

# PRODUCT MONOGRAPH

## <sup>Pr</sup>**MINT-METFORMIN**

Metformin Hydrochloride Tablets

Tablet, 500 mg, 850 mg metformin  
hydrochloride, Oral

USP

Antihyperglycemic Agent

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## PRODUCT MONOGRAPH

### PrMINT-METFORMIN

Metformin Hydrochloride Tablets

Oral Antihyperglycemic Agent

## PART I: HEALTH PROFESSIONAL INFORMATION

### SUMMARY PRODUCT INFORMATION

Route of Administration	Dosage Form / Strength	Clinically Relevant Nonmedicinal Ingredients
Oral	Tablet / 500 mg and 850 mg	<i>For a complete listing see DOSAGE FORMS, COMPOSITION AND PACKAGING section.</i>

### INDICATIONS AND CLINICAL USE

MINT-METFORMIN (metformin hydrochloride) is indicated to improve glycemic control in adult patients with responsive, stable, mild, non-ketosis prone, type 2 diabetes mellitus as an adjunct to proper dietary management, exercise, and weight reduction, or when insulin therapy is not appropriate. MINT-METFORMIN can be used as monotherapy or in combination with other antidiabetic agents.

**Pediatrics (< 18 years of age):** The safety and effectiveness of metformin has not been studied in patients under 18 years of age. MINT-METFORMIN should not be used in pediatric patients (see **WARNINGS AND PRECAUTIONS, Special Populations, Pediatrics**).

**Geriatrics (> 65 years of age):** Controlled clinical studies of metformin did not include sufficient numbers of elderly patients to determine whether they respond differently from younger patients. Metformin is substantially excreted by the kidney and because the risk of serious adverse reactions to the drug is greater in patients with impaired renal function, MINT-METFORMIN should only be used in patients with normal renal function (see **CONTRAINDICATIONS** and **WARNINGS AND PRECAUTIONS, Renal**). Because aging is associated with reduced renal function, MINT-METFORMIN should be used with caution in geriatric patients. MINT-METFORMIN treatment should not be initiated in patients older than 80 years of age, unless measurement of creatinine clearance demonstrates that renal function is not reduced (see **WARNINGS AND PRECAUTIONS, Endocrine and Metabolism**, Lactic Acidosis, **Special Populations, Geriatrics**, and **DOSAGE AND ADMINISTRATION**).

## CONTRAINDICATIONS

- Unstable and/or insulin-dependent (Type I) diabetes mellitus.
- Acute or chronic metabolic acidosis, diabetic ketoacidosis, with or without coma, history of ketoacidosis with or without coma. Diabetic ketoacidosis should be treated with insulin.
- In patients with a history of lactic acidosis, irrespective of precipitating factors.
- In the presence of renal impairment or when renal function is not known, and also in patients with serum creatinine levels above the upper limit of normal range. Renal disease or renal dysfunction (e.g., as suggested by serum creatinine levels  $\geq 136$   $\mu\text{mol/L}$  (males),  $\geq 124$   $\mu\text{mol/L}$  (females) or abnormal creatinine clearance  $<60$  mL/min)) which may result from conditions such as cardiovascular collapse (shock), acute myocardial infarction, and septicemia (see also **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, MINT-METFORMIN should generally be avoided in patients with clinical or laboratory evidence of hepatic disease.
- MINT-METFORMIN should be temporarily discontinued in patients undergoing radiologic studies involving intravascular administration of iodinated contrast materials, because use of such products may result in acute alteration of renal function (see **WARNINGS AND PRECAUTIONS**).
- 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 or allergy to metformin hydrochloride or any of the excipients. For a complete listing, see the **DOSAGE FORMS, COMPOSITION AND PACKAGING** section of the product monograph.
- During pregnancy and breastfeeding.

## WARNINGS AND PRECAUTIONS

### Serious Warnings and Precautions

- Lactic acidosis is a rare, but serious, metabolic complication that occurs due to metformin accumulation during treatment with MINT-METFORMIN (see **Endocrine and Metabolism**, Lactic Acidosis section below).
- Patients should be cautioned against excessive alcohol intake, either acute or chronic, when taking MINT-METFORMIN, since alcohol intake potentiates the effect of metformin on lactate metabolism (see **Endocrine and Metabolism**, Lactic Acidosis section below).

### **Driving and Operating Machinery**

Patients should be warned about driving a vehicle or operating machinery under conditions where risks of hypoglycemia are present (see **WARNINGS AND PRECAUTIONS, Endocrine and Metabolism**, Hypoglycemia).

### **General**

#### **Patient Selection and Follow-up**

Careful selection of patients is important. It is imperative that there be rigid attention to diet and careful adjustment of dosage. Regular thorough follow-up examinations are necessary.

If vomiting occurs, withdraw drug temporarily, exclude lactic acidosis, and then resume dosage cautiously (see **ADVERSE REACTIONS**).

Particular attention should be paid to short range and long-range complications which are peculiar to diabetes (see **Monitoring and Laboratory Tests**).

Use of MINT-METFORMIN must be considered as treatment in addition to proper dietary regimen and not as a substitute for diet.

If during MINT-METFORMIN therapy the patient develops acute intercurrent disease such as: clinically significant hepatic dysfunction, cardiovascular collapse, congestive heart failure, acute myocardial infarction, or other conditions complicated by hypoxemia, the drug should be discontinued.

#### **Change in clinical status of previously controlled diabetes patients**

A diabetic patient previously well controlled on MINT-METFORMIN 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, MINT-METFORMIN must be stopped

immediately and appropriate corrective measures must be initiated.

Hypoxic states: Cardiovascular collapse (shock) from whatever cause, 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. When such events occur in patients on MINT-METFORMIN therapy, the drug should be promptly discontinued.

## **Endocrine and Metabolism**

### Hypoglycemia

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 or ethanol.

Elderly, debilitated or malnourished patients and patients with adrenal, pituitary, or hepatic 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 induces a reduction in thyrotropin (thyroid stimulating hormone (TSH)) levels in patients with treated or untreated hypothyroidism (see **ADVERSE REACTIONS, Post-Market Adverse Drug Reactions**). Regular monitoring of TSH levels is recommended in patients with hypothyroidism (see **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 **Monitoring and Laboratory Tests** and **DRUG INTERACTIONS, Levothyroxine**).

### Lactic Acidosis

Lactic acidosis is a rare, but serious, metabolic complication that occurs due to metformin accumulation during treatment with metformin. 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 µg/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) and occurs primarily in diabetic patients with significant renal insufficiency, including both intrinsic renal disease and renal hypoperfusion, often in the setting of multiple concomitant medical/surgical problems and multiple concomitant medications. 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. MINT-METFORMIN treatment should not be initiated in patients  $\geq 80$  years of age, unless measurement of creatinine clearance demonstrates that renal function is not reduced, as the patients are more susceptible to developing lactic acidosis. The risk of lactic acidosis increases with the degree of renal dysfunction and the patient's age. The risk of lactic acidosis may, therefore, be significantly decreased by regular monitoring of renal function in patients taking MINT-METFORMIN and by use of the minimum effective dose of MINT-METFORMIN. In addition, MINT-METFORMIN 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, MINT-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 MINT-METFORMIN (metformin hydrochloride), since alcohol intake potentiates the effect of metformin hydrochloride on lactate metabolism. In addition, MINT-METFORMIN should be temporarily discontinued prior to any intravascular radiocontrast study and for any surgical procedure.

The onset of lactic acidosis is often subtle, and accompanied only by nonspecific symptoms such as malaise, myalgia, respiratory distress, increasing somnolence and non-specific abdominal distress. There may be associated hypothermia, hypotension and resistance 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. MINT-METFORMIN 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 MINT-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. In patients taking MINT-METFORMIN, levels of fasting venous plasma lactate above the upper limit of normal but less than 5 mmol/L, 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 MINT-METFORMIN, the drug should be discontinued immediately and general supportive measures should be promptly instituted. Because metformin hydrochloride is dialyzable (with clearance of up to 170 mL/min under good hemodynamic conditions), prompt hemodialysis is recommended to correct the acidosis and remove the accumulated metformin.

Physicians should instruct their patients to recognize the symptoms which could be signal onset of lactic acidosis. If acidosis of any kind develops, MINT-METFORMIN should be discontinued immediately and the patient should be immediately hospitalized.

#### Loss of control of blood glucose

When a patient stabilized on any antidiabetic 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 MINT-METFORMIN and temporarily administer insulin. MINT-METFORMIN may be reinstated after the acute episode is resolved.

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 MINT-METFORMIN, therapeutic alternatives should be considered.

#### Vitamin B<sub>12</sub> levels

Impairment of vitamin B<sub>12</sub> absorption has been reported in some patients. 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 MINT-METFORMIN.

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 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 MINT-METFORMIN (see **Monitoring and Laboratory Tests**), and any apparent abnormalities should be appropriately investigated and managed. 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 in the context of vitamin B<sub>12</sub> deficiency (see **ADVERSE REACTIONS, Post-Market Adverse Drug Reactions**). Monitoring of serum vitamin B<sub>12</sub> levels is recommended (see **Monitoring and Laboratory Tests**).

#### **Hematologic**

Serious cases of metformin-induced hemolytic anemia, some with a fatal outcome, have been reported (see **ADVERSE REACTIONS, Post-Market Adverse Drug 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 **Monitoring and Laboratory Tests**).

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

Since impaired hepatic function has been associated with some cases of lactic acidosis, MINT-METFORMIN should generally be avoided in patients with clinical or laboratory evidence of hepatic disease.

MINT-METFORMIN is contraindicated in patients suffering from severe hepatic dysfunction (see **CONTRAINDICATIONS**).

Serious cases of pancreatitis have been reported in patients receiving metformin (see **ADVERSE REACTIONS, Post-Market Adverse Drug 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.

### **Neurologic**

Serious cases of metformin-induced encephalopathy have been reported (see **ADVERSE REACTIONS, Post-Market Adverse Drug Reactions**). Some of these cases were reported without association with lactic acidosis, hypoglycemia, or renal impairment.

### **Peri-Operative Considerations**

MINT-METFORMIN therapy should be temporarily suspended for any surgical procedure Metformin (except minor procedures not associated with restricted intake of food and fluids). MINT-METFORMIN should be discontinued 2 days before surgical intervention and should not be restarted or until the patient's oral intake has resumed and renal function has been evaluated as normal.

### **Renal**

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. Thus, patients with serum creatinine levels above the upper limit of the normal range for their age should not receive MINT-METFORMIN. In patients with advanced age, MINT-METFORMIN should be carefully titrated to establish the minimum dose for adequate glycemic effect, because aging is associated with reduced renal function. In elderly patients, renal function should be monitored regularly and generally, MINT-METFORMIN should not be titrated to the maximum dose (see **DOSAGE AND ADMINISTRATION**).

Before initiation of MINT-METFORMIN therapy, and every 6 months while on MINT-METFORMIN therapy, renal function should be assessed and verified as being within normal range.

In patients in whom development of renal dysfunction is anticipated, renal function should be assessed more frequently and MINT-METFORMIN must be 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 an NSAID.

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 MINT-METFORMIN, such as cationic drugs that are eliminated by renal tubular secretion (see **DRUG INTERACTIONS**), should be used with caution.

Radiological studies involving the use of intravascular iodinated contrast materials (for example, intravenous urogram, intravenous cholangiography, angiography, and computed tomography (CT) scans with intravascular contrast material

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 in whom any such study is planned, MINT-METFORMIN should be temporarily discontinued at the time of or prior to the procedure, withheld for 48 hours subsequent to the procedure, and reinstated only after renal function has been re-evaluated and found to be normal.

**Special Populations**

**Pregnant Women:** Safety of metformin hydrochloride in pregnant women has not been established. There are no adequate and well-controlled studies of metformin in pregnant women. MINT-METFORMIN is contraindicated in pregnant women (see **CONTRAINDICATIONS**).

Metformin was not teratogenic in rats and rabbits at doses up to 600 mg/kg/day, or about two 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, MINT-METFORMIN is contraindicated during pregnancy (see **CONTRAINDICATIONS**).

**Breast-feeding:** Studies in lactating rats show that metformin is excreted into milk and reaches levels comparable to those in plasma. Metformin hydrochloride is also excreted into human breast milk in very small amounts. MINT-METFORMIN is contraindicated in breast-feeding women (see **CONTRAINDICATIONS**).

**Pediatrics (< 18 years of age):** Safety and effectiveness in pediatric patients have not been established. Therefore, MINT-METFORMIN should not be used in this population (see **INDICATIONS AND CLINICAL USE**).

**Geriatrics (> 65 years of age):** Controlled clinical studies of metformin did not include sufficient numbers of elderly patients to determine whether they respond differently from younger patients. Metformin is known to be substantially excreted by the kidney and because the risk of serious adverse reactions to the drug is greater in patients with impaired renal function, MINT-METFORMIN should only be used in patients with normal renal function (see **CONTRAINDICATIONS** and **WARNINGS AND PRECAUTIONS, Renal**). Because aging is associated with reduced renal function, MINT-METFORMIN should be used with caution as age

increases. MINT-METFORMIN treatment should not be initiated in patients older than 80 years of age, unless measurement of creatinine clearance demonstrates that renal function is not reduced, as elderly patients are more susceptible to developing lactic acidosis (see **WARNINGS AND PRECAUTIONS, Endocrine and Metabolism**, Lactic Acidosis). Care should be taken in dose selection which should be based on careful and regular monitoring of renal function. MINT-METFORMIN should be carefully titrated to establish the minimum dose for adequate glycemic effect. Generally, elderly patients should not be titrated to the maximum dose of MINT-METFORMIN (see **DOSAGE AND ADMINISTRATION, Geriatrics**).

### **Monitoring and Laboratory Tests**

Response to all antidiabetic therapies should be monitored by periodic measurements of fasting blood glucose and glycosylated hemoglobin levels, with a goal of decreasing these levels toward the normal range. During initial dose titration, fasting glucose can be used to determine the therapeutic response. Thereafter, both glucose and glycosylated hemoglobin should be monitored.

Measurements of glycosylated hemoglobin may be especially useful for evaluating long-term control. Periodic monitoring of blood and/or urinary glucose is necessary to detect primary and secondary failure (see **WARNINGS AND PRECAUTIONS, Endocrine and Metabolism**, Loss of control of blood glucose).

More frequent glucose monitoring should be considered when MINT-METFORMIN is simultaneously administered with cationic drugs that are excreted via renal tubular secretion, or with drugs that produce hyperglycemia or hypoglycaemia, especially at the initiation of treatment with the interfering drug(s) (see **DRUG INTERACTIONS, Cationic Drugs and Other**).

Periodic cardiovascular, ophthalmic, hematological, hepatic, and renal assessments are advisable (see **WARNINGS AND PRECAUTIONS**).

Initial and periodic monitoring of hematologic parameters (e.g., hemoglobin/hematocrit and red blood cell indices) and renal function (serum creatinine) should be performed, at least on an annual basis (see **WARNINGS AND PRECAUTIONS, Hematologic and Renal**). While megaloblastic anemia has rarely been seen with metformin therapy, if this is suspected, vitamin B<sub>12</sub> deficiency should be excluded.

Impairment of vitamin B<sub>12</sub> absorption has been reported in some patients, and long-term treatment with metformin has been associated with reductions in vitamin B<sub>12</sub> serum levels. Periodic measurements of serum vitamin B<sub>12</sub> levels should be performed in patients on long-term treatment with MINT-METFORMIN, especially in patients with anemia or neuropathy (see **WARNINGS AND PRECAUTIONS, Endocrine and Metabolism**, Vitamin B<sub>12</sub> levels).

Regular monitoring of thyroid-stimulating hormone (TSH) levels is recommended in patients with hypothyroidism (see **WARNINGS AND PRECAUTIONS, Hypothyroidism and ADVERSE REACTIONS, Post-Market Adverse Drug Reactions**).

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, Hypothyroidism and DRUG INTERACTIONS**,

**Levothyroxine**).

For patients concurrently administering MINT-METFORMIN and phenprocoumon or other antivitamin K anticoagulants, a close monitoring of the International Normalized Ratio (INR) is recommended (see **DRUG INTERACTIONS, Other**).

## **ADVERSE REACTIONS**

### **Adverse Drug Reaction Overview**

Lactic acidosis is a rare, but serious adverse reaction associated with metformin treatment. Lactic acidosis is fatal in approximately 50% of cases (see **WARNINGS AND PRECAUTIONS, Endocrine and Metabolism**, Lactic Acidosis).

The adverse reactions most commonly associated with metformin treatment are diarrhea, nausea, vomiting, abdominal pain, abdominal distention, dyspepsia, and flatulence.

The most common adverse reactions resulting in discontinuation of metformin treatment are gastrointestinal disturbances described as diarrhea, nausea, vomiting, abdominal pain, and dyspepsia.

### **Clinical Trial Adverse Drug Reactions**

*Because clinical trials are conducted under very specific conditions the adverse drug 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.*

The clinical trials which formed the basis of approval for the original metformin submission are not available (see **CLINICAL TRIALS**).

The following adverse drug reactions (a combination of clinical trials and post-marketing data) were reported for metformin:

**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 MINT-METFORMIN with meals (see **DOSAGE AND ADMINISTRATION, Dosing Considerations**).

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

For patients who have been stabilized on MINT-METFORMIN, nonspecific gastrointestinal symptoms should not be attributed to therapy unless intercurrent illness or lactic acidosis has 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:** During controlled clinical trials of 29 weeks duration, approximately 9% of patients on metformin monotherapy and 6% of patients on metformin/sulfonylurea therapy developed asymptomatic subnormal serum vitamin B<sub>12</sub> levels; serum folic acid levels did not decrease significantly. However, only five cases of megaloblastic anemia have been reported with metformin administration (none during U.S. clinical studies) and no increased incidence of neuropathy has been observed in clinical trials. 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, Endocrine and Metabolism**, Vitamin B<sub>12</sub> levels).

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 aetiology 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.

### **Post-Market Adverse Drug Reactions**

**Blood and Lymphatic System Disorders:** Hemolytic anemia, some with a fatal outcome (see **WARNINGS AND PRECAUTIONS, Hematologic**).

**Gastrointestinal Disorders:** Abdominal discomfort, abdominal distension, abdominal pain, abdominal pain upper, 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, pancreatitis (see **WARNINGS AND PRECAUTIONS, Hepatic/Biliary/Pancreatic**).

**Investigations:** Blood lactic acid increased.

Reduction of thyrotropin level in patients with treated or untreated hypothyroidism (see **WARNINGS AND PRECAUTIONS, Hypothyroidism and Monitoring and Laboratory Tests**).

**Nervous System Disorders:** Encephalopathy (see **WARNINGS AND PRECAUTIONS, Neurologic**).

**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 (see **WARNINGS AND PRECAUTIONS, Endocrine and Metabolism**, Vitamin B<sub>12</sub> levels).

Hypomagnesemia in the context of diarrhea.

**Skin and Subcutaneous Tissue Disorders:** Photosensitivity, erythema, pruritus, rash, skin lesion, and urticaria.

## **DRUG INTERACTIONS**

### **Overview**

Certain drugs may potentiate the effect of MINT-METFORMIN, particularly sulfonylurea type of drugs in the treatment of diabetes. The simultaneous administration of these two types of drugs 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.

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 proteins.

## **Drug-Drug Interactions**

**Glyburide:** In a single-dose interaction study in NIDDM subjects, 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 pharmacodynamics effects, make the clinical significance of this interaction uncertain.

**Furosemide:** A single-dose study, metformin- furosemide drug interaction study in healthy subjects demonstrated that pharmacokinetic parameters of both compounds were affected by co-administration. Furosemide increased 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 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.

**Cationic Drugs:** Cationic drugs (e.g., amiloride, digoxin, morphine, procainamide, quinidine, quinine, ranitidine, triamterene, trimethoprim, and vancomycin) that are eliminated by renal tubular secretion, theoretically have the potential for interaction with metformin by competing for common renal tubular transport systems. Such an interaction has been observed between metformin and oral cimetidine in normal healthy volunteers. In both single and multiple-dose metformin-cimetidine drug interaction studies, there was a 60% increase in peak metformin plasma and whole blood concentrations, as well as 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. Therefore, careful patient monitoring (see **WARNINGS AND PRECAUTIONS, Monitoring and Laboratory Tests**) and dose adjustment of MINT-METFORMIN or the interfering drug is recommended in patients who are taking cationic medications that are excreted via renal tubular secretion (see **DOSAGE AND ADMINISTRATION, Dosing Considerations**).

**Levothyroxine:** Levothyroxine can reduce the hypoglycemic effect of metformin. Monitoring of blood glucose levels is recommended, especially when thyroid hormone therapy is initiated, changed, or stopped (see **WARNINGS AND PRECAUTIONS, Monitoring and Laboratory Tests**), and MINT-METFORMIN dosage adjusted as necessary (see **DOSAGE AND ADMINISTRATION, Dosing Considerations**).

### **Other**

Other drugs tend to produce hyperglycemia and may lead to a loss of blood sugar control. These

include thiazide and other diuretics, corticosteroids, phenothiazines, thyroid hormone replacement drugs e.g. levothyroxine, 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 patients receiving MINT-METFORMIN, the patient should be closely observed to maintain adequate glycemic control. More frequent blood glucose monitoring may be required, especially at the beginning of treatment (see **WARNINGS AND PRECAUTIONS, Monitoring and Laboratory Tests**). If necessary, adjust the metformin dosage during therapy with the respective medicinal product and upon its discontinuation (see **DOSAGE AND ADMINISTRATION, Dosing Considerations**).

Diuretics, especially loop diuretics, may increase the risk of lactic acidosis due to their potential to decrease renal function (see **DOSAGE AND ADMINISTRATION, Dosing Considerations**).

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 MINT-METFORMIN and phenprocoumon or other antivitamin K anticoagulants (see **WARNINGS AND PRECAUTIONS, Monitoring and Laboratory Tests**). In such cases, an important increase of prothrombin time may occur upon cessation of metformin therapy, with an increased risk of hemorrhage.

#### **Drug-Food Interactions**

Interactions with food have not been established.

#### **Drug-Herb Interactions**

Interactions with herbal products have not been established.

#### **Drug-Laboratory Test Interactions**

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, Renal**).

#### **Drug-Lifestyle Interactions**

Patients should be cautioned against excessive alcohol intake, either acute or chronic, when taking MINT-METFORMIN, 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.

### **DOSAGE AND ADMINISTRATION**

#### **Dosing Considerations**

In diabetic patients, individual determination of the minimum dose that will lower blood glucose

adequately should be made, aiming for glycemic targets as close to normal as possible. A lower recommended starting dose and gradually increased dosage is advised to minimize gastrointestinal symptoms (see **ADVERSE REACTIONS, Clinical Trial Adverse Drug Reactions, Gastrointestinal Reactions**).

Over a period of time, patients may become progressively less responsive to therapy with oral hypoglycemic agents because of the deterioration of their diabetic state. Patients should therefore be monitored with regular clinical and laboratory evaluations, including blood glucose and glycosylated hemoglobin (A<sub>1c</sub>) determinations, to determine the minimum effective dosage and to detect primary failure or secondary failure (see **WARNINGS AND PRECAUTIONS, Endocrine and Metabolism**, Loss of control of blood glucose and **Monitoring and Laboratory Tests**).

In patients in whom the maximum dose fails to lower the blood glucose adequately, therapeutic alternatives should be considered.

Metformin is substantially excreted by the kidney, and the risk of metformin accumulation and lactic acidosis increases with the degree of impairment of renal function. MINT-METFORMIN is contraindicated in patients with serum creatinine levels above the upper limit of the normal range for their age (see **CONTRAINDICATIONS**).

In elderly patients, MINT-METFORMIN should be carefully titrated to establish the minimum dose for adequate glycemic effect, because aging is associated with reduced renal function and the risk of developing lactic acidosis (see **WARNINGS AND PRECAUTIONS, Endocrine and Metabolism**, Lactic Acidosis). MINT-METFORMIN treatment should not be initiated in patients older than 80 years of age, unless measurement of creatinine clearance demonstrates that renal function is not reduced, as elderly patients are more susceptible to developing lactic acidosis (see **WARNINGS AND PRECAUTIONS, Special Populations, Geriatrics, and Monitoring and Laboratory Tests**).

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 MINT-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, Cationic Drugs and Other**).

Consideration for MINT-METFORMIN dosage adjustment, as necessary, should be made when MINT-METFORMIN is simultaneously administered with cationic drugs that are excreted via renal tubular secretion, or with drugs that produce hyperglycemia or hypoglycaemia, especially at the initiation of treatment with the interfering drug and upon its discontinuation (see **DRUG INTERACTIONS, Cationic Drugs and Other**).

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

The usual dose is 500 mg three or four times a day, or 850 mg two or three times a day. Maximal dose should not exceed 2.55 g a day. To minimize gastric intolerance such as nausea and vomiting, MINT-METFORMIN (metformin hydrochloride) should be taken with food whenever possible.

### Transfer from Other Antidiabetic Therapy

When transferring patients to MINT-METFORMIN from standard oral hypoglycaemic agents, other than chlorpropamide, no transition period is generally necessary. When transferring patients from chlorpropamide, care should be exercised during the first two weeks because of the prolonged retention of chlorpropamide in the body, leading to overlapping drug effects and possible hypoglycaemia.

**Pediatrics (< 18 years of age):** Safety and effectiveness of metformin in pediatric and adolescent patients have not been established. Therefore, MINT-METFORMIN should not be used in this population (see **WARNINGS AND PRECAUTIONS, Special Populations, Pediatrics**).

**Geriatrics (> 65 years of age):** MINT-METFORMIN should be carefully titrated in geriatric patients to establish the minimum dose for adequate glycemic effect, because of reduced renal function associated with aging and the risk of developing lactic acidosis (see **WARNINGS AND PRECAUTIONS, Endocrine and Metabolism, Lactic Acidosis**). In elderly patients, the initial and maintenance dose of MINT-METFORMIN should be conservative, and any dose adjustment should be based on careful assessment of renal function. Renal function should be monitored regularly and generally, MINT-METFORMIN should not be titrated to the maximum dose (see **WARNINGS AND PRECAUTIONS, Special Populations, Geriatrics**).

**Renal Impairment:** MINT-METFORMIN is contraindicated in patients with impaired renal function, unknown renal function, or in patients with serum creatinine levels above the upper limit of the normal range for their age, due to the risk of lactic acidosis (see **CONTRAINDICATIONS**).

**Hepatic Impairment:** MINT-METFORMIN is contraindicated in patients with severe hepatic dysfunction (see **CONTRAINDICATIONS**). Since impaired hepatic function has been associated with some cases of lactic acidosis, MINT-METFORMIN should not be used in patients with clinical or laboratory evidence of hepatic disease (see **WARNINGS AND PRECAUTIONS, Hepatic/Biliary/Pancreatic**).

### **Missed Dose**

In case the patient forgets to take MINT-METFORMIN tablets, he/she should wait for the next dose at the usual time. He/she should not double the dose to make up for the forgotten dose.

## **OVERDOSAGE**

Available information concerning treatment of a massive overdose of metformin 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 should be 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, Endocrine and Metabolism**, Lactic Acidosis). Metformin is dialyzable with a clearance of up to 170 mL/min under good hemodynamic conditions. Therefore, hemodialysis may be useful for the removal of accumulated drug from patients in whom metformin overdosage is suspected.

Pancreatitis may occur in the context of a metformin overdose (see **WARNINGS AND PRECAUTIONS, Hepatic/Biliary/Pancreatic**).

For management of a suspected drug overdose, contact your regional poison control centre.

## **ACTION AND CLINICAL PHARMACOLOGY**

### **Mechanism of Action**

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**

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.

### **Pharmacokinetics**

**Absorption:** Metformin absorption is relatively slow and may extend over about 6 hours.

**Distribution:** Plasma protein binding is negligible. Metformin partitions into erythrocytes. The blood peak is lower than the plasma peak and appears at approximately the same time. The red blood cells most likely represent a secondary compartment of distribution. The mean volume of distribution ( $V_d$ ) ranged between 63-276 l.

**Metabolism:** Metformin is not metabolized. Its main sites of concentration are the intestinal mucosa and the salivary glands. The plasma concentration at steady-state ranges about 1 to 2 mcg/mL. Certain drugs may potentiate the effects of metformin (see **WARNINGS AND PRECAUTIONS and DRUG INTERACTIONS**).

**Excretion:** The drug is excreted in urine at high renal clearance rate of about 450 mL/min. The initial elimination of metformin is rapid with a half-life varying between 1.7 and 3 hours. The terminal elimination phase accounting for about 4 to 5 % of the absorbed dose is slow with a half-life between 9 and 17 hours.

## **STORAGE AND STABILITY**

Store at room temperature (15°to 30°C) in well closed containers.

Keep out of reach and sight of children.

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

MINT-METFORMIN 500 mg Tablet contains 500 mg metformin hydrochloride. Each tablet also contains as non-medicinal ingredients: magnesium stearate and povidone, and a tablet coating comprised of HPMC 2910/Hypromellose, Titanium Dioxide, Macrogol/Peg and Artificial Blackberry Flavor 501167 AP0551.

MINT-METFORMIN 500 mg tablets are white to off-white, round, biconvex film coated tablets, debossed with “0” and “31” on either side of score line on one side and “500” on other side. Available in bottles of 100, 360, and 500 tablets.

MINT-METFORMIN 850 mg Tablet contains 850 mg metformin hydrochloride. Each tablet also contains as non-medicinal ingredients: magnesium stearate and povidone, and a tablet coating comprised of HPMC 2910/Hypromellose, Titanium Dioxide, Macrogol/Peg and Artificial Blackberry Flavor 501167 AP0551

MINT-METFORMIN 850 mg tablets are white to off-white oblonged film-coated tablets, debossed with “030” on one side and “850” on the other side. Available in bottles of 100, 360, and 500 tablets.

## PART II: SCIENTIFIC INFORMATION

### PHARMACEUTICAL INFORMATION

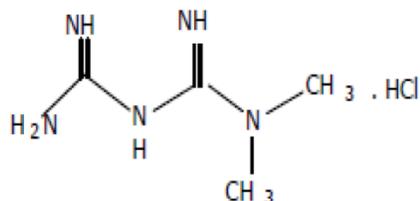
#### Drug Substance

Proper name: Metformin Hydrochloride

Chemical name: 1,1-dimethylbiguanide hydrochloride

Molecular formula and molecular mass: 165.62

Structural formula:



Physicochemical properties: Metformin Hydrochloride is a white crystalline powder.

Metformin Hydrochloride is freely soluble in water and slightly soluble in alcohol. It is practically insoluble in acetone and methylene chloride.

Melting Point: 232°C.

## CLINICAL TRIALS

### Comparative Bioavailability Studies

A blinded, randomized, single dose (1 x 500 mg), two-treatment, comparative bioavailability study of MINT-METFORMIN (Mint Pharmaceuticals Inc.) and GLUCOPHAGE (Sanofi-Aventis Canada Inc.) was performed in healthy male subjects under fasting conditions. A summary of the data from the 23 subjects that were included in the statistical analysis is presented in the table below:

**Table 1. SUMMARY TABLE OF THE COMPARATIVE BIOAVAILABILITY DATA**

Metformin (1 x 500 mg metformin hydrochloride) Geometric Mean Arithmetic Mean (CV%)				
Parameter	Test <sup>1</sup>	Reference <sup>2</sup>	% Ratio of Geometric Means	90% Confidence Interval
AUC <sub>T</sub> (ng h/mL)	9098.30 9380.58(26.49)	8725.90 8892.08 (20.81)	104.2	98.7 – 110.1
AUC <sub>I</sub> (ng h/mL)	9307.25 9590.76 (26.18)	8927.90 9095.29 (20.61)	104.2-	98.7 – 110.0-
C <sub>max</sub> (ng/mL)	1332.19 1369.48 (24.67)	1288.14 1318.89 (23.03)	103.5	97.6 – 109.7
T <sub>max</sub> <sup>3</sup> (h)	3.00 (0.67 – 4.50)	3.33 (1.00 – 4.50)	-	-
t <sub>1/2</sub> <sup>4</sup> (h)	3.35 (8.65)	3.30 (7.73)	-	-

<sup>1</sup> MINT-METFORMIN (metformin hydrochloride) tablets 500 mg (Mint Pharmaceuticals Inc.)

<sup>2</sup> GLUCOPHAGE (metformin hydrochloride) tablets 500 mg (Sanofi-Aventis Canada Inc.)

<sup>3</sup> Expressed as the median (range) only

<sup>4</sup> Expressed as the arithmetic mean (CV%) only

A blinded, randomized, single dose (1 x 500 mg), two-treatment, comparative bioavailability study of MINT-METFORMIN (Mint Pharmaceuticals Inc.) and GLUCOPHAGE (Sanofi-Aventis Canada Inc.) was performed in healthy male subjects under fed conditions. A summary of the data from the 21 subjects that were included in the statistical analysis is presented in the table below:

**Table 2. SUMMARY TABLE OF THE COMPARATIVE BIOAVAILABILITY DATA**

Metformin (1 x 500 mg metformin hydrochloride) Geometric Mean Arithmetic Mean (CV%)				
Parameter	Test <sup>1</sup>	Reference <sup>2</sup>	% Ratio of Geometric Means	90% Confidence Interval
AUC <sub>T</sub> (ng h/mL)	6181.74 6287.19 (18.94)	6493.78 6610.07 (20.30)	95.3	90.5 – 100.3
AUC <sub>I</sub> (ng h/mL)	6379.19 6490.50 (19.17)	6738.70 6853.05 (19.87)	94.8	89.9 – 99.9

C <sub>max</sub> (ng/mL)	817.74 832.18 (18.96)	856.08 877.80 (21.37)	95.6	89.7 – 101.9
T <sub>max</sub> <sup>3</sup> (h)	4.00 (1.00 – 4.67)	4.00 (1.33 – 9.00)	-	-
t <sub>1/2</sub> <sup>4</sup> (h)	3.52 (11.03)	3.59 (16.35)	-	-

<sup>1</sup> MINT-METFORMIN (metformin hydrochloride) tablets 500 mg (Mint Pharmaceuticals Inc.)

<sup>2</sup> GLUCOPHAGE (metformin hydrochloride) tablets 500 mg (Sanofi-Aventis Canada Inc.)

<sup>3</sup> Expressed as the median (range) only

<sup>4</sup> Expressed as the arithmetic mean (CV %) only

The data which formed the basis of approval for the original metformin submission are not available. Rather, this section presents data from a published study which investigated the safety and efficacy of metformin.

The prospective randomised (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

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 glycemia.

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

### 1. Animal Toxicity

Acute Toxicity (LD <sub>50</sub> )		
<u>Animal</u>	<u>Subcutaneously</u>	<u>Orally</u>
Mouse	225 mg/kg	3500 mg/kg
Chicken	150 mg/kg	
Rat	300 mg/kg	1000 mg/kg
Rabbit	150 mg/kg	350 mg/kg
Guinea Pig	150 mg/kg	500 mg/kg

### Chronic Toxicity

- A) The following doses of metformin produced no organ toxicity:
- |         |           |                            |
|---------|-----------|----------------------------|
| Rats    | 125 mg/kg | per os for one year        |
| Rabbits | 100 mg/kg | per os for one year        |
| Dogs    | 50 mg/kg  | subcutaneously for 2 years |

Acute or chronic organ toxicity was not produced in the animal species involved.

- B) A study was carried out during 9 months with 80 rats, male and female, divided in 4 groups, with the following dosage regimen:

1st Group	control
2nd Group	150 mg/kg per os

3rd Group	300 mg/kg per os
4th Group	300 mg/kg per os, dose increased by 100 mg/kg/day every 15 days

In summary, the authors report the excellent tolerance of metformin by rats, even when administered in very high doses. No drug related lesion has been observed.

- C) Chronic toxicity studies of 9 months duration were carried through with 16 beagle dogs, although the complete intolerance of this animal species to oral hypoglycemic agents is a well-established fact. Trophic and neurologic disorders with cachexia rapidly lead to the dog's death. During the periods of metformin administration, laboratory findings were within normal limits. The levels of enzymes were somewhat elevated, but it is difficult to ascribe a pathological significance to their values, since subjects in the control group were at the same level as treated animals.

Pathological studies show an extreme degree of undernutrition in all metformin treated animals. Profound wasting especially marked in fat tissues was evident in all organs. Cachexia appears as the common cause of death of these animals.

## 2. Human Toxicity

In man, no adverse effect has been reported on liver or kidney function, the hematopoietic system or on the blood vessels.

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 patients/years).

The consecutive administration of both phenformin and metformin to the same patient has allowed for the demonstration of a fundamental difference between these two biguanides in relation to lactacidemia. In some instances, patients developed hyperlactacidemia with phenformin when the same patients were presenting normal lactic acid levels while being treated with metformin. In other instances, hyperlactacidemia observed during a treatment with phenformin did regress when metformin was substituted for phenformin. Metformin may increase lactacidemia but to a degree that is clinically less significant than the elevation seen after phenformin.

## 3. Teratology

Teratological studies were carried out in albino rats divided in three groups: No abnormalities were found, even when high doses were administered. The number of animals was the same in each group.

Death rate in the three groups of treated animals and controls was approximately the same. However, the number of living animals in each group treated was slightly lower than in the control group. Also, the frequency of litters exceeding 10 live animals was slightly higher in the control group. A loss of weight at the time of weaning has been observed when compared to the control group.

Nevertheless, on a statistical basis, differences were shown to be non-significant. There is no difference between the groups of treated animals and the control group regarding the number of stillborn. The number of deaths after birth was slightly higher in metformin treated groups than in the control group, but the comparison of average death rates is not significant ( $p < 0.05$ ).

## REFERENCES

1. Alberti KGM, et al. Lactic Acidosis. *The Lancet*. 1977 July 2:25-29.
2. Beckmann R. Résorption, distribution dans l'organisme et élimination de la Metformine. *Diabétologia*. 1969;5:318-324.
3. Benoit R, et al. Acidose lactique et phenformine. *L'Union Médicale du Canada*. 1976;105:1810-1814.
4. Berger W, et al. Problèmes d'actualité concernant le mécanisme d'action des biguanides. *Jour. Diab. Hôtel-Dieu Paris*. 1975; 239-258.
5. Bermond P, The coefficient of insulin efficacy. Effect of Metformin on this parameter. *Xième Congrès Fédération Int. Diabétologie, Stockholm; 1967*. Ed. Excerpta Medica F. Amsterdam; 1968.
6. Biron P. Metformin monitoring. *C.M.A.J.* 1980;123:11-12.
7. Bouaziz Pl. Apport à l'étude de l'épreuve d'hyperglycémie provoquée par voie veineuse sous thérapie diabétique. Thèse de doctorat en Médecine, Paris. 1966.
8. Canadian Diabetes Association. Nephropathy. *Canadian Journal of Diabetes*. 2003 *Clinical Practice Guidelines*;2013:S142-144.
9. Canadian Diabetes Association. Pharmacologic management of type 2 diabetes. *Canadian Journal of Diabetes*. 2013 *Clinical Practice Guidelines*;2013:S61-68.
10. Canadian Diabetes Association. Physical activity and diabetes. *Canadian Journal of Diabetes*. 2013 *Clinical Practice Guidelines*;2013:S40-44.
11. Canadian Diabetes Association. Targets for glycemic control. *Canadian Journal of Diabetes*. 2013 *Clinical Practice Guidelines*;2013:S31-34.
12. Canadian Diabetes Association. Pre-existing diabetes and pregnancy. *Canadian Journal of Diabetes*. *Clinical Practice Guidelines Expert Committee*;2013;S168-183.
13. Chan JCN, et al. Drug-induced disorders of glucose metabolism. Mechanisms and management. *Drug Safety*, 1996 Aug; 15(2):135-157.
14. Cohen RD. The relative risks of different biguanides in the causation of lactic acidosis. *Research and Clinical Forums*. 1979;1(4):125-134.
15. Cohen Y, et al. Etude autoradiographique chez la souris d'un antidiabétique oral, le N.N. Diméthylbiguanide, marqué au C<sup>14</sup> Thérapie. 1961;109-120.

16. Cohen Y, et al. Etude autoradiographique chez la souris d'un antidiabétique oral marqué au C<sup>14</sup>, le N.N. Diméthylbiguanide, après administrations répétées. *Thérapie*. 1968;23:1185-1191.
17. Cox D, et al. The effects of glucose fluctuation on cognitive function and QOL: the functional costs of hypoglycaemia and hyperglycaemia among adults with Type 1 or Type 2 diabetes. *IJCP* 2002 July; (Suppl.129):20-26.
18. Daubresse JC, et al. Acidose lactique et thérapeutique par biguanides. *Méd. et Hyg.* 1975;1168.
19. Debry G, et al. Etude du mode d'excrétion du N.N. Diméthylbiguanide chez le diabétique adulte. *Thérapie*. 1965;20:351-358.
20. Derot M, et al. Retrospective study of the cardiovascular fate of 190 patients treated for 5 year or more with biguanides alone. Abstracts, 11<sup>th</sup> Annual Meeting, Munich. Sept.; 1975.
21. Duval D. Contribution à l'étude de l'action hypoglycémisante des biguanides. Thèse de Doctorat en Médecine, Paris. 1960.
22. Duwoos H, et al: Hyperlactacidémie réversible induite par la phenformine avec asthénie musculaire et signes cardio-respiratoires. *Presse Méd.* 1970;78:23-26.
23. Glueck CJ, Wang P, Kobayashi S, Phillips H, Sieve-Smith L. Metformin therapy throughout pregnancy reduces the development of gestational diabetes in women with polycystic ovary syndrome. *Fertility and Sterility*. 2002;77(3):520-525.
24. Hermann LS. Metformin: A review of its pharmacological properties and therapeutic use. *Diabète et Métabolisme*. 1979;3:233-245.
25. Hermann LS. Metabolic effects of Metformin in relation to clinical effects and side effects in Biguanide Therapy Today. International Congress and Symposium, series published by the Royal Society of Medicine. 1981;48:17-43.
26. Holle A, et al. Biguanide treatment increases the number of insulin receptor sites on human erythrocytes. *The New Engl. J. Med.* 1981;305(10):563-566.
27. Hunt JA, et al. The use of phenformin and metformin. Letter to the Editor, *C.M.A.J.* 1977;117(5):429-430.
28. Irsigler K. Glucoseutilisation and Plasmaliporide bei adiposen Patienten unter dem Einfluss von Dimethylbiguanide (GLUCOPHAGE). *wiener med. Wsch.* 1969;119:191-194.
29. Isnard F, et al. Acidose lactique et biguanides. Etat actuel de la question en France. *Journées Annuelles de diabétologie de l'Hôtel-Dieu*. 1977;362-375.

30. Joncas F. Evaluation clinique de GLUCOPHAGE pour le traitement du diabète de l'adulte. Hôpital Maisonneuve, Montréal. L'Union Médicale du Canada, Jan. Issue, 1972.
31. Laurendeau Ed, et al: Traitement du diabète sucré chez des patients âgés, hospitalisés avec le N.N. Diméthylbiguanide (GLUCOPHAGE). Hôpital Notre-Dame de la Merci. Montréal. 1970. Ref Lab. Franca (non publié).
32. Lefebvre P, et al. Le mécanisme d'action des biguanides. Biguanides et sécrétion insulinique. Congrès International de Diabétologie de Rémini. 1968.
33. Le Jeune C, et al: Les effets hyperglycémiant des médicaments. *Sem. Hop. Paris.* January 1994:100-107.
34. Mainguet P, et al. Le diabète. 1972;20(1):39.
35. McKlish A. Toxicité du N.N. Diméthylbiguanide chez le chien Beagle. Centre de recherches Laval, Québec (1970). Ref. Laboratoires Franca Inc. (non publié).
36. Meyer F, et al. Données nouvelles sur le mécanisme d'action des biguanide hypoglycémiant. Journée annuelles de diabétologie de l'hôtel-Dieu. 1976;341-347.
37. Pelletier G, et al. Etude de toxicité chronique de N.N. Diméthylbiguanide chez le rat. Centre de recherche Laval, Québec. Ref. Laboratoires Franca Inc. (non publiée).
38. Pelletier G, et al. Etude tératologique avec le N.N. Diméthylbiguanide chez le rat. Centre de Recherche Laval, Québec (1970). Ref. laboratoires Franca Inc. (non publiée).
39. Pignard P. Dosage spectrotométrique du N.N. Diméthylbiguanide dans le sang et l'urine. *Annales de Biologie Clinique.* 1962;20:225-233.
40. Sterne J. Oral Hypoglycemic agents. *Medicinal Chemistry.* 1969;9(5):193-294.
41. Sterne JM, et al. Oral hypoglycemic agents: Clinical Pharmacology and Therapeutic Use. *Drugs.* 1977;14:41-56.
42. Sterne J. Pharmacology and mechanism of action of the antidiabetic biguanides. Paperread in Moscow, April 1977, Unpublished.
43. Stowers JM. Long-term therapy with biguanides in Biguanide Therapy Today. International Congress and Symposium, series published by the Royal Society of Medicine. 1981;48:49-57.
44. Stowers JM, et al. Oral hypoglycemic agents: Clinical pharmacology and therapeutic use. *Drugs.* 1977;14:41-56.

45. Vague P. Effet d'une dose unique de metformine sur la tolérance au glucose des sujets normaux ou obèses. *Le Diabète*. 1970;18:35-39.
46. Vermulen A, et al. Influence of dimethylbiguanide (metformin) on carbohydrate metabolism in obese, non diabetic women. *Diabetologia*. 1972;8:8-11.
47. UK Prospective Diabetes Study (UKPDS) Group. Effect of intensive blood-glucose control with metformin on complications in overweight patients with type 2 diabetes (UKPDS 34). *The Lancet*. 1998;352:854-865.
48. UK Prospective Diabetes Study (UKPDS) Group. Intensive blood-glucose control with sulphonylureas or insulin compared with conventional treatment and risk of complications in patients with type 2 diabetes (UKPDS 33). *The Lancet*. 1998;352:837- 853.
49. GLUCOPHAGE® (Metformin Hydrochloride) 500 and 850 mg Tablets Product Monograph. Sanofi-Aventis Canada Inc. Date of Revision: March 2, 2018 Control No.: 211582

## PART III: PATIENT MEDICATION INFORMATION

### IMPORTANT: READ THIS FOR SAFE AND EFFECTIVE USE OF YOUR MEDICINE

#### <sup>Pr</sup>MINT-METFORMIN Metformin Hydrochloride Tablets

This leaflet is part III of a three-part "Product Monograph" published when MINT-METFORMIN was approved for sale in Canada and is designed specifically for Consumers. Read this leaflet carefully before you start taking MINT-METFORMIN and each time you get a refill. This leaflet is a summary and will not tell you everything about this drug. Talk to your healthcare professional about your medical condition and treatment, and ask if there is any new information about MINT-METFORMIN.

#### ABOUT THIS MEDICATION

##### **What is MINT-METFORMIN used for?**

MINT-METFORMIN (metformin hydrochloride) is used, in addition to proper diet, exercise and weight reduction, to improve blood sugar levels in adults with type 2 diabetes mellitus.

##### **How does MINT-METFORMIN work?**

People with type 2 diabetes mellitus are not able to make enough insulin or respond normally to the insulin their bodies make. When this happens, sugar (glucose) builds up in the blood. This can lead to serious medical problems including kidney damage, amputations, and blindness. Diabetes is also closely linked to heart disease. The main goal of treating diabetes is to lower your blood sugar to a normal level.

High blood sugar can be lowered by diet and exercise, by a number of medicines taken by mouth, and by insulin shots. While you take your diabetes medicine, continue to exercise and follow the diet advised by your doctor for your diabetes.

No matter what your recommended diabetes management plan is, studies have shown that maintaining good blood sugar control can prevent or delay complications of diabetes, such as blindness.

MINT-METFORMIN helps to control your blood sugar.

Although the mode of action of MINT-METFORMIN is not fully understood, it is believed to help your body respond better to the insulin it makes naturally by:

- Decreasing the amount of sugar your liver makes, and
- Decreasing the amount of sugar your intestines absorb.

##### **What are the ingredients in MINT-METFORMIN?**

###### **Medicinal ingredients:**

The medicinal ingredient in MINT-METFORMIN is metformin hydrochloride.

###### **Nonmedicinal ingredients:**

MINT-METFORMIN tablets contain the following non-medicinal ingredients: magnesium stearate and povidone, and a tablet coating comprised of HPMC 2910/Hypromellose, Titanium Dioxide, Macrogol/Peg and Artificial Blackberry Flavor 501167 AP0551

##### **MINT-METFORMIN comes in the following dosage forms:**

Tablets; 500 mg, 850 mg

##### **Do not use MINT-METFORMIN if:**

- You have unstable and/or insulin-dependent (Type I) diabetes mellitus
- You have metabolic acidosis (including diabetic ketoacidosis, with or without coma, history of ketoacidosis with or without coma)

- You have a history of lactic acidosis (too much acid in the blood)
- You drink a lot of alcohol (regularly drink alcohol or sometimes drink a lot of alcohol, binge drinking)
- You have liver or kidney problems (severe liver dysfunction or liver disease, or kidney disease or impairment)
- You are going to have an x-ray procedure with injection of dyes (iodinated contrast materials).
- You are stressed, have a severe infection, or are experiencing trauma
- Before surgery and during ~~your~~ recovery after your surgery
- You suffer from severe dehydration (have lost a lot of water from your body)
- You are hypersensitive (have a high blood pressure) or allergic to metformin hydrochloride or any ingredient in the formulation or component of the container
- You are pregnant or planning to become pregnant
- You are breastfeeding (nursing a child)
- You have cardiovascular collapse (abrupt failure of blood circulation) or a disease that can cause hypoxemia (low oxygen in the blood) such as cardiorespiratory insufficiency

## WARNINGS AND PRECAUTIONS

### Serious Warnings and Precautions

- MINT-METFORMIN may rarely cause a serious, life-threatening condition called lactic acidosis (see **Lactic Acidosis** section below).
- You should not drink a lot of alcohol if you take MINT-METFORMIN (see **Lactic Acidosis** section below).

**To help avoid side effects and ensure proper use, talk to your healthcare professional before you take MINT-METFORMIN. Talk about any health conditions or problems you may have.**

### Lactic Acidosis

MINT-METFORMIN may rarely cause a serious, life-threatening condition called lactic acidosis.

You should not take MINT-METFORMIN due to greater risk for lactic acidosis if you:

- Have kidney problems or a history of kidney disease
- Are 80 years of age or older and you have NOT had your kidney function tested
- Are seriously dehydrated (have lost a lot of water from your body)
- Have liver disease
- Have metabolic acidosis (e.g. diabetic ketoacidosis)
- Drink a lot of alcohol (regularly drink alcohol or sometimes drink a lot of alcohol, binge drinking)
- Have an x-ray procedure with injection of dyes (contrast agents)
- Before surgery and during the recovery phase thereafter
- Develop a serious medical condition, such as heart attack, severe infection, or a stroke

Due to greater risk for lactic acidosis, you should talk to your doctor if you take MINT-METFORMIN and if you:

- Develop or experience a worsening of heart disease and particularly heart failure

Signs and symptoms of lactic acidosis include: discomfort, muscle pain, difficult or fast breathing, extreme tiredness, weakness, upset stomach, stomach pain, feeling cold, low blood pressure or slow heartbeat.

If any of the above side effects occur, consult your doctor immediately.

### Other warnings you should know about:

You should tell your doctor if you have any other medical condition including: Vitamin B-12 deficiency or anemia, excessive alcohol use, allergies, or hypothyroidism (low levels of thyroid hormones).

Do not drive or operate machines if you develop hypoglycemia (low blood sugar levels).

Do not start or stop any medicine without the approval of your healthcare professional.

## INTERACTIONS WITH THIS MEDICATION

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

The following drugs may interact with MINT-METFORMIN and require careful monitoring of your dose or condition:

- Other diabetes drugs such as glyburide
- Furosemide (diuretic (water pills)), used for œdema (fluid retention), and high blood pressure)
- Nifedipine (calcium-channel blocker used for high blood pressure; angina; Raynaud's phenomenon)
- Cationic drugs (e.g., amiloride, digoxin, morphine, procainamide, quinidine, quinine, ranitidine, triamterene, trimethoprim, and vancomycin)
- Certain "blood thinners" (phenprocoumon or other antivitamin K anticoagulants)
- Diuretics (water pills), especially loop diuretics, that may increase the risk of lactic acidosis (too much acid in the blood) due to their potential to decrease renal function
- Drugs that tend to produce hyperglycemia (high blood sugar) 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 (such as prednisone)
  - Phenothiazines (antipsychotic medicine)
  - Thyroid hormone replacement drugs e.g. Levothyroxine
  - Estrogens or estrogens plus progestogen (female hormones)
  - Oral contraceptives
  - Phenytoin (medicine used to treat epilepsy)
  - Nicotinic Acid (medicine used to prevent and treat niacin deficiency)
  - Sympathomimetics
  - Calcium channel blocking drugs (such as nifedipine, amlodipine, felodipine, verapamil, diltiazem)
  - Isoniazid (medicine used to treat active tuberculosis infections)
  - Medicines for asthma such as salbutamol or formoterol (Beta-2-agonists)
- ACE inhibitors (drugs used to treat hypertension (high blood pressure)) may lower blood glucose and the combination with MINT-METFORMIN should be carefully monitored.

Before using any drugs or herbal products, consult your healthcare professional.

## PROPER USE OF THIS MEDICATION

### **How to take MINT-METFORMIN:**

MINT-METFORMIN tablets are to be taken orally (by mouth).

### **Usual dose:**

Your doctor will tell you how much medicine to take and when to take it. Follow the directions provided by your doctor for using this medicine. Taking this medicine with food will decrease symptoms such as nausea and vomiting.

### **Overdose:**

In general, an overdose may lead to increased symptoms as described under "SIDE EFFECTS AND WHAT TO DO ABOUT THEM" including stomach discomfort, nausea, vomiting, diarrhea, drowsiness, weakness, dizziness, malaise, and headache.

A serious, life-threatening condition called lactic acidosis may also occur (see **WARNINGS and PRECAUTIONS , Lactic Acidosis**).

If you think you, or a person you are caring for, have taken too much MINT-METFORMIN, contact a healthcare professional, hospital emergency department, or a regional poison control centre immediately, even if there are no symptoms.

**Missed Dose:**

If you forget to take MINT-METFORMIN tablets, do not take a double dose to make up for forgotten individual doses. Take the next dose at the usual time.

**SIDE EFFECTS AND WHAT TO DO ABOUT THEM****What are possible side effects from using MINT-METFORMIN?**

*The side effects described below are not all the possible side effects you may feel when taking MINT-METFORMIN. If you experience any side effects not listed here, contact your healthcare professional. Please also see **Warnings and Precautions**.*

Common side effects of MINT-METFORMIN include:

- diarrhea
- nausea
- upset stomach
- abdominal bloating
- gas
- loss of appetite

These side effects generally go away after you take the medicine for a while. Taking your medicine with meals can help reduce these side effects. Tell your doctor if the side effects bother you a lot, last for more than a few weeks, come back after they've gone away, or start later in treatment. You may need a lower dose of MINT-METFORMIN or need to stop taking the medicine for a short period or for good.

After you are on the same dose of MINT-METFORMIN for several days or weeks, if any of these side effects come back, tell your doctor immediately. A late reappearance of stomach symptoms may be due to a serious medical condition (lactic acidosis).

MINT-METFORMIN rarely causes hypoglycemia (low blood sugar) by itself. However, hypoglycemia can happen if you do not eat enough, if you drink alcohol, or if you take other medicines to lower blood sugar.

**Lactic Acidosis: In rare cases, MINT-METFORMIN can cause a serious side effect called lactic acidosis. This is caused by a buildup of lactic acid in your blood. This build-up can cause serious damage.** Lactic acidosis caused by MINT-METFORMIN is rare and has occurred mostly in people whose kidneys were not working normally. Although rare, if lactic acidosis does occur, it can be fatal in up to half of the people who develop it.

It is also important for your liver to be working normally when you take MINT-METFORMIN. Your liver helps remove lactic acid from your blood.

Make sure you tell your doctor before you use MINT-METFORMIN if you have kidney or liver problems.

Your skin may be more sensitive to sunlight when you take MINT-METFORMIN. Protect your skin from the sun.

You should also **stop using MINT-METFORMIN and call your doctor right away if you have signs of lactic acidosis. Lactic acidosis is a medical emergency that must be treated in a hospital.**

If your medical condition suddenly changes, stop taking MINT-METFORMIN and call your doctor right away. This may be a sign of lactic acidosis or another serious side effect.

<b>Serious side effects and what to do about them</b>	
<b>Symptom / effect</b>	<b>Stop taking drug and call your doctor or pharmacist</b>
<b>UNCOMMON</b>	
<b>Feeling very weak, tired or uncomfortable</b>	√
<b>Unusual muscle pain</b>	√
<b>Trouble breathing</b>	√
<b>Unusual or unexpected stomach discomfort</b>	√
<b>Feeling cold</b>	√
<b>Feeling dizzy or lightheaded</b>	√
<b>Suddenly developing a slow or irregular heartbeat</b>	√
<b>RARE</b>	
<b>Lactic Acidosis (a build up of lactic acid in the blood) that can cause death or cardiovascular mortality</b> <b>Symptoms include:</b> <ul style="list-style-type: none"> <li>• Feeling very weak, tired, or uncomfortable</li> <li>• Unusual muscle pain</li> <li>• Trouble breathing</li> <li>• Unusual or unexpected stomach discomfort</li> <li>• Stomach pain with nausea and vomiting, or diarrhea</li> <li>• Feeling cold</li> <li>• Feeling dizzy or lightheaded</li> <li>• Suddenly developing a slow or irregular heartbeat</li> </ul>	√
<b>Pancreatitis</b> (inflammation of the pancreas): prolonged severe abdominal pain which may be accompanied by vomiting; pain may spread out towards the back.	√
<b>Hemolytic anemia</b> (when red blood cells are destroyed faster than bone marrow can replace them): symptoms may include fatigue, pale color, rapid heartbeat, shortness of breath, dark urine, chills, and backache.	√
<b>Encephalopathy</b> (disease of the brain that severely alters thinking): Possible neurological symptoms include: muscle weakness in one area, poor decision-making or concentration, involuntary twitching, trembling, difficulty speaking or swallowing, seizures.	√
<b>Peripheral neuropathy</b> (a result of damage to your peripheral nerves): signs and symptoms might include 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.	√

*This is not a complete list of side effects. For any unexpected effects while taking MINT-METFORMIN, contact your healthcare professional. 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.*

## **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.

## **HOW TO STORE IT**

Store at room temperature (15° to 30°C) in well closed containers. Throw away any medication that is outdated or no longer needed. Talk to your pharmacist about the proper disposal of your medication.

Keep out of reach and sight of children.

## **MORE INFORMATION**

**If you want more information about MINT-METFORMIN:**

- Talk to your healthcare professional
- Find the full product monograph, prepared for healthcare professionals (which includes this document) by visiting the Health Canada website (<https://www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/drug-product-database.html>); the manufacturer's website ([www.mintpharmaceuticals.com](http://www.mintpharmaceuticals.com)), or by contacting the sponsor, Mint Pharmaceuticals Inc. at 1-877-398-9696.

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