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# **Guidance for Industry**

## **Levothyroxine Sodium Tablets — In Vivo Pharmacokinetic and Bioavailability Studies and In Vitro Dissolution Testing**

**U.S. Department of Health and Human Services  
Food and Drug Administration  
Center for Drug Evaluation and Research (CDER)**

**December 2000  
Clinical Medical**

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# GUIDANCE FOR INDUSTRY<sup>1</sup>

## Levothyroxine Sodium Tablets — In Vivo Pharmacokinetic and Bioavailability Studies and In Vitro Dissolution Testing

This guidance represents the Food and Drug Administration's (FDA's) current thinking on this topic. It does not create or confer any rights for or on any person and does not operate to bind FDA or the public. An alternative approach may be used if such approach satisfies the requirements of the applicable statutes and regulations.

### I. INTRODUCTION

This guidance is intended to assist sponsors of new drug applications (NDAs) for levothyroxine sodium tablets who wish to conduct in vivo pharmacokinetic and bioavailability studies and in vitro dissolution testing for their products. Information from these studies would generally be submitted in section 6 of an NDA. Sponsors who wish to use approaches other than those recommended in this guidance should discuss their plans with the FDA prior to preparing an NDA.

### II. BACKGROUND

Levothyroxine sodium is the sodium salt of the levo isomer of the thyroid hormone thyroxine. Thyroid hormones affect protein, lipid, and carbohydrate metabolism, growth, and development. They stimulate the oxygen consumption of most cells of the body, resulting in increased energy expenditure and heat production, and possess a cardiostimulatory effect that may be the result of a direct action on the heart.

The production of levothyroxine hormone is regulated by the hypothalamus-pituitary axis through a negative feedback system. When hormone levels are inadequate, the hypothalamus secretes thyroid stimulating hormone-releasing hormone (TSH-RH), which stimulates the anterior pituitary to produce thyroid stimulating-hormone (TSH). TSH then stimulates the thyroid gland to produce levothyroxine

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<sup>1</sup> This guidance has been prepared by the Division of Pharmaceutical Evaluation II, Office of Clinical Pharmacology and Biopharmaceutics, which operates under the direction of the Office of Pharmaceutical Science in the Center for Drug Evaluation and Research (CDER) at the Food and Drug Administration (FDA). The guidance has also been reviewed by the Guidances Technical Committee of the Biopharmaceutics Coordinating Committee, as well as the Division of Metabolic and Endocrine Drug Products in CDER.

(T<sub>4</sub>) and triiodothyronine (T<sub>3</sub>). T<sub>4</sub> is subsequently converted to the highly active T<sub>3</sub> in the peripheral tissues. High levels of T<sub>4</sub> inhibit the production of TSH and (to a lesser degree) TSH-RH. This effect in turn decreases the further production of T<sub>4</sub> (Farwell 1996).

Orally administered levothyroxine sodium is used as replacement therapy in conditions characterized by diminished or absent thyroid function such as cretinism, myxedema, nontoxic goiter, or hypothyroidism. The diminished or absent thyroid function may result from functional deficiency, primary atrophy, partial or complete absence of the thyroid gland, or the effects of surgery, radiation, or antithyroid agents. Levothyroxine sodium may also be used for replacement or supplemental therapy in patients with secondary (pituitary) or tertiary (hypothalamic) hypothyroidism.

Levothyroxine sodium is a compound with a narrow therapeutic range. If a drug product of lesser potency or bioavailability is substituted in the regimen of a patient who has been controlled on another product, a suboptimal response and hypothyroidism could result. Conversely, substitution of a drug product of greater potency or bioavailability could result in toxic manifestation of hyperthyroidism such as cardiac pain, palpitation, or cardiac arrhythmia. In patients with coronary heart disease, even a small increase in the dose of levothyroxine sodium may be hazardous. Hyperthyroidism is a known risk factor for osteoporosis (Paul et al. 1988). To minimize the risk of osteoporosis, it is advisable that levothyroxine sodium be titrated to the lowest effective dose. Because of the risks associated with over- or under-treatment with levothyroxine sodium, it is critical that patients have available to them products that are consistent in potency and bioavailability.

It is a challenge to determine the bioavailability of levothyroxine sodium products because levothyroxine is naturally present in minute quantities in the blood, with the total levels reaching 5.0-12.0 µg/dl and free (or unbound) levels reaching 0.8-2.7 ng/dl in a healthy adult. To assess the bioavailability of levothyroxine sodium after a single dose, several times the normal dose should be given to raise the levels of the drug significantly above baseline to allow measurement. Furthermore, levothyroxine has a long half-life of 6 to 9 days, and therefore, a long washout period is necessary between treatments.

### **III. PHARMACOKINETIC AND BIOAVAILABILITY STUDIES IN VIVO**

Information on the pharmacokinetics (absorption, distribution, metabolism, and excretion) of levothyroxine sodium can be obtained from the literature and/or from original studies. If the studies cited have used levothyroxine sodium formulations other than the formulation intended for marketing, the submission should contain information identifying how those formulations differ from the to-be-marketed formulation.

For sponsors who have a product on the market, we recommend that in vivo bioavailability studies be conducted using the formulation(s) already on the market, assuming that the sponsor intends to keep marketing the formulation(s). The tablets used in the study should be made from a full-scale production batch and should meet all compendial requirements. The formulations used should demonstrate sufficient stability for the length of the study. Stability evaluations should be made for the bio-batch prior

to and after the study. All dissolution, potency, and content uniformity data should be submitted to the NDA for review.

For sponsors who do not have a levothyroxine sodium formulation on the market, the usual approaches to developing pilot-scale batches for bioavailability studies apply.<sup>2</sup>

#### **A. Inclusion Criteria**

For each pharmacokinetic and bioavailability study outlined below, at least 24 volunteers should complete the trial. The subjects should be healthy volunteers, 18 to 50 years of age and within 15 percent of ideal body weight for their height and build. Sponsors should attempt to enroll an equal number of men and women, if possible. Volunteers recruited for the study should have an acceptable medical history, physical examination, and clinical laboratory tests. All thyroid function tests should be within normal limits. Volunteers with any current or past medical condition that might significantly affect their pharmacokinetic or pharmacodynamic response to levothyroxine sodium should be excluded. Female volunteers should be given a pregnancy test prior to beginning the study. Pregnant women should be excluded from the study. Written informed consent should be obtained from all volunteers before they are accepted into the study.

#### **B. Single-Dose Bioavailability Study**

*Objective:* To determine the bioavailability of the to-be-marketed formulation of levothyroxine relative to a reference (oral solution) under fasting conditions.

*Design:* The study is a single-dose, two-treatment, two-sequence crossover design. An equal number of volunteers should be randomly assigned to each sequence. The washout period between treatments should be at least 35 days.

*Tablet Strength and Dose:* A multiple of the highest tablet strength to achieve a total dose of 600 µg should be given to detect T<sub>4</sub> above baseline levels.

*Procedure:* Following a 10-hour overnight fast, volunteers should be administered a single dose of levothyroxine sodium orally with 240-mL water. The treatments should be as follows:

Treatment 1: Multiples of the highest strength of levothyroxine sodium tablets to be marketed.

Treatment 2: Levothyroxine sodium as an oral solution at an equivalent dose with treatment 1. The intravenous formulation can be used as a convenient source of an oral levothyroxine solution.

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<sup>2</sup> See *QIA Stability Testing of New Drug Substances and Products* (59 FR 48754, September 1994).

Volunteers should remain fasted for 4 hours after dosing, with water only allowed after the first hour. Volunteers should be served standardized meals according to the schedule throughout the study.

*Blood Sampling:* Blood samples should be drawn at -0.5, -0.25, 0, 0.5, 1, 1.5, 2, 2.5, 3, 4, 6, 8, 10, 12, 18, 24, and 48 hours post dose.

*Data Analysis:* Individual and mean plasma/serum concentration-time profiles of total (bound + free)  $T_4$  and  $T_3$  should be included in the report. The plasma/serum profiles and pharmacokinetic measures should be presented without the adjustment of baseline levels since endogenous levothyroxine concentrations are unpredictable during the course of the study. The following pharmacokinetic measures should be computed:

- Area under the plasma/serum concentration-time curve from time 0 to the last measurable time point ( $AUC_{0-t}$ )
- Peak concentration ( $C_{max}$ )
- Time to peak concentration ( $T_{max}$ )

Analysis of variance (ANOVA) should be performed for both log-transformed  $AUC_{0-t}$  and  $C_{max}$  using the SAS General Linear Models (GLM) procedure. The oral solution should be used as the reference formulation. The geometric means and 90 percent confidence intervals of the geometric mean ratio (test/reference) in  $AUC_{0-t}$  and  $C_{max}$  should be presented as evidence of bioavailability.

### **C. Dosage-Form Proportionality Study**

*Objective:* To determine the dosage-form proportionality among the to-be-marketed tablet strengths of levothyroxine sodium.<sup>3</sup>

*Design:* The recommended study is a single-dose, three-treatment, six-sequence crossover design. An equal number of volunteers should be randomly assigned to each sequence. The washout period between treatments should be at least 35 days.

*Tablet Strengths and Dose:* Three strengths of tablets should be studied that represent the low, middle, and high strength of the formulations to be marketed. Generally, the middle strength studied is the 100- $\mu$ g tablet. A multiple of each tablet strength should be given to detect  $T_4$  above baseline levels. The total dose given for each treatment in the study will usually be 600  $\mu$ g and should be the same dose for each treatment.

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<sup>3</sup> Available strengths of levothyroxine sodium tablets from many manufacturers include 25, 50, 75, 88, 100, 112, 125, 137, 150, 200 and 300  $\mu$ g.

*Procedure:* Following a 10-hour overnight fast, volunteers should be given a single dose of levothyroxine sodium orally with 240-mL water. The treatments consisting of equal doses of levothyroxine should be as follows:

Treatment 1: Multiples of the representative low strength tablets (usually 50 µg).

Treatment 2: Multiples of the representative mid-strength tablets. This is normally the 100-µg tablet, and should be considered as the reference for this study.

Treatment 3: Multiples of the representative high strength tablets (usually 300 µg).

Volunteers should fast for an additional 4 hours after dosing, with only water allowed after the first hour. Volunteers should be served standardized meals throughout the study according to the schedule.

*Blood Sampling:* The blood sampling schedule for this study should be identical to that recommended for the bioavailability study.

*Data Analysis:* Individual and mean plasma/serum concentration-time profiles of total (bound + free) T<sub>4</sub> and T<sub>3</sub> should be included in the report. The plasma/serum profiles and pharmacokinetic measures should be presented without adjustment of baseline levels since endogenous levothyroxine concentrations are unpredictable during the course of the study.

The pharmacokinetic measures, including AUC<sub>0-t</sub>, C<sub>max</sub> and T<sub>max</sub>, should be computed for both total T<sub>4</sub> and T<sub>3</sub>. For the assessment of proportionality between strengths, both log-transformed AUC<sub>0-t</sub> and C<sub>max</sub> should be analyzed with ANOVA using the SAS GLM procedure. The geometric means and 90 percent confidence intervals of the geometric mean ratio of AUC<sub>0-t</sub> and C<sub>max</sub> should be presented for each pairwise comparison. Dosage-form proportionality is demonstrated if the 90 percent confidence intervals fall within the 80-125 percent range.

For both single-dose bioavailability and dosage-form proportionality studies, the assessment of bioavailability should be based on the measurement of total (bound + free) T<sub>4</sub> and total T<sub>3</sub> levels. The determination of free T<sub>4</sub> and T<sub>3</sub> is not necessary. However, if sufficiently precise and accurate assays are available for free T<sub>4</sub> and T<sub>3</sub>, these moieties can be measured as well. Statistical analyses of free T<sub>4</sub> and T<sub>3</sub> should then be performed, with the results used as supportive data. If free T<sub>4</sub> and T<sub>3</sub> are measured, the assays used should be based on the immuno-extraction (two-step) method, rather than the labeled analog (one-step) method. Levels of TSH should be measured as part of the volunteer-screening process as well as post-study examination. These TSH data should be reported in the NDA.

#### **IV. DISSOLUTION TESTING IN VITRO**

Dissolution studies can be performed using an appropriate method developed by a sponsor<sup>4</sup> or the current USP method. For each tablet strength to be marketed, multi-point dissolution studies should be performed on three production-sized batches using 12 tablets per batch. The time points used should be 10, 20, 30, 45, 60, 80, 100, and 120 minutes, or until 80 percent of the labeled claim is dissolved, so that a complete profile may be obtained. Dissolution testing should include lots used in the bioavailability studies.

#### **V. FORMULATION**

The composition of the formulation for each tablet strength of levothyroxine sodium to be marketed should be provided in the NDA.

#### **VI. BIOWAIVER**

For tablet strengths not studied in the dosage-form proportionality study (see section III. C), the sponsor should request biowaivers and provide appropriate formulation information as well as in vitro dissolution data as covered under 21 CFR 320.22(d)(2). Specifically, all of the following conditions should be met:

1. The dosage-form proportionality study among the to-be-marketed tablet strengths of levothyroxine sodium (low, medium, and high strengths) has been found acceptable, and proportionality has been shown among the strengths included in the study (also see section III. C. *Data Analysis*).
2. For tablet strengths to be covered under the waiver request, they should differ only in the amount of levothyroxine sodium and filler needed to maintain the tablet weights.
3. Multi-point dissolution profiles are similar across tablet strengths using an f2 test. If both test and reference products dissolve 85 percent or more of the label amount of the drug in #15 minutes, the f2 test is not necessary.<sup>4</sup> The dissolution method as well as dissolution data have been found acceptable by the Agency.

Sponsors whose products do not meet the above conditions should contact the Division of Pharmaceutical Evaluation II for further guidance.

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<sup>4</sup> See FDA's guidance for industry on *Dissolution Testing of Immediate Release Solid Oral Dosage Forms* (August 1997).

## **VII. ASSAY VALIDATION**

Assays used for both in vivo and in vitro studies should be fully validated, reproducible, precise, accurate, specific, stable, and linear. If commercial kits are used, they should be validated in-house at the analytical site where the assay for the study is performed. Please note that the validation data from the kit manufacturer alone is insufficient.

## REFERENCES

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