

**MICRO LABS LTD**  
**COMMON TECHNICAL DOCUMENT MODULE 1, ADMINISTRATIVE AND**  
**PRODUCT INFORMATION**  
**DAPAGLIFLOZIN TABLETS 10 mg**



**Module 1 : Administrative and Product Information**

**1.3 : Product Information**

**1.3.1 : Summary of product characteristics (SmPC)**

Enclosed



**National Agency for Food & Drug Administration & Control (NAFDAC)**

**Registration & Regulatory Affairs (R & R) Directorate**

**SUMMARY OF PRODUCT CHARACTERISTICS (SmPC) TEMPLATE**

*[Instructions in this font/colour are from the World Health Organisation Public Assessment Report WHOPAR guidelines.]*

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

### **1.1 Product Name:**

Dapagliflozin Tablets

DAPZIN

### **1.2**

#### **Strength:**

10mg

## **2. QUALITATIVE AND QUANTITATIVE COMPOSITION**

Each film coated tablet contains:

Dapagliflozin ..... 10 mg

## **3. PHARMACEUTICAL FORM**

Film coated tablet

## **4. CLINICAL PARTICULARS**

### **4.1 Therapeutic indications**

Dapagliflozin is indicated in adults aged 18 years and older with type 2 diabetes mellitus to improve glycaemic control as:

#### ***Monotherapy***

When diet and exercise alone do not provide adequate glycaemic control in patients for whom use of metformin is considered inappropriate due to intolerance.

#### ***Add-on combination therapy***

In combination with other glucose-lowering medicinal products including insulin, when these, together with diet and exercise, do not provide adequate glycaemic control

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

#### **Posology**

### *Monotherapy and add-on combination therapy*

The recommended dose is 10 mg dapagliflozin once daily for monotherapy and add-on combination therapy with other glucose-lowering medicinal products including insulin. When dapagliflozin is used in combination with insulin or an insulin secretagogue, such as a sulphonylurea, a lower dose of insulin or insulin secretagogue may be considered to reduce the risk of hypoglycaemia

### *Special populations*

#### *Renal impairment*

The efficacy of dapagliflozin is dependent on renal function, and efficacy is reduced in patients who have moderate renal impairment and likely absent in patients with severe renal impairment. Dapagliflozin is not recommended for use in patients with moderate to severe renal impairment (patients with creatinine clearance [CrCl] < 60 ml/min or estimated glomerular filtration rate [eGFR] < 60 ml/min/1.73 m<sup>2</sup>

No dosage adjustment is indicated in patients with mild renal impairment.

#### *Hepatic impairment*

No dosage adjustment is necessary for patients with mild or moderate hepatic impairment. In patients with severe hepatic impairment, a starting dose of 5 mg is recommended. If well tolerated, the dose may be increased to 10 mg.

#### *Elderly (≥ 65 years)*

In general, no dosage adjustment is recommended based on age. Renal function and risk of volume depletion should be taken into account. Due to the limited therapeutic experience in patients 75 years and older, initiation of dapagliflozin therapy is not recommended.

#### *Paediatric population*

The safety and efficacy of dapagliflozin in children aged 0 to < 18 years have not yet been established. No data are available.

#### *Method of administration*

Dapagliflozin can be taken orally once daily at any time of day with or without food. Tablets are to be swallowed whole.

### 4.3 Contraindications

Hypersensitivity to the active substance or to any of the excipients

### 4.4 Special warnings and precautions for use

#### *Renal impairment*

The efficacy of dapagliflozin is dependent on renal function, and efficacy is reduced in patients who have moderate renal impairment and likely absent in patients with severe renal impairment (see section 4.2). In subjects with moderate renal impairment (patients with CrCl < 60 ml/min or eGFR < 60 ml/min/1.73 m<sup>2</sup>), a higher proportion of subjects treated with dapagliflozin had adverse reactions of increase in creatinine, phosphorus, parathyroid hormone (PTH) and hypotension, compared with placebo. Dapagliflozin is not recommended for use in patients with moderate to severe renal impairment (patients with CrCl < 60 ml/min or eGFR < 60 ml/min/1.73 m<sup>2</sup>). Dapagliflozin has not been studied in severe renal impairment (CrCl < 30 ml/min or eGFR < 30 ml/min/1.73 m<sup>2</sup>) or end-stage renal disease (ESRD).

*Monitoring of renal function is recommended as follows:*

- Prior to initiation of dapagliflozin and at least yearly, thereafter
- Prior to initiation of concomitant medicinal products that may reduce renal function and periodically thereafter
- For renal function approaching moderate renal impairment, at least 2 to 4 times per year. If renal function falls below CrCl < 60 ml/min or eGFR < 60 ml/min/1.73 m<sup>2</sup>, dapagliflozin treatment should be discontinued.

#### *Hepatic impairment*

There is limited experience in clinical trials in patients with hepatic impairment. Dapagliflozin exposure is increased in patients with severe hepatic impairment.

Use in patients at risk for volume depletion, hypotension and/or electrolyte imbalances

Due to its mechanism of action, dapagliflozin increases diuresis associated with a modest decrease in blood pressure, which may be more pronounced in patients with very high blood glucose concentrations.

Dapagliflozin is not recommended for use in patients receiving loop diuretics or who are volume depleted, e.g. due to acute illness (such as gastrointestinal illness).

Caution should be exercised in patients for whom a dapagliflozin-induced drop in blood pressure could pose a risk, such as patients with known cardiovascular disease, patients on anti-

hypertensive therapy with a history of hypotension or elderly patients.

For patients receiving dapagliflozin, in case of intercurrent conditions that may lead to volume depletion, careful monitoring of volume status (e.g. physical examination, blood pressure measurements, and laboratory tests including haematocrit) and electrolytes is recommended. Temporary interruption of treatment with dapagliflozin is recommended for patients who develop volume depletion until the depletion is corrected.

### ***Diabetic ketoacidosis***

Rare cases of diabetic ketoacidosis (DKA), including life-threatening and fatal cases, have been reported in patients treated with sodium-glucose co-transporter 2 (SGLT2) inhibitors, including dapagliflozin. In a number of cases, the presentation of the condition was atypical with only moderately increased blood glucose values, below 14 mmol/l (250 mg/dl). It is not known if DKA is more likely to occur with higher doses of dapagliflozin.

The risk of diabetic ketoacidosis must be considered in the event of non-specific symptoms such as nausea, vomiting, anorexia, abdominal pain, excessive thirst, difficulty breathing, confusion, unusual fatigue or sleepiness. Patients should be assessed for ketoacidosis immediately if these symptoms occur, regardless of blood glucose level.

In patients where DKA is suspected or diagnosed, treatment with dapagliflozin should be discontinued immediately.

Treatment should be interrupted in patients who are hospitalized for major surgical procedures or acute serious medical illnesses. In both cases, treatment with dapagliflozin may be restarted once the patient's condition has stabilized.

Before initiating dapagliflozin, factors in the patient history that may predispose to ketoacidosis should be considered.

Patients who may be at higher risk of DKA include patients with a low beta-cell function reserve (e.g. type 2 diabetes patients with low C-peptide or latent autoimmune diabetes in adults (LADA) or patients with a history of pancreatitis), patients with conditions that lead to restricted food intake or severe dehydration, patients for whom insulin doses are reduced and patients with increased insulin requirements due to acute medical illness, surgery or alcohol abuse. SGLT2 inhibitors should be used with caution in these patients.

Restarting SGLT2 inhibitor treatment in patients with previous DKA while on SGLT2 inhibitor treatment is not recommended, unless another clear precipitating factor is identified and resolved.

The safety and efficacy of dapagliflozin in patients with type 1 diabetes have not been established and dapagliflozin should not be used for treatment of patients with type 1 diabetes. Limited data from clinical trials suggest that DKA occurs with common frequency when patients with type 1 diabetes are treated with SGLT2 inhibitors.

### ***Urinary tract infections***

Urinary tract infections were more frequently reported for dapagliflozin 10 mg compared to placebo in a pooled analysis up to 24 weeks. Pyelonephritis was uncommon and occurred at a similar frequency to control. Urinary glucose excretion may be associated with an increased risk of urinary tract infection; therefore, temporary interruption of dapagliflozin should be considered when treating pyelonephritis or urosepsis.

### ***Elderly ( $\geq 65$ years)***

Elderly patients are more likely to have impaired renal function, and/or to be treated with anti-hypertensive medicinal products that may cause changes in renal function such as angiotensin-converting enzyme inhibitors (ACE-I) and angiotensin II type 1 receptor blockers (ARB). The same recommendations for renal function apply to elderly patients as to all patients.

In subjects  $\geq 65$  years of age, a higher proportion of subjects treated with dapagliflozin had adverse reactions related to renal impairment or failure compared with placebo. The most commonly reported adverse reaction related to renal function was serum creatinine increases, the majority of which were transient and reversible.

Elderly patients may be at a greater risk for volume depletion and are more likely to be treated with diuretics. In subjects  $\geq 65$  years of age, a higher proportion of subjects treated with dapagliflozin had adverse reactions related to volume depletion.

Therapeutic experience in patients 75 years and older is limited. Initiation of dapagliflozin therapy in this population is not recommended.

### ***Cardiac failure***

Experience in NYHA class I-II is limited, and there is no experience in clinical studies with dapagliflozin in NYHA class III-IV.

### ***Use in patients treated with pioglitazone***

While a causal relationship between dapagliflozin and bladder cancer is unlikely, as a

precautionary measure, dapagliflozin is not recommended for use in patients concomitantly treated with pioglitazone. Available epidemiological data for pioglitazone suggest a small increased risk of bladder cancer in diabetic patients treated with pioglitazone.

### ***Elevated haematocrit***

Haematocrit increase was observed with dapagliflozin treatment; therefore, caution in patients with already elevated haematocrit is warranted.

### ***Lower limb amputations***

An increase in cases of lower limb amputation (primarily of the toe) has been observed in ongoing long-term, clinical studies with another SGLT2 inhibitor. It is unknown whether this constitutes a class effect. Like for all diabetic patients it is important to counsel patients on routine preventative foot care.

### ***Urine laboratory assessments***

Due to its mechanism of action, patients taking Dapagliflozin will test positive for glucose in their urine.

### ***Lactose***

The tablets contain lactose. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency, or glucose-galactose malabsorption should not take this medicinal product.

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

### **Pharmacodynamic interactions**

#### ***Diuretics***

Dapagliflozin may add to the diuretic effect of thiazide and loop diuretics and may increase the risk of dehydration and hypotension.

#### ***Insulin and insulin secretagogue***

Insulin and insulin secretagogue, such as sulphonylureas, cause hypoglycaemia. Therefore, a lower dose of insulin or an insulin secretagogue may be required to reduce the risk of hypoglycaemia when used in combination with dapagliflozin.

### ***Pharmacokinetic interactions***

The metabolism of dapagliflozin is primarily via glucuronide conjugation mediated by UDP glucuronosyltransferase 1A9 (UGT1A9).

In *in vitro* studies, dapagliflozin neither inhibited cytochrome P450 (CYP) 1A2, CYP2A6, CYP2B6, CYP2C8, CYP2C9, CYP2C19, CYP2D6, CYP3A4, nor induced CYP1A2, CYP2B6 or CYP3A4. Therefore, dapagliflozin is not expected to alter the metabolic clearance of coadministered medicinal products that are metabolised by these enzymes.

### ***Effect of other medicinal products on dapagliflozin***

Interaction studies conducted in healthy subjects, using mainly a single-dose design, suggest that the pharmacokinetics of dapagliflozin are not altered by metformin, pioglitazone, Sitagliptin, glimepiride, voglibose, hydrochlorothiazide, bumetanide, valsartan, or simvastatin.

Following coadministration of dapagliflozin with rifampicin (an inducer of various active transporters and drug-metabolising enzymes) a 22% decrease in dapagliflozin systemic exposure (AUC) was observed, but with no clinically meaningful effect on 24-hour urinary glucose excretion. No dose adjustment is recommended. A clinically relevant effect with other inducers (e.g. carbamazepine, phenytoin, and phenobarbital) is not expected.

Following coadministration of dapagliflozin with mefenamic acid (an inhibitor of UGT1A9), a 55% increase in dapagliflozin systemic exposure was seen, but with no clinically meaningful effect on 24-hour urinary glucose excretion. No dose adjustment is recommended.

### ***Effect of dapagliflozin on other medicinal products***

In interaction studies conducted in healthy subjects, using mainly a single-dose design, dapagliflozin did not alter the pharmacokinetics of metformin, pioglitazone, Sitagliptin, glimepiride, hydrochlorothiazide, bumetanide, valsartan, digoxin (a P-gp substrate) or warfarin (S-warfarin, a CYP2C9 substrate), or the anticoagulatory effects of warfarin as measured by INR. Combination of a single dose of dapagliflozin 20 mg and simvastatin (a CYP3A4 substrate) resulted in a 19% increase in AUC of simvastatin and 31% increase in AUC of simvastatin acid. The increase in simvastatin and simvastatin acid exposures are not considered clinically relevant.

Interference with 1,5-anhydroglucitol (1,5-AG) assay

Monitoring glycaemic control with 1,5-AG assay is not recommended as measurements of 1,5-AG are unreliable in assessing glycaemic control in patients taking SGLT2 inhibitors. Use of

alternative methods to monitor glycaemic control is advised.

### ***Paediatric population***

Interaction studies have only been performed in adults.

## **4.6 Pregnancy and lactation**

### ***Pregnancy***

There are no data from the use of dapagliflozin in pregnant women. Studies in rats have shown toxicity to the developing kidney in the time period corresponding to the second and third trimesters of human pregnancy. Therefore, the use of dapagliflozin is not recommended during the second and third trimesters of pregnancy.

When pregnancy is detected, treatment with dapagliflozin should be discontinued.

### ***Lactation***

It is unknown whether dapagliflozin and/or its metabolites are excreted in human milk. Available Pharmacodynamic/toxicological data in animals have shown excretion of dapagliflozin/metabolites in milk, as well as pharmacologically-mediated effects in nursing offspring. A risk to the newborns/infants cannot be excluded. Dapagliflozin should not be used while breast-feeding.

### ***Fertility***

The effect of dapagliflozin on fertility in humans has not been studied. In male and female rats, dapagliflozin showed no effects on fertility at any dose tested.

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

Dapagliflozin has no or negligible influence on the ability to drive and use machines. Patients should be alerted to the risk of hypoglycaemia when dapagliflozin is used in combination with a sulphonylurea or insulin.

## **4.8 Undesirable effects**

### ***Summary of the safety profile***

In a pre-specified pooled analysis of 13 placebo-controlled studies, 2,360 subjects were treated with dapagliflozin 10 mg and 2,295 were treated with placebo.

The most frequently reported adverse reaction was hypoglycaemia, which depended on the type of

background therapy used in each study. The frequency of minor episodes of hypoglycaemia was similar between treatment groups, including placebo, with the exceptions of studies with add-on sulphonylurea (SU) and add-on insulin therapies. Combination therapies with sulphonylurea and add-on insulin had higher rates of hypoglycaemia (see *Hypoglycaemia* below).

#### Tabulated list of adverse reactions

The following adverse reactions have been identified in the placebo-controlled clinical trials. None were found to be dose-related. Adverse reactions listed below are classified according to frequency and system organ class (SOC). Frequency categories are defined according to 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 ( $< 1/10,000$ ), and not known (cannot be estimated from the available data).

Table 1. Adverse reactions in placebo-controlled clinical studies<sup>a</sup> and post marketing experience

System organ class	Very common	Common <sup>*</sup>	Uncommon <sup>**</sup>	Rare
<i>Infections and infestations</i>		Vulvovaginitis, balanitis and related genital infections <sup>*,b,c</sup> Urinary tract infection <sup>*,b,d</sup>	Fungal infection <sup>**</sup>	
<i>Metabolism and nutrition disorders</i>	Hypoglycaemia (when used with SU or insulin) <sup>b</sup>		Volume depletion <sup>b,e</sup> Thirst <sup>**</sup>	Diabetic ketoacidosis <sup>i</sup>
<i>Nervous system disorders</i>		Dizziness		
<i>Gastrointestinal disorders</i>			Constipation <sup>**</sup> Dry mouth <sup>**</sup>	
<i>Skin and subcutaneous tissue disorders</i>		Rash <sup>j</sup>		
<i>Musculoskeletal and connective tissue disorders</i>		Back pain <sup>*</sup>		

<i>Renal and urinary disorders</i>		Dysuria Polyuria <sup>*.f</sup>	Nocturia <sup>**</sup> Renal impairment <sup>**,b</sup>	
<i>Reproductive system and breast disorders</i>			Vulvovaginal pruritus <sup>**</sup> Pruritus genital <sup>**</sup>	
<i>Investigations</i>		Haematocrit increased <sup>g</sup> Creatinine renal clearance decreased <sup>b</sup> Dyslipidaemia <sup>h</sup>	Blood creatinine increased <sup>**,b</sup> Blood urea increased <sup>**</sup> Weight decreased <sup>**</sup>	

<sup>a</sup>The table shows up to 24-week (short-term) data regardless of glycaemic rescue.

<sup>b</sup>See corresponding subsection below for additional information.

<sup>c</sup>Vulvovaginitis, balanitis and related genital infections includes, e.g. the predefined preferred terms: vulvovaginal mycotic infection, vaginal infection, balanitis, genital infection fungal, vulvovaginal candidiasis, Vulvovaginitis, balanitis candida, genital candidiasis, genital infection, genital infection male, penile infection, vulvitis, vaginitis bacterial, vulval abscess.

<sup>d</sup>Urinary tract infection includes the following preferred terms, listed in order of frequency reported: urinary tract infection, cystitis, Escherichia urinary tract infection, genitourinary tract infection, pyelonephritis, trigonitis, urethritis, kidney infection and prostatitis.

<sup>e</sup>Volume depletion includes, e.g. the predefined preferred terms: dehydration, hypovolaemia, hypotension.

<sup>f</sup>Polyuria includes the preferred terms: pollakiuria, polyuria, urine output increased.

<sup>g</sup>Mean changes from baseline in haematocrit were 2.30% for dapagliflozin 10 mg versus -0.33% for placebo. Haematocrit values >55% were reported in 1.3% of the subjects treated with dapagliflozin 10 mg versus 0.4% of placebo subjects.

<sup>h</sup>Mean percent change from baseline for dapagliflozin 10 mg versus placebo, respectively, was: total cholesterol 2.5% versus 0.0%; HDL cholesterol 6.0% versus 2.7%; LDL cholesterol 2.9% versus -1.0%; triglycerides -2.7% versus -0.7%.

<sup>i</sup> See section 4.4.

<sup>j</sup>Adverse reaction was identified through post marketing surveillance. Rash includes the following preferred terms, listed in order of frequency in clinical trials: rash, rash generalized, rash pruritic, rash macular, rash maculo-papular, rash pustular, rash vesicular, and rash erythematous. In active-

and placebo-controlled clinical trials (dapagliflozin, N=5936, All control, N=3403), the frequency of rash was similar for dapagliflozin (1.4 %) and all control (1.4%), respectively.

\*Reported in  $\geq 2\%$  of subjects and  $\geq 1\%$  more and at least 3 more subjects treated with dapagliflozin 10 mg compared to placebo.

\*\*Reported by the investigator as possibly related, probably related or related to study treatment and reported in  $\geq 0.2\%$  of subjects and  $\geq 0.1\%$  more and at least 3 more subjects treated with dapagliflozin 10 mg compared to placebo.

## **Description of selected adverse reactions**

### ***Hypoglycaemia***

The frequency of hypoglycaemia depended on the type of background therapy used in each study. For studies of dapagliflozin in monotherapy, as add-on to metformin or as add-on to Sitagliptin (with or without metformin), the frequency of minor episodes of hypoglycaemia was similar ( $< 5\%$ ) between treatment groups, including placebo up to 102 weeks of treatment. Across all studies, major events of hypoglycaemia were uncommon and comparable between the groups treated with dapagliflozin or placebo. Studies with add-on sulphonylurea and add-on insulin therapies had higher rates of hypoglycaemia.

In an add-on to glimepiride study, at weeks 24 and 48, minor episodes of hypoglycaemia were reported more frequently in the group treated with dapagliflozin 10 mg plus glimepiride (6.0% and 7.9%, respectively) than in the placebo plus glimepiride group (2.1% and 2.1%, respectively).

In an add-on to insulin study, episodes of major hypoglycaemia were reported in 0.5% and 1.0% of subjects treated with dapagliflozin 10 mg plus insulin at Weeks 24 and 104, respectively, and in 0.5% of subjects treated with placebo plus insulin groups at Weeks 24 and 104. At Weeks 24 and 104, minor episodes of hypoglycaemia were reported, respectively, in 40.3% and 53.1% of subjects who received dapagliflozin 10 mg plus insulin and in 34.0% and 41.6% of the subjects who received placebo plus insulin.

In an add-on to metformin and a sulphonylurea study, up to 24 weeks, no episodes of major hypoglycaemia were reported. Minor episodes of hypoglycaemia were reported in 12.8% of subjects who received dapagliflozin 10 mg plus metformin and a sulphonylurea and in 3.7% of subjects who received placebo plus metformin and a sulphonylurea.

### ***Volume depletion***

Reactions related to volume depletion (including, reports of dehydration, hypovolaemia or hypotension) were reported in 1.1% and 0.7% of subjects who received dapagliflozin 10 mg and placebo, respectively; serious reactions occurred in < 0.2% of subjects balanced between dapagliflozin 10 mg and placebo.

### ***Vulvovaginitis, balanitis and related genital infections***

Vulvovaginitis, balanitis and related genital infections were reported in 5.5% and 0.6% of subjects who received dapagliflozin 10 mg and placebo, respectively. Most infections were mild to moderate, and subjects responded to an initial course of standard treatment and rarely resulted in discontinuation from dapagliflozin treatment. These infections were more frequent in females (8.4% and 1.2% for dapagliflozin and placebo, respectively), and subjects with a prior history were more likely to have a recurrent infection.

### ***Urinary tract infections***

Urinary tract infections were more frequently reported for dapagliflozin 10 mg compared to placebo. Most infections were mild to moderate, and subjects responded to an initial course of standard treatment and rarely resulted in discontinuation from dapagliflozin treatment. These infections were more frequent in females, and subjects with a prior history were more likely to have a recurrent infection.

### ***Increased creatinine***

Adverse reactions related to increased creatinine were grouped (e.g. decreased renal creatinine clearance, renal impairment, increased blood creatinine and decreased glomerular filtration rate). This grouping of reactions was reported in 3.2% and 1.8% of patients who received dapagliflozin 10 mg and placebo, respectively. In patients with normal renal function or mild renal impairment (baseline eGFR  $\geq$  60 ml/min/1.73m<sup>2</sup>) this grouping of reactions were reported in 1.3% and 0.8% of patients who received dapagliflozin 10 mg and placebo, respectively. These reactions were more common in patients with baseline eGFR  $\geq$  30 and < 60 ml/min/1.73m<sup>2</sup> (18.5% dapagliflozin 10 mg vs 9.3% placebo).

Further evaluation of patients who had renal-related adverse events showed that most had serum creatinine changes of  $\leq$  0.5 mg/dl from baseline. The increases in creatinine were generally transient during continuous treatment or reversible after discontinuation of treatment.

### ***Parathyroid hormone (PTH)***

Small increases in serum PTH levels were observed with increases being larger in subjects with higher baseline PTH concentrations. Bone mineral density measurements in patients with normal or mildly impaired renal function did not indicate bone loss over a treatment period of two years.

### ***Malignancies***

During clinical trials, the overall proportion of subjects with malignant or unspecified tumours was similar between those treated with dapagliflozin (1.50%) and placebo/comparator (1.50%), and there was no carcinogenicity or mutagenicity signal in animal data. When considering the cases of tumours occurring in the different organ systems, the relative risk associated with dapagliflozin was above 1 for some tumours (bladder, prostate, breast) and below 1 for others (e.g. blood and lymphatic, ovary, renal tract), not resulting in an overall increased tumour risk associated with dapagliflozin. The increased/decreased risk was not statistically significant in any of the organ systems. Considering the lack of tumour findings in non-clinical studies as well as the short latency between first drug exposure and tumour diagnosis, a causal relationship is considered unlikely. Since the numerical imbalance of breast, bladder and prostate tumours must be considered with caution, it will be further investigated in post-authorisation studies.

### ***Special populations***

#### ***Elderly ( $\geq 65$ years)***

In subjects  $\geq 65$  years of age, adverse reactions related to renal impairment or failure were reported in 7.7% of subjects treated with dapagliflozin and 3.8% of subjects treated with placebo. The most commonly reported adverse reaction related to renal function was increased serum creatinine. The majority of these reactions were transient and reversible. In subjects  $\geq 65$  years of age, adverse reactions of volume depletion, most commonly reported as hypotension, were reported in 1.7% and 0.8% of dapagliflozin-treated subjects and placebo-treated subjects, respectively.

### **4.9 Overdose**

Dapagliflozin did not show any toxicity in healthy subjects at single oral doses up to 500 mg (50 times the maximum recommended human dose). These subjects had detectable glucose in the urine for a dose-related period of time (at least 5 days for the 500 mg dose), with no reports of dehydration, hypotension or electrolyte imbalance, and with no clinically meaningful effect on QTc interval. The incidence of hypoglycaemia was similar to placebo. In clinical studies where

once-daily doses of up to 100 mg (10 times the maximum recommended human dose) were administered for 2 weeks in healthy subjects and type 2 diabetes subjects, the incidence of hypoglycaemia was slightly higher than placebo and was not dose-related. Rates of adverse events including dehydration or hypotension were similar to placebo, and there were no clinically meaningful dose-related changes in laboratory parameters, including serum electrolytes and biomarkers of renal function.

In the event of an overdose, appropriate supportive treatment should be initiated as dictated by the patient's clinical status. The removal of dapagliflozin by hemodialysis has not been studied.

## **5. PHARMACOLOGICAL PROPERTIES**

### **5.1 Pharmacodynamic properties**

Pharmacotherapeutic group: Drugs used in diabetes, Sodium-glucose co-transporter 2 (SGLT2) inhibitors, ATC code: A10BK01

#### ***Mechanism of action***

Dapagliflozin is a highly potent ( $K_i$ : 0.55 nM), selective and reversible inhibitor of SGLT2.

The SGLT2 is selectively expressed in the kidney with no expression detected in more than 70 other tissues including liver, skeletal muscle, adipose tissue, breast, bladder and brain. SGLT2 is the predominant transporter responsible for reabsorption of glucose from the glomerular filtrate back into the circulation. Despite the presence of hyperglycemia in type 2 diabetes, reabsorption of filtered glucose continues. Dapagliflozin improves both fasting and post-prandial plasma glucose levels by reducing renal glucose reabsorption leading to urinary glucose excretion. This glucose excretion (glucuronic effect) is observed after the first dose, is continuous over the 24-hour dosing interval and is sustained for the duration of treatment. The amount of glucose removed by the kidney through this mechanism is dependent upon the blood glucose concentration and GFR. Dapagliflozin does not impair normal endogenous glucose production in response to hypoglycaemia. Dapagliflozin acts independently of insulin secretion and insulin action. Improvement in homeostasis model assessment for beta cell function (HOMA beta-cell) has been observed in clinical studies with Dapagliflozin.

Urinary glucose excretion (glucuresis) induced by dapagliflozin is associated with caloric loss and reduction in weight. Inhibition of glucose and sodium co-transport by dapagliflozin is also associated with mild diuresis and transient natriuresis.

Dapagliflozin does not inhibit other glucose transporters important for glucose transport into

peripheral tissues and is > 1,400 times more selective for SGLT2 versus SGLT1, the major transporter in the gut responsible for glucose absorption.

### ***Pharmacodynamic effects***

Increases in the amount of glucose excreted in the urine were observed in healthy subjects and in subjects with type 2 diabetes mellitus following the administration of dapagliflozin. Approximately 70 g of glucose was excreted in the urine per day (corresponding to 280 kcal/day) at a dapagliflozin dose of 10 mg/day in subjects with type 2 diabetes mellitus for 12 weeks. Evidence of sustained glucose excretion was seen in subjects with type 2 diabetes mellitus given dapagliflozin 10 mg/day for up to 2 years.

This urinary glucose excretion with dapagliflozin also results in osmotic diuresis and increases in urinary volume in subjects with type 2 diabetes mellitus. Urinary volume increases in subjects with type 2 diabetes mellitus treated with dapagliflozin 10 mg were sustained at 12 weeks and amounted to approximately 375 ml/day. The increase in urinary volume was associated with a small and transient increase in urinary sodium excretion that was not associated with changes in serum sodium concentrations.

Urinary uric acid excretion was also increased transiently (for 3-7 days) and accompanied by a sustained reduction in serum uric acid concentration. At 24 weeks, reductions in serum uric acid concentrations ranged from -48.3 to -18.3 micromoles/l (-0.87 to -0.33 mg/dl).

## **5.2 Pharmacokinetic properties**

### ***Absorption***

Dapagliflozin was rapidly and well absorbed after oral administration. Maximum dapagliflozin plasma concentrations ( $C_{max}$ ) were usually attained within 2 hours after administration in the fasted state. Geometric mean steady-state dapagliflozin

$C_{max}$  and AUC values following once daily 10 mg doses of dapagliflozin were 158 ng/ml and 628 ng h/ml, respectively. The absolute oral bioavailability of dapagliflozin following the administration of a 10 mg dose is 78%. Administration with a high-fat meal decreased dapagliflozin  $C_{max}$  by up to 50% and prolonged  $T_{max}$  by approximately 1 hour, but did not alter AUC as compared with the fasted state. These changes are not considered to be clinically meaningful. Hence, Dapagliflozin can be administered with or without food.

### ***Distribution***

Dapagliflozin is approximately 91% protein bound. Protein binding was not altered in various

disease states (e.g. renal or hepatic impairment). The mean steady-state volume of distribution of dapagliflozin was 118 litres.

### ***Biotransformation***

Dapagliflozin is extensively metabolised, primarily to yield dapagliflozin 3-O-glucuronide, which is an inactive metabolite. Dapagliflozin 3-O-glucuronide or other metabolites do not contribute to the glucose-lowering effects. The formation of dapagliflozin 3-O-glucuronide is mediated by UGT1A9, an enzyme present in the liver and kidney, and CYP-mediated metabolism was a minor clearance pathway in humans.

### ***Elimination***

The mean plasma terminal half-life ( $t_{1/2}$ ) for dapagliflozin was 12.9 hours following a single oral dose of dapagliflozin 10 mg to healthy subjects. The mean total systemic clearance of dapagliflozin administered intravenously was 207 ml/min. Dapagliflozin and related metabolites are primarily eliminated via urinary excretion with less than 2% as unchanged dapagliflozin. After administration of a 50 mg [<sup>14</sup>C]-dapagliflozin dose, 96% was recovered, 75% in urine and 21% in faeces. In faeces, approximately 15% of the dose was excreted as parent drug.

### ***Linearity***

Dapagliflozin exposure increased proportional to the increment in dapagliflozin dose over the range of 0.1 to 500 mg and its pharmacokinetics did not change with time upon repeated daily dosing for up to 24 weeks.

### ***Special populations***

#### ***Renal impairment***

At steady-state (20 mg once-daily dapagliflozin for 7 days), subjects with type 2 diabetes mellitus and mild, moderate or severe renal impairment (as determined by iohexol plasma clearance) had mean systemic exposures of dapagliflozin of 32%, 60% and 87% higher, respectively, than those of subjects with type 2 diabetes mellitus and normal renal function. The steady-state 24-hour urinary glucose excretion was highly dependent on renal function and 85, 52, 18 and 11 g of glucose/day was excreted by subjects with type 2 diabetes mellitus and normal renal function or mild, moderate or severe renal impairment, respectively. The impact of hemodialysis on dapagliflozin exposure is not known.

### ***Hepatic impairment***

In subjects with mild or moderate hepatic impairment (Child-Pugh classes A and B), mean  $C_{max}$  and AUC of dapagliflozin were up to 12% and 36% higher, respectively, compared to healthy matched control subjects. These differences were not considered to be clinically meaningful. In subjects with severe hepatic impairment (Child-Pugh class C) mean  $C_{max}$  and AUC of dapagliflozin were 40% and 67% higher than matched healthy controls, respectively.

### ***Elderly ( $\geq 65$ years)***

There is no clinically meaningful increase in exposure based on age alone in subjects up to 70 years old. However, an increased exposure due to age-related decrease in renal function can be expected. There are insufficient data to draw conclusions regarding exposure in patients > 70 years old.

### ***Paediatric population***

Pharmacokinetics in the paediatric population have not been studied.

### ***Gender***

The mean dapagliflozin  $AUC_{ss}$  in females was estimated to be about 22% higher than in males.

### ***Race***

There were no clinically relevant differences in systemic exposures between White, Black or Asian races.

### ***Body weight***

Dapagliflozin exposure was found to decrease with increased weight. Consequently, low-weight patients may have somewhat increased exposure and patients with high weight somewhat decreased exposure. However, the differences in exposure were not considered clinically meaningful.

## **5.3 Preclinical safety data**

Non-clinical data reveal no special hazard for humans based on conventional studies of safety pharmacology, repeated dose toxicity, genotoxicity, carcinogenic potential and fertility. Dapagliflozin did not induce tumours in either mice or rats at any of the doses evaluated in two-year carcinogenicity studies.

### ***Reproductive and developmental toxicity***

Direct administration of dapagliflozin to weanling juvenile rats and indirect exposure during late pregnancy (time periods corresponding to the second and third trimesters of pregnancy with

respect to human renal maturation) and lactation are each associated with increased incidence and/or severity of renal pelvic and tubular dilatations in progeny.

In a juvenile toxicity study, when dapagliflozin was dosed directly to young rats from postnatal day 21 until postnatal day 90, renal pelvic and tubular dilatations were reported at all dose levels; pup exposures at the lowest dose tested were  $\geq 15$  times the maximum recommended human dose. These findings were associated with dose-related increases in kidney weight and macroscopic kidney enlargement observed at all doses. The renal pelvic and tubular dilatations observed in juvenile animals did not fully reverse within the approximate 1-month recovery period.

In a separate study of pre- and postnatal development, maternal rats were dosed from gestation day 6 through postnatal day 21, and pups were indirectly exposed *in utero* and throughout lactation. (A satellite study was conducted to assess dapagliflozin exposures in milk and pups.) Increased incidence or severity of renal pelvic dilatation was observed in adult offspring of treated dams, although only at the highest dose tested (associated maternal and pup dapagliflozin exposures were 1,415 times and 137 times, respectively, the human values at the maximum recommended human dose). Additional developmental toxicity was limited to dose-related reductions in pup body weights and observed only at doses  $\geq 15$  mg/kg/day (associated with pup exposures that are  $\geq 29$  times the human values at the maximum recommended human dose). Maternal toxicity was evident only at the highest dose tested, and limited to transient reductions in body weight and food consumption at dose. The no observed adverse effect level (NOAEL) for developmental toxicity, the lowest dose tested, is associated with a maternal systemic exposure multiple that is approximately 19 times the human value at the maximum recommended human dose.

In additional studies of embryo-foetal development in rats and rabbits, dapagliflozin was administered for intervals coinciding with the major periods of organogenesis in each species. Neither maternal nor developmental toxicities were observed in rabbits at any dose tested; the highest dose tested is associated with a systemic exposure multiple of approximately 1,191 times the maximum recommended human dose. In rats, dapagliflozin was neither embryo lethal nor teratogenic at exposures up to 1,441 times the maximum recommended human dose.

## **6. PHARMACEUTICAL PARTICULARS**

### **6.1 List of excipients**

#### **Dapagliflozin Tablets**

##### **CORE**

Microcrystalline cellulose

Lactose anhydrous

Crospovidone

Polysorbate 80

Methylemne chloride

Isopropyl alcohol

Colloidal silicon dioxide

Hydroxy propyl methyl cellulose

Magnesium Stearate

Talc

Polyethylene glycol 6000 PF

##### **COAT**

Opadry Yellow 85F520253

Purified water

### **6.2 Incompatibilities**

Not Applicable

### **6.3 Shelf life**

24 months

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

Not applicable

### **6.5 Nature and contents of container**

Blister pack of 3x 10's (Alu-Alu)

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

No Special requirement

**7. Marketing Authorization Holder**

MICRO LABS LIMITED

# 27 Race course road

Bangalore-560001

INDIA

**8. Number from the register of medicinal product.**

Not applicable

**9. Date of authorization or of the last renewal of the authorization**

Not applicable

**10. Date of revision of the text**

Sep 2018