.

The tip caps of the FLUVIRIN<sup>®</sup> prefilled syringes may contain natural rubber latex which may cause allergic reactions in latex sensitive individuals.

#### 5.4 Limitations of Vaccine Effectiveness

Vaccination with FLUVIRIN<sup>®</sup> may not protect all individuals.

#### 5.5 Syncope

Syncope (fainting) can occur in association with administration of injectable vaccines, including Fluvirin. Syncope can be accompanied by transient neurological signs such as visual disturbance, paresthesia, and tonic-clonic limb movements. Procedures should be in place to avoid falling injury and to restore cerebral perfusion following syncope by maintaining a supine or Trendelenburg position.

### 6 ADVERSE REACTIONS

#### 6.1 Overall Adverse Reaction Profile

Serious allergic reactions, including anaphylactic shock, have been observed in individuals receiving FLUVIRIN<sup>®</sup> during postmarketing surveillance.

#### 6.2 Clinical Trial Experience

Adverse event information from clinical trials provides a basis for identifying adverse events that appear to be related to vaccine use and for approximating the rates of these events. However, because clinical trials are conducted under widely varying conditions, the adverse reaction rates observed in the clinical trials of a vaccine cannot be directly compared to rates in the clinical trials of another vaccine, and may not reflect rates observed in clinical practice.

#### Adult and Geriatric Subjects

Safety data were collected in a total of 2768 adult and geriatric subjects (18 years of age and older) who have received FLUVIRIN<sup>®</sup> in 29 clinical studies since 1982.

In 9 clinical studies since 1997, among 1261 recipients of FLUVIRIN<sup>®</sup>, 745 (59%) were women; 1211 (96%) were White, 23 (2%) Asian, 15 (1%) Black and 12 (1%) other; 370 (29%) of subjects were elderly (≥65 years of age). All studies have been conducted in the UK, apart from a study run in the US in 2005-2006 where FLUVIRIN<sup>®</sup> was used as a comparator for an unlicensed vaccine.

After vaccination, the subjects were observed for 30 minutes for hypersensitivity or other immediate reactions. Subjects were instructed to complete a diary card for three days following immunization (i.e. Day 1 to 4) to collect local and systemic reactions (see Tables 2 and 3). All local and systemic adverse events were considered to be at least possibly related to the vaccine. Local and systemic reactions mostly began between day 1 and day 2. The overall adverse events reported in clinical trials since 1998 in at least 5% of the subjects are summarized in Table 4.

**TABLE 2**

**Solicited Adverse Events in the First 72-96 Hours After Administration of FLUVIRIN<sup>®</sup> in Adult (18-64 years of age) and Geriatric (≥65 years of age) Subjects.**

	1998-1999 <sup>§</sup>		1999-2000 <sup>§</sup>		2000-2001 <sup>§</sup>	
	18-64 yrs	≥ 65 yrs	18-64 yrs	≥ 65 yrs	18-64 yrs	≥ 65 yrs
	N = 66	N = 44	N = 76	N = 34	N = 75	N = 35
<b>Local Adverse Events</b>						
Pain	16 (24%)	4 (9%)	16 (21%)	-	9 (12%)	-
Mass	7 (11%)	1 (2%)	4 (5%)	-	8 (11%)	1 (3%)
Inflammation	5 (8%)	2 (5%)	6 (8%)	-	7 (9%)	1 (3%)
Ecchymosis	4 (6%)	1 (2%)	3 (4%)	1 (3%)	4 (5%)	-
Edema	2 (3%)	1 (2%)	1 (1%)	2 (6%)	3 (4%)	1 (3%)
Reaction	2 (3%)	-	2 (3%)	-	4 (5%)	1 (3%)
Hemorrhage	-	-	1 (1%)	-	-	-
<b>Systemic Adverse Events</b>						
Headache	7 (11%)	1 (2%)	17 (22%)	3 (9%)	4 (5%)	-
Fatigue	3 (5%)	2 (5%)	4 (5%)	1 (3%)	3 (4%)	-
Malaise	2 (3%)	1 (2%)	2 (3%)	1 (3%)	1 (1%)	-
Myalgia	1 (2%)	-	2 (3%)	-	-	-
Fever	1 (2%)	-	1 (1%)	-	-	-
Arthralgia	-	1 (2%)	-	1 (3%)	-	-
Sweating	-	-	3 (4%)	-	1 (1%)	1 (3%)

	2001-2002 <sup>*,^</sup>		2002-2003 <sup>*,^</sup>		2004-2005 <sup>*,^</sup>	
	18-64 yrs	≥ 65 yrs	18-64 yrs	≥ 65 yrs	18-64 yrs	≥ 65 yrs
	N = 75	N = 35	N = 107	N = 88	N = 74	N = 61
<b>Local Adverse Events</b>						
Pain	12 (16%)	1 (3%)	14 (13%)	7 (8%)	15 (20%)	9 (15%)
Mass	4 (5%)	1 (3%)	-	-	-	-
Ecchymosis	2 (3%)	-	3 (3%)	3 (3%)	2 (3%)	1 (2%)
Edema	2 (3%)	1 (3%)	6 (6%)	2 (2%)	-	-
Erythema	5 (7%)	-	11 (10%)	5 (6%)	16 (22%)	5 (8%)
Swelling	-	-	-	-	11 (15%)	4 (7%)
Reaction	-	-	2 (2%)	-	-	-
Induration	-	-	14 (13%)	3 (3%)	11 (15%)	1 (2%)
Pruritus	-	-	1 (1%)	-	-	-
<b>Systemic Adverse Events</b>						
Headache	8 (11%)	1 (3%)	12 (11%)	9 (10%)	14 (19%)	3 (5%)
Fatigue	1 (1%)	1 (3%)	-	-	5 (7%)	2 (3%)
Malaise	3 (4%)	-	3 (3%)	4 (5%)	1 (1%)	1 (2%)
Myalgia	3 (4%)	-	5 (5%)	3 (3%)	8 (11%)	1 (2%)
Fever	-	-	-	1 (1%)	-	-
Arthralgia	-	-	2 (2%)	-	1 (1%)	-
Sweating	3 (4%)	1 (3%)	-	2 (2%)	-	-
Shivering	-	-	-	1 (1%)	-	-

Results reported to the nearest whole percent; Fever defined as >38°C

- not reported

\* Solicited adverse events in the first 72 hours after administration of FLUVIRIN<sup>®</sup>

§ Solicited adverse events reported by COSTART preferred term

^ Solicited adverse events reported by MEDDRA preferred term

**TABLE 3**

**Solicited Adverse Events in the First 72 Hours After Administration of FLUVIRIN<sup>®</sup> in Adult Subjects (18-49 years of age).**

	2005-2006 US Trial FLUVIRIN <sup>®</sup> N = 304
<b>Local Adverse Events</b>	
Pain	168 (55%)
Erythema	48 (16%)
Ecchymosis	22 (7%)
Induration	19 (6%)
Swelling	16 (5%)
<b>Systemic Adverse Events</b>	
Headache	91 (30%)
Myalgia	64 (21%)
Malaise	58 (19%)
Fatigue	56 (18%)
Sore throat	23 (8%)
Chills	22 (7%)
Nausea	21 (7%)
Arthralgia	20 (7%)
Sweating	17 (6%)
Cough	18 (6%)
Wheezing	4 (1%)
Chest tightness	4 (1%)
Other difficulties breathing	3 (1%)
Facial edema	-

Results reported to the nearest whole percent

- not reported

**TABLE 4**

**Adverse Events Reported by at least 5% of Subjects in Clinical Trials since 1998**

	1998-1999 <sup>§</sup>		1999-2000 <sup>§</sup>		2000-2001 <sup>§</sup>	
	18-64 yrs	≥ 65 yrs	18-64 yrs	≥ 65 yrs	18-64 yrs	≥ 65 yrs
	N = 66	N = 44	N = 76	N = 34	N = 75	N = 35
<b>Adverse Events</b>						
Fatigue	8 (12%)	2 (5%)	8 (11%)	2 (6%)	5 (7%)	-
Back pain	4 (6%)	3 (7%)	-	-	-	-
Cough increased	2 (3%)	2 (5%)	-	-	-	-
Ecchymosis	4 (6%)	1 (2%)	4 (5%)	1 (3%)	5 (7%)	-
Fever	3 (5%)	-	-	-	-	-
Headache	12 (18%)	5 (11%)	22 (29%)	5 (15%)	14 (19%)	2 (6%)
Infection	3 (5%)	2 (5%)	-	-	-	-
Malaise	4 (6%)	4 (9%)	4 (5%)	1 (3%)	-	-
Migraine	4 (6%)	1 (2%)	-	-	-	-
Myalgia	4 (6%)	1 (2%)	-	-	-	-
Sweating	5 (8%)	1 (2%)	-	-	-	-
Rhinitis	3 (5%)	1 (2%)	-	-	5 (7%)	2 (6%)
Pharyngitis	6 (9%)	1 (2%)	10 (13%)	-	6 (8%)	-
Arthralgia	-	-	-	2 (6%)	-	-
Injection site pain	16 (24%)	4 (9%)	16 (21%)	-	9 (12%)	-
Injection site ecchymosis	4 (6%)	1 (2%)	-	-	4 (5%)	-
Injection site mass	7 (11%)	1 (2%)	4 (5%)	-	8 (11%)	1 (3%)
Injection site edema	-	-	1 (1%)	2 (6%)	-	-
Injection site inflammation	5 (8%)	2 (5%)	6 (8%)	-	7 (9%)	1 (3%)
Injection site reaction	-	-	-	-	4 (5%)	1 (3%)

	2001-2002 <sup>^</sup>		2002-2003 <sup>^</sup>		2004-2005 <sup>^</sup>	
	18-64 yrs	≥ 65 yrs	18-64 yrs	≥ 65 yrs	18-64 yrs	≥ 65 yrs
	N = 75	N = 35	N = 107	N = 88	N = 74	N = 61
<b>Adverse Events</b>						
Fatigue	5 (7%)	4 (11%)	11 (10%)	8 (9%)	4 (5%)	2 (3%)
Hypertension	-	-	1 (1%)	4 (5%)	-	-
Rinorrhea	-	-	2 (2%)	5 (6%)	-	-
Headache	20 (27%)	2 (6%)	35 (33%)	18 (20%)	12 (16%)	1 (2%)
Malaise	6 (8%)	1 (3%)	13 (12%)	8 (9%)	-	-
Myalgia	4 (5%)	1 (3%)	10 (9%)	4 (5%)	-	-
Sweating	3 (4%)	3 (9%)	2 (2%)	5 (6%)	-	-
Rhinitis	4 (5%)	-	-	-	-	-
Pharyngitis	-	-	-	-	6 (8%)	-
Arthralgia	-	-	5 (5%)	4 (5%)	-	-
Sore throat	4 (5%)	1 (3%)	5 (5%)	4 (5%)	-	-
Injection site pain	13 (17%)	3 (9%)	14 (13%)	7 (8%)	6 (8%)	2 (3%)
Injection site ecchymosis	4 (5%)	1 (3%)	4 (4%)	4 (5%)	-	-
Injection site erythema	5 (7%)	2 (6%)	11 (10%)	5 (6%)	4 (5%)	-
Injection site mass	4 (5%)	1 (3%)	-	-	-	-
Injection site edema	-	-	6 (6%)	2 (2%)	4 (5%)	1 (2%)
Injection site induration	-	-	14 (13%)	3 (3%)	7 (9%)	-

Results reported to the nearest whole percent; Fever defined as >38°C

- not reaching the cut-off of 5%

§ Solicited adverse events reported by COSTART preferred term

^ Solicited adverse events reported by MEDDRA preferred term

### Adults (18 to 64 years of age)

In adult subjects, solicited local adverse events occurred with similar frequency in all trials. The most common solicited adverse events occurring in the first 96 hours after administration (Tables 2 and 3) were associated with the injection site (such as pain, erythema, mass, induration and swelling) but were generally mild/moderate and transient. The most common solicited systemic adverse events were headache and myalgia.

The most common overall events in adult subjects (18-64 years of age) were headache, fatigue, injection site reactions (pain, mass, erythema, and induration) and malaise (Table 4).

### Geriatric Subjects (65 years of age and older)

In geriatric subjects, solicited local and systemic adverse events occurred less frequently than in adult subjects. The most common solicited local and systemic adverse events were injection site pain, and headache (Tables 2 and 3). All were considered mild/moderate and were transient.

The most common overall events in elderly subjects ( $\geq 65$  years of age) were headache and fatigue.

Only 11 serious adverse events in adult and geriatric subjects (18 years and older) have been reported to date from all the trials performed. These serious adverse events were a minor stroke experienced by a 67 year old subject 14 days after vaccination (1990), death of an 82 year old subject 35 days after vaccination (1990) in very early studies; death of a 72 year old subject 19 days after vaccination (1998-1999), a hospitalization for hemorrhoidectomy of a 38 year old male subject (1999-2000), a severe respiratory tract infection experienced by a 74 year old subject 12 days after vaccination (2002-2003), a planned transurethral resection of the prostate in a subject with prior history of prostatism (2004-2005), two cases of influenza (2005-2006), a drug overdose (2005-2006), cholelithiasis (2005-2006) and a nasal septal operation (2005-2006). None of these events were considered causally related to vaccination.

### Clinical Trial Experience in Pediatric Subjects

In 1987 a clinical study was carried out in 38 'at risk' children aged between 4 and 12 years (17 females and 21 males). To record the safety of FLUVIRIN<sup>®</sup>, participants recorded their symptoms on a diary card during the three days after vaccination and noted any further symptoms they thought were attributable to the vaccine. The only reactions recorded were tenderness at the site of vaccination in 21% of the participants on day 1, which was still present in 16% on day 2 and 5% on day 3. In one child, the tenderness was also accompanied by redness at the site of injection for two days. The reactions were not age-dependent and there was no bias towards the younger children. Three clinical studies were carried out between 1995 and 2004 in a total of 520 pediatric subjects (age range 6 - 47 months). Of these, 285 healthy subjects plus 41 'at risk' subjects received FLUVIRIN<sup>®</sup>. No serious adverse events were reported.

FLUVIRIN<sup>®</sup> should only be used for the immunization of persons aged 4 years and over.

### 6.3 Postmarketing Experience

The following additional adverse reactions have been reported during post-approval use of FLUVIRIN<sup>®</sup>. 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 vaccine exposure. Adverse events described here are included because: a) they represent reactions which are known to occur following immunizations generally or influenza immunizations specifically; b) they are potentially serious; or c) the frequency of reporting.

- *Body as a whole*: Local injection site reactions (including pain, pain limiting limb movement, redness, swelling, warmth, ecchymosis, induration), hot flashes/flushes; chills; fever; malaise; shivering; fatigue; asthenia; facial edema.
- *Immune system disorders*: Hypersensitivity reactions (including throat and/or mouth edema). In rare cases, hypersensitivity reactions have led to anaphylactic shock and death.
- *Cardiovascular disorders*: Vasculitis (in rare cases with transient renal involvement), presyncope, syncope shortly after vaccination.
- *Digestive disorders*: Diarrhea; nausea; vomiting; abdominal pain.
- *Blood and lymphatic disorders*: Local lymphadenopathy; thrombocytopenia (some very rare cases were severe with platelet counts less than 5,000 per mm<sup>3</sup>).
- *Metabolic and nutritional disorders*: Loss of appetite.
- *Musculoskeletal*: Arthralgia; myalgia; myasthenia.
- *Nervous system disorders*: Headache; dizziness; neuralgia; paraesthesia; confusion; febrile convulsions; Guillain-Barré Syndrome; myelitis (including encephalomyelitis and transverse myelitis); neuropathy (including neuritis); paralysis (including Bell's Palsy).
- *Respiratory disorders*: Dyspnea; chest pain; cough; pharyngitis; rhinitis.

- *Skin and appendages*: Stevens-Johnson syndrome; sweating; pruritus; urticaria; rash (including non-specific, maculopapular, and vesiculobulbous).
- *General disorders and administration site conditions*: Injection site cellulitis-like reaction (very rare cases of swelling, pain, and redness were large and extended to the entire arm).

### 6.4 Other Adverse Reactions Associated with Influenza Vaccination

Anaphylaxis has been reported after administration of FLUVIRIN<sup>®</sup>. Although FLUVIRIN<sup>®</sup> contains only a limited quantity of egg protein, this protein can induce immediate hypersensitivity reactions among persons who have severe egg allergy. Allergic reactions include hives, angioedema, allergic asthma, and systemic anaphylaxis [see CONTRAINDICATIONS (4)].

The 1976 swine influenza vaccine was associated with an increased frequency of Guillain-Barré syndrome (GBS). Evidence for a causal relation of GBS with subsequent vaccines prepared from other influenza viruses is unclear. If influenza vaccine does pose a risk, it is probably slightly more than 1 additional case/1 million persons vaccinated.

Neurological disorders temporally associated with influenza vaccination such as encephalopathy, optic neuritis/neuropathy, partial facial paralysis, and brachial plexus neuropathy have been reported.

Microscopic polyangiitis (vasculitis) has been reported temporally associated with influenza vaccination.

## 7 DRUG INTERACTIONS

### 7.1 Concomitant Administration with Other Vaccines

There are no data to assess the concomitant administration of FLUVIRIN<sup>®</sup> with other vaccines. If FLUVIRIN<sup>®</sup> is to be given at the same time as another injectable vaccine(s), the vaccines should always be administered at different injection sites.

FLUVIRIN<sup>®</sup> should not be mixed with any other vaccine in the same syringe or vial.

### 7.2 Concurrent Use with Immunosuppressive Therapies

Immunosuppressive therapies, including irradiation, antimetabolites, alkylating agents, cytotoxic drugs, and corticosteroids (used in greater than physiologic doses), may reduce the immune response to FLUVIRIN<sup>®</sup>.

## 8 USE IN SPECIFIC POPULATIONS

### 8.1 Pregnancy

Pregnancy Category B: A reproductive and developmental toxicity study has been performed in rabbits at a dose level that was approximately 15 times the human dose based on body weight. The study revealed no evidence of impaired fertility or harm to the fetus due to FLUVIRIN<sup>®</sup>. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this vaccine should be used during pregnancy only if clearly needed.

In a reproductive and developmental toxicity study, the effect of FLUVIRIN<sup>®</sup> on embryo-fetal and post-natal development was evaluated in pregnant rabbits. Animals were administered FLUVIRIN<sup>®</sup> by intramuscular injection twice prior to gestation, during the period of organogenesis (gestation day 7) and later in pregnancy (gestation day 20), 0.5 mL/rabbit/occasion (approximately 15-fold excess relative to the projected human dose on a body weight basis). No adverse effects on mating, female fertility, pregnancy, embryo-fetal development, or post-natal development were observed. There were no vaccine related fetal malformations or other evidence of teratogenicity.

### 8.3 Nursing Mothers

It is not known whether FLUVIRIN<sup>®</sup> is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when FLUVIRIN<sup>®</sup> is administered to a nursing woman.

### 8.4 Pediatric Use

The safety and immunogenicity of FLUVIRIN<sup>®</sup> have not been established in children under 4 years of age.

The safety and immunogenicity of FLUVIRIN<sup>®</sup> have been established in the age group 4 years to 16 years. The use of FLUVIRIN<sup>®</sup> in these age groups is supported by evidence from adequate and well controlled studies of FLUVIRIN<sup>®</sup> in adults that demonstrate the immunogenicity of FLUVIRIN<sup>®</sup> [see ADVERSE REACTIONS (6) and CLINICAL STUDIES (14)].

### 8.5 Geriatric Use

Since 1997, of the total number of geriatric subjects (n = 397) in clinical studies of FLUVIRIN<sup>®</sup>, 29% were 65 years and over, while 2.1% were 75 years and over. Antibody responses were lower in the geriatric population than in younger subjects. Adverse events occurred less frequently in geriatric subjects ( $\geq 65$  years) than in younger adults. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. [See ADVERSE REACTION (6) and CLINICAL STUDIES (14)].

## 11 DESCRIPTION

FLUVIRIN<sup>®</sup> is a trivalent, sub-unit (purified surface antigen) influenza virus vaccine prepared from virus propagated in the allantoic cavity of embryonated hens' eggs inoculated with a specific type of influenza virus suspension containing neomycin and polymyxin. Each of the influenza virus strains is harvested and clarified separately by centrifugation and filtration prior to inactivation with betapropiolactone. The inactivated virus is concentrated and purified by zonal centrifugation. The surface antigens, hemagglutinin and neuraminidase, are obtained from the influenza virus particle by further centrifugation in the presence of nonylphenol ethoxylate, a process which removes most of the internal proteins. The nonylphenol ethoxylate is removed from the surface antigen preparation.

FLUVIRIN<sup>®</sup> is a homogenized, sterile, slightly opalescent suspension in a phosphate buffered saline. FLUVIRIN<sup>®</sup> has been standardized according to USPHS requirements for the 2016-2017 influenza season and is formulated to contain 45 mcg hemagglutinin (HA) per 0.5-mL dose in the recommended ratio of 15 mcg HA of each of the following 3 viruses: A/Christchurch/16/2010, NIB-74 (H1N1) (an A/California/7/2009 pdm09-like virus); A/Hong Kong/4801/2014, NYMC X-263B (H3N2) (an A/Hong Kong/4801/2014-like virus); and B/Brisbane/60/2008, wild type (a B/Brisbane/60/2008-like virus). The 0.5-mL prefilled syringe presentation is formulated without preservative. However, thimerosal, a mercury derivative used during manufacturing, is removed by subsequent purification steps to a trace amount ( $\leq 1$  mcg mercury per 0.5-mL dose).

The 5-mL multidose vial formulation contains thimerosal, a mercury derivative, added as a preservative. Each 0.5-mL dose from the multidose vial contains 25 mcg mercury.

Each dose from the multidose vial or from the prefilled syringe may also contain residual amounts of egg proteins ( $\leq 1$  mcg ovalbumin), polymyxin ( $\leq 3.75$  mcg), neomycin ( $\leq 2.5$  mcg), betapropiolactone (not more than 0.5 mcg) and nonylphenol ethoxylate (not more than 0.015% w/v).

The tip caps of the FLUVIRIN<sup>®</sup> prefilled syringes may contain natural rubber latex. The multidose vial stopper and the syringe stopper/plunger do not contain latex.

## 12 CLINICAL PHARMACOLOGY

### 12.1 Mechanism of Action

Influenza illness and its complications follow infection with influenza viruses. Global surveillance of influenza identifies yearly antigenic variants. For example, since 1977, antigenic variants of influenza A (H1N1 and H3N2) viruses and influenza B viruses have been in global circulation. Specific levels of hemagglutination inhibition (HI) antibody titers post-vaccination with inactivated influenza virus vaccine have not been correlated with protection from influenza illness. In some human studies, antibody titer of  $\geq 1:40$  have been associated with protection from influenza illness in up to 50% of subjects [see REFERENCES (15.1, 15.2)].

Antibody against one influenza virus type or subtype confers limited or no protection against another. Furthermore, antibody to one antigenic variant of influenza virus might not protect against a new antigenic variant of the same type or subtype. Frequent development of antigenic variants through antigenic drift is the virologic basis for seasonal epidemics and the reason for the usual change of one or more new strains in each year's influenza vaccine. Therefore, inactivated influenza vaccines are standardized to contain the hemagglutinin of strains (i.e., typically two type A and one type B), representing the influenza viruses likely to be circulating in the United States in the upcoming winter. Annual revaccination with the current vaccine is recommended because immunity declines during the year after vaccination, and because circulating strains of influenza virus change from year to year [see REFERENCES (15.3)].

## 13 NONCLINICAL TOXICOLOGY

### 13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

FLUVIRIN<sup>®</sup> has not been evaluated for carcinogenic or mutagenic potential, or for impairment of fertility.

## 14 CLINICAL STUDIES

Between 1982 and 1991, twelve clinical studies were conducted in healthy adult and geriatric subjects and one in children between 4 and 12 years of age who were considered to be 'at risk'. Since 1991 an annual clinical study has been conducted in the UK in healthy adults aged 18 years or older. FLUVIRIN<sup>®</sup> was also used as a control in a US clinical trial in adults (18-49 years of age). In all the trials, blood samples were taken prior to vaccination and approximately three weeks after vaccination to assess the immunogenic response to vaccination by measurement of anti-HA antibodies.

Three clinical studies were carried out between 1995 and 2004 in a total of 520 pediatric subjects (age range 6-47 months). Of these, 285 healthy subjects plus 41 'at risk' pediatric subjects received FLUVIRIN<sup>®</sup>.

FLUVIRIN<sup>®</sup> should only be used for the immunization of persons aged 4 years and over.

### 14.1 Immunogenicity in Adults (18 to 64 years of age)

Tables 5 and 6 show the immunogenicity data for the adult age group. The seven clinical studies presented enrolled a total of 774 adult subjects. In the adult group, for all antigens (A/H1N1, A/H3N2 and B) at least one of the following point estimate criteria was met: the proportion of subjects with seroconversion (post-vaccination titer  $\geq 1:40$  from a pre-vaccination titer  $< 1:10$ ) or significant increase (at least a four-fold increase from pre-vaccination titer  $\geq 1:10$ ) in antibody titer was greater than 40%; the geometric mean titer (GMT) increase was  $> 2.5$ ; the proportion of subjects with a post-vaccination hemagglutination inhibition (HI) antibody titer  $\geq 1:40$  was greater than 70%.

TABLE 5

Summary of the Seroconversion and Proportion of Subjects Achieving an HI Titer  $\geq 1:40$  for Adult Subjects

Year/Strain	No. of subjects	Seroconversion <sup>™</sup>			HI titer $\geq 1:40$ <sup>†</sup>		
		N	%	95% CI <sup>‡</sup>	N	%	95% CI <sup>‡</sup>
<b>1998-1999</b>							
A/H1N1	66	48	73	(62, 83)	50	76	(65, 86)
A/H3N2		43	65	(54, 77)	47	71	(60, 82)
B		42	64	(52, 75)	62	94	(88, 100)
<b>1999-2000</b>							
A/H1N1	76	45	59	(48, 70)	50	66	(55, 76)
A/H3N2		51	67	(57, 78)	66	87	(79, 94)
B		53	70	(59, 80)	75	99	(96, 100)
<b>2000-2001</b>							
A/H1N1	74	41	55	(44, 67)	41	55	(44, 67)
A/H3N2		45	61	(50, 72)	52	84	(75, 92)
B		50	68	(57, 78)	73	99	(96, 100)
<b>2001-2002</b>							
A/H1N1	75	44	59	(48, 70)	48	64	(53, 75)
A/H3N2		46	61	(50, 72)	68	91	(84, 97)
B		42	56	(45, 67)	66	88	(81, 95)
<b>2002-2003</b>							
A/H1N1	106	62	58	(49, 68)	73	69	(60, 78)
A/H3N2		72	68	(59, 77)	93	88	(81, 94)
B		78	74	(65, 82)	101	95	(91, 99)
<b>2004-2005</b>							
A/H1N1	74	52	70	(59, 80)	66	89	(80, 95)
A/H3N2		60	81	(70, 89)	73	99	(93, 100)
B		57	77	(66, 86)	69	93	(85, 98)
<b>2005-2006</b>							
A/H1N1	303	191	63	(57, 68)	296	98	(95, 99)
A/H3N2		273	90	(86, 93)	294	97	(94, 99)
B		213	70	(65, 75)	263	87	(82, 90)

<sup>™</sup> Seroconversion: proportion of subjects with either a post-vaccination HI titer  $\geq 1:40$  from a pre-vaccination titer  $< 1:10$  or at least a four-fold increase from pre-vaccination HI titer  $\geq 1:10$  in antibody titer.

<sup>†</sup> HI titer  $\geq 1:40$ : proportion of subjects with a post-vaccination titer  $\geq 1:40$ .

<sup>‡</sup> 95% CI: 95% confidence interval

TABLE 6

Summary of the Geometric Mean Hemagglutination Inhibition Antibody Titers, Pre- and Post-Immunization, for Adult Subjects

Year/Strain	No. of subjects	Geometric Mean Titer (GMT)			
		Pre-vaccination	Post-vaccination	Fold Increase	(95% CI)*
<b>1998-1999</b>					
A/H1N1	66	7.26	160.87	22.16	(14.25, 34.46)
A/H3N2		8.23	87.02	10.57	(6.91, 16.16)
B		20.97	231.07	110.2	(6.90, 17.59)
<b>1999-2000</b>					
A/H1N1	76	7.43	58.95	7.93	(5.73, 10.97)
A/H3N2		15.29	122.83	8.03	(5.80, 11.13)
B		25.70	254.76	9.91	(6.97, 14.10)
<b>2000-2001</b>					
A/H1N1	74	5.42	33.80	6.24	(4.49, 8.69)
A/H3N2		15.98	126.01	7.89	(5.61, 11.09)
B		26.24	308.25	11.75	(7.73, 17.85)
<b>2001-2002</b>					
A/H1N1	75	7.76	54.78	7.06	(5.24, 9.52)
A/H3N2		23.67	153.81	6.50	(4.78, 8.84)
B		19.91	107.53	5.40	(3.95, 7.38)

Year/Strain	No. of subjects	Geometric Mean Titer (GMT)			
		Pre-vaccination	Post-vaccination	Fold Increase	(95% CI)*
<b>2002-2003</b>					
A/H1N1	106	7.78	60.39	7.77	(5.81, 10.39)
A/H3N2		23.32	292.03	12.52	(8.77, 17.87)
B		30.20	314.11	10.40	(7.54, 14.34)
<b>2004-2005</b>					
A/H1N1	74	13	159	12	(8.39, 17)
A/H3N2		37	658	18	(12, 26)
B		15	156	11	(7.87, 14)
<b>2005-2006</b>					
A/H1N1	303	29	232	8	(6.68, 9.59)
A/H3N2		14	221	15	(14, 17)
B		13	83	6.5	(5.73, 7.37)

\* 95% CI: 95% confidence interval

#### 14.2 Immunogenicity in Geriatric Subjects (65 years of age and older)

Tables 7 and 8 show the immunogenicity of FLUVIRIN<sup>®</sup> in the geriatric age group. The six clinical studies presented enrolled a total of 296 geriatric subjects. For each of the influenza antigens, the percentage of subjects who achieved seroconversion and the percentage of subjects who achieved HI titers of  $\geq 1:40$  are shown, as well as the fold increase in GMT.

For all antigens (A/H1N1, A/H3N2 and B) at least one of the following point estimate criteria was met: the proportion of subjects with seroconversion (post-vaccination titer  $\geq 1:40$  from a pre-vaccination titer  $< 1:10$ ) or significant increase (at least a four-fold increase from pre-vaccination titer  $\geq 1:10$ ) in antibody titer was greater than 30%; the geometric mean titer (GMT) increase was  $> 2.0$ ; the proportion of subjects with a post-vaccination hemagglutination inhibition (HI) antibody titer  $\geq 1:40$  was greater than 60%. The pre-specified efficacy criteria were met in each study, although a relatively lower immunogenicity of A/H1N1 strain was seen in the last four studies (the same strain was in each of the formulations).

**TABLE 7**

**Summary of the Seroconversion and Proportion of Subjects Achieving an HI titer  $\geq 1:40$  for Geriatric Subjects**

Year/Strain	No. of subjects	Seroconversion <sup>™</sup>			HI titer $\geq 1:40$ <sup>‡</sup>		
		N	%	95% CI <sup>§</sup>	N	%	95% CI <sup>§</sup>
<b>1998-1999</b>							
A/H1N1	42	33	79	(66, 91)	38	90	(82, 99)
A/H3N2		33	79	(66, 91)	36	86	(75, 96)
B		13	31	(17, 45)	42	100	(100, 100)
<b>1999-2000</b>							
A/H1N1	34	10	29	(14, 45)	23	68	(52, 83)
A/H3N2		18	53	(36, 70)	31	91	(82, 100)
B		9	26	(12, 41)	32	94	(86, 100)
<b>2000-2001</b>							
A/H1N1	35	5	14	(3, 26)	10	29	(14, 44)
A/H3N2		22	63	(47, 79)	31	89	(78, 99)
B		13	37	(21, 53)	33	94	(87, 100)
<b>2001-2002</b>							
A/H1N1	35	5	14	(3, 26)	14	40	(24, 56)
A/H3N2		15	43	(26, 59)	33	94	(87, 100)
B		6	17	(5, 30)	32	91	(82, 100)
<b>2002-2003</b>							
A/H1N1	89	24	27	(18, 36)	52	58	(48, 69)
A/H3N2		42	47	(37, 58)	85	96	(91, 100)
B		41	46	(36, 56)	86	97	(93, 100)
<b>2004-2005</b>							
A/H1N1	61	17	28	(17, 41)	46	75	(63, 86)
A/H3N2		29	48	(35, 61)	60	98	(91, 100)
B		38	62	(49, 74)	51	84	(72, 92)

<sup>™</sup> Seroconversion: proportion of subjects with either a post-vaccination HI titer  $\geq 1:40$  from a pre-vaccination titer  $< 1:10$  or at least a four-fold increase from pre-vaccination HI titer  $\geq 1:10$  in antibody titer

<sup>‡</sup> HI titer  $\geq 1:40$ : proportion of subjects with a post-vaccination titer  $\geq 1:40$

<sup>§</sup> 95% CI: 95% confidence interval

**TABLE 8**

**Summary of the Geometric Mean Hemagglutination Inhibition Antibody Titers, Pre- and Post-Immunization, for Geriatric Subjects**

Year/Strain	No. of subjects	Geometric Mean Titer (GMT)			
		Pre-vaccination	Post-vaccination	Fold Increase	(95% CI)*
<b>1998-1999</b>					
A/H1N1	42	13.92	176.65	12.69	(8.24, 19.56)
A/H3N2		10.69	124.92	11.69	(7.02, 19.46)
B		114.1	273.56	2.40	(1.82, 3.17)
<b>1999-2000</b>					
A/H1N1	34	15.82	50.58	3.20	(2.13, 4.80)
A/H3N2		28.00	133.19	4.76	(2.92, 7.76)
B		57.16	127.86	2.24	(1.56, 3.20)
<b>2000-2001</b>					
A/H1N1	35	6.66	18.85	2.83	(1.91, 4.18)
A/H3N2		25.87	140.68	5.44	(3.72, 7.96)
B		61.24	191.23	3.12	(2.13, 4.59)
<b>2001-2002</b>					
A/H1N1	35	12.69	26.65	2.10	(1.55, 2.84)
A/H3N2		47.33	114.26	2.41	(1.73, 3.38)
B		45.49	91.89	2.02	(1.47, 2.78)
<b>2002-2003</b>					
A/H1N1	89	13.29	31.92	2.40	(1.90, 3.03)
A/H3N2		65.86	272.79	4.14	(3.09, 5.55)
B		74.87	288.57	3.85	(2.89, 5.13)
<b>2004-2005</b>					
A/H1N1	61	21	64	3.13	(2.33, 4.2)
A/H3N2		72	320	4.43	(3.13, 6.27)
B		20	114	5.69	(4.39, 7.38)

\* 95% CI: 95% confidence interval

#### 14.3 Immunogenicity in Pediatric Subjects

A small-scale study, was conducted in 1987 to evaluate safety and immunogenicity of FLUVIRIN<sup>®</sup> in 38 'at risk' children, with diabetes and/or asthma, or lymphoid leukemia. Thirty-eight participants aged between 4 and 12 years of age were assessed. Ten subjects had diabetes, 21 had asthma, two had both diabetes and asthma, and one had lymphoid leukemia. There were four healthy control subjects. All participants received a single 0.5-mL dose of FLUVIRIN<sup>®</sup>.

Immunogenicity results were obtained for 19 of the 38 subjects enrolled in the study. The point estimate of the percentage of subjects achieving a titer of  $\geq 1:40$  was 84% for the A/H1N1 strain 79% for the B strain, and 53% for the A/H3N2 strain. The GMT fold increases were 5.8 for the A/H1N1 strain, 40 for the B strain and 17.7 for the A/H3N2 strain.

Three clinical studies were carried out between 1995 and 2004 in a total of 520 pediatric subjects (age range 6-47 months). Of these, 285 healthy subjects plus 41 'at risk' pediatric subjects, received FLUVIRIN<sup>®</sup>.

In a 1995/1996 clinical study, 41 subjects (aged 6-36 months) at increased risk for influenza-related complications received two 0.25-mL doses of FLUVIRIN<sup>®</sup>. At least 49% of subjects showed a  $\geq 4$ -fold increase in HI antibody titer to all three strains. HI antibody titers of 1:40 or greater were seen in at least 71% of the subjects for all three influenza strains, with increases in geometric mean titer of 6.0-fold or greater to all three strains.

Two clinical studies (1999-2000 and 2004) indicated a lower immunogenicity profile for FLUVIRIN<sup>®</sup> compared with two commercial split vaccines; in a study in the age group 6-47 months the comparator was a US licensed vaccine, Fluzone<sup>®</sup>, and in another study in the age group 6-36 months the comparator was a non-US licensed inactivated influenza vaccine. Despite the small sample size (a total of 285 healthy subjects received FLUVIRIN<sup>®</sup> in these two clinical studies) the lower immunogenicity profile of FLUVIRIN<sup>®</sup> was greatest versus the comparator vaccines in children  $< 36$  months but was also evident in those 36-47 months of age, though the differences were less.

FLUVIRIN<sup>®</sup> should only be used for the immunization of persons aged 4 years and over.

## References

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## 16 HOW SUPPLIED/STORAGE AND HANDLING

### 16.1 How Supplied

FLUVIRIN® product presentations are listed in Table 9 below:

**TABLE 9**

**Fluvirin Product Presentations**

Presentation	Carton NDC Number	Components
Pre-filled syringe	70461-119-02	0.5 mL single dose pre-filled syringe, package of 10 syringes per carton (may contain latex) [NDC 70461-119-12]
Multi-dose vial	70461-119-10	5.0 mL multi-dose vial, individually packaged in a carton (contains no latex) [NDC 70461-119-11]

### 16.2 Storage and Handling

Store FLUVIRIN® refrigerated between 2° and 8°C (36° and 46°F).

**Do not freeze.** Discard if the vaccine has been frozen.

Store in the original package to protect from light.

Do not use after the expiration date.

Between uses, return the multidose vial to the recommended storage conditions.

## 17 PATIENT COUNSELING INFORMATION

Vaccine recipients and guardians should be informed by their healthcare provider of the potential benefits and risks of immunization with FLUVIRIN®. When educating vaccine recipients and guardians regarding the potential side effects, clinicians should emphasize that (1) FLUVIRIN® contains non-infectious particles and cannot cause influenza and (2) FLUVIRIN® is intended to provide protection against illness due to influenza viruses only, and cannot provide protection against all respiratory illness.

Vaccine recipients and guardians should be instructed to report any severe or unusual adverse reactions to their healthcare provider.

Vaccine recipients and guardians should be instructed that annual vaccination is recommended.



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