Mirena® (levonorgestrel) 20 micrograms/24 hours intrauterine delivery system
Prescribing Information for United Kingdom
(Refer to full Summary of Product Characteristics (SmPC) before prescribing)

Presentation: Intrauterine system consisting of T-shaped frame containing 52mg levonorgestrel. **Indication(s):** Contraception, idiopathic menorrhagia, protection from endometrial hyperplasia during oestrogen replacement therapy. **Posology & method of administration:** Before insertion, examine the patient to detect any contraindications, and exclude pregnancy & sexually transmitted infections. Mirena is not suitable for use as a post-coital contraceptive. Consider the possibility of ovulation and conception before use. *Contraception:* Mirena is effective for 8 years for contraception and should be removed no later than 8 years after insertion. *Idiopathic menorrhagia:* Mirena is effective for 5 years in the indication idiopathic menorrhagia. Remove or replace if symptoms return (for idiopathic menorrhagia). If symptoms have not returned after 5 years of use, continued use of the system may be considered. Remove or replace no later than 8 years after insertion. *Contraception*, *Idiopathic menorrhagia*: Women of fertile age: insert into uterine cavity within 7 days of onset of menstruation. Postpartum insertions should be postponed until the uterus is fully involuted and performed no earlier than 6 weeks after delivery (unless involution is substantially delayed, consider waiting until 12 weeks postpartum). Immediate postpartum insertion (IPPI), immediately after placental removal, may be offered only where it is part of locally accepted clinical practice, following an individual benefit-risk assessment, and should be performed by healthcare professionals trained and experienced in IPPI. Where applicable, counsel women prenatally on IPPI availability, the increased risk of expulsion, which may be unnoticed, the need for self-examination after 6–8 weeks & alternative contraceptive methods to ensure informed decision-making. The supplied inserter must not be used for IPPI, as this increases the likelihood of incorrect placement and expulsion. For IPPI, remove Mirena from the inserter by first loading and then releasing the IUS from the inserter, and insert according to accepted practice and local guidelines; see SmPC for full instructions. Mirena can be inserted immediately after first trimester termination. *Protection from endometrial hyperplasia during oestrogen replacement therapy:* Insert at any time in an amenorrhoeic woman or during last days of menstruation or withdrawal bleeding - remove no later than 4 years after insertion. In women receiving HRT, Mirena can be used with unopposed oestrogens. Removal/Replacement: Mirena is removed by gently pulling on the threads with forceps. The use of excessive force/sharp instruments during removal may cause breakage of the system. After removal of Mirena, the system should be examined to ensure that it is intact and has been completely removed. Prescribers should consult the SmPC for full information on inserting, removing and replacing Mirena. **Contra-indications:** Known/suspected pregnancy; confirmed/suspected hormone sensitive tumours (incl. breast cancer); (re-)current pelvic inflammatory disease (PID); cervicitis; current genital infection; postpartum endometritis, infected abortion during past 3 months; increased susceptibility to infections; cervical dysplasia; uterine/cervical malignancy; undiagnosed abnormal genital bleeding; congenital/acquired uterine abnormality incl. fibroids that distort the uterine cavity; liver tumour or other acute/severe liver disease; acute malignancies affecting the blood or leukaemias except when in remission; recent trophoblastic disease with elevated hCG levels; hypersensitivity to the active substance or excipients. Active/previous severe arterial disease (e.g. stroke or myocardial infarction), when used with concomitant oestrogen for HRT use. **Warnings & precautions:** Use with caution & consider removal if the following exist or occur for the first time: migraine with aura, unusually severe or frequent headache, jaundice, marked increase of blood pressure, malignancies affecting the blood or leukaemias in remission, use of chronic corticosteroid therapy, history of ovarian cysts, active/previous severe arterial disease, severe/multiple risk factors for arterial disease, thrombotic arterial or any current embolic disease, acute VTE. Use with caution in postmenopausal women with advanced uterine atrophy. Insertion technique is different from other intrauterine devices (IUDs); special emphasis should be given to training in the correct insertion technique. Insertion/removal may be associated with pain & bleeding & may result in fainting as a vasovagal reaction or seizure in epileptics. In cases of difficult insertion, exceptional pain/bleeding during or after insertion, exclude perforation of uterus or cervix – physical examination may not be sufficient. The use of excessive force/sharp instruments during removal may cause breakage of the system. After removal of Mirena, the system should be examined to ensure that it is intact and has been completely removed. If perforation suspected, remove system; surgery may be required. Risk of perforation is increased in breastfeeding women, insertions up to 36 weeks post-partum & in women with fixed retroverted uterus. The Mirena inserter has been designed to minimise the risk of infections. Although extremely rare, severe infection or sepsis (including group A streptococcal sepsis) can occur following IUS insertion. If pelvic infection suspected bacteriological examinations & monitoring is recommended, even with discrete symptoms. Start appropriate antibiotics & remove Mirena if symptoms do not resolve within 72hrs, if recurrent endometritis or pelvic infection occurs, or if an acute infection is severe. Bleeding, pain, increased menstrual flow may indicate partial/complete expulsion. The insertion instructions and the inserter provided with Mirena are not applicable for IPPI. Prescribers should consult the SmPC for further guidance on perforation, infection or expulsion. Reduction in menorrhagia is usually achieved in 3 to 6 months of treatment. If menorrhagia persists: re-examine & consider alternative treatments. Exclude endometrial pathology before insertion. If bleeding irregularities develop during prolonged treatment use appropriate diagnostic measures, as irregular bleeding may mask symptoms/signs of endometrial polyps or cancer. Consider ectopic pregnancy if lower abdominal pain occurs, especially if period is missed or if an amenorrhoeic woman starts bleeding - higher risk of further ectopic pregnancy if previous history exists. Breast cancer: The diagnostic risk in users of progestogen-only methods (POPs, implants and injectables), including Mirena, is possibly of similar magnitude to that associated with COC. Observational studies of levonorgestrel IUS users versus non-users or non-hormonal users show inconsistent breast cancer risk findings, with evidence less conclusive than for COCs. Risk of breast cancer when Mirena used as progestogen component of HRT unknown. See SmPC for full details. Advise women to contact their physician in case of mood changes and depressive symptoms, including shortly after initiating treatment. Depression can be serious and is a well-known risk factor for suicidal behaviour and suicide. Monitor blood glucose in diabetic users. Not suitable for use as a post-coital contraceptive. **Fertility, pregnancy & lactation:** *Pregnancy:* If pregnancy occurs with Mirena in situ, exclude ectopic pregnancy, remove system & consider termination of pregnancy. Removal of Mirena or probing of uterus may result in spontaneous abortion. If removal impossible, inform woman about increased risk of spontaneous abortion/premature labour. Monitor pregnancy closely. Teratogenicity (esp. virilisation) cannot be excluded. *Lactation*: About 0.1% of the levonorgestrel dose is transferred during breastfeeding but no known deleterious effects on infant growth/development after 6 weeks postpartum. Uterine bleeding has been reported rarely during lactation. *Fertility:* Once Mirena is removed for planned pregnancy, pregnancy rate at one year is similar to those who do not use contraception. **Undesirable effects:** *Very Common* - uterine/vaginal bleeding (incl. spotting), oligomenorrhoea, amenorrhoea. *Common* - depressed mood/depression, nervousness, decreased libido, headache, migraine, dizziness, abdominal pain, nausea, acne, hirsutism, back pain, ovarian cysts, pelvic pain, dysmenorrhoea, vaginal discharge, vulvovaginitis, breast tenderness, breast pain, Intrauterine contraceptive device expulsion (this is *very common* when insertion is performed immediately postpartum), weight increase. *Serious side effects* - cf. CI/Warnings & Precautions *in addition:* hypersensitivity (incl. urticaria, angioedema), PID, endometritis, cervicitis. Cases of sepsis (incl. group A streptococcal sepsis) have been reported following IUD insertion. A large post authorisation safety study shows an increased risk of perforation in breastfeeding women or insertions up to 36 weeks post-partum. Prescribers should consult the SmPC in relation to other side effects. **Legal Category:** POM **Package Quantities & Basic NHS Costs:** £88.00 **MA Number(s):** PL 00010/0547 **Further information available from:** Bayer plc, 400 South Oak Way, Reading, RG2 6AD, U.K. Telephone: 0118 206 3000. **Date of preparation:** October 2026.

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Reporting adverse events and quality complaints
Adverse events should be reported. Reporting forms and information can be found at https://yellowcard.mhra.gov.uk or search for MHRA Yellow Card in Google Play or Apple App Store. Adverse events should also be reported to Bayer plc. Tel.: 0118 206 3500, Email: pvuk@bayer.com
Please report information of when Mirena was inserted and removed, as applicable