

## PRODUCT MONOGRAPH

### JANUMET<sup>®</sup>

sitagliptin and metformin hydrochloride tablets

50 mg/500 mg, 50 mg/850 mg and 50 mg/1000 mg  
sitagliptin (as sitagliptin phosphate monohydrate)/metformin hydrochloride, tablets, oral

### JANUMET<sup>®</sup> XR

sitagliptin and metformin hydrochloride modified-release tablets

50 mg/500 mg, 50 mg/1000 mg, and 100 mg/1000 mg  
sitagliptin (as sitagliptin phosphate monohydrate)/metformin hydrochloride, tablets, oral

ATC Code: A10BD07

Combinations of oral blood glucose lowering drugs

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# JANUMET<sup>®</sup>

sitagliptin and metformin hydrochloride tablets  
(as sitagliptin phosphate monohydrate and metformin hydrochloride)

# JANUMET<sup>®</sup> XR

sitagliptin and metformin hydrochloride modified-release tablets  
(as sitagliptin phosphate monohydrate and metformin hydrochloride)

## PART I: HEALTH PROFESSIONAL INFORMATION

### SUMMARY PRODUCT INFORMATION

Route of Administration	Dosage Form / Strength	Clinically Relevant Non-medicinal Ingredients
Oral	Tablets: sitagliptin (as sitagliptin phosphate monohydrate) / metformin hydrochloride 50 mg/500 mg, 50 mg/850 mg, and 50 mg/1000 mg  Modified-release Tablets: immediate release sitagliptin (as sitagliptin phosphate monohydrate) / extended-release metformin hydrochloride 50 mg/500 mg, 50 mg/1000 mg, and 100 mg/1000 mg	<i>For a complete listing see <a href="#">DOSAGE FORMS, COMPOSITION AND PACKAGING</a> section.</i>

### INDICATIONS AND CLINICAL USE

JANUMET<sup>®</sup> (sitagliptin/metformin hydrochloride) and JANUMET<sup>®</sup> XR (sitagliptin/metformin hydrochloride modified-release) are indicated as an adjunct to diet and exercise to improve glycemic control in adult patients with type 2 diabetes mellitus inadequately controlled on metformin or in patients already being treated with the combination of sitagliptin and metformin.

JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR are indicated in combination with a sulfonylurea (i.e., triple combination therapy) as an adjunct to diet and exercise to improve glycemic control in adult patients with type 2 diabetes mellitus inadequately controlled on metformin and a sulfonylurea.

JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR are indicated in combination with premixed or long/intermediate acting insulin as an adjunct to diet and exercise to improve glycemic control in adult patients with type 2 diabetes mellitus inadequately controlled on metformin, and premixed or long/intermediate acting insulin.

JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR are indicated in combination with pioglitazone in adult patients with type 2 diabetes mellitus to improve glycemic control when diet and exercise, and dual therapy with metformin and pioglitazone do not provide adequate glycemic control.

See [CLINICAL TRIALS](#) section.

**Geriatrics (≥65 years of age):** JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR should be used with caution in geriatric patients. Sitagliptin and metformin are substantially excreted by the kidney. Because aging can be associated with reduced renal function, care should be taken in dose selection and should be based on careful and regular monitoring of renal function (see [WARNINGS AND PRECAUTIONS, Endocrine and Metabolism](#), and [Special Populations](#)).

**Pediatrics (<18 years of age):** Safety and effectiveness of JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR in pediatric patients have not been established. Therefore, JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR should not be used in this population.

## CONTRAINDICATIONS

- Unstable and/or insulin-dependent (type 1) diabetes mellitus.
- Acute or chronic metabolic acidosis, including diabetic ketoacidosis, with or without coma, history of ketoacidosis with or without coma.
- In patients with a history of lactic acidosis, irrespective of precipitating factors (see [WARNINGS AND PRECAUTIONS](#)).
- In the presence of severe renal impairment [estimated glomerular filtration rate (eGFR) <30 mL/min/1.73 m<sup>2</sup>], end-stage renal disease, in patients on dialysis or when renal function is not known (see [WARNINGS AND PRECAUTIONS](#)).
- In excessive alcohol intake, acute or chronic.
- In patients suffering from severe hepatic dysfunction, since severe hepatic dysfunction has been associated with some cases of lactic acidosis, JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR should not be used in patients with clinical or laboratory evidence of hepatic disease.
- In cases of cardiovascular collapse and in disease states associated with hypoxemia such as cardiorespiratory insufficiency, which are often associated with hyperlactacidemia.
- During stress conditions, such as severe infections, trauma or surgery and the recovery phase thereafter.
- In patients suffering from severe dehydration or shock.
- Known hypersensitivity to sitagliptin, metformin or to any ingredient in the formulation, including any non-medicinal ingredient, or component of the container (see [WARNINGS AND PRECAUTIONS](#) and [ADVERSE REACTIONS](#)). For a complete listing, see the [DOSAGE FORMS, COMPOSITION AND PACKAGING](#) section.
- During pregnancy and breastfeeding (see [WARNINGS AND PRECAUTIONS, Special populations](#)).

- During period around administration of iodinated contrast materials, because the use of such products may result in acute alteration of renal function (see [WARNINGS AND PRECAUTIONS](#)).

## WARNINGS AND PRECAUTIONS

### Serious Warnings and Precautions

#### Lactic Acidosis

- Lactic acidosis is a rare, but serious, metabolic complication that can occur due to metformin accumulation during treatment with JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR (see [WARNINGS AND PRECAUTIONS, Endocrine and Metabolism – Lactic Acidosis](#)).
- Patients should be cautioned against excessive alcohol intake, either acute or chronic, when taking JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR, since alcohol intake potentiates the effect of metformin on lactate metabolism (see [WARNINGS AND PRECAUTIONS, Endocrine and Metabolism – Lactic Acidosis](#)).

#### General

JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR should not be used in patients with type 1 diabetes or for the treatment of diabetic ketoacidosis.

#### Cardiovascular

##### Hypoxic States:

###### *Metformin hydrochloride*

Cardiovascular collapse (shock) from whatever cause (e.g., acute congestive heart failure, acute myocardial infarction and other conditions characterized by hypoxemia) have been associated with lactic acidosis and may also cause prerenal azotemia (see [WARNINGS AND PRECAUTIONS, Endocrine and Metabolism](#)). When such events occur in patients on JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR therapy, the drug should be promptly discontinued.

#### Endocrine and Metabolism

##### Hypoglycemia:

###### *Sitagliptin*

When sitagliptin and metformin were used in combination with a sulfonylurea or in combination with insulin, the incidence of hypoglycemia was increased over that of placebo and metformin used in combination with a sulfonylurea or in combination with insulin (see [ADVERSE REACTIONS](#)). To reduce the risk of hypoglycemia associated with these regimens, a lower dose of sulfonylurea or insulin may be considered (see [DOSAGE AND ADMINISTRATION](#)).

###### *Metformin hydrochloride*

Hypoglycemia does not occur in patients receiving metformin alone under usual circumstances of use, but could occur when caloric intake is deficient, when strenuous exercise is not compensated by caloric supplementation, or during concomitant use with other glucose-lowering agents (such as sulfonylureas and insulin) or ethanol. Elderly, debilitated, or malnourished patients and those with adrenal or pituitary insufficiency or alcohol intoxication are particularly

susceptible to hypoglycemic effects. Hypoglycemia may be difficult to recognize in the elderly, and in people who are taking  $\beta$ -adrenergic blocking drugs.

### **Hypothyroidism:**

#### *Metformin hydrochloride*

Metformin induces a reduction in thyrotropin (thyroid stimulating hormone (TSH) levels in patients with treated or untreated hypothyroidism (see [ADVERSE REACTIONS](#)). Regular monitoring of TSH levels is recommended in patients with hypothyroidism (see [WARNINGS AND PRECAUTIONS, Monitoring and Laboratory Tests](#)).

Studies have shown that metformin reduces plasma TSH levels, often to subnormal levels, when it is administered to patients with untreated hypothyroidism or to hypothyroid patients effectively treated with Levothyroxine. The metformin-induced reduction of plasma TSH levels is not observed when metformin is administered to patients with normal thyroid function. Metformin has been suggested to enhance the inhibitory modulation of thyroid hormones on TSH secretion.

Levothyroxine can reduce the hypoglycemic effect of metformin. Careful monitoring of blood glucose levels is recommended in patients with hypothyroidism treated with levothyroxine, especially when thyroid hormone therapy is initiated, changed, or stopped (see [WARNINGS AND PRECAUTIONS, Monitoring and Laboratory Tests](#) and [DRUG INTERACTIONS](#)).

### **Lactic Acidosis:**

#### *Metformin hydrochloride*

Lactic acidosis is a rare, but serious, metabolic complication that can occur due to metformin accumulation during treatment with JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR; when it occurs, it is fatal in approximately 50% of cases. Lactic acidosis may also occur in association with a number of pathophysiologic conditions, including diabetes mellitus, and whenever there is significant tissue hypoperfusion and hypoxemia. Lactic acidosis is characterized by elevated blood lactate levels (>5 mmol/L), decreased blood pH, electrolyte disturbances with an increased anion gap, and an increased lactate/pyruvate ratio. When metformin is implicated as the cause of lactic acidosis, metformin plasma levels >5  $\mu$ g/mL are generally found.

The reported incidence of lactic acidosis in patients receiving metformin hydrochloride is very low (approximately 0.03 cases/1000 patient-years, with approximately 0.015 fatal cases/1000 patient-years). Reported cases have occurred primarily in diabetic patients with significant renal impairment, including both intrinsic renal disease and renal hypoperfusion, often in the setting of multiple concomitant medical/surgical problems and multiple concomitant medications (see [DOSAGE AND ADMINISTRATION](#)).

Patients with congestive heart failure requiring pharmacologic management, in particular those with unstable or acute congestive heart failure who are at risk of hypoperfusion and hypoxemia, are at increased risk of lactic acidosis. In particular, treatment of the elderly should be accompanied by careful monitoring of renal function. The risk of lactic acidosis increases with the degree of renal dysfunction and the patient's age (see [WARNINGS AND PRECAUTIONS, Special Populations](#)). The risk of lactic acidosis may, therefore, be significantly decreased by regular monitoring of renal function in patients taking metformin and by use of the minimum effective dose of metformin.

In addition, JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR should be promptly withheld in the presence of any condition associated with hypoxemia, dehydration, or sepsis. Because impaired hepatic function may significantly limit the ability to clear lactate, metformin should generally be avoided in patients with clinical or laboratory evidence of hepatic disease.

Patients should be cautioned against excessive alcohol intake, either acute or chronic, when taking JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR, since alcohol potentiates the effects of metformin hydrochloride on lactate metabolism. In addition, JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR should be temporarily discontinued prior to any intravascular radiocontrast study and for any surgical procedure.

The onset of lactic acidosis often is subtle, and accompanied only by nonspecific symptoms such as malaise, myalgia, respiratory distress, increasing somnolence, and nonspecific abdominal distress. There may be associated hypothermia, hypotension, and resistant bradyarrhythmias with more marked acidosis. The patient and the patient's physician must be aware of the possible importance of such symptoms and the patient should be instructed to notify the physician immediately if they occur. JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR should be withdrawn until the situation is clarified. Serum electrolytes, ketones, blood glucose, and if indicated, blood pH, lactate levels, and even blood metformin levels may be useful. Once a patient is stabilized on any dose level of metformin, gastrointestinal symptoms, which are common during initiation of therapy, are unlikely to be drug related. Later occurrence of gastrointestinal symptoms could be due to lactic acidosis or other serious disease.

Levels of fasting venous plasma lactate above the upper limit of normal but less than 5 mmol/L in patients taking metformin do not necessarily indicate impending lactic acidosis and may be explainable by other mechanisms, such as poorly controlled diabetes or obesity, vigorous physical activity, or technical problems in sample handling.

Lactic acidosis should be suspected in any diabetic patient with metabolic acidosis lacking evidence of ketoacidosis (ketonuria and ketonemia).

Lactic acidosis is a medical emergency that must be treated in a hospital setting. In a patient with lactic acidosis who is taking JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR, the drug should be discontinued immediately and general supportive measures promptly instituted. Because metformin hydrochloride is dialyzable (with a clearance of up to 170 mL/min under good hemodynamic conditions), prompt hemodialysis is recommended to correct the acidosis and remove the accumulated metformin (see [CONTRAINDICATIONS](#) and [WARNINGS AND PRECAUTIONS, Cardiovascular, Hepatic/Biliary/Pancreatic and Renal](#)).

Physicians should instruct their patients to recognize the symptoms which could be a signal of the onset of lactic acidosis. If acidosis of any kind develops, JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR should be discontinued immediately and the patient should be immediately hospitalized.

### **Change in Clinical Status of Previously Controlled Diabetes Patients:**

#### *Metformin hydrochloride*

A diabetic patient previously well controlled on JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR who develops laboratory abnormalities or clinical illness (especially vague and poorly defined illness) should be evaluated promptly for evidence of ketoacidosis or lactic acidosis. Evaluation should include

serum electrolytes and ketones, blood glucose and, if indicated, blood pH, lactate, pyruvate and metformin levels. If acidosis of either form occurs, JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR must be stopped immediately and appropriate corrective measures initiated.

### **Loss of Control of Blood Glucose:**

The effectiveness of oral antidiabetic drugs in lowering blood glucose to a targeted level decreases in many patients over a period of time. This phenomenon, which may be due to progression of the underlying disease or to diminished responsiveness to the drug, is known as secondary failure, to distinguish it from primary failure in which the drug is ineffective during initial therapy. Should secondary failure occur with JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR, therapeutic alternatives should be considered.

#### *Metformin hydrochloride*

When a patient stabilized on any diabetic regimen is exposed to stress such as fever, trauma, infection, or surgery, a temporary loss of glycemic control may occur. At such times, it may be necessary to withhold JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR and temporarily administer insulin. JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR may be reinstated after the acute episode is resolved.

### **Vitamin B<sub>12</sub> Levels:**

#### *Metformin hydrochloride*

Impairment of vitamin B<sub>12</sub> absorption has been reported in some patients treated with metformin. Therefore, measurements of serum vitamin B<sub>12</sub> are advisable at least every one to two years in patients on long-term treatment with JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR.

A decrease to subnormal levels of previously normal serum vitamin B<sub>12</sub> levels, without clinical manifestations, is observed in approximately 7% of patients receiving metformin in controlled clinical trials of 28 weeks duration. Such decrease, possibly due to interference with B<sub>12</sub> absorption from the B<sub>12</sub>-intrinsic factor complex, is, however, very rarely associated with anemia and appears to be rapidly reversible with discontinuation of metformin or vitamin B<sub>12</sub> supplementation. Measurement of hematologic parameters on an annual basis is advised in patients on JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR and any apparent abnormalities should be appropriately investigated and managed (see [WARNINGS AND PRECAUTIONS, Monitoring and Laboratory Tests](#)). Certain individuals (those with inadequate vitamin B<sub>12</sub> or calcium intake or absorption) appear to be predisposed to developing subnormal vitamin B<sub>12</sub> levels.

Long-term treatment with metformin has been associated with a decrease in serum vitamin B<sub>12</sub> levels which may cause peripheral neuropathy. Serious cases of peripheral neuropathy have been reported with metformin treatment, one of the components of JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR, in the context of vitamin B<sub>12</sub> deficiency (see [ADVERSE REACTIONS](#)). Monitoring of serum vitamin B<sub>12</sub> levels is recommended (see [WARNINGS AND PRECAUTIONS, Monitoring and Laboratory Tests](#)).

### **Hematologic**

#### *Metformin hydrochloride*

Serious cases of metformin-induced hemolytic anemia, some with fatal outcome, have been reported (see [ADVERSE REACTIONS](#)). Two mechanisms were described for the metformin-induced immune hemolytic anemia; formation of an antibody against the erythrocyte-metformin



complex and autoantibody formation. Monitoring of hematologic parameters is recommended (see [WARNINGS AND PRECAUTIONS, Monitoring and Laboratory Tests](#)).

### **Hepatic/Biliary/Pancreatic**

**Hepatic:** JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR is contraindicated in patients with severe hepatic dysfunction and should not be used in patients with clinical or laboratory evidence of hepatic disease (see [CONTRAINDICATIONS](#)).

#### *Sitagliptin*

There are limited clinical experiences in patients with moderate hepatic impairment and no clinical experience in patients with severe hepatic impairment. Use in patients with severe hepatic impairment is not recommended (see [ACTION AND CLINICAL PHARMACOLOGY](#)).

#### *Metformin hydrochloride*

Impaired hepatic function has been associated with some cases of lactic acidosis.

### **Pancreatitis:**

#### *Sitagliptin*

There have been reports of acute pancreatitis, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis, in patients taking sitagliptin, one of the components of JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR. In a long-term cardiovascular outcomes trial (see [ADVERSE REACTIONS](#) and [CLINICAL TRIALS](#)), there were two adjudication-confirmed deaths due to acute pancreatitis in sitagliptin patients compared to none in the placebo group. After initiation of JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR, patients should be observed carefully for signs and symptoms of pancreatitis. If pancreatitis is suspected, JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR should promptly be discontinued and appropriate management should be initiated. Risk factors for pancreatitis include a history of: pancreatitis, gallstones, alcoholism, or hypertriglyceridemia.

#### *Metformin hydrochloride*

Serious cases of pancreatitis have been reported in patients receiving metformin (see [ADVERSE REACTIONS](#)). The reported pancreatitis cases occurred either in the context of an acute metformin overdose (see [OVERDOSAGE](#)) or in patients receiving therapeutic doses of metformin with concurrent renal failure and/or lactic acidosis, indicating metformin accumulation.

### **Immune**

#### **Hypersensitivity Reactions:**

#### *Sitagliptin*

There have been post-marketing reports of serious hypersensitivity reactions in patients treated with sitagliptin, one of the components of JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR. These reactions include anaphylaxis, angioedema, and exfoliative skin conditions including Stevens-Johnson syndrome. Onset of these reactions occurred within the first 3 months after initiation of treatment with sitagliptin, with some reports occurring after the first dose. If a hypersensitivity reaction is suspected, discontinue JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR, assess for other potential causes for the event, and institute alternative treatment for diabetes (see [CONTRAINDICATIONS](#) and [ADVERSE REACTIONS](#)).

## **Immunocompromised Patients:**

### *Sitagliptin*

A dose-related mean decrease in absolute lymphocyte count was observed with other dipeptidyl peptidase 4 (DPP-4) inhibitors. When clinically indicated, such as in settings of unusual or prolonged infection, lymphocyte count should be measured. The effect of sitagliptin, a component of JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR, on lymphocyte counts in patients with lymphocyte abnormalities (e.g. human immunodeficiency virus) is unknown.

Immunocompromised patients, such as patients who have undergone organ transplantation or patients diagnosed with human immunodeficiency syndrome have not been studied in the sitagliptin clinical program. Therefore, the efficacy and safety profile of sitagliptin in these patients has not been established.

## **Monitoring and Laboratory Tests**

**Blood Glucose and HbA<sub>1c</sub>:** Response to JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR treatment should be monitored by periodic measurements of blood glucose and HbA<sub>1c</sub> levels.

**Hematology:** Initial and periodic monitoring of hematologic parameters (e.g., hemoglobin/hematocrit and red blood cell indices) should be performed, regularly. While megaloblastic anemia has rarely been seen with metformin therapy, if this is suspected, vitamin B<sub>12</sub> deficiency should be excluded. Periodic measurements of serum vitamin B<sub>12</sub> levels should be performed in patients on long-term treatment with JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR, especially in patients with anemia or neuropathy (see [WARNINGS AND PRECAUTIONS, Endocrine and Metabolism](#)).

A close monitoring of the International Normalized Ratio (INR) is recommended in patients concurrently administering metformin and phenprocoumon or other antivitamin K anticoagulants (see [DRUG INTERACTIONS](#)).

**Hypothyroidism:** Regular monitoring of thyroid-stimulating hormone (TSH) levels is recommended in patients with hypothyroidism.

For hypothyroid patients treated with levothyroxine, careful monitoring of blood glucose levels is recommended, especially when thyroid hormone therapy is initiated, changed, or stopped (see [WARNINGS AND PRECAUTIONS, Endocrine and Metabolism](#), and [DRUG INTERACTIONS](#)).

**Renal Function:** JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR are contraindicated in patients with an estimated glomerular rate (eGFR) <30 mL/min/1.73 m<sup>2</sup> (see [CONTRAINDICATIONS](#)). Renal function must be assessed prior to initiation of JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR and periodically thereafter, with more frequent monitoring in patients whose eGFR decreases to less than 60 mL/min/1.73 m<sup>2</sup> (see [DOSAGE AND ADMINISTRATION](#)).

Monitoring of renal function is recommended prior to and following initiation of any concomitant drug which might have an impact on renal function (see [DRUG INTERACTIONS](#)).

## **Neurologic**

### *Metformin hydrochloride*

Serious cases of metformin-induced encephalopathy have been reported (see [ADVERSE REACTIONS](#)). Some of these cases were reported without association with lactic acidosis, hypoglycemia, or renal impairment.

## **Peri-Operative Consideration**

### *Metformin hydrochloride*

JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR therapy should be temporarily suspended for any surgical procedure (except minor procedures not associated with restricted intake of food and fluids). JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR should be discontinued 2 days before surgical intervention and should not be restarted until the patient's oral intake has resumed and renal function has been evaluated as acceptable and found to be stable (see [DOSAGE AND ADMINISTRATION](#)).

## **Renal**

JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR are contraindicated in patients with severe renal impairment (eGFR <30 mL/min/1.73 m<sup>2</sup>) (see [CONTRAINDICATIONS](#)).

Before initiation of JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR therapy and regularly thereafter, renal function must be assessed. In patients with eGFR less than 60 mL/min/1.73m<sup>2</sup>, more intensive monitoring for glycemic and renal biomarkers and signs and symptoms of renal dysfunction is recommended, especially if the eGFR is less than 45 mL/min/1.73 m<sup>2</sup> (see [WARNINGS AND PRECAUTIONS, Monitoring and Laboratory Tests](#) and [DOSAGE AND ADMINISTRATION](#)).

In patients in whom development of renal dysfunction is anticipated, renal function should be assessed more frequently and JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR discontinued if evidence of renal impairment is present.

Special caution should be exercised in situations where renal function may become impaired, for example in the elderly, in the case of dehydration when initiating antihypertensive therapy or diuretic therapy or when starting therapy with a non-steroidal anti-inflammatory drug (NSAID). Therefore, consider more frequent monitoring of patients.

### *Sitagliptin*

Sitagliptin is renally excreted. Renal adverse events, including acute renal failure, have been observed during clinical trials and post-marketing use of sitagliptin, a component of JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR, in patients with and without known risk factors (see [ADVERSE REACTIONS](#)).

### *Metformin hydrochloride*

Metformin is known to be substantially excreted by the kidney, and the risk of metformin accumulation and lactic acidosis increases with the degree of impairment of renal function.

### Use of concomitant medications that may affect renal function or metformin disposition:

Concomitant medication(s) that may affect renal function or result in significant hemodynamic change or may interfere with the disposition of metformin, such as cationic drugs, that are eliminated by renal tubular secretion (see [DRUG INTERACTIONS](#)) should be used with caution. The concomitant use of JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR with these specific drugs may

increase the risk of metformin-associated lactic acidosis and therefore, consider more frequent monitoring of patients.

Radiologic studies involving the use of intravascular iodinated contrast materials (for example, intravenous urogram, intravenous cholangiography, angiography, and computed tomography (CT) scans with intravascular contrast materials): Intravascular contrast studies with iodinated materials can lead to acute alteration of renal function and have been associated with lactic acidosis in patients receiving metformin (see [CONTRAINDICATIONS](#)). Therefore, in patients with an eGFR  $\geq 30$  to  $< 60$  mL/min/1.73 m<sup>2</sup>, in patients with a history of hepatic impairment, alcoholism, or heart failure, or in patients who will be administered intra-arterial iodinated contrast, JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR should be discontinued at the time of or prior to the procedure, and withheld for 48 hours subsequent to the procedure and reinstated only after renal function has been re-evaluated and found to be acceptable and stable (see [DOSAGE AND ADMINISTRATION](#)).

## **Skin**

### *Sitagliptin*

With other members of this class, DPP-4 inhibitors, ulcerative and necrotic skin lesions have been reported in monkeys in non-clinical toxicology studies. There is limited experience in patients with diabetic skin complications with sitagliptin, a component of JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR. In keeping with routine care of the diabetic patient, monitoring for skin disorders is recommended.

**Bullous Pemphigoid:** Post-marketing cases of bullous pemphigoid requiring hospitalization have been reported with the use of DPP-4 inhibitors, including sitagliptin, a component of JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR. In reported cases, patients typically recovered with topical or systemic immunosuppressive treatment and discontinuation of the DPP-4 inhibitor. Tell patients to report development of blisters or erosions while receiving JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR. If bullous pemphigoid is suspected, JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR should be discontinued and referral to a dermatologist should be considered for diagnosis and appropriate treatment.

## **Special Populations**

**Pregnant Women:** JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR are contraindicated in pregnancy (see [CONTRAINDICATIONS](#)). There are no adequate and well-controlled studies in pregnant women with JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR or their individual components; therefore, the safety of JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR in pregnant women is not known. When pregnancy is detected, JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR should be discontinued.

### *Sitagliptin*

There are very limited data for the use of sitagliptin in pregnant women in clinical studies, including no adequate and well-controlled studies in this population; therefore, the safety of sitagliptin in pregnant women is not known.

### *Metformin hydrochloride*

Metformin was not teratogenic in rats and rabbits at doses up to 600 mg/kg/day, or about two and six times the maximum recommended human daily dose on a body surface area basis. Determination of fetal concentrations demonstrated a partial placental barrier to metformin.

Because animal reproduction studies are not always predictive of human response, JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR are contraindicated during pregnancy (see [CONTRAINDICATIONS](#)).

**Nursing Women:** JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR are contraindicated during breast-feeding (see [CONTRAINDICATIONS](#)). No studies in lactating animals have been conducted with the combined components of JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR. Both sitagliptin and metformin are present in the milk of lactating rats. Metformin hydrochloride is also excreted into human breast milk in very small amounts but it is not known whether sitagliptin is secreted in human milk. Therefore, JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR should not be used by a woman during breastfeeding.

**Pediatrics (<18 years of age):** Safety and effectiveness of JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR in pediatric patients have not been established. Therefore, JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR should not be used in this population.

**Geriatrics (≥65 years of age):** Because sitagliptin and metformin are substantially excreted by the kidney and because aging can be associated with reduced renal function, JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR should be used with caution as age increases. Care should be taken in dose selection and should be based on careful and regular monitoring of renal function (see [WARNINGS AND PRECAUTIONS, Renal](#), and [DOSAGE AND ADMINISTRATION](#)).

#### *Sitagliptin*

In clinical studies, no overall differences in safety or effectiveness were observed between subjects 65 years and over and younger subjects. While this and other reported clinical experience have not identified differences in responses between the geriatric and younger patients, greater sensitivity of some older individuals cannot be ruled out. Renal function should be assessed prior to initiating dosing and periodically thereafter in geriatric patients (see [DOSAGE AND ADMINISTRATION](#) and [ACTION AND CLINICAL PHARMACOLOGY](#)).

#### *Metformin hydrochloride*

Controlled clinical studies of metformin did not include sufficient numbers of elderly patients to determine whether they respond differently from younger patients, although other reported clinical experience has not identified differences in responses between the elderly and younger patients. The risk of metformin-associated lactic acidosis increases with the patient's age because elderly patients have a greater likelihood of having hepatic, renal, or cardiac impairment than younger patients. Assess renal function more frequently in elderly patients.

## **ADVERSE REACTIONS**

### **Adverse Drug Reaction Overview**

#### *Sitagliptin*

Sitagliptin was generally well tolerated in controlled clinical studies as monotherapy and as part of a combination therapy with metformin or combination therapy with metformin and a sulfonylurea or combination therapy with metformin, insulin and pioglitazone.

The incidences of serious adverse reactions and discontinuation of therapy due to clinical adverse reactions were generally similar to placebo. The most frequent adverse events in trials of sitagliptin as monotherapy (placebo-controlled) and as add-on combination therapy with

metformin (reported regardless of causality and more common with sitagliptin than other treatments) was nasopharyngitis. The most frequent adverse reaction with sitagliptin as add-on combination therapy with metformin and a sulfonylurea agent or with metformin and insulin was hypoglycemia.

#### *Metformin hydrochloride*

The adverse events most commonly associated with metformin (sitagliptin/metformin) are diarrhea, nausea, and upset stomach. Similar adverse reactions were seen in patients treated with modified-release metformin products. Lactic acidosis is a rare, but serious side effect. Lactic acidosis is fatal in approximately 50% of cases.

**Lactic Acidosis:** very rare (<1/10,000 and isolated reports) (see [WARNINGS AND PRECAUTIONS](#) and [OVERDOSAGE](#)).

**Gastrointestinal Reactions:** very common (>1/10): Gastrointestinal symptoms (diarrhea, nausea, vomiting, abdominal bloating, flatulence, and anorexia) are the most common reactions to metformin and are approximately 30% more frequent in patients on metformin monotherapy than in placebo-treated patients, particularly during initiation of metformin therapy. These symptoms are generally transient and resolve spontaneously during continued treatment. Occasionally, temporary dose reduction may be useful.

Because gastrointestinal symptoms during therapy initiation appear to be dose-related, they may be decreased by gradual dose escalation and by having patients take metformin (metformin hydrochloride) with meals (see [DOSAGE AND ADMINISTRATION](#)).

Because significant diarrhea and/or vomiting can cause dehydration and prerenal azotemia, metformin should be temporarily discontinued, under such circumstances.

For patients who have been stabilized on metformin, nonspecific gastrointestinal symptoms should not be attributed to therapy unless intercurrent illness or lactic acidosis have been excluded.

**Special Senses:** common ( $\geq 1/100$ ): During initiation of metformin therapy complaints of taste disturbance are common, i.e. metallic taste.

**Dermatologic Reactions:** very rare (<1/10,000 and isolated reports): The incidence of rash/dermatitis in controlled clinical trials was comparable to placebo for metformin monotherapy and to sulfonylurea for metformin /sulfonylurea therapy. Reports of skin reactions such as erythema, pruritus, and urticaria are very rare.

**Hematologic:** Decrease of vitamin B<sub>12</sub> absorption with decrease of serum levels during long-term use of metformin is rare ( $\geq 1/10,000$  and <1/1,000). Consideration of such etiology is recommended if a patient presents with megaloblastic anemia.

**Hepatic:** very rare (<1/10,000 and isolated reports): Liver function tests abnormalities or hepatitis resolving upon metformin discontinuation has been documented in isolated reports.

## **Clinical Trial Adverse Drug Reactions**

*Because clinical trials are conducted under very specific conditions the adverse reaction rates observed in the clinical trials may not reflect the rates observed in practice and should not be compared to the rates in the clinical trials of another drug. Adverse drug reaction information from clinical trials is useful for identifying drug-related adverse events and for approximating rates.*

### **Combination Therapy – Sitagliptin Add-on to Metformin:**

In a 24-week placebo-controlled clinical study of patients receiving sitagliptin (100 mg daily) as add-on combination therapy with metformin, the incidence of adverse events, reported regardless of causality assessment, in  $\geq 1\%$  of patients are shown in Table 1.

**Table 1 – Adverse Events  $\geq 1\%$  in Any Treatment Group (regardless of causality) Reported in Patients in a 24-week Placebo-Controlled, Double-Blind Clinical Trial of Sitagliptin in Add-on Combination Use with Metformin**

Body system/Organ class Adverse event	Number of patients (%)	
	Sitagliptin 100 mg + Metformin n=464	Placebo + Metformin n=237
<b>Ear and labyrinth disorders</b>		
Vertigo	5 (1.1)	4 (1.7)
<b>Eye disorders</b>		
Vision blurred	1 (0.2)	3 (1.3)
<b>Gastrointestinal disorders</b>		
Abdominal pain	2 (0.4)	6 (2.5)
Abdominal pain upper	6 (1.3)	2 (0.8)
Constipation	5 (1.1)	1 (0.4)
Diarrhea	11 (2.4)	6 (2.5)
Nausea	6 (1.3)	2 (0.8)
Vomiting	5 (1.1)	2 (0.8)
<b>General disorders and administration site conditions</b>		
Fatigue	2 (0.4)	4 (1.7)
Edema peripheral	4 (0.9)	3 (1.3)
<b>Infections and infestations</b>		
Bronchitis	12 (2.6)	6 (2.5)
Bronchitis acute	2 (0.4)	3 (1.3)
Gastroenteritis	4 (0.9)	5 (2.1)
Influenza	19 (4.1)	12 (5.1)
Nasopharyngitis	19 (4.1)	7 (3.0)
Pharyngitis	6 (1.3)	1 (0.4)
Pneumonia	5 (1.1)	0 (0.0)
Sinusitis	7 (1.5)	2 (0.8)
Tooth infection	5 (1.1)	2 (0.8)
Upper respiratory tract infection	34 (7.3)	22 (9.3)
Urinary tract infection	9 (1.9)	2 (0.8)
<b>Injury, poisoning and procedural complications</b>		
Contusion	5 (1.1)	1 (0.4)
<b>Investigations</b>		

**Table 1 – Adverse Events  $\geq 1\%$  in Any Treatment Group (regardless of causality) Reported in Patients in a 24-week Placebo-Controlled, Double-Blind Clinical Trial of Sitagliptin in Add-on Combination Use with Metformin**

Body system/Organ class Adverse event	Number of patients (%)	
	Sitagliptin 100 mg + Metformin n=464	Placebo + Metformin n=237
Blood glucose increased	3 (0.6)	6 (2.5)
<b>Metabolism and nutrition disorders</b>		
Hyperglycemia	2 (0.4)	7 (3.0)
Hypoglycemia	6 (1.3)	5 (2.1)
<b>Musculoskeletal and connective tissue disorders</b>		
Arthralgia	14 (3.0)	1 (0.4)
Back pain	15 (3.2)	6 (2.5)
Muscle spasm	1 (0.2)	3 (1.3)
Myalgia	1 (0.2)	3 (1.3)
Pain in extremity	5 (1.1)	4 (1.7)
Shoulder pain	3 (0.6)	3 (1.3)
<b>Nervous system disorders</b>		
Dizziness	7 (1.5)	2 (0.8)
Headache	12 (2.6)	7 (3.0)
Sciatica	1 (0.2)	3 (1.3)
Sinus headache	0 (0.0)	3 (1.3)
<b>Psychiatric disorders</b>		
Insomnia	5 (1.1)	3 (1.3)
<b>Renal and urinary disorders</b>		
Nephrolithiasis	3 (0.6)	3 (1.3)
<b>Respiratory, thoracic and mediastinal disorders</b>		
Cough	14 (3.0)	4 (1.7)
<b>Vascular disorders</b>		
Hypertension	7 (1.5)	6 (2.5)

Nausea was the only drug-related adverse reaction reported by the investigator that occurred with an incidence  $\geq 1\%$  in patients receiving sitagliptin (1.1%) and greater than in patients receiving placebo (0.4%).

In pooled studies of up to one year duration which compared sitagliptin added to metformin or a sulfonylurea agent (glipizide) added to metformin, adverse events, reported regardless of causality assessment, in  $\geq 1\%$  of patients are shown in Table 2.



**Table 2 – Adverse Events  $\geq 1\%$  in Any Treatment Group (regardless of causality) Reported in Patients from Double-Blind Clinical Trials of Sitagliptin in Add-on Combination Use with Metformin in Studies Up to One Year Compared to a Sulfonylurea Agent (Glipizide)**

Body system/Organ class Adverse event	Number of patients (%)	
	Sitagliptin 100 mg + Metformin n=979	Glipizide + Metformin n=748
<b>Gastrointestinal disorders</b>		
Abdominal pain	10 (1.0)	6 (0.8)
Abdominal pain upper	13 (1.3)	7 (0.9)
Constipation	17 (1.7)	13 (1.7)
Diarrhea	42 (4.3)	36 (4.8)
Dyspepsia	14 (1.4)	12 (1.6)
Nausea	19 (1.9)	16 (2.1)
Toothache	2 (0.2)	13 (1.7)
Vomiting	11 (1.1)	9 (1.2)
<b>General disorders and administration site conditions</b>		
Fatigue	20 (2.0)	8 (1.1)
Non-cardiac chest pain	10 (1.0)	6 (0.8)
Edema peripheral	16 (1.6)	14 (1.9)
<b>Infections and infestations</b>		
Bronchitis	27 (2.8)	22 (2.9)
Cellulitis	7 (0.7)	10 (1.3)
Gastroenteritis	19 (1.9)	13 (1.7)
Gastroenteritis viral	8 (0.8)	9 (1.2)
Herpes zoster	4 (0.4)	8 (1.1)
Influenza	35 (3.6)	32 (4.3)
Nasopharyngitis	75 (7.7)	49 (6.6)
Sinusitis	20 (2.0)	12 (1.6)
Upper respiratory tract infection	78 (8.0)	70 (9.4)
Urinary tract infection	41 (4.2)	21 (2.8)
<b>Investigations</b>		
Blood glucose decreased	5 (0.5)	16 (2.1)
Blood glucose increased	13 (1.3)	5 (0.7)
Weight increased	1 (0.1)	8 (1.1)
<b>Metabolism and nutrition disorders</b>		
Hyperglycemia	10 (1.0)	6 (0.8)
Hypoglycemia	32 (3.3)	217 (29.0)
<b>Musculoskeletal and connective tissue disorders</b>		
Arthralgia	34 (3.5)	29 (3.9)
Back pain	39 (4.0)	32 (4.3)
Muscle spasms	9 (0.9)	8 (1.1)
Neck pain	4 (0.4)	8 (1.1)
Osteoarthritis	18 (1.8)	5 (0.7)
Pain in extremity	23 (2.3)	9 (1.2)
Shoulder pain	7 (0.7)	14 (1.9)
<b>Nervous system disorders</b>		
Dizziness	26 (2.7)	14 (1.9)
Headache	34 (3.5)	31 (4.1)
Hypoaesthesia	3 (0.3)	11 (1.5)
<b>Psychiatric disorders</b>		

**Table 2 – Adverse Events  $\geq 1\%$  in Any Treatment Group (regardless of causality) Reported in Patients from Double-Blind Clinical Trials of Sitagliptin in Add-on Combination Use with Metformin in Studies Up to One Year Compared to a Sulfonylurea Agent (Glipizide)**

Body system/Organ class Adverse event	Number of patients (%)	
	Sitagliptin 100 mg + Metformin n=979	Glipizide + Metformin n=748
Anxiety	13 (1.3)	7 (0.9)
Depression	10 (1.0)	7 (0.9)
Insomnia	12 (1.2)	11 (1.5)
<b>Reproductive system and breast disorders</b>		
Erectile dysfunction	6 (0.6)	8 (1.1)
<b>Respiratory, thoracic and mediastinal disorders</b>		
Cough	19 (1.9)	23 (3.1)
Pharyngolaryngeal pain	10 (1.0)	9 (1.2)
Sinus congestion	5 (0.5)	8 (1.1)
Eczema	4 (0.4)	12 (1.6)
<b>Vascular disorders</b>		
Hypertension	33 (3.4)	29 (3.9)

Combination Therapy: Sitagliptin Add-on to Metformin and a Sulfonylurea

In a 24-week placebo-controlled study of sitagliptin 100 mg in combination with metformin and glimepiride (sitagliptin, N=116; placebo, N=113), the incidence of adverse events, reported regardless of causality assessment, in  $\geq 1\%$  of patients are shown in Table 3. The overall incidence of adverse events with sitagliptin was higher than with placebo, in part related to higher incidence of hypoglycemia (see Table 3).

**Table 3 – Adverse Events  $\geq 1\%$  in Any Treatment Group (regardless of causality) Reported in Patients in a 24-Week Placebo-Controlled, Double-Blind Clinical Trial of Sitagliptin Add-on Combination Use with Metformin and a Sulfonylurea Agent (Glimepiride)**

Body system/Organ class Adverse event	Number of patients (%)	
	Sitagliptin 100 mg + Metformin + Glimepiride n=116	Placebo + Metformin + Glimepiride n=113
<b>Ear and Labyrinth Disorders</b>		
Vertigo	2 (1.7)	0 (0.0)
<b>Eye Disorders</b>		
Diabetic retinopathy	0 (0.0)	2 (1.8)
Vision blurred	0 (0.0)	2 (1.8)
<b>Gastrointestinal disorders</b>		
Abdominal pain upper	2 (1.7)	2 (1.8)
Constipation	4 (3.4)	0 (0.0)
Diarrhea	1 (0.9)	4 (3.5)
Dyspepsia	3 (2.6)	2 (1.8)
Gastritis	0 (0.0)	4 (3.5)
Toothache	2 (1.7)	2 (1.8)
Vomiting	2 (1.7)	1 (0.9)
<b>General disorders and administration site conditions</b>		

**Table 3 – Adverse Events ≥1% in Any Treatment Group (regardless of causality) Reported in Patients in a 24-Week Placebo-Controlled, Double-Blind Clinical Trial of Sitagliptin Add-on Combination Use with Metformin and a Sulfonylurea Agent (Glimepiride)**

Body system/Organ class Adverse event	Number of patients (%)	
	Sitagliptin 100 mg + Metformin + Glimepiride n=116	Placebo + Metformin + Glimepiride n=113
Fatigue	0 (0.0)	3 (2.7)
Non-Cardiac chest pain	2 (1.7)	1 (0.9)
Pyrexia	0 (0.0)	2 (1.8)
<b>Hepatobiliary disorders</b>		
Cholelithiasis	0 (0.0)	2 (1.8)
<b>Infections and infestations</b>		
Bronchitis	2 (1.7)	2 (1.8)
Gastroenteritis	3 (2.6)	0 (0.0)
Gastroenteritis viral	2 (1.7)	2 (1.8)
Influenza	3 (2.6)	2 (1.8)
Nasopharyngitis	7 (6.0)	9 (8.0)
Pharyngitis	1 (0.9)	3 (2.7)
Pneumonia	3 (2.6)	0 (0.0)
Rhinitis	2 (1.7)	0 (0.0)
Sinusitis	1 (0.9)	2 (1.8)
Tooth abscess	2 (1.7)	1 (0.9)
Upper respiratory tract infection	8 (6.9)	9 (8.0)
Urinary tract infection	2 (1.7)	1 (0.9)
<b>Injury, poisoning and procedural complications</b>		
Fall	0 (0.0)	3 (2.7)
Polytraumatism	1 (0.9)	2 (1.8)
<b>Investigations</b>		
Blood glucose decreased	0 (0.0)	2 (1.8)
<b>Metabolism and nutrition disorders</b>		
Hypoglycemia	19 (16.4)	1 (0.9)
<b>Musculoskeletal and connective tissue disorders</b>		
Arthralgia	5 (4.3)	1 (0.9)
Back pain	1 (0.9)	2 (1.8)
Muscle spasms	2 (1.7)	1 (0.9)
Osteoarthritis	2 (1.7)	0 (0.0)
Pain in extremity	4 (3.4)	1 (0.9)
Shoulder pain	0 (0.0)	2 (1.8)
<b>Nervous system disorders</b>		
Dizziness	3 (2.6)	1 (0.9)
Headache	8 (6.9)	3 (2.7)
Hypoaesthesia	2 (1.7)	0 (0.0)
Somnolence	0 (0.0)	2 (1.8)
<b>Respiratory, thoracic and mediastinal disorders</b>		
Asthma	2 (1.7)	1 (0.9)
<b>Skin and subcutaneous tissue disorders</b>		
Pruritus	2 (1.7)	1 (0.9)

**Table 3 – Adverse Events  $\geq 1\%$  in Any Treatment Group (regardless of causality) Reported in Patients in a 24-Week Placebo-Controlled, Double-Blind Clinical Trial of Sitagliptin Add-on Combination Use with Metformin and a Sulfonylurea Agent (Glimepiride)**

Body system/Organ class Adverse event	Number of patients (%)	
	Sitagliptin 100 mg + Metformin + Glimepiride n=116	Placebo + Metformin + Glimepiride n=113
Rash	2 (1.7)	1 (0.9)
<b>Vascular disorders</b>		
Hypertension	2 (1.7)	0 (0.0)

In a combination therapy study with metformin and a sulfonylurea, hypoglycemia (sitagliptin 13.8%; placebo 0.9%) and constipation (sitagliptin 1.7%; placebo 0.0%) were the only drug-related adverse reactions reported by the investigator that occurred with an incidence  $\geq 1\%$  in patients receiving sitagliptin and metformin and a sulfonylurea and greater than in patients receiving placebo and metformin and a sulfonylurea.

Combination Therapy: Add-on to Metformin and Insulin

In a 24-week placebo-controlled study of sitagliptin 100 mg once daily added to ongoing combination treatment with metformin and insulin (sitagliptin, N=229; placebo, N=233), the only adverse experience reported regardless of causality assessment in  $\geq 5\%$  of patients treated with sitagliptin and more commonly than in patients treated with placebo was hypoglycemia (sitagliptin 15.3%; placebo 8.2%).

**Table 4 – Adverse Events  $\geq 1\%$  in Any Treatment Group (regardless of causality) Reported in Patients in a 24-Week Placebo-Controlled, Double-Blind Clinical Trial of Sitagliptin in Add-on Combination Use with Metformin and Insulin**

Body system/Organ class Adverse event	Number of patients (%)	
	Sitagliptin 100 mg + Metformin + Insulin n=229	Placebo + Metformin + Insulin n=233
<b>Gastrointestinal Disorders</b>		
Constipation	4 (1.7)	0 (0.0)
Diarrhea	4 (1.7)	4 (1.7)
Nausea	2 (0.9)	4 (1.7)
Vomiting	4 (1.7)	2 (0.9)
<b>General disorders and administration site conditions</b>		
Asthenia	3 (1.3)	1 (0.4)
Fatigue	0 (0.0)	3 (1.3)
<b>Infections and infestations</b>		
Bronchitis	5 (2.2)	4 (1.7)
Gastroenteritis	1 (0.4)	3 (1.3)
Influenza	9 (3.9)	9 (3.9)
Nasopharyngitis	7 (3.1)	7 (3.0)
Respiratory tract infection	3 (1.3)	2 (0.9)
Sinusitis	2 (0.9)	4 (1.7)
Upper respiratory tract infection	8 (3.5)	10 (4.3)
Urinary tract infection	5 (2.2)	5 (2.1)
Viral infection	0 (0.0)	3 (1.3)

	Number of patients (%)	
Body system/Organ class Adverse event	Sitagliptin 100 mg + Metformin + Insulin n=229	Placebo + Metformin + Insulin n=233
<b>Investigations</b>		
Creatinine renal clearance decreased	3 (1.3)	0 (0.0)
<b>Metabolism and nutrition disorders</b>		
Hypoglycemia	35 (15.3)	19 (8.2)
<b>Musculoskeletal and connective tissue disorders</b>		
Arthralgia	1 (0.4)	5 (2.1)
Muscle spasms	0 (0.0)	4 (1.7)
Musculoskeletal pain	2 (0.9)	3 (1.3)
Pain in extremity	4 (1.7)	2 (0.9)
<b>Nervous system disorders</b>		
Dizziness	2 (0.9)	3 (1.3)
Headache	3 (1.3)	2 (0.9)
<b>Respiratory, thoracic and mediastinal disorders</b>		
Cough	2 (0.9)	3 (1.3)

#### Combination Therapy: Sitagliptin Add-on to Metformin and Pioglitazone

In a 26-week placebo-controlled clinical study of patients receiving sitagliptin (100 mg daily) as add-on combination therapy with metformin and pioglitazone, the incidence of adverse events reported regardless of causality assessment, in  $\geq 1\%$  of patients are shown in Table 5.

**Table 5 – Adverse Events  $\geq 1\%$  in Any Treatment Group (regardless of causality) Reported in Patients in a 26-Week Placebo-Controlled, Double-Blind Clinical Trial of Sitagliptin in Add-on Combination Use with Metformin and Pioglitazone**

	Number of patients (%)	
Body system/Organ class Adverse event	Sitagliptin 100 mg + Metformin + Pioglitazone n=157	Placebo + Metformin + Pioglitazone n=156
<b>Ear and Labyrinth Disorders</b>		
Cerumen impaction	2 (1.3)	1 (0.6)
<b>Eye Disorders</b>		
Conjunctivitis	3 (1.9)	1 (0.6)
Ocular hyperaemia	0 (0.0)	2 (1.3)
<b>Gastrointestinal disorders</b>		
Abdominal pain upper	1 (0.6)	2 (1.3)
Constipation	2 (1.3)	1 (0.6)
Dental Caries	2 (1.3)	1 (0.6)
Diarrhea	3 (1.9)	4 (2.6)
Dyspepsia	1 (0.6)	2 (1.3)
Gastritis	0 (0.0)	2 (1.3)
Toothache	2 (1.3)	0 (0.0)
Vomiting	2 (1.3)	0 (0.0)
<b>General disorders and administration site conditions</b>		

**Table 5 – Adverse Events ≥1% in Any Treatment Group (regardless of causality) Reported in Patients in a 26-Week Placebo-Controlled, Double-Blind Clinical Trial of Sitagliptin in Add-on Combination Use with Metformin and Pioglitazone**

Body system/Organ class Adverse event	Number of patients (%)	
	Sitagliptin 100 mg + Metformin + Pioglitazone n=157	Placebo + Metformin + Pioglitazone n=156
Fatigue	0 (0.0)	2 (1.3)
Oedema peripheral	3 (1.9)	7 (4.5)
<b>Infections and infestations</b>		
Bronchitis	3 (1.9)	1 (0.6)
Cellulitis	2 (1.3)	0 (0.0)
Gastroenteritis	2 (1.3)	0 (0.0)
Gastroenteritis viral	2 (1.3)	0 (0.0)
Herpes zoster	2 (1.3)	0 (0.0)
Influenza	2 (1.3)	3 (1.9)
Nasopharyngitis	5 (3.2)	5 (3.2)
Tooth abscess	0 (0.0)	2 (1.3)
Upper respiratory tract infection	13 (8.3)	14 (9.0)
Urinary tract infection	5 (3.2)	6 (3.8)
<b>Injury, poisoning and procedural complications</b>		
Muscle strain	2 (1.3)	0 (0.0)
<b>Investigations</b>		
Blood creatine phosphokinase increased	1 (0.6)	3 (1.9)
Glomerular filtration rate decreased	2 (1.3)	0 (0.0)
Lymphocyte count increased	2 (1.3)	1 (0.6)
Neutrophil count decreased	2 (1.3)	1 (0.6)
<b>Metabolism and nutrition disorders</b>		
Hyperglycemia	2 (1.3)	2 (1.3)
Hypoglycemia	10 (6.4)	7 (4.5)
<b>Musculoskeletal and connective tissue disorders</b>		
Arthralgia	2 (1.3)	3 (1.9)
Back pain	7 (4.5)	4 (2.6)
Muscle spasms	2 (1.3)	0 (0.0)
Musculoskeletal pain	3 (1.9)	4 (2.6)
Pain in extremity	5 (3.2)	2 (1.3)
<b>Nervous system disorders</b>		
Headache	1 (0.6)	2 (1.3)
<b>Psychiatric disorders</b>		
Depression	4 (2.5)	1 (0.6)
Stress	2 (1.3)	0 (0.0)
<b>Respiratory, thoracic and mediastinal disorders</b>		
Cough	2 (1.3)	2 (1.3)
Oropharyngeal pain	2 (1.3)	0 (0.0)
Rhinitis allergic	2 (1.3)	0 (0.0)

In a combination therapy study with metformin and pioglitazone, hypoglycemia (sitagliptin 3.2%; placebo 1.9%), was the only drug-related adverse reaction reported by the investigator that

occurred with an incidence  $\geq 1\%$  in patients receiving sitagliptin and greater than in patients receiving placebo.

**Less Common Clinical Trial Adverse Drug Reactions  $\geq 0.1\%$  and  $< 1\%$  (Drug-Related and Greater than Placebo)**

**Blood and Lymphatic System Disorders:** anemia

**Cardiac Disorders:** bundle branch block, palpitations

**Eye Disorders:** vision blurred

**Gastrointestinal Disorders:** abdominal discomfort, abdominal pain upper, abdominal tenderness, constipation, diarrhea, dry mouth, dyspepsia, flatulence, irritable bowel syndrome, reflux esophagitis disease, frequent bowel movements, retching, salivary hypersecretion

**General Disorders and Administration Site Conditions:** asthenia, chest discomfort, face edema, hunger, irritability, malaise, peripheral edema, pain, pyrexia, thirst, xerosis

**Hepatobiliary Disorders:** hepatic steatosis

**Infections and Infestations:** gastric ulcer helicobacter, genital abscess, helicobacter gastritis, localized infection, oropharyngeal candidiasis, upper respiratory tract infection, urinary tract infection

**Investigations:** alanine aminotransferase increased, aspartate aminotransferase increased, blood glucose decreased, blood glucose increased, blood pressure decreased, blood pressure increased, creatinine renal clearance decreased, glomerular filtration rate decreased, white blood cell count increased

**Metabolism and Nutrition Disorders:** decreased appetite, hypoglycemia

**Musculoskeletal and Connective Tissue Disorders:** muscle tightness, muscle fatigue

**Nervous System Disorders:** coordination abnormal, dizziness, headache, migraine, neuropathy peripheral, parosmia, somnolence

**Psychiatric Disorders:** anxiety, depression, insomnia, libido decreased

**Renal and Urinary Disorders:** renal disorders

**Reproductive System and Breast Disorders:** balanoposthitis, dysmenorrhea, erectile dysfunction

**Respiratory, Thoracic and Mediastinal Disorders:** cough

**Skin and Subcutaneous Tissue Disorders:** angioneurotic oedema, dermatitis acneiform, dry skin, erythema, exanthem, hyperhidrosis, leukocytoclastic vasculitis, nail disorder, prurigo, pruritus generalized, rash, rash macular, rosacea, urticaria

**Vascular Disorders:** orthostatic hypotension

**Atrial fibrillation/atrial flutter:** In a pooled analysis of randomized clinical trials, the pooled terms atrial fibrillation/atrial flutter were observed at an incidence rate of 0.45 events per 100 patient-years in the sitagliptin-exposed group compared to 0.28 events per 100 patient-years in the non-exposed group.

**TECOS Cardiovascular Safety Study:**

For details pertaining to study design and patient population, see [CLINICAL TRIALS, TECOS Cardiovascular Safety Study](#).

The incidence of adjudication-confirmed pancreatitis events was higher in the sitagliptin group (0.3%) compared to the placebo group (0.2%). The sitagliptin group experienced a greater

number of severe cases of pancreatitis including two confirmed deaths due to pancreatitis, compared to none in the placebo group.

Among patients who were using insulin and/or a sulfonylurea at baseline, the incidence of severe hypoglycemia was 2.7% in sitagliptin-treated patients and 2.5% in placebo-treated patients; among patients who were not using insulin and/or a sulfonylurea at baseline, the incidence of severe hypoglycemia was 1.0% in sitagliptin-treated patients and 0.7% in placebo-treated patients.

### **Abnormal Hematologic and Clinical Chemistry Findings**

#### *Sitagliptin*

The incidence of laboratory adverse experiences was similar in patients treated with sitagliptin 100 mg compared to patients treated with placebo. In most clinical studies, a slight decrease in alkaline phosphatase and small increases in uric acid and white blood cell (WBC) count (due to an increase in neutrophils) were observed. In active comparator studies versus a sulfonylurea agent (glipizide) similar changes were seen in alkaline phosphatase and uric acid.

<b>Mean Change from Baseline (Standard Error)</b>				
<b>Study</b>	<b>Treatment Group</b>	<b>Alkaline Phosphatase (IU/L)</b>	<b>Uric Acid (mg/dL)</b>	<b>WBC (cell/microl)</b>
Placebo-controlled <sup>1</sup>	Sitagliptin	-3.1 (0.4)	0.17 (0.04)	346.0 (64.3)
	Placebo	-1.3 (0.7)	0.05 (0.06)	142.4 (98.8)
Active-controlled <sup>2</sup>	Sitagliptin	-5.7 (0.5)	0.21 (0.05)	207.8 (67.4)
	Glipizide	-3.4 (0.5)	0.20 (0.05)	86.0 (62.5)

<sup>1</sup> Sitagliptin in Combination with Metformin – Placebo-Controlled Study, see [CLINICAL TRIALS](#)

<sup>2</sup> Sitagliptin in Combination with Metformin – Active-Controlled (Sulfonylurea Agent) Study, see [CLINICAL TRIALS](#)

In a combination therapy study with insulin and metformin, a greater proportion of patients were observed to have a decrease in hemoglobin  $\geq 1.5$  g/dL in the sitagliptin group (6.8%) compared with the placebo group (2.3%).

#### *Metformin hydrochloride*

During controlled clinical trials of 29 weeks duration, approximately 9% of patients on metformin monotherapy developed asymptomatic subnormal serum vitamin B<sub>12</sub> levels; serum folic acid levels did not decrease significantly. Five cases of megaloblastic anemia have been reported with metformin administration and no increased incidence of neuropathy has been observed. However, serious cases of peripheral neuropathy have been reported with metformin treatment in the post-marketing experience in patients with vitamin B<sub>12</sub> deficiency (see [WARNINGS AND PRECAUTIONS](#) and [ADVERSE REACTIONS, Post-Marketing Adverse Drug Reactions](#)).

### **Post-Marketing Adverse Drug Reactions**

Because these reactions are reported voluntarily from a population of uncertain size, it is generally not possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

**Blood and lymphatic system disorders:** hemolytic anemia, some with a fatal outcome (see [WARNINGS AND PRECAUTIONS](#))



**Gastrointestinal disorders:** abdominal discomfort, abdominal distension, abdominal pain, abdominal pain upper, acute pancreatitis, including fatal and non-fatal hemorrhagic and necrotizing pancreatitis (see [WARNINGS AND PRECAUTIONS](#)), constipation, diarrhea, dry mouth, dyspepsia, flatulence, gastric disorder, gastric ulcer, gastrointestinal disorder, nausea, vomiting

**Hepatobiliary disorders:** liver function tests abnormalities or hepatitis resolving upon metformin discontinuation, autoimmune hepatitis, drug-induced liver injury, hepatitis (see [WARNINGS AND PRECAUTIONS](#))

**Immune system disorders:** hypersensitivity reactions including anaphylaxis, angioedema, rash, urticaria, cutaneous vasculitis and exfoliative skin conditions, including Stevens-Johnson syndrome (see [CONTRAINDICATIONS](#) and [WARNINGS AND PRECAUTIONS](#))

**Investigations:** blood lactic acid increased, reduction of thyrotropin level in patients with treated or untreated hypothyroidism (see [WARNINGS AND PRECAUTIONS](#))

**Metabolism and nutrition disorders:** lactic acidosis, decrease of vitamin B<sub>12</sub> absorption with decrease of serum levels during long-term use of metformin, weight decreased, decreased appetite, peripheral neuropathy in patients with vitamin B<sub>12</sub> deficiency, hypomagnesemia in the context of diarrhea (see [WARNINGS AND PRECAUTIONS](#))

**Musculoskeletal and connective tissue disorders:** arthralgia, myalgia, pain in extremity, back pain

**Nervous system disorders:** encephalopathy (see [WARNINGS AND PRECAUTIONS](#)), headache

**Renal and urinary disorders:** worsening renal function, including acute renal failure (sometimes requiring dialysis) (see [WARNINGS AND PRECAUTIONS](#))

**Skin and subcutaneous tissue disorder:** photosensitivity, erythema, pruritus, rash, skin lesion, urticaria, bullous pemphigoid (see [WARNINGS AND PRECAUTIONS](#))

## DRUG INTERACTIONS

### Overview

Pharmacokinetic drug interaction studies with JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR have not been performed; however, such studies have been conducted with the individual sitagliptin and metformin components of JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR.

The simultaneous administration of JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR and a sulfonylurea could produce a hypoglycemic reaction, especially if they are given in patients already receiving other drugs which, themselves, can potentiate the effect of sulfonylureas. These drugs can be: long-acting sulfonamides, tuberculostatics, phenylbutazone, clofibrate, monoamine oxidase inhibitors, salicylates, probenecid and propranolol.

### *Sitagliptin*

***In Vitro* Assessment of Drug Interactions:** Sitagliptin is not an inhibitor of CYP isozymes CYP3A4, 2C8, 2C9, 2D6, 1A2, 2C19 or 2B6, and is not an inducer of CYP3A4. Sitagliptin is a p-glycoprotein substrate, but does not inhibit p-glycoprotein mediated transport of digoxin. Based on these results, sitagliptin is considered unlikely to cause interactions with other drugs that utilize these pathways.

Sitagliptin is not extensively bound to plasma proteins. Therefore, the propensity of sitagliptin to be involved in clinically meaningful drug-drug interactions mediated by plasma protein binding displacement is very low.

#### *Metformin hydrochloride*

**In Vivo Assessment of Drug Interactions:** In healthy volunteers, the pharmacokinetics of propranolol and ibuprofen were not affected by metformin when co-administered in single-dose interaction studies. Metformin is negligibly bound to plasma proteins and is therefore, less likely to interact with highly protein-bound drugs such as salicylates, sulfonamides, chloramphenicol and probenecid, as compared to sulfonylureas, which are extensively bound to serum protein.

### **Drug-Drug Interactions**

#### *Sitagliptin*

In clinical studies, as described below, sitagliptin did not meaningfully alter the pharmacokinetics of metformin, glyburide, simvastatin, rosiglitazone, warfarin, or oral contraceptives, providing *in vivo* evidence of a low propensity for causing drug interactions with substrates of CYP3A4, CYP2C8, CYP2C9, and organic cationic transporter (OCT). Multiple doses of sitagliptin slightly increased digoxin concentrations; however, these increases are not considered likely to be clinically meaningful and are not attributed to a specific mechanism.

#### **Effects of other drugs on the pharmacokinetics of sitagliptin**

**Metformin:** Co-administration of multiple twice-daily doses of metformin with sitagliptin did not meaningfully alter the pharmacokinetics of sitagliptin in patients with type 2 diabetes.

**Cyclosporine:** A study was conducted to assess the effect of cyclosporine, a potent inhibitor of p-glycoprotein, on the pharmacokinetics of sitagliptin. Co-administration of a single 100 mg oral dose of sitagliptin and a single 600 mg oral dose of cyclosporine increased the area under the plasma concentration versus time curve (AUC) and  $C_{max}$  of sitagliptin by approximately 29% and 68%, respectively. These modest changes in sitagliptin pharmacokinetics were not considered to be clinically meaningful. The renal clearance of sitagliptin was also not meaningfully altered. Therefore, meaningful interactions would not be expected with other p-glycoprotein inhibitors.

#### **Effects of sitagliptin on the pharmacokinetics of other drugs**

**Metformin:** Co-administration of multiple twice-daily doses of sitagliptin with metformin, an OCT substrate, did not meaningfully alter the pharmacokinetics of metformin or sitagliptin in patients with type 2 diabetes. Therefore, sitagliptin is not an inhibitor of OCT-mediated transport.

**Sulfonylureas:** Single-dose pharmacokinetics of glyburide, a CYP2C9 substrate, were not meaningfully altered in subjects receiving multiple doses of sitagliptin. Clinically meaningful interactions would not be expected with other sulfonylureas (e.g., glipizide, tolbutamide, and glimepiride) which, like glyburide, are primarily eliminated by CYP2C9.

**Simvastatin:** Single-dose pharmacokinetics of simvastatin, a CYP3A4 substrate, were not meaningfully altered in subjects receiving multiple daily doses of sitagliptin. Therefore, sitagliptin is not an inhibitor of CYP3A4-mediated metabolism.

**Thiazolidinediones:** Single-dose pharmacokinetics of rosiglitazone were not meaningfully altered in subjects receiving multiple daily doses of sitagliptin. Therefore, sitagliptin is not an inhibitor of CYP2C8-mediated metabolism. Clinically meaningful interactions with pioglitazone are not expected because pioglitazone predominantly undergoes CYP2C8- or CYP3A4-mediated metabolism.

**Warfarin:** Multiple daily doses of sitagliptin did not meaningfully alter the pharmacokinetics, as assessed by measurement of S(-) or R(+) warfarin enantiomers, or pharmacodynamics (as assessed by measurement of prothrombin International Normalized Ratio) of a single dose of warfarin. Since S(-) warfarin is primarily metabolized by CYP2C9, these data also support the conclusion that sitagliptin is not a CYP2C9 inhibitor.

**Oral Contraceptives:** Co-administration with sitagliptin did not meaningfully alter the steady state pharmacokinetics of norethindrone or ethinyl estradiol.

**Digoxin:** Sitagliptin had a minimal effect on the pharmacokinetics of digoxin. Following administration of 0.25 mg digoxin concomitantly with 100 mg of sitagliptin daily for 10 days, the plasma AUC of digoxin was increased by 11%, and the plasma  $C_{max}$  by 18%. These increases are not considered likely to be clinically meaningful.

#### *Metformin*

**Carbonic Anhydrase Inhibitors:** Topiramate or other carbonic anhydrase inhibitors (e.g., zonisamide, acetazolamide or dichlorphenamide) frequently cause a decrease in serum bicarbonate and induce non-anion gap, hyperchloremic metabolic acidosis. Concomitant use of these drugs with JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR may increase the risk of lactic acidosis. Consider more frequent monitoring of these patients.

**Glyburide:** In a single-dose interaction study in type 2 diabetes patients, co-administration of metformin and glyburide did not result in any changes in either metformin pharmacokinetics or pharmacodynamics. Decreases in glyburide AUC and  $C_{max}$  were observed, but were highly variable. The single-dose nature of this study and the lack of correlation between glyburide blood levels and pharmacodynamic effects make the clinical significance of this interaction uncertain.

**Furosemide:** A single-dose, metformin-furosemide drug interaction study in healthy subjects demonstrated that pharmacokinetic parameters of both compounds were affected by co-administration. Furosemide increased the metformin plasma and blood  $C_{max}$  by 22% and blood AUC by 15%, without any significant change in metformin renal clearance. When administered with metformin, the  $C_{max}$  and AUC of furosemide were 31% and 12% smaller, respectively, than when administered alone, and the terminal half-life was decreased by 32%, without any significant change in furosemide renal clearance. No information is available about the interaction of metformin and furosemide when co-administered chronically.

**Nifedipine:** A single-dose, metformin-nifedipine drug interaction study in normal healthy volunteers demonstrated that co-administration of nifedipine increased plasma metformin  $C_{max}$  and AUC by 20% and 9%, respectively, and increased the amount excreted in the urine.  $T_{max}$  and half-life were unaffected. Nifedipine appears to enhance the absorption of metformin. Metformin had minimal effects on nifedipine.

**Drugs that reduce metformin clearance:** Concomitant use of drugs that interfere with common renal tubular transport systems involved in the renal elimination of metformin (e.g., organic cationic transporter-2 [OCT2] / multidrug and toxin extrusion [MATE] inhibitors such as ranolazine, vandetanib, dolutegravir, and cimetidine) could increase systemic exposure to metformin and may increase the risk for lactic acidosis (see [WARNINGS AND PRECAUTIONS](#)). In both single- and multiple-dose metformin-cimetidine drug interaction studies, there was a 60% increase in peak metformin plasma and whole blood concentrations and a 40% increase in plasma and whole blood metformin AUC. There was no change in elimination half-life in the single-dose study. Metformin had no effect on cimetidine pharmacokinetics. Close monitoring of glycemic control, dose adjustment within the recommended posology and changes in diabetic treatment should be considered when such products are co-administered.

**Levothyroxine:** Levothyroxine can reduce the glucose-lowering effect of metformin. Monitoring of blood glucose levels is recommended, especially when thyroid hormone therapy is initiated, changed, or stopped (see [WARNINGS AND PRECAUTIONS](#)), and JANUMET<sup>®</sup>/JANUMET<sup>®</sup> XR dosage adjusted as necessary.

**Anticoagulant:** Elimination rate of the anticoagulant phenprocoumon has been reported to be increased by 20% when used concurrently with metformin. Therefore, a close monitoring of the International Normalized Ratio (INR) is recommended in patients concurrently administering metformin and phenprocoumon or other antivitamin K anticoagulants (see [WARNINGS AND PRECAUTIONS](#)). In such cases, an important increase of prothrombin time may occur upon cessation of JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR therapy, with an increased risk of hemorrhage.

**Other:** Certain drugs tend to produce hyperglycemia and may lead to loss of glycemic control. These drugs include the thiazides and other diuretics, corticosteroids, phenothiazines, thyroid products, estrogens, estrogen plus progestogen, oral contraceptives, phenytoin, nicotinic acid, sympathomimetics, calcium channel blocking drugs, isoniazid and beta-2-agonists. ACE-inhibitors may decrease the blood glucose levels. When such drugs are administered to a patient receiving JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR the patient should be closely observed to maintain adequate glycemic control.

Diuretics, especially loop diuretics, may increase the risk of lactic acidosis due to their potential to decrease renal function.

### **Drug-Food Interactions**

There are no known interactions with food.

### **Drug-Herb Interactions**

Interactions with herbal products have not been established.

### **Drug-Laboratory Interactions**

#### *Sitagliptin*

Interactions with laboratory tests have not been established.

### *Metformin hydrochloride*

Intravascular contrast studies with iodinated materials can lead to acute alteration of renal function and have been associated with lactic acidosis in patients receiving metformin (see [CONTRAINDICATIONS](#) and [WARNINGS AND PRECAUTIONS](#)).

### **Drug-Lifestyle Interactions**

**Effects of Smoking, Alcohol, and Diet:** The effects of smoking, diet, and alcohol use on the pharmacokinetics of JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR have not been specifically studied. Patients should be cautioned against excessive alcohol intake, either acute or chronic, when taking JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR, since alcohol intake potentiates the effect of metformin on lactate metabolism (see [CONTRAINDICATIONS](#)). The risk of lactic acidosis is increased in acute alcohol intoxication, particularly in case of fasting or malnutrition or hepatic insufficiency. It is recommended that consumption of alcohol and alcohol-containing medicinal product be avoided.

**Effects on Ability to Drive and Use Machines:** No formal studies have been conducted with JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR on the effects on the ability to drive and use machines. However, patients should be warned about driving a vehicle or operating machinery under conditions where a risk of hypoglycemia is present (see [WARNINGS AND PRECAUTIONS](#)). When JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR is used in combination with a sulfonylurea or in combination with insulin patients should be advised to take precautions to avoid hypoglycaemia while driving or using machinery.

## **DOSAGE AND ADMINISTRATION**

### **Dosing Considerations**

The dosage of JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR should be individualized on the basis of the patient's current regimen, effectiveness, and tolerability while not exceeding the maximum recommended daily dose of 100 mg sitagliptin and 2000 mg metformin hydrochloride. Dose escalation should be gradual to reduce the gastrointestinal side effects associated with metformin use. Factors that may increase the risk of lactic acidosis should be reviewed before considering initiation of metformin-containing products in patients with renal impairment. Maximum daily dose of sitagliptin and metformin, as single components, in patients with an eGFR  $\geq 30$  mL/min/1.73 m<sup>2</sup> to  $<45$  mL/min/1.73 m<sup>2</sup> is 50 mg and 1000 mg, respectively.

There have been reports of incompletely dissolved JANUMET<sup>®</sup> XR tablets being eliminated in the feces. If a patient reports seeing tablets in feces, the healthcare provider should assess adequacy of glycemic control (see [PART III: CONSUMER INFORMATION](#)). If glycemic control is found to be reduced, alternative treatments should be considered.

### **Concomitant Use with Insulin or an Insulin Secretagogue (e.g., Sulfonylurea)**

When JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR is used as add-on therapy with insulin or an insulin secretagogue (e.g., sulfonylurea), a lower dose of insulin or the insulin secretagogue may be considered to reduce the risk of hypoglycemia (see [WARNINGS AND PRECAUTIONS](#) and [ADVERSE REACTIONS](#)).

### **Concomitant Use with Medication(s) that May Decrease Renal Function**

Caution should be exercised when using concomitant medication(s) that may decrease renal function (like diuretics, particularly loop diuretics) or may interfere with the disposition of metformin, such as cationic drugs, that are eliminated by renal tubular secretion, due to the increased risk of developing lactic acidosis during co-administration (see [DRUG INTERACTIONS](#)).

### **Recommended Dose and Dosage Adjustment**

JANUMET<sup>®</sup> is available in the following dosage strengths:

- 50 mg sitagliptin/500 mg metformin hydrochloride
- 50 mg sitagliptin/850 mg metformin hydrochloride
- 50 mg sitagliptin/1000 mg metformin hydrochloride

**One JANUMET<sup>®</sup> tablet should be taken orally twice a day with meals** to reduce the risk of gastrointestinal side effects associated with metformin use. Tablets are to be swallowed whole.

For the following dosage strengths of JANUMET<sup>®</sup> XR:

- 50 mg sitagliptin/500 mg metformin hydrochloride modified release tablet
- 50 mg sitagliptin/1000 mg metformin hydrochloride modified release tablet

**Two JANUMET<sup>®</sup> XR tablets should be taken orally once a day with a meal** preferably in the evening. Administration of JANUMET<sup>®</sup> XR with food enhances plasma concentrations of metformin. The two tablets should be taken one immediately after the other and to preserve the modified-release properties, the tablets must not be split, broken crushed, or chewed before swallowing.

For the following dosage strength of JANUMET<sup>®</sup> XR:

- 100 mg sitagliptin/1000 mg metformin hydrochloride modified release tablet

**One single JANUMET<sup>®</sup> XR tablet should be taken orally once a day with a meal** preferably in the evening. Administration of JANUMET<sup>®</sup> XR with food enhances plasma concentrations of metformin. To preserve the modified-release properties, the tablets must not be split, broken crushed, or chewed before swallowing.

**In patients on metformin (alone or in combination with a sulfonylurea, pioglitazone, or insulin),** the recommended total daily dose of JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR is 100 mg sitagliptin and the nearest therapeutically appropriate dose of metformin already being taken.

**In patients already treated with sitagliptin and metformin,** switching to JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR may be initiated at the dose of sitagliptin and metformin already being taken.

**Renal Impairment:** Renal function must be assessed prior to initiation of JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR and periodically thereafter because there is a dosage adjustment based upon renal function. In patients with eGFR <60 mL/min/1.73m<sup>2</sup>, more intensive monitoring for glycemic biomarkers, renal biomarkers and signs and symptoms of renal dysfunction is recommended especially if the eGFR is less than 45 mL/min/1.73 m<sup>2</sup> (see [WARNINGS AND PRECAUTIONS, Monitoring and Laboratory Tests](#)).

JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR are contraindicated in patients with severe renal impairment (eGFR <30 mL/min/1.73 m<sup>2</sup>), end stage renal disease or patients on dialysis (see [CONTRAINDICATIONS](#)).

No dosage adjustment for JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR is necessary in patients with mild (eGFR ≥60 mL/min/1.73 m<sup>2</sup> to <90 mL/min/1.73 m<sup>2</sup>) to moderate renal impairment (eGFR ≥45 mL/min/1.73 m<sup>2</sup> to <60 mL/min/1.73 m<sup>2</sup>).

#### JANUMET<sup>®</sup>

JANUMET<sup>®</sup> is not recommended in patients with an eGFR ≥30 mL/min/1.73 m<sup>2</sup> and <45 mL/min/1.73 m<sup>2</sup> because these patients require a lower dosage of sitagliptin than what is available in the fixed combination JANUMET<sup>®</sup> product.

#### JANUMET<sup>®</sup> XR

Initiation of JANUMET<sup>®</sup> XR in patients with an eGFR ≥30 mL/min/1.73 m<sup>2</sup> and <45 mL/min/1.73 m<sup>2</sup> is not recommended. In patients taking JANUMET<sup>®</sup> XR whose eGFR later falls below 45 mL/min/1.73 m<sup>2</sup>, assess the benefit and risk of continuing therapy and limit dose of the sitagliptin component to 50 mg once day:

- JANUMET<sup>®</sup> XR 50 mg/500 mg – 1 tablet once daily
- JANUMET<sup>®</sup> XR 50 mg/1000 mg – 1 tablet once daily

Discontinue JANUMET<sup>®</sup> XR if the patient's eGFR later falls below 30 mL/min/1.73 m<sup>2</sup>.

#### Discontinuation for iodinated contrast imaging procedures:

Discontinue JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR at the time of, or prior to, an iodinated contrast imaging procedure in patients with an eGFR ≥30 to <60 mL/min/1.73 m<sup>2</sup>; in patients with a history of liver disease, alcoholism or heart failure; or in patients who will be administered intra-arterial iodinated contrast. Re-evaluate eGFR 48 hours after the imaging procedure; restart JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR if renal function is acceptable and found to be stable (see [WARNINGS AND PRECAUTIONS](#)).

**Hepatic Impairment:** JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR is contraindicated in patients with severe hepatic impairment and should not be used in patients with clinical or laboratory evidence of hepatic disease (see [CONTRAINDICATIONS](#)). Metformin use in patients with impaired hepatic function has been associated with some cases of lactic acidosis (see [WARNINGS AND PRECAUTIONS](#)).

**Pediatrics (<18 years of age):** There are no data available on the use of JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR in patients younger than 18 years of age. Therefore, use of JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR in pediatric patients is not recommended.

**Geriatrics (≥65 years of age):** JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR should be used with caution in patients 65 years and older. Regular assessment of renal function is necessary. Metformin and sitagliptin are excreted by the kidneys, and elderly patients are more likely to have decreased renal function associated with aging and be at risk of developing lactic acidosis (see [WARNINGS AND PRECAUTION, Special Populations](#)).

### **Missed Dose**

If a dose of JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR is missed, it should be taken as soon as the patient remembers. If he/she does not remember until it is time for the next dose, the missed dose should be skipped and returned to the regular schedule. A double dose of JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR should not be taken at the same time.

### **OVERDOSAGE**

For management of a suspected drug overdose, contact your regional Poison Control Centre.

#### *Sitagliptin*

In the event of an overdose, it is reasonable to employ the usual supportive measures, e.g., remove unabsorbed material from the gastrointestinal tract, employ clinical monitoring (including obtaining an electrocardiogram), and institute supportive therapy if required.

Sitagliptin is modestly dialyzable. In clinical studies, approximately 13.5% of the dose was removed over a 3- to 4-hour hemodialysis session. Prolonged hemodialysis may be considered if clinically appropriate. It is not known if sitagliptin is dialyzable by peritoneal dialysis.

#### *Metformin hydrochloride*

Available information concerning treatment of a massive overdose of metformin hydrochloride is very limited. It would be expected that adverse reactions of a more intense character including epigastric discomfort, nausea and vomiting followed by diarrhea, drowsiness, weakness, dizziness, malaise and headache might be seen. Should those symptoms persist, lactic acidosis should be excluded. The drug should be discontinued and proper supportive therapy instituted.

Overdose of metformin hydrochloride has occurred, including ingestion of amounts greater than 50 grams. Hypoglycemia was reported in approximately 10% of cases, but no causal association with metformin hydrochloride has been established. Lactic acidosis has been reported in approximately 32% of metformin overdose cases (see [WARNINGS AND PRECAUTIONS](#)). Metformin is dialyzable with a clearance of up to 170 mL/min under good hemodynamic conditions. Therefore, hemodialysis may be useful for removal of accumulated drug from patients in whom metformin overdose is suspected.

Pancreatitis may occur in the context of a metformin overdose (see [WARNINGS AND PRECAUTIONS](#)).

### **ACTION AND CLINICAL PHARMACOLOGY**

#### **Mechanism of Action**

##### *Sitagliptin and Metformin hydrochloride*

JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR combine two antihyperglycemic agents with complementary mechanisms of action to improve glycemic control in patients with type 2 diabetes: sitagliptin phosphate, a dipeptidyl peptidase 4 (DPP-4) inhibitor, and metformin hydrochloride, a member



of the biguanide class. JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR targets three core defects of type 2 diabetes which are: decreased insulin synthesis and release, increased hepatic glucose production and decreased insulin sensitivity.

### *Sitagliptin*

Sitagliptin is an orally-active, potent, and highly selective inhibitor of the dipeptidyl peptidase 4 (DPP-4) enzyme for the treatment of type 2 diabetes. The DPP-4 inhibitors are a class of agents that act as incretin enhancer.

Incretin hormones, including glucagon-like peptide-1 (GLP-1) and glucose-dependent insulinotropic polypeptide (GIP), are released by the intestine throughout the day, and levels are increased in response to a meal. The incretins are part of an endogenous system involved in the physiologic regulation of glucose homeostasis. When blood glucose concentrations are normal or elevated, GLP-1 and GIP increase insulin synthesis and release from pancreatic beta cells by intracellular signaling pathways involving cyclic AMP. Progressive beta-cell failure is a feature characterizing the pathogenesis of type 2 diabetes. Treatment with GLP-1 or with DPP-4 inhibitors in animal models of type 2 diabetes has been demonstrated to improve beta cell responsiveness to glucose and stimulate insulin biosynthesis and release. With higher insulin levels, tissue glucose uptake is enhanced.

In addition, GLP-1 lowers glucagon secretion from pancreatic alpha cells. Decreased glucagon concentrations, along with higher insulin levels, lead to reduced hepatic glucose production, resulting in a decrease in blood glucose levels. When blood glucose concentrations are low, stimulation of insulin release and suppression of glucagon secretion by GLP-1 are not observed. GLP-1 does not impair the normal glucagon response to hypoglycemia.

The activity of GLP-1 and GIP is limited by the DPP-4 enzyme, which rapidly hydrolyzes the incretin hormones to produce inactive products. Sitagliptin prevents the hydrolysis of incretin hormones by DPP-4, thereby increasing plasma concentrations of the active forms of GLP-1 and GIP. By enhancing active incretin levels, sitagliptin increases insulin release and decreases glucagon levels in a glucose-dependent manner.

In patients with type 2 diabetes with hyperglycemia, these changes in insulin and glucagon levels lead to lower hemoglobin A<sub>1c</sub> (HbA<sub>1c</sub>) and lower fasting and postprandial glucose concentrations. Sitagliptin demonstrates selectivity for DPP-4, and does not inhibit the DPP-8 or DPP-9 activity *in vitro* at concentrations approximating those from therapeutic doses. Inhibition of DPP-8 or DPP-9, but not DPP-4, is associated with toxicity in preclinical animal models and alteration of immune function *in vitro*.

### *Metformin hydrochloride*

Metformin is a biguanide derivative producing an antihyperglycemic effect which can only be observed in man or in the diabetic animal and only when there is insulin secretion. Metformin, at therapeutic doses, does not cause hypoglycemia when used alone in man or in the non-diabetic animal, except when using a near lethal dose. Metformin has no effects on the pancreatic beta cells. The mode of action of metformin is not fully understood. It has been postulated that metformin might potentiate the effect of insulin or that it might enhance the effect of insulin on the peripheral receptor site. This increased sensitivity seems to follow an increase in the number of insulin receptors on cell surface membranes.

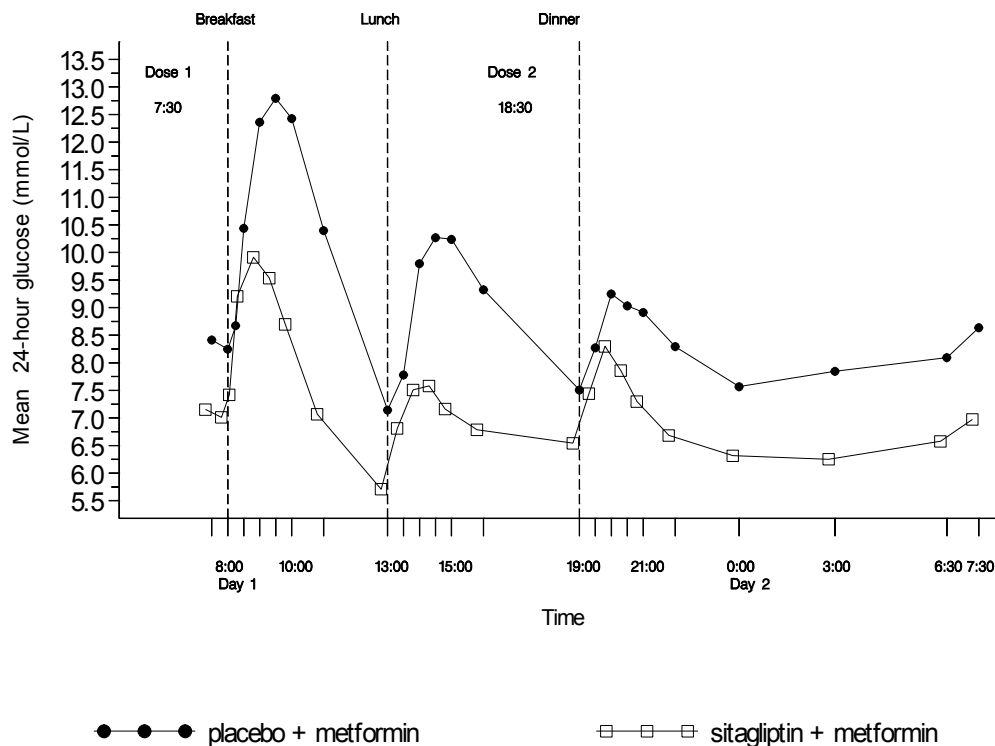
## Pharmacodynamics

### *Sitagliptin*

In patients with type 2 diabetes, administration of single oral doses of sitagliptin leads to inhibition of DPP-4 enzyme activity for a 24-hour period, resulting in a 2- to 3-fold increase in circulating levels of active GLP-1 and GIP, increased plasma levels of insulin and C-peptide, decreased glucagon concentrations, reduced fasting glucose, and reduced glucose excursion following an oral glucose load or a meal.

In a study of patients with type 2 diabetes inadequately controlled on metformin monotherapy, glucose levels monitored throughout the day were significantly lower ( $p < 0.001$ ) in patients who received sitagliptin 100 mg per day (50 mg twice daily) in combination with metformin compared with patients who received placebo with metformin (see Figure 1).

**Figure 1 – 24-Hour Plasma Glucose Profile after 4-Week Treatment with Sitagliptin 50 mg BID with Metformin or Placebo with Metformin**



In studies with healthy subjects, sitagliptin did not lower blood glucose or cause hypoglycemia, suggesting that the insulinotropic and glucagon suppressive actions of the drug are glucose dependent.

**Cardiac Electrophysiology:** In a randomized, placebo-controlled crossover study, 79 healthy subjects were administered a single oral dose of sitagliptin 100 mg, sitagliptin 800 mg (8 times the recommended dose), and placebo. At the recommended dose of 100 mg, there was no effect

on the QTc interval obtained at the peak plasma concentration, or at any other time during the study. Following the 800 mg dose, the maximum increase in the placebo-corrected mean change in QTc from baseline at 3 hours post-dose was 8.0 msec (90% CI; 5.5, 10.6). At the 800 mg dose, peak sitagliptin plasma concentrations were approximately 11times higher than the peak concentrations following a 100 mg dose.

In patients with type 2 diabetes administered sitagliptin 100 mg (N=81) or sitagliptin 200 mg (N=63) daily, there were no meaningful changes in QTc interval based on ECG data obtained at the time of expected peak plasma concentration.

#### *Metformin hydrochloride*

Few data are available on the relationship between pharmacodynamics and pharmacokinetics, and therefore the effect of metformin on glucose control cannot be predicted from pharmacokinetic data alone. Tissue concentrations of metformin in the dual target sites of the liver and muscle appear to be more informative, and the deep metformin compartment supplying these tissues is critical and related to plasma concentrations. This view substantiates the clinical observation that the glucose-lowering action of metformin takes time to be fully expressed and also that activity is not lost immediately on drug withdrawal.

#### *Sitagliptin and Metformin Co-Administration*

In a two-day study in healthy subjects, sitagliptin alone increased active GLP-1 concentrations, whereas metformin alone increased active and total GLP-1 concentrations to similar extents. Co-administration of sitagliptin and metformin has an additive effect on active GLP-1 concentrations. Sitagliptin, but not metformin, increased active GIP concentrations. It is unclear what these findings mean for changes in glycemic control in patient with type 2 diabetes.

### **Pharmacokinetics**

#### *JANUMET<sup>®</sup>*

In a bioequivalence study of JANUMET<sup>®</sup> 50/500 and 50/1000 (mg/mg sitagliptin/metformin hydrochloride), both the sitagliptin component and the metformin component were bioequivalent to co-administered 50 mg sitagliptin phosphate tablet and metformin hydrochloride tablets 500 and 1000 mg, respectively under fasted conditions in healthy subjects.

Because bioequivalence is demonstrated at the lowest and highest combination tablet dose strengths available, bioequivalence is conferred to the (sitagliptin/metformin) 50 mg/850 mg fixed dose combination (FDC) tablet.

**Table 6 – Geometric Mean Pharmacokinetic Parameters for Sitagliptin and Metformin Following Single Dose of JANUMET<sup>®</sup> or Co-administration of Corresponding Doses of Sitagliptin and Metformin as Individual Tablets to Healthy Subjects Under Fasted Conditions**

<b>Sitagliptin</b>					
<b>Treatment</b>	<b>Subject Number</b>	<b>AUC<sub>0-∞</sub> (μM·hr)</b>	<b>C<sub>max</sub> (nM)</b>	<b>T<sub>max</sub><sup>†</sup> (hr)</b>	<b>t<sub>1/2</sub><sup>‡</sup> (hr)</b>
A	24	4.09	415	2.50	12.3
B	24	4.01	414	2.75	12.6
C	24	4.05	423	2.50	13.1
D	24	3.94	397	2.50	13.7

**Table 6 – Geometric Mean Pharmacokinetic Parameters for Sitagliptin and Metformin Following Single Dose of JANUMET® or Co-administration of Corresponding Doses of Sitagliptin and Metformin as Individual Tablets to Healthy Subjects Under Fasted Conditions**

<b>Metformin</b>					
<b>Treatment</b>	<b>Subject Number</b>	<b>AUC<sub>0-∞</sub> (µg/mL·hr)</b>	<b>C<sub>max</sub> (ng/mL)</b>	<b>T<sub>max</sub><sup>†</sup> (hr)</b>	<b>t<sub>1/2</sub><sup>‡</sup> (hr)</b>
A	24	7.26	1180	2.50	9.79
B	24	7.25	1180	2.75	11.6
C	24	11.9	1850	2.50	13.6
D	24	11.9	1870	2.00	13.9

<sup>†</sup> Median  
<sup>‡</sup> Harmonic Mean  
 Treatment A = sitagliptin 50 mg + metformin hydrochloride 500 mg  
 Treatment B = JANUMET® sitagliptin (50 mg)/metformin hydrochloride (500 mg)  
 Treatment C = sitagliptin 50 mg + metformin hydrochloride 1000 mg  
 Treatment D = JANUMET® sitagliptin (50 mg)/metformin hydrochloride (1000 mg)

When administered in the fed state (following a standard high-fat breakfast), the metformin component of JANUMET® was bioequivalent to metformin taken together with sitagliptin as individual tablets.

#### *JANUMET® XR*

The results of studies in healthy subjects demonstrated that the JANUMET® XR 50 mg/500 mg and 100 mg/1000 mg combination tablets are bioequivalent to co-administration of corresponding individual doses of sitagliptin tablets and metformin hydrochloride extended-release tablets.

After administration of two JANUMET® XR 50 mg/1000 mg tablets once daily with the evening meal for 7 days in healthy adult subjects, steady state for sitagliptin and metformin was reached by Day 4 and 5, respectively. The median T<sub>max</sub> values for sitagliptin and metformin at steady state were approximately 3 and 8 hours post-dose, respectively. The median T<sub>max</sub> values for sitagliptin and metformin after administration of a single 50 mg/1000 mg tablet of JANUMET® were 3 and 3.5 hours post-dose, respectively.

#### **Absorption:**

##### *Sitagliptin*

The absolute bioavailability of sitagliptin is approximately 87%. Co-administration of a high-fat meal with sitagliptin had no effect on the pharmacokinetics of sitagliptin.

##### *Metformin hydrochloride*

The absolute bioavailability of a metformin hydrochloride 500 mg tablet given under fasting conditions is approximately 50-60%. Studies using single oral doses of metformin hydrochloride immediate-release tablets 500 mg to 1500 mg, and 850 mg to 2550 mg, indicate that there is a lack of dose proportionality with increasing doses, which is due to decreased absorption rather than an alteration in elimination. Food decreases the extent of and slightly delays the absorption of metformin, as shown by approximately a 40% lower mean peak plasma concentration (C<sub>max</sub>), a 25% lower area under the plasma concentration versus time curve (AUC), and a 35-minute prolongation of time to peak plasma concentration (T<sub>max</sub>) following administration of a single 850 mg tablet of metformin with food, compared to the same tablet strength administered fasting. The clinical relevance of these decreases is unknown.

Low-fat and high-fat meals increased the systemic exposure (as measured by AUC) from 500 mg metformin hydrochloride extended-release tablets by about 38% and 73%, respectively, relative to fasting. Both meals prolonged metformin  $T_{max}$  by approximately 3 hours but  $C_{max}$  was not affected.

### **Distribution:**

#### *Sitagliptin*

The mean volume of distribution at steady state following a single 100 mg intravenous dose of sitagliptin to healthy subjects is approximately 198 liters. The fraction of sitagliptin reversibly bound to plasma proteins is low (38%).

#### *Metformin hydrochloride*

The apparent volume of distribution (V/F) of metformin following single oral doses of metformin hydrochloride tablets 850 mg averaged  $654 \pm 358$  L. Metformin is negligibly bound to plasma proteins, in contrast to sulfonylureas, which are more than 90% protein bound. Metformin partitions into erythrocytes, most likely as a function of time. At usual clinical doses and dosing schedules of metformin hydrochloride tablets, steady state plasma concentrations of metformin are reached within 24-48 hours and are generally  $<1$   $\mu\text{g/mL}$ . During controlled clinical trials of metformin, maximum metformin plasma levels did not exceed 5  $\mu\text{g/mL}$ , even at maximum doses.

### **Metabolism:**

#### *Sitagliptin*

Sitagliptin is primarily eliminated unchanged in urine, and metabolism is a minor pathway. Approximately 79% of sitagliptin is excreted unchanged in the urine.

Following a [ $^{14}\text{C}$ ] sitagliptin oral dose, approximately 16% of the radioactivity was excreted as metabolites of sitagliptin. Six metabolites were detected at trace levels and are not expected to contribute to the plasma DPP-4 inhibitory activity of sitagliptin. *In vitro* studies indicated that the primary enzyme responsible for the limited metabolism of sitagliptin was CYP3A4, with contribution from CYP2C8.

#### *Metformin hydrochloride*

Intravenous single-dose studies in normal subjects demonstrate that metformin is excreted unchanged in the urine and does not undergo hepatic metabolism (no metabolites have been identified in humans) nor biliary excretion.

### **Excretion:**

#### *Sitagliptin*

Following administration of an oral [ $^{14}\text{C}$ ] sitagliptin dose to healthy subjects, approximately 100% of the administered radioactivity was eliminated in feces (13%) or urine (87%) within one week of dosing. The apparent terminal  $t_{1/2}$  following a 100-mg oral dose of sitagliptin was approximately 12.4 hours and renal clearance was approximately 350 mL/min.

Elimination of sitagliptin occurs primarily via renal excretion and involves active tubular secretion. Sitagliptin is a substrate for human organic anion transporter-3 (hOAT-3), which may be involved in the renal elimination of sitagliptin. The clinical relevance of hOAT-3 in sitagliptin transport has not been established. Sitagliptin is also a substrate of p-glycoprotein, which may

also be involved in mediating the renal elimination of sitagliptin. However, cyclosporine, a p-glycoprotein inhibitor, did not reduce the renal clearance of sitagliptin.

#### *Metformin hydrochloride*

Renal clearance is approximately 3.5 times greater than creatinine clearance, which indicates that tubular secretion is the major route of metformin elimination. Following oral administration, approximately 90% of the absorbed drug is eliminated via the renal route within the first 24 hours, with a plasma elimination half-life of approximately 6.2 hours. In blood, the elimination half-life is approximately 17.6 hours, suggesting that the erythrocyte mass may be a compartment of distribution.

### **Special Populations and Conditions**

**Pediatrics:** No studies with JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR have been performed in pediatric patients.

#### **Geriatrics:**

##### *Sitagliptin*

Age did not have a clinically meaningful impact on the pharmacokinetics of sitagliptin based on a population pharmacokinetic analysis of Phase I and Phase II data. Elderly subjects (65 to 80 years) had approximately 19% higher plasma concentrations of sitagliptin compared to younger subjects.

#### *Metformin hydrochloride*

Limited data from controlled pharmacokinetic studies of metformin in healthy elderly subjects suggest that total plasma clearance of metformin is decreased, the half-life is prolonged, and  $C_{max}$  is increased, compared to healthy young subjects. From these data, it appears that the change in metformin pharmacokinetics with aging is primarily accounted for by a change in renal function (see [WARNINGS AND PRECAUTIONS](#)).

#### **Gender:**

##### *Sitagliptin*

Gender had no clinically meaningful effect on the pharmacokinetics of sitagliptin based on a composite analysis of Phase I pharmacokinetic data and on a population pharmacokinetic analysis of Phase I and Phase II data.

#### *Metformin hydrochloride*

Metformin pharmacokinetic parameters did not differ significantly between normal subjects and patients with type 2 diabetes when analyzed according to gender. Similarly, in controlled clinical studies in patients with type 2 diabetes, the antihyperglycemic effect of metformin was comparable in males and females.

#### **Race:**

##### *Sitagliptin*

Race had no clinically meaningful effect on the pharmacokinetics of sitagliptin based on a composite analysis of Phase I pharmacokinetic data and on a population pharmacokinetic analysis of Phase I and Phase II data, including subjects of White, Hispanic, Black and Asian racial groups.

### *Metformin hydrochloride*

No studies of metformin pharmacokinetic parameters according to race have been performed. In controlled clinical studies of metformin in patients with type 2 diabetes, the antihyperglycemic effect was comparable in Whites (n=249), Blacks (n=51), and Hispanics (n=24).

### **Hepatic Impairment:**

JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR is contraindicated in patients with severe hepatic impairment and should not be used in patients with clinical or laboratory evidence of hepatic disease (see [CONTRAINDICATIONS](#)).

### *Sitagliptin*

In patients with moderate hepatic impairment (Child-Pugh score 7 to 9), mean AUC and C<sub>max</sub> of sitagliptin increased approximately 21% (90% CI: 1%, 46%) and 13% (90% CI: -9%, 42%), respectively, compared to healthy matched controls following administration of a single 100 mg dose of sitagliptin.

### *Metformin hydrochloride*

No pharmacokinetic studies of metformin have been conducted in patients with hepatic impairment.

**Renal Impairment:** JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR is contraindicated in patients with severe renal impairment (eGFR <30 mL/min/1.73 m<sup>2</sup>) (see [CONTRAINDICATIONS](#)).

### *Sitagliptin*

A single-dose, open-label study was conducted to evaluate the pharmacokinetics of a reduced dose of sitagliptin (50 mg) in patients with varying degrees of chronic renal insufficiency compared to normal healthy control subjects. The study included patients with mild, moderate, and severe renal impairment, as well as patients with ESRD on hemodialysis. In addition, the effects of renal impairment on sitagliptin pharmacokinetics in patients with type 2 diabetes and mild, moderate or severe renal impairment (including ESRD) were assessed using population pharmacokinetic analyses.

Compared to normal healthy control subjects, an approximate 1.2 to 1.6-fold increase in plasma AUC of sitagliptin was observed in patients with mild renal impairment (eGFR  $\geq 60$  mL/min/1.73 m<sup>2</sup> to <90 mL/min/1.73 m<sup>2</sup>) and patients with moderate renal impairment (eGFR  $\geq 45$  mL/min/1.73 m<sup>2</sup> to <60 mL/min/1.73 m<sup>2</sup>), respectively, which is not a clinically meaningful increase to require dosage adjustment.

An approximately 2-fold increase in the plasma AUC of sitagliptin was observed in patients with moderate renal impairment (eGFR  $\geq 30$  mL/min/1.73 m<sup>2</sup> to <45 mL/min/1.73 m<sup>2</sup>) and an approximately 4-fold increase was observed in patients with severe renal impairment (eGFR <30 mL/min/1.73 m<sup>2</sup>) including patients with ESRD on hemodialysis, as compared to normal healthy control subjects.

To achieve plasma concentrations of sitagliptin similar to those in patients with normal renal function, lower dosages are recommended in patients with eGFR <45 mL/min/1.73 m<sup>2</sup> (see [WARNINGS AND PRECAUTIONS](#) and [DOSAGE AND ADMINISTRATION](#)).

### *Metformin hydrochloride*

In patients with decreased renal function, the plasma and blood half-life of metformin is prolonged and the renal clearance is decreased (see [CONTRAINDICATIONS](#) and [WARNINGS AND PRECAUTIONS](#)).

## **STORAGE AND STABILITY**

The product should be stored at 15°C to 30 °C.

## **DOSAGE FORMS, COMPOSITION AND PACKAGING**

### *JANUMET<sup>®</sup>*

Tablets JANUMET<sup>®</sup>, 50 mg/500 mg, are light pink, capsule-shaped, film-coated tablets with “575” debossed on one side. They are supplied in bottles of 60.

Tablets JANUMET<sup>®</sup>, 50 mg/850 mg, are pink, capsule-shaped, film-coated tablets with “515” debossed on one side. They are supplied in bottles of 60.

Tablets JANUMET<sup>®</sup>, 50 mg/1000 mg, are red, capsule-shaped, film coated tablets with “577” debossed on one side. They are supplied in bottles of 60.

JANUMET<sup>®</sup> is available for oral administration as tablets containing 64.25 mg sitagliptin phosphate monohydrate and metformin hydrochloride equivalent to: 50 mg sitagliptin as free base and 500 mg metformin hydrochloride (JANUMET<sup>®</sup> 50 mg/500 mg), 850 mg metformin hydrochloride (JANUMET<sup>®</sup> 50 mg/850 mg) or 1000 mg metformin hydrochloride (JANUMET<sup>®</sup> 50 mg/1000 mg).

Each film-coated tablet of JANUMET<sup>®</sup> contains the following inactive ingredients: microcrystalline cellulose, polyvinylpyrrolidone, sodium lauryl sulfate, and sodium stearyl fumarate. In addition, the film coating contains the following inactive ingredients: polyvinyl alcohol, polyethylene glycol, talc, titanium dioxide, red iron oxide, and black iron oxide.

### *JANUMET<sup>®</sup> XR*

Tablets JANUMET<sup>®</sup> XR, 50 mg/500 mg, are light blue, bi-convex oval, film coated tablet, debossed “78” on one side and plain on the other. They are supplied in bottles of 60.

Tablets JANUMET<sup>®</sup> XR, 50 mg/1000 mg, light green, bi-convex oval, film coated tablet, debossed “80” on one side and plain on the other. They are supplied in bottles of 60.

Tablets JANUMET<sup>®</sup> XR, 100 mg/1000 mg, blue, bi-convex oval, film coated tablet, debossed “81” on one side and plain on the other. They are supplied in bottles of 30.

JANUMET<sup>®</sup> XR consists of an extended-release metformin core tablet coated with an immediate release layer of sitagliptin. The sitagliptin layer is coated with a soluble polymeric film that provides taste masking.



JANUMET<sup>®</sup> XR is available for oral administration as tablets containing 64.25 mg sitagliptin phosphate monohydrate (equivalent to 50 mg sitagliptin as free base) and either 500 mg metformin hydrochloride extended-release (JANUMET<sup>®</sup> XR 50 mg/500 mg) or 1000 mg metformin hydrochloride extended-release (JANUMET<sup>®</sup> XR 50 mg/1000 mg). Additionally, JANUMET<sup>®</sup> XR is available for oral administration as tablets containing 128.5 mg sitagliptin phosphate monohydrate (equivalent to 100 mg sitagliptin as free base) and 1000 mg metformin hydrochloride extended-release (100 mg/1000 mg).

All doses of JANUMET<sup>®</sup> XR contain the following inactive ingredients: povidone, hypromellose, colloidal silicon dioxide, sodium stearyl fumarate, propyl gallate, polyethylene glycol, and kaolin. The JANUMET<sup>®</sup> XR 50 mg/500 mg tablet contains the additional inactive ingredient microcrystalline cellulose. In addition, the film coating contains the following inactive ingredients: hypromellose, hydroxypropyl cellulose, titanium dioxide, FD&C Blue #2/Indigo Carmine Aluminum Lake and carnauba wax. The JANUMET<sup>®</sup> XR 50 mg/1000 mg tablet contains the additional inactive ingredient yellow iron oxide.

## PART II : SCIENTIFIC INFORMATION

### PHARMACEUTICAL INFORMATION

#### Drug Substance

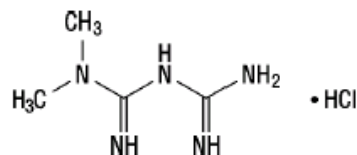
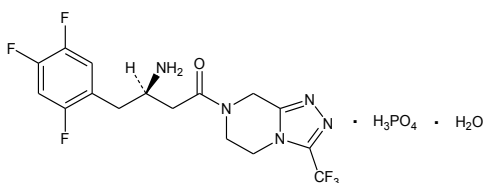
Common name/ Proper name : sitagliptin phosphate monohydrate metformin hydrochloride

Chemical name : 7-[(3*R*)-3-amino-1-oxo-4-(2,4,5-trifluorophenyl)butyl]-5,6,7,8-tetrahydro-3-(trifluoromethyl)-1,2,4-triazolo[4,3-*a*]pyrazine phosphate (1 : 1) monohydrate. *N,N*-dimethyl biguanide hydrochloride

Molecular formula :  $C_{16}H_{15}F_6N_5O \cdot H_3PO_4 \cdot H_2O$   $C_4H_{11}N_5 \cdot HCl$

Molecular mass : 523.32 165.63

Structural formula :



Physicochemical properties :

Sitagliptin phosphate monohydrate is a white to off-white, crystalline, non-hygroscopic powder. It is soluble in water and *N,N*-dimethyl formamide; slightly soluble in methanol; very slightly soluble in ethanol, acetone, and acetonitrile; and insoluble in isopropanol and isopropyl acetate.

Metformin hydrochloride is a white to off-white crystalline compound. It is freely soluble in water and is practically insoluble in acetone, ether and chloroform. The  $pK_a$  of metformin is 12.4. The pH of a 1% aqueous solution of metformin hydrochloride is 6.68.

## CLINICAL TRIALS

Clinical studies of the co-administration of sitagliptin and metformin demonstrated significant improvements in glycemic control in patients with type 2 diabetes. None of the clinical efficacy studies described below were conducted with JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR tablets; however, bioequivalence of JANUMET<sup>®</sup> tablets with co-administered sitagliptin and immediate-release metformin hydrochloride tablets and JANUMET<sup>®</sup> XR tablets with co-administered sitagliptin and extended-release metformin tablets has been demonstrated (see [ACTION AND CLINICAL PHARMACOLOGY](#)).

Regimens of extended-release 500 mg metformin were at least as effective as corresponding regimens of an immediate-release 500 mg metformin in all measures of glycemic control. Additionally, once daily administration of two 500 mg extended-release metformin tablets was as effective as the commonly prescribed twice daily administration of the 500 mg immediate-release metformin formulation.

The combination of sitagliptin and metformin has been evaluated for safety and efficacy in four double-blind, placebo-controlled studies and in one double-blind, active controlled clinical study in patients with type 2 diabetes mellitus. In all studies, patients with inadequate glycemic control on stable doses of metformin  $\geq 1500$  mg were randomized to receive either sitagliptin 100 mg per day, or placebo or an active comparator, in addition to ongoing background therapy.

### **Sitagliptin in Combination with Metformin**

**Placebo-Controlled Study:** A total of 701 patients with type 2 diabetes participated in a 24-week, randomized, double-blind, placebo-controlled study designed to assess the efficacy of sitagliptin in combination with metformin. All patients were started on metformin monotherapy and the dose increased to at least 1500 mg per day. Patients were randomized to the addition of either 100 mg of sitagliptin or placebo, administered once daily. Patients with congestive heart failure requiring pharmacological treatment were excluded from this study.

In combination with metformin, sitagliptin provided significant improvements in HbA<sub>1c</sub>, FPG, and 2-hour PPG compared to placebo with metformin (Table 7). The improvement in HbA<sub>1c</sub> was not affected by baseline HbA<sub>1c</sub>, prior anti-hyperglycemic therapy, gender, age, baseline BMI, length of time since diagnosis of diabetes, presence of metabolic syndrome (according to NCEP criteria), or standard indices of insulin resistance (HOMA-IR) or insulin secretion (HOMA- $\beta$ ). Body weight decreased from baseline in both treatment groups.

**Table 7 – Glycemic Parameters and Body Weight at Final Visit (24 Week Study) for Sitagliptin in Combination with Metformin<sup>†</sup>**

	<b>Sitagliptin 100 mg + Metformin</b>	<b>Placebo + Metformin</b>
<b>HbA<sub>1c</sub> (%)</b>	<b>N=453</b>	<b>N=224</b>
Baseline (mean)	8.0	8.0
Change from baseline (adjusted mean <sup>‡</sup> )	-0.7	-0.0
Difference from placebo + metformin (adjusted mean <sup>‡</sup> )	-0.7 <sup>§</sup>	
Patients (%) achieving HbA <sub>1c</sub> <7%	213 (47.0%)	41 (18.3%)
<b>FPG (mmol/L)</b>	<b>N=454</b>	<b>N=226</b>
Baseline (mean)	9.4	9.6
Change from baseline (adjusted mean <sup>‡</sup> )	-0.9	0.5
Difference from placebo + metformin (adjusted mean <sup>‡</sup> )	-1.4 <sup>§</sup>	
<b>2-hour PPG (mmol/L)</b>	<b>N=387</b>	<b>N=182</b>
Baseline (mean)	15.3	15.1
Change from baseline (adjusted mean <sup>‡</sup> )	-3.4	-0.6
Difference from placebo + metformin (adjusted mean <sup>‡</sup> )	-2.8 <sup>§</sup>	
<b>Body Weight (kg)<sup>*</sup></b>	<b>N=399</b>	<b>N=169</b>
Baseline (mean)	86.9	87.6
Change from baseline (adjusted mean <sup>‡</sup> )	-0.7	-0.6
Difference from placebo + metformin (adjusted mean <sup>‡</sup> )	-0.1 <sup>¶</sup>	

<sup>†</sup> All Patients Treated Population (an intention-to-treat analysis).

<sup>‡</sup> Least squares means adjusted for prior antihyperglycemic therapy and baseline value.

<sup>§</sup> p<0.001 compared to placebo + metformin.

<sup>\*</sup> All Patients as Treated (APaT) population, excluding patients given glycemic rescue therapy.

<sup>¶</sup> Not statistically significant (p≥0.05) compared to placebo + metformin.

**Active-Controlled (Sulfonylurea Agent) Study:** Long-term maintenance of effect was evaluated in a 52-week, double-blind, glipizide-controlled trial in patients with type 2 diabetes and inadequate glycemic control on metformin monotherapy at ≥1500 mg/day. In this study, patients were randomized to the addition of either sitagliptin 100 mg daily (N=588) or glipizide (N=584) for 52 weeks. Patients receiving glipizide were given an initial dosage of 5 mg/day and then electively titrated by the investigator to a target FPG of 6.1 mmol/L, without significant hypoglycemia, over the next 18 weeks. A maximum dosage of 20 mg/day was allowed to optimize glycemic control. Thereafter, the glipizide dose was to have been kept constant. The mean daily dose of glipizide after the titration period was 10.3 mg.

Both treatments resulted in a statistically significant improvement in glycemic control from baseline. After 52 weeks, the reduction from baseline in HbA<sub>1c</sub> was 0.67% for sitagliptin 100 mg daily and 0.67% for glipizide, confirming the non-inferiority of sitagliptin compared to glipizide. The reduction in FPG was 0.6 mmol/L for sitagliptin and 0.4 mmol/L for glipizide. In this study, the proinsulin to insulin ratio, a marker of efficiency of insulin synthesis and release, improved with sitagliptin relative to glipizide. The incidence of hypoglycemia in the sitagliptin group (4.9%) was significantly lower than that in the glipizide group (32.0%). Patients treated with sitagliptin exhibited a significant mean decrease from baseline in body weight compared to a significant weight gain in patients administered glipizide (-1.5 kg vs. +1.1 kg).

### **Sitagliptin Add-on Combination Therapy**

**Add-on Combination Therapy with Metformin plus Glimepiride:** In a 24-week, randomized, double-blind, placebo-controlled study designed to assess the efficacy of sitagliptin 100 mg once daily (N=116) compared to placebo (N=113), 229 patients were on the combination of glimepiride (≥4 mg per day) and metformin (≥1500 mg per day); the results of the glycemic endpoints, including HbA<sub>1c</sub> and FPG, are described below.

The combination of sitagliptin, glimepiride, and metformin provided significant reduction from baseline in HbA<sub>1c</sub> and FPG compared to placebo (see Table 8). Mean reductions from baseline in HbA<sub>1c</sub> compared with placebo were generally greater for patients with higher baseline HbA<sub>1c</sub> values. Patients treated with sitagliptin, had a modest increase in body weight (0.4 kg) compared to those given placebo who had a significant decrease in body weight (-0.7 kg).

**Table 8 – Glycemic Parameters and Body Weight at Final Visit (24-Week Study) for Sitagliptin in Add-on Combination Therapy with Metformin plus Glimepiride<sup>†</sup>**

	<b>Sitagliptin 100 mg + Metformin + Glimepiride</b>	<b>Placebo + Metformin + Glimepiride</b>
<b>HbA<sub>1c</sub> (%)</b>	<b>N=115</b>	<b>N=105</b>
Baseline (mean)	8.27	8.28
Change from baseline (adjusted mean <sup>‡</sup> )	-0.59	0.30
Difference from placebo (adjusted mean <sup>‡</sup> )	-0.89 <sup>§</sup>	
Patients (%) achieving HbA <sub>1c</sub> <7%	26 (22.6)	1 (1.0)
<b>FPG (mmol/L)</b>	<b>N=115</b>	<b>N=109</b>
Baseline (mean)	9.95	9.93
Change from baseline (adjusted mean <sup>‡</sup> )	-0.43	0.72
Difference from placebo (adjusted mean <sup>‡</sup> )	-1.15 <sup>§</sup>	
<b>Body Weight (kg)<sup>*</sup></b>	<b>N=102</b>	<b>N=74</b>
Baseline (mean)	86.5	84.6
Change from baseline (adjusted mean <sup>‡</sup> )	0.4	-0.7
Difference from placebo (adjusted mean <sup>‡</sup> )	1.1 <sup>††</sup>	

<sup>†</sup> All Patients Treated Population (an intention-to-treat analysis).

<sup>‡</sup> Least squares means adjusted for prior antihyperglycemic therapy status and baseline value.

<sup>§</sup> p<0.001 compared to placebo.

<sup>\*</sup> All Patients as Treated (APaT) population, excluding patients given glycemic rescue therapy.

<sup>††</sup> p=0.007 compared to placebo.

**Add-on Combination Therapy with Metformin and Insulin:** A total of 641 patients with type 2 diabetes participated in a 24-week, randomized, double-blind, placebo-controlled study designed to assess the efficacy of sitagliptin 100 mg once daily in combination with insulin.

Approximately 75% (n=462) of patients were also taking metformin. Patients with an HbA<sub>1c</sub> of 7.5% to 11.0% while on a stable regimen of pre-mixed, long-acting or intermediate acting insulin, and metformin ( $\geq 1500$  mg per day) were randomized to the addition of either 100 mg of sitagliptin or placebo. Patients using pre-meal short-acting or rapid-acting insulins that were not components of a pre-mixed insulin formulation, or that were administered via insulin pumps, were not included in this study. Glycemic endpoints measured included HbA<sub>1c</sub>, FPG and 2-hour PPG. The combination of sitagliptin, metformin and insulin provided significant improvements in HbA<sub>1c</sub>, FPG and 2-hour PPG compared to placebo, metformin and insulin (Table 9). There was no meaningful change from baseline in body weight in either group.

**Table 9 – Glycemic Parameters and Body Weight at Final Visit (24-Week Study) for Sitagliptin as Add-on Combination Therapy with Metformin and Insulin<sup>†</sup>**

	<b>Sitagliptin 100 mg + Insulin + Metformin</b>	<b>Placebo + Insulin + Metformin</b>
<b>HbA<sub>1c</sub> (%)</b>	<b>N=223</b>	<b>N=229</b>
Baseline (mean)	8.7	8.6
Change from baseline (adjusted mean <sup>‡</sup> )	-0.7	-0.1
Difference from placebo (adjusted mean <sup>‡,§</sup> )	-0.5*	
Patients (%) achieving HbA <sub>1c</sub> <7%	32 (14.3)	12 (5.2)
<b>FPG (mmol/L)</b>	<b>N=225</b>	<b>N=229</b>
Baseline (mean)	9.6	9.8
Change from baseline (adjusted mean <sup>‡</sup> )	-1.2	-0.2
Difference from placebo (adjusted mean <sup>‡</sup> )	-1.0*	
<b>2-hour PPG (mmol/L)</b>	<b>N=182</b>	<b>N=189</b>
Baseline (mean)	15.6	15.6
Change from baseline (adjusted mean <sup>‡</sup> )	-2.2	0.1
Difference from placebo (adjusted mean <sup>‡</sup> )	-2.2*	
<b>Body Weight (kg)<sup>¶</sup></b>	<b>N=201</b>	<b>N=200</b>
Baseline (mean)	87.9	88.0
Change from baseline (adjusted mean <sup>‡</sup> )	-0.1	0.0
Difference from placebo (adjusted mean <sup>‡</sup> )	-0.1 <sup>#</sup>	

<sup>†</sup> All Patients Treated Population (an intention-to-treat analysis).

<sup>‡</sup> Least squares mean adjusted for insulin use at Visit 1 (premixed vs. non-pre-mixed [intermediate- or long-acting]), and baseline value.

<sup>§</sup> Treatment by insulin stratum interaction was not significant (p>0.10).

\* p<0.001 compared to placebo.

<sup>¶</sup> All Patients as Treated (APaT) population, excluding data following glycemic rescue therapy.

<sup>#</sup> Not statistically significant (p $\geq$ 0.05) compared to placebo.

**Add-on Combination Therapy with Metformin plus Pioglitazone:** A total of 313 patients with type 2 diabetes participated in a 26-week, randomized, double-blind, placebo-controlled study designed to assess the efficacy of sitagliptin in combination with pioglitazone and metformin. Patients with inadequate glycemic control on a stable regimen of pioglitazone (30 or 45 mg per day) and metformin ( $\geq 1500$  mg per day) were randomized to the addition of either 100 mg of sitagliptin or placebo, administered once daily.

In combination with pioglitazone and metformin, sitagliptin provided significant improvements in HbA<sub>1c</sub>, FPG, and 2-hour PPG compared to placebo with pioglitazone and metformin

(Table 10). Lipid effects were generally neutral. The difference between sitagliptin and placebo in body weight change was not significant.

**Table 10 – Glycemic Parameters and Body Weight at Final Visit (26-Week Study) for Sitagliptin as Add-on Combination Therapy with Pioglitazone and Metformin<sup>†</sup>**

	Sitagliptin 100 mg + Pioglitazone 30 or 45 mg + Metformin	Placebo + Pioglitazone 30 or 45 mg + Metformin
<b>HbA<sub>1c</sub> (%)</b>	<b>N=152</b>	<b>N=153</b>
Baseline (mean)	8.8	8.6
Change from baseline (adjusted mean <sup>‡</sup> )	-1.2	-0.4
Difference from placebo (adjusted mean <sup>‡</sup> )	-0.7 <sup>§</sup>	
Patients (%) achieving HbA <sub>1c</sub> <7%	38 (25.0)	15 (9.8)
<b>FPG (mmol/L)</b>	<b>N=155</b>	<b>N=153</b>
Baseline (mean)	10.0	9.6
Change from baseline (adjusted mean <sup>‡</sup> )	-1.1	-0.2
Difference from placebo (adjusted mean <sup>‡</sup> )	-1.0 <sup>§</sup>	
<b>2-hour PPG (mmol/L)</b>	<b>N=141</b>	<b>N=135</b>
Baseline (mean)	15.3	14.7
Change from baseline (adjusted mean <sup>‡</sup> )	-3.0	-0.8
Difference from placebo (adjusted mean <sup>‡</sup> )	-2.2 <sup>§</sup>	
<b>Body Weight (kg)<sup>*</sup></b>	<b>N=146</b>	<b>N=128</b>
Baseline (mean)	81.4	82.0
Change from baseline (adjusted mean <sup>‡</sup> )	1.3	1.1
Difference from placebo (adjusted mean <sup>‡</sup> )	0.1 <sup>¶</sup>	

<sup>†</sup> Full Analysis Set population (an intention-to-treat analysis).

<sup>‡</sup> Least squares mean adjusted for baseline value.

<sup>§</sup> p<0.001 compared to placebo.

<sup>\*</sup> All Patients as Treated (APaT) population, excluding data following glycemic rescue therapy.

<sup>¶</sup> Not statistically significant (p≥0.05) compared to placebo.

**TECOS Cardiovascular Safety Study:** The Trial Evaluating Cardiovascular Outcomes with Sitagliptin (TECOS) was a randomized, double-blind, placebo-controlled, parallel-group, event-driven, multicenter study in patients with type 2 diabetes mellitus (HbA<sub>1c</sub> ≥6.5 to 8.0%) and established vascular disease (coronary artery disease, ischemic cerebrovascular disease, atherosclerotic peripheral artery disease). The study included 14,671 patients (70.7% male, 29.3% female) in the intention-to-treat population who received sitagliptin (N=7,332) 100 mg daily (or 50 mg daily if the baseline eGFR was ≥30 and <50 mL/min/1.73 m<sup>2</sup>) or placebo (N=7,339) added to usual care targeting regional standards for HbA<sub>1c</sub> and CV risk factors. The median duration of treatment was 31 months and the median duration of follow-up was 36 months. Patients with an eGFR <30 mL/min/1.73 m<sup>2</sup> were not to be enrolled in the study. The study population included 10,863 patients with coronary artery disease, 3,588 patients with cerebrovascular disease, 2,433 patients with peripheral artery disease, 2,643 patients with prior congestive heart failure (including 373 with New York Heart Association [NYHA] class 3 or higher), 2,004 patients ≥75 years of age and 3,324 patients with renal impairment (eGFR <60 mL/min/1.73 m<sup>2</sup>).

The primary cardiovascular endpoint was a composite of the first occurrence of cardiovascular death, non-fatal myocardial infarction, non-fatal stroke, or hospitalization for unstable angina. Secondary cardiovascular endpoints included a composite of the first occurrence of cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke; as well as first occurrence of the following independent CV endpoints: cardiovascular death, myocardial infarction (fatal + non-fatal), stroke (fatal + non-fatal), hospitalization for unstable angina, hospitalization for heart failure, and all-cause mortality. A composite endpoint of first occurrence of death due to heart failure or hospitalization for congestive heart failure was also assessed.

Sitagliptin, when added to usual care, did not increase the risk of major adverse cardiovascular events or the risk of death or hospitalization for heart failure compared to usual care without sitagliptin patients with type 2 diabetes. Superiority to placebo was not demonstrated for any endpoint (Table 11).



**Table 11 – Rates of Composite Cardiovascular Outcomes and Key Secondary Outcomes Censored at End of Follow-up (Intention-to-Treat Population)**

	Sitagliptin (N=7,332)		Placebo (N=7,339)		Hazard Ratio (95% CI)	p-value <sup>†</sup>
	Subjects with Events N (%)	Incidence Rate per 100 Patient- Years*	Subjects with Events N (%)	Incidence Rate per 100 Patient- Years*		
<b>Primary Composite Endpoint</b> (Cardiovascular death, non-fatal myocardial infarction, non-fatal stroke, or hospitalization for unstable angina)	839 (11.4)	4.1	851 (11.6)	4.2	0.98 (0.89, 1.08)	<0.001
<b>Secondary Composite Endpoint</b> (Cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke)	745 (10.2)	3.6	746 (10.2)	3.6	0.99 (0.89, 1.10)	<0.001
<b>Secondary Outcome</b>						
Cardiovascular death	380 (5.2)	1.7	366 (5.0)	1.7	1.03 (0.89, 1.19)	0.711
All myocardial infarction (fatal and non-fatal)	300 (4.1)	1.4	316 (4.3)	1.5	0.95 (0.81, 1.11)	0.487
All stroke (fatal and non-fatal)	178 (2.4)	0.8	183 (2.5)	0.9	0.97 (0.79, 1.19)	0.760
Hospitalization for unstable angina	116 (1.6)	0.5	129 (1.8)	0.6	0.90 (0.70, 1.16)	0.419
Death from any cause	547 (7.5)	2.5	537 (7.3)	2.5	1.01 (0.90, 1.14)	0.875
Hospitalization for heart failure <sup>‡</sup>	228 (3.1)	1.1	229 (3.1)	1.1	1.00 (0.83, 1.20)	0.983
Death due to heart failure or hospitalization for heart failure <sup>‡</sup>	237 (3.2)	1.1	240 (3.3)	1.1	0.99 (0.83, 1.18)	0.909

\* Incidence rate per 100 patient-years is calculated as  $100 \times (\text{total number of patients with } \geq 1 \text{ event during eligible exposure period per total patient-years of follow-up})$ .

<sup>†</sup> Based on a Cox model stratified by region. For composite endpoints, the p-values correspond to a test of non-inferiority seeking to show that the hazard ratio is less than 1.3. For all other endpoints, the p-values correspond to a test of differences in hazard rates.

<sup>‡</sup> The analysis of hospitalization for heart failure was adjusted for a history of heart failure at baseline.

### *Metformin hydrochloride*

The prospective randomized (UKPDS) study has established the long-term benefit of intensive blood glucose control in adult patients with type 2 diabetes. Analysis of the results for overweight patients treated with metformin after failure of diet alone showed:

- A significant reduction of the absolute risk of any diabetes-related complication in the metformin group (29.8 events/1000 patient-years) versus diet alone (43.3 events/1000 patient-years),  $p=0.0023$ , and versus the combined sulfonylurea and insulin monotherapy groups (40.1 events/1000 patient-years),  $p=0.0034$ .

- A significant reduction of the absolute risk of diabetes-related mortality: metformin 7.5 events/1000 patient-years, diet alone 12.7 events/1000 patient-years,  $p=0.017$ . There was no significant difference between the metformin group and those assigned intensive therapy with sulfonylurea or insulin.
- A significant reduction of the absolute risk of overall mortality: metformin 13.5 events/1000 patient-years versus diet alone 20.6 events/1000 patient-years ( $p=0.011$ ), and versus the combined sulfonylurea and insulin monotherapy groups 18.9 events/1000 patient-years ( $p=0.021$ ).
- A significant reduction in the absolute risk of myocardial infarction: metformin 11 events/1000 patient-years, diet alone 18 events/1000 patient-years ( $p=0.01$ ). There was no significant difference between the metformin group and those assigned intensive therapy with sulfonylurea or insulin.
- There were no significant differences between the metformin group and the diet alone in the other aggregate endpoints (stroke, peripheral vascular disease and microvascular complications).

## DETAILED PHARMACOLOGY

### *Sitagliptin*

Sitagliptin was assessed for its ability to improve glucose tolerance in lean and diet-induced obese (DIO) mice following dextrose challenge and in diabetic (db/db) mice. In lean and DIO mice, single oral doses of sitagliptin reduced blood glucose levels in a dosage-dependent manner. Acute lowering of blood glucose was also demonstrated in diabetic db/db mice. A 2- to 3-fold increase in active GLP-1 was seen at the maximally effective dose of 1 mg/kg sitagliptin in lean mice. These results are consistent with the action of sitagliptin as an anti-hyperglycemic agent.

Treatment with GLP-1 or with DPP-4 inhibitors in animal models of type 2 diabetes has been demonstrated to improve beta cell responsiveness to glucose, stimulate insulin biosynthesis and release, increase beta cell neogenesis, and decrease beta cell death. The effects on beta cell neogenesis and beta cell death have not been studied in humans.

### *Metformin hydrochloride*

Metformin absorption is relatively slow and may extend over about 6 hours. Animal studies with metformin, labelled with  $^{14}\text{C}$  have shown that the drug is neither concentrated by liver cells nor is it excreted in the bile; it is concentrated in the intestinal mucosa and salivary glands.

It has been shown that, following a 2 g dose of metformin, the blood level remains under 10 mcg/mL even at the peak, occurring 2 hours after absorption. During the experiments, metformin was shown to be devoid of any notable action in the body, apart from its specific metabolic activity.

In the healthy animal, metformin lowers blood sugar only at a nearly lethal dose. Different animal species are of unequal sensitivity. On the other hand, the animal with experimental diabetes, is sensitive to a much lower dosage, providing some insulin is still secreted.

The antihyperglycemic action of metformin is probably mediated through insulin:

Metformin improves the K co-efficient of glucose assimilation.

Metformin improves the co-efficient of insulin efficiency.

In the obese diabetic with hyperinsulinemia, metformin is reported to normalize insulin output. This normalizing effect is concurrent to that of glycaemia.

Metformin has little effect on liver glycogen of the healthy animal. In low and average doses, no change occurs. In high doses nearing lethal levels, liver glycogen decreases. This lowering precedes the fall in blood sugar. This reaction represents a defense mechanism tending to mobilize body reserves in order to combat hypoglycemia.

In the diabetic animal with a low liver glycogen reserve, the opposite occurs and metformin builds up glycogen stores of the liver. *In vitro*, on muscular tissue isolated in Warburg's apparatus, metformin increases glucose uptake by the muscle. This action follows an aerobic pathway. Even in high concentration, contrary to phenethyl-biguanide, metformin apparently does not block respiration or change carbohydrate metabolism via the anaerobic pathway.

Metformin is eliminated in faeces and urine. It is rapidly excreted by the kidneys in an unchanged form.

Renal clearance is 450 mL/minute; this appears to explain the absence of accumulation.

Metabolites of metformin have not been identified, neither by radio-active nor by chemical methods.

A single Rf spot is always present following radiochromatographic study of urine and always corresponds to that of pure metformin. Administration during 10 consecutive days has not shown any sign of accumulation.

Inhibition of glyconeogenesis has been observed in animals following its stimulation by fasting, cortisol, alcohol or other substrates such as alanine lactate or pyruvate. However, such an effect varies according to the type and dosage of the biguanide used, nutritional state of the animal species and design of experimental model.

This inhibition of glyconeogenesis is observed only in the presence of insulin and it does not appear to play an important role in man.

Inhibition of intestinal absorption of sugars, which is not related to a malabsorption phenomenon has been observed with biguanides under certain experimental conditions in animal and in man. In one study, a 20% retardation of galactose absorption was observed in man receiving metformin. However, such an effect of metformin could not be confirmed in another study in man.

Recent findings appear to indicate that most of the metabolic effects of the biguanides are exerted through a single mechanism, namely inhibition of fatty acid oxidation and of acetyl-CoA generation.

However, inhibition of insulin-stimulated lipogenesis which has also been observed appears to be due to the inhibition of acetyl-CoA carboxylase by the biguanides. Such an effect may explain, at least partly, the weight-reducing effect exerted by these drugs in obese diabetic patients.

## **TOXICOLOGY**

No animal studies have been conducted with the combined products in JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR to evaluate carcinogenesis, mutagenesis, impairment of fertility or effects on reproduction. The following data are based on the findings in studies with sitagliptin and metformin individually and a 16 week toxicity study in dogs with the concomitant administration of sitagliptin and metformin.

### **Acute Toxicity**

#### *Sitagliptin*

The approximate LD<sub>50</sub> of sitagliptin given orally to rats is >3000 mg/kg (maximum dose tested). This dose is equivalent to  $\geq 200$  times the human exposure based on the recommended daily adult human dose of 100 mg/day. In mice the approximate oral LD<sub>50</sub> of sitagliptin is 4000 mg/kg. This dose is equivalent to >385 times the human exposure based on recommended daily adult human dose of 100 mg/day.

### **Chronic Toxicity**

#### *Sitagliptin and Metformin*

Preclinical toxicokinetic and oral toxicity studies in dogs have been conducted with the combined products in JANUMET<sup>®</sup>.

In a sixteen-week oral toxicity study, female dogs were administered 20 mg/kg/day of metformin, alone or in combination with 2, 10, or 50 mg/kg/day of sitagliptin. Transient ataxia and/or tremors were observed in the high-dose combination-treatment group. These signs were considered to be an effect of sitagliptin because they were seen in previous dog studies with sitagliptin alone at 50 mg/kg/day. The no-effect level for treatment-related changes in this study was 10 mg/kg/day of sitagliptin plus 20 mg/kg/day of metformin, which provided systemic exposure to sitagliptin of approximately 6 times that in patients treated with 100 mg/day of sitagliptin and systemic exposure to metformin of approximately 2.5 times that in patients treated with 2000 mg/day of metformin.

### *Sitagliptin*

The toxicity potential of sitagliptin was evaluated in a series of repeated dose toxicity studies of up to 53 weeks in dogs and up to 27 weeks in rats. In dogs administered sitagliptin orally at dosages of 2, 10 and 50 mg/kg/day, the no-observed effect level was 10 mg/kg/day (up to 6 times the human exposure based on the recommended daily adult human dose of 100 mg/day).

Treatment-related physical signs observed in the 50 mg/kg/day group included open-mouth breathing, salivation, white foamy emesis, ataxia, trembling, decreased activity, and/or hunched posture. These signs were transient, slight in degree, and occurred with decreased incidence during the course of the study. In addition, very slight to slight skeletal muscle degeneration was observed histologically in the 14- and 27-week toxicity studies at the 50 mg/kg/day dose.

However, no skeletal muscle degeneration was found in the 53-week toxicity study, indicating the lack of reproducibility or progression of this change with increased duration of treatment.

The 50 mg/kg/day dose in dogs resulted in systemic exposure values 26 times the human exposure at the recommended daily adult human dose of 100 mg/day. In rats, sitagliptin administered orally at dosages of up to 180 mg/kg/day (up to 23 times the human exposure based on the recommended daily adult human dose of 100 mg/day), no significant toxicity was observed. The only drug-related effect observed was post-dose salivation, likely related to poor palatability of the drug, at doses of 60 mg/kg/day and 180 mg/kg/day.

The treatment-related changes noted in animals do not suggest any clinical concerns at the recommended therapeutic dosages in humans.

### *Metformin hydrochloride*

In a 26-week oral toxicity study in rats, decrease in body weight gains were observed at 450 and 900 mg/kg/day, and changes in clinical laboratory parameters (decreased total leukocyte, lymphocyte and neutrophil count) and in some organ weights were noted at 900 mg/kg/day. The no-observed-adverse-effect level was 150 mg/kg/day (approximately 1.5 times the maximum recommended human daily dose based on body surface area comparisons).

In a 39-week oral toxicity study in dogs, treatment-related effects in food consumption were limited to females at 80 mg/kg/day. The no-observed-adverse-effect level was 80 mg/kg/day (approximately 2.6 times the maximum recommended human daily dose based on body surface area comparisons).

## **Carcinogenicity**

### *Sitagliptin*

A two-year carcinogenicity study was conducted in male and female rats given oral doses of sitagliptin of 50, 150, and 500 mg/kg/day. There was an increased incidence of hepatic adenomas and carcinomas in the high-dose males and hepatic carcinomas in the high-dose females. This dose in rats results in approximately 58 times the human exposure based on the recommended daily adult human dose of 100 mg/day. This dose level was associated with hepatotoxicity in rats. The no-observed effect level for induction of hepatic neoplasia was 150 mg/kg/day, approximately 19-fold the human exposure at the 100-mg recommended dose. Since hepatotoxicity has been shown to correlate with induction of hepatic neoplasia in rats, this increased incidence of hepatic tumors in rats was likely secondary to chronic hepatic toxicity at this high dose. The clinical significance of these findings for humans is unknown.

A two-year carcinogenicity study was conducted in male and female mice at oral doses of 50, 125, 250, and 500 mg/kg/day. Sitagliptin did not increase tumor incidence in mice in any organ at doses up to 500 mg/kg/day (approximately 68 times the human exposure based on the recommended daily adult human dose of 100 mg/day).

#### *Metformin hydrochloride*

Long-term carcinogenicity studies have been performed in rats (dosing duration of 104 weeks) and mice (dosing duration of 91 weeks) at doses up to and including 900 mg/kg/day and 1500 mg/kg/day, respectively. These doses are both approximately three times the maximum recommended human daily dose based on body surface area comparisons. No evidence of carcinogenicity with metformin was found in either male or female mice. Similarly, there was no tumorigenic potential observed with metformin in male rats. There was, however, an increased incidence of benign stromal uterine polyps in female rats treated with 900 mg/kg/day.

A carcinogenicity study was also conducted via dermal administration in Tg.AC transgenic mice at doses up to and including 2000 mg/kg/day. No evidence of carcinogenicity was observed in either male or female mice.

### **Mutagenesis**

#### *Sitagliptin*

Sitagliptin was not mutagenic or clastogenic in a battery of genetic toxicology studies, including the Ames bacterial assay (microbial mutagenesis test), Chinese hamster ovary cells (CHO cells) chromosome aberration assay, an *in vitro* cytogenetics assay using CHO cells, an *in vitro* rat hepatocyte DNA alkaline elution assay (an assay which measures the compound's ability to induce single strand breaks in DNA), and an *in vivo* micronucleus assay.

#### *Metformin hydrochloride*

There was no evidence of a mutagenic potential of metformin in the following *in vitro* tests: Ames test (*S. typhimurium*), gene mutation test (mouse lymphoma cells), or chromosomal aberrations test (human lymphocytes). Results in the *in vivo* mouse micronucleus test were also negative.

### **Reproduction**

#### *Sitagliptin*

No adverse effects upon fertility were observed in male and female rats given sitagliptin orally at doses up to 1000 mg/kg daily (up to approximately 100 times the human exposure based on the recommended daily adult human dose of 100 mg/day) prior to and throughout mating.

#### *Metformin hydrochloride*

Fertility of male or female rats was unaffected by metformin when administered at doses as high as 600 mg/kg/day, which is approximately three times the maximum recommended human daily dose based on body surface area comparisons.

A decrease in male reproductive organ weights was observed at higher oral dose of 900 mg/kg/day in a fertility and developmental toxicity study in rats.

## **Development**

No animal studies have been conducted with the combined products in JANUMET<sup>®</sup> or JANUMET XR<sup>®</sup> to evaluate effects on reproduction. The following data are based on findings in studies performed with sitagliptin or metformin individually.

### *Sitagliptin*

Sitagliptin was not teratogenic in rats at oral doses up to 250 mg/kg or in rabbits given up to 125 mg/kg during organogenesis (up to 32 and 22 times the human exposure based on the recommended daily adult human dose of 100 mg/day). A slight, treatment-related increased incidence of fetal rib malformations (absent, hypoplastic and wavy ribs) was observed in the offspring of rats at oral doses of 1000 mg/kg/day (approximately 100 times the human exposure based on the recommended daily adult human dose of 100 mg/day). The no-observed effect level for developmental effects was 250 mg/kg/day (32 times the human exposure based on the recommended daily adult human dose of 100 mg/day). Treatment-related decreases in the mean preweaning body weight of both sexes and postweaning body weight gain of male animals was observed in offspring of rats at oral doses of 1000 mg/kg.

### *Metformin hydrochloride*

Metformin was not teratogenic in rats and rabbits at doses up to 600 mg/kg/day. This represents an exposure of about 2 times the maximum recommended human daily dose based on body surface area comparisons. Determination of fetal concentrations demonstrated a partial placental barrier to metformin.

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**PART III: CONSUMER INFORMATION****JANUMET<sup>®</sup>**

**sitagliptin and metformin hydrochloride tablets**  
(as sitagliptin phosphate monohydrate and metformin hydrochloride)

**JANUMET<sup>®</sup> XR**

**sitagliptin and metformin hydrochloride modified-release tablets**  
(as sitagliptin phosphate monohydrate and metformin hydrochloride)

This leaflet is Part III of a three-part “Product Monograph” published when JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR was approved for sale in Canada and is designed specifically for Consumers. This leaflet is a summary and will not tell you everything about JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR. Contact your physician or pharmacist if you have any questions about the drug.

**ABOUT THIS MEDICATION**What the medication is used for:

JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR are used in addition to diet and exercise to improve blood sugar levels in patients with type 2 diabetes mellitus

- Alone, in patients who are not controlled on metformin alone or currently on sitagliptin and metformin; OR
- In combination with a sulfonylurea, in patients who are not controlled on metformin and a sulfonylurea.
- JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR can be taken with premixed or long/intermediate acting insulin.
- In combination with pioglitazone, in patients who are not controlled on metformin and pioglitazone.

What it does:

JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR are a tablet that contains sitagliptin and metformin. These two medicines work together to help you achieve better blood sugar control.

Sitagliptin is a member of a class of medicines called DPP-4 inhibitors (dipeptidyl peptidase-4 inhibitors). Sitagliptin helps to improve the levels of insulin when blood sugar level is high, especially after a meal. Sitagliptin also helps to decrease the amount of sugar made by the body. Sitagliptin is unlikely to cause low blood sugar (**hypoglycemia**).

Metformin is a member of the biguanide class of medicines, it helps to lower the amount of sugar made by the liver. Together, these medicines help you to achieve better blood sugar control.

What is type 2 diabetes?

Type 2 diabetes is a condition in which your body does not make enough insulin, and/or does not use the insulin that your body

produces as well as it should. When this happens, sugar (glucose) builds up in the blood. This can lead to serious problems.

When it should not be used:

Do not take JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR if you:

- Have unstable and/or insulin-dependent (type 1) diabetes mellitus.
- Have metabolic acidosis (including diabetic ketoacidosis, history or ketoacidosis or lactic acidosis – too much acid in the blood).
- Have severe kidney disease.
- Have liver problems.
- Drink alcohol very often, or drink a lot of alcohol in the short term (“binge” drinking).
- Have severe heart problems or heart failure.
- Have a lack of oxygen in the blood. This is called hypoxemia. This can happen when you have conditions that affect your heart or breathing.
- Are stressed, have severe infections, are experiencing trauma, are about to have surgery, or are recovering from surgery.
- Have severe **dehydration** (have lost a lot of water from your body) or shock.
- Are allergic to sitagliptin, metformin, or any of the ingredients in JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR. See “What the non-medicinal ingredients are”.
- Are breastfeeding.
- Are pregnant or planning to become pregnant.
- Are going to get or receive an injection of dye or contrast agent for an x-ray procedure. Talk to your physician or pharmacist about when to stop JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR and when to start again.

What the medicinal ingredients are:

Sitagliptin phosphate monohydrate and metformin hydrochloride

What the non-medicinal ingredients are:

Each film-coated tablet of JANUMET<sup>®</sup> contains the following inactive ingredients: microcrystalline cellulose, polyvinylpyrrolidone, sodium lauryl sulfate, and sodium stearyl fumarate. In addition, the film coating contains the following inactive ingredients: polyvinyl alcohol, polyethylene glycol, talc, titanium dioxide, red iron oxide, and black iron oxide.

Each modified-release tablet of JANUMET<sup>®</sup> XR contains the following inactive ingredients: colloidal silicon dioxide, hypromellose, kaolin, polyethylene glycol, povidone, propyl gallate, and sodium stearyl fumarate. The JANUMET<sup>®</sup> XR 50 mg/500 mg tablet contains the additional inactive ingredient microcrystalline cellulose. In addition, the film coating contains the following inactive ingredients: hypromellose, hydroxypropyl cellulose, titanium dioxide, FD&C Blue #2/Indigo Carmine Aluminum Lake and carnauba wax. The JANUMET<sup>®</sup> XR 50 mg/1000 mg tablet contains the additional inactive ingredient yellow iron oxide.

What dosage forms it comes in:

JANUMET<sup>®</sup> tablets contain sitagliptin/metformin hydrochloride 50 mg/500 mg, 50 mg/850 mg, or 50 mg/1000 mg.

JANUMET<sup>®</sup> XR tablets contain immediate release sitagliptin (as sitagliptin phosphate monohydrate) /extended-release metformin hydrochloride 50 mg/500 mg, 50 mg/1000 mg or 100 mg/1000 mg.

**WARNINGS AND PRECAUTIONS**

**Serious Warnings and Precautions**

**Lactic acidosis** is a rare but serious buildup of acid in the blood. It can cause death. It must be treated in the hospital. JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR contains a drug called metformin hydrochloride. If you build up too much metformin in your blood you are at risk for lactic acidosis.

Alcohol increases the risk of lactic acidosis caused by metformin. Do not “binge” drink or drink alcohol often when you are taking JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR.

**Lactic Acidosis**

**Stop taking JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR if you get the following symptoms of lactic acidosis:**

- You feel very weak and tired.
- You have unusual (not normal) muscle pain.
- You have trouble breathing.
- You have stomach pain with nausea and vomiting, or diarrhea.
- You feel cold, especially in your arms and legs.
- You feel dizzy or lightheaded.
- You have a slow or irregular heartbeat.
- Your medical condition suddenly changes.

**You have a higher chance of getting lactic acidosis if you:**

- have severe kidney problems. Your kidneys can be affected by certain x-ray tests that use injected dye. JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR is usually stopped before and for two days after such a test. Your doctor should discuss this with you;
- have liver problems
- have congestive heart failure that requires treatment with medicines;
- drink a lot of alcohol (very often or short-term “binge” drinking);
- get **dehydration** (lose a large amount of body fluids). This can happen if you are sick with a fever, vomiting, or diarrhea. Dehydration can also happen when you sweat a lot with activity or exercise and don’t drink enough fluids;
- have certain x-ray tests with injectable dyes or contrast agents used;
- have surgery. Talk with your doctor before any surgery if you must restrict what you eat and drink. In these cases, JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR should be stopped for 2 days before the surgery. Wait until you are eating and

drinking again before you restart JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR. You doctor should discuss this with you;

- have a heart attack, severe infection, or stroke;
- take other medications;

BEFORE or while taking JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR talk to your physician or pharmacist if:

- you are older than 65 years of age;
- you have or have had pancreatitis (inflammation of the pancreas);
- you have risk factors for pancreatitis such as:
  - gallstones (solid particles that form in the gall bladder),
  - a history of alcoholism,
  - high triglyceride levels;
- you are receiving treatment with insulin or are taking a sulfonylurea. When JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR is used in combination with sulfonylurea or insulin, low blood sugar can occur. Your physician may consider lowering the dose of the sulfonylurea or insulin. Take precautions to avoid low blood sugar while driving or using machinery;
- you have heart problems including congestive heart failure (a condition where your heart becomes weaker and less able to pump the blood that your body needs);
- you have or have had severe kidney problems;
- you have liver problems;
- you had an organ transplant;
- you have human immunodeficiency syndrome (HIV);
- you have vitamin B<sub>12</sub> deficiency or anemia;
- you have hypothyroidism (low levels of thyroid hormones).

JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR are not recommended for use in patients under 18 years of age.

JANUMET<sup>®</sup> and JANUMET<sup>®</sup> XR may cause abnormal kidney function.

Cases of inflammation of the pancreas (**pancreatitis**) have been reported in patients taking JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR. Pancreatitis can be severe and lead to death.

Cases of **serious skin reactions** can occur and have been reported in patients taking JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR. These skin reactions are called **Stevens-Johnson syndrome** and **bullous pemphigoid**. They can happen after the first dose or up to 3 months on the drug. You may need treatment in a hospital. You may need to see a dermatologist to diagnose and treat these skin reactions.

**INTERACTIONS WITH THIS MEDICATION**

**Tell your healthcare professional about all the medicines you take, including any drugs, vitamins, minerals, natural supplements, or alternative medicines.**

If you start any new medicine, tell your healthcare professional.

**The following may interact with JANUMET® or JANUMET® XR:**

- Other diabetes drugs such as glyburide.
- Furosemide.
- Nifedipine (used to treat high blood pressure and chest pain).
- Drugs that decrease the rate of elimination of metformin from your body (e.g., ranolazine, vandetanib, dolutegravir and cimetidine).
- Certain “blood thinners” (phenprocoumon or other antivitamin K anticoagulants).
- Other drugs that tend to produce high blood sugar (hyperglycemia) and may lead to a loss of blood sugar control. Some example of drugs that can increase the blood sugar include:
  - Thiazide and other diuretics (water pills)
  - Corticosteroids (used to treat joint pain and swelling)
  - Phenothiazines (used to treat schizophrenia)
  - Thyroid products
  - Estrogens or estrogens plus progestogen
  - Oral contraceptives (birth control pills)
  - Phenytoin (used to treat epilepsy)
  - Nicotinic Acid
  - Sympathomimetics (used for heart problems)
  - Calcium channel blocking drugs (used for high blood pressure)
  - Isoniazid (used to treat tuberculosis)
  - Beta-2-agonists (used to treat breathing problems)
  - Carbonic anhydrase inhibitors
- ACE inhibitors drugs may lower blood glucose and the combination with JANUMET® or JANUMET® XR should be carefully monitored.

**PROPER USE OF THIS MEDICATION**

Your doctor will individualize your starting dose of JANUMET® or JANUMET® XR based on your current treatment regimen. Take JANUMET® or JANUMET® XR exactly as your physician has prescribed. Your physician will tell you how many JANUMET® or JANUMET® XR tablets to take and how often you should take them.

Your physician may adjust your dose, if needed to further control your blood sugar level.

Usual adult dose:

JANUMET® should be given 2 times a day by mouth with a meal to lower your chance of an upset stomach.

JANUMET® XR should be taken once a day with food preferably in the evening to lower your chance of an upset stomach.

If you take JANUMET® XR, swallow the JANUMET® XR tablets whole. Do not chew, cut, or crush the tablets. Tell your doctor if you cannot swallow JANUMET® XR whole. You may see something that looks like the JANUMET® XR tablet in your stool (bowel movement). If this happens, check your

blood sugar. If your blood sugar control has changed, contact your doctor. Do not stop taking JANUMET® XR without talking to your doctor.

Continue to take JANUMET® or JANUMET® XR as long as your physician prescribes it so you can continue to help control your blood sugar.

**You may need to stop JANUMET® or JANUMET® XR for a short time. Call your physician for instructions if you:**

- have a condition that may be associated with dehydration (large loss of body fluids) such as being sick with severe vomiting, diarrhea or fever, or if you drink fluids a lot less than normal;
- plan to have surgery;
- are going to get or receive an injection of dye or contrast agent for an x-ray procedure.

Overdose:

If you think you have taken too much JANUMET® or JANUMET® XR, contact your healthcare professional, hospital emergency department or regional Poison Control Centre immediately, even if there are no symptoms.

Missed Dose:

If you miss a dose, take it with food as soon as you remember. If you do not remember until it is time for your next dose, skip the missed dose and go back to your regular schedule. Do not take two doses of JANUMET® or JANUMET® XR at the same time.

**SIDE EFFECTS AND WHAT TO DO ABOUT THEM**

These are not all the possible side effects that you may have when taking JANUMET® or JANUMET® XR. If you experience any side effects not listed here, contact your healthcare professional.

Side effects of JANUMET® or JANUMET® XR include:

- Stuffiness or runny nose
- Sore throat
- Gastrointestinal symptoms: diarrhea, constipation, nausea, vomiting, abdominal bloating, upset stomach, gas and loss of appetite
- Headache
- Joint pain
- Arm or leg pain
- Back pain
- Muscle aches
- Itching
- Blisters

When JANUMET® or JANUMET® XR is used with a sulfonylurea medicine or with insulin, low blood sugar (hypoglycemia) can occur. Lower doses of the sulfonylurea medicine or insulin may be required while you used JANUMET® or JANUMET® XR.

JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR can cause abnormal blood test results. Your doctor will do blood tests before you start JANUMET<sup>®</sup> or JANUMET<sup>®</sup> XR and while you take it. They may check your blood sugar, liver and thyroid function, amount of vitamin B<sub>12</sub> and how well your kidneys are working. Your doctor will decide when to perform blood tests and will interpret the results.

**SERIOUS SIDE EFFECTS, HOW OFTEN THEY HAPPEN AND WHAT TO DO ABOUT THEM**

Symptoms / Effects	Talk with your physician or pharmacist		Stop taking drug and call your physician or pharmacist
	Only if severe	In all cases	
<b>Very common</b>			
<b>Hypoglycemia (low blood sugar - when used with a sulfonylurea or with insulin):</b> shaking, sweating, rapid heartbeat, change in vision, hunger, headache and change in mood.		✓	
<b>Rare</b>			
<b>Pancreatitis (inflammation of the pancreas):</b> prolonged severe stomach pain and possible vomiting			✓
<b>Allergic reactions:</b> rash, hives, and swelling of the face, lips, tongue, and throat that may cause difficulty in breathing or swallowing.			✓
<b>Serious skin reactions including Stevens-Johnson syndrome, bullous pemphigoid:</b> blisters or breakdown of your skin.		✓	
<b>Lactic acidosis (buildup of lactic acid in the blood):</b> malaise or a feeling of general discomfort, uneasiness or pain; feeling very weak or tired; sleepiness, drowsiness or an increasing strong desire for sleep; low blood pressure, dizziness, lightheadedness; cold hands or feet; slow or irregular heartbeat, trouble breathing; unusual muscle pain; stomach pain with nausea, vomiting, or diarrhea.			✓
<b>Encephalopathy (disease of the brain that severely alters thinking):</b> muscle weakness in one area, poor decision-making or concentration, involuntary twitching, trembling, difficulty speaking or swallowing, seizures.			✓
<b>Lowering of Thyroid Stimulating hormone level in patients with low thyroid function:</b> fatigue, feeling cold, dry skin, poor memory and concentration, weight gain.		✓	

**SERIOUS SIDE EFFECTS, HOW OFTEN THEY HAPPEN AND WHAT TO DO ABOUT THEM**

Symptoms / Effects	Talk with your physician or pharmacist		Stop taking drug and call your physician or pharmacist
	Only if severe	In all cases	
<b>Acute kidney failure (sometimes requiring dialysis):</b> nausea, loss of appetite and weakness, pass little or no urine, breathlessness.			✓
<b>Hemolytic anemia (when red blood cells are destroyed faster than bone marrow can replace them):</b> fatigue, pale color, rapid heartbeat, shortness of breath, dark urine, chills, and backache.			✓
<b>Peripheral neuropathy (a result of damage to your peripheral nerves):</b> gradual onset of numbness, prickling or tingling in your feet or hands, which can spread upward into your legs and arms, sharp, jabbing, throbbing, freezing or burning pain, extreme sensitivity to touch, lack of coordination and falling, muscle weakness or paralysis if motor nerves are affected.			✓
<b>Very rare</b>			
<b>Vitamin B<sub>12</sub> deficiency (decreased vitamin B<sub>12</sub> levels in the blood):</b> fatigue, shortness of breath, tingling or numbness of the fingers or toes, difficulty walking properly, irritability, confusion, tender calves.		✓	
<b>Hepatitis (inflammation of the liver) or liver disorder:</b> yellow of the skin or eyes, dark urine, abdominal pain, nausea, vomiting, loss of appetite.			✓

*If you have a troublesome symptom or side effect that is not listed here or becomes bad enough to interfere with your daily activities, talk to your healthcare professional.*

**HOW TO STORE IT**

The product should be stored at 15°C to 30°C.

**Keep out of reach and sight of children.**

**Reporting Side Effects**

You can report any suspected side effects associated with the use of health products to Health Canada by.

- Visiting the Web page on Adverse Reaction Reporting (<https://www.canada.ca/en/health-canada/services/drugs-health-products/medeffect-canada/adverse-reaction-reporting.html>) for information on how to report online, by mail or by fax; or
- Calling toll-free at 1-866-234-2345.

*NOTE: Contact your health professional if you need information about how to manage your side effects. The Canada Vigilance Program does not provide medical advice.*

**MORE INFORMATION****If you want more information about****JANUMET<sup>®</sup>/JANUMET<sup>®</sup> XR:**

- Talk to your healthcare professional
- Find the full product monograph that is prepared for healthcare professionals and includes this Consumer Information by visiting the [Health Canada website](#) or Merck Canada website [www.merck.ca](http://www.merck.ca) or by calling Merck Canada at 1-800-567-2594.

To report an adverse event related to JANUMET<sup>®</sup>/JANUMET<sup>®</sup> XR, please contact 1-800-567-2594.

This leaflet was prepared by Merck Canada Inc.

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