

SUMMARY OF PRODUCT CHARACTERISTICS

1. NAME OF THE MEDICINAL PRODUCT

Dronis 30 Tablet

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains:

Drospirenone.....3 mg

Ethinylestradiol0.030 mg

For the full list of excipients, see **section 6.1**.

3. PHARMACEUTICAL FORM

Film-coated tablets

4. CLINICAL PARTICULARS

4.1 *Therapeutic indications*

Oral contraception

The decision to prescribe **Dronis 30** should take into consideration the individual woman's current risk factors, particularly those for venous thromboembolism (VTE), and how the risk of VTE with Drospirenone 3 mg and Ethinylestradiol 0.03 mg tablets compares with other combined hormonal contraceptives (CHCs), see **sections 4.3** and **4.4**.

4.2 *Posology and method of administration*

Posology

How to take Dronis 30

The tablets must be taken every day at about the same time, if necessary with a little liquid, in the order shown on the blister pack. One tablet is to be taken daily for 21 consecutive days. Each subsequent pack is started after a 7-day tablet-free interval, during which time a withdrawal bleed usually occurs. This usually starts on day 2-3 after the last tablet and may not have finished before the next pack is started.

How to start Dronis 30

- No preceding hormonal contraceptive use (in the past month)

Tablet-taking has to start on day 1 of the woman's natural cycle (i.e. the first day of her menstrual bleeding).

- Changing from a combined hormonal contraceptive (combined oral contraceptive (COC), vaginal ring, or transdermal patch)

The woman should start with **Dronis 30** preferably on the day after the last active tablet (the last tablet containing the active substances) of her previous COC, but at the latest on the day following the usual tablet-free or placebo tablet interval of her previous COC. In case a vaginal ring or transdermal patch has been used, the woman should start using **Dronis 30** preferably on the day of removal, but at the latest when the next application would have been due.

- Changing from a progestogen-only-method (progestogen-only pill, injection, implant) or from a progestogen-releasing intrauterine system (IUS)

The woman may switch any day from the progestogen-only pill (from an implant or the IUS on the day of its removal, from an injectable when the next injection would be due) but should in all of these cases be advised to additionally use a barrier method for the first 7 days of tablet taking.

- Following first-trimester abortion

The woman may start immediately. When doing so, she need not take additional contraceptive measures.

- Following delivery or second-trimester abortion

Women should be advised to start at day 21 to 28 after delivery or second-trimester abortion. When starting later, the woman should be advised to additionally use a barrier method for the first 7 days. However, if intercourse has already occurred, pregnancy should be excluded before the actual start of COC use or the woman has to wait for her first menstrual period.

For breastfeeding women see Section 4.6

Management of missed tablets

If the user is **less than 12 hours** late in taking any tablet, contraceptive protection is not reduced. The woman should take the tablet as soon as she remembers and should take further tablets at the usual time.

If she is **more than 12 hours** late in taking any tablet, contraceptive protection may be reduced. The management of missed tablets can be guided by the following two basic rules:

1. tablet-taking must never be discontinued for longer than 7 days
2. 7 days of uninterrupted tablet-taking are required to attain adequate suppression of the hypothalamic-pituitary-ovarian-axis.

Accordingly, the following advice can be given in daily practice:

- Week 1

The user should take the last missed tablet as soon as she remembers, even if this means taking two tablets at the same time. She then continues to take tablets at her usual time. In addition, a barrier method such as a condom should be used for the next 7 days. If intercourse took place

in the preceding 7 days, the possibility of a pregnancy should be considered. The more tablets are missed and the closer they are to the regular tablet-free interval, the higher the risk of a pregnancy.

- Week 2

The user should take the last missed tablet as soon as she remembers, even if this means taking two tablets at the same time. She then continues to take tablets at her usual time. Provided that the woman has taken her tablets correctly in the 7 days preceding the first missed tablet, there is no need to use extra contraceptive precautions. However, if she has missed more than 1 tablet, the woman should be advised to use extra precautions for 7 days.

- Week 3

The risk of reduced reliability is imminent because of the forthcoming 7-day tablet-free interval. However, by adjusting the tablet-intake schedule, reduced contraceptive protection can still be prevented. By adhering to either of the following two options, there is therefore no need to use extra contraceptive precautions, provided that in the 7 days preceding the first missed tablet the woman has taken all tablets correctly. If this is not the case, she should follow the first of these two options and use extra precautions for the next 7 days as well.

1. The user should take the last missed tablet as soon as she remembers, even if this means taking two tablets at the same time. She then continues to take tablets at her usual time. The next blister pack must be started as soon as the current blister pack is finished, i.e., no gap should be left between packs. The user is unlikely to have a withdrawal bleed until the end of the second pack, but she may experience spotting or breakthrough bleeding on tablet-taking days.
2. The woman may also be advised to discontinue tablet-taking from the current blister pack. She should then have a tablet-free interval of up to 7 days, including the days she missed tablets, and subsequently continue with the next blister pack.

If the woman missed tablets and subsequently has no withdrawal bleed in the first normal tablet-free interval, the possibility of a pregnancy should be considered.

Advice in case of gastro-intestinal disturbances

In case of severe gastro-intestinal disturbances (e.g. vomiting or diarrhoea), absorption may not be complete and additional contraceptive measures should be taken.

If vomiting occurs within 3-4 hours after tablet taking, a new (replacement) tablet should be taken as soon as possible. The new tablet should be taken within 12 hours of the usual time of tablet-taking if possible. If more than 12 hours elapse, the advice concerning missed tablets, as given in Section 4.2 “Management of missed tablets”, is applicable. If the woman does not want to change her normal tablet-taking schedule, she has to take the extra tablet(s) from another blister pack.

How to postpone a withdrawal bleed

To delay a period the woman should continue with another blister pack of **Dronis 30** without a tablet-free interval. The extension can be carried on for as long as wished until the end of the second pack. During the extension the woman may experience breakthrough-bleeding or spotting. Regular intake of **Dronis 30** is then resumed after the usual 7-day tablet-free interval. To shift her periods to another day of the week than the woman is used to with her current scheme, she can be advised to shorten her forthcoming tablet-free interval by as many days as she likes. The shorter the interval, the higher the risk that she does not have a withdrawal bleed and will experience breakthrough-bleeding and spotting during the subsequent pack (just as when delaying a period).

Additional information on special populations

Children and adolescents

Dronis 30 is only indicated after menarche. Based on reported epidemiological data collected on more than 2000 adolescent women aged below 18 years, there are no data indicating that safety and efficacy in this young age group is different from that known in women aged above 18 years.

Elderly

Dronis 30 is not indicated after menopause.

Patients with hepatic impairment

Dronis 30 is contraindicated in women with severe hepatic diseases. See also **sections 4.3 and 5.2**.

Patients with renal impairment

Dronis 30 is contraindicated in women with severe renal insufficiency or acute renal failure. See also **sections 4.3 and 5.2**.

Method of administration

Oral use

4.3 Contraindications

Combined hormonal contraceptives (CHCs) should not be used in the following conditions. Should any of the conditions appear for the first time during CHC use, the product should be stopped immediately.

- Presence or risk of venous thromboembolism (VTE)
 - Venous thromboembolism – current VTE (on anticoagulants) or history of (e.g. deep venous thrombosis [DVT] or pulmonary embolism [PE])

- Known hereditary or acquired predisposition for venous thromboembolism, such as APC resistance, (including Factor V Leiden), antithrombin-III-deficiency, protein C deficiency, protein S deficiency
- Major surgery with prolonged immobilisation (see **section 4.4**)
- A high risk of venous thromboembolism due to the presence of multiple risk factors (see **section 4.4**)
- Presence or risk of arterial thromboembolism (ATE)
 - Arterial thromboembolism – current arterial thromboembolism, history of arterial thromboembolism (e.g. myocardial infarction) or prodromal condition (e.g. angina pectoris)
 - Cerebrovascular disease – current stroke, history of stroke or prodromal condition (e.g. transient ischaemic attack, TIA)
 - Known hereditary or acquired predisposition for arterial thromboembolism, such as hyperhomocysteinaemia and antiphospholipid-antibodies (anticardiolipin-antibodies, lupus anticoagulant)
 - History of migraine with focal neurological symptoms
 - A high risk of arterial thromboembolism due to multiple risk factors (see **section 4.4**) or to the presence of one serious risk factor such as:
 - diabetes mellitus with vascular symptoms
 - severe hypertension
 - severe dyslipoproteinaemia
- Presence or history of severe hepatic disease as long as liver function values have not returned to normal
- Severe renal insufficiency or acute renal failure
- Presence or history of liver tumours (benign or malignant)
- Known or suspected sex-steroid influenced malignancies (e.g. of the genital organs or the breasts)
- Undiagnosed vaginal bleeding
- Hypersensitivity to the active substances or to any of the excipients listed in **section 6.1**.

Dronis 30 is contraindicated for concomitant use with the medicinal products containing ombitasvir/paritaprevir/ritonavir and dasabuvir medicinal products containing glecaprevir/pibrentasvir or sofosbuvir/velpatasvir/voxilaprevir (see **section 4.5**).

4.4 Special warnings and precautions for use

Warnings

- If any of the conditions or risk factors mentioned below is present, the suitability of Drospirenone 3 mg and Ethinylestradiol 0.03 mg tablets should be discussed with the woman.
- In the event of aggravation, or first appearance of any of these conditions or risk factors, the woman should be advised to contact her doctor to determine whether the use of Drospirenone 3 mg and Ethinylestradiol 0.03 mg tablets should be discontinued.

- In case of suspected or confirmed VTE or ATE, CHC use should be discontinued. In case anticoagulant therapy is started, adequate alternative contraception should be initiated because of the teratogenicity of anticoagulant therapy (coumarins).
- Circulatory Disorders

Risk of venous thromboembolism (VTE)

The use of any combined hormonal contraceptive (CHC) increases the risk of venous thromboembolism (VTE) compared with no use. **Products that contain levonorgestrel, norgestimate or norethisterone are associated with the lowest risk of VTE. Other products such as Drospirenone 3 mg and Ethinylestradiol 0.03 mg tablets may have up to twice this level of risk. The decision to use any product other than one with the lowest VTE risk should be taken only after a discussion with the woman to ensure she understands the risk of VTE with Drospirenone 3 mg and Ethinylestradiol 0.03 mg tablets, how her current risk factors influence this risk, and that her VTE risk is highest in the first ever year of use. There is also some reported evidence that the risk is increased when a CHC is re-started after a break in use of 4 weeks or more.**

In women who do not use a CHC and are not pregnant, about 2 out of 10,000 will develop a VTE over the period of one year. However, in any individual woman the risk may be far higher, depending on her underlying risk factors (see below).

It is estimated that out of 10,000 women who use a CHC containing drospirenone between 9 and 12 women will develop a VTE in one year; this compares with about 6 in women who use a levonorgestrel-containing CHC.

In both cases, the number of VTEs per year is fewer than the number expected during pregnancy or in the postpartum period.

VTE may be fatal in 1-2% of the cases.

Number of VTE events per 10,000 women in one year

- Non-CHC user (2 events)
- Levonorgestrel-containing CHC (5-7 events)
- Drospirone-containing CHC (9-12 events)

Extremely rarely, thrombosis has been reported to occur in CHC users in other blood vessels, e.g. hepatic, mesenteric, renal or retinal veins and arteries.

Risk factors for VTE

The risk for venous thromboembolic complications in CHC users may increase substantially in a woman with additional risk factors, particularly if there are multiple risk factors (see table).

Dronis 30 is contraindicated if a woman has multiple risk factors that put her at high risk of venous thrombosis (see **section 4.3**). If a woman has more than one risk factor, it is possible that the increase in risk is greater than the sum of the individual factors – in this case her total risk of VTE should be considered. If the balance of benefits and risks is considered to be negative a CHC should not be prescribed (see **section 4.3**).

Table: Risk factors for VTE

Risk factor	Comment
Obesity (body mass index over 30 kg/m ²)	Risk increases substantially as BMI rises. Particularly important to consider if other risk factors also present.
Prolonged immobilisation, major surgery, any surgery to the legs or pelvis, neurosurgery, or major trauma Note: temporary immobilisation including air travel >4 hours can also be a risk factor for VTE, particularly in women with other risk factors	In these situations it is advisable to discontinue use of the pill (in the case of elective surgery at least four weeks in advance) and not resume until two weeks after complete remobilisation. Another method of contraception should be used to avoid unintentional pregnancy. Antithrombotic treatment should be considered if Drospirenone 3 mg and Ethinylestradiol 0.03 mg tablets have not been discontinued in advance.
Positive family history (venous thromboembolism ever in a sibling or parent especially at a relatively early age e.g. before 50).	If a hereditary predisposition is suspected, the woman should be referred to a specialist for advice before deciding about any CHC use
Other medical conditions associated with VTE	Cancer, systemic lupus erythematosus, haemolytic uraemic syndrome, chronic inflammatory bowel disease (Crohn's disease or ulcerative colitis) and sickle cell disease
Increasing age	Particularly above 35 years

There is no consensus about the possible role of varicose veins and superficial thrombophlebitis in the onset or progression of venous thrombosis.

The increased risk of thromboembolism in pregnancy, and particularly the 6-week period of the puerperium, must be considered (for information on “Pregnancy and lactation” see **section 4.6**).

Symptoms of VTE (deep vein thrombosis and pulmonary embolism)

In the event of symptoms women should be advised to seek urgent medical attention and to inform the healthcare professional that she is taking a CHC.

Symptoms of deep vein thrombosis (DVT) can include:

- unilateral swelling of the leg and/or foot or along a vein in the leg;
- pain or tenderness in the leg which may be felt only when standing or walking,

- increased warmth in the affected leg; red or discoloured skin on the leg.

Symptoms of pulmonary embolism (PE) can include:

- sudden onset of unexplained shortness of breath or rapid breathing;
- sudden coughing which may be associated with haemoptysis;
- sharp chest pain;
- severe light headedness or dizziness;
- rapid or irregular heartbeat.

Some of these symptoms (e.g. “shortness of breath”, “coughing”) are non-specific and might be misinterpreted as more common or less severe events (e.g. respiratory tract infections).

Other signs of vascular occlusion can include: sudden pain, swelling and slight blue discolouration of an extremity.

If the occlusion occurs in the eye symptoms can range from painless blurring of vision which can progress to loss of vision. Sometimes loss of vision can occur almost immediately.

Risk of arterial thromboembolism (ATE)

Reported epidemiological studies have associated the use of CHCs with an increased risk for arterial thromboembolism (myocardial infarction) or for cerebrovascular accident (e.g. transient ischaemic attack, stroke). Arterial thromboembolic events may be fatal.

Risk factors for ATE

The risk of arterial thromboembolic complications or of a cerebrovascular accident in CHC users increases in women with risk factors (see table). **Dronis 30** is contraindicated if a woman has one serious or multiple risk factors for ATE that puts her at high risk of arterial thrombosis (see **section 4.3**). If a woman has more than one risk factor, it is possible that the increase in risk is greater than the sum of the individual factors - in this case her total risk should be considered. If the balance of benefits and risks is considered to be negative a CHC should not be prescribed (see **section 4.3**).

Table: Risk factors for ATE

<u>Risk factor</u>	<u>Comment</u>
Increasing age	Particularly above 35 years
Smoking	Women should be advised not to smoke if they wish to use a CHC. Women over 35 who continue to smoke should be strongly advised to use a different method of contraception.
Hypertension	
Obesity (body mass index over 30 kg/m ²)	Risk increases substantially as BMI increases. Particularly important in women with additional risk factors

Positive family history (arterial thromboembolism ever in a sibling or parent especially at relatively early age e.g. below 50).	If a hereditary predisposition is suspected, the woman should be referred to a specialist for advice before deciding about any CHC use
Migraine	An increase in frequency or severity of migraine during CHC use (which may be prodromal of a cerebrovascular event) may be a reason for immediate discontinuation
Other medical conditions associated with adverse vascular events	Diabetes mellitus, hyperhomocysteinaemia, valvular heart disease and atrial fibrillation, dyslipoproteinaemia and systemic lupus erythematosus.

Symptoms of ATE

In the event of symptoms women should be advised to seek urgent medical attention and to inform the healthcare professional that she is taking a CHC.

Symptoms of a cerebrovascular accident can include:

- sudden numbness or weakness of the face, arm or leg, especially on one side of the body;
- sudden trouble walking, dizziness, loss of balance or coordination;
- sudden confusion, trouble speaking or understanding;
- sudden trouble seeing in one or both eyes;
- sudden, severe or prolonged headache with no known cause;
- loss of consciousness or fainting with or without seizure.

Temporary symptoms suggest the event is a transient ischaemic attack (TIA).

Symptoms of myocardial infarction (MI) can include:

- pain, discomfort, pressure, heaviness, sensation of squeezing or fullness in the chest, arm, or below the breastbone;
- discomfort radiating to the back, jaw, throat, arm, stomach;
- feeling of being full, having indigestion or choking;
- sweating, nausea, vomiting or dizziness;
- extreme weakness, anxiety, or shortness of breath;
- rapid or irregular heartbeats.

• Tumours

An increased risk of cervical cancer in long-term users of COCs (> 5 years) has been reported in some reported epidemiological studies, but there continues to be controversy about the extent to which this finding is attributable to the confounding effects of sexual behaviour and other factors such as human papilloma virus (HPV).

A reported meta-analysis from many epidemiological studies shown that there is a slightly increased relative risk (RR = 1.24) of having breast cancer diagnosed in women who are

currently using COCs. The excess risk gradually disappears during the course of the 10 years after cessation of COC use. Because breast cancer is rare in women under 40 years of age, the excess number of breast cancer diagnoses in current and recent COC users is small in relation to the overall risk of breast cancer. These reported studies do not provide evidence for causation. The observed pattern of increased risk may be due to an earlier diagnosis of breast cancer in COC users, the biological effects of COCs or a combination of both. The breast cancers diagnosed in ever-users tend to be less advanced clinically than the cancers diagnosed in never-users.

In rare cases, benign liver tumours, and even more rarely, malignant liver tumours have been reported in users of COCs. In isolated cases, these tumours have led to life-threatening intra-abdominal haemorrhages. A hepatic tumour should be considered in the differential diagnosis when severe upper abdominal pain, liver enlargement or signs of intra-abdominal haemorrhage occur in women taking COCs.

With the use of the higher-dosed COCs (50 µg ethinylestradiol) the risk of endometrial and ovarian cancer is reduced. Whether this also applies to lower-dosed COCs remains to be confirmed.

- Other conditions

The progestogen component in **Dronis 30** is an aldosterone antagonist with potassium sparing properties. In most cases, no increase of potassium levels is to be expected. In a reported clinical study, however, in some patients with mild or moderate renal impairment and concomitant use of potassium-sparing medicinal products, serum potassium levels slightly, but not significantly, increased during drospirenone intake. Therefore, it is recommended to check serum potassium during the first treatment cycle in patients presenting with renal insufficiency and a pretreatment serum potassium in the upper reference range, and particularly during concomitant use of potassium sparing medicinal products. See also **section 4.5**.

Women with hypertriglyceridaemia, or a family history thereof, may be at an increased risk of pancreatitis when using COCs.

Although small increases in blood pressure have been reported in many women taking COCs, clinically relevant increases are rare. Only in these rare cases an immediate discontinuation of COC use is justified. If, during the use of a COC in preexisting hypertension, constantly elevated blood pressure values or a significant increase in blood pressure do not respond adequately to antihypertensive treatment, the COC must be withdrawn. Where considered appropriate, COC use may be resumed if normotensive values can be achieved with antihypertensive therapy.

The following conditions have been reported to occur or deteriorate with both pregnancy and COC use, but the evidence of an association with COC use is inconclusive: jaundice and/or

pruritus related to cholestasis; gallstones; porphyria; systemic lupus erythematosus; haemolytic uraemic syndrome; Sydenham's chorea; herpes gestationis; otosclerosis-related hearing loss.

Exogenous oestrogens may induce or exacerbate symptoms of hereditary and acquired angioedema.

Acute or chronic disturbances of liver function may necessitate the discontinuation of COC use until markers of liver function return to normal. Recurrence of cholestatic jaundice and/or cholestasis-related pruritus which previously occurred during pregnancy or during previous use of sex steroids necessitates the discontinuation of COCs.

Although COCs may have an effect on peripheral insulin resistance and glucose tolerance, there is no evidence for a need to alter the therapeutic regimen in diabetics using low-dose COCs (containing < 0.05 mg ethinylestradiol). However, diabetic women should be carefully observed, particularly in the early stage of COC use.

Worsening of endogenous depression, of epilepsy, of Crohn's disease and of ulcerative colitis has been reported during COC use.

Depressed mood and depression are well-known undesirable effects of hormonal contraceptive use (see **section 4.8**). Depression can be serious and is a well-known risk factor for suicidal behavior and suicide. Women should be advised to contact their physician in case of mood changes and depressive symptoms, including shortly after initiating the treatment.

Chloasma may occasionally occur, especially in women with a history of chloasma gravidarum. Women with a tendency to chloasma should avoid exposure to the sun or ultraviolet radiation whilst taking COCs.

Medical examination/consultation

Prior to the initiation or reinstitution of **Dronis 30** a complete medical history (including family history) should be taken and pregnancy must be ruled out. Blood pressure should be measured and a physical examination should be performed, guided by the contra-indications (see **section 4.3**) and warnings (see **section 4.4**). It is important to draw a woman's attention to the information on venous and arterial thrombosis, including the risk of Drospirenone 3 mg and Ethinylestradiol 0.03 mg tablets compared with other CHCs, the symptoms of VTE and ATE, the known risk factors and what to do in the event of a suspected thrombosis.

The woman should also be instructed to carefully read the user leaflet and to adhere to the advice given. The frequency and nature of examinations should be based on established practice guidelines and be adapted to the individual woman.

Women should be advised that hormonal contraceptives do not protect against HIV infections (AIDS) and other sexually transmitted diseases.

Reduced efficacy

The efficacy of COCs may be reduced in the event of e.g. missed tablets (see **section 4.2**), gastro-intestinal disturbances (see **section 4.2**) or concomitant medication (see **section 4.5**).

Reduced cycle control

With all COCs, irregular bleeding (spotting or breakthrough bleeding) may occur, especially during the first months of use. Therefore, the evaluation of any irregular bleeding is only meaningful after an adaptation interval of about three cycles.

If bleeding irregularities persist or occur after previously regular cycles, then non-hormonal causes should be considered and adequate diagnostic measures are indicated to exclude malignancy or pregnancy. These may include curettage.

In some women withdrawal bleeding may not occur during the tablet-free interval. If the COC has been taken according to the directions described in Section 4.2, it is unlikely that the woman is pregnant. However, if the COC has not been taken according to these directions prior to the first missed withdrawal bleed or if two withdrawal bleeds are missed, pregnancy must be ruled out before COC use is continued.

Dronis 30 contains lactose

This medicinal product contains lactose. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption who are on a lactose-free diet should take this amount into consideration.

4.5 Interaction with other medicinal products and other forms of interaction

Note: The prescribing information of concomitant medications should be consulted to identify potential interactions.

- **Effects of other medicinal products on Drospirenone 3 mg and Ethinylestradiol 0.03 mg tablets**

Interactions can occur with drugs that induce microsomal enzymes which can result in increased clearance of sex hormones and which may lead to breakthrough bleeding and/or contraceptive failure.

Management

Enzyme induction can already be observed after a few days of treatment. Maximal enzyme induction is generally seen within a few weeks. After the cessation of drug therapy enzyme induction may be sustained for about 4 weeks.

Short-term treatment

Women on treatment with enzyme-inducing drugs should temporarily use a barrier method or another method of contraception in addition to the COC. The barrier method must be used during the whole time of the concomitant drug therapy and for 28 days after its discontinuation. If the drug therapy runs beyond the end of the tablets in the COC pack, the next COC pack should be started right after the previous one without the usual tablet-free interval.

Long-term treatment

In women on long-term treatment with hepatic enzyme-inducing active substances, another reliable, non-hormonal, method of contraception is recommended.

The following interactions have been reported in the literature.

Substances increasing the clearance of COCs (diminished efficacy of COCs by enzyme-induction), e.g.:

Barbiturates, bosentan, carbamazepine, phenytoin, primidone, rifampicin, and HIV medication ritonavir, nevirapine and efavirenz and possibly also felbamate, griseofulvin, oxcarbazepine, topiramate and products containing the herbal remedy St. John's Wort (*Hypericum perforatum*).

Substances with variable effects on the clearance of COCs:

When co-administered with COCs many combinations of HIV protease inhibitors and non-nucleoside reverse transcriptase inhibitors, including combinations with HCV inhibitors can increase or decrease plasma concentrations of estrogen or progestins. The net effect of these changes may be clinically relevant in some cases.

Therefore, the prescribing information of concomitant HIV/HCV medications should be consulted to identify potential interactions and any related recommendations. In case of any doubt, an additional barrier contraceptive method should be used by women on protease inhibitor or non-nucleoside reverse transcriptase inhibitor therapy.

Substances decreasing the clearance of COCs (enzyme inhibitors)

The clinical relevance of potential interactions with enzyme inhibitors remains unknown. Concomitant administration of strong CYP3A4 inhibitors can increase plasma concentrations of the estrogen or the progestin or both.

In a reported multiple dose study with a drospirenone (3 mg/day) / ethinylestradiol (0.02 mg/day) combination, co-administration of the strong CYP3A4 inhibitor ketoconazole for 10 days increased the AUC(0-24h) of drospirenone and ethinylestradiol 2.7 fold and 1.4 fold respectively.

Etoricoxib doses of 60 to 120 mg/day have been reported to increase plasma concentrations of ethinylestradiol 1.4 to 1.6-fold, respectively when taken concomitantly with a combined hormonal contraceptive containing 0.035 mg ethinylestradiol.

- **Effects of Drospirenone 3 mg and Ethinylestradiol 0.03 mg tablets on other medicinal products**

COCs may affect the metabolism of certain other active substances. Accordingly, plasma and tissue concentrations may either increase (e.g. ciclosporin) or decrease (e.g. lamotrigine).

Based on reported *in vivo* interaction studies in female volunteers using omeprazole, simvastatin or midazolam as marker substrate, a clinically relevant interaction of drospirenone at doses of 3 mg with the cytochrome P450 mediated metabolism of other active substances is unlikely.

Reported clinical data suggests that ethinylestradiol is inhibiting the clearance of CYP1A2 substrates leading to a weak (e.g. theophylline) or moderate (e.g. tizanidine) increase in their plasma concentration.

- **Pharmacodynamic interactions**

During reported clinical trials with patients treated for hepatitis C virus infections (HCV) with medicinal products containing ombitasvir/paritaprevir/ritonavir and dasabuvir with or without ribavirin, transaminase (ALT) elevations higher than 5 times the upper limit of normal (ULN) occurred significantly more frequent in women using ethinylestradiol-containing medications such as combined hormonal contraceptives (CHCs). Additionally, also in patients treated with glecaprevir/pibrentasvir or sofosbuvir/velpatasvir/voxilaprevir, ALT elevations were observed in women using ethinylestradiol-containing medications such as CHCs (see **section 4.3**).

Therefore, Drospirenone 3 mg and Ethinylestradiol 0.03 mg tablets-users must switch to an alternative method of contraception (e.g., progestagen-only contraception or non-hormonal methods) prior to starting therapy with this combination drug regimen. Drospirenone 3 mg and Ethinylestradiol 0.03 mg tablets can be restarted 2 weeks following completion of treatment with this combination drug regimen.

In patients without renal insufficiency, the concomitant use of drospirenone and ACE-inhibitors or NSAIDs have been reported to not show a significant effect on serum potassium. Nevertheless, concomitant use of Drospirenone 3 mg and Ethinylestradiol 0.03 mg tablets with aldosterone antagonists or potassium-sparing diuretics has not been reported. In this case, serum potassium should be tested during the first treatment cycle. See also **section 4.4**.

- **Other forms of interaction**

Laboratory tests

The use of contraceptive steroids may influence the results of certain laboratory tests, including biochemical parameters of liver, thyroid, adrenal and renal function, plasma levels of (carrier)

proteins, e.g. corticosteroid-binding globulin and lipid/lipoprotein fractions, parameters of carbohydrate metabolism and parameters of coagulation and fibrinolysis. Changes generally remain within the normal laboratory range. Drospirenone causes an increase in plasma renin activity and plasma aldosterone induced by its mild antimineralocorticoid activity.

4.6 Fertility, pregnancy and lactation

Pregnancy

Dronis 30 is not indicated during pregnancy.

If pregnancy occurs during use of Drospirenone 3 mg and Ethinylestradiol 0.03 mg tablets, the preparation should be withdrawn immediately. Extensive epidemiological studies have reported neither an increased risk of birth defects in children born to women who used COCs prior to pregnancy, nor a teratogenic effect when COCs were taken inadvertently during pregnancy.

Reported animal studies have shown undesirable effects during pregnancy and lactation (see **section 5.3**). Based on these animal data, undesirable effects due to hormonal action of the active compounds cannot be excluded. However, general experience with COCs during pregnancy did not provide evidence for an actual undesirable effect in humans.

The reported data regarding the use of Drospirenone 3 mg and Ethinylestradiol 0.03 mg tablets during pregnancy are too limited to permit conclusions concerning negative effects of Drospirenone 3 mg and Ethinylestradiol 0.03 mg tablets on pregnancy, health of the foetus or neonate. To date, no relevant epidemiological data are reported.

The increased risk of VTE during the postpartum period should be considered when re-starting Drospirenone 3 mg and Ethinylestradiol 0.03 mg tablets (see **section 4.2** and **4.4**).

Breastfeeding

Lactation may be influenced by COCs as they may reduce the quantity and change the composition of breast milk. Therefore, the use of COCs should generally not be recommended until the breast-feeding mother has completely weaned her child. Small amounts of the contraceptive steroids and/or their metabolites may be excreted with the milk during COC use. These amounts may affect the child.

4.7 Effects on ability to drive and use machines

No studies on the effects on the ability to drive and use machines have been reported. No effects on ability to drive and use machines have been observed in users of COCs.

4.8 Undesirable effects

For serious undesirable effects in COC users see also **section 4.4**.

The following adverse drug reactions have been reported during use of Drospirenone 3 mg and Ethinylestradiol 0.03 mg tablets:

System Organ Class (MedDRA)	Frequency of adverse reactions			
	Common ≥ 1/100 to <1/10	Uncommon ≥ 1/1,000 to < 1/100	Rare ≥ 1/10,000 to < 1/1000	Not known
Immune system disorders			Hypersensitivity Asthma	Exacerbation of symptoms of hereditary and acquired angioedema
Psychiatric disorders	Depressive mood	Libido increased Libido decreased		
Nervous system disorders	Headache			
Ear and labyrinth disorders			Hypoacusis	
Vascular disorders	Migraine	Hypertension, Hypotension	Venous thromboembolism (VTE) Arterial thromboembolism (ATE)	
Gastrointestinal disorders	Nausea	Vomiting, Diarrhoea		
Skin and subcutaneous tissue disorders		Acne, Eczema, Pruritus, Alopecia	Erythema nodosum Erythema multiforme	
Reproductive system and breast disorders	Menstrual disorders, Intermenstrual bleeding, Breast pain, Breast tenderness, Vaginal discharge, Vulvovaginal candidiasis	Breast enlargement, Vaginal infection	Breast discharge	
General disorders and administration site conditions		Fluid retention, Weight increased, Weight decreased		

Description of selected adverse reactions

An increased risk of arterial and venous thrombotic and thrombo-embolic events, including myocardial infarction, stroke, transient ischaemic attacks, venous thrombosis and pulmonary embolism has been reported in women using CHCs, which are discussed in more detail in **section 4.4**.

The following serious adverse events have been reported in women using COCs, which are discussed in section 4.4 Special warnings and precautions for use:

- Venous thromboembolic disorders;
- Arterial thromboembolic disorders;
- Hypertension;
- Liver tumours;
- Occurrence or deterioration of conditions for which association with COC use is not conclusive: Crohn's disease, ulcerative colitis, epilepsy, uterine myoma, porphyria, systemic lupus erythematosus, herpes gestationis, Sydenham's chorea, haemolytic uremic syndrome, cholestatic jaundice;
- Chloasma;
- Acute or chronic disturbances of liver function may necessitate the discontinuation of COC use until markers of liver function return to normal.

The frequency of diagnosis of breast cancer is very slightly increased among COC users. As breast cancer is rare in women under 40 years of age the excess number is small in relation to the overall risk of breast cancer. Causation with COC use is unknown. For further information, see **sections 4.3** and **4.4**.

Interactions

Breakthrough bleeding and/or contraceptive failure may result from interactions of other drugs (enzyme inducers) with oral contraceptives (see **section 4.5**).

Reporting of suspected adverse reactions

Reporting of suspected adverse reactions: Healthcare professionals are requested to report any suspected adverse reactions via the Pharmacy and Poisons Reporting System ([PvERS](https://pv.pharmacyboardkenya.org)) <https://pv.pharmacyboardkenya.org>

4.9 Overdose

There has not yet been any experience of overdose reported with Drospirenone 3 mg and Ethinylestradiol 0.03 mg tablets. On the basis of general experience with combined oral contraceptives, symptoms that may possibly occur in this case are nausea, vomiting and, withdrawal bleeding. Withdrawal bleeding may even occur in girls before their menarche, if they accidentally take the medicinal product. There are no antidotes and further treatment should be symptomatic.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group (ATC): Progestogens and estrogens, fixed combinations

ATC Code: G03AA 12

Pearl Index for method failure: 0.09 (upper two-sided 95 % confidence limit: 0.32).

Overall Pearl Index (method failure + patient failure): 0.57 (upper two-sided 95 % confidence limit: 0.90).

The contraceptive effect of Drospirenone 3 mg and Ethinylestradiol 0.03 mg tablets is based on the interaction of various factors, the most important of which are seen as the inhibition of ovulation and the changes in the endometrium.

Dronis 30 is a combined oral contraceptive with ethinylestradiol and the progestogen drospirenone. In a therapeutic dosage, drospirenone also possesses antiandrogenic and mild antimineralocorticoid properties. It has no estrogenic, glucocorticoid and antiglucocorticoid activity. This gives drospirenone a pharmacological profile closely resembling the natural hormone progesterone.

There are indications from reported clinical studies that the mild antimineralocorticoid properties of Drospirenone 3 mg and Ethinylestradiol 0.03 mg tablets result in a mild antimineralocorticoid effect.

5.2 Pharmacokinetics properties

- **Drospirenone**

Absorption

Orally administered drospirenone is rapidly and almost completely absorbed. Maximum concentrations of the active substance in serum of about 38 ng/ml are reached at about 1-2 h after single ingestion. Bioavailability is between 76 and 85 %. Concomitant ingestion of food has no influence on the bioavailability of drospirenone.

Distribution

After oral administration, serum drospirenone levels decrease with a terminal half-life of 31 h. Drospirenone is bound to serum albumin and does not bind to sex hormone binding globulin (SHBG) or corticoid binding globulin (CBG). Only 3 - 5 % of the total serum concentrations of the active substance are present as free steroid. The ethinylestradiol-induced increase in SHBG does not influence the serum protein binding of drospirenone. The mean apparent volume of distribution of drospirenone is 3.7 ± 1.2 l/kg.

Biotransformation

Drospirenone is extensively metabolized after oral administration. The major metabolites in plasma are the acid form of drospirenone, generated by opening of the lactone ring, and the 4,5-dihydro-drospirenone-3-sulfate, formed by reduction and subsequent sulfation. Drospirenone is also subject to oxidative metabolism catalyzed by CYP3A4.

In vitro, drospirenone is capable to inhibit weakly to moderately the cytochrome P450 enzymes CYP1A1, CYP2C9, CYP2C19 and CYP3A4.

Elimination

The metabolic clearance rate of drospirenone in serum is 1.5 ± 0.2 ml/min/kg. Drospirenone is excreted only in trace amounts in unchanged form. The metabolites of drospirenone are excreted with the faeces and urine at an excretion ratio of about 1.2 to 1.4. The half-life of metabolite excretion with the urine and faeces is about 40 h.

Steady-State Conditions

During a treatment cycle, maximum steady-state concentrations of drospirenone in serum of about 70 ng/ml are reached after about 8 days of treatment. Serum drospirenone levels accumulated by a factor of about 3 as a consequence of the ratio of terminal half-life and dosing interval.

Special Populations

Effect of renal impairment

Steady-state serum drospirenone levels in women with mild renal impairment (creatinine clearance CL_{Cr}, 50-80 mL/min) were reported to be comparable to those of women with normal renal function. The reported serum drospirenone levels were on average 37 % higher in women with moderate renal impairment (CL_{Cr}, 30 - 50 mL/min) compared to those in women with normal renal function. Drospirenone treatment has also been reported to be well tolerated by women with mild and moderate renal impairment. Drospirenone treatment has also been reported to not show any clinically significant effect on serum potassium concentration.

Effect of hepatic impairment

In a reported single dose study, oral clearance (CL/F) was decreased approximately 50 % in volunteers with moderate hepatic impairment as compared to those with normal liver function. The observed decline in drospirenone clearance in volunteers with moderate hepatic impairment did not translate into any apparent difference in terms of serum potassium concentrations. Even in the presence of diabetes and concomitant treatment with spironolactone (two factors that can predispose a patient to hyperkalemia) an increase in serum potassium concentrations above the upper limit of the normal range was not observed. It can be concluded that drospirenone is well tolerated in patients with mild or moderate hepatic impairment (Child-Pugh B).

Ethnic groups

No clinically relevant differences in the pharmacokinetics of drospirenone or ethinylestradiol between Japanese and Caucasian women have been observed.

- **Ethinylestradiol**

Absorption

Ethinylestradiol is rapidly and completely absorbed after ingestion. After administration of 30 µg, peak plasma concentrations (100 pg/ml) has been reported to be reached 1-2 hours after ingestion. Ethinylestradiol undergoes an extensive first-pass effect, which displays great inter-individual variation. The absolute bioavailability is approx. 45 %.

Distribution

Ethinylestradiol has an apparent volume of distribution of 5 l/kg and binding to plasma proteins is approx. 98 %. Ethinylestradiol induces the hepatic synthesis of SHBG and CBG. During treatment with 30 µg ethinylestradiol the plasma concentration of SHBG increases from 70 to about 350 nmol/l.

Ethinylestradiol passes in small amounts into breast milk (0.02 % of the dose).

Biotransformation

Ethinylestradiol is subject to significant gut and hepatic first-pass metabolism. Ethinylestradiol is primarily metabolized by aromatic hydroxylation but a wide variety of hydroxylated and methylated metabolites are formed, and these are present as free metabolites and as conjugates with glucuronides and sulfate. The metabolite clearance rate of ethinylestradiol is about 5 ml/min/kg.

In vitro, ethinylestradiol is a reversible inhibitor of CYP2C19, CYP1A1 and CYP1A2 as well as a mechanism based inhibitor of CYP3A4/5, CYP2C8 and CYP2J2.

Elimination

Ethinylestradiol is not excreted in unchanged form to any significant extent. The metabolites of ethinylestradiol are excreted at a urinary to biliary ratio of 4:6. The half-life of metabolite excretion is about 1 day. The elimination half-life is reported to be 20 hours.

Steady-state conditions

Steady-state conditions are reached during the second half of a treatment cycle and serum levels of ethinylestradiol accumulate by a factor of about 1.4 to 2.1.

5.3 Preclinical safety data

In laboratory animals, the effects of drospirenone and ethinylestradiol have been reported to be confined to those associated with the recognised pharmacological action. In particular, reported reproduction toxicity studies revealed embryotoxic and fetotoxic effects in animals which are

considered as species specific. At exposures exceeding those in users of Drospirenone 3 mg and Ethinylestradiol 0.03 mg tablets, effects on sexual differentiation have been reported in rat foetuses but not in monkeys. Reported environmental risk assessment studies have shown that ethinylestradiol and drospirenone have the potential of posing a risk to the aquatic environment (see **section 6.6**).

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Ethinyl estradiol,
Lactose monohydrate,
Corn starch,
Colloidal silicon dioxide,
Hypromellose, talc,
Colloidal silicon dioxide,
Magnesium stearate,
Opadry II yellow

6.2 Incompatibilities

Not applicable

6.3 Shelf life

24 Months

6.4 Special precautions for storage

No special requirement

6.5 Nature and contents of container

Blister of 21 active film coated Tablets

6.6 Special precautions for disposal and other handling

No special requirement

7. MARKETING AUTHORISATION HOLDER

Sun Pharmaceutical Industries Limited
Halol - Baroda highway, Halol - 389350,
Gujrat, India

8. MARKETING AUTHORISATION NUMBER

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9. DATE OF FIRST REGISTRATION /RENEWAL OF THE AUTHORISATION

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10. DATE OF REVISION OF THE TEXT

June 2026

