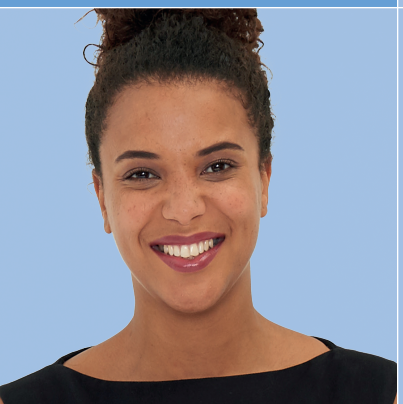
BAYER

I want an end to my monthly headaches

DIFFERENT WOMEN DIFFERENT NEEDS

COULD QLAIRA® BE RIGHT FOR HER TOO?

I want to be free from regular pelvic pain



Qlaira®

The shortcut to the right choice

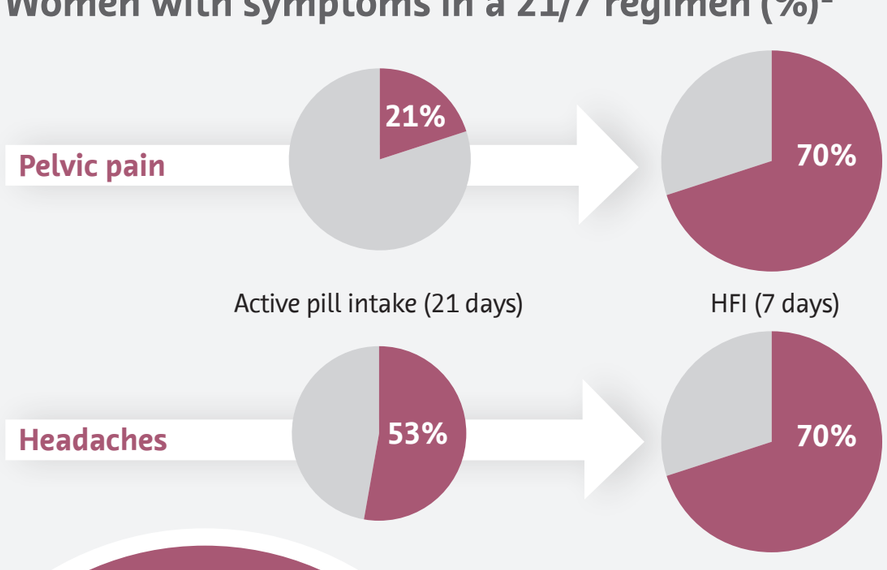
“Why are periods such a pain?”

Over two thirds of COC users suffer from headache and pelvic pain related to hormone withdrawal during the HFI[1,2]

HWAS can be exacerbated by hormone fluctuations and therefore are:

- Most prevalent during the conventional 7-day HFI[1,3]
- A class effect of 21/7 regimen COCs[3]

Women with symptoms in a 21/7 regimen (%)[1]

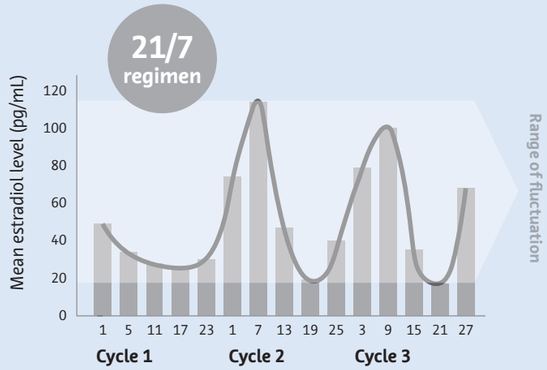


Women suffering from painful periods can benefit from stable levels of estradiol and a shorter HFI

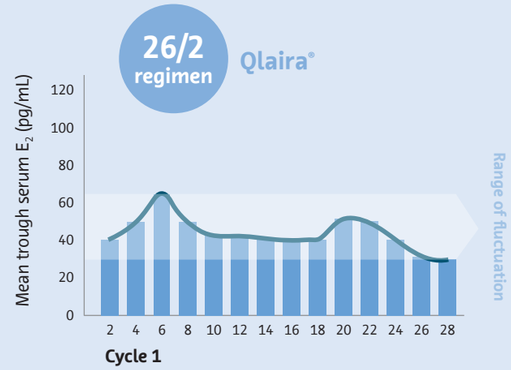
COC – combined oral contraceptive; HFI – hormone-free interval; HWAS – hormone withdrawal-associated symptoms

Qlaira®: A unique 2-day HFI for women suffering from painful periods due to HWAS[4]

Qlaira® has an innovative regimen with a 2-day HFI, which is the shortest of all cyclical COCs. It helps to stabilize hormone levels even during the HFI, unlike 21/7 regimens[4,5]



Mean serum estradiol concentration with a 21/7 regimen COC[6]



Mean serum estradiol concentration with Qlaira®[5]

Qlaira® is proven to significantly reduce headache and pelvic pain related to hormone withdrawal[2]

Qlaira®, a good option for women suffering from painful periods

Qlaira® is the only estradiol-releasing COC with robust data from a large real-world study[7,8]

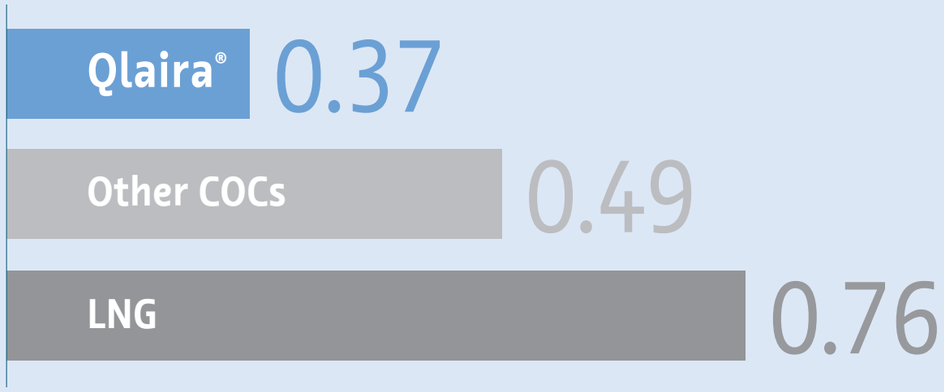
NEW DATA[9]

It was studied in a real-life setting in the INAS-SCORE study[7,8]

included **>50,000** women

Up to **5 years'** follow up

New data confirm a **lower contraceptive failure rate** in real life in women aged 18–35 years[9]



Overall contraceptive failure rate (women aged 18–35 years)[9]

COC – combined oral contraceptive; LNG – levonorgestrel

Young women also want high efficacy[10]

90% of women rank **reliability as the most important attribute** when it comes to contraception[10]

With Qlaira®:

- Women <25 years of age have adjusted Pearl Index of:[*11]

- **80%** of young women are **satisfied or very satisifed** after switching from a standard COC to **Qlaira®**[12]

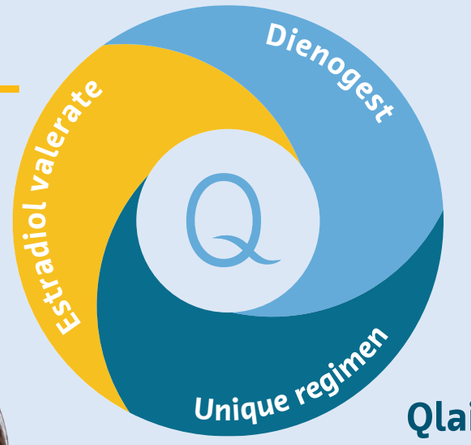
These data confirm that Qlaira® is easy to use for women of all ages[11,12]

* Data from a pooled post-hoc analysis of primary data from 12 studies of Qlaira®, stratified by age (<25 [n = 1309] and >25 [n = 2132] years).[11]

Qlaira®: An innovative regimen for proven benefits beyond contraception[4]

Qlaira® releases estradiol, the estrogen identical to the endogenously produced 17ß-estradiol[4,13]

Dienogest exerts **a potent anti-inflammatory action on the endometrium,** leading to a reduced likelihood of symptoms, such as pelvic and back pain[14,15]



Qlaira®'s 2-day HFI is the shortest of all cyclical COCs, providing **stable levels of estradiol throughout her cycle**[4,5]

COC – combined oral contraceptive; HFI – hormone-free interval

Your partner in women's health for over 60 years

We are celebrating the **invention of the pill 60 years ago** – an innovation that has revolutionized the worlds of women. Empowering women to have children by choice not chance[16-18]

Bayer (then Schering) introduced the **first ever oral contraceptive** (Anovlar®) and has since continually been developing **innovative and reliable solutions, bringing benefits to women** in birth control and beyond for over 60 years[16-18]

60 YEARS EMPOWERING WOMEN

Help women find a contraceptive option that best meets their needs

Qlaira®: A good option for her

- Significantly reducing her monthly headache and pelvic pain (HWAS)[2]
- With robust efficacy, which is a strong need also in young women[8-10]

by Bayer, a pioneer in Women's Health for 60 years

HWAS – hormone withdrawal-associated symptoms

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Qlaira® film-coated tablets – Abridged Summary of Product Characteristics

Qlaira® film-coated tablets. Please refer to full Summary of Product Characteristics (SmPC) before prescribing. Presentation: Each wallet (28 film-coated tablets) contains in the following order: 2 dark yellow tablets (3 mg estradiol valerate), 5 medium red tablets (2 mg estradiol valerate and 2 mg dienogest), 17 light yellow (2 mg estradiol valerate and 3 mg dienogest), 2 dark red tablets (1 mg estradiol valerate), and 2 white tablets (no active substances). Excipients: Contains lactose. Indication: Oral contraception. Treatment of heavy menstrual bleeding in women without organic pathology who desire oral contraception. Dosage and Administration: One tablet is to be taken daily for 28 consecutive days in the order directed on the package at about the same time of day. Missed tablets and gastro-intestinal disturbances may reduce efficacy (see SmPC for guidance). Contraindications: Presence or risk of venous thromboembolism (VTE): current, history of, or high risk of deep venous thrombosis (DVT) or pulmonary embolism (PE), known hereditary or acquired predisposition for VTE (e.g. APC-resistance, antithrombin-III-deficiency, protein C deficiency, protein S deficiency), major surgery with prolonged immobilization. High risk of VTE due to presence of multiple risk factors. Presence or risk of arterial thromboembolism (ATE): current, history of (e.g. myocardial infarction), or high risk of ATE (due to multiple risk factors or to the presence of one of the following serious risk factors – diabetes mellitus with vascular symptoms, severe hypertension or severe dyslipoproteinaemia), or prodromal conditions (e.g. angina pectoris), cerebrovascular disease (current or history of stroke or prodromal condition (e.g. transient ischaemic attack (TIA)), known hereditary or acquired predisposition for ATE (e.g. hyperhomocysteinaemia and antiphospholipid antibodies (anticardiolipin-antibodies, lupus anticoagulant)), history of migraine with focal neurological symptoms. Presence or history of severe hepatic disease as long as liver function values have not returned to normal, presence or history of liver tumours (benign or malignant), known or suspected sex-steroid influenced malignancies (e.g. of the genital organs or the breasts), undiagnosed vaginal bleeding, hypersensitivity to the active substances or to any of the excipients. Precautions and warnings: If any of these conditions or risk factors are present, the suitability of Qlaira should be discussed with the woman. In the event of aggravation, or first appearance of any of these conditions or risk factors, the woman should be advised to contact her doctor to determine whether the use of Qlaira should be discontinued. In case of suspected or confirmed VTE or ATE, combined hormonal contraceptives (CHC) use should be discontinued. Prior to the initiation or reinstitution of Qlaira a complete medical history (including family history) should be taken and pregnancy must be ruled out. Women should be advised that CHC do not protect against HIV infections (AIDS) or other sexually transmitted diseases. In case anti-coagulant therapy is started, adequate alternative contraception should be initiated because of the teratogenicity of anticoagulant therapy (coumarins). Risk of VTE: The use of any CHC increases the risk of VTE compared with no use. Products that contain levonorgestrel, norgestimate or norethisterone are associated with the lowest risk of VTE. Limited data suggests that Qlaira may have a risk of VTE in the same range. The decision to use any other product (such as Qlaira) than one known to have the lowest VTE risk should be taken only after a discussion with the woman to ensure she understands the risk of VTE with CHCs, how her current risk factors influence this risk, and that her VTE risk is highest in the first year of use. There is also some evidence that the risk is increased when a CHC is re-started after a break of 4 weeks or more. Risk factors include obesity (BMI over 30 kg/m2), prolonged immobilisation (or temporary immobilisation including air travel >4 hours can also be a risk factor), major surgery, any surgery to the legs or pelvis, neurosurgery, or major trauma (discontinue use of the pill at least four weeks before elective surgery and not resume until two weeks after complete remobilisation), positive family history (the woman should be referred to a specialist), other medical conditions associated with VTE (cancer, systemic lupus erythematous, haemolytic uraemic syndrome, chronic inflammatory bowel disease such as Chrohn's disease or ulcerative colitis and sickle cell anaemia, increasing age (particularly above 35 years). There is no consensus about the possible role of varicose veins and superficial thrombophlebitis in the onset or progression of venous thrombosis. The increased risk of thromboembolism in pregnancy and particularly the 6-week period puerperium, must be considered. Risk of ATE: Epidemiological studies have associated the use of CHCs with an increased risk for ATE (myocardial infarction) or for cerebrovascular accident (e.g.TIA, stroke). Risk factors for ATE include increasing age particularly if above 35 years, smoking, hypertension, obesity, positive family history, migraine, other medical conditions associated with adverse vascular events such as diabetes mellitus, hyperhomocysteinaemia, valvular heart disease and atrial fibrillation, dyslipoproteinaemia and systemic lupus erythematosus. Refer to SmPC for symptoms of ATE. Advise patients to seek urgent medical attention if experiencing possible symptoms of thrombosis. Tumours: An increased risk of cervical cancer in long-term users of COCs (> 5 years) has been reported. A meta-analysis from 54 epidemiological studies reported that there is a slightly increased relative risk (RR = 1.24) of having breast cancer diagnosed in women who are currently using COCs. In rare cases, benign liver tumours, and even more rarely, malignant liver tumours have been reported in users of COCs. Other conditions: Women with or a family history of hypertriglyceridaemia may be at an increased risk of pancreatitis when using COCs. Although small, increases in blood pressure have been reported with COCs, clinically relevant increases are rare. However, if a sustained clinically significant hypertension develops during the use of a COC then withdraw the COC and treat the hypertension. In women with hereditary angioedema exogenous estrogens may induce or exacerbate symptoms of angioedema. Acute or chronic disturbances of liver function may necessitate the discontinuation of COC use until markers of liver function return to normal. Recurrence of cholestatic jaundice which occurred first during pregnancy or previous use of sex steroids necessitates the discontinuation of COCs. Diabetic women should be carefully observed while taking COCs, particularly in the early stage of COC use. Worsening of endogenous depression, of epilepsy, of Crohn's disease and of ulcerative colitis has been reported during COC use. Depressed mood and depression are well-known undesirable effects of hormonal contraceptive use. Chloasma may occasionally occur, especially in women with a history of chloasma gravidarum. Women with a tendency to chloasma should avoid exposure to the sun or ultraviolet radiation whilst taking COCs. Estrogens may cause fluid retention, and therefore patients with cardiac or renal dysfunction should be carefully observed. This medicinal product contains not more than 50 mg lactose per tablet. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption who are on a lactose-free diet should take this amount into consideration. Interaction with other medicinal products and other forms of interaction: Interactions can occur with drugs that induce microsomal enzymes which can result in increased clearance of sex hormones and which may lead to breakthrough bleeding and/or contraceptive failure. Management: Enzyme induction can already be observed after a few days of treatment. Maximal enzyme induction is generally seen within a few weeks. After the cessation of drug therapy enzyme induction may be sustained for about 4 weeks. Short-term treatment: Women on treatment with enzyme-inducing drugs should temporarily use a barrier method or another method of contraception in addition to the COC. The barrier method must be used during the whole time of the concomitant drug therapy and for 28 days after its discontinuation. Long-term treatment: In women on long-term treatment with hepatic enzyme-inducing active substances, another reliable, non-hormonal, method of contraception is recommended. Substances increasing COC clearance: Barbiturates, carbamazepine, phenytoin, primidone, rifampicin, and HIV medication ritonavir, nevirapine and efavirenz and possibly also felbamate, griseofulvin, oxcarbazepine, topiramate and products containing the herbal remedy St. John's Wort (hypericum perforatum). Substances with variable effects on COC clearance: When co-administered with COCs, many combinations of HIV protease inhibitors and non-nucleoside reverse transcriptase inhibitors, including combinations with HCV inhibitors can increase or decrease plasma concentrations of estrogen or progestins. Substances decreasing COC clearance: Concomitant administration of strong CYP3A4 inhibitors (such as ketoconazole and erythromycin) can increase plasma concentrations of the estrogen or the progestin or both. Oral contraceptives may affect the metabolism of certain other active substances; plasma and tissue concentrations may either increase (e.g. cyclopsorin) or decrease (e.g. lamotrigine). The use of contraceptive steroids may influence the results of certain laboratory tests. Fertility, pregnancy and lactation: Pregnancy: Qlaira should not be used during pregnancy, withdraw immediately if pregnancy occurs. Lactation: The use of COCs is not recommended. Undesirable effects: Common side effects: headache, abdominal pain, nausea, acne, amenorrhea, breast discomfort, dysmenorrhoea, intracyclic bleeding (metrorrhagia), weight increased. Uncommon side effects: fungal infections, vulvovaginal mycotic infection, vaginal infection, increased appetite, depression/depressed mood, emotional disorder, insomnia, libido decreased, mental disorder, mood change, dizziness, migraine, hot flush, hypertension, diarrhea, vomiting, liver enzymes increased, alopecia, hyperhidrosis, pruritus, rash, muscle spasms, breast enlargement, breast mass, cervical dysplasia, dysfunctional uterine bleeding, dyspareunia, fibrocystic breast disease, menorrhagia, menstrual disorder, ovarian cyst, pelvic pain, premenstrual syndrome, uterine leiomyoma, uterine spasm, uterine/vaginal bleeding incl. spotting, vaginal discharge, vulvovaginal dryness, fatigue, irritability, oedema, weight decreased, blood pressure changes. Rare side effects: candidiasis, oral herpes, pelvic inflammatory disease, presumed ocular histoplasmosis syndrome, tinea versicolor, urinary tract infection, vaginitis bacterial, fluid retention, hypertriglyceridaemia, aggression, anxiety, dysphoria, libido increased, nervousness, nightmare, restlessness, sleep disorder, stress, disturbance in attention, paraesthesia, vertigo, contact lens intolerance, dry eye, eye swelling, myocardial infraction, palpitations, bleeding varicose veins, VTE, ATE, hypotension, phlebitis superficialis, vein pain, constipation, dry mouth, dyspepsia, gastrooesophageal reflux disease, focal nodular hyperplasia of the liver, cholecystitis chronic, allergic skin reaction, chloasma, dermatitis, hirsutism, hypertrichosis, neurodermatitis, pigmentation disorder, seborrhea, skin disorder, back pain, pain in jaw, sensation of heaviness, urinary tract pain, abnormal withdrawal bleeding, benign breast neoplasm, breast cancer in situ, breast cyst, breast discharge, cervical polyp, cervix erythema, coital bleeding, galactorrhea, genital hemorrhage, hypomenorrhoea, menstruation delayed, ovarian cyst ruptured, vaginal odour, vulvovaginal burning sensation, vulvovaginal discomfort, lymphadenopathy, asthma, dyspnoea, epistaxis, chest pain, malaise, pyrexia, smear cervix abnormal. 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Qlaira®
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