

## **1 NAME OF THE MEDICINAL PRODUCT**

**STAMARIL, powder and solvent for suspension for injection in pre-filled syringe.  
Yellow fever vaccine (Live).**

## **2 QUALITATIVE AND QUANTITATIVE COMPOSITION**

After reconstitution, 1 dose (0.5 mL) contains:

Yellow fever virus<sup>1</sup>, 17D-204 strain (live, attenuated) ..... not less than 1000 IU

<sup>1</sup> produced in specified pathogen-free chick embryos

Excipient with known effect:

This product contains about 8 mg of sorbitol (E420) per dose.

For the full list of excipients, see section 6.1.

## **3 PHARMACEUTICAL FORM**

Powder and solvent for suspension for injection.

Before reconstitution, the powder is homogeneous, beige to orange beige, and the solvent is a clear and colourless solution.

## **4 CLINICAL PARTICULARS**

### **4.1 Therapeutic indications**

STAMARIL is indicated for active immunization against yellow fever in persons:

- travelling to, passing through or living in an area where there is a persisting or periodical risk of yellow fever transmission
- travelling to any country that requires an International Certificate of Vaccination for entry (which may or may not depend on the previous itinerary),
- handling potentially infectious materials (e.g. laboratory personnel).

See sections 4.2, 4.3 and 4.4 regarding the minimum age for vaccination of children under special circumstances and guidance for vaccination of other specific patient populations.

See the regular updates related to obligations and recommendations for yellow fever vaccination on the dedicated site of the World Health Organisation (WHO) or on the official sites of local health authorities.

In order to comply with vaccine regulations and to be officially recognised, yellow fever vaccines must be administered by a qualified and trained health professional in an approved WHO vaccination centre and registered on an International Certificate of Vaccination. The validity period of this Certificate is established according to International Health Regulations (IHR) recommendations, and starts 10 days after primary vaccination and immediately after re-vaccination (see section 4.2).

## **4.2 Posology and method of administration**

### **Posology**

#### *Primary vaccination*

The vaccine should be given at least 10 days before entering an endemic area since protective immunity may not be achieved until at least this time has elapsed.

*Adults:* a single dose of 0.5 mL of the reconstituted vaccine.

#### *Persons aged 60 years and older:*

The dose is the same as for adults. However due to a potentially higher risk of yellow fever vaccine-associated severe and potentially fatal disease in persons from 60 years of age, the vaccine should only be given when it is considered that there is a significant and unavoidable risk of acquiring yellow fever infection, such as in case of travel in an area where there is persisting or periodical risk of yellow fever transmission (see sections 4.4 and 4.8).

#### *Paediatric population:*

- Children aged 9 months and older: a single dose of 0.5 mL of the reconstituted vaccine.
- Children from 6 to 9 months of age: vaccination against yellow fever is not recommended in children aged from 6 months up to 9 months except in specific circumstances and in accordance with available official recommendations (see section 4.4), in which case the dose is the same as in children aged 9 months and older.
- Children under 6 months of age: STAMARIL is contraindicated in children less than 6 months of age (see section 4.3).

#### *Re-vaccination*

The duration of protection following administration of one single 0.5 mL dose of STAMARIL is expected to be at least 10 years and may be life-long.

According to the recommendations of WHO and International Health Regulations, a yellow fever vaccination certificate is valid for the entire life of the vaccinated person. However, re-vaccination with one dose of 0.5 mL may be needed in subjects who had an insufficient immune response after their primary vaccination and are still at risk of infection with the yellow fever virus. Re-vaccination may also be required according to official recommendations of local Health Authorities..

### **Method of administration**

It is preferable that the vaccine is injected by the subcutaneous route.

Intramuscular injection may be performed if this is in accordance with applicable official recommendations.

For intramuscular use the recommended injection sites are the anterolateral aspect of the thigh in children less than 12 months of age, the anterolateral aspect of the thigh (or the deltoid muscle if muscle mass is adequate) in children 12 months through 35 months of age or the deltoid muscle in children from 36 months of age onwards and adults.

DO NOT INJECT INTRAVASCULARLY.

*Precautions to be taken before handling or administering the medicinal product*

For instructions on reconstitution of the medicinal product before administration, see section 6.6.

### **4.3 Contraindications**

- Hypersensitivity to the active substance or to any of the excipients listed in section 6.1 or to eggs or chicken proteins.
- Severe hypersensitivity reactions (*e.g.*, anaphylaxis) after a previous dose of any yellow fever vaccine.
- Age less than 6 months (see sections 4.2 and 4.4).
- Immunosuppression, whether congenital or acquired. This includes individuals receiving immunosuppressive therapies, such as treatment with high-dose systemic steroids (for example, a daily dose of 20 mg or 2 mg/kg body weight of prednisone or the equivalent for 2 weeks or more or a daily dose of 40 mg or more of prednisone for more than one week), any other medicinal product including biological products with known immunosuppressive properties, radiotherapy, cytotoxic drugs or any other situation that may cause immunodepression.
- History of thymus dysfunction (including *myasthenia gravis*, thymoma)
- Thymectomy (regardless of cause).
- Symptomatic HIV infection.
- Asymptomatic HIV infection when accompanied by evidence of impaired immune function (see section 4.4).
- Moderate or severe febrile illness or acute illness.

### **4.4 Special warnings and precautions for use**

#### **Traceability**

In order to improve the traceability of biological medicinal products, the name and the batch number of the administered product should be clearly registered.

As with all injectable vaccines, appropriate medical treatment and supervision should always be readily available in case of anaphylaxis or other severe hypersensitivity reaction following administration of the vaccine.

Syncope (fainting) can occur following, or even before, any vaccination as a psychogenic response to the needle injection. Procedures should be in place to prevent injury from faints and manage syncopal reactions.

DO NOT INJECT INTRAVASCULARLY.

Because intramuscular injection can cause injection site haematoma, STAMARIL should not be given by the intramuscular route to persons with any bleeding disorder, such as haemophilia or

thrombocytopenia, or to persons on anticoagulant therapy. The subcutaneous route of administration should be used instead.

STAMARIL should be administered only to persons who are/will be at risk of infection with yellow fever virus or who must be vaccinated to comply with international health regulations. Before considering administration of yellow fever vaccine, care should be taken to identify those who might be at increased risk of adverse reactions following vaccination (see section 4.3 and below).

#### **Yellow fever vaccine-associated neurotropic disease (YEL-AND)**

Very rarely, YEL-AND has been reported following vaccination, with sequelae or with fatal outcome in some cases (see section 4.8). To date, most of cases of YEL-AND have been reported in primary vaccinees with an onset within 30 days of vaccination. The risk appears to be higher in those aged over 60 years and below 9 months of age (including infants exposed to vaccine through breast-feeding), although cases have been also reported in other age groups. Congenital or acquired immunodeficiency has also been recognised as a predisposing factor (see section 4.3). However, YEL-AND cases have also been reported in persons without identified risk factors. The vaccinated persons must be informed of the need to request a medical opinion if they feel, after vaccination, any symptoms indicative of YEL-AND such as high fever together with headache or confusion, personality change, or if they feel extreme fatigue, neck stiffness, seizures, loss of movement or feeling in part or all of the body. Vaccinated persons should also be reminded to inform their health care provider that they received a yellow fever vaccine (see section 4.8).

#### **Yellow fever vaccine-associated viscerotropic disease (YEL-AVD)**

Very rarely, YEL-AVD resembling fulminant infection by wild-type virus has been reported following vaccination (see section 4.8). The mortality rate has been around 60%. To date, most of cases of YEL-AVD have been reported in primary vaccinees with an onset within 10 days of vaccination. The risk appears to be higher in those aged over 60 years although cases have also been reported in other age groups. Thymectomy or history of thymus dysfunction has also been recognised as predisposing factors (see section 4.3). However, YEL-AVD cases have also been reported in persons without identified risk factors.

The vaccinated persons must be informed of the need to request a medical opinion if they feel, after vaccination, any symptoms indicative of YEL-AVD such as fever, myalgia, fatigue, headache or hypotension, because these symptoms can potentially rapidly progress to liver dysfunction with jaundice, muscle cytolysis, thrombocytopenia and acute respiratory and renal failure. Vaccinated persons should also be reminded to inform their health care provider that they received a yellow fever vaccine (see section 4.8).

#### **Immunosuppressed persons**

STAMARIL must not be administered to immunosuppressed persons (see section 4.3).

If the immunosuppression is temporary, vaccination should be delayed until the immune function has recovered. In patients who have received systemic corticosteroids for 14 days or more, it is advisable to delay vaccination until at least one month after completing the course.

#### HIV infection

STAMARIL must not be administered to persons with symptomatic HIV infection or with asymptomatic HIV infection when accompanied by evidence of impaired immune function (see section 4.3). However, there are insufficient data at present to determine the immunological parameters that might differentiate persons who could be safely vaccinated and who might mount a protective immune response from those in whom vaccination could be both hazardous and ineffective. Therefore, if an asymptomatic HIV-infected person cannot avoid travel to an endemic area available official guidance should be taken into account when considering the potential risks and benefits of vaccination.

#### Children born to HIV positive mothers

Children aged at least 6 months (see sections 4.2 and 4.3 and below) may be vaccinated if it is confirmed that they are not infected with HIV.

HIV infected children aged at least 6 months who are potentially in need of protection against yellow fever should be referred to a specialist paediatric team for advice on whether or not to vaccinate.

#### Age

##### Paediatric population: children less than 9 months of age

Children aged from 6 months up to 9 months should only be vaccinated under special circumstances (e.g. during major outbreaks) and on the basis of current official advice.

STAMARIL is contraindicated in children less than 6 months of age (see section 4.3).

##### Older people: persons aged 60 years and older

Persons aged 60 years and older may have an increased risk of serious and potentially fatal adverse reactions (including systemic and neurological reactions persisting more than 48 hours, YEL-AVD and YEL-AND) when compared to other age groups. Therefore, the vaccine should only be given to those who visit areas where there is a risk of yellow fever transmission at the time of travel. The countries designated by WHO, where vaccination is not recommended generally, or not recommended, should be considered as not presenting an inevitable significant risk (refer to the list of countries with yellow fever infection risk updated by WHO) (see above and section 4.8).

##### Pregnant and breast-feeding women

STAMARIL should not be used in pregnant and breast-feeding woman unless when clearly needed and following an assessment of the risks and benefits (see section 4.6).

### **Transmission**

There are very few reports suggesting that transmission of Yellow Fever vaccine virus may occur from nursing mothers, who received Yellow Fever vaccine postpartum, to the infant. Following transmission the infants may develop YEL-AND from which the infants recover (see section 4.6). As with any vaccine, vaccination with STAMARIL may not protect 100% of vaccinated individuals.

### **Latex**

The tip-caps of the prefilled syringes contain a natural latex derivative that could cause allergic reactions in people sensitive to latex.

### **Excipients with a known effect**

STAMARIL contains less than 1 mmol (23 mg) of sodium per dose, i.e. it is essentially "sodium-free."

STAMARIL contains less than 1 mmol (39 mg) of potassium per dose, i.e. it is essentially "potassium-free".

STAMARIL contains about 8 mg of sorbitol (E420) per dose.

## **4.5 Interaction with other medicinal products and other forms of interaction**

STAMARIL must not be mixed with any other vaccine or medicinal product in the same syringe. If there is a need to administer another injectable vaccine(s) at the same time as STAMARIL each vaccine should be injected into a separate site (and preferably a separate limb).

This vaccine may be administered at the same time as measles vaccine if this is in accordance with official recommendations.

It may be administered at the same time as vaccines containing typhoid Vi capsular polysaccharide and/or inactivated hepatitis A virus.

It must not be administered to persons who are receiving immunosuppressant therapies such as treatment with high-dose systemic steroids (for example, a daily dose of 20 mg or 2 mg/kg body weight of prednisone or the equivalent for 2 weeks or more or a daily dose of 40 mg or more of prednisone for more than one week), any other medicinal product including biological products with known immunosuppressive properties, radiotherapy, cytotoxic drugs or any other situation that may cause immunodepression (see section 4.3). In case of uncertainty regarding the degree of immunosuppression, vaccination should be suspended and the opinion of a specialist should be requested.

It can induce false positive results with laboratory and/or diagnostic tests for other flavivirus related diseases such as dengue or Japanese encephalitis.

## **4.6 Fertility, pregnancy and lactation**

### **Pregnancy**

No animal developmental and reproductive studies have been conducted with STAMARIL and the potential risk for humans is unknown. Data on a limited number of exposed pregnancies indicate no adverse effects of STAMARIL on pregnancy or the health of the foetus/new-born

child. Nevertheless, as STAMARIL is a live attenuated vaccine, it should not be used during pregnancy unless clearly needed and only after careful consideration of the potential risks and benefits. Pregnancy should be avoided in the month after the vaccination.

### **Breast-feeding**

As there is a probable risk of transmission of the vaccine virus strain to the infants from breast-feeding mothers, STAMARIL should not be given to nursing mothers unless when clearly needed such as during an outbreak and only if the potential benefits to the mother are higher than the potential risks, including those for the breastfed child (see section 4.4). In the case where vaccination is needed, it is recommended to discontinue breast-feeding for at least 2 weeks after vaccination.

### **Fertility**

No animal fertility studies have been conducted with STAMARIL and no fertility data are available in humans.

## **4.7 Effects on ability to drive and use machines**

No studies on the effects on the ability to drive or use machines have been performed.

## **4.8 Undesirable effects**

### **a. Summary of the safety profile**

Cases of serious adverse events such as severe hypersensitivity or anaphylactic reactions, neurotropic or viscerotropic disease (YEL-AND; YEL-AVD) have been reported from post-marketing experience (see subsections **b. Tabulated list of adverse reactions** and **c. Description of selected adverse reactions**).

In all clinical studies, 4896 subjects (all ages) received STAMARIL.

In the most representative study in general population, the most frequently reported reactions (between 12% and 18% of subjects) were cephalalgia, asthenia, injection site pain and myalgia.

In the most representative study in toddler population, the most frequently reported reactions (between 32% and 35% of toddlers) were irritability, crying and appetite loss.

Adverse reactions usually occurred within the first three days following vaccination except fever, which occurred between Day 4 and Day 14.

These reactions usually lasted for not more than 3 days.

Both local and systemic reactions were usually of mild intensity; however at least one severe injection site reaction was reported in 0.8% of subjects in general population and in 0.3% of toddlers and at least one severe systemic reaction was reported in 1.4% of subjects in general population and 4.9% in toddlers.

**b. Tabulated list of adverse reactions**

The table below summarises the frequencies of the adverse reactions that were recorded following vaccination with STAMARIL during clinical studies and worldwide post-marketing experience.

The adverse reactions are ranked under headings of frequency, using the following convention:

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 ( $< 1/10,000$ )

Not known (cannot be estimated from available data)

Adverse reactions in each frequency group are presented in the decreasing order of severity.

<b>System Organ Class</b>	<b>Frequency</b>	<b>Adverse reactions</b>
Infections and infestations	Rare	Rhinitis
	Very rare	YEL-AVD‡
Blood and Lymphatic System Disorders	Not known	Lymphadenopathy
Immune System Disorders	Not known	Anaphylactoid reaction including angioedema
Metabolism and nutrition disorders	Very common	Appetite loss*
Nervous System Disorders	Very common	Drowsiness*, Cephalalgia
	Uncommon	Dizziness
	Very rare	YEL-AND‡, seizures, aseptic meningitis
	Not known	Paraesthesia
Gastrointestinal disorders	Very common	Vomiting†
	Common	Nausea
	Uncommon	Abdominal pain
	Rare	Diarrhoea
Skin and Subcutaneous tissue Disorders	Common	Rash
	Uncommon	Pruritus
	Not known	Urticaria
Musculoskeletal and Connective Tissue Disorders	Very common	Myalgia
	Common	Arthralgia
General Disorders and Administration Site Conditions	Very common	Irritability*, Crying*, Fever†, Asthenia, Injection site pain/tenderness
	Common	Injection site erythema/redness, Injection site haematoma, Injection site induration;

		Injection site oedema/swelling
	Uncommon	Injection site papule
	Not known	Influenza-like illness

\*Specific to paediatric population, (see section d. Paediatric population)

‡ For clinical features see section c. Description of selected adverse reactions

† Very common in toddlers (see section d. Paediatric population), Common in general population

### **c. Description of selected adverse reactions**

Cases of neurotropic disease (known as YEL-AND), some of which have had a fatal outcome, have been reported to occur within 30 days following vaccination with STAMARIL, and other yellow fever vaccines. YEL-AND may manifest either as an encephalitis (with or without demyelination), or as a neurobiological disease affecting the peripheral nervous system (for example Guillain-Barré syndrome). Encephalitis usually starts with high fever with cephalalgia that may progress to encephalopathy (for example confusion, lethargy, personality change for more than 24h, focal neurological deficits, cerebellar dysfunction or seizures. YEL-AND affecting the peripheral nervous system manifests generally with bilateral weakness of the limbs, or peripheral paresis of the cranial nerves with reduction or disappearance of tendon reflexes (see section 4.4).

Neurological diseases not fulfilling the YEL-AND criteria have been reported. The manifestations may include cases of aseptic meningitis or seizures not associated with focal neurological signs. These cases are generally of mild or moderate severity and resolve spontaneously.

Cases of viscerotropic disease (known as YEL-AVD and formerly described as “Febrile Multiple Organ-System Failure”) have been reported following vaccination with STAMARIL, and other yellow fever vaccines, some of which have been fatal. In the majority of cases reported, the onset of signs and symptoms was within 10 days after the vaccination. Initial signs and symptoms are non-specific and may include fever, myalgia, fatigue, cephalalgia and hypotension, potentially progressing quickly to liver dysfunction with jaundice, muscle cytolysis, thrombocytopenia and acute respiratory and renal failure (see section 4.4).

### **d. Paediatric population**

The safety of STAMARIL in paediatric population has been studied through a clinical study performed in 393 toddlers aged 12 to 13 months who received STAMARIL and placebo concomitantly.

The safety profile was assessed during the first 4 weeks following vaccination.

The following most frequently reported adverse reactions specific to the paediatric population were reported as “very common”: irritability (34.7%), appetite loss (33.7%), crying (32.1%) and drowsiness (22%).

The other adverse reactions reported in toddlers were also reported from studies in general population:

- Injection site pain (17.6%), fever (16.5%) and vomiting (17.1%) were reported as “very common” in toddlers. Fever and vomiting were more frequently reported than in general population (see table in subsection **b. Tabulated summary of adverse reactions**).
- Injection site erythema (9.8%) and injection site swelling (4.4%) were reported as “common” in toddlers, like in general population, however with significantly higher frequencies compared to general population.

#### **e. Other special population**

Congenital or acquired immunodeficiency has been recognised as a potential risk factor for serious adverse events, including YEL-AND (see sections 4.3 and 4.4).

Age of more than 60 years (see section 4.4) has been recognised as a potential risk factor for YEL-AVD and YEL-AND.

Age below 9 months (including infants exposed to vaccine through breast-feeding) (see section 4.4) has been recognised as a potential risk factor for YEL-AND.

A medical history of thymus dysfunction or thymectomy (see sections 4.3 and 4.4) have been recognised as predisposing factors for YEL-AVD.

#### **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 via the national reporting system.

### **4.9 Overdose**

Cases of administration of more than the recommended dose (overdose) have been reported with STAMARIL. When adverse reactions were reported, the information was consistent with the known safety profile of STAMARIL described in section 4.8.

## **5 PHARMACOLOGICAL PROPERTIES**

### **5.1 Pharmacodynamic properties**

**Pharmacotherapeutic group: Yellow Fever Vaccine (Live), ATC code: J07B –L01.**

STAMARIL is a live attenuated yellow fever virus vaccine. As with other live attenuated viral vaccines, there is a sub-clinical infection in healthy recipients that results in the production of specific B and T cells and the appearance of specific circulating antibody. A neutralising antibody titre of 1:10 is assumed to correlate with protection.

Protective immunity appears from about 10 days after vaccination, lasts at least 10 years and may be life-long.

In clinical studies in adults it has been shown that 28 days following vaccination with STAMARIL seroconversion rates of 93% and 100% were obtained.

### **Paediatric population**

In a clinical study conducted in 337 toddlers aged 12 to 13 months the yellow fever seropositivity rates 28 days post injection of STAMARIL were 99.7% (98.5; 100.0) and the Geometric Mean Titres were 423 (375; 478). In another clinical study conducted in 30 children and adolescents aged 2 to 17 years a seroconversion rate of 90 to 100% was observed, confirming results observed in earlier clinical studies.

### **5.2 Pharmacokinetic properties**

No pharmacokinetic studies have been performed.

### **5.3 Preclinical safety data**

No non-clinical studies have been performed.

## **6 PHARMACEUTICAL PARTICULARS**

### **6.1 List of Excipients**

#### **Powder:**

Lactose  
Sorbitol E420  
L-Histidine hydrochloride  
L-Alanine  
Sodium chloride  
Potassium chloride  
Disodium phosphate dihydrate  
Potassium dihydrogen phosphate  
Calcium chloride  
Magnesium sulphate

#### **Solvent:**

Sodium chloride  
Water for injections.

### **6.2 Incompatibilities**

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

### **6.3 Shelf life**

3 years.

After reconstitution, the medicinal product must be used immediately.

### **6.4 Special precautions for storage**

Store in a refrigerator (2°C – 8°C). Do not freeze. Keep the vial of powder and the syringe of solvent in the outer carton in order to protect from light.

For storage conditions after reconstitution of the medicinal product, see section 6.3.

### **6.5 Nature and Contents of Container**

Powder in vial (type I glass), with a stopper (chlorobutyl) and a flip-off cap (aluminium) + 0.5 mL of solvent in pre-filled syringe (type I glass), with a plunger-stopper (halobutyl), and an attached needle and a needle-shield (natural rubber or polyisoprene) – box of 1, 10 or 20.

Powder in vial (type I glass), with a stopper (chlorobutyl) and a flip-off cap (aluminium) + 0.5 mL of solvent in pre-filled syringe (type I glass), with a plunger-stopper (halobutyl), and a tip cap (styrene butadiene) – box of 1 or 10. The tip-caps of the pre-filled syringes contain a natural latex derivative.

Powder in vial (type I glass), with a stopper (chlorobutyl) and a flip-off cap (aluminium) + 0.5 mL of solvent in pre-filled syringe (type I glass), with a plunger-stopper (halobutyl), and a tip cap (styrene butadiene) with 1 or 2 separate needle(s) provided in the blister – box of 1 or 10. The tip-caps of the pre-filled syringes contain a natural latex derivative.

Not all pack sizes may be marketed.

### **6.6 Special precautions for disposal and other handling**

For syringe without attached needle only: after removing the syringe tip cap, a needle should be firmly placed on the tip of the syringe and secured by rotating a quarter of a turn (90°).

The vaccine is reconstituted by adding the solvent provided in the pre-filled syringe to the vial of powder. The vial is shaken and, after complete dissolution, the suspension obtained is withdrawn into the same syringe for injection.

Before administration, the reconstituted vaccine should be vigorously shaken.

Use immediately after reconstitution.

After reconstitution the suspension is beige to pink beige, more or less opalescent.

Contact with disinfectants is to be avoided since they may inactivate the virus.

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

## **7 MANUFACTURER**

### **Sanofi Winthrop Industrie**

Parc industriel d'Incarville Voie de l'institut,  
P.O. Box 101, 27100 Val de Reuil, France (VDR)

## **8 DATE OF REVISION OF TEXT**

Jun 2025