

SUMMARY OF PRODUCT CHARACTERISTICS

▼ This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions. See section 4.8 for how to report adverse reactions.

1. NAME OF THE MEDICINAL PRODUCT

Bexsero[®] ▼ suspension for injection in pre-filled syringe
Meningococcal group B Vaccine (rDNA, component, adsorbed)

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

One dose (0.5 ml) contains:

Recombinant <i>Neisseria meningitidis</i> group B NHBA fusion protein ^{1,2,3}	50 micrograms
Recombinant <i>Neisseria meningitidis</i> group B NadA protein ^{1,2,3}	50 micrograms
Recombinant <i>Neisseria meningitidis</i> group B fHbp fusion protein ^{1,2,3}	50 micrograms
Outer membrane vesicles (OMV) from <i>Neisseria meningitidis</i> group B strain NZ98/254 measured as amount of total protein containing the PorA P1.4 ²	25 micrograms

¹ produced in *E. coli* cells by recombinant DNA technology

² adsorbed on aluminium hydroxide (0.5 mg Al³⁺)

³ NHBA (Neisseria Heparin Binding Antigen), NadA (Neisserial adhesin A), fHbp (factor H binding protein)

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Suspension for injection.
White opalescent liquid suspension.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Bexsero is indicated for active immunisation of individuals from 2 months of age and older against invasive meningococcal disease caused by *Neisseria meningitidis* group B.

The impact of invasive disease in different age groups as well as the variability of antigen epidemiology for group B strains in different geographical areas should be considered when vaccinating. See section 5.1 for information on protection against specific group B strains.

The use of this vaccine should be in accordance with official recommendations.

4.2 Posology and method of administration

Posology

Table 1. Summary of posology

Age Group	Primary Immunisation	Intervals between Primary Doses	Booster
Infants, 2 months to 5 months	Three doses each of 0.5 ml, with first dose given at 2 months of age ^a	Not less than 1 month	Yes, one dose between 12 and 23 months ^b
Unvaccinated infants, 6 months to 11 months	Two doses each of 0.5 ml	Not less than 2 months	Yes, one dose in the second year of life with an interval of at least 2 months between the primary series and booster dose ^b

Age Group	Primary Immunisation	Intervals between Primary Doses	Booster
Unvaccinated children, 12 months to 23 months	Two doses each of 0.5 ml	Not less than 2 months	Yes, one dose with an interval of 12 months to 23 months between the primary series and booster dose ^b
Children, 2 years to 10 years	Two doses each of 0.5 ml	Not less than 2 months	Need not established ^c
Adolescents (from 11 years of age) and adults*	Two doses each of 0.5 ml	Not less than 1 month	Need not established ^c

^a The first dose should be given at 2 months of age. The safety and efficacy of Bexsero in infants less than 8 weeks of age has not yet been established. No data are available.

^b see section 5.1. The need for, and timing of, further booster doses has not yet been determined.

^c see section 5.1.

* There are no data in adults above 50 years of age.

Method of administration

The vaccine is given by deep intramuscular injection, preferably in the anterolateral aspect of the thigh in infants or in the deltoid muscle region of the upper arm in older subjects.

Separate injection sites must be used if more than one vaccine is administered at the same time.

The vaccine must not be injected intravenously, subcutaneously or intradermally and must not be mixed with other vaccines in the same syringe.

For instructions on the handling of the vaccine before administration, see section 6.6.

4.3 Contraindications

Hypersensitivity to the active substances or to any of the excipients listed in section 6.1.

4.4 Special warnings and precautions for use

As with other vaccines, administration of Bexsero should be postponed in subjects suffering from an acute severe febrile illness. However, the presence of a minor infection, such as cold, should not result in the deferral of vaccination.

Do not inject intravascularly.

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

This vaccine should not be given to individuals with thrombocytopenia or any coagulation disorder that would contraindicate intramuscular injection, unless the potential benefit clearly outweighs the risk of administration.

Bexsero is not expected to provide protection against all circulating meningococcal group B strains (see section 5.1).

As with many vaccines, healthcare professional should be aware that a temperature elevation may occur following vaccination of infants and children (less than 2 years of age). Prophylactic administration of antipyretics at the time and closely after vaccination can reduce the incidence and intensity of post-vaccination febrile reactions. Antipyretic medication should be initiated according to local guidelines in infants and children (less than 2 years of age).

There are no data on the use of Bexsero in subjects with impaired immune responsiveness. In immunocompromised individuals, vaccination may not result in a protective antibody response.

There are no data on the use of Bexsero in subjects above 50 years of age or in patients with chronic medical conditions.

The potential risk of apnoea and the need for respiratory monitoring for 48-72 hours should be considered when administering the primary immunisation 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.

The tip cap of the syringe may contain natural rubber latex. Although the risk for developing allergic reactions is very small, healthcare professionals should consider the benefit-risk prior to administering this vaccine to subjects with known history of hypersensitivity to latex.

Kanamycin is used in early manufacturing process and is removed during the later stages of manufacture. If present, kanamycin levels in the final vaccine are less than 0.01 micrograms per dose.

4.5 Interaction with other medicinal products and other forms of interaction

Use with other vaccines

Bexsero can be given concomitantly with any of the following vaccine antigens, either as monovalent or as combination vaccines: diphtheria, tetanus, acellular pertussis, *Haemophilus influenzae* type b, inactivated poliomyelitis, hepatitis B, heptavalent pneumococcal conjugate, measles, mumps, rubella, and varicella.

Clinical studies demonstrated that the immune responses of the co-administered routine vaccines were unaffected by concomitant administration of Bexsero, based on non-inferior antibody response rates to the routine vaccines given alone. Inconsistent results were seen across studies for responses to inactivated poliovirus type 2 and pneumococcal conjugate serotype 6B and lower antibody titres to the pertussis pertactin antigen were also noted, but these data do not suggest clinically significant interference.

Due to an increased risk of fever, tenderness at the injection site, change in eating habits and irritability when Bexsero was co-administered with the above vaccines, separate vaccinations can be considered when possible. Prophylactic use of paracetamol reduces the incidence and severity of fever without affecting the immunogenicity of either Bexsero or routine vaccines. The effect of antipyretics other than paracetamol on the immune response has not been studied.

Concomitant administration of Bexsero with vaccines other than those mentioned above has not been studied.

When given concomitantly with other vaccines Bexsero must be administered at separate injection sites (see section 4.2).

4.6 Fertility, pregnancy and lactation

Pregnancy

Insufficient clinical data on exposed pregnancies are available.

The potential risk for pregnant women is unknown. Nevertheless, vaccination should not be withheld when there is a clear risk of exposure to meningococcal infection.

There was no evidence of maternal or foetal toxicity, and no effects on pregnancy, maternal behaviour, female fertility, or postnatal development in a study in which female rabbits received Bexsero at approximately 10 times the human dose equivalent based on body weights.

Breast-feeding

Information on the safety of the vaccine to women and their children during breast-feeding is not available. The benefit-risk ratio must be examined before making the decision to immunise during breast-feeding.

No adverse reactions were seen in vaccinated maternal rabbits or in their offspring through day 29 of lactation. Bexsero was immunogenic in maternal animals vaccinated prior to lactation, and antibodies were detected in the offspring, but antibody levels in milk were not determined.

Fertility

There are no data on fertility in humans.

There were no effects on female fertility in animal studies.

4.7 Effects on ability to drive and use machines

Bexsero has no or negligible influence on the ability to drive and use machines. However, some of the effects mentioned under section 4.8 "Undesirable effects" may temporarily affect the ability to drive or use machines.

4.8 Undesirable effects

Summary of the safety profile

The safety of Bexsero was evaluated in 13 studies including 9 randomised controlled clinical trials with 7802 subjects (from 2 months of age) who received at least one dose of Bexsero. Among Bexsero recipients, 5849 were infants and children (less than 2 years of age), 250 were children (2 to 10 years of age) and 1703 were adolescents and adults. Of the subjects who received primary infant series of Bexsero, 3285 received a booster dose in the second year of life.

In infants and children (less than 2 years of age) the most common local and systemic adverse reactions observed in clinical trials were tenderness and erythema at the injection site, fever and irritability.

In clinical studies in infants vaccinated at 2, 4 and 6 months of age, fever ($\geq 38^{\circ}\text{C}$) was reported by 69% to 79% of subjects when Bexsero was co administered with routine vaccines (containing the following antigens: pneumococcal 7 valent conjugate, diphtheria, tetanus, acellular pertussis, hepatitis B, inactivated poliomyelitis and *Haemophilus influenzae* type b) compared with 44% to 59% of subjects receiving the routine vaccines alone. Higher rates of antipyretic use were also reported for infants vaccinated with

Bexsero and routine vaccines. When Bexsero was given alone, the frequency of fever was similar to that associated with routine infant vaccines administered during clinical trials. When fever occurred, it generally followed a predictable pattern, with the majority resolving by the day after vaccination.

In adolescents and adults the most common local and systemic adverse reactions observed were pain at the injection site, malaise and headache.

No increase in the incidence or severity of the adverse reactions was seen with subsequent doses of the vaccination series.

Tabulated list of adverse reactions

Adverse reactions (following primary immunisation or booster dose) considered as being at least possibly related to vaccination have been categorised by frequency.

Frequencies are defined as follows:

Very common:	($\geq 1/10$)
Common:	($\geq 1/100$ to $< 1/10$)
Uncommon:	($\geq 1/1,000$ to $< 1/100$)
Rare:	($\geq 1/10,000$ to $< 1/1,000$)
Very rare:	($< 1/10,000$)

Within each frequency grouping, undesirable effects are presented in order of decreasing seriousness.

Infants and children (up to 10 years of age)

Metabolism and nutrition disorders

Very common: eating disorders

Nervous system disorders

Very common: sleepiness, unusual crying

Uncommon: seizures (including febrile seizures)

Vascular disorders

Uncommon: pallor (rare after booster)

Rare: Kawasaki syndrome

Gastrointestinal disorders

Very common: diarrhoea, vomiting (uncommon after booster)

Skin and subcutaneous tissue disorders

Very common: rash (children aged 12 to 23 months) (uncommon after booster)

Common: rash (infants and children 2 to 10 years of age)

Uncommon: eczema

Rare: urticaria

General disorders and administration site conditions

Very common: fever ($\geq 38^{\circ}\text{C}$), injection site tenderness (including severe injection site tenderness defined as crying when injected limb is moved), injection site erythema, injection site swelling, injection site induration, irritability

Uncommon: fever ($\geq 40^{\circ}\text{C}$)

Adolescents (from 11 years of age) and adults

Nervous system disorders

Very common: headache

Gastrointestinal disorders

Very common: nausea

General disorders and administration site conditions

Very common: injection site pain (including severe injection site pain defined as unable to perform normal daily activity), injection site swelling, injection site induration, injection site erythema, malaise

Musculoskeletal and connective tissue disorders

Very common: myalgia, arthralgia

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation 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 to the Medicines and Healthcare products Regulatory Agency (MHRA) at www.mhra.gov.uk/yellowcard.

4.9 Overdose

Experience of overdose is limited. In the event of overdose, monitoring of vital functions and possible symptomatic treatment is recommended.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: meningococcal vaccines, ATC code: J07AH09

Mechanism of action

Immunisation with Bexsero is intended to stimulate the production of bactericidal antibodies that recognize the vaccine antigens NHBA, NadA, fHbp, and PorA P1.4 (the immunodominant antigen present in the OMV component) and are expected to be protective against Invasive Meningococcal Disease (IMD). As these antigens are variably expressed by different strains, meningococci that express them at sufficient levels are susceptible to killing by vaccine-elicited antibodies. The Meningococcal Antigen Typing System (MATS) was developed to relate antigen profiles of different strains of meningococcal group B bacteria to killing of the strains in the serum bactericidal assay with human complement (hSBA). A survey of approximately 1,000 different invasive meningococcal group B isolates collected during 2007-2008 in 5 European countries showed that, depending on the country of origin, between 73% and 87% of meningococcal group B isolates had an appropriate MATS antigen profile to be covered by the vaccine. Overall, 78% (95% confidence limits from 63-90%) of the approximately 1,000 strains were potentially susceptible to vaccine-induced antibodies.

Clinical efficacy

The efficacy of Bexsero has not been evaluated through clinical trials. Vaccine efficacy has been inferred by demonstrating the induction of serum bactericidal antibody responses to each of the vaccine antigens (see section Immunogenicity).

Immunogenicity

Serum bactericidal antibody responses to each of the vaccine antigens NadA, fHbp, NHBA and PorA P1.4 was evaluated using a set of four meningococcal group B reference strains. Bactericidal antibodies against these strains were measured by the Serum Bactericidal Assay using human serum as the source of complement (hSBA). Data are not available from all vaccine schedules using the reference strain for NHBA. Most of the primary immunogenicity studies were conducted as randomised, controlled, multicentre, clinical trials. Immunogenicity was evaluated in infants, children, adolescents and adults.

Immunogenicity in infants and children

In infant studies, participants received three doses of Bexsero either at 2, 4 and 6 or 2, 3 and 4 months of age and a booster dose in their second year of life, as early as 12 months of age. Sera were obtained both before vaccination, one month after the third vaccination (see Table 2) and one month after booster vaccination (see Table 3). In an extension study the persistence of the immune response was assessed one year after the booster dose (see Table 3). Previously unvaccinated children also received two doses in the second year of life, with antibody persistence being measured at one year after the second dose (see Table 4). The immunogenicity after two doses has been also documented in another study in infants 6 months to 8 months of age at enrolment (see Table 4).

Immunogenicity in infants 2 months to 6 months of age

Immunogenicity results at one month after three doses of Bexsero administered at 2, 3, 4 and 2, 4, 6 months of age are summarised in Table 2. Bactericidal antibody responses one month after the third vaccination against meningococcal reference strains were high against the fHbp, NadA and PorA P1.4 antigens at both Bexsero vaccination schedules. The bactericidal responses against the NHBA antigen were also high in infants vaccinated at the 2, 4, 6-month schedule, but this antigen appeared to be less immunogenic at the 2, 3, 4-month schedule. The clinical consequences of the reduced immunogenicity of the NHBA antigen at this schedule are not known.

Table 2. Serum bactericidal antibody responses at 1 month following the third dose of Bexsero given at 2, 3, 4 or 2, 4, 6 months of age

Antigen		Study V72P13 2, 4, 6 months	Study V72P12 2, 3, 4 months	Study V72P16 2, 3, 4 months
fHbp	% seropositive* (95% CI)	N=1149 100% (99-100)	N=273 99% (97-100)	N=170 100% (98-100)
	hSBA GMT** (95% CI)	91 (87-95)	82 (75-91)	101 (90-113)
NadA	% seropositive (95% CI)	N=1152 100% (99-100)	N=275 100% (99-100)	N=165 99% (97-100)
	hSBA GMT (95% CI)	635 (606-665)	325 (292-362)	396 (348-450)
PorA P1.4	% seropositive (95% CI)	N=1152 84% (82-86)	N=274 81% (76-86)	N=171 78% (71-84)
	hSBA GMT (95% CI)	14 (13-15)	11 (9.14-12)	10 (8.59-12)
NHBA	% seropositive (95% CI)	N=100 84% (75-91)	N=112 37% (28-46)	N=35 43% (26-61)
	hSBA GMT (95% CI)	16 (13-21)	3.24 (2.49-4.21)	3.29 (1.85-5.83)

* % seropositive = the percentage of subjects who achieved an hSBA \geq 1:5.

** GMT = geometric mean titre.

Data on bactericidal antibody persistence at 8 months after Bexsero vaccination at 2, 3 and 4 months of age, and at 6 months after Bexsero vaccination at 2, 4 and 6 months of age (pre booster time point) and booster data after a fourth dose of Bexsero administered at 12 months of age are summarised in Table 3. Persistence of the immune response one year after the booster dose is also presented in Table 3. The need for additional booster doses to maintain longer term protective immunity has not been established.

Table 3. Serum bactericidal antibody responses following a booster at 12 months after a primary series administered at 2, 3 and 4 or 2, 4 and 6 months of age, and persistence of bactericidal antibody one year after the booster

Antigen		2, 3, 4, 12 months	2, 4, 6, 12 months
fHbp	pre-booster* % seropositive** (95% CI) hSBA GMT*** (95% CI)	N=81 58% (47-69) 5.79 (4.54-7.39)	N=426 82% (78-85) 10 (9.55-12)
	1 month after booster % seropositive (95% CI) hSBA GMT (95% CI)	N=83 100% (96-100) 135 (108-170)	N=422 100% (99-100) 128 (118-139)
	12 months after booster % seropositive (95% CI) hSBA GMT (95% CI)	-	N=299 62% (56-67) 6.5 (5.63-7.5)
NadA	pre-booster % seropositive (95% CI) hSBA GMT (95% CI)	N=79 97% (91-100) 63 (49-83)	N=423 99% (97-100) 81 (74-89)
	1 month after booster % seropositive (95% CI) hSBA GMT (95% CI)	N=84 100% (96-100) 1558 (1262-1923)	N=421 100% (99-100) 1465 (1350-1590)
	12 months after booster % seropositive (95% CI) hSBA GMT (95% CI)	-	N=298 97% (95-99) 81 (71-94)

Antigen		2, 3, 4, 12 months	2, 4, 6, 12 months
PorA P1.4	pre-booster % seropositive (95% CI) hSBA GMT (95% CI)	N=83 19% (11-29) 1.61 (1.32-1.96)	N=426 22% (18-26) 2.14 (1.94-2.36)
	1 month after booster % seropositive (95% CI) hSBA GMT (95% CI)	N=86 97% (90-99) 47 (36-62)	N=424 95% (93-97) 35 (31-39)
	12 months after booster % seropositive (95% CI) hSBA GMT (95% CI)	-	N=300 17% (13-22) 1.91 (1.7-2.15)
NHBA	pre-booster % seropositive (95% CI) hSBA GMT (95% CI)	N=69 25% (15-36) 2.36 (1.75-3.18)	N=100 61% (51-71) 8.4 (6.4-11)
	1 month after booster % seropositive (95% CI) hSBA GMT (95% CI)	N=67 76% (64-86) 12 (8.52-17)	N=100 98% (93-100) 42 (36-50)
	12 months after booster % seropositive (95% CI) hSBA GMT (95% CI)	-	N=291 36% (31-42%) 3.35 (2.88-3.9)

* pre-booster time point represents persistence of bactericidal antibody at 8 months after Bexsero vaccination at 2, 3 and 4 months of age and 6 months after Bexsero vaccination at 2, 4 and 6 months of age.

** % seropositive = the percentage of subjects who achieved an hSBA \geq 1:5.

*** GMT = geometric mean titre.

Immunogenicity in children 6 to 11 months, 12 to 23 months and 2 to 10 years of age

The immunogenicity after two doses administered two months apart in children 6 months to 26 months of age has been documented in three studies whose results are summarised in Table 4. Against each of the vaccine antigens, seroresponse rates and hSBA GMTs were high and similar after the two-dose series in infants 6-8 months of age and children, 13-15 and 24-26 months of age. Data on antibody persistence one year after the two doses at 13 and 15 months of age are also summarised in Table 4.

Table 4. Serum bactericidal antibody responses following Bexsero vaccination at 6 and 8 months of age, 13 and 15 months of age, or 24 and 26 months of age and persistence of bactericidal antibody one year after the two doses at 13 and 15 months of age

Antigen		Age range		
		6 to 11 months of age	12 to 23 months of age	2 to 10 years of age
		Age of vaccination		
	6, 8 months	13, 15 months	24, 26 months	
fHbp	1 month after 2nd dose % seropositive* (95% CI) hSBA GMT** (95% CI)	N=23 100% (85-100) 250 (173-361)	N=163 100% (98-100) 271 (237-310)	N=105 100% (97-100) 220 (186-261)
	12 months after 2nd dose % seropositive (95% CI) hSBA GMT (95% CI)	-	N=68 74% (61-83) 14 (9.4-20)	-
NadA	1 month after 2nd dose % seropositive (95% CI) hSBA GMT (95% CI)	N=23 100% (85-100) 534 (395-721)	N=164 100% (98-100) 599 (520-690)	N=103 99% (95-100) 455 (372-556)
	12 months after 2nd dose % seropositive (95% CI) hSBA GMT (95% CI)	-	N=68 97% (90-100) 70 (47-104)	-

Antigen		Age range		
		6 to 11 months of age	12 to 23 months of age	2 to 10 years of age
		Age of vaccination		
		6, 8 months	13, 15 months	24, 26 months
PorA P1.4	1 month after 2nd dose % seropositive (95% CI) hSBA GMT (95% CI)	N=22 95% (77-100) 27 (21-36)	N=164 100% (98-100) 43 (38-49)	N=108 98% (93-100) 27 (23-32)
	12 months after 2nd dose % seropositive (95% CI) hSBA GMT (95% CI)	-	N=68 18% (9-29) 1.65 (1.2-2.28)	-
NHBA	1 month after 2nd dose % seropositive (95% CI) hSBA GMT (95% CI)	-	N=46 63% (48-77) 11 (7.07-16)	N=100 97% (91-99) 38 (32-45)
	12 months after 2nd dose % seropositive (95% CI) hSBA GMT (95% CI)	-	N=65 38% (27-51) 3.7 (2.15-6.35)	-

* % seropositive = the percentage of subjects who achieved an hSBA \geq 1:4 (in the 6 to 11 months range of age) and hSBA \geq 1:5 (in the 12 to 23 months and 2 to 10 years ranges of age).

** GMT = geometric mean titre.

In an additional group of 67 children evaluated after vaccination with Bexsero at 40 to 44 months of age in two extension studies (N=36 and N=29-31, respectively), an increase in hSBA titres for the four reference antigens was observed. Percentages of seropositive subjects were 100% for fHbp and NadA; 94% and 90% for PorA P1.4; 89% and 72% for NHBA.

Immunogenicity in adolescents (from 11 years of age) and adults

Adolescents received two doses of Bexsero with one, two or six month intervals between doses; these data are summarised in Tables 5 and 6. In adult studies, data were also obtained after two doses of Bexsero with a one month or two month interval between doses (see Table 5).

The vaccination schedules of two doses administered with an interval of one or two months showed similar immune responses in both adults and adolescents. Similar responses were also observed for adolescents administered two doses of Bexsero with an interval of six months.

Table 5. Serum bactericidal antibody responses in adolescents or adults one month after two doses of Bexsero administered according to different two-dose schedules.

Antigen		Adolescents			Adults	
		0, 1 months	0, 2 months	0, 6 months	0, 1 months	0, 2 months
fHbp	% seropositive* (95% CI)	N=638 100% (99-100)	N=319 100% (99-100)	N=86 100% (99-100)	N=28 100% (88-100)	N=46 100% (92-100)
	hSBA GMT** (95% CI)	210 (193-229)	234 (209-263)	218 (157-302)	100 (75-133)	93 (71-121)
NadA	% seropositive (95% CI)	N=639 100% (99-100)	N=320 99% (98-100)	N=86 99% (94-100)	N=28 100% (88-100)	N=46 100% (92-100)
	hSBA GMT (95% CI)	490 (455-528)	734 (653-825)	880 (675-1147)	566 (338-948)	144 (108-193)
PorA P1.4	% seropositive (95% CI)	N=639 100% (99-100)	N=319 100% (99-100)	N=86 100% (96-100)	N=28 96% (82-100)	N=46 91% (79-98)
	hSBA GMT (95% CI)	92 (84-102)	123 (107-142)	140 (101-195)	47 (30-75)	32 (21-48)

Antigen		Adolescents			Adults	
		0, 1 months	0, 2 months	0, 6 months	0, 1 months	0, 2 months
NHBA	% seropositive (95% CI)	N=46 100% (92-100)	N=46 100% (92-100)	-	-	-
	hSBA GMT (95% CI)	99 (76-129)	107 (82-140)	-	-	-

* % seropositive = the percentage of subjects who achieved an hSBA \geq 1:4.

** GMT = geometric mean titre.

In the adolescent study, bactericidal responses following two doses of Bexsero were stratified by baseline hSBA less than 1:4 or equal to or greater than 1:4. Seroreponse rates and percentages of subjects with at least a 4-fold increase in hSBA titre from baseline one month after the second dose of Bexsero are summarised in Table 6. Following Bexsero vaccination, a high percentage of subjects were seropositive and achieved 4-fold increases in hSBA titres independent of pre-vaccination status.

Table 6. Percentage of adolescents with seroreponse and at least 4-fold rise in bactericidal titres one month after two doses of Bexsero administered according to different two-dose schedules - stratified by pre-vaccination titres.

Antigen			0, 1 months	0, 2 months	0, 6 months
fHbp	% seropositive* (95% CI)	pre-vaccination titre <1:4	N=369 100% (98-100)	N=179 100% (98-100)	N=55 100% (94-100)
		pre-vaccination titre \geq 1:4	N=269 100% (99-100)	N=140 100% (97-100)	N=31 100% (89-100)
	% 4-fold increase (95% CI)	pre-vaccination titre <1:4	N=369 100% (98-100)	N=179 100% (98-100)	N=55 100% (94-100)
		pre-vaccination titre \geq 1:4	N=268 90% (86-93)	N=140 86% (80-92)	N=31 90% (74-98)
NadA	% seropositive (95% CI)	pre-vaccination titre <1:4	N=427 100% (99-100)	N=211 99% (97-100)	N=64 98% (92-100)
		pre-vaccination titre \geq 1:4	N=212 100% (98-100)	N=109 100% (97-100)	N=22 100% (85-100)
	% 4-fold increase (95% CI)	pre-vaccination titre <1:4	N=426 99% (98-100)	N=211 99% (97-100)	N=64 98% (92-100)
		pre-vaccination titre \geq 1:4	N=212 96% (93-98)	N=109 95% (90-98)	N=22 95% (77-100)
PorA P1.4	% seropositive (95% CI)	pre-vaccination titre <1:4	N=427 100% (98-100)	N=208 100% (98-100)	N=64 100% (94-100)
		pre-vaccination titre \geq 1:4	N=212 100% (98-100)	N=111 100% (97-100)	N=22 100% (85-100)
	% 4-fold increase (95% CI)	pre-vaccination titre <1:4	N=426 99% (98-100)	N=208 100% (98-100)	N=64 100% (94-100)
		pre-vaccination titre \geq 1:4	N=211 81% (75-86)	N=111 77% (68-84)	N=22 82% (60-95)
NHBA	% seropositive (95% CI)	pre-vaccination titre <1:4	N=2 100% (16-100)	N=9 100% (66-100)	-
		pre-vaccination titre \geq 1:4	N=44 100% (92-100)	N=37 100% (91-100)	-
	% 4-fold increase (95% CI)	pre-vaccination titre <1:4	N=2 100% (16-100)	N=9 89% (52-100)	-
		pre-vaccination titre \geq 1:4	N=44 30% (17-45)	N=37 19% (8-35)	-

* % seropositive = the percentage of subjects who achieved an hSBA \geq 1:4.

The European Medicines Agency has deferred the obligation to submit the results of studies with Bexsero in one or more subsets of the paediatric population in the prevention of meningococcal disease caused by *Neisseria meningitidis* group B (see section 4.2 for information on paediatric use).

5.2 Pharmacokinetic properties

Not applicable.

5.3 Preclinical safety data

Non-clinical data reveal no special hazard for humans based on repeated dose toxicity and reproductive and developmental toxicity studies.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Sodium chloride
Histidine
Sucrose
Water for injections

For adsorbent see section 2.

6.2 Incompatibilities

In the absence of compatibility studies, this medicinal product must not be mixed with other medicinal products.

6.3 Shelf life

2 years.

6.4 Special precautions for storage

Store in a refrigerator (2°C - 8°C).

Do not freeze.

Store in the original package in order to protect from light.

6.5 Nature and contents of container

0.5 ml suspension in a pre-filled syringe (Type I glass) with a plunger stopper (Type I bromobutyl rubber) and with a protective tip cap (Type I or Type II rubber) with or without needles.

Pack sizes of 1 or 10 syringes. Not all pack sizes may be marketed.

6.6 Special precautions for disposal and other handling

Upon storage a fine off-white deposit may be observed in the pre-filled syringe containing the suspension.

Before use, the pre-filled syringe should be well shaken in order to form a homogeneous suspension.

The vaccine should be visually inspected for particulate matter and discolouration prior to administration. In the event of any foreign particulate matter and/or variation of physical aspect being observed, discard the vaccine.

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

7. MARKETING AUTHORISATION HOLDER

Novartis Vaccines and Diagnostics S.r.l.,
Via Fiorentina 1,
53100 Siena,
Italy

8. MARKETING AUTHORISATION NUMBERS

EU/1/12/812/001
EU/1/12/812/002
EU/1/12/812/003
EU/1/12/812/004

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 14 January 2013

10. DATE OF REVISION OF THE TEXT

October 2013

Detailed information on this medicinal product is available on the website of the European Medicines Agency <http://www.ema.europa.eu>

