
SHINGRIX

Version : GDSv10 & v13-IPIv06

SHINGRIX

Herpes zoster (HZ, or shingles) vaccine (non-live recombinant, AS01_B adjuvanted)

Qualitative and Quantitative Composition

After reconstitution, 1 dose (0.5 ml) contains 50 micrograms of gE antigen¹ adjuvanted with AS01_B².

¹ Varicella Zoster Virus (VZV) glycoprotein E (gE) produced by recombinant DNA technology in Chinese Hamster Ovary (CHO) cells.

² The GlaxoSmithKline proprietary AS01_B Adjuvant System is composed of the plant extract *Quillaja saponaria* Molina, fraction 21 (QS-21) (50 micrograms) and 3-O-desacyl-4'-monophosphoryl lipid A (MPL) from *Salmonella minnesota* (50 micrograms)

The powder is white. The suspension is an opalescent, colourless to pale brownish liquid.

Clinical Information

Indications

SHINGRIX is indicated for the prevention of herpes zoster (HZ) and HZ-related complications, such as post-herpetic neuralgia (PHN), in:

- adults 50 years of age or older;
- adults 18 years of age or older at increased risk of HZ.

The use of **SHINGRIX** should be based on official recommendations.

Dosage and Administration

Pharmaceutical form: powder and suspension for suspension for injection.

The immunisation schedules for **SHINGRIX** should be based on official recommendations.

Posology

The primary vaccination schedule consists of two doses of 0.5 ml each; an initial dose followed by a second dose 2 to 6 months later.

For subjects who are immunodeficient, immunosuppressed or likely to become immunosuppressed due to known disease or therapy, and whom would benefit from a shorter vaccination schedule, the second dose can be given 1 to 2 months after the initial dose (see *Pharmacodynamic Effects*).

The need for booster doses has not been established.

SHINGRIX can be given with the same schedule in individuals previously vaccinated with live attenuated HZ vaccine (see *Pharmacodynamic Effects*).

SHINGRIX is not indicated for prevention of primary varicella infection.

Method of administration

SHINGRIX is for intramuscular injection only, preferably in the deltoid muscle.

For instructions on reconstitution of the medicinal product before administration, see *Use and Handling*.

Contraindications

Hypersensitivity to the active substances or to any component of the vaccine (see *Qualitative and Quantitative Composition* and *List of Excipients*).

Warnings and Precautions

Prior to immunization

It is good clinical practice to precede vaccination by a review of the medical history (especially with regard to previous vaccination and possible occurrence of undesirable events) and a clinical examination.

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

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

As with any vaccine, a protective immune response may not be elicited in all vaccinees.

An increased risk of Guillain-Barré syndrome has been observed following vaccination with Shingrix (see *Adverse Reactions*).

Precautions for use

Do not administer the vaccine intravascularly, intradermally or subcutaneously.

Maladministration via the subcutaneous route may lead to an increase in transient local reactions.

As with other vaccines administered intramuscularly, **SHINGRIX** should be given with caution to individuals with thrombocytopenia or any coagulation disorder since bleeding may occur following an intramuscular administration to these subjects.

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

Interactions

Use with other vaccines.

Shingrix can be given concomitantly with seasonal influenza vaccine (unadjuvanted), 23-valent pneumococcal polysaccharide vaccine (PPV23), pneumococcal conjugate vaccine (PCV), reduced antigen diphtheria-tetanus-acellular pertussis vaccine (dTpa), coronavirus disease 2019 (COVID-19) messenger ribonucleic acid (mRNA) vaccine or respiratory syncytial virus (RSV) vaccine (recombinant, adjuvanted) (see *Pharmacodynamic Effects*).

The adverse reactions of fever and shivering were more frequent when PPV23 vaccine was co-administered with **SHINGRIX** compared to when **SHINGRIX** was given alone (see *Adverse Reactions*).

If **SHINGRIX** is to be given at the same time as another injectable vaccine, the vaccines should always be administered at different injection sites.

Pregnancy and Lactation

Fertility

Animal studies indicate no effects of **SHINGRIX** on male or female fertility.

Pregnancy

There are no data on the use of **SHINGRIX** in pregnant women. Animal studies performed with **SHINGRIX** administered to female rats do not indicate any harmful effects with respect to pregnancy (see *Non-Clinical Information*).

Lactation

The effect on breast-fed infants of administration of **SHINGRIX** to their mothers has not been studied.

Effects on Ability to Drive and Use Machines

No studies on the effects of **SHINGRIX** on the ability to drive and use machines have been performed.

Adverse Reactions

Clinical trial data

The safety profile presented below is based on a pooled analysis of more than 14500 adults ≥ 50 years of age, who have received at least one dose of **SHINGRIX**. These data were generated in placebo-controlled clinical studies (conducted in Europe, North America, Latin America, Asia and Australia) where Shingrix was administered according to a 0, 2-month schedule. A long-term follow-up extension study included more than 7000 of these adults over a follow-up period of approximately 11 years after vaccination.

Additionally, in clinical studies, 1587 subjects ≥ 18 years of age who are immunodeficient or immunosuppressed due to disease or therapy (referred to as immunocompromised (IC)), were vaccinated with at least 1 dose of **SHINGRIX**. The reported adverse reactions were consistent with those presented in the Table below.

Adverse reactions reported are listed according to the following frequency:

Very common (≥1/10); Common (≥1/100 to <1/10); Uncommon (≥1/1000 to <1/100); Rare (≥1/10000 to <1/1000); Very rare (<1/10000)

System Organ Class	Frequency	Adverse reactions
Nervous system disorders	Very common	headache
Gastrointestinal disorders	Very common	gastrointestinal symptoms (including nausea, vomiting, diarrhoea and/or abdominal pain)
Musculoskeletal and connective tissue disorders	Very common	myalgia
	Uncommon	arthralgia
General disorders and administration site conditions	Very common	injection site reactions (such as pain, redness, swelling), fatigue, chills, fever
	Common	injection site pruritus, malaise

Overall, there was a higher incidence of some adverse reactions in younger age groups. However, the overall frequency and severity of these events did not indicate a clinically meaningful different reactogenicity profile in the younger age strata. In IC adult studies, there was a higher incidence of pain at the injection site, fatigue, myalgia, headache, shivering and fever in subjects aged 18 to 49 years compared with those aged 50 years and older. In older adult studies, there was a higher incidence of pain and swelling at the injection site, fatigue, myalgia, headache, shivering, fever and gastrointestinal symptoms in subjects aged 50 to 69 years compared with those aged 70 years and older.

In a clinical study where 119 subjects ≥ 50 years of age were vaccinated with **SHINGRIX** following a 0, 6-month schedule, the safety profile was similar to that observed in subjects vaccinated with **SHINGRIX** following a 0, 2-month schedule.

In a clinical study including 865 adults ≥ 50 years of age, fever and shivering were reported more frequently when PPV23 vaccine was co-administered with **SHINGRIX** (16% and 21%, respectively) compared to when **SHINGRIX** was given alone (7% for both adverse reactions).

In the long-term follow-up study (follow-up period of approximately 11 years) including more than 7000 adults ≥ 50 years of age, no new adverse reactions were identified.

Post-marketing data

System Organ Class	Frequency	Adverse reactions
Immune system disorders	Rare	hypersensitivity reactions including rash, urticaria, angioedema
An increased risk of Guillain-Barré syndrome has been observed following vaccination with Shingrix (see <i>Adverse Reactions</i>).	An increased risk of Guillain-Barré syndrome has been observed following vaccination with Shingrix (see <i>Adverse Reactions</i>).	An increased risk of Guillain-Barré syndrome has been observed following vaccination with Shingrix (see <i>Adverse Reactions</i>).

Post-marketing observational studies of the risk of Guillain-Barré syndrome

In 2 similar post-marketing observational studies in the US among individuals aged 65 years or older, an increased risk of Guillain-Barré syndrome (estimated 3 to 7 excess cases per million doses administered) was observed during the 42 days following any dose of Shingrix. In further analyses, the increased risk was observed following the first dose of Shingrix (estimated 6 to 12 excess cases of Guillain-Barré syndrome per million doses administered), but no increased risk was observed following the second dose.

Overdose

Insufficient data are available.

Pharmacological Properties

Pharmacodynamics

ATC Code

Pharmacotherapeutic group: Varicella zoster vaccines, ATC code: J07BK03.

Mechanism of Action

SHINGRIX is designed to induce antigen-specific cellular and humoral immune responses in individuals with pre-existing immunity against VZV.

Non-clinical data show that AS01_B induces a local and transient activation of the innate immune system through specific molecular pathways. This facilitates the recruitment and activation of antigen presenting cells carrying gE-derived antigens in the draining lymph node, which in turn leads to the generation of gE-specific CD4+ T cells and antibodies. The adjuvant effect of AS01_B is the result of interactions between MPL and QS-21 formulated in liposomes.

Pharmacodynamic Effects

Efficacy of SHINGRIX

Efficacy Against Herpes Zoster (HZ) and Post-Herpetic Neuralgia (PHN)

Two phase III, placebo-controlled, observer-blind efficacy studies of **SHINGRIX** were conducted in adults ≥ 50 years with 2 doses administered 2 months apart:

- Zoster-006 (ZOE-50): total vaccinated cohort (TVC) of 15405 subjects ≥ 50 years who received at least one dose of either **SHINGRIX** (N=7695) or placebo (N=7710).
- Zoster-022 (ZOE-70): TVC of 13900 subjects ≥ 70 years who received at least one dose of either **SHINGRIX** (N=6950) or placebo (N=6950).

Two phase III, placebo-controlled, observer-blind studies evaluating **SHINGRIX** efficacy were conducted in IC adults ≥ 18 years with 2 doses administered 1-2 months apart:

- Zoster-002: TVC of 1846 autologous hematopoietic stem cell transplants (aH SCT) recipients who received at least one dose of either **SHINGRIX** (N=922) or placebo (N=924) post-transplant.
- Zoster-039: TVC of 562 subjects with hematologic malignancies who received at least one dose of either **SHINGRIX** (N=283) or placebo (N=279) during a cancer therapy course or after the full cancer therapy course.

Incidence of HZ and PHN cases as well as vaccine efficacy were evaluated in the modified Total Vaccinated Cohort (mTVC) i.e. excluding subjects who did not receive the second dose of vaccine or who had a confirmed diagnosis of HZ within one month after the second dose).

SHINGRIX significantly decreased the incidence of HZ and PHN compared with placebo in:

- adults ≥ 50 years (Zoster-006): 6 vs. 210 HZ cases and 0 vs. 18 PHN cases.
- adults ≥ 70 years (pooled analysis of Zoster-006 and Zoster-022): 25 vs. 284 HZ cases and 4 vs. 36 PHN cases.
- adults ≥ 18 years with aH SCT (Zoster-002): 49 vs. 135 HZ cases and 1 vs. 9 PHN cases.
- adults ≥ 18 years with hematologic malignancies (Zoster-039): 2 vs. 14 HZ cases (PHN was not assessed as study endpoint). Vaccine efficacy was calculated post-hoc.

Vaccine efficacy results are presented in Table 1.

Table 1: SHINGRIX efficacy against HZ and PHN (mTVC)

Age (years)	HZ			PHN		
	N	Efficacy (%)	95% CI	N	Efficacy (%)	95% CI
Zoster-006*						
≥ 50	7344	97.2	93.7; 99.0	7340	100.0	77.1; 100.0
50-59	3492	96.6	89.6; 99.4	3491	100.0	40.8; 100.0
≥ 60	3852	97.6	92.7; 99.6	3849	100.0	55.2; 100.0
60-69	2141	97.4	90.1; 99.7	2140	100.0 [§]	< 0; 100.0
Pooled Zoster-006 and Zoster-022**						
≥ 70	8250	91.3	86.8; 94.5	8250	88.8	68.7; 97.1
70-79	6468	91.3	86.0; 94.9	6468	93.0	72.4; 99.2
≥ 80	1782	91.4	80.2; 97.0	1782	71.2 [§]	< 0; 97.1
Zoster-002*** (aH SCT recipients[§])						
≥ 18	870	68.2	55.5; 77.6	870	89.3	22.5; 99.8
18-49	213	71.8	38.7; 88.3	213	100.0 [§]	< 0; 100.0
≥ 50	657	67.3	52.6; 77.9	657	88.0	10.4; 99.8
Zoster-039 (hematologic malignancy patients[§])						
≥ 18	259	87.2****	44.2; 98.6	-	-	-

N Number of evaluable subjects
 CI Confidence interval
 * Descriptive efficacy analysis
 Zoster-049 mTVC: N (Shingrix) = 7258 (HZ), 7271 (PHN), 7273 (other HZ-related complications). The same N were assumed for the corresponding historical control groups.
 Zoster-049 mTVC started at a median of 5.6 years post-vaccination in Zoster-006/022 and ended at a median of 11.4 years post-vaccination.
 Zoster-006 / 022 / 049 mTVC: N (Shingrix) = 13881, N (Placebo / Historical control) = 14035. Placebo group in Zoster-006 / 022 was used for Year 1 through Year 4 analysis and to form the historical control data for Year 6 and onwards analysis in Zoster-049.
 In the eleventh year after vaccination, the efficacy against HZ was 82.0% (95% CI: 63.0; 92.2) and 72.0% (95% CI: 33.4; 89.8) in subjects ≥ 50 years (Shingrix group: N=5849) and subjects ≥ 70 years (Shingrix group: N=2891), respectively.

Zoster-006 mTVC: N (**SHINGRIX**) = 7344, N (Placebo) = 7415
Pooled analysis of Zoster-006 and Zoster-022 mTVC: N (**SHINGRIX**) = 8,250, N (Placebo) = 8346
Zoster-002 mTVC: N (**SHINGRIX**) = 870, N (Placebo) = 851
Zoster-039 mTVC: N (**SHINGRIX**) = 259, N (Placebo) = 256
 In the fourth year after vaccination, the efficacy against HZ was 93.1% (95% CI: 81.2; 98.2) and 87.9% (95% CI: 73.3; 95.4) in subjects ≥ 50 years (Zoster-006) and subjects ≥ 70 years (pooled Zoster-006 and Zoster-022), respectively.
 In Zoster-002, during a follow-up period starting 1 month post-dose 2 (i.e. corresponding to approximately 6 months after aH SCT) until 1 year after aH SCT, when the risk for HZ is the highest, the efficacy against HZ was 76.2% (95% CI: 61.1; 86.0).

Efficacy Against Other HZ-Related Complications

The evaluated HZ-related complications (other than PHN) were: HZ vasculitis, disseminated disease, ophthalmic disease, neurologic disease including stroke, and visceral disease.

In the pooled analysis of Zoster-006 and Zoster-022, **SHINGRIX** significantly reduced HZ-related complications by 93.7% (95% CI: 59.5; 99.9) and 91.6% (95% CI: 43.3; 99.8) in subjects ≥ 50 years (1 vs. 16 cases) and subjects ≥ 70 years (1 vs. 12 cases), respectively.

In Zoster-002, **SHINGRIX** significantly reduced HZ-related complications by 77.8% (95% CI: 19.0; 96.0) in aH SCT recipients ≥ 18 years (3 vs 13 cases).

In addition, in Zoster-002, **SHINGRIX** significantly reduced HZ-related hospitalisations by 84.7% (95% CI: 32.1; 96.6) (2 vs. 13 cases).

Effect of SHINGRIX on HZ-Associated Pain

In Zoster-022, **SHINGRIX** significantly reduced the use and the duration of HZ-associated pain medication by 39.6% (95% CI: 10.7; 64.8) and 49.3% (95% CI: 2.9; 73.5), respectively, in subjects ≥ 70 years with at least one confirmed HZ episode. The median duration of pain medication use was 30.0 and 38.0 days in the **SHINGRIX** and placebo group, respectively.

Overall there was a general trend towards less severe HZ-associated pain in subjects vaccinated with **SHINGRIX** compared to placebo.

In Zoster-002, **SHINGRIX** significantly reduced the duration of severe 'worst' HZ-associated pain by 38.5% (95% CI: 11.0; 57.6) in aH SCT recipients ≥ 18 years with at least one confirmed HZ episode.

Long-term efficacy against HZ, PHN and HZ-related complications other than PHN

A phase IIIb, open-label, long-term follow-up study of Shingrix (Zoster-049) was conducted in adults ≥ 50 years from Zoster-006 and Zoster-022. The TVC for efficacy included 7408 subjects.

Vaccine efficacy was calculated descriptively against HZ, PHN and HZ-related complications other than PHN in the mTVC (i.e., excluding subjects who did not receive the second dose of vaccine in the primary studies, or who developed a confirmed case of HZ within one month after the second dose). Estimates of incidence rates in the control group to assess the vaccine efficacy during Zoster-049 study were historical, derived from the Zoster-006 and Zoster-022 placebo vaccine.

Shingrix long-term efficacy results against HZ, PHN and other HZ-related complications up to approximately 11 years post-vaccination are presented in Table 2.

The number of cases of HZ, PHN and other HZ-related complications in subjects who received Shingrix compared to controls (see Table 2 for details on controls used) were as follows (age at the time of vaccination):

Over the duration of Zoster-049:

- In adults ≥ 50 years: 69 vs. 341 HZ cases, 4 vs. 32 PHN cases, 1 vs. 12 other HZ-related complication cases;
- In adults ≥ 70 years: 48 vs. 179 HZ cases, 3 vs. 23 PHN cases, 1 vs. 9 other HZ-related complication cases;

From 1 month post-dose 2 in Zoster-006 and Zoster-022 until the end of Zoster-049:

- In adults ≥ 50 years: 101 vs. 818 HZ cases, 8 vs. 78 PHN cases, 2 vs. 28 other HZ-related complication cases;
- In adults ≥ 70 years: 73 vs. 463 HZ cases, 7 vs. 59 PHN cases, 2 vs. 21 other HZ-related complication cases.

Table 2: Long-term Shingrix efficacy against HZ, PHN and HZ-related complications other than PHN (mTVC)

Age at the time of vaccination (years)	HZ			PHN			HZ-related complications other than PHN		
	N	Efficacy* (%)	95% CI	N	Efficacy* (%)	95% CI	N	Efficacy* (%)	95% CI
Over the duration of Zoster-049									
≥ 50	7258	79.8	73.7; 84.6	7271	87.5	64.8; 96.8	7273	91.7	43.7; 99.8
≥ 70	3973	73.2	62.9; 80.9	3982	87.0	56.8; 97.5	3984	88.9	19.8; 99.8
From 1 month post-dose 2 in Zoster-006/Zoster-022 until the end of Zoster-049									
≥ 50	13881	87.7	84.9; 90.1	13881	89.7	78.7; 95.7	13881	92.8	71.6; 99.2
≥ 70	8250	84.3	79.9; 87.9	8250	88.1	73.9; 95.4	8250	90.5	60.9; 98.9

N Number of evaluable subjects
 CI Confidence interval
 * Descriptive efficacy analysis
 Zoster-049 mTVC: N (Shingrix) = 7258 (HZ), 7271 (PHN), 7273 (other HZ-related complications). The same N were assumed for the corresponding historical control groups.
 Zoster-049 mTVC started at a median of 5.6 years post-vaccination in Zoster-006/022 and ended at a median of 11.4 years post-vaccination.
 Zoster-006 / 022 / 049 mTVC: N (Shingrix) = 13881, N (Placebo / Historical control) = 14035. Placebo group in Zoster-006 / 022 was used for Year 1 through Year 4 analysis and to form the historical control data for Year 6 and onwards analysis in Zoster-049.
 In the eleventh year after vaccination, the efficacy against HZ was 82.0% (95% CI: 63.0; 92.2) and 72.0% (95% CI: 33.4; 89.8) in subjects ≥ 50 years (Shingrix group: N=5849) and subjects ≥ 70 years (Shingrix group: N=2891), respectively.

Subjects with a history of HZ prior to vaccination

In a phase III, randomised, placebo-controlled, observer-blind, multicentre clinical study (Zoster-062), subjects ≥ 50 years of age, with a prior history of HZ (resolved > 6 months prior to enrolment), received 2 doses of either Shingrix or placebo 2 months apart. The Exposed Set (ES) included 1426 subjects who received at least one dose of either Shingrix (N=714) or placebo (N=712). **A total of 1286 subjects in the ES completed the study with a minimum follow-up period of 26 months.**

The incidence of HZ recurrence (Shingrix vs. placebo) was evaluated in the modified Exposed Set (mES i.e., excluding subjects who did not receive the second dose of vaccine or who had a confirmed diagnosis of HZ within 30 days after the second dose). The mES included 1350 subjects [N=668 (Shingrix), N=682 (placebo)].

In subjects with a prior history of HZ, Shingrix vaccination did not increase the recurrence of HZ (0 HZ cases in the Shingrix group vs. 8 HZ cases in the placebo group). The incidence rate ratio of HZ recurrence (Shingrix vs. placebo) in the mES from 30 days post-dose 2 until end of Zoster-062 was 0.00 (95% CI: 0.00; 0.46).

Immunogenicity of SHINGRIX

An immunological correlate of protection has not been established; therefore the level of immune response that provides protection against HZ is unknown.

In adults ≥ 50 years, the immune responses to **SHINGRIX** were evaluated in a subset of subjects from the phase III efficacy studies Zoster-006 [humoral immunity and cell-mediated immunity (CMI)] and Zoster-022 (humoral immunity). The gE-specific immune responses (humoral and CMI) elicited by **SHINGRIX** at 1 month post-dose 2 are presented in Tables 3 and 4, respectively.

Table 3: Humoral immunogenicity of SHINGRIX in adults ≥ 50 years at 1 month post-dose 2 (ATP cohort for immunogenicity)

Anti-gE immune response [^]				
Age group (years)	N	VRR§ (%) (95% CI)	GMC (95% CI)	Median fold increase of concentrations vs pre-vaccination (Q1; Q3)
Zoster-006				
≥ 50	1070	98.5 (97.6; 99.1)	52376.6 (50264.1; 54577.9)	41.9 (20.8; 86.9)
Pooled Zoster-006 and Zoster-022				
≥ 70	742	96.6 (95.1; 97.8)	49,691.5 (47,250.8; 52,258.2)	34.3 (16.7; 68.5)
ATP	According-To-Protocol			
^	Anti-gE immune response = anti-gE antibody levels, measured by anti-gE enzyme-linked immunosorbent assay (gE ELISA)			
N	Number of evaluable subjects at the specified time point (for the GMC)			
§	Vaccine response rate (VRR) for anti-gE is defined as the percentage of subjects who have at least a 4-fold increase in the post-dose 2 anti-gE antibodies concentration as compared to the pre-vaccination anti-gE antibodies (subjects seropositive at baseline), or as compared to the anti-gE antibodies cut-off value for seropositivity (subjects seronegative at baseline)			
CI	Confidence interval			
GMC	Geometric Mean Concentration			
Q1; Q3	First and third quartiles			

At 3 years post-dose 2, the median fold increase over baseline was 9.3 (Q1: 4.9; Q3: 19.5) in adults ≥ 50 years (Zoster-006) and 7.2 (Q1: 3.5; Q3: 14.5) in adults ≥ 70 years (pooled Zoster-006 and Zoster-022).

Table 4: Cell-mediated immunogenicity of SHINGRIX in adults ≥ 50 years at 1 month post-dose 2 (ATP cohort for immunogenicity)

gE-specific CD4[2+] T cell response [^]			
Age group (years)	N	Median frequency (Q1; Q3)	Median fold increase of frequency vs. pre-vaccination (Q1; Q3)
Zoster-006			
≥ 50	164	1,844.1 (1253.6; 2932.3)	24.6 (9.9; 744.2)
≥ 70*	52	1494.6 (922.9; 2,067.1)	33.2 (10.0; 1,052.0)
ATP	According-To-Protocol		
^	gE-specific CD4[2+] T cell response = gE-specific CD4+ T cell activity, measured by intracellular cytokine staining (ICS) assay (CD4[2+] T cells = CD4+ T cells expressing at least 2 of 4 selected immune markers)		
N	Number of evaluable subjects at the specified time point for the median frequency.		
Q1; Q3	First and third quartiles		
*	The gE-specific CD4[2+] data in the ≥70 YOA group were only generated in Zoster-006 because CD4+ T cell activity was not assessed in Zoster-022		
	At 3 years post-dose 2, in Zoster-006, the median fold increase over baseline was 7.9 (Q1: 2.7; Q3: 31.6) in adults ≥ 50 years and 7.3 (Q1: 1.7; Q3: 31.6) in adults ≥ 70 years.		

In IC adults ≥ 18 years, the humoral and CMI responses to **SHINGRIX** were evaluated in:

- one phase I/II study: Zoster-015 (HIV infected subjects);
- one phase II/III study: Zoster-028 (patients with solid tumors undergoing chemotherapy);
- three phase III studies: Zoster-002 (aHSCT recipients vaccinated post-transplant), Zoster-039 (patients with hematologic malignancies vaccinated during a cancer therapy course or after the full cancer therapy course) and Zoster-041 (renal transplant recipients on chronic immunosuppressive treatment at the time of vaccination).

The gE-specific immune responses (humoral and CMI) elicited by **SHINGRIX** at 1 month post-dose 2 in all IC populations studied are presented in Tables 4 and 5, respectively.

Table 5: Humoral Immunogenicity of SHINGRIX in IC adults ≥ 18 years at 1 month post-dose 2 (ATP cohort for immunogenicity)

Anti-gE immune response [^]			
N	VRR§ (%) (95% CI)	GMC (95% CI)	Median fold increase of concentrations vs pre-vaccination (Q1; Q3)
Zoster-002 (aHSCT recipients)			
82	67.1 (55.8; 77.1)	12,753.2 (7973.0; 20399.4)	14.1 (1.7; 137.0)
Zoster-028 (solid tumor patients)			
87	86.2 (77.1; 92.7)	18291.7 (14432.1; 23183.5)	21.5 (7.0; 45.2)
Zoster-039 (hematologic malignancy patients)			
217	65.4 (58.7; 71.7)	13445.6 (10158.9; 17795.6)	17.2 (1.4; 87.4)
Zoster-041 (renal transplant recipients)			
121	80.2 (71.9; 86.9)	19163.8 (15041.5; 24416.0)	15.1 (6.1; 35.0)
Zoster-015 (HIV infected subjects)			
53	98.1 (89.9; 100)	42723.6 (31233.0; 58441.6)	40.9 (18.8; 93.0)
ATP	According-To-Protocol		

^	Anti-gE immune response = anti-gE antibody levels, measured by anti-gE enzyme-linked immunosorbent assay (gE ELISA)
N	Number of evaluable subjects at the specified time point (for the GMC)
§	Vaccine response rate (VRR) for anti-gE is defined as the percentage of subjects who have at least a 4-fold increase in the post-dose 2 anti-gE antibodies concentration as compared to the pre-vaccination anti-gE antibodies (subjects seropositive at baseline), or as compared to the anti-gE antibodies cut-off value for seropositivity (subjects seronegative at baseline)
CI	Confidence interval
GMC	Geometric Mean Concentration
Q1; Q3	First and third quartiles

Table 6: Cell-mediated immunogenicity of SHINGRIX in IC adults ≥ 18 years at 1 month post-dose 2 (ATP cohort for immunogenicity)

gE-specific CD4[2+] T cell response [^]		
N	Median frequency (Q1; Q3)	Median fold increase of frequency vs. pre-vaccination (Q1; Q3)
Zoster-002 (aHSCT recipients)		
51	6644.9 (1438.3; 13298.6)	109.0 (34.4; 2,716.4)
Zoster-028* (solid tumor patients)		
22	778.8 (393.1; 1098.2)	4.9 (1.7; 33.0)
Zoster-039 (hematologic malignancy patients)		
53	3081.9 (1766.2; 7413.6)	45.9 (16.4; 2,221.9)
Zoster-041 (renal transplant recipients)		
32	2149.0 (569.4; 3695.1)	47.7 (14.7; 439.6)
Zoster-015 (HIV infected subjects)		
41	2809.7 (1554.5; 4663.7)	23.4 (8.5; 604.1)
ATP	According-To-Protocol	
^	gE-specific CD4[2+] T cell response = gE-specific CD4+ T cell activity, measured by intracellular cytokine staining (ICS) assay (CD4[2+] T cells = CD4+ T cells expressing at least 2 of 4 selected immune markers)	
N	Number of evaluable subjects at the specified time point for the median frequency.	
Q1; Q3	First and third quartiles	
*	Blood for CMI was only collected from the group of subjects that received the first dose of SHINGRIX 8-30 days before the start of a chemotherapy cycle (i.e. largest group of the study)	

At 1 year post-dose 2, the median fold increase over baseline ranged from 2.7 to 6.5 in terms of anti-gE antibody concentration and from 2.0 to 43.6 in terms of gE-specific CD4[2+] T-cell frequencies (studies Zoster-002, Zoster-028, Zoster-039 and Zoster-041).

At 2 years post-dose 2, in Zoster-002, the median fold increase over baseline was 1.3 in terms of anti-gE antibody concentration and 50.9 in terms of gE-specific CD4[2+] T-cell frequencies.

Immunogenicity Following Concomitant Vaccination

In six phase III, controlled, open-label clinical studies, adults ≥ 50 years of age were randomised to receive 2 doses of Shingrix 2 months apart administered either concomitantly at the first dose or non-concomitantly with seasonal influenza vaccine (unadjuvanted) (N=828; Zoster-004); PPV23 vaccine (N=865; Zoster-035); PCV13 vaccine (N=912; Zoster-059); dTpa vaccine formulated with 0.3 milligrams Al³⁺ (N=830; Zoster-042); monovalent COVID-19 mRNA-1273 50 micrograms booster vaccine (Original SARS-CoV-2 strain) (N=539; Zoster-091); or RSV vaccine (recombinant, adjuvanted) (N=530; RSV OA=ADJ-020). The vaccine response rates (in terms of anti-gE antibodies) were 95.8% (95% CI: 93.3; 97.6), 98.3% (95% CI: 96.4; 99.3), 99.1% (95% CI: 97.6; 99.7), 97.8% (95% CI: 95.8; 99.1), 97.4% (95% CI: 94.4; 99.0) and 92.9% (95% CI: 88.4; 96.1) following co-administration of Shingrix with the influenza, PPV23, PCV13, dTpa, COVID-19 mRNA-1273 booster and RSV (recombinant, adjuvanted) vaccines, respectively. The immune responses of the co-administered vaccines were unaffected, with the exception of lower geometric mean concentrations (GMCs) for one of the pertussis antigens (pertactin) when Shingrix is coadministered with the dTpa vaccine. However, these data do not suggest clinically relevant interference.

Immunogenicity in Subjects with a History of HZ Prior to Vaccination

In adults ≥ 50 years with a prior history of HZ (resolved > 6 months prior to enrolment), the immune responses to Shingrix were evaluated in subjects from the phase III study Zoster-062. The gE-specific immune responses (humoral) elicited by Shingrix at 30 days post-dose 2 are presented in Table 7.

Table 7: Humoral immunogenicity of Shingrix in adults ≥ 50 years, with a prior history of HZ, at 30 days post-dose 2 (PPS cohort for immunogenicity)

Anti-gE immune response [^]			
N	VRR§ (%) (95% CI)	GMC (95% CI)	Median fold increase of concentrations vs pre-vaccination (Q1; Q3)
534	95.3 (93.1; 96.9)	49175.8 (46500.4; 52005.1)	24.4 (11.9; 47.5)
PPS	Per Protocol Set		
^	Anti-gE immune response = anti-gE antibody levels, measured by anti-gE enzyme-linked immunosorbent assay (gE ELISA)		
N	Number of evaluable subjects at the specified time point (for the GMC)		
§	Vaccine response rate (VRR) for anti-gE is defined as the percentage of subjects who have at least a 4-fold increase in the post-dose 2 anti-gE antibodies concentration as compared to the pre-vaccination anti-gE antibodies (subjects seropositive at baseline), or as compared to the anti-gE antibodies cut-off value for seropositivity (subjects seronegative at baseline)		
CI	Confidence interval		
GMC	Geometric Mean Concentration		
Q1; Q3	First and third quartiles		

Immunogenicity in Subjects Receiving 2 Doses of SHINGRIX 6 Months Apart

In a phase III, open-label clinical study (Zoster-026) where 238 subjects ≥ 50 years of age were equally randomised to receive 2 doses of **SHINGRIX** 2 or 6 months apart, the vaccine response rate (anti-gE antibodies) at 1 month post-vaccination following the 0, 6-month schedule was 96.5% (95% CI: 90.4; 99.2).

The humoral immune response (anti-gE antibodies concentration) following the 0, 6-month schedule was not inferior to the humoral immune response following the 0, 2-month schedule, as the 97.5% CI upper limit of the antibodies concentration ratio was below 1.50 [1.16 (97.5% CI: 0.98; 1.39)].

Immunogenicity in Individuals Previously Vaccinated with Live Attenuated Herpes Zoster (HZ) Vaccine

In a phase III, open-label, multicentre clinical study (Zoster-048), 430 adults \geq 65 years of age with or without a previous history of vaccination with live attenuated HZ vaccine \geq 5 years earlier were group-matched at a 1:1 ratio to receive 2 doses of **SHINGRIX** 2 months apart. The immune response to **SHINGRIX** was unaffected by prior vaccination with live attenuated HZ vaccine.

Persistence of immunogenicity

Persistence of immunogenicity was evaluated in a subset of subjects in a phase IIIb, open-label, long-term follow-up study (Zoster-049) in adults \geq 50 years from Zoster-006 and Zoster-022. At Year 12 post-vaccination, MGI (Mean Geometric Increase versus pre-vaccination) of anti-gE antibody concentrations in 435 evaluable subjects was 5.8 (95% CI: 5.2; 6.4). Median frequency of gE-specific CD4[2+] T cells at Year 12 post-vaccination in 73 evaluable subjects remained above pre-vaccination level.

Persistence of immunogenicity was evaluated in a phase IIIb, open-label study (Zoster-073) in 68 renal transplant recipients aged \geq 18 years on chronic immunosuppressive therapy from Zoster-041. Zoster-073 study started 4 to 6 years post-vaccination in Zoster-041. At Month 24 (approximately 6 to 8 years post-dose 2), MGI of anti-gE antibody concentration in 49 evaluable subjects was 2.4 (95% CI: 1.6; 3.7). Median frequency of gE specific CD4[2+] T cells at Month 24 in 19 evaluable subjects in CMI subset remained above pre-vaccination level.

Pharmacokinetics

Evaluation of pharmacokinetic properties is not required for vaccines.

Clinical Studies

See *Pharmacodynamic Effects*.

Non-Clinical Information

Reproductive Toxicology

Administration of VZV gE AS01_B to female rats did not indicate any harmful effects with respect to fertility, pregnancy, embryo-foetal development, parturition or postnatal development.

Treatment of male rats did not affect mating performance, fertility or early embryonic development.

Animal Toxicology and/or Pharmacology

Non-clinical data reveal no special hazard for humans based on conventional studies of acute and repeated dose toxicity, local tolerance and cardiovascular/respiratory safety pharmacology.

Pharmaceutical Information

List of Excipients

Powder (gE Antigen):

Sucrose, polysorbate 80, sodium dihydrogen phosphate dihydrate, dipotassium phosphate

Suspension (AS01_B Adjuvant System):

Dioleoyl phosphatidylcholine, cholesterol, sodium chloride, disodium phosphate anhydrous, potassium dihydrogen phosphate, water for injections

Shelf Life

The expiry date is indicated on the packaging.

For shelf-life after reconstitution of the medicinal product, see *Use and Handling*.

Storage

Store in a refrigerator (2°C – 8°C). Do not freeze. Store in the original package in order to protect from light. The storage conditions are detailed on the packaging.

For storage conditions after reconstitution of the medicinal product, see *Use and Handling*.

Nature and Contents of Container

- Powder for 1 dose in a vial (type I glass) with a stopper (butyl rubber)
- Suspension for 1 dose in a vial (type I glass) with a stopper (butyl rubber).

SHINGRIX is available in a pack size of 1 vial of powder plus 1 vial of suspension or in a pack size of 10 vials of powder plus 10 vials of suspension.

Not all pack sizes may be marketed.

Incompatibilities

This medicinal product must not be mixed with other medicinal products.

Use and Handling

The powder and suspension should be inspected visually for any foreign particulate matter and/or variation of appearance. If either is observed, do not reconstitute the vaccine.

How to Prepare **SHINGRIX**

SHINGRIX must be reconstituted prior to administration.

1. Withdraw the entire contents of the vial containing the suspension into a syringe with a suitable needle (21G to 25G).
2. Add the entire contents of the syringe into the vial containing the powder.
3. Shake gently until the powder is completely dissolved.

The reconstituted vaccine is an opalescent, colourless to pale brownish liquid.

The reconstituted vaccine should be inspected visually for any foreign particulate matter and/or variation of appearance. If either is observed, do not administer the vaccine.

After reconstitution, the vaccine should be used promptly; if this is not possible, the vaccine should be stored in a refrigerator (2°C – 8°C). If not used within 6 hours it should be discarded.

Before Administration

1. Withdraw the entire contents of the vial containing the reconstituted vaccine into the syringe.

2. Change the needle so that you are using a new needle to administer the vaccine.

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

Version

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