Controlling Levonorgestrel Binding and Release in a Multi-Purpose Prevention Technology Vaginal Ring Device

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ABSTRACT

Despite a long history of incorporating steroids into silicone elastomers for drug delivery applications, little is presently known about the propensity for irreversible drug binding in these systems. In this study, the ability of the contraceptive progestin levonorgestrel to bind chemically with hydrosilane groups in addition-cure silicone elastomers has been thoroughly investigated. Cure time, cure temperature, levonorgestrel particle size, initial levonorgestrel loading and silicone elastomer type were demonstrated to be key parameters impacting the extent of levonorgestrel binding, each through their influence on the solubility of levonorgestrel in the silicone elastomer. Understanding and overcoming this levonorgestrel binding phenomenon is critical for the ongoing development of a number of drug delivery products, including a multi-purpose technology vaginal ring device offering simultaneous release of levonorgestrel and dapivirine – a lead candidate antiretroviral microbicide – for combination HIV prevention and hormonal contraception.
1. **Introduction**

Silicone elastomers have been widely used in controlled release drug delivery applications since Dzuik and Cook first demonstrated in 1966 that various steroid molecules were capable of effectively permeating and releasing from silicone rubber capsules subcutaneously implanted in ewes [1]. Numerous steroid-releasing silicone elastomer devices, including subdermal implants, vaginal rings and intrauterine systems, have since reached market (Table 1). The past ten years have seen considerable interest in silicone elastomer vaginal ring technology for controlled release of antiretroviral (ARV) drug molecules for prevention of sexual transmission of human immunodeficiency virus (HIV) (Table 1) [2–9]. The International Partnership for Microbicides (IPM) and the Microbicide Trial Network (MTN) are currently in Phase III clinical trials in Africa with a matrix-type silicone elastomer vaginal ring developed by IPM. This ring device provides controlled release of dapivirine (Figure 1A), a non-nucleoside reverse transcriptase inhibitor, over 28 days and has already been shown to be safe and well tolerated *in vivo*. If successful, the dapivirine ring will likely provide both further impetus and a viable technology platform for development of multi-purpose prevention technologies (MPTs) aimed at combining HIV prevention with prevention of unintended pregnancy and prevention/treatment of other sexually transmitted infections (STIs) through use of a single formulation or drug-device combination product [10–13]. Many of the MPT products currently undergoing development have prioritised use of levonorgestrel (Figure 1A) as the contraceptive hormone component, based on its historical record of safety and efficacy [12–14].
**Table 1.** Controlled release drug delivery devices for humans that use silicone elastomer as the rate controlling material. Marketed products (current or previous), discontinued development products and products presently undergoing clinical testing are included.

VR – vaginal rings

<table>
<thead>
<tr>
<th>Product name</th>
<th>Product type</th>
<th>Drug(s)</th>
<th>Indication / duration of action</th>
<th>Developer</th>
<th>Stage</th>
</tr>
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<tbody>
<tr>
<td>Norplant®</td>
<td>reservoir-type</td>
<td>levonorgestrel</td>
<td>female contraception / 5 years</td>
<td>Population Council</td>
<td>Discontinued</td>
</tr>
<tr>
<td>(Norplant II)</td>
<td>subdermal implant</td>
<td></td>
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<td></td>
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<tr>
<td>Jadelle®</td>
<td>reservoir-type</td>
<td>levonorgestrel</td>
<td>female contraception / 5 years</td>
<td>Population Council</td>
<td>Marketed</td>
</tr>
<tr>
<td></td>
<td>subdermal implant</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Mirena®</td>
<td>reservoir-type</td>
<td>levonorgestrel</td>
<td>female contraception / 5 years</td>
<td>Bayer</td>
<td>Marketed</td>
</tr>
<tr>
<td></td>
<td>intrauterine system</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skyla®</td>
<td>reservoir-type</td>
<td>levonorgestrel</td>
<td>female contraception / 5 years</td>
<td>Bayer</td>
<td>Marketed</td>
</tr>
<tr>
<td></td>
<td>intrauterine system</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Femring®</td>
<td>reservoir-type VR</td>
<td>17β-estradiol-3-acetate</td>
<td>estrogen replacement therapy / 3 months</td>
<td>Warner Chilcott</td>
<td>Marketed</td>
</tr>
<tr>
<td>Estring®</td>
<td>reservoir-type VR</td>
<td>17β-estradiol</td>
<td>estrogen replacement therapy / 90 days</td>
<td>Pfizer</td>
<td>Marketed</td>
</tr>
<tr>
<td>Progering®</td>
<td>matrix-type VR</td>
<td>progesterone</td>
<td>female contraception / 1 year</td>
<td>Population Council</td>
<td>Marketed (South America only)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fertiring®</td>
<td>matrix-type VR</td>
<td>progesterone</td>
<td>in vitro fertilization / hormone replacement therapy / 3 months</td>
<td>Population Council</td>
<td>Marketed</td>
</tr>
<tr>
<td>–</td>
<td>matrix-type VR</td>
<td>progesterone</td>
<td>luteal phase support</td>
<td>Italfarmaco</td>
<td>Phase I/II</td>
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<tr>
<td>–</td>
<td>matrix-type VR</td>
<td>progesterone</td>
<td>luteal phase support</td>
<td>TEVA</td>
<td>Discontinued</td>
</tr>
<tr>
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<td>reservoir-type VR</td>
<td>oxybutynin</td>
<td>overactive bladder</td>
<td>TEVA</td>
<td>Discontinued</td>
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<td>–</td>
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<td>nestorone and ethinyl estradiol</td>
<td>female contraception</td>
<td>Population Council</td>
<td>Phase III</td>
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<tr>
<td>–</td>
<td>matrix-type VR</td>
<td>dapivirine</td>
<td>HIV prevention / 30 days</td>
<td>IPM</td>
<td>Phase III</td>
</tr>
<tr>
<td>–</td>
<td>matrix-type VR</td>
<td>dapivirine and maraviroc</td>
<td>HIV prevention / 30 days</td>
<td>IPM</td>
<td>Phase I</td>
</tr>
<tr>
<td>–</td>
<td>matrix-type VR</td>
<td>dapivirine and levonorgestrel</td>
<td>HIV prevention / 90 days</td>
<td>IPM</td>
<td>Phase I</td>
</tr>
</tbody>
</table>
Silicone elastomers for use in medical and pharmaceutical applications are prepared through the chemical crosslinking of functionalised, linear, polydimethylsiloxane molecules. The most important chemical crosslinking mechanisms involve either condensation-cure or addition-cure chemistries. Condensation-cure systems involve the tin-catalysed reaction between hydroxy-terminated polydimethylsiloxane molecules and a tetraalkoxysilane, resulting in the formation of the cured elastomer and an alcohol by-product [15,16]. Although the chemistry of this silicone elastomer crosslinking reaction is generally compatible with a very wide range of chemical functional groups, the alcohol produced can be problematic when the incorporated drug(s) is highly soluble in the alcohol [17,18]. Crosslinking of addition-cure silicone elastomer systems relies on the platinum-catalysed hydrosilylation reaction between hydride- and vinyl-functionalised polydimethylsiloxane molecules (Figure 1B). No by-product is formed with this reaction. However, the platinum catalyst is particularly sensitive to poisoning by certain chemical functional groups, most notably organotin, organosulfur and certain amine containing compounds.
It is well established that small molecules containing ethylenic (C=C) and acetylenic (C≡C) functional groups can undergo hydrosilylation reaction with molecules containing hydrosilane (Si–H) groups (Figures 1C and 1D, respectively) [19–23]. In general, the alkyne hydrosilylation reaction catalysed by platinum proceeds at a faster rate compared to alkenes, and is less susceptible to many electronic and structural factors that may impede alkene hydrosilylation [19]. Given the large number of steroid molecules containing ethylenic or acetylenic functional groups that have been previously formulated in silicone elastomers, it is rather surprising that only a single article (a 1980 US patent) has reported the potential for covalent binding of such steroids to the silicone elastomer [24]. Furthermore, the patent states that the quantity of drug that reacts with the silicone elastomer is “negligible for the sustained drug release rate”. On the contrary, here we report that levonorgestrel, a common contraceptive progestin, reacts with addition-cure silicone elastomer systems such that a very significant fraction of the incorporated levonorgestrel can be irreversibly bonded to the silicone elastomer impacting levonorgestrel release rates. The extent of binding is dependent on the silicone elastomer cure conditions and the particle size of the levonorgestrel material used. Aside from recent U.S. patent applications by IPM [25,26], this issue has not been reported previously for...
levonorgestrel, despite its long history of incorporation into addition-cure silicone elastomer drug delivery systems (Table 1).
2. Methods and Materials

2.1. Materials

Medical grade, addition-cure silicone elastomers DDU-4320 and MED-4870, condensation-cure silicone elastomer MED-6382, and MED-360 silicone oil were supplied by NuSil Silicone Technology Inc. (Carpinteria, CA, USA). Micronized dapivirine was supplied by S.A. Ajinomoto OmniChem N.V. (Wetteren, Belgium). Micronised levonorgestrel was supplied by CHEMO Group (Saronno, Italy). Non-micronized and sieved fractions of non-micronized levonorgestrel (non-micronised levonorgestrel) were supplied by Tecoland (Irvine, CA, US) and CHEMO Group (Saronno, Italy); except where explicitly stated, non-micronised levonorgestrel in the text refers to material sourced from Tecoland. Particle size data (d10, d50 and d90; measured via laser diffraction) for each of the levonorgestrel materials was provided by the suppliers (Table 2). HPLC-grade acetonitrile, isopropanol and dichloromethane, and phosphoric acid (85% w/w in water) were purchased from Sigma Aldrich (Gillingham, UK). HPLC-grade water was obtained using a Millipore Direct-Q 3 UV Ultrapure Water System (Watford, UK). 19-norethindrone was supplied by LGM Pharma (Boca Raton, Florida, USA) and used as an internal standard for HPLC. Analytical grade potassium dihydrogen orthophosphate was obtained from VWR (Dublin, Ireland).
Table 2. Influence of levonorgestrel particle size on its recovery from 0.4% w/w levonorgestrel-loaded DDU-4320 silicone elastomer slabs cured at 100 °C for 90 s. Each levonorgestrel recovery value is the mean of four replicates and reported errors denote standard deviations.

<table>
<thead>
<tr>
<th>levonorgestrel batch</th>
<th>Particle size (µm)</th>
<th>% levonorgestrel recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (micronized)</td>
<td>d90, d50, d10</td>
<td>41.3 ± 6.5</td>
</tr>
<tr>
<td>2 (sieved fraction)</td>
<td>294, 81, 5</td>
<td>56.7 ± 5.2</td>
</tr>
<tr>
<td>3 (sieved fraction)</td>
<td>384, 170, 6</td>
<td>55.6 ± 2.8</td>
</tr>
<tr>
<td>4 (non-micronized) *</td>
<td>542, 348, 156</td>
<td>98.4 ± 11.4</td>
</tr>
</tbody>
</table>

* This non-micronized material was supplied by CHEMO.

2.2. Manufacture of silicone rings and slabs

Matrix-type, silicone elastomer vaginal rings containing 200 mg micronized dapivirine and 32 mg levonorgestrel (either micronized or non-micronized) and measuring 57 mm overall diameter x 7.8 mm cross-sectional diameter were manufactured by reaction injection molding of active silicone elastomer mixes using a Babyplast 6/10P injection-molding machine in semi-automatic mode fitted with custom, stainless steel, single-cavity injection molds. These rings were cured at 160°C for 90 s. Briefly, the appropriate quantities of dapivirine and levonorgestrel powders were added to both Parts A and B of the addition-cure silicone elastomer system MED-4870 and mixed at 3000 rpm for 3 min using a SpeedMixer DAC 150 FVZ-K (Synergy Devices, UK). These active premixes were stored at 4°C until use. Prior to combining the premixes, they were first hand-mixed with a spatula for 30 s and then speedmixed for 120 s at 3000 rpm. Equal weights of Part A and Part B active premixes were then combined, handmixed for 30 s, speedmixed for 30 s at 3000 rpm, and then transferred to a 65 cc low-density polyethylene Semco 220316 cartridge system (Polymer Systems Technology Ltd., Buckinghamshire, UK) that
operates with the dosing meter fitted to the Babyplast injection molder.

Silicone elastomer slabs (20.0 × 30.0 × 2.0 mm) or vaginal rings containing levonorgestrel or dapivirine were also manufactured in a similar fashion using a custom, aluminium, multi-cavity mold fitted to a electrically-heated, laboratory-scale injection molding machine. For rings and slabs prepared using the DDU-4320 silicone elastomer (a low temperature cure system), cure time and temperature were varied between 1.5–120 min and 60–160°C, respectively. For slabs prepared with the MED-4870 silicone elastomer (a high temperature cure system), cure time and temperature were varied between 1.5–120 min and 120–200°C, respectively. Levonorgestrel-loaded silicone elastomer slabs were also prepared using condensation-cure MED-6382 silicone elastomer using cure conditions of 80°C / 5 min. For some silicone elastomer slabs, the drug powder was first dispersed in MED-360 silicone oil prior to preparing the silicone elastomer premixes.

2.3. Quantification of levonorgestrel by HPLC

Levonorgestrel concentrations were quantified by HPLC using a BDS Hypersil C18, 3 μm column (150 x 4.6 mm; Thermo Scientific, UK), fitted with an Analytical Guard Cartridge System (Phenomenex, UK), at 25°C on a system comprising a Waters 1525 binary HPLC pump, 717 Plus autosampler, in-line degasser AF unit, and 2487 dual absorbance detector. Isocratic HPLC was performed with a mobile phase of 7.7 mM phosphate buffer, pH 3.0 and acetonitrile (55:45) at flow rate of 1.2 mL/min with detection at 240 nm. The retention times of norethindrone (internal standard) and levonorgestrel were 5.2 and 8.2 min, respectively. All chromatograms
were processed using the supplied Waters Breeze software.

2.4. In vitro release testing of rings

In vitro levonorgestrel release from vaginal rings (n=6) was assessed over a 15-day period. Each vaginal ring was placed into a glass flask containing 200 mL of isopropanol (IPA)/water mixture (1:1 volume ratio). This IPA/H$_2$O mixture has been widely used for in vitro release testing of silicone elastomer vaginal rings, since it offers greater solvating power for poorly water-soluble drugs compared with aqueous media, such as simulated vaginal fluid [2–5,17]. The volumes of media for release testing were selected based on previously measured solubility values in 1:1 IPA/water (LNG – 0.75 mg/mL at 25°C; DPV – 0.80 mg/mL at 37°C). The flasks were sealed and placed in an orbital shaking incubator (Infors HT AGCH-4103; 37°C, 60 rpm, throw 25 mm). After 24 h (± 15 min), each flask was removed from the incubator and a sample (2 mL) of the release medium was retained for HPLC analysis. The remaining release medium was discarded and replaced with fresh medium (100 mL IPA:H$_2$O). This sampling procedure was continued on a daily basis, except weekends when 200 mL of release medium were added to the flasks each Friday so as to maintain sink conditions through the following Monday.

2.5. Levonorgestrel content analysis of manufactured rings and slabs

The total amount of levonorgestrel recoverable from silicone elastomer rings and slabs was determined using a solvent extraction method followed by quantification using HPLC. Each device was weighed, cut into approximately 2 mm sections, and placed in a 250 mL screw-top glass flask. 5 mL of a 2.5 mg/mL solution of 19-norethindrone in methanol (internal standard)
was added along with 95 mL of dichloromethane (extraction solvent). The flasks were placed in an orbital shaking incubator (37°C, 60 rpm, throw 25 mm) for 72 h. A 2 mL aliquot of the solution was evaporated to dryness and the residue reconstituted in 10 mL of methanol before being diluted ten-fold in a mixture of methanol and deionised water prior to analysis by HPLC. Control flasks containing known amounts of a levonorgestrel standard solution were also tested in each set of experiments.

2.6. Drug extraction and swelling studies

Cured silicone elastomer slabs containing 1% w/w loading of either dapivirine, micronised levonorgestrel or non-micronised levonorgestrel were manufactured, extracted with dichloromethane (100 mL), and then the resulting drug-depleted slabs swollen in n-hexane to assess cross-linking density [27]. A pictorial representation of the experimental method is shown in Figure 2. Briefly, drugs were weighed into the appropriate amounts of part A and part B silicone elastomer and speedmixed for 2 min. Part A and part B active mixes were then hand mixed (10 s), speedmixed (30 s), and then injection molded at 90 °C for 3 min. These slabs were individually weighed and the weights were recorded (W₀). These slabs were then placed into screw-top glass flasks containing 45 mL of dichloromethane. 5 mL of 500 μg/mL methanolic solution containing norethindrone was added as an internal standard. The flasks were placed in a shaking orbital shaker (37 °C, 60 rpm, throw 25 mm) and the release medium was sampled (~5 mL) after a period of 72 h. Quantification of drug concentrations in the samples was performed using HPLC-UV.
Figure 2. Experimental protocol for hexane swelling experiments to assess crosslinking density in drug-loaded silicone silicone silicone slabs.

Immediately after drug sampling, the swollen slabs were removed from the dichloromethane, wiped with tissue paper to remove any excess solvent, placed in a tightly closed flasks and weighed ($W_1$). These slabs were then dried overnight in a fume hood at room temperature, followed by drying at 60°C for 1 h. The dry weights of the slabs were recorded ($W_2$). The dried slabs were then placed in 50 mL of n-hexane. As before, the swollen slabs were weighed ($W_3$), dried, and weighed again ($W_4$). The amount of drug extracted, swelling ratio and total mass extracted from these silicone elastomer slabs in both solvents were calculated (Equations 1 – 4).

$$Swelling\ ratio\ in\ CH_2Cl_2 = \frac{(W_1 - W_2)}{W_2} \times 100 \quad (1)$$
\[ \text{Mass extraction in } CH_2Cl_2 = \frac{(W_0 - W_2)}{W_2} \times 100 \quad (2) \]

\[ \text{Swelling ratio in } n\text{-hexane} = \frac{(W_3 - W_4)}{W_4} \times 100 \quad (3) \]

\[ \text{Swelling ratio in } n\text{-hexane} = \frac{(W_2 - W_4)}{W_2} \times 100 \quad (4) \]

2.7. Oscillatory rheology

Silicone elastomer samples containing 1, 5, 10, 15 and 20% w/w of dapivirine, micronised or non-micronised levonorgestrel were prepared by adding appropriate quantities of each drug powder to Parts A and B of silicone elastomer DDU-4320. Following mixing with a Speedmixer for 30 s, a sample of each silicone elastomer active mix (1.0 g) was placed onto the lower stationary plate of a TA instruments AR 1500 rotational rheometer, maintained at 25°C, and the upper plate (40 mm cross-hatch plate) was lowered to produce a gap between the plates of 1000 µm. The time taken from loading of the sample to commencement of the experiment was typically less than 30 s. Each sample was heated to 80°C and maintained at that temperature for 15 min at 10 Hz oscillation frequency and the storage modulus monitored over 900 s, corresponding to the initial cure period for the silicone elastomer [28].
3. Results and Discussion

3.1. Particle size analysis

Representative digital microscopy images of the four different levonorgestrel materials used in this study (one micronized material, two non-micronized and sieved fractions, and one non-micronized and non-sieved material) are presented in Figure 3 and clearly illustrate visual differences in the particle size distributions. Quantitative measures of particle size (d10, d50 and d90 values) for each of the four materials are also presented in Table 2.

3.2. In vitro release testing of rings demonstrating bound levonorgestrel

The mean daily release vs. time and mean cumulative release vs. root time profiles for MED-4870 silicone elastomer matrix-type vaginal rings containing 200 mg micronized dapivirine and 32 mg of either micronised levonorgestrel or non-micronised levonorgestrel and cured at 160 °C for 90 s are presented in Figure 4. Dapivirine and non-micronised levonorgestrel are effectively released from the vaginal rings, with relatively high quantities of each drug released on Day 1 (~6000 μg and ~750 μg for dapivirine and levonorgestrel, respectively) followed by steadily declining release rates on subsequent days. Dapivirine release was very similar irrespective of the particle size of the levonorgestrel incorporated into the vaginal rings. The lower rate of release observed of non-micronised levonorgestrel from the vaginal rings compared with dapivirine is attributed to both its lower initial loading and its unique molecular permeability characteristics in the silicone elastomer. In general, the daily release profiles are typical of matrix-type vaginal rings containing solid drug dispersed within a non-degradable polymer matrix. The linear cumulative release vs. root time profiles (Figure 4C and 4D) confirm
root time ($t^{1/2}$) kinetics, and are indicative of a permeation-controlled mechanism [29,30].

However, surprisingly, vaginal rings containing micronised levonorgestrel showed no drug release (Figures 4B and 4D). Repeat experiments confirmed that the correct quantity of micronised levonorgestrel was added to the silicone elastomer premixes and that no levonorgestrel release was observed (repeat data not shown). Based on scant evidence from the literature [24], we hypothesized that all 32 mg micronised levonorgestrel initially incorporated into the vaginal ring formulation had dissolved in the ring matrix and subsequently covalently bonded to the silicone elastomer via a hydrosilylation reaction (Figure 1D) between the alkynyl (i.e. ethinyl) group in levonorgestrel (Figure 1A) and the Si–H groups in the silicone elastomer system (Figure 1B). This drug-binding hypothesis was supported by attempting to solvent-extract the levonorgestrel content from the vaginal rings; only 0.5% levonorgestrel was recovered for vaginal rings containing micronised levonorgestrel compared to 57.3% for non-micronised levonorgestrel vaginal rings. Dapivirine does not contain alkenyl or alkynyl functional groups (Figure 1A), and therefore is incapable of undergoing hydrosilylation reaction. 96.7% and 97.7% of incorporated dapivirine content was recovered from vaginal rings containing 200 mg dapivirine + 32 mg non-micronised levonorgestrel and 200 mg dapivirine + 32 mg micronised levonorgestrel, respectively. In previous studies, complete recovery of dapivirine was also achieved with rings containing just 25 mg dapivirine, further confirming that dapivirine does not have the chemical functionality required to take part in the hydrosilylation reaction [4,18].
Figure 3. Digital microscopy images at x 100 magnification of different particle size batches of levonorgestrel. A – \( d_{90} \leq 6.11 \mu m \), B – \( d_{90} \leq 294 \mu m \), C – \( d_{90} \leq 384 \mu m \) and D – \( d_{90} \leq 542 \mu m \). 50 \( \mu m \) size bars (---) are presented bottom right in each photograph. Particle size values are also summarized in Table 2.
Figure 4. Mean daily release versus time and mean cumulative release versus root time profiles for matrix-type MED-4870 silicone elastomer vaginal rings containing 200 mg micronized dapivirine and 32 mg of either micronised levonorgestrel or non-micronised levonorgestrel (n=4). A – Daily dapivirine release vs. time plots. B – Daily levonorgestrel release vs time plots. C – Cumulative dapivirine release vs. root time plots. D – Cumulative levonorgestrel vs. root time plots. DPV – dapivirine. LNG – levonorgestrel. All rings were manufactured by injection molding at 160 °C for 90 s.
In order for effective drug release to occur from a silicone elastomer vaginal ring device, incorporated drug substances must permeate through the bulk of the silicone elastomer matrix. This permeation process can be considered as two discrete steps – dissolution of the drug in the silicone elastomer, followed by molecular diffusion of the solvated drug molecules through the silicone elastomer [30]. Both the degree of solubility and the rate of diffusion of drugs incorporated into silicone elastomers are temperature-dependent, and are expected to increase significantly at the high temperatures commonly used in injection molding manufacture of silicone elastomer vaginal rings. Solubility of the drug in the silicone elastomer matrix also increases the proportion of levonorgestrel molecules available for chemical binding via the hydrosilylation reaction. Thus, a rational explanation for the differences observed in release between micronised levonorgestrel and non-micronised levonorgestrel is that the micronized form of the drug exhibits faster rate of solubilization in the silicone elastomer at the 160 °C manufacturing temperature (levonorgestrel melting point is 240 °C), such that a significant proportion of the levonorgestrel molecules subsequently react with the hydrosilane groups within the silicone elastomer. By contrast, the observation that vaginal rings containing 32 mg non-micronised levonorgestrel exhibited significant levonorgestrel release was attributed to the reduced rate of dissolution associated with the larger levonorgestrel particles and, in turn, reduced levonorgestrel binding to the silicone elastomer. This observation concurs with the well-established principle of increased surface area leading to increased rate of dissolution, as expressed in the Noyes-Whitney equation [31].

3.3. Levonorgestrel binding studies
To explore this levonorgestrel-binding hypothesis further, additional solvent extraction experiments were conducted using levonorgestrel-loaded silicone elastomer slabs manufactured under different cure conditions. No levonorgestrel could be recovered by solvent extraction from MED-4870 silicone elastomer slabs containing 0.4% w/w micronised levonorgestrel manufactured at (i) various cure temperatures (120–200 °C) and a fixed cure time (10 min) (Figure 5A) and (ii) various cure times (1.5–120 min) and a fixed cure temperature (160 °C) (Figure 5B). By contrast, MED-4870 silicone elastomer slabs containing 0.4% w/w non-micronised levonorgestrel produced measurable recovery of levonorgestrel by solvent extraction at all but the most extreme cure conditions (i.e. 200 °C at 10 min and 120 min at 160 °C; Figures 6A and 6B, respectively). In fact, the non-micronised levonorgestrel MED-4870 slabs showed a clear trend of decreasing levonorgestrel recovery values as a function of both increasing cure temperature (Figure 5A) and increasing cure time (Figure 5B). These data and trends strongly support the hypothesis that levonorgestrel binding to the silicone elastomer system is dependent on its solubilization in the elastomer.
Figure 5. Influence of cure temperature and cure time on percentage recovery of micronized and non-micronised levonorgestrel from MED-4870 and DDU-4320 silicone elastomer slabs. Levonorgestrel loading for all samples was 0.4% w/w (equivalent to 32 mg in a human-sized vaginal ring device). Each data point represents the mean ± SD of 4 replicates. Error bars are often smaller than the plot symbols.
For the MED-4870 system, the highest recovery of levonorgestrel (66.2%) was measured for the non-micronised levonorgestrel slabs prepared at the 120 °C / 10 min cure condition (Figure 5A). This value is significantly below the range of acceptable assay values (85–115%) commonly specified for a Phase 1 product. Although higher values for levonorgestrel recovery could be achieved for the MED-4870 system by curing at lower temperatures, this would lead to significantly increased process cycle times such that scaled manufacture would be impractical. For example, in additional experiments, we demonstrated that MED-4870 silicone elastomer containing 0.4% w/w non-micronised levonorgestrel can be cured at 80 °C for 2.5 h to give a levonorgestrel recovery value of 86.2%. However, injection molding cycle times less than 2 min are preferable. Reducing cure time is also not an option, since 90 s at 160 °C was the minimum cure condition required to produce a ring or slab device having sufficient mechanical properties for demolding.

An alternative medical grade addition-cure silicone elastomer system, DDU-4320, was selected for testing based on its recommended low cure temperature characteristics. For silicone elastomer slabs containing micronised levonorgestrel and prepared at 60 °C for 7 min, levonorgestrel recovery was 75.6%, with values decreasing as cure temperature was increased (Figure 5C). However, no levonorgestrel recovery was obtained for cure temperatures 120 °C and above (Figure 5C). For the non-micronised levonorgestrel DDU-4320 samples, levonorgestrel recovery values were significantly higher (87.3% at 60 °C declining to 58.5% at 160 °C; Figure 5C) compared to those for micronised levonorgestrel, mimicking the trend observed previously with the high temperature cure MED-4870 system. Selecting an
intermediate cure temperature of 100 °C for this DDU-4320 system, the effect of varying cure
time has a greater influence on the micronised levonorgestrel compared with the non-
micronized material (Figure 5D). Importantly, the DDU-4320 slabs containing non-micronised
levonorgestrel offered levonorgestrel recovery values close to the specified range for content
assay / uniformity (90–110% label claim).

For comparison, incorporation of 0.4% w/w micronised levonorgestrel and non-micronised
levonorgestrel into MED-6382 silicone elastomer (a medical grade tin-catalysed condensation
cure system) produced levonorgestrel recovery values of 98.9 and 100.8%, respectively.
However, this condensation-cure silicone elastomer produces isopropanol as a by-product of
the curing reaction. Both levonorgestrel and dapivirine are highly soluble in isopropanol, and
therefore these condensation cure silicone elastomers are not preferred in order to avoid drug
migration to the ring surface as isopropanol migrates to the vaginal ring surface and evaporates
[17].

Initially, the influence of levonorgestrel particle size on the extent of binding was tested using a
single batch of micronised levonorgestrel and non-micronised levonorgestrel (Batches 1 and 4,
respectively; Table 2; Figure 3; supplied by CHEMO). Two additional levonorgestrel materials
(Batches 2 and 3) were sieved at source so that particles intermediate in size could be tested
(Table 2). Silicone elastomer DDU-4320 slabs containing 0.4% w/w levonorgestrel were
prepared at 100 °C for 90 s for each levonorgestrel batch. As expected, the levonorgestrel
recovery values for these sieved levonorgestrel materials (56.7% and 55.6%; Table 2) lie
between the values for the previously tested non-micronised levonorgestrel and micronised levonorgestrel (98.4% and 41.3%, respectively; Table 2), further supporting the solubilisation hypothesis. The similarity in levonorgestrel recovery values for Batches 2 and 3 is most likely due to the equivalence in d10 values (despite the very different d90 and d50 values), since the fines are expected to contribute disproportionately to the overall surface area of the material.

The percentage recovery of levonorgestrel from DDU-4320 silicone elastomer vaginal rings cured at 90°C for 3 min increased (55.0 – 84.9%) as the loading amount of micronised levonorgestrel incorporated into the device was increased from 25 to 100 and 400 mg (Table 3). This trend is consistent with the proposed solubility hypothesis, since progressively smaller fractions of the total levonorgestrel loading are expected to dissolve and bind to the silicone elastomer as the levonorgestrel loading is increased. For the vaginal rings containing non-micronised levonorgestrel, recoveries were close to 100% irrespective of levonorgestrel loading (Table 3). These recovery values are also slightly higher than those predicted based on the previous slab data (Figure 5). This is likely attributed to a temperature-insulating effect for drug particles located in the bulk of the vaginal rings, attributed to the larger volume and/or the smaller surface area-to-volume ratio associated with the vaginal ring devices compared with slabs. This insulation effect is further illustrated by the data presented in Supplementary Information in which reported non-micronised levonorgestrel recovery values were lower (but not significantly) for slabs compared with vaginal rings, and where both are manufactured under the same cure conditions.
Table 3. Percentage recovery levonorgestrel from matrix-type DDU-4320 silicone elastomer vaginal rings cured at 90 °C for 3 min and containing different amounts of micronized and non-micronised levonorgestrel. Each levonorgestrel recovery value is the mean of four replicates and reported errors denote standard deviations.

<table>
<thead>
<tr>
<th>Levonorgestrel loading (mg, % w/w)</th>
<th>% Levonorgestrel Recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Non-micronized</td>
</tr>
<tr>
<td>25, 0.3125</td>
<td>99.5 ± 2.3</td>
</tr>
<tr>
<td>100, 1.25</td>
<td>96.1 ± 6.9</td>
</tr>
<tr>
<td>400, 5.00</td>
<td>100.6 ± 8.0</td>
</tr>
</tbody>
</table>

MED-4870 and DDU-4320 addition-cure silicone elastomer systems are supplied as two-part kits. Both parts contain the silicone elastomer base material, which comprises various vinyl-functionalised (Figure 1B) and hydroxy-terminated polydimethylsiloxane molecules. Part A also includes the platinum catalyst, while Part B also includes the poly(methylhydrosiloxane) component that ultimately reacts with the vinyl-functionalised polydimethylsiloxane molecules (Figure 1B). (Both parts also contain other components that are not pertinent to this discussion.) Therefore, it is conceivable that addition of levonorgestrel to only one of the parts might impact its propensity to bind when the two parts are subsequently mixed and cured.

Percentage levonorgestrel recovery values for slabs made with either MED-4870 or DDU-4320 and in which micronised levonorgestrel or non-micronised levonorgestrel is added to Part A only, Part B only or to both Parts are reported in Figure 6. For DDU-4320 slabs, the addition of levonorgestrel to one, other or both parts of the silicone elastomer system had no impact on
levonorgestrel recovery, although, as expected, differences in levonorgestrel recovery were observed for the micronized versus non-micronized materials (Figure 6B). However, addition of non-micronised levonorgestrel to Part B only of MED-4870 resulted in increased levonorgestrel recovery (57%) compared to adding it to Part A only (33%) or to both parts (30%) (Figure 6A). As previously observed, levonorgestrel recovery values were significantly higher for DDU-4320 compared to MED-4870, and for non-micronised levonorgestrel compared to micronised levonorgestrel.
Figure 6. Influence of order of addition of levonorgestrel upon levonorgestrel recovery from MED-4870 and DDU-4320 silicone elastomer slabs (n=4). MED-4870 slabs were cured at 160 °C for 90 s. DDU-4320 slabs were cured at 100 °C for 90 s. Part A – levonorgestrel added only to Part A of the silicone elastomer prior to curing; Part B – levonorgestrel added only to Part B of the silicone elastomer only prior to curing; Part A & B – equal amounts of levonorgestrel added.
to both parts prior to curing; NM – non-micronised levonorgestrel, M – micronised levonorgestrel.

Silicone oils are sometimes used as dispersing agents for addition of drug powders to silicone elastomer systems. The impact of dispersing levonorgestrel in MED-360 silicone oil prior to manufacture of DDU-4320 silicone elastomer slabs was investigated for selected cure conditions. The results, presented in Supplementary Information, show that levonorgestrel recovery was typically 4–10% higher with use of the silicone oil. However, at the highest cure temperature tested (160 °C), no significant difference in levonorgestrel recovery was observed for either non-micronised or micronised levonorgestrel.

In an additional set of experiments, silicone elastomer DDU-4320 slabs containing 1% w/w dapivirine, non-micronised levonorgestrel or micronised levonorgestrel and prepared via injection molding at 90 °C for 3 min were subjected to drug extraction via dichloromethane to measure drug recovery followed by swelling in hexane to determine the silicone elastomer crosslinking density. Similar to previous results, percentage drug recovery decreased in the order dapivirine (99.3%) > non-micronised levonorgestrel (87.6%) > micronised levonorgestrel (79.4%), reflecting the extent of reaction of each drug with the hydrosilane groups in the silicone elastomer system under the conditions of cure (Figure 7A). Following drug extraction, the slabs were dried and reweighed; the values for total percentage mass extracted are presented in Figure 7B. The ~5% mass loss observed for the control sample (containing no drug) was attributed to the extraction of non-reactive silicone oil components in the silicone
elastomer formulation. The same mass loss due to extraction of these oils was presumably also observed in each the drug-loaded samples, with any additional mass loss due to extraction of either non-bound drug or unreacted polydimethylsiloxane components. Interestingly, the highest extraction mass was observed for the micronised levonorgestrel slab, which is counter-intuitive if only the propensity for the micronised levonorgestrel crystalline material to rapidly solubilize and undergo hydrosilylation reaction within the silicone elastomer is considered. However, these levonorgestrel molecules compete with the vinyl-functionalised polydimethylsiloxane molecules in the silicone elastomer system for reaction with the hydride-functionalised polydimethylsiloxane molecules. In this way, the overall crosslink density is reduced in the silicone elastomer and there is increased opportunity for extraction of non-reactive polydimethylsiloxane molecules. This effectively explains the trends in percentage mass extraction values (Figure 7B). An entirely similar trend is also observed for the percentage swelling values (in dichloromethane; Figure 7C), adding further support to the different impact of the various drug molecules on the silicone elastomer crosslinking density. Conventionally, crosslinking densities in silicone elastomer systems are measured by swelling samples in hexane rather than dichloromethane. Subsequent placement of the silicone elastomer slabs into hexane resulted in minimal additional mass loss (Figure 7D), and confirmed the previous trend in crosslinking density obtained with dichloromethane (compare Figures 8C and 7E). The plot of mean percentage mass extraction verses mean percentage swelling for the various silicone elastomer slab formulations showed a linear positive correlation ($r^2 = 0.972$) (Figure 7F).
Figure 7. Results of hexane swelling experiments to assess degree of crosslinking in silicone elastomer slabs after extraction of non-bound drug (n=4). nmLNG – non-micronised levonorgestrel; mLNG – micronised levonorgestrel; DPV – dapivirine. A – Percentage drug extraction in dichloromethane. B – Percentage mass extraction in dichloromethane. C – Percentage swelling in dichloromethane. D – Percentage mass extraction in dichloromethane. E – Percentage swelling in hexane. F - % Extraction (w/w) vs. swelling (w/w) in hexane.

Given the observation that levonorgestrel covalently binds to the silicone elastomer during cure, oscillatory rheology was used to monitor changes in storage modulus (a measure of the stored energy, representing the elastic portion) of different non-micronised levonorgestrel,
micronised levonorgestrel and dapivirine-loaded DDU-4320 silicone elastomer systems during the curing process. Consistent with previous reports [28], the storage modulus for each formulation increased with time, as exemplified by the rheograms for the non-micronised levonorgestrel formulations presented in Figure 8A and reflecting the increase in viscosity as cure progresses. However, the relationship between storage modulus and drug concentration is not simple. For example, for the non-micronised levonorgestrel formulations, storage modulus increased in the concentration rank order 1% < 5% ≅ 10% ≅ 15% < 0% < 20% (Figure 8B). This trend reflects the interplay between levonorgestrel's ability to inhibit cure (via dissolution and reaction with the silicone elastomer) and to act as mechanical filler. For silicone elastomer formulations having relatively low levonorgestrel concentrations (e.g. 1% w/w), cure inhibition predominates and the storage modulus is reduced significantly compared to the control formulation (0% levonorgestrel). However, at higher levonorgestrel loadings (e.g. 20% w/w), the cure inhibition effect is masked by the mechanical filler effect, as evidenced by storage modulus values significantly greater than the control formulation (Figure 8A). By plotting the value of the storage modulus at 800 s cure time versus drug concentration (Figure 8B), it is apparent that this complex interplay exists for both micronised levonorgestrel and non-micronised levonorgestrel. Unsurprisingly, the extent of cure inhibition is generally lower for the slower-dissolving (less prone to binding) non-micronised levonorgestrel samples. Dapivirine, on the other hand, lacks the chemical functionality to react with the silicone elastomer components and therefore does not exhibit the initial decline in storage modulus at low dapivirine concentrations compared with the non-medicated control. Instead, dapivirine acts solely as
a mechanical filler by increasing the storage modulus at relatively high dapivirine concentrations (Figure 8B).

**Figure 8.** A – Oscillatory rheograms (storage modulus versus time) following the cure process for silicone elastomer samples containing different concentrations of non-micronised levonorgestrel. Plot symbols and error bars represent the mean and standard deviation of four
replicates. Similar rheograms were obtained for samples containing dapivirine and micronised levonorgestrel. B – Graph showing storage modulus at 800 s versus concentration of dapivirine, non-micronised levonorgestrel and micronised levonorgestrel.

3.4. In vitro release of dapivirine and levonorgestrel from rings manufactured under optimised cure conditions

Finally, armed with the knowledge that silicone elastomer type, cure temperature, cure time, levonorgestrel loading and levonorgestrel particle size all have a role to play in determining the extent of levonorgestrel binding, additional dapivirine+levonorgestrel matrix-type DDU-4320 silicone elastomer vaginal rings were fabricated under processing conditions (94 °C cure temperature and 90 s cure time) selected to minimise levonorgestrel binding. The vaginal rings, all containing 200 mg micronized dapivirine and either 32, 48 or 64 mg non-micronised levonorgestrel were then tested for in vitro release and content assay. The 92-day in vitro dapivirine and levonorgestrel release profiles are presented in Figure 9. Dapivirine release characteristics over the first 15 days were entirely similar to those measured for the original MED-4870 vaginal rings (Figure 4). Dapivirine release on day 90 was in the range 325–342 μg for all vaginal ring formulations (Figure 9A) and dapivirine content assay values matched the label claim (99.3–100.4 %). For DDU-4320 vaginal rings manufactured using the optimised cure conditions, the mean day 1 amount of levonorgestrel released from the 200 mg dapivirine + 32 mg non-micronised levonorgestrel vaginal ring was 1219 ± 37 μg (Figure 9B), a significant increase over the 732 ± 166 mean day 1 value for the MED-4870 rings (Figure 4B) and a consequence of a reduction in the extent of levonorgestrel binding. For the same DDU-4320
vaginal ring formulation, day 90 levonorgestrel release was 85 ± 5 μg (Figure 9B). The total percentage DPV release was approximately 33% (66 mg from initial 200 mg loading), while total percentage LNG release ranged from 54% – 64% depending on initial drug loading.

These 92-day release values for both dapivirine and levonorgestrel bode well for a viability of a 3-month MPT vaginal ring product offering both HIV prevention and contraception. As expected, increasing the non-micronised levonorgestrel loading within the DDU-4320 vaginal ring from 32 mg to either 48 mg or 64 mg produced increases in the levonorgestrel release rate proportional to the loading (Figure 9B and 9D). Critically, the percentage levonorgestrel recovery values in the content assay (93.0%, 94.4% and 95.9% for the 200/32, 200/48 and 200/64 vaginal rings, respectively) now fall within the 90–110% label claim range.
Figure 9. *In vitro* daily release vs. time graph for release of micronised dapivirine and non-micronised levonorgestrel from human-type, silicone elastomer, matrix vaginal rings into 1:1 isopropanol/water. Cure conditions for these rings were 94 °C for 90 s. Daily release plot symbols and error bars (mostly not visible due to being smaller in size than the plot symbol) represent the mean and standard deviation of six replicates.

4. Conclusions
Chemical reaction between the ethynyl functional group in levonorgestrel and the hydrosilane functional groups in addition-cure silicone elastomers takes place via the same hydrosilylation reaction used to cure the silicone elastomer, and leads to irreversible covalent binding of levonorgestrel molecules to the elastomer. The extent of levonorgestrel binding depends upon the processing conditions, including cure temperature, cure time, levonorgestrel particle size, levonorgestrel loading and the type of silicone elastomer. This API-binding phenomenon raises challenges for the future development of certain silicone elastomer drug delivery devices that incorporate drug molecules with similar chemically reactive functional groups, including a significant number of other steroid molecules.
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Author Contributions

All authors contributed to the design of experiments and analysis of the data. D.J.M, P.B, C.F.M and S.K conducted the experimental work. The manuscript was drafted by R.K.M and D.J.M, with input from other authors.

Notes

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REFERENCES


