

LUTERA - levonorgestrel and ethinyl estradiol
Watson Laboratories, Inc.

Lutera® (Levonorgestrel and Ethinyl Estradiol Tablets)

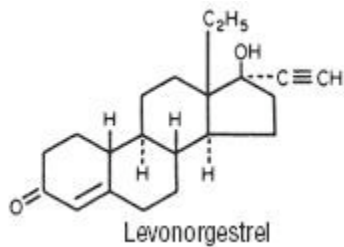
Rx only

Patients should be counseled that this product does not protect against HIV infection (AIDS) and other sexually transmitted diseases.

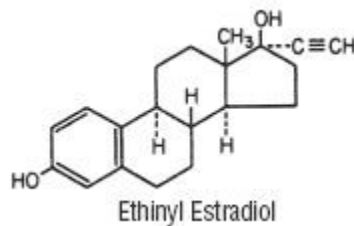
DESCRIPTION

Each active, white tablet (21) contains 0.1 mg of levonorgestrel, d(-)-13 β - ethyl-17 α -ethinyl-17 β -hydroxygon-4-en-3-one, a totally synthetic progestogen, and 0.02 mg of ethinyl estradiol, 17 α -ethinyl-1,3,5(10)-estratriene-3, 17 β -diol. The inactive ingredients present are croscarmellose sodium, lactose monohydrate, magnesium stearate, microcrystalline cellulose, and povidone.

Each inactive, peach tablet (7) contains the following inactive ingredients: FD&C Yellow #6, lactose anhydrous, lactose monohydrate, magnesium stearate, and microcrystalline cellulose.



C₂₁H₂₈O₂



M.W. 312.45

C₂₀H₂₄O₂

M.W.296.4

CLINICAL PHARMACOLOGY

Combination oral contraceptives act by suppression of gonadotropins. Although the primary mechanism of this action is inhibition of ovulation, other alterations include changes in the cervical mucus (which increase the difficulty of sperm entry into the uterus) and the endometrium (which reduce the likelihood of implantation).

PHARMACOKINETICS

Absorption

No specific investigation of the absolute bioavailability of Lutera in humans has been conducted. However, literature indicates that levonorgestrel is rapidly and completely absorbed after oral administration (bioavailability about 100%) and is not subject to first-pass metabolism. Ethinyl estradiol is rapidly and almost completely absorbed from the

gastrointestinal tract but, due to first-pass metabolism in gut mucosa and liver, the bioavailability of ethinyl estradiol is between 38% and 48%.

After a single dose of Lutera to 22 women under fasting conditions, maximum serum concentrations of levonorgestrel are 2.8 ± 0.9 ng/ml (mean \pm SD) at 1.6 ± 0.9 hours. At steady state, attained from day 19 onwards, maximum levonorgestrel concentrations of 6 ± 2.7 ng/mL are reached at 1.5 ± 0.5 hours after the daily dose. The minimum serum levels of levonorgestrel at steady state are 1.9 ± 1 ng/mL. Observed levonorgestrel concentrations increased from day 1 (single dose) to days 6 and 21 (multiple doses) by 34% and 96%, respectively (Figure 1). Unbound levonorgestrel concentrations increased from day 1 to days 6 and 21 by 25% and 83%, respectively. The kinetics of total levonorgestrel are non-linear due to an increase in binding of levonorgestrel to sex hormone binding globulin (SHBG), which is attributed to increased SHBG levels that are induced by the daily administration of ethinyl estradiol.

Following a single dose, maximum serum concentrations of ethinyl estradiol of 62 ± 21 pg/mL are reached at 1.5 ± 0.5 hours. At steady state, attained from at least day 6 onwards, maximum concentrations of ethinyl estradiol were 77 ± 30 pg/mL and were reached at 1.3 ± 0.7 hours after the daily dose. The minimum serum levels of ethinyl estradiol at steady state are 10.5 ± 5.1 pg/mL. Ethinyl estradiol concentrations did not increase from days 1 to 6, but did increase by 19% from days 1 to 21 (Figure 1).

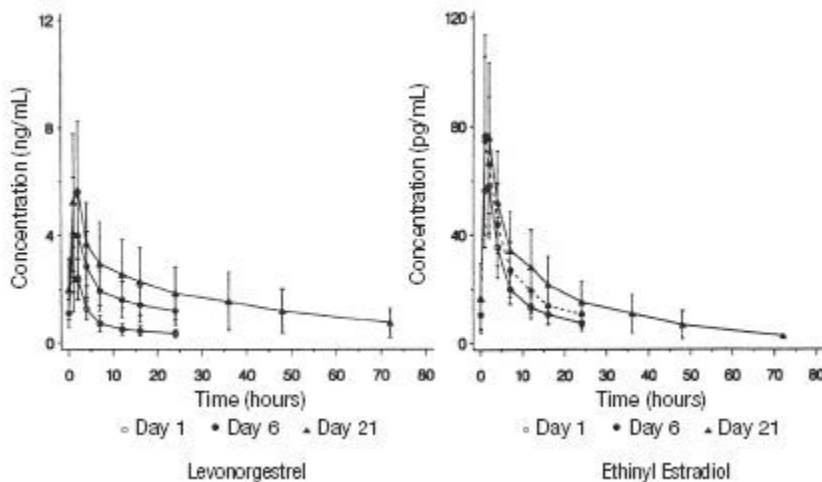


FIGURE 1 Mean (SE) levonorgestrel and ethinyl estradiol serum concentrations in 22 subjects receiving Lutera (100 mcg levonorgestrel and 20 mcg ethinyl estradiol)

Table I provides a summary of levonorgestrel and ethinyl estradiol pharmacokinetic parameters.

TABLE I: MEAN (SD) PHARMACOKINETIC PARAMETERS OF LUTERA OVER A 21-DAY DOSING PERIOD

Levonorgestrel						
Day	C _{max} ng/mL	T _{max} h	AUC ng•h/mL	CL/F mL/h/kg	V _{λz} /F L/kg	SHBG nmol/L
1	2.75 (0.88)	1.6 (0.9)	35.2 (12.8)	53.7 (20.8)	2.66 (1.09)	57 (18)
6	4.52 (1.79)	1.5 (0.7)	46.0 (18.8)	40.8(14.5)	2.05 (0.86)	81 (25)
21	6.00 (2.65)	1.5 (0.5)	68.3 (32.5)	28.4 (10.3)	1.43 (0.62)	93 (40)
Unbound Levonorgestrel						
Day	pg/mL	h	pg•h/mL	L/h/kg	L/kg	fu%
1	51.2 (12.9)	1.6 (0.9)	654 (201)	2.79 (0.97)	135.9 (41.8)	1.92 (0.30)
6	77.9 (22.0)	1.5 (0.7)	794 (240)	2.24 (0.59)	112.4 (40.5)	1.80 (0.24)
21	103.6 (36.9)	1.5 (0.5)	1177 (452)	1.57 (0.49)	78.6 (29.7)	1.78 (0.19)
Ethinyl Estradiol						
Day	pg/mL	h	pg•h/mL	mL/h/kg	L/kg	
1	62.0 (20.5)	1.5 (0.5)	653 (227)	567 (204)	14.3 (3.7)	
6	76.7 (29.9)	1.3 (0.7)	604 (231)	610 (196)	15.5 (4.0)	
21	82.3 (33.2)	1.4 (0.6)	776 (308)	486 (179)	12.4 (4.1)	

TABLE I: MEAN (SD) PHARMACOKINETIC PARAMETERS OF LUTERA OVER A 21-DAY DOSING PERIOD

Levonorgestrel

Distribution

Levonorgestrel in serum is primarily bound to SHBG. Ethinyl estradiol is about 97% bound to plasma albumin. Ethinyl estradiol does not bind to SHBG, but induces SHBG synthesis.

Metabolism

Levonorgestrel: The most important metabolic pathway occurs in the reduction of the Δ^4 -3-oxo group and hydroxylation at positions 2 α , 1 β , and 16 β , followed by conjugation. Most of the metabolites that circulate in the blood are sulfates of 3 α ,5 β -tetrahydro-levonorgestrel, while excretion occurs predominantly in the form of glucuronides. Some of the parent levonorgestrel also circulates as 17 β -sulfate. Metabolic clearance rates may differ among individuals by several-fold, and this may account in part for the wide variation observed in levonorgestrel concentrations among users.

Ethinyl estradiol: Cytochrome P450 enzymes (CYP3A4) in the liver are responsible for the 2-hydroxylation that is the major oxidative reaction. The 2-hydroxy metabolite is further transformed by methylation and glucuronidation prior to urinary and fecal excretion. Levels of Cytochrome P450 (CYP3A) vary widely among individuals and can explain the variation in rates of ethinyl estradiol 2-hydroxylation. Ethinyl estradiol is excreted in the urine and feces as glucuronide and sulfate conjugates, and undergoes enterohepatic circulation.

Excretion

The elimination half-life for levonorgestrel is approximately 36 ± 13 hours at steady state. Levonorgestrel and its metabolites are primarily excreted in the urine (40% to 68%) and about 16% to 48% are excreted in feces. The elimination half-life of ethinyl estradiol is 18 ± 4.7 hours at steady state.

SPECIAL POPULATIONS

Race

Based on the pharmacokinetic study with Lutera, there are no apparent differences in pharmacokinetic parameters among women of different races.

Hepatic Insufficiency

No formal studies have evaluated the effect of hepatic disease on the disposition of Lutera. However, steroid hormones may be poorly metabolized in patients with impaired liver function.

Renal Insufficiency

No formal studies have evaluated the effect of renal disease on the disposition of Lutera.

Drug-Drug Interactions

Interactions between ethinyl estradiol and other drugs have been reported in the literature.

- *Interactions with Absorption:* Diarrhea may increase gastrointestinal motility and reduce hormone absorption. Similarly, any drug which reduces gut transit time may reduce hormone concentrations in the blood.
- *Interactions with Metabolism:*
Gastrointestinal Wall: Sulfation of ethinyl estradiol has been shown to occur in the gastrointestinal (GI) wall. Therefore, drugs which act as competitive inhibitors for sulfation in the GI wall may increase ethinyl estradiol bioavailability (e.g., ascorbic acid).
Hepatic Metabolism: Interactions can occur with drugs that induce microsomal enzymes which can decrease ethinyl estradiol concentrations (e.g., rifampin, barbiturates, phenylbutazone, phenytoin, griseofulvin).
- *Interference with Enterohepatic Circulation:* Some clinical reports suggest that enterohepatic circulation of estrogens may decrease when certain antibiotic agents are given, which may reduce ethinyl estradiol concentrations (e.g., ampicillin, tetracycline).
- *Interference in the Metabolism of Other Drugs:* Ethinyl estradiol may interfere with the metabolism of other drugs by inhibiting hepatic microsomal enzymes or by inducing hepatic drug conjugation, particularly glucuronidation. Accordingly, plasma and tissue concentrations may either be increased or decreased, respectively (e.g., cyclosporine, theophylline).

See **PRECAUTIONS, DRUG INTERACTIONS**.

INDICATIONS AND USAGE

Oral contraceptives are indicated for the prevention of pregnancy in women who elect to use this product as a method of contraception.

Oral contraceptives are highly effective. Table II lists the typical accidental pregnancy rates for users of combination oral contraceptives and other methods of contraception. The efficacy of these contraceptive methods, except sterilization, the IUD, and Norplant[®] System, depends upon the reliability with which they are used. Correct and consistent use of methods can result in lower failure rates.

TABLE II: PERCENTAGE OF WOMEN EXPERIENCING AN UNINTENDED PREGNANCY DURING THE FIRST YEAR OF USE OF A CONTRACEPTIVE METHOD

Method	Perfect Use	Typical Use
Levonorgestrel implants	0.1	0.1
Male sterilization	0.1	0.15
Female sterilization	0.4	0.4
Injectable progestogen	0.3	0.3
Oral contraceptives		3
Combined	0.1	NA
Progestin only	0.5	NA
IUD		
Progesterone	1.5	2
Copper T 380A	0.6	0.8
Condom (male) without spermicide	3	12
(female) without spermicide	5	21
Cervical cap		
Nulliparous women	9	18
Parous women	26	36
Diaphragm with spermicidal cream or jelly	6	18
Spermicides alone		
(foam, creams, jellies, and vaginal suppositories) 6 21		
Periodic abstinence (all methods)	1-9*	20
Withdrawal	4	19
No contraception (planned pregnancy)	85	85
NA - not available		
*Depending on method (calendar, ovulation, symptothermal, post-ovulation)		

Adapted from Hatcher RA et al., *Contraceptive Technology*, 16th Revised Edition. New York, NY: Irvington Publishers, 1994.

Method	Perfect Use	Typical Use
NA - not available		
*Depending on method (calendar, ovulation, symptothermal, post-ovulation)		
Adapted from Hatcher RA et al., <i>Contraceptive Technology</i> , 16th Revised Edition. New York, NY: Irvington Publishers, 1994.		

In a clinical trial with Lutera, 1,477 subjects had 7,720 cycles of use and a total of 5 pregnancies were reported. This represents an overall pregnancy rate of 0.84 per 100 woman-years. This rate includes patients who did not take the drug correctly. One or more pills were missed during 1,479 (18.8%) of the 7,870 cycles; thus all tablets were taken during 6,391 (81.2%) of the 7,870 cycles. Of the total 7,870 cycles, a total of 150 cycles were excluded from the calculation of the Pearl index due to the use of backup contraception and/or missing 3 or more consecutive pills.

CONTRAINDICATIONS

Oral contraceptives should not be used in women with any of the following conditions:

- Thrombophlebitis or thromboembolic disorders
- A past history of deep-vein thrombophlebitis or thromboembolic disorders
- Cerebrovascular or coronary artery disease
- Known or suspected carcinoma of the breast
- Carcinoma of the endometrium or other known or suspected estrogen-dependent neoplasia
- Undiagnosed abnormal genital bleeding
- Cholestatic jaundice of pregnancy or jaundice with prior pill use
- Hepatic adenomas or carcinomas
- Known or suspected pregnancy

WARNINGS

Cigarette smoking increases the risk of serious cardiovascular side effects from oral-contraceptive use. This risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over 35 years of age. Women who use oral contraceptives should be strongly advised not to smoke.

The use of oral contraceptives is associated with increased risks of several serious conditions including myocardial infarction, thromboembolism, stroke, hepatic neoplasia, gallbladder disease, and hypertension, although the risk of serious morbidity or mortality is very small in healthy women without underlying risk factors. The risk of morbidity and mortality increases significantly in the presence of other underlying risk factors such as hypertension, hyperlipidemias, obesity and diabetes.

Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks.

The information contained in this package insert is principally based on studies carried out in patients who used oral contraceptives with higher formulations of estrogens and progestogens than those in common use today. The effect of long-term use of the oral contraceptives with lower doses of both estrogens and progestogens remains to be determined.

Throughout this labeling, epidemiological studies reported are of two types: retrospective or case control studies and prospective or cohort studies. Case control studies provide a measure of the relative risk of disease, namely, a ratio of the incidence of a disease among oral contraceptive users to that among non-users. The relative risk does not provide information on the actual clinical occurrence of a disease. Cohort studies provide a measure of attributable risk, which is the difference in the incidence of disease between oral-contraceptive users and non-users. The attributable risk does provide information about the actual occurrence of a disease in the population. For further information, the reader is referred to a text on epidemiological methods.

1. THROMBOEMBOLIC DISORDERS AND OTHER VASCULAR PROBLEMS

a. Myocardial Infarction

An increased risk of myocardial infarction has been attributed to oral contraceptive use. This risk is primarily in smokers or women with other underlying risk factors for coronary-artery disease such as hypertension, hypercholesterolemia, morbid obesity, and diabetes. The relative risk of heart attack for current oral-contraceptive users has been estimated to be two to six. The risk is very low under the age of 30.

Smoking in combination with oral-contraceptive use has been shown to contribute substantially to the incidence of myocardial infarction in women in their mid-thirties or older with smoking accounting for the majority of excess cases. Mortality rates associated with circulatory disease have been shown to increase substantially in smokers over the age of 35 and nonsmokers over the age of 40 (Table III) among women who use oral contraceptives.

Oral contraceptives may compound the effects of well-known risk factors, such as hypertension, diabetes, hyperlipidemias, age and obesity. In particular, some progestogens are known to decrease HDL cholesterol and cause glucose intolerance, while estrogens may create a state of hyperinsulinism. Oral contraceptives have been shown to increase blood pressure among users (see **section 9 in WARNINGS**). Similar effects on risk factors have been associated with an increased risk of heart disease. Oral contraceptives must be used with caution in women with cardiovascular disease risk factors.

**CIRCULATORY DISEASE MORTALITY RATES PER 100,000 WOMAN YEARS
BY AGE, SMOKING STATUS AND ORAL-CONTRACEPTIVE USE**

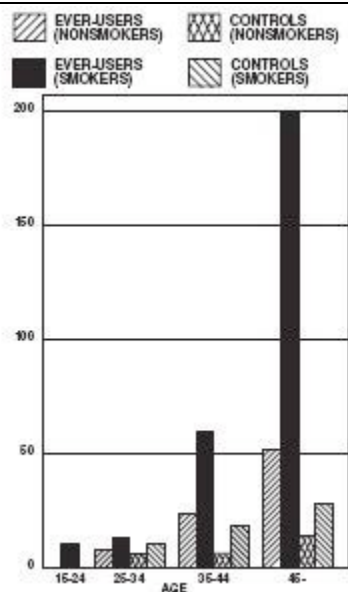


TABLE III. (Adapted from P.M. Layde and V. Beral, Lancet, 1:541-546, 1981.)

b. Thromboembolism

An increased risk of venous thromboembolic and thrombotic disease associated with the use of oral contraceptives is well established. Case control studies have found the relative risk of users compared to non-users to be 3 for the first episode of superficial venous thrombosis, 4 to 11 for deep vein thrombosis or pulmonary embolism, and 1.5 to 6 for women with predisposing conditions for venous thromboembolic disease. Cohort studies have shown the relative risk to be somewhat lower, about 3 for new cases and about 4.5 for new cases requiring hospitalization. The risk of thromboembolic disease due to oral contraceptives is not related to length of use and disappears after pill use is stopped.

A two- to four-fold increase in relative risk of postoperative thromboembolic complications has been reported with the use of oral contraceptives. The relative risk of venous thrombosis in women who have predisposing conditions is twice that of women without such medical conditions. If feasible, oral contraceptives should be discontinued at least four weeks prior to and for two weeks after elective surgery of a type associated with an increase in risk of thromboembolism and during and following prolonged immobilization. Since the immediate post-partum period is also associated with an increased risk of thromboembolism, oral contraceptives should be started no earlier than four to six weeks after delivery in women who elect not to breast-feed, or a midtrimester pregnancy termination.

c. Cerebrovascular diseases

Oral contraceptives have been shown to increase both the relative and attributable risks of cerebrovascular events (thrombotic and hemorrhagic strokes), although, in general, the risk is greatest among older (>35 years), hypertensive women who also smoke. Hypertension was found to be a risk factor for both users and non-users, for both types of strokes, while smoking interacted to increase the risk for hemorrhagic strokes.

In a large study, the relative risk of thrombotic strokes has been shown to range from 3 for normotensive users to 14 for users with severe hypertension. The relative risk of hemorrhagic stroke is reported to be 1.2 for nonsmokers who used oral contraceptives, 2.6 for smokers who did not use oral contraceptives, 7.6 for smokers who used oral contraceptives, 1.8 for normotensive users and 25.7 for users with severe hypertension. The attributable risk is also greater in older women.

d. Dose-related risk of vascular disease from oral contraceptives

A positive association has been observed between the amount of estrogen and progestogen in oral contraceptives and the risk of vascular disease. A decline in serum high-density lipoproteins (HDL) has been reported with many progestational agents. A decline in serum high-density lipoproteins has been associated with an increased incidence of ischemic heart disease. Because estrogens increase HDL cholesterol, the net effect of an oral contraceptive depends on a balance achieved between doses of estrogen and progestogen and the nature and absolute amount of progestogen used in the contraceptive. The amount of both hormones should be considered in the choice of an oral contraceptive.

Minimizing exposure to estrogen and progestogen is in keeping with good principles of therapeutics. For any particular estrogen/progestogen combination, the dosage regimen prescribed should be one which contains the least amount of estrogen and progestogen that is compatible with a low failure rate and the needs of the individual patient. New acceptors of oral contraceptive agents should be started on preparations containing less than 50 mcg of estrogen.

e. Persistence of risk of vascular disease

There are two studies which have shown persistence of risk of vascular disease for ever-users of oral contraceptives. In a study in the United States, the risk of developing myocardial infarction after discontinuing oral contraceptives persists for at least 9 years for women 40-49 years who had used oral contraceptives for five or more years, but this increased risk was not demonstrated in other age groups.

In another study in Great Britain, the risk of developing cerebrovascular disease persisted for at least 6 years after discontinuation of oral contraceptives, although excess risk was very small. However, both studies were performed with oral contraceptive formulations containing 50 micrograms or higher of estrogens.

2. ESTIMATES OF MORTALITY FROM CONTRACEPTIVE USE

One study gathered data from a variety of sources which have estimated the mortality rate associated with different methods of contraception at different ages (Table IV). These estimates include the combined risk of death associated with contraceptive methods plus the risk attributable to pregnancy in the event of method failure. Each method of contraception has its specific benefits and risks. The study concluded that with the exception of oral-contraceptive users 35 and older who smoke and 40 and older who do not smoke, mortality associated with all methods of birth control is less than that associated with childbirth. The observation of a possible increase in risk of mortality with age for oral-contraceptive users is based on data gathered in the 1970's-but not reported until 1983. However, current clinical practice involves the use of lower estrogen dose formulations combined with careful restriction of oral contraceptive use to women who do not have the various risk factors listed in this labeling.

Because of these changes in practice and, also, because of some limited new data which suggest that the risk of cardiovascular disease with the use of oral contraceptives may now be less than previously observed, the Fertility and Maternal Health Drugs Advisory Committee was asked to review the topic in 1989. The Committee concluded that although cardiovascular disease risks may be increased with oral-contraceptive use after age 40 in healthy non-smoking women (even with the newer lowdose formulations), there are greater potential health risks associated with pregnancy in older women and with the alternative surgical and medical procedures which may be necessary if such women do not have access to effective and acceptable means of contraception.

Therefore, the Committee recommended that the benefits of oral contraceptive use by healthy non-smoking women over 40 may outweigh the possible risks. Of course, older women, as all women who take oral contraceptives, should take the lowest possible dose formulation that is effective.

TABLE IV: ANNUAL NUMBER OF BIRTH-RELATED OR METHOD-RELATED DEATHS ASSOCIATED WITH CONTROL OF FERTILITY PER 100,000 NONSTERILE WOMEN, BY FERTILITY-CONTROL METHOD AND ACCORDING TO AGE

Method of control and outcome	15-19	20-24	25-29	30-34	35-39	40-44
No fertility-control methods*	7.0	7.4	9.1	14.8	25.7	28.2
Oral contraceptives						
nonsmoker**	0.3	0.5	0.9	1.9	13.8	31.6
Oral contraceptives						
smoker**	2.2	3.4	6.6	13.5	51.1	117.2
IUD**	0.8	0.8	1.0	1.0	1.4	1.4
Condom*	1.1	1.6	0.7	0.2	0.3	0.4
Diaphragm/spermicide*	1.9	1.2	1.2	1.3	2.2	2.8
Periodic abstinence*	2.5	1.6	1.6	1.7	2.9	3.6

* Deaths are birth-related

** Deaths are method-related

Adapted from H.W. Ory, Family Planning Perspectives, 15: 57-63, 1983.

3. CARCINOMA OF THE REPRODUCTIVE ORGANS

Numerous epidemiological studies have been performed on the incidence of breast, endometrial, ovarian and cervical cancer in women using oral contraceptives. The overwhelming evidence in the literature suggests that use of oral contraceptives is not associated with an increase in the risk of developing breast cancer, regardless of the age and parity of first use or with most of the marketed brands and doses. The Cancer and Steroid Hormone (CASH) study also showed no latent effect on the risk of breast cancer for at least a decade following long-term use. A few studies have shown a slightly increased relative risk of developing breast cancer, although the methodology of these studies, which included differences in examination of users and nonusers and differences in age at start of use, has been questioned.

Some studies suggest that oral contraceptive use has been associated with an increase in the risk of cervical intraepithelial neoplasia in some populations of women. However, there continues to be controversy about the extent to which such findings may be due to differences in sexual behavior and other factors.

In spite of many studies of the relationship between oral contraceptive use and breast and cervical cancers, a cause-and-effect relationship has not been established.

4. HEPATIC NEOPLASIA

Benign hepatic adenomas are associated with oral-contraceptive use, although the incidence of these benign tumors is rare in the United States. Indirect calculations have estimated the

attributable risk to be in the range of 3.3 cases/100,000 for users, a risk that increases after four or more years of use. Rupture of rare, benign, hepatic adenomas may cause death through intra-abdominal hemorrhage.

Studies from Britain have shown an increased risk of developing hepatocellular carcinoma in long-term (>8 years) oral-contraceptive users. However, these cancers are extremely rare in the U.S. and the attributable risk (the excess incidence) of liver cancers in oral-contraceptive users approaches less than one per million users.

5. OCULAR LESIONS

There have been clinical case reports of retinal thrombosis associated with the use of oral contraceptives that may lead to partial or complete loss of vision. Oral contraceptives should be discontinued if there is unexplained partial or complete loss of vision; onset of proptosis or diplopia; papilledema; or retinal vascular lesions. Appropriate diagnostic and therapeutic measures should be undertaken immediately.

6. ORAL-CONTRACEPTIVE USE BEFORE OR DURING EARLY PREGNANCY

Extensive epidemiological studies have revealed no increased risk of birth defects in women who have used oral contraceptives prior to pregnancy. Studies also do not suggest a teratogenic effect, particularly in so far as cardiac anomalies and limb-reduction defects are concerned, when taken inadvertently during early pregnancy (see **CONTRAINDICATIONS**).

The administration of oral contraceptives to induce withdrawal bleeding should not be used as a test for pregnancy. Oral contraceptives should not be used during pregnancy to treat threatened or habitual abortion.

It is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing oral-contraceptive use. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. Oral-contraceptive use should be discontinued if pregnancy is confirmed.

7. GALLBLADDER DISEASE

Earlier studies have reported an increased lifetime relative risk of gallbladder surgery in users of oral contraceptives and estrogens. More recent studies, however, have shown that the relative risk of developing gallbladder disease among oral-contraceptive users may be minimal. The recent findings of minimal risk may be related to the use of oral contraceptive formulations containing lower hormonal doses of estrogens and progestogens.

8. CARBOHYDRATE AND LIPID METABOLIC EFFECTS

Oral contraceptives have been shown to cause glucose intolerance in a significant percentage of users. Oral contraceptives containing greater than 75 micrograms of estrogens cause hyperinsulinism, while lower doses of estrogen cause less glucose intolerance. Progestogens increase insulin secretion and create insulin resistance, this effect varying with different progestational agents. However, in the nondiabetic woman, oral contraceptives appear to have no effect on fasting blood glucose. Because of these demonstrated effects, prediabetic and diabetic women should be carefully observed while taking oral contraceptives.

A small proportion of women will have persistent hypertriglyceridemia while on the pill. As discussed earlier (see **WARNINGS, 1a.** and **1d.**), changes in serum triglycerides and lipoprotein levels have been reported in oral-contraceptive users.

9. ELEVATED BLOOD PRESSURE

An increase in blood pressure has been reported in women taking oral contraceptives and this increase is more likely in older oral-contraceptive users and with continued use. Data from the Royal College of General Practitioners and subsequent randomized trials have shown that the incidence of hypertension increases with increasing quantities of progestogens.

Women with a history of hypertension or hypertension-related diseases, or renal disease should be encouraged to use another method of contraception. If women with hypertension elect to use oral contraceptives, they should be monitored closely and if significant elevation of blood pressure occurs, oral contraceptives should be discontinued. For most women, elevated blood pressure will return to normal after stopping oral contraceptives, and there is no difference in the occurrence of hypertension among ever- and never-users.

10. HEADACHE

The onset or exacerbation of migraine or development of headache with a new pattern that is recurrent, persistent or severe requires discontinuation of oral contraceptives and evaluation of the cause. (See **WARNINGS, 1c.**)

11. BLEEDING IRREGULARITIES

Breakthrough bleeding and spotting are sometimes encountered in patients on oral contraceptives, especially during the first three months of use. The type and dose of progestogen may be important. Nonhormonal causes should be considered and adequate diagnostic measures taken to rule out malignancy or pregnancy in the event of breakthrough bleeding, as in the case of any abnormal vaginal bleeding. If pathology has been excluded, time or a change to another formulation may solve the problem. In the event of amenorrhea, pregnancy should be ruled out.

Some women may encounter post-pill amenorrhea or oligomenorrhea, especially when such a condition was pre-existent.

PRECAUTIONS

Patients should be counseled that this product does not protect against HIV infection (AIDS) and other sexually transmitted diseases.

1. PHYSICAL EXAMINATION AND FOLLOW-UP

A periodic history and physical examination are appropriate for all women, including women using oral contraceptives. The physical examination, however, may be deferred until after initiation of oral contraceptives if requested by the woman and judged appropriate by the clinician. The physical examination should include special reference to blood pressure, breasts, abdomen and pelvic organs, including cervical cytology, and relevant laboratory tests.

In case of undiagnosed, persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures should be conducted to rule out malignancy. Women with a strong family history of breast cancer or who have breast nodules should be monitored with particular care.

2. LIPID DISORDERS

Women who are being treated for hyperlipidemias should be followed closely if they elect to use oral contraceptives. Some progestogens may elevate LDL levels and may render the control of hyperlipidemias more difficult. (See **WARNINGS, 1d.**)

3. LIVER FUNCTION

If jaundice develops in any woman receiving such drugs, the medication should be discontinued. Steroid hormones may be poorly metabolized in patients with impaired liver function.

4. FLUID RETENTION

Oral contraceptives may cause some degree of fluid retention. They should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated by fluid retention.

5. EMOTIONAL DISORDERS

Patients becoming significantly depressed while taking oral contraceptives should stop the medication and use an alternate method of contraception in an attempt to determine whether the symptom is drug related. Women with a history of depression should be carefully observed and the drug discontinued if depression recurs to a serious degree.

6. CONTACT LENSES

Contact-lens wearers who develop visual changes or changes in lens tolerance should be assessed by an ophthalmologist.

7. DRUG INTERACTIONS

Reduced efficacy and increased incidence of breakthrough bleeding and menstrual irregularities have been associated with concomitant use of rifampin. A similar association, though less marked, has been suggested with barbiturates, phenylbutazone, phenytoin, and possibly with griseofulvin, ampicillin, and tetracyclines.

8. INTERACTIONS WITH LABORATORY TESTS

Certain endocrine- and liver-function tests and blood components may be affected by oral contraceptives:

- a. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.
- b. Increased thyroid-binding globulin (TBG) leading to increased circulating total thyroid

hormone, as measured by protein-bound iodine (PBI), T4 by column or by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered.

- c. Other binding proteins may be elevated in serum.
- d. Sex-hormone binding globulins are increased and result in elevated levels of total circulating sex steroids; however, free or biologically active levels remain unchanged.
- e. Triglycerides may be increased.
- f. Glucose tolerance may be decreased.
- g. Serum folate levels may be depressed by oral-contraceptive therapy. This may be of clinical significance if a woman becomes pregnant shortly after discontinuing oral contraceptives.

9. CARCINOGENESIS

See **WARNINGS**.

10. PREGNANCY

Pregnancy Category X. (See **CONTRAINDICATIONS** and **WARNINGS**.)

11. NURSING MOTHERS

Small amounts of oral-contraceptive steroids have been identified in the milk of nursing mothers, and a few adverse effects on the child have been reported, including jaundice and breast enlargement. In addition, combination oral contraceptives given in the postpartum period may interfere with lactation by decreasing the quantity and quality of breast milk. If possible, the nursing mother should be advised not to use oral contraceptives but to use other forms of contraception until she has completely weaned her child.

INFORMATION FOR THE PATIENT

See [Patient Labeling Printed Below](#).

ADVERSE REACTIONS

An increased risk of the following serious adverse reactions has been associated with the use of oral contraceptives (see **WARNINGS**):

- Thrombophlebitis
- Arterial thromboembolism
- Pulmonary embolism
- Myocardial infarction
- Cerebral hemorrhage
- Cerebral thrombosis
- Hypertension
- Gallbladder disease
- Hepatic adenomas or benign liver tumors.

There is evidence of an association between the following conditions and the use of oral contraceptives, although additional confirmatory studies are needed:

- Mesenteric thrombosis
- Retinal thrombosis

The following adverse reactions have been reported in patients receiving oral contraceptives and are believed to be drug related:

- Nausea
- Vomiting
- Gastrointestinal symptoms (such as abdominal cramps and bloating)
- Breakthrough bleeding
- Spotting
- Change in menstrual flow
- Amenorrhea
- Temporary infertility after discontinuation of treatment
- Edema
- Melasma which may persist
- Breast changes: tenderness, enlargement, secretion
- Change in weight (increase or decrease)
- Change in cervical erosion and secretion
- Diminution in lactation when given immediately postpartum
- Cholestatic jaundice
- Migraine
- Rash (allergic)
- Mental depression
- Reduced tolerance to carbohydrates
- Vaginal candidiasis
- Change in corneal curvature (steepening)
- Intolerance to contact lenses

The following adverse reactions have been reported in users of oral contraceptives and the association has been neither confirmed nor refuted:

- Premenstrual syndrome
- Cataracts
- Optic neuritis
- Changes in appetite
- Cystitis-like syndrome
- Headache
- Nervousness
- Dizziness
- Hirsutism
- Loss of scalp hair

- Erythema multiforme
- Erythema nodosum
- Hemorrhagic eruption
- Vaginitis
- Porphyria
- Impaired renal function
- Hemolytic uremic syndrome
- Budd-Chiari syndrome
- Acne
- Changes in libido
- Colitis

OVERDOSAGE

Serious ill effects have not been reported following acute ingestion of large doses of oral contraceptives by young children. Overdosage may cause nausea, and withdrawal bleeding may occur in females.

Noncontraceptive Health Benefits

The following noncontraceptive health benefits related to the use of oral contraceptives are supported by epidemiological studies which largely utilized oral-contraceptive formulations containing doses exceeding 0.035 mg of ethinyl estradiol or 0.05 mg of mestranol.

Effects on menses:

- Increased menstrual cycle regularity
- Decreased blood loss and decreased incidence of iron-deficiency anemia
- Decreased incidence of dysmenorrhea

Effects related to inhibition of ovulation:

- Decreased incidence of functional ovarian cysts
- Decreased incidence of ectopic pregnancies

Effects from long-term use:

- Decreased incidence of fibroadenomas and fibrocystic disease of the breast
- Decreased incidence of acute pelvic inflammatory disease
- Decreased incidence of endometrial cancer
- Decreased incidence of ovarian cancer

DOSAGE AND ADMINISTRATION

To achieve maximum contraceptive effectiveness, Lutera[®] must be taken exactly as directed and at intervals not exceeding 24 hours.

The dosage of Lutera is one white tablet daily for 21 consecutive days, followed by one peach inert tablet daily for 7 consecutive days, according to the prescribed schedule.

It is recommended that Lutera tablets be taken at the same time each day.

Sunday start:

During the first cycle of medication, the patient is instructed to begin taking Lutera on the first Sunday after the onset of menstruation. If menstruation begins on a Sunday, the first tablet (white) is taken that day. One white tablet should be taken daily for 21 consecutive days, followed by one peach inert tablet daily for seven consecutive days. Withdrawal bleeding should usually occur within three days following discontinuation of white tablets. During the first cycle, contraceptive reliance should not be placed on Lutera until a white tablet has been taken daily for 7 consecutive days. The possibility of ovulation and conception prior to initiation of medication should be considered.

The patient begins her next and all subsequent 28-day courses of tablets on the same day of the week (Sunday) on which she began her first course, following the same schedule: 21 days on white tablets—7 days on peach inert tablets. If in any cycle the patient starts tablets later than the proper day, she should protect herself against pregnancy by using another method of birth control until she has taken a white tablet daily for 7 consecutive days.

Day 1 start:

During the first cycle of medication, the patient is instructed to begin taking Lutera during the first 24 hours of her period (day one of her menstrual cycle). One white tablet should be taken daily for 21 consecutive days, followed by one peach inert tablet daily for seven consecutive days. Withdrawal bleeding should usually occur within three days following discontinuation of white tablets. If medication is begun on day one of the menstrual cycle, no back-up contraception is necessary. If Lutera tablets are started later than day one of the first menstrual cycle or postpartum, contraceptive reliance should not be placed on Lutera tablets until after the first 7 consecutive days of administration. The possibility of ovulation and conception prior to initiation of medication should be considered.

When the patient is switching from a 21-day regimen of tablets, she should wait 7 days after her last tablet before she starts Lutera. She will probably experience withdrawal bleeding during that week. She should be sure that no more than 7 days pass after her previous 21-day regimen. When the patient is switching from a 28-day regimen of tablets, she should start her first pack of Lutera on the day after her last tablet. She should not wait any days between packs.

If spotting or breakthrough bleeding occur, the patient is instructed to continue on the same regimen. This type of bleeding is usually transient and without significance; however, if the bleeding is persistent or prolonged, the patient is advised to consult her physician. While there is little likelihood of ovulation occurring if only one or two white tablets are missed, the possibility of ovulation increases with each successive day that scheduled white tablets are missed. Although the occurrence of pregnancy is unlikely if Lutera is taken according to directions, if withdrawal bleeding does not occur, the possibility of pregnancy must be considered. If the patient has not adhered to the prescribed schedule (missed one or more tablets or started taking them on a day later than she should have), the probability of pregnancy should be considered at the time of the first missed period and appropriate diagnostic measures taken before the medication is resumed. If the patient has adhered to the

prescribed regimen and misses two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen.

The risk of pregnancy increases with each active (white) tablet missed. For additional patient instructions regarding missed tablets, see the **“WHAT TO DO IF YOU MISS PILLS”** section in the **DETAILED PATIENT LABELING**, below.

In the nonlactating mother, Lutera may be initiated postpartum, for contraception. When the tablets are administered in the postpartum period, the increased risk of thromboembolic disease associated with the postpartum period must be considered (see **CONTRAINDICATIONS**, **WARNINGS**, and **PRECAUTIONS** concerning thromboembolic disease).

HOW SUPPLIED

Lutera[®] tablets (0.1 mg levonorgestrel and 0.02 mg ethinyl estradiol) are available in a 28 Tablet Dispenser, arranged in 3 rows of 7 active tablets and 1 row of inert tablets, as follows:

21 active tablets: white, round tablet debossed with “WATSON” on one side and “949” on the other side.

7 inert tablets: peach, round tablet debossed with “WATSON” on one side and “P1” on the other side.

Store at 20°-25°C (68°-77°F). [See USP controlled room temperature].

BRIEF SUMMARY PATIENT PACKAGE INSERT

This product (like all oral contraceptives) is intended to prevent pregnancy. It does not protect against HIV infection (AIDS) and other sexually transmitted diseases.

Oral contraceptives, also known as “birth-control pills” or “the pill”, are taken to prevent pregnancy, and when taken correctly, have a failure rate of less than 1% per year when used without missing any pills. The typical failure rate of large numbers of pill users is less than 3% per year when women who miss pills are included. For most women oral contraceptives are also free of serious or unpleasant side effects. However, forgetting to take pills considerably increases the chances of pregnancy.

For the majority of women, oral contraceptives can be taken safely. But there are some women who are at high risk of developing certain serious diseases that can be life-threatening or may cause temporary or permanent disability or death. The risks associated with taking oral contraceptives increase significantly if you:

- smoke
- have high blood pressure, diabetes, high cholesterol
- have or have had clotting disorders, heart attack, stroke, angina pectoris, cancer of the breast or sex organs, jaundice, or malignant or benign liver tumors

You should not take the pill if you suspect you are pregnant or have unexplained vaginal bleeding.

Cigarette smoking increases the risk of serious cardiovascular side effects from oral-contraceptive use. This risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over 35 years of age. Women who use oral contraceptives should be strongly advised not to smoke.

Most side effects of the pill are not serious. The most common such effects are nausea, vomiting, bleeding between menstrual periods, weight gain, breast tenderness, and difficulty wearing contact lenses. These side effects, especially nausea and vomiting, may subside within the first three months of use.

The serious side effects of the pill occur very infrequently, especially if you are in good health and do not smoke. However, you should know that the following medical conditions have been associated with or made worse by the pill:

1. Blood clots in the legs (thrombophlebitis), lungs (pulmonary embolism), stoppage or rupture of a blood vessel in the brain (stroke), blockage of blood vessels in the heart (heart attack and angina pectoris) or other organs of the body. As mentioned above, smoking increases the risk of heart attacks and strokes and subsequent serious medical consequences.
2. Liver tumors, which may rupture and cause severe bleeding. A possible but not definite association has been found with the pill and liver cancer. However, liver cancers are extremely rare. The chance of developing liver cancer from using the pill is thus even rarer.
3. High blood pressure, although blood pressure usually returns to normal when the pill is stopped.

The symptoms associated with these serious side effects are discussed in the detailed leaflet given to you with your supply of pills. Notify your doctor or health-care provider if you notice any unusual physical disturbances while taking the pill. In addition, drugs such as rifampin, as well as some anticonvulsants and some antibiotics, may decrease oral contraceptive effectiveness.

Studies to date of women taking the pill have not shown an increase in the incidence of cancer of the breast or cervix. There is, however, insufficient evidence to rule out the possibility that pills may cause such cancers. Taking the pill provides some important noncontraceptive benefits. These include less painful menstruation, less menstrual blood loss and anemia, fewer pelvic infections, and fewer cancers of the ovary and the lining of the uterus.

Be sure to discuss any medical condition you may have with your healthcare provider. Your health-care provider will take a medical and family history before prescribing oral contraceptives and will examine you. The physical examination may be delayed to another time if you request it and the health-care provider believes that it is appropriate to postpone it. You should be re-examined at least once a year while taking oral contraceptives. The detailed patient information leaflet gives you further information which you should read and discuss with your health-care provider.

This product (like all oral contraceptives) is intended to prevent pregnancy. It does not protect

against transmission of HIV (AIDS) and other sexually transmitted diseases such as chlamydia, genital herpes, genital warts, gonorrhea, hepatitis B, and syphilis.

DETAILED PATIENT LABELING

This product (like all oral contraceptives) is intended to prevent pregnancy. It does not protect against HIV infection (AIDS) and other sexually transmitted diseases.

INTRODUCTION

Any woman who considers using oral contraceptives (the birth-control pill or the pill) should understand the benefits and risks of using this form of birth control. This leaflet will give you much of the information you will need to make this decision and will also help you determine if you are at risk of developing any of the serious side effects of the pill. It will tell you how to use the pill properly so that it will be as effective as possible. However, this leaflet is not a replacement for a careful discussion between you and your health-care provider. You should discuss the information provided in this leaflet with him or her, both when you first start taking the pill and during your revisits. You should also follow your health-care provider's advice with regard to regular check-ups while you are on the pill.

EFFECTIVENESS OF ORAL CONTRACEPTIVES

Oral contraceptives or "birth-control pills" or "the pill" are used to prevent pregnancy and are more effective than other nonsurgical methods of birth control. When they are taken correctly, the chance of becoming pregnant is less than 1% per year when used perfectly, without missing any pills. Typical failure rates are less than 3% per year. The chance of becoming pregnant increases with each missed pill during the menstrual cycle.

In comparison, typical failure rates for other methods of birth control during the first year of use are as follows:

IUD: 3%	Female condom alone: 21%
Depo-Provera® (injectable progestogen): 0.3%	Cervical cap
Norplant® System (implants): 0.1%	Nulliparous women: 18%
Diaphragm with spermicides: 18%	Parous women: 36%
Spermicides alone: 21%	Periodic abstinence: 20%
Male condom alone: 12%	No methods: 85%

WHO SHOULD NOT TAKE ORAL CONTRACEPTIVES

Cigarette smoking increases the risk of serious adverse effects on the heart and blood vessels from oral-contraceptive use. This risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over 35 years of age. Women who use oral contraceptives should not smoke.

Some women should not use the pill. For example, you should not take the pill if you are

pregnant or think you may be pregnant. You should also not use the pill if you have had any of the following conditions:

- Heart attack or stroke
- Blood clots in the legs (thrombophlebitis), lungs (pulmonary embolism), or eyes
- Blood clots in the deep veins of your legs
- Known or suspected breast cancer or cancer of the lining of the uterus, cervix or vagina
- Liver tumor (benign or cancerous)

Or, if you have any of the following:

- Chest pain (angina pectoris)
- Unexplained vaginal bleeding (until a diagnosis is reached by your doctor)
- Yellowing of the whites of the eyes or of the skin (jaundice) during pregnancy or during previous use of the pill
- Known or suspected pregnancy

Tell your health-care provider if you have ever had any of these conditions. Your health-care provider can recommend another method of birth control.

OTHER CONSIDERATIONS BEFORE TAKING ORAL CONTRACEPTIVES

Tell your health-care provider if you or any family member has ever had:

- Breast nodules, fibrocystic disease of the breast, an abnormal breast X-ray or mammogram
- Diabetes
- Elevated cholesterol or triglycerides
- High blood pressure
- Migraine or other headaches or epilepsy
- Mental depression
- Gallbladder, heart, or kidney disease
- History of scanty or irregular menstrual periods

Women with any of these conditions should be checked often by their health-care provider if they choose to use oral contraceptives. Also, be sure to inform your doctor or health-care provider if you smoke or are on any medications.

RISKS OF TAKING ORAL CONTRACEPTIVES

1. Risk of developing blood clots

Blood clots and blockage of blood vessels are the most serious side effects of taking oral contraceptives and can be fatal. In particular, a clot in the legs can cause thrombophlebitis and a clot that travels to the lungs can cause a sudden blocking of the vessel carrying blood to the lungs. Rarely, clots occur in the blood vessels of the eye and may cause blindness, double vision, or impaired vision.

If you take oral contraceptives and need elective surgery, need to stay in bed for a prolonged illness, or have recently delivered a baby, you may be at risk of developing blood clots. You should consult your doctor about stopping oral contraceptives three to four weeks before surgery and not taking oral contraceptives for two weeks after surgery or during bed rest. You should also not take oral contraceptives soon after delivery of a baby or a midtrimester pregnancy termination. It is advisable to wait for at least four weeks after delivery if you are not breast-feeding. If you are breast-feeding, you should wait until you have weaned your child before using the pill. (See also the section on [breast-feeding in GENERAL PRECAUTIONS](#).)

2. Heart attacks and strokes

Oral contraceptives may increase the tendency to develop strokes (stoppage or rupture of blood vessels in the brain) and angina pectoris and heart attacks (blockage of blood vessels in the heart). Any of these conditions can cause death or serious disability.

Smoking greatly increases the possibility of suffering heart attacks and strokes. Furthermore, smoking and the use of oral contraceptives greatly increase the chances of developing and dying of heart disease.

3. Gallbladder disease

Oral-contraceptive users probably have a greater risk than non-users of having gallbladder disease, although this risk may be related to pills containing high doses of estrogens.

4. Liver tumors

In rare cases, oral contraceptives can cause benign but dangerous liver tumors. These benign liver tumors can rupture and cause fatal internal bleeding. In addition, a possible but not definite association has been found with the pill and liver cancers in two studies in which a few women who developed these very rare cancers were found to have used oral contraceptives for long periods. However, liver cancers are extremely rare. The chance of developing liver cancer from using the pill is thus even rarer.

5. Cancer of the reproductive organs

There is, at present, no confirmed evidence that oral contraceptives increase the risk of cancer of the reproductive organs in human studies. Several studies have found no overall increase in the risk of developing breast cancer. However, women who use oral contraceptives and have a strong family history of breast cancer or who have breast nodules or abnormal mammograms should be closely followed by their doctors.

Some studies have found an increase in the incidence of cancer of the cervix in women who use oral contraceptives. However, this finding may be related to factors other than the use of oral contraceptives.

ESTIMATED RISK OF DEATH FROM A BIRTH-CONTROL METHOD OR PREGNANCY

All methods of birth control and pregnancy are associated with a risk of developing certain

diseases which may lead to disability or death. An estimate of the number of deaths associated with different methods of birth control and pregnancy has been calculated and is shown in the following table.

ANNUAL NUMBER OF BIRTH-RELATED OR METHOD-RELATED DEATHS ASSOCIATED WITH CONTROL OF FERTILITY PER 100,000 NONSTERILE WOMEN, BY FERTILITY-CONTROL METHOD AND ACCORDING TO AGE

Method of control and outcome	15–19	20–24	25–29	30–34	35–39	40–44
No fertility-control methods*	7.0	7.4	9.1	14.8	25.7	28.2
Oral contraceptives						
nonsmoker**	0.3	0.5	0.9	1.9	13.8	31.6
Oral contraceptives						
smoker**	2.2	3.4	6.6	13.5	51.1	117.2
IUD**	0.8	0.8	1.0	1.0	1.4	1.4
Condom*	1.1	1.6	0.7	0.2	0.3	0.4
Diaphragm/spermicide*	1.9	1.2	1.2	1.3	2.2	2.8
Periodic abstinence*	2.5	1.6	1.6	1.7	2.9	3.6

* Deaths are birth-related

** Deaths are method-related

In the above table, the risk of death from any birth-control method is less than the risk of childbirth, except for oral-contraceptive users over the age of 35 who smoke and pill users over the age of 40 even if they do not smoke. It can be seen in the table that for women aged 15 to 39, the risk of death was highest with pregnancy (7 to 26 deaths per 100,000 women, depending on age). Among pill users who do not smoke, the risk of death was always lower than that associated with pregnancy for any age group, except for those women over the age of 40, when the risk increases to 32 deaths per 100,000 women, compared to 28 associated with pregnancy at that age. However, for pill users who smoke and are over the age of 35, the estimated number of deaths exceeds those for other methods of birth control. If a woman is over the age of 40 and smokes, her estimated risk of death is four times higher (117/100,000 women) than the estimated risk associated with pregnancy (28/100,000 women) in that age group.

The suggestion that women over 40 who don't smoke should not take oral contraceptives is based on information from older high-dose pills and on less-selective use of pills than is practiced today. An Advisory Committee of the FDA discussed this issue in 1989 and recommended that the benefits of oral-contraceptive use by healthy, non-smoking women over 40 years of age may outweigh the possible risks. However, all women, especially older women, are cautioned to use the lowest-dose pill that is effective.

WARNINGS SIGNALS

If any of these adverse effects occur while you are taking oral contraceptives, call your doctor immediately:

- Sharp chest pain, coughing of blood, or sudden shortness of breath (indicating a possible

clot in the lung)

- Pain in the calf (indicating a possible clot in the leg)
- Crushing chest pain or heaviness in the chest (indicating a possible heart attack)
- Sudden severe headache or vomiting, dizziness or fainting, disturbances of vision or speech, weakness, or numbness in an arm or leg (indicating a possible stroke)
- Sudden partial or complete loss of vision (indicating a possible clot in the eye)
- Breast lumps (indicating possible breast cancer or fibrocystic disease of the breast; ask your doctor or health-care provider to show you how to examine your breasts)
- Severe pain or tenderness in the stomach area (indicating a possibly ruptured liver tumor)
- Difficulty in sleeping, weakness, lack of energy, fatigue, or change in mood (possibly indicating severe depression)
- Jaundice or a yellowing of the skin or eyeballs, accompanied frequently by fever, fatigue, loss of appetite, dark-colored urine, or light-colored bowel movements (indicating possible liver problems)

SIDE EFFECTS OF ORAL CONTRACEPTIVES

1. Vaginal bleeding

Irregular vaginal bleeding or spotting may occur while you are taking the pills. Irregular bleeding may vary from slight staining between menstrual periods to breakthrough bleeding which is a flow much like a regular period. Irregular bleeding occurs most often during the first few months of oral-contraceptive use, but may also occur after you have been taking the pill for some time. Such bleeding may be temporary and usually does not indicate any serious problems. It is important to continue taking your pills on schedule. If the bleeding occurs in more than one cycle or lasts for more than a few days, talk to your doctor or health-care provider.

2. Contact lenses

If you wear contact lenses and notice a change in vision or an inability to wear your lenses, contact your doctor or health-care provider.

3. Fluid retention

Oral contraceptives may cause edema (fluid retention) with swelling of the fingers or ankles and may raise your blood pressure. If you experience fluid retention, contact your doctor or health-care provider.

4. Melasma

A spotty darkening of the skin is possible, particularly of the face.

5. Other side effects

Other side effects may include change in appetite, headache, nervousness, depression,

dizziness, loss of scalp hair, rash, and vaginal infections.

If any of these side effects bother you, call your doctor or healthcare provider.

GENERAL PRECAUTIONS

1. Missed periods and use of oral contraceptives before or during early pregnancy.

There may be times when you may not menstruate regularly after you have completed taking a cycle of pills. If you have taken your pills regularly and miss one menstrual period, continue taking your pills for the next cycle but be sure to inform your health-care provider before doing so. If you have not taken the pills daily as instructed and missed a menstrual period, or if you missed two consecutive menstrual periods, you may be pregnant. Check with your health-care provider immediately to determine whether you are pregnant. Do not continue to take oral contraceptives until you are sure you are not pregnant, but continue to use another method of contraception.

There is no conclusive evidence that oral-contraceptive use is associated with an increase in birth defects, when taken inadvertently during early pregnancy. Previously, a few studies had reported that oral contraceptives might be associated with birth defects, but these studies have not been confirmed. Nevertheless, oral contraceptives or any other drugs should not be used during pregnancy unless clearly necessary and prescribed by your doctor. You should check with your doctor about risks to your unborn child of any medication taken during pregnancy.

2. While breast-feeding

If you are breast-feeding, consult your doctor before starting oral contraceptives. Some of the drug will be passed on to the child in the milk. A few adverse effects on the child have been reported, including yellowing of the skin (jaundice) and breast enlargement. In addition, oral contraceptives may decrease the amount and quality of your milk. If possible, do not use oral contraceptives while breast-feeding. You should use another method of contraception since breast-feeding provides only partial protection from becoming pregnant and this partial protection decreases significantly as you breast-feed for longer periods of time. You should consider starting oral contraceptives only after you have weaned your child completely.

3. Laboratory tests

If you are scheduled for any laboratory tests, tell your doctor you are taking birth-control pills. Certain blood tests may be affected by birth-control pills.

4. Drug interactions

Certain drugs may interact with birth-control pills to make them less effective in preventing pregnancy or cause an increase in breakthrough bleeding. Such drugs include rifampin, drugs used for epilepsy such as barbiturates (for example, phenobarbital) and phenytoin (Dilantin is one brand of this drug), phenylbutazone (Butazolidin is one brand) and possibly certain antibiotics. You may need to use an additional method of contraception during any cycle in which you take drugs that can make oral contraceptives less effective.

HOW TO TAKE THE PILL

This product (like all oral contraceptives) is intended to prevent pregnancy. It does not protect against transmission of HIV (AIDS) and other sexually transmitted diseases such as chlamydia, genital herpes, genital warts, gonorrhea, hepatitis B, and syphilis.

IMPORTANT POINTS TO REMEMBER

BEFORE YOU START TAKING YOUR PILLS:

1. BE SURE TO READ THESE DIRECTIONS:

Before you start taking your pills.

And

Anytime you are not sure what to do.

2. THE RIGHT WAY TO TAKE THE PILL IS TO TAKE ONE PILL EVERY DAY AT THE SAME TIME.

If you miss pills you could get pregnant. This includes starting the pack late. The more pills you miss, the more likely you are to get pregnant.

3. MANY WOMEN HAVE SPOTTING OR LIGHT BLEEDING, OR MAY FEEL SICK TO THEIR STOMACH DURING THE FIRST 1-3 PACKS OF PILLS.

If you feel sick to your stomach, do not stop taking the pill. The problem will usually go away. If it doesn't go away, check with your doctor or clinic.

4. MISSING PILLS CAN ALSO CAUSE SPOTTING OR LIGHT BLEEDING, even when you make up these missed pills. On the days you take 2 pills to make up for missed pills, you could also feel a little sick to your stomach.

5. IF YOU HAVE VOMITING OR DIARRHEA, for any reason, or IF YOU TAKE SOME MEDICINES, including some antibiotics, your pills may not work as well.

Use a back-up method (such as condoms or foam) until you check with your doctor or clinic.

6. IF YOU HAVE TROUBLE REMEMBERING TO TAKE THE PILL, talk to your doctor or clinic about how to make pill-taking easier or about using another method of birth control.

7. IF YOU HAVE ANY QUESTIONS OR ARE UNSURE ABOUT THE INFORMATION IN THIS LEAFLET, call your doctor or clinic.

BEFORE YOU START TAKING YOUR PILLS

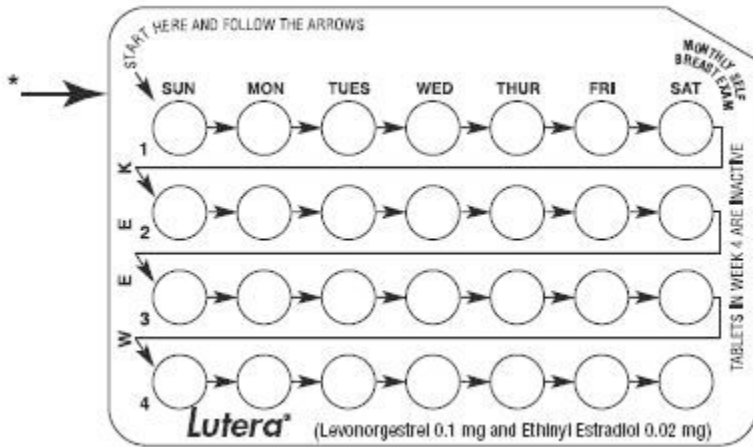
1. DECIDE WHAT TIME OF DAY YOU WANT TO TAKE YOUR PILL. It is important to take it at about the same time every day.

2. LOOK AT YOUR PILL PACK TO SEE IF IT HAS 28 PILLS:

The 28-pill pack has 21 “active” white pills (with hormones) to take for 3 weeks, followed by 1 week of reminder peach pills (without hormones).

3. ALSO FIND:

- 1) where on the pack to start taking pills, and
- 2) in what order to take the pills (follow the arrows).



4. BE SURE YOU HAVE READY AT ALL TIMES:

ANOTHER KIND OF BIRTH CONTROL (such as condoms or foam) to use as a back-up in case you miss pills.

AN EXTRA, FULL PILL PACK.

* For use of day labels, see **WHEN TO START THE FIRST PACK OF PILLS** below.

WHEN TO START THE FIRST PACK OF PILLS

You have a choice of which day to start taking your first pack of pills. Decide with your doctor or clinic which is the best day for you. Pick a time of day which will be easy to remember.

DAY 1 START:

1. Pick the day label strip that starts with the first day of your period. Place this day label strip over the area that has the days of the week (starting with Sunday) pre-printed on the tablet dispenser.

Note: if the first day of your period is a Sunday, you can skip step #1.

2. Take the first “active” white pill of the first pack during the *first 24 hours of your period*.

3. You will not need to use a back-up method of birth control, since you are starting the pill at the beginning of your period.

SUNDAY START:

1. Take the first “active” white pill of the first pack on the Sunday after your period starts, even if you are still bleeding. If your period begins on Sunday, start the pack that same day.
2. *Use another method of birth control* as a back-up method if you have sex anytime from the Sunday you start your first pack until the next Sunday (7 days). Condoms or foam are good back-up methods of birth control.

WHAT TO DO DURING THE MONTH

1. TAKE ONE PILL AT THE SAME TIME EVERY DAY UNTIL THE PACK IS EMPTY.

Do not skip pills even if you are spotting or bleeding between monthly periods or feel sick to your stomach (nausea).

Do not skip pills even if you do not have sex very often.

2. WHEN YOU FINISH A PACK OR SWITCH YOUR BRAND OF PILLS:

Start the next pack on the day after your last “reminder” pill. Do not wait any days between packs.

WHAT TO DO IF YOU MISS PILLS

If you **MISS 1** white “active” pill:

1. Take it as soon as you remember. Take the next pill at your regular time. This means you may take 2 pills in 1 day.
2. You do not need to use a back-up birth-control method if you have sex. If you **MISS 2** white “active” pills in a row in **WEEK 1 OR WEEK 2** of your pack:

1. Take 2 pills on the day you remember and 2 pills the next day.
2. Then take 1 pill a day until you finish the pack.
3. You **MAY BECOME PREGNANT** if you have sex in the 7 days after you miss pills. You **MUST** use another birth-control method (such as condoms or foam) as a back-up for those 7 days.

If you **MISS 2** white “active” pills in a row in **THE 3rd WEEK**:

1. *If you are a Day 1 Starter:*

THROW OUT the rest of the pill pack and start a new pack that same day.

If you are a Sunday Starter:

Keep taking 1 pill every day until Sunday.

On Sunday, THROW OUT the rest of the pack and start a new pack of pills that same day.

2. You may not have your period this month but this is expected. However, if you miss your

period 2 months in a row, call your doctor or clinic because you might be pregnant.

3. You MAY BECOME PREGNANT if you have sex in the 7 days after you miss pills. You MUST use another birth-control method (such as condoms, or foam) as a back-up for those 7 days.

If you **MISS 3 OR MORE** white “active” pills in a row (during the first 3 weeks):

1. If you are a Day 1 Starter:

THROW OUT the rest of the pill pack and start a new pack that same day.

If you are a Sunday Starter:

Keep taking 1 pill every day until Sunday.

On Sunday, THROW OUT the rest of the pack and start a new pack of pills that same day.

2. You may not have your period this month but this is expected.

However, if you miss your period 2 months in a row, call your doctor or clinic because you might be pregnant.

3. You MAY BECOME PREGNANT if you have sex in the 7 days after you miss pills. You MUST use another birth-control method (such as condoms, or foam) as a back-up for those 7 days.

A REMINDER FOR THOSE ON 28-DAY PACKS

If you forget any of the 7 peach “reminder” pills in Week 4:

THROW AWAY the pills you missed.

Keep taking 1 pill each day until the pack is empty.

You do not need a back-up method if you start your next pack on time.

FINALLY, IF YOU ARE STILL NOT SURE WHAT TO DO ABOUT THE PILLS YOU HAVE MISSED

Use a BACK-UP METHOD anytime you have sex.

KEEP TAKING ONE PILL EACH DAY until you can reach your doctor or clinic.

Pregnancy due to pill failure

The incidence of pill failure resulting in pregnancy is approximately less than 1% if taken every day as directed, but more typical failure rates are less than 3%. If failure does occur, the risk to the fetus is minimal.

RISKS TO THE FETUS

If you do become pregnant while using oral contraceptives, the risk to the fetus is small, on the order of no more than one per thousand. You should, however, discuss the risks to the developing child with your doctor.

Pregnancy after stopping the pill

There may be some delay in becoming pregnant after you stop using oral contraceptives, especially if you had irregular menstrual cycles before you used oral contraceptives. It may be advisable to postpone conception until you begin menstruating regularly once you have stopped taking the pill and desire pregnancy.

There does not appear to be any increase in birth defects in newborn babies when pregnancy occurs soon after stopping the pill.

Overdosage

Serious ill effects have not been reported following ingestion of large doses of oral contraceptives by young children. Overdosage may cause nausea and withdrawal bleeding in females. In case of overdosage, contact your health-care provider or pharmacist.

Other information

Your health-care provider will take a medical and family history before prescribing oral contraceptives and will examine you. The physical examination may be delayed to another time if you request it and the health-care provider believes that it is appropriate to postpone it. You should be re-examined at least once a year. Be sure to inform your health-care provider if there is a family history of any of the conditions listed previously in this leaflet. Be sure to keep all appointments with your health-care provider, because this is a time to determine if there are early signs of side effects of oral-contraceptive use.

Do not use the drug for any condition other than the one for which it was prescribed. This drug has been prescribed specifically for you; do not give it to others who may want birth-control pills.

HEALTH BENEFITS FROM ORAL CONTRACEPTIVES

In addition to preventing pregnancy, use of oral contraceptives may provide certain benefits. They are:

- Menstrual cycles may become more regular
- Blood flow during menstruation may be lighter, and less iron may be lost. Therefore, anemia due to iron deficiency is less likely to occur
- Pain or other symptoms during menstruation may be encountered less frequently
- Ovarian cysts may occur less frequently
- Ectopic (tubal) pregnancy may occur less frequently
- Noncancerous cysts or lumps in the breast may occur less frequently
- Acute pelvic inflammatory disease may occur less frequently
- Oral-contraceptive use may provide some protection against developing two forms of cancer: cancer of the ovaries and cancer of the lining of the uterus

If you want more information about birth-control pills, ask your doctor or pharmacist. They have a more technical leaflet called the Professional Labeling which you may wish to read.

Mfd. for: WATSON PHARMA, INC.

A subsidiary of Watson Pharmaceuticals, Inc.
Corona, CA 92880 USA

Mfd. by: Patheon, Inc.
Mississauga, Ontario L5N 7K9 Canada

Revised: April 2007

IN-5351/S

LUTERA

levonorgestrel and ethinyl estradiol tablet

Product Information

Product Type	HUMAN PRESCRIPTION DRUG	NDC Product Code (Source)	52544-949
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Packaging

#	NDC	Package Description	Multilevel Packaging
1	52544-949-28	6 BLISTER PACK In 1 CARTON	contains a BLISTER PACK
1		1 KIT In 1 BLISTER PACK	This package is contained within the CARTON (52544-949-28)

QUANTITY OF PARTS

Part #	Package Quantity	Total Product Quantity
Part 1	1 BLISTER PACK	21 TABLET in 1
Part 2	1 BLISTER PACK	7 TABLET in 1

Part 1 of 2

LUTERA

levonorgestrel and ethinyl estradiol tablet

Product Information

Route of Administration	ORAL	DEA Schedule	
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INGREDIENTS

Name (Active Moiety)	Type	Strength
levonorgestrel (levonorgestrel)	Active	0.1 MILLIGRAM In 1 TABLET
ethinyl estradiol (ethinyl)	Active	0.02 MILLIGRAM In 1 TABLET
croscarmellose sodium	Inactive	
lactose monohydrate	Inactive	
magnesium stearate	Inactive	
microcrystalline cellulose	Inactive	
povidone	Inactive	

Product Characteristics

Color	WHITE	Score	no score
Shape	ROUND	Size	6mm
Flavor		Imprint Code	WATSON;949
Contains			
Coating	false	Symbol	false

Packaging

#	NDC	Package Description	Multilevel Packaging
1		21 TABLET In 1 BLISTER PACK	None

Part 2 of 2

LUTERA
levonorgestrel and ethinyl estradiol tablet

Product Information

Route of Administration	ORAL	DEA Schedule	
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INGREDIENTS

Name (Active Moiety)	Type	Strength
FD & C Yellow #6	Inactive	
lactose anhydrous	Inactive	
lactose monohydrate	Inactive	
magnesium stearate	Inactive	
microcrystalline cellulose	Inactive	

Product Characteristics

Color	ORANGE (peach)	Score	no score
Shape	ROUND	Size	6mm
Flavor		Imprint Code	WATSON;949
Contains			
Coating	false	Symbol	false

Packaging

#	NDC	Package Description	Multilevel Packaging
1		7 TABLET In 1 BLISTER PACK	None

Labeler - Watson Laboratories, Inc.

Watson Laboratories, Inc.