

## AUSTRALIAN PRODUCT INFORMATION

### INFANRIX IPV (combined diphtheria, tetanus, acellular pertussis (DTPa) and inactivated poliovirus vaccine) suspension for injection

#### 1 NAME OF THE MEDICINE

Combined diphtheria, tetanus, acellular pertussis (DTPa) and inactivated poliovirus vaccine.

#### 2 QUALITATIVE AND QUANTITATIVE COMPOSITION

1 dose (0.5 mL) contains:

Diphtheria toxoid<sup>1</sup> not less than 30 International units (25 Lf)

Tetanus toxoid<sup>1</sup> not less than 40 International units (10 Lf)

*Bordetella pertussis* antigens

Pertussis toxoid (PT)<sup>1</sup> 25 micrograms

Filamentous Haemagglutinin (FHA)<sup>1</sup> 25 micrograms

Pertactin (PRN)<sup>1</sup> 8 micrograms

Poliovirus (inactivated) (IPV)

type 1 (Mahoney strain)<sup>2</sup> 40 D-antigen unit

type 2 (MEF-1 strain)<sup>2</sup> 8 D-antigen unit

type 3 (Saukett strain)<sup>2</sup> 32 D-antigen unit

<sup>1</sup>adsorbed on aluminium hydroxide hydrate (Al(OH)<sub>3</sub>) 0.5 milligrams Al<sup>3+</sup>

<sup>2</sup>propagated in VERO cells

The diphtheria and tetanus toxoids are obtained by formaldehyde treatment of purified *Corynebacterium diphtheriae* and *Clostridium tetani* toxins. The acellular pertussis vaccine components are obtained by extraction and purification from phase I *Bordetella pertussis* cultures, followed by irreversible detoxification of the pertussis toxin by glutaraldehyde and formaldehyde treatment, and formaldehyde treatment of FHA and pertactin. The three polioviruses are cultivated on a continuous VERO cell line, purified and inactivated with formaldehyde.

The manufacture of this product includes exposure to bovine derived materials. No evidence exists that any case of vCJD (considered to be the human form of bovine spongiform encephalopathy) has resulted from the administration of any vaccine product.

INFANRIX IPV vaccine meets the World Health Organisation requirements for manufacture of biological substances, of diphtheria, tetanus, pertussis and combined vaccines, and of inactivated poliomyelitis vaccines.

#### **List of excipients with known effect**

INFANRIX IPV also contains residual amounts of neomycin sulfate and polymyxin B sulfate, which are carried over from the manufacturing process.

For the full list of excipients, see Section 6.1 LIST OF EXCIPIENTS.

This medicine contains less than 1 mmol (39 mg) per dose of potassium and less than 1 mmol (23 mg) per dose of sodium, i.e., essentially 'potassium-free' and 'sodium-free'.

### **3 PHARMACEUTICAL FORM**

INFANRIX IPV vaccine is a sterile suspension for injection.

INFANRIX IPV is presented as a turbid white suspension. Upon storage, a white deposit and clear supernatant can be observed.

### **4 CLINICAL PARTICULARS**

#### **4.1 THERAPEUTIC INDICATIONS**

INFANRIX IPV is indicated for use in a three dose primary schedule for immunisation of infants from 6 weeks of age and over, against diphtheria, tetanus, pertussis and poliomyelitis.

INFANRIX IPV is also indicated as a single booster dose for children, up to and including 6 years of age, who have previously been immunised against DTP and polio.

#### **4.2 DOSE AND METHOD OF ADMINISTRATION**

All parenteral drug and vaccine products should be inspected visually for any particulate matter or discolouration prior to administration. Before use of INFANRIX IPV, the vaccine should be well shaken to obtain a homogenous turbid suspension. Discard the vaccine if it appears otherwise. The vaccine should be administered immediately after opening.

#### **Dosage**

Each dose consists of a 0.5 mL ready to use sterile suspension.

#### **Administration**

INFANRIX IPV is administered by deep intramuscular injection.

For infants, the preferred site of injection is the anterolateral aspect of the thigh because of the small size of their deltoid muscle. In older children, the booster vaccination should be administered in the deltoid region of the arm.

The recommended dose (0.5 mL) of vaccine must be administered. Each dose of INFANRIX IPV is for single use only. Any residual vaccine must be discarded.

INFANRIX IPV VACCINE SHOULD NEVER BE ADMINISTERED INTRAVENOUSLY.

### **Immunisation Schedule**

#### **Primary**

The primary vaccination course consists of three doses of INFANRIX IPV. INFANRIX IPV is recommended for administration at 2, 4 and 6 months of age. An interval of at least 1 month should be maintained between subsequent doses.

#### **Booster**

A single booster dose of INFANRIX IPV can be given up to and including 6 years of age.

### **4.3 CONTRAINDICATIONS**

INFANRIX IPV should not be administered to subjects with known hypersensitivity to the active substances or to any of the excipients or residues (see Section 2 QUALITATIVE AND QUANTITATIVE COMPOSITION and Section 6.1 LIST OF EXCIPIENTS).

INFANRIX IPV should not be administered to subjects having shown signs of hypersensitivity after previous administration of diphtheria, tetanus, pertussis, or inactivated polio vaccines.

INFANRIX IPV is contraindicated if the child has experienced an encephalopathy of unknown aetiology occurring within 7 days following previous vaccination with a pertussis containing vaccine. In these circumstances pertussis vaccination should be discontinued and the vaccination should be continued with diphtheria-tetanus and polio vaccines.

### **4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE**

**INFANRIX IPV should under no circumstances be administered intravenously.**

It is good clinical practice that immunisation should be preceded by a review of the medical history (especially with regard to previous immunisation and possible occurrence of undesirable events) and a clinical examination.

As with all injectable vaccines, appropriate medical treatment and supervision should always be readily available in case of a rare anaphylactic reaction following the administration of the vaccine.

If any of the following events are known to have occurred in temporal relation to receipt of whole cell or acellular pertussis-containing vaccine, the decision to give further doses of vaccine containing the pertussis component should be carefully considered. There may be circumstances, such as a high incidence of pertussis, when the potential benefits of vaccination outweigh the possible risks, particularly since these events are not associated with permanent sequelae.

- Temperature of  $\geq 40.0^{\circ}\text{C}$  within 48 hours, not due to another identifiable cause.
- Collapse or shock-like state (hypotonic-hyporesponsive episode) within 48 hours of vaccination.

- Persistent, inconsolable crying lasting  $\geq 3$  hours, occurring within 48 hours of vaccination.
- Convulsions with or without fever, occurring within 3 days of vaccination.

In children with progressive neurological disorders, including infantile spasms, uncontrolled epilepsy or progressive encephalopathy, it is better to defer pertussis (Pa or Pw) immunisation until the condition is corrected or stable. However, the decision to give pertussis vaccine must be made on an individual basis after careful consideration of the risks and benefits.

A history of febrile convulsions, a family history of convulsions, a family history of Sudden Infant Death Syndrome (SIDS) or a family history of an adverse event following DTPa and/or IPV vaccination do not constitute contra-indications.

As with other vaccines, the administration of INFANRIX IPV should be postponed in subjects suffering from acute severe febrile illness. The presence of a minor infection, however, is not a contraindication.

INFANRIX IPV should be administered with caution to subjects with thrombocytopenia or a bleeding disorder since bleeding may occur following an intramuscular administration to these subjects. Firm pressure should be applied to the injection site (without rubbing) for at least two minutes.

INFANRIX IPV contains traces of neomycin sulfate and polymyxin sulfate. The vaccine should be used with caution in patients with known hypersensitivity to one of these antibiotics.

Human Immunodeficiency Virus (HIV) infection is not considered a contra-indication to INFANRIX IPV vaccination. However in patients with immunodeficiency or in patients receiving immunosuppressive therapy, the expected immunologic response may not be achieved. No data currently exist on use of INFANRIX IPV in these patients.

The potential risk of apnoea and the need for respiratory monitoring for 48-72h should be considered when administering the primary immunization series to very premature infants (born  $\leq 28$  weeks of gestation) and particularly for those with a previous history of respiratory immaturity. As the benefit of vaccination is high in this group of infants, vaccination should not be withheld or delayed.

Syncope (fainting) can occur following, or even before, any vaccination as a psychogenic response to the needle injection. It is important that procedures are in place to avoid injury from faints.

### **Use in the elderly**

No data available

### **Paediatric use**

See Section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE

### **Effects on laboratory tests**

No data available

## **4.5 INTERACTIONS WITH OTHER MEDICINES AND OTHER FORMS OF INTERACTIONS**

It is routine practice in paediatric vaccination to co-administer different vaccines during the same session. Injectable vaccines should always be given at different injection sites.

INFANRIX IPV can be administered concomitantly with hepatitis B vaccine, and/or Haemophilus influenzae type b vaccine, the injections being administered at different injection sites. Routine simultaneous administration of Hib vaccine and hepatitis B vaccine may be performed for children who are at the recommended age to receive these vaccines.

Concomitant administration of INFANRIX IPV and the PRP-OMP type Hib vaccine, measles, mumps and rubella combined vaccine, and varicella vaccine has not been assessed in clinical studies. The Australian Immunisation Handbook accepts that these vaccines may be given at the same time if separate injection sites are used.

INFANRIX IPV should not be mixed with other vaccines in the same syringe.

## **4.6 FERTILITY, PREGNANCY AND LACTATION**

### **Effects on fertility**

No data available

### **Use in pregnancy**

Adequate human data on use during pregnancy and adequate animal reproduction studies are not available.

### **Use in lactation**

Adequate human data on use during lactation and adequate animal reproduction studies are not available.

## **4.7 EFFECTS ON ABILITY TO DRIVE AND USE MACHINES**

The effects of this medicine on a person's ability to drive and use machines were not assessed as part of its registration.

## **4.8 ADVERSE EFFECTS (UNDESIRABLE EFFECTS)**

### **Clinical Trial Experience**

Adverse reactions associated with INFANRIX IPV vaccination have been evaluated in 13 clinical trials, with more than 2,400 doses administered. Adverse event data were actively collected using diary cards and by questioning the parents at clinic visits.

Events are listed within body systems and categorised by frequency according to the following definitions:

Frequencies per dose are defined as follows:

Very common:  $\geq 1/10$

Common:  $\geq 1/100$  and  $< 1/10$

Uncommon:  $\geq 1/1,000$  and  $< 1/100$

Rare:  $\geq 1/10,000$  and  $< 1/1,000$

Very rare:  $< 1/10,000$

### **Primary vaccination with INFANRIX IPV**

*Incidence (%) of general solicited symptoms reported within 48 hours following primary immunisation of infants with INFANRIX® IPV at a 3, 4.5, 6 month schedule*

<b>Solicited Symptoms</b>	<b>% incidence (N = 726)</b>
<b>Local Reactions:</b>	
Pain at the injection site	16.3
Redness (>20 mm)	4.4
Swelling (>20 mm)	3.4
<b>General Symptoms:</b>	
Fever:	
Any <sup>#</sup>	6.1
Grade 3 <sup>@</sup>	0.1
Loss of appetite	10.7
Restlessness	22.7
Unusual crying	18.2
Vomiting	6.5
Diarrhoea	11.6

*N = Total number of doses administered over a 3 dose primary vaccination course*

*# = A temperature of  $\geq 37.5^{\circ}\text{C}$  (axillary or oral) or  $\geq 38^{\circ}\text{C}$  (rectal)*

*@ = A temperature of  $> 39^{\circ}\text{C}$  (axillary or oral) or  $> 39.5^{\circ}\text{C}$  (rectal)*

The following events were also reported in temporal association with vaccination in clinical trials evaluating the 3 dose primary vaccination schedules. It should be noted that causality has not necessarily been established for these events.

Events are listed within body systems and categorised by frequency according to the following definitions:

Frequencies per dose are defined as follows:

Very common:  $\geq 1/10$

Common:  $\geq 1/100$  and  $< 1/10$

Uncommon:  $\geq 1/1,000$  and  $< 1/100$

Rare:  $\geq 1/10,000$  and  $< 1/1,000$

Very rare:  $< 1/10,000$

Body as a whole:

*Uncommon:* bacterial infection, fungal infection, viral infection, herpes zoster (chicken pox), moniliasis

Cardiovascular:

*Uncommon:* haematoma

Central Nervous System:

*Very Common:* somnolence

Dermatological:

*Uncommon:* rash<sup>3</sup>, dermatitis, dermatitis contact, eczema, rash erythematous, urticaria

Gastrointestinal:

*Common:* tooth ache, vomiting

*Uncommon:* dyspepsia, hiccup, abdominal pain, gastroenteritis, gastro-oesophageal reflux, constipation, flatulence

General disorders and administration site conditions:

*Very common:* redness, local swelling at injection site ( $\leq 50$  mm), fever ( $> 38^{\circ}\text{C}$ )

*Common:* injection site mass ( $> 50$  mm)<sup>1</sup>, asthenia, injection site reactions including induration

*Uncommon:* diffuse swelling of the injected limb, sometimes involving the adjacent joint<sup>1</sup>, fever ( $\geq 39.5^{\circ}\text{C}$ )

Nervous System:

*Uncommon:* insomnia

Psychiatric:

*Very common:* irritability

Respiratory:

*Common:* rhinitis, pharyngitis, upper respiratory tract infection

*Uncommon:* asthma, coughing<sup>3</sup>, pneumonia, respiratory disorder, bronchitis<sup>3</sup>

Special senses:

*Common:* otitis media;

*Uncommon:* conjunctivitis

Urogenital:

Uncommon: pyelonephritis

**Booster vaccination with INFANRIX IPV at 4-6 years of age**

Incidence (%) of solicited symptoms reported within 48 hours from a study of booster immunisation with INFANRIX IPV at 4-6 years of age

	following primary immunisation (study A)	following primary and first booster immunisation (study B)
<b>Solicited Symptoms</b>	<b>% incidence</b> (*N = 210 )	<b>% incidence</b> (*N = 73)
<b>Local Reactions:</b>		
Pain at the injection site:		
Any	71.4	82.2
Grade 3	2.9	5.5
Redness:		
Any	61.0	65.8
>50 mm	25.7	9.6
Swelling:		
Any	53.3	52.1
>50 mm	13.3	5.5
<b>General Symptoms:</b>		
Fever:		
Any <sup>#</sup>	21.0	9.6
Grade 3 <sup>@</sup>	0.5	0.0
Irritability	16.7	13.7
Vomiting	not solicited	1.4
Diarrhoea	not solicited	2.7
Loss of appetite	19.0	12.3
Restlessness	not solicited	6.8
Sleeping more than usual/drowsiness	24.8	17.8

Note: Study A: Primary immunisation with DTPa-containing vaccines at 3, 5, 11 months of age; Study B: Primary and first booster immunisation with DTPw-IPV or DTPw-IPV/Hib vaccine  
The occurrence and severity of symptoms was assessed using diary cards listing the events tabulated. "Not solicited" indicates that the event was not listed on the diary card for evaluation.

\*N = Number of subjects

# = A temperature of  $\geq 37.5^{\circ}\text{C}$  (axillary or oral) or  $\geq 38^{\circ}\text{C}$  (rectal)

@ = A temperature of  $> 39^{\circ}\text{C}$  (axillary or oral) or  $> 39.5^{\circ}\text{C}$  (rectal)

The following events were also reported in temporal association with vaccination in clinical trials evaluating booster vaccination schedules. It should be noted that causality has not necessarily been established for these events.

Events are listed within body systems and categorised by frequency according to the following definitions:

Frequencies per dose are defined as follows:



Very common:  $\geq 1/10$

Common:  $\geq 1/100$  and  $< 1/10$

Uncommon:  $\geq 1/1,000$  and  $< 1/100$

Rare:  $\geq 1/1,000$  and  $< 1/10,000$

Very rare:  $< 1/10,000$

Injection site:

*Very common:* local swelling at the injection site ( $\leq 50$  mm)

*Common:* local swelling at the injection site ( $>50$  mm)<sup>1</sup>, injection site reactions including induration.

*Uncommon:* diffuse swelling of the injected limb, sometimes involving the adjacent joint<sup>1</sup>

Body as a whole:

*Common:* asthenia, malaise;

*Uncommon:* viral infection

Blood and lymphatic system disorders:

*Rare:* Lymphadenopathy

Dermatological:

*Common:* pruritis

*Uncommon:* dermatitis allergic

*Rare:* urticaria,

Gastrointestinal:

*Common:* nausea, vomiting, diarrhoea

*Uncommon:* abdominal pain

Musculoskeletal:

*Uncommon:* myalgia

Nervous system disorders:

*Very common:* Headache (age range 6-13 years old), somnolence

Psychiatric disorders:

*Very common:* restlessness, crying abnormally

Respiratory:

*Common:* coughing<sup>3</sup>, rhinitis, pharyngitis;

*Uncommon:* bronchitis<sup>3</sup>

Special senses:

*Common:* otitis media

**Post-marketing Experience**

During post marketing surveillance, other reactions have been reported in temporal association with INFANRIX IPV or with other DTPa-containing vaccines. None of the reactions were reported with a frequency higher than 0.01%.

Note that exact incidence rates cannot be calculated under post-marketing experience.

Administration site conditions:

*Very rare:* injection site mass, swelling of the entire injected limb<sup>1</sup>, injection site vesicles.

Body as a whole:

*Very rare:* Allergic reactions (including rash and pruritus), including anaphylactic<sup>3</sup> and anaphylactoid reactions (including urticaria),

Blood and lymphatic system disorders:

Thrombocytopenia<sup>2</sup>

Dermatological:

*Very rare:* angioneurotic oedema.<sup>3</sup>

Neurological disorders:

*Very rare:* convulsions (with or without fever) within 2 to 3 days of vaccination, collapse or shock-like state (hypotonic-hyporesponsiveness episode).

Respiratory disorders:

Apnoea<sup>3</sup> (see Section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE for apnoea in very premature infants ( $\leq$  28weeks of gestation))

<sup>1</sup>Children primed with acellular pertussis vaccines are more likely to experience swelling reactions after booster administration in comparison with children primed with whole cell vaccines. Local swelling at the injection site (> 50 mm) and diffuse swelling may be more frequent (very common and common, respectively) when the booster dose is administered between 4 and 6 years. These reactions resolve over an average of 4 days.

<sup>2</sup>Reported with D and T vaccines

<sup>3</sup>Reported with GSK's DTPa containing vaccines

## Reporting suspected adverse effects

Reporting suspected adverse reactions after registration of the medicinal product is important. It allows continued monitoring of the benefit-risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions at [www.tga.gov.au/reporting-problems](http://www.tga.gov.au/reporting-problems).

## 4.9 OVERDOSE

Cases of overdose have been reported during post-marketing surveillance. Adverse events, when reported, are not specific but similar to adverse events reported with normal vaccine administration.

For information on the management of overdose, contact the Poisons Information Centre on 13 11 26 (Australia).

# 5 PHARMACOLOGICAL PROPERTIES

## 5.1 PHARMACODYNAMIC PROPERTIES

### Mechanism of action

INFANRIX IPV is providing immunity against diphtheria, tetanus, pertussis and poliovirus by inducing the production of antibodies and the ability to mount an immunological memory.

### Clinical trials

More than 1,800 doses of *INFANRIX IPV* have been administered in clinical studies evaluating use in primary vaccination schedules. In addition, 721 doses have been administered as a single booster dose in infants and children ranging from 15 months to 13 years.

#### Immune response to the DT components:

One month after a 3 dose primary vaccination course with *INFANRIX IPV*, more than 99% of vaccinated infants had antibody titres of  $\geq 0.1$  IU/mL to both tetanus and diphtheria.

Following administration of a booster dose of *INFANRIX IPV*, more than 99.5% of children had antibody titres of  $\geq 0.1$  IU/mL for both antigens.

Antibody titres  $\geq 0.1$  IU/mL are deemed to correlate with seroprotection against diphtheria and tetanus.

#### Immune response to the Pa component:

One month after the 3-dose primary vaccination course with *INFANRIX IPV*, 100% of infants were seropositive (antibodies  $\geq 5$  EL.U/mL) for the three pertussis components (PT, FHA, pertactin). Overall response rates, for each of the three individual pertussis antigens were  $\geq 94\%$ . A vaccine response was defined as induction of antibodies to the individual pertussis antigens, taking into account the age and the pre-vaccination serological status of the subject.

In booster studies, a vaccine response was seen in  $\geq 96.6\%$  of vaccinees against the pertussis antigens; lower response rates were seen in studies where the pre-vaccination levels of antibodies were high. A vaccine response was defined as a post-vaccination titre  $\geq 2x$  the pre-vaccination titre for subjects initially seropositive, and a titre  $\geq$  the assay cut-off (5 EL.U/ml) for subjects initially seronegative. All subjects were seropositive one month after this dose.

Protective efficacy of the Pa component:

As the immune response to pertussis antigens following *INFANRIX IPV* administration is equivalent to that of *INFANRIX*, it can be assumed that the protective efficacy of the two vaccines will also be equivalent.

The clinical protection of the DTPa component, against WHO-defined typical pertussis ( $\geq 21$  days of paroxysmal cough) was demonstrated in:

- a prospective blinded household contact study was performed in Germany (3, 4, 5 months schedule). Based on data collected from secondary contacts in households where there was an index case with typical pertussis, the protective efficacy of the vaccine was calculated to be 88.7%.
- a US National Institute of Health (NIH) sponsored efficacy study was performed in Italy (2, 4, 6 months schedule). This study determined the vaccine efficacy to be 84%. In a follow-up of the same cohort, the efficacy was confirmed for up to 4 years of age.

Immune response to the IPV component:

One month after the 3 dose primary vaccination course with *INFANRIX IPV*, the overall seropositivity for each of the three polio serotypes (type 1, 2 and 3) was  $\geq 99.5\%$ . Antibody titres  $\geq 8$  are deemed to correlate with seroprotection against poliomyelitis.

Following administration of a booster dose of *INFANRIX IPV*, 100% of children were seropositive for the three polio serotypes.

In all booster trials, vaccination with *INFANRIX IPV* induced a marked increase in antibody levels with respect to pre-booster values.

*Geometric Mean Antibody Titres (GMTs) following primary immunisation with INFANRIX® IPV vaccine in children at 7 months of age*

Antigen	Primary immunisation GMT [95% confidence interval]
Diphtheria Toxoid (N=203)	1.83 [1.69 – 1.98]
Tetanus Toxoid (N=193)	3.72 [3.47 – 3.99]
Pertussis Toxoid (N=198)	87.2 [81.7 – 93.0]

Pertussis FHA (N=188)	91.1 [80.6 – 102.9]
Pertactin (N=188)	166.6 [151.6 – 183.1]
Poliovirus Type 1 (N=174)	374.5 [326.8 – 429.1]
Poliovirus Type 2 (N=175)	406.1 [352.9 – 467.2]
Poliovirus Type 3 (N=175)	1115.0 [978.4 – 1270.6]

Note: Primary immunisation with DTPa-IPV vaccine at 3, 4.5, 6 months  
 IU = International Units; EL.U = ELISA Units; N = Number of subjects  
 Assay cut-offs for each antigen are as follows: D & T:  $\geq 0.1\text{IU/mL}$ ; PT, FHA & PRN: 5 EL.U/mL; POLIO types 1,2,3:  $\geq 8$ .  
 The cut-off values for diphtheria, tetanus and polio correlate with seroprotection. Currently there are no known serological correlates for protection for the pertussis antigens.

Geometric Mean Antibody Titres (GMTs) from a study of booster immunisation with INFANRIX IPV at 4-6 years of age, following primary immunisation

Antigen	Booster immunisation GMT (95% confidence interval)	
	Pre-booster	Post-booster
<b>Diphtheria Toxoid</b> (N=201 [pre] and 208 [post])	0.08 (0.07-0.09)	6.24 (5.39 – 7.23)
<b>Tetanus Toxoid</b> (N=200 [pre] and 208 [post])	0.15 (0.12-0.17)	9.96 (8.79-11.28)
<b>Pertussis Toxoid</b> (N= 200 [pre] and 208 [post])	3.6 (3.2-4.0)	63.2 (56.1-71.2)
<b>Pertussis FHA</b> (N=201 [pre] and 208 [post])	30.0 (24.9-36.2)	735.2 (653.4-827.4)
<b>Pertactin</b> (N=201 [pre] and 208 [post])	27.2 (23.0-32.3)	995.6 (863.5-1147.9)
<b>Poliovirus Type 1</b> (N=193 [pre] and 193 [post])	65.3 (49.9-85.4)	2096.0 (1817.6-2417.0)
<b>Poliovirus Type 2</b> (N=194 [pre] and 197 [post])	41.4 (32.0-53.5)	1702.4 (1482.1-1955.4)
<b>Poliovirus Type 3</b> N=192 [pre] and 189 [post])	23.5 (19.3-28.7)	2542.6 (2122.0-3046.5)

Note: Primary immunisation with DTPa-containing vaccines at 3, 5 and 11 months of age

N = Number of subjects; IU = International Units; EL.U = ELISA Units

Assay cut-offs for each antigen are as follows: D & T:  $\geq 0.1\text{IU/mL}$ ; PT, FHA & PRN: 5 EL.U/mL; POLIO types 1,2,3:  $\geq 8$ .

The cut-off values for diphtheria, tetanus and polio correlate with seroprotection. Currently there are no known serological correlates for protection for the pertussis antigens.

Geometric Mean Antibody Titres (GMTs) from a study of booster immunisation with INFANRIX® IPV at 5-6 years of age, following primary and first booster immunisation

Antigen	Booster immunisation GMT (95% confidence interval)	
	Pre-booster	Post-booster
<b>Diphtheria Toxoid</b> (N=72 [pre] and 73 [post])	0.12 (0.09 – 0.15)	6.19 (4.83 – 7.93)
<b>Tetanus Toxoid</b> (N=72 [pre] and 73 [post])	0.25 (0.20 – 0.32)	13.58 (11.30 – 16.31)
<b>Pertussis Toxoid</b> (N=72 [pre] and 66 [post])	3.6 (3.0 – 4.3)	84.7 (62.5 – 114.9)
<b>Pertussis FHA</b> (N=70 [pre] and 72 [post])	31.8 (22.1 – 45.9)	1051.1 (898.3 – 1299.8)
<b>Pertactin</b> (N=72 [pre] and 73 [post])	16.8 (12.7 – 22.3)	820.1 (656.8 – 1024.0)
<b>Poliovirus Type 1</b> (N=72)	15.6 (11.7 – 20.8)	1533.2 (1156.6 – 2032.2)
<b>Poliovirus Type 2</b> (N=72 [pre] and 71 [post])	21.8 (16.3 – 29.0)	1053.4 (819.7 – 1353.6)
<b>Poliovirus Type 3</b> (N=71)	44.4 (31.9 – 61.7)	1740.7 (1315.7 – 2303.0)

Note: Primary and first booster immunisation with DTPw-IPV or DTPw-IPV/Hib vaccine

N = Number of subjects; IU = International Units; EL.U = ELISA Units

Assay cut-offs for each antigen are as follows: D & T:  $\geq 0.1\text{IU/mL}$ ; PT, FHA & PRN: 5 EL.U/mL; POLIO types 1,2,3:  $\geq 8$ .

The cut-off values for diphtheria, tetanus and polio correlate with seroprotection. Currently there are no known serological correlates for protection for the pertussis antigens.

## 5.2 PHARMACOKINETIC PROPERTIES

Not relevant to vaccines.

## 5.3 PRECLINICAL SAFETY DATA

### Genotoxicity

No data available.

### Carcinogenicity

No data available.

## 6 PHARMACEUTICAL PARTICULARS

### 6.1 LIST OF EXCIPIENTS

The final vaccine also contains the excipients aluminium hydroxide hydrate, medium 199, sodium chloride and water for injections. The vaccine also contains the following residues: neomycin sulfate and polymyxin B sulfate.

## **6.2 INCOMPATIBILITIES**

See Section 4.5 INTERACTIONS WITH OTHER MEDICINES AND OTHER FORMS OF INTERACTIONS.

## **6.3 SHELF LIFE**

In Australia, information on the shelf life can be found on the public summary of the Australian Register of Therapeutic Goods (ARTG). The expiry date can be found on the packaging.

## **6.4 SPECIAL PRECAUTIONS FOR STORAGE**

INFANRIX IPV should be stored between +2°C and +8°C. DO NOT FREEZE. Discard if vaccine has been frozen. Protect from light.

The expiry date of the vaccine is indicated on the label and packaging.

## **6.5 NATURE AND CONTENTS OF CONTAINER**

INFANRIX IPV is presented as a turbid white suspension in a prefilled syringe, supplied in packs of 1's or packs of 10's.

The syringes are made of neutral glass type I, which conforms to European Pharmacopoeia Requirements.

Not all pack sizes may be distributed in Australia.

## **6.6 SPECIAL PRECAUTIONS FOR DISPOSAL**

In Australia, any unused medicine or waste material should be disposed of by taking to your local pharmacy.

## **6.7 PHYSICOCHEMICAL PROPERTIES**

Not relevant to vaccines

## **7 MEDICINE SCHEDULE (POISONS STANDARD)**

Schedule 4 – Prescription Only Medicine

## **8 SPONSOR**

GlaxoSmithKline Australia Pty Ltd  
Level 4, 436 Johnston Street,  
Abbotsford, Victoria, 3067

## **9 DATE OF FIRST APPROVAL**

21 April 2009

## 10 DATE OF REVISION

24 August 2022

### SUMMARY TABLE OF CHANGES

<b>Section Changed</b>	<b>Summary of new information</b>
<b>2</b>	Inserted 'List of excipients of known effect' statement with neomycin sulfate and polymyxin B sulfate
<b>2</b>	Added statement on potassium-free and sodium-free content
<b>6.1</b>	Removal of reference to the following residues: polysorbate 80, formaldehyde, glycine, potassium chloride, dibasic sodium phosphate dihydrate, monobasic potassium phosphate

Version 8.0

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