

For the Use of a Registered Medical Practitioner Only

1. GENERIC NAME AND BRAND NAME

Dapagliflozin Tablets 10 mg

Gluject® 10

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film coated Tablet contains:

Dapagliflozin Propanediol USP

Eq. to Dapagliflozin..... 10 mg

Colour: Ferric Oxide USPNF Yellow

3. DOSAGE FORM AND STRENGTH

Refer section 1 & 2

4. CLINICAL PARTICULARS

4.1 THERAPEUTIC INDICATIONS

In adult aged 18 years and older with Type-II diabetic mellitus to improve glycemic control:

- As mono-therapy when diet and exercise alone do not provide adequate glycemic control in patients for whom use of metformin is considered inappropriate due to intolerance.

- As add-on combination therapy in combination with other glucose- lowering medicinal products including insulin, when these, together with diet and exercise, do not provide adequate glycemic control.

- Dapagliflozin is indicated in adults for the treatment of heart failure with reduced ejection fraction.

Limitations of Use:

Dapagliflozin is not indicated for use in patients with type 1 diabetes.

Dapagliflozin should not be used for the treatment of diabetic ketoacidosis.

4.2 POSOLOGY AND METHOD OF ADMINISTRATION

Posology

To improve glycemic control, the recommended starting dose of Dapagliflozin is 5 mg orally once daily, taken in the morning, with or without food. In patients tolerating Dapagliflozin 5 mg once daily who require additional glycemic control, the dose can be increased to 10 mg once daily.

To reduce the risk of hospitalization for heart failure in patients with type 2 diabetes mellitus and established CVD or multiple CV risk factors, the recommended dose of Dapagliflozin is 10 mg orally once daily.

Special populations

Renal impairment

No dose adjustment is required based on renal function.

It is not recommended to initiate treatment with dapagliflozin in patients with an estimated glomerular filtration rate (eGFR) < 15 mL/min/1.73m².

In patients with type 2 diabetes mellitus, the glucose lowering efficacy of dapagliflozin is reduced when eGFR is $< 45 \text{ mL/min/1.73m}^2$ and is likely absent in patients with severe renal impairment. Therefore, if eGFR falls below $45 \text{ mL/min/1.73m}^2$, additional glucose lowering treatment should be considered in patients with type 2 diabetes mellitus.

Hepatic impairment

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

Elderly (≥ 65 years)

No dose adjustment is recommended based on age.

Paediatric population

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

Method of administration: For oral administration only.

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

4.3 CONTRAINDICATIONS

- History of a serious hypersensitivity reaction to Dapagliflozin, such as anaphylactic reactions or Angioedema.
- Patients who are being treated for glycemic control without established CVD or multiple CV risk factors with severe renal impairment, (eGFR less than $30 \text{ mL/min/1.73 m}^2$)
- Patients on dialysis.

4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE

Renal impairment

There is limited experience with initiating treatment with dapagliflozin in patients with eGFR $< 25 \text{ mL/min/1.73m}^2$, and no experience with initiating treatment in patients with eGFR $< 15 \text{ mL/min/1.73m}^2$. Therefore, it is not recommended to initiate treatment with dapagliflozin in patients with eGFR $< 15 \text{ mL/min/1.73m}^2$ (see section 4.2).

The glucose lowering efficacy of dapagliflozin is dependent on renal function and is reduced in patients with eGFR $< 45 \text{ mL/min/1.73m}^2$ and is likely absent in patients with severe renal impairment. In patients with moderate renal impairment (eGFR $< 60 \text{ mL/min/1.73m}^2$), a higher proportion of patients treated with dapagliflozin had adverse reactions of increase in parathyroid hormone (PTH) and hypotension, compared with placebo.

Hepatic impairment

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

Use in patients at risk for volume depletion and/or hypotension.

Due to its mechanism of action, dapagliflozin increases diuresis which may lead to the modest decrease in blood pressure observed in clinical studies. It may be more pronounced in patients with very high blood glucose concentrations.

Caution should be exercised in patients for whom a dapagliflozin-induced drop in blood pressure could pose a risk, such as patients on anti-hypertensive therapy with a history of hypotension or elderly patients.

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

Diabetic ketoacidosis

Rare cases of diabetic ketoacidosis (DKA), including life-threatening and fatal cases, have been reported in patients treated with sodium-glucose co-transporter 2 (SGLT2) inhibitors, including dapagliflozin. In a number of cases, the presentation of the condition was atypical with only moderately increased blood glucose values, below 14 mmol/L (250 mg/dL).

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

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

Treatment should be interrupted in patients who are hospitalized for major surgical procedures or acute serious medical illnesses. Monitoring of ketones is recommended in these patients. Measurement of blood ketone levels is preferred to urine. Treatment with dapagliflozin may be restarted when the ketone values are normal, and the patient's condition has stabilized.

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

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

In type 1 diabetes mellitus studies with dapagliflozin, DKA was reported with common frequency. Dapagliflozin should not be used for treatment of patients with type 1 diabetes.

Necrotizing fasciitis of the perineum (Fournier's gangrene)

Post-marketing cases of necrotizing fasciitis of the perineum (also known as Fournier's gangrene) have been reported in female and male patients taking SGLT2 inhibitors. This is a rare but serious and potentially life-threatening event that requires urgent surgical intervention and antibiotic treatment.

Patients should be advised to seek medical attention if they experience a combination of symptoms of pain, tenderness, erythema, or swelling in the genital or perineal area, with fever or malaise. Be aware that either uro-genital infection or perineal abscess may precede necrotizing fasciitis. If Fournier's gangrene is suspected, Dapagliflozin should be discontinued, and prompt treatment (including antibiotics and surgical debridement) should be instituted.

Urinary tract infections

Urinary glucose excretion may be associated with an increased risk of urinary tract infection; therefore, temporary interruption of dapagliflozin should be considered when treating pyelonephritis or urosepsis.

Elderly (≥ 65 years)

Elderly patients may be at a greater risk for volume depletion and are more likely to be treated with diuretics.

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

Cardiac failure

Experience with dapagliflozin in NYHA class IV is limited.

Chronic kidney disease

There is no experience with dapagliflozin for the treatment of chronic kidney disease in patients without diabetes who do not have albuminuria. Dapagliflozin has not been studied for the treatment of chronic kidney disease in patients with polycystic kidney disease, glomerulonephritis with flares (lupus nephritis or ANCA-associated vasculitis), ongoing or recent requirements of cytotoxic, immunosuppressive, or other immunomodulating renal therapy, or in patients who received an organ transplant.

Lower limb amputations

An increase in cases of lower limb amputation (primarily of the toe) has been observed in long-term, clinical studies in type 2 diabetes mellitus with SGLT2 inhibitors. It is unknown whether this constitutes a class effect. It is important to counsel patients with diabetes on routine preventative foot care.

Urine laboratory assessments

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

4.5 DRUG INTERACTION

Pharmacodynamic interactions

Diuretics

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

Insulin and insulin secretagogues

Insulin and insulin secretagogues, such as sulphonylureas, cause hypo glycaemia. Therefore, a lower dose of insulin or an insulin secretagogue may be required to reduce the risk of hypoglycaemia when used in combination with dapagliflozin in patients with type 2 diabetes mellitus.

Pharmacokinetic interactions

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

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

Effect of other medicinal products on dapagliflozin

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

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

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

Effect of dapagliflozin on other medicinal products

Dapagliflozin may increase renal lithium excretion and the blood lithium levels may be decreased. Serum concentration of lithium should be monitored more frequently after dapagliflozin initiation and dose changes. Please refer the patient to the lithium prescribing doctor in order to monitor serum concentration of lithium.

In interaction studies conducted in healthy subjects, using mainly a single-dose design, dapagliflozin did not alter the pharmacokinetics of metformin, pioglitazone, sitagliptin, glimepiride, hydrochlorothiazide, bumetanide, valsartan, digoxin (a P-gp substrate) or warfarin (S-

warfarin, a CYP2C9 substrate), or the anticoagulatory effects of warfarin as measured by INR. Combination of a single dose of dapagliflozin 20 mg and simvastatin (a CYP3A4 substrate) resulted in a 19% increase in AUC of simvastatin and 31% increase in AUC of simvastatin acid. The increase in simvastatin and simvastatin acid exposures are not considered clinically relevant.

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

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

Paediatric population

Interaction studies have only been performed in adults.

4.6 USE IN SPECIAL POPULATIONS

Pregnancy

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

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

Breast-feeding

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

Fertility

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

4.7 EFFECTS ON ABILITY TO DRIVE AND USE MACHINES

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

4.8 UNDESIRABLE EFFECTS

Summary of the safety profile

Type 2 diabetes mellitus

In the clinical studies in type 2 diabetes, more than 15,000 patients have been treated with dapagliflozin. The primary assessment of safety and tolerability was conducted in a pre-specified

pooled analysis of 13 short-term (up to 24 weeks) placebo-controlled studies with 2,360 subjects treated with dapagliflozin 10 mg and 2,295 treated with placebo.

In the dapagliflozin cardiovascular outcomes study in type 2 diabetes mellitus (DECLARE study, see section 5.1), 8,574 patients received dapagliflozin 10 mg and 8,569 received placebo for a median exposure time of 48 months. In total, there were 30,623 patient-years of exposure to dapagliflozin.

The most frequently reported adverse reactions across the clinical studies were genital infections.

Heart failure

In the dapagliflozin cardiovascular outcome study in patients with heart failure with reduced ejection fraction (DAPA-HF study), 2,368 patients were treated with dapagliflozin 10 mg and 2,368 patients with placebo for a median exposure time of 18 months. The patient population included patients with type 2 diabetes mellitus and without diabetes, and patients with eGFR ≥ 30 mL/min/1.73 m². In the dapagliflozin cardiovascular outcome study in patients with heart failure with left ventricular ejection fraction $> 40\%$ (DELIVER), 3,126 patients were treated with dapagliflozin 10 mg and 3,127 patients with placebo for a median exposure time of 27 months. The patient population included patients with type 2 diabetes mellitus and without diabetes, and patients with eGFR ≥ 25 mL/min/1.73 m².

The overall safety profile of dapagliflozin in patients with heart failure was consistent with the known safety profile of dapagliflozin.

Tabulated list of adverse reactions

The following adverse reactions have been identified in the placebo-controlled clinical studies and post marketing surveillance. None were found to be dose-related. Adverse reactions listed below are classified according to frequency and system organ class (SOC). Frequency categories are defined according to the following convention: very common ($\geq 1/10$), common ($\geq 1/100$ to $< 1/10$), uncommon ($\geq 1/1,000$ to $< 1/100$), rare ($\geq 1/10,000$ to $< 1/1,000$), very rare ($< 1/10,000$), and not known (cannot be estimated from the available data).

Table 1. Adverse reactions in placebo-controlled clinical studies^a and postmarketing experience

System organ class	Very common	Common [*]	Uncommon ^{**}	Rare	Very rare
Infections and infestations		Vulvovaginitis, balanitis and related genital infections ^{*,b,c} Urinary tract infection ^{*,b,d}	Fungal infection ^{**}		Necrotising fasciitis of the perineum (Fournier's gangrene) ^{b,i}
Metabolism and nutrition disorders	Hypoglycaemia (when used with SU or insulin) ^b		Volume depletion ^{b,e} Thirst ^{**}	Diabetic ketoacidosis (when used in	

				type 2 diabetes mellitus) ^{b,i,k}	
Nervous system disorders		Dizziness			
Gastrointestinal disorders			Constipation** Dry mouth**		
Skin and subcutaneous tissue disorders		Rash ^j			Angioedema
Musculoskeletal and connective tissue disorders		Back pain*			
Renal and urinary disorders		Dysuria Polyuria ^{*,f}	Nocturia**		
Reproductive system and breast disorders			Vulvovaginal pruritus** Pruritus genital**		
Investigations		Haematocrit increased ^g Creatinine renal clearance decreased during initial treatment ^b Dyslipidaemia ^h	Blood creatinine increased during initial treatment ^{**,b} Blood urea increased** Weight decreased**		

^aThe table shows up to 24-week (short-term) data regardless of glycaemic rescue.

^bSee corresponding subsection below for additional information.

^cVulvovaginitis, balanitis and related genital infections includes, e.g., the predefined preferred terms: vulvovaginal mycotic infection, vaginal infection, balanitis, genital infection fungal, vulvovaginal candidiasis, vulvovaginitis, balanitis candida, genital candidiasis, genital infection, genital infection male, penile infection, vulvitis, vaginitis bacterial, vulval abscess.

^dUrinary tract infection includes the following preferred terms, listed in order of frequency reported: urinary tract infection, cystitis, Escherichia urinary tract infection, genitourinary tract infection, pyelonephritis, trigonitis, urethritis, kidney infection and prostatitis.

^eVolume depletion includes, e.g., the predefined preferred terms: dehydration, hypovolaemia, hypotension.

^fPolyuria includes the preferred terms: pollakiuria, polyuria, urine output increased.

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

^hMean percent change from baseline for dapagliflozin 10 mg versus placebo, respectively, was: total cholesterol 2.5% versus 0.0%; HDL cholesterol 6.0% versus 2.7%; LDL cholesterol 2.9% versus -1.0%; triglycerides -2.7% versus -0.7%.

^jAdverse reaction was identified through post marketing surveillance. Rash includes the following preferred terms, listed in order of frequency in clinical studies: rash, rash generalized, rash pruritic, rash macular, rash maculo-papular, rash pustular, rash vesicular, and rash erythematous. In active- and placebo-controlled clinical studies (dapagliflozin, N=5936, All control, N=3403), the frequency of rash was similar for dapagliflozin (1.4%) and all control (1.4%), respectively.

^kReported in the cardiovascular outcomes study in patients with type 2 diabetes (DECLARE). Frequency is based on annual rate.

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

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

Description of selected adverse reactions

Vulvovaginitis, balanitis and related genital infections

In the 13-study safety pool, vulvovaginitis, balanitis and related genital infections were reported in 5.5% and 0.6% of subjects who received dapagliflozin 10 mg and placebo, respectively. Most infections were mild to moderate, and subjects responded to an initial course of standard treatment and rarely resulted in discontinuation from dapagliflozin treatment. These infections were more frequent in females (8.4% and 1.2% for dapagliflozin and placebo, respectively), and subjects with a prior history were more likely to have a recurrent infection.

In the DECLARE study, the numbers of patients with serious adverse events of genital infections were few and balanced: 2 patients in each of the dapagliflozin and placebo groups.

In the DAPA-HF study, no patient reported serious adverse events of genital infections in the dapagliflozin group and one in the placebo group. There were 7 (0.3%) patients with adverse events leading to discontinuations due to genital infections in the dapagliflozin group and none in the placebo group. In the DELIVER study, one (< 0.1%) patient in each treatment group reported a serious adverse event of genital infections. There were 3 (0.1%) patients with adverse events leading to discontinuations due to genital infection in the dapagliflozin group and none in the placebo group.

In the DAPA-CKD study, there were 3 (0.1%) patients with serious adverse events of genital infections in the dapagliflozin group and none in the placebo group. There were 3 (0.1%) patients with adverse events leading to discontinuation due to genital infections in the dapagliflozin group and none in the placebo group. Serious adverse events of genital infections or adverse events leading to discontinuation due to genital infections were not reported for any patients without diabetes.

Cases of phimosis/acquired phimosis have been reported concurrent with genital infections and in some cases, circumcision was required.

Necrotizing fasciitis of the perineum (Fournier's gangrene)

Cases of Fournier's gangrene have been reported post marketing in patients taking SGLT2 inhibitors, including dapagliflozin. In the DECLARE study with 17,160 type 2 diabetes mellitus patients and a median exposure time of 48 months, a total of 6 cases of Fournier's gangrene were reported, one in the dapagliflozin-treated group and 5 in the placebo group.

Hypoglycemia

The frequency of hypoglycaemia depended on the type of background therapy used in the clinical studies in diabetes mellitus.

For studies of dapagliflozin in monotherapy, as add-on to metformin or as add-on to sitagliptin (with or without metformin), the frequency of minor episodes of hypoglycaemia was similar (< 5%) between treatment groups, including placebo up to 102 weeks of treatment. Across all studies, major events of hypoglycaemia were uncommon and comparable between the groups treated with dapagliflozin or placebo. Studies with add-on sulphonylurea and add-on insulin therapies had higher rates of hypoglycaemia (see section 4.5).

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

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

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

In the DECLARE study, no increased risk of major hypoglycaemia was observed with dapagliflozin therapy compared with placebo. Major events of hypoglycaemia were reported in 58 (0.7%) patients treated with dapagliflozin and 83 (1.0%) patients treated with placebo.

In the DAPA-HF study, major events of hypoglycaemia were reported in 4 (0.2%) patients in both the dapagliflozin and placebo treatment groups and observed only in patients with type 2 diabetes mellitus.

In the DAPA-CKD study, major events of hypoglycaemia were reported in 14 (0.7%) patients in the dapagliflozin group and 28 (1.3%) patients in the placebo group and observed only in patients with type 2 diabetes mellitus.

Volume depletion

In the 13-study safety pool, reactions suggestive of volume depletion (including, reports of dehydration, hypovolaemia or hypotension) were reported in 1.1% and 0.7% of subjects who received dapagliflozin 10 mg and placebo, respectively; serious reactions occurred in < 0.2% of subjects balanced between dapagliflozin 10 mg and placebo.

In the DECLARE study, the numbers of patients with events suggestive of volume depletion were balanced between treatment groups: 213 (2.5%) and 207 (2.4%) in the dapagliflozin and placebo groups, respectively. Serious adverse events were reported in 81 (0.9%) and 70 (0.8%) in the dapagliflozin and placebo group, respectively. Events were generally balanced between treatment groups across subgroups of age, diuretic use, blood pressure and angiotensin converting enzyme inhibitors (ACE-I)/angiotensin II type 1 receptor blockers (ARB) use. In patients with eGFR < 60 mL/min/1.73 m² at baseline, there were 19 events of serious adverse events suggestive of volume depletion in the dapagliflozin group and 13 events in the placebo group.

In the DAPA-HF study, the numbers of patients with events suggestive of volume depletion were 170 (7.2%) in the dapagliflozin group and 153 (6.5%) in the placebo group. There were fewer patients with serious events of symptoms suggestive of volume depletion in the dapagliflozin group (23 [1.0%]) compared with the placebo group (38 [1.6%]). Results were similar irrespective of presence of diabetes at baseline and baseline eGFR.

In the DAPA-CKD study, the numbers of patients with events suggestive of volume depletion were 120 (5.6%) in the dapagliflozin group and 84 (3.9%) in the placebo group. There were 16 (0.7%) patients with serious events of symptoms suggestive of volume depletion in the dapagliflozin group and 15 (0.7%) patients in the placebo group.

Diabetic ketoacidosis in type 2 diabetes mellitus

In the DECLARE study, with a median exposure time of 48 months, events of DKA were reported in 27 patients in the dapagliflozin 10 mg group and 12 patients in the placebo group. The events occurred evenly distributed over the study period. Of the 27 patients with DKA events in the dapagliflozin group, 22 had concomitant insulin treatment at the time of the event. Precipitating factors for DKA were as expected in a type 2 diabetes mellitus population. In the DAPA-HF study, events of DKA were reported in 3 patients with type 2 diabetes mellitus in the dapagliflozin group and none in the placebo group. In the DAPA-CKD study, events of DKA were not reported in any patient in the dapagliflozin group and in 2 patients with type 2 diabetes mellitus in the placebo group.

Urinary tract infections

In the 13-study safety pool, urinary tract infections were more frequently reported for dapagliflozin 10 mg compared to placebo. Most infections were mild to moderate, and subjects responded to an initial course of standard treatment and rarely resulted in discontinuation from dapagliflozin treatment. These infections were more frequent in females, and subjects with a prior history were more likely to have a recurrent infection. In the DECLARE study, serious events of urinary tract infections were reported less frequently for dapagliflozin 10 mg compared with placebo, 79 (0.9%) events versus 109 (1.3%) events, respectively. In the DAPA-HF study, the numbers of patients with serious adverse events of urinary tract infections were 14 (0.6%) in the dapagliflozin group

and 17 (0.7%) in the placebo group. There were 5 (0.2%) patients with adverse events leading to discontinuations due to urinary tract infections in each of the dapagliflozin and placebo groups.

In the DAPA-CKD study, the numbers of patients with serious adverse events of urinary tract infections were 29 (1.3%) in the dapagliflozin group and 18 (0.8%) in the placebo group. There were 8 (0.4%) patients with adverse events leading to discontinuations due to urinary tract infections in the dapagliflozin group and 3 (0.1%) in the placebo group. The numbers of patients without diabetes reporting serious adverse events of urinary tract infections or adverse events leading to discontinuation due to urinary tract infections were similar between treatment groups (6 [0.9%] versus 4 [0.6%] for serious adverse events, and 1 [0.1%] versus 0 for adverse events leading to discontinuation, in the dapagliflozin and placebo groups, respectively).

Increased creatinine

Adverse reactions related to increased creatinine were grouped (e.g., decreased renal creatinine clearance, renal impairment, increased blood creatinine and decreased glomerular filtration rate). In the 13-study safety pool, this grouping of reactions was reported in 3.2% and 1.8% of patients who received dapagliflozin 10 mg and placebo, respectively. In patients with normal renal function or mild renal impairment (baseline eGFR ≥ 60 mL/min/1.73 m²) this grouping of reactions were reported in 1.3% and 0.8% of patients who received dapagliflozin 10 mg and placebo, respectively. These reactions were more common in patients with baseline eGFR ≥ 30 and < 60 mL/min/1.73 m² (18.5% dapagliflozin 10 mg versus 9.3% placebo).

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

In the DECLARE study, including elderly patients and patients with renal impairment (eGFR less than 60 mL/min/1.73 m²), eGFR decreased over time in both treatment groups. At 1-year, mean eGFR was slightly lower, and at 4 years, mean eGFR was slightly higher in the dapagliflozin group compared with the placebo group.

In the DAPA-HF study, eGFR decreased over time in both the dapagliflozin group and the placebo group. The initial decrease in mean eGFR was -4.3 mL/min/1.73 m² in the dapagliflozin group and -1.1 mL/min/1.73 m² in the placebo group. At 20 months, change from baseline in eGFR was similar between the treatment groups: -5.3 mL/min/1.73 m² for dapagliflozin and -4.5 mL/min/1.73 m² for placebo.

In the DAPA-CKD study, eGFR decreased over time in both the dapagliflozin group and the placebo group. The initial (day 14) decrease in mean eGFR was -4.0 mL/min/1.73 m² in the dapagliflozin group and -0.8 mL/min/1.73 m² in the placebo group. At 28 months, change from baseline in eGFR was -7.4 mL/min/1.73 m² in the dapagliflozin group and -8.6 mL/min/1.73 m² in the placebo group.

4.9 OVERDOSE

Dapagliflozin did not show any toxicity in healthy subjects at single oral doses up to 500 mg (50 times the maximum recommended human dose). These subjects had detectable glucose in the urine

for a dose-related period of time (at least 5 days for the 500 mg dose), with no reports of dehydration, hypotension or electrolyte imbalance, and with no clinically meaningful effect on QTc interval. The incidence of hypoglycaemia was similar to placebo. In clinical studies where once-daily doses of up to 100 mg (10 times the maximum recommended human dose) were administered for 2 weeks in healthy subjects and type 2 diabetes subjects, the incidence of hypoglycaemia was slightly higher than placebo and was not dose-related. Rates of adverse events including dehydration or hypotension were similar to placebo, and there were no clinically meaningful dose-related changes in laboratory parameters, including serum electrolytes and biomarkers of renal function.

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

5. PHARMACOLOGICAL PROPERTIES

5.1 PHARMACODYNAMIC PROPERTIES

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

Mechanism of action

Dapagliflozin is a highly potent (K_i : 0.55 nM), selective and reversible inhibitor of SGLT2. Inhibition of SGLT2 by dapagliflozin reduces reabsorption of glucose from the glomerular filtrate in the proximal renal tubule with a concomitant reduction in sodium reabsorption leading to urinary excretion of glucose and osmotic diuresis. Dapagliflozin therefore increases the delivery of sodium to the distal tubule which increases tubuloglomerular feedback and reduces intraglomerular pressure. This combined with osmotic diuresis leads to a reduction in volume overload, reduced blood pressure, and lower preload and afterload, which may have beneficial effects on cardiac remodelling and preserve renal function. Other effects include an increase in haematocrit and reduction in body weight.

Dapagliflozin improves both fasting and post-prandial plasma glucose levels by reducing renal glucose reabsorption leading to urinary glucose excretion. This glucose excretion (glucuretic effect) is observed after the first dose, is continuous over the 24-hour dosing interval and is sustained for the duration of treatment. The amount of glucose removed by the kidney through this mechanism is dependent upon the blood glucose concentration and GFR. Thus, in subjects with normal blood glucose and/or low GFR, dapagliflozin has a low propensity to cause hypoglycaemia, as the amount of filtrated glucose is small and can be reabsorbed by SGLT1 and unblocked SGLT2 transporters. Dapagliflozin does not impair normal endogenous glucose production in response to hypoglycaemia. Dapagliflozin acts independently of insulin secretion and insulin action. Improvement in homeostasis model assessment for beta cell function (HOMA beta-cell) has been observed in clinical studies with dapagliflozin.

The SGLT2 is selectively expressed in the kidney. Dapagliflozin does not inhibit other glucose transporters important for glucose transport into peripheral tissues and is > 1,400 times more selective for SGLT2 versus SGLT1, the major transporter in the gut responsible for glucose absorption.

Pharmacodynamic effects

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

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

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

5.2 PHARMACOKINETIC PROPERTIES

Absorption

Dapagliflozin was rapidly and well absorbed after oral administration. Maximum dapagliflozin plasma concentrations (C_{max}) were usually attained within 2 hours after administration in the fasted state. Geometric mean steady-state dapagliflozin C_{max} and AUC_{τ} values following once daily 10 mg doses of dapagliflozin were 158 ng/mL and 628 ng h/mL, respectively. The absolute oral bioavailability of dapagliflozin following the administration of a 10 mg dose is 78%. Administration with a high-fat meal decreased dapagliflozin C_{max} by up to 50% and prolonged T_{max} by approximately 1 hour but did not alter AUC as compared with the fasted state. These changes are not considered to be clinically meaningful. Hence, Dapagliflozin can be administered with or without food.

Distribution

Dapagliflozin is approximately 91% protein bound. Protein binding was not altered in various disease states (e.g., renal or hepatic impairment). The mean steady-state volume of distribution of dapagliflozin was 118 liters.

Biotransformation

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

Elimination

The mean plasma terminal half-life ($t_{1/2}$) for dapagliflozin was 12.9 hours following a single oral dose of dapagliflozin 10 mg to healthy subjects. The mean total systemic clearance of dapagliflozin

administered intravenously was 207 mL/min. Dapagliflozin and related metabolites are primarily eliminated via urinary excretion with less than 2% as unchanged dapagliflozin. After administration of a 50 mg [¹⁴C]-dapagliflozin dose, 96% was recovered, 75% in urine and 21% in faeces. In faeces, approximately 15% of the dose was excreted as parent drug.

Linearity

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

Special populations

Renal impairment

At steady-state (20 mg once-daily dapagliflozin for 7 days), subjects with type 2 diabetes mellitus and mild, moderate or severe renal impairment (as determined by iohexol plasma clearance) had mean systemic exposures of dapagliflozin of 32%, 60% and 87% higher, respectively, than those of subjects with type 2 diabetes mellitus and normal renal function. The steady-state 24-hour urinary glucose excretion was highly dependent on renal function and 85, 52, 18 and 11 g of glucose/day was excreted by subjects with type 2 diabetes mellitus and normal renal function or mild, moderate or severe renal impairment, respectively. The impact of haemodialysis on dapagliflozin exposure is not known. The effect of reduced renal function on systemic exposure was evaluated in a population pharmacokinetic model. Consistent with previous results, model predicted AUC was higher in patients with chronic kidney disease compared with patients with normal renal function and was not meaningfully different in chronic kidney disease patients with type 2 diabetes mellitus and without diabetes.

Hepatic impairment

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

Elderly (≥ 65 years)

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

Pediatric population

Pharmacokinetics in the paediatric population have not been studied.

Gender

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

Race

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

Body weight

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

6. NON-CLINICAL PROPERTIES

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

Reproductive and developmental toxicity

Direct administration of dapagliflozin to weanling juvenile rats and indirect exposure during late pregnancy (time periods corresponding to the second and third trimesters of pregnancy with respect to human renal maturation) and lactation are each associated with increased incidence and/or severity of renal pelvic and tubular dilatations in progeny. In a juvenile toxicity study, when dapagliflozin was dosed directly to young rats from postnatal day 21 until postnatal day 90, renal pelvic and tubular dilatations were reported at all dose levels; pup exposures at the lowest dose tested were ≥ 15 times the maximum recommended human dose. These findings were associated with dose-related increases in kidney weight and macroscopic kidney enlargement observed at all doses. The renal pelvic and tubular dilatations observed in juvenile animals did not fully reverse within the approximate 1-month recovery period. In a separate study of pre- and postnatal development, maternal rats were dosed from gestation day 6 through postnatal day 21, and pups were indirectly exposed in utero and throughout lactation. (A satellite study was conducted to assess dapagliflozin exposures in milk and pups.)

Increased incidence or severity of renal pelvic dilatation was observed in adult offspring of treated dams, although only at the highest dose tested (associated maternal and pup dapagliflozin exposures were 1,415 times and 137 times, respectively, the human values at the maximum recommended human dose). Additional developmental toxicity was limited to dose-related reductions in pup body weights and observed only at doses ≥ 15 mg/kg/day (associated with pup exposures that are ≥ 29 times the human values at the maximum recommended human dose).

Maternal toxicity was evident only at the highest dose tested, and limited to transient reductions in body weight and food consumption at dose. The no observed adverse effect level (NOAEL) for developmental toxicity, the lowest dose tested, is associated with a maternal systemic exposure multiple that is approximately 19 times the human value at the maximum recommended human dose. In additional studies of embryo-foetal development in rats and rabbits, dapagliflozin was administered for intervals coinciding with the major periods of organogenesis in each species.

Neither maternal nor developmental toxicities were observed in rabbits at any dose tested; the highest dose tested is associated with a systemic exposure multiple of approximately 1,191 times the maximum recommended human dose. In rats, dapagliflozin was neither embryo-lethal nor teratogenic at exposures up to 1,441 times the maximum recommended human dose.

7. DESCRIPTION

Gluject 10:

Gluject 10 is supplied for oral administration, as film coated tablet of Dapagliflozin Propanediol equivalent to Dapagliflozin 10 mg. Each film coated tablet of Gluject 10 contains Dapagliflozin Propanediol equivalent to Dapagliflozin 10 mg.

8. PHARMACEUTICAL PARTICULARS

8.1. INCOMPATIBILITIES

Not applicable

8.2. SHELF LIFE

Refer pack

8.3. PACKAGING INFORMATION

Refer pack

8.4. STORAGE AND HANDLING INSTRUCTION

Refer pack

9. PATIENT COUNSELLING INSTRUCTION

Read this entire leaflet carefully before you start taking this medicine because it contains important information for you.

- Keep this leaflet. You may need to read it again.
- If you have any further questions, ask your doctor or pharmacist.
- This medicine has been prescribed for you only. Do not pass it on to others. It may harm them, even if their signs of illness are the same as yours.
- If you get any side effects, talk to your doctor or pharmacist. This includes any possible side effects not listed in this leaflet.

What Dapagliflozin is and what it is used for?

Dapagliflozin contains the active substance dapagliflozin. It belongs to a group of medicines called “sodium glucose co-transporter-2 (SGLT2) inhibitors”. They work by blocking the SGLT2 protein in your kidney. By blocking this protein, blood sugar (glucose), salt (sodium) and water are removed from your body via the urine. Dapagliflozin is used in adult patients (aged 18 years and older) to treat: Type 2 diabetes.

If your type 2 diabetes cannot be controlled with diet and exercise.

Dapagliflozin can be used on its own or together with other medicines to treat diabetes.

It is important to continue to follow the advice on diet and exercise given to you by your doctor, pharmacist or nurse.

What need to know before you take tablets?

Do not take Dapagliflozin.

- if you are allergic to dapagliflozin or any of the other ingredients of this medicine.
- History of a serious hypersensitivity reaction to Dapagliflozin, such as anaphylactic reactions or Angioedema.
- Patients who are being treated for glycemic control without established CVD or multiple CV risk factors with severe renal impairment, (eGFR less than 30 mL/min/1.73 m²)
- Patients on dialysis.

Warnings and precautions

Talk to your doctor or pharmacist before taking Dapagliflozin tablet if you have:

Diabetic ketoacidosis

- If you have diabetes and experience feeling sick or being sick, stomach pain, excessive thirst, fast and deep breathing, confusion, unusual sleepiness or tiredness, a sweet smell to your breath, a sweet or metallic taste in your mouth, or a different odour to your urine or sweat or rapid weight loss.
- The above symptoms could be a sign of “diabetic ketoacidosis” – a rare but serious, sometimes life-threatening problem you can get with diabetes because of increased levels of “ketone bodies” in your urine or blood, seen in tests.
- The risk of developing diabetic ketoacidosis may be increased with prolonged fasting, excessive alcohol consumption, dehydration, sudden reductions in insulin dose, or a higher need of insulin due to major surgery or serious illness.
- When you are treated with Dapagliflozin, diabetic ketoacidosis can occur even if your blood sugar is normal. If you suspect you have diabetic ketoacidosis, contact a doctor or the nearest hospital straight away and do not take this medicine.

Necrotising fasciitis of the perineum

- Talk to your doctor immediately if you develop a combination of symptoms of pain, tenderness, redness, or swelling of the genitals or the area between the genitals and the anus with fever or feeling generally unwell. These symptoms could be a sign of a rare but serious or even life threatening infection, called necrotising fasciitis of the perineum or Fournier’s gangrene which destroys the tissue under the skin. Fournier’s gangrene has to be treated immediately.

Talk to your doctor, pharmacist or nurse before taking Dapagliflozin:

- if you have “type 1 diabetes” – the type that usually starts when you are young, and your body does not produce any insulin.
- if you have diabetes and have a kidney problem – your doctor may ask you to take additional or a different medicine to control your blood sugar.
- if you have a liver problem – your doctor may start you on a lower dose.
- if you are on medicines to lower your blood pressure (anti-hypertensive) and have a history of low blood pressure (hypotension). More information is given below under ‘Other medicines and Dapagliflozin’.
- if you have very high levels of sugar in your blood which may make you dehydrated (lose too much body fluid). Tell your doctor before you start taking Dapagliflozin if you have any of these signs.

- if you have or develop nausea (feeling sick), vomiting or fever or if you are not able to eat or drink. These conditions can cause dehydration. Your doctor may ask you to stop taking Dapagliflozin until you recover to prevent dehydration.
- if you often get infections of the urinary tract. If any of the above applies to you (or you are not sure), talk to your doctor, pharmacist or nurse before taking Dapagliflozin.

Other medicines and Dapagliflozin

Tell your doctor, pharmacist or nurse if you are taking, have recently taken or might take any other medicines. Especially tell your doctor:

- if you are taking a medicine used to remove water from the body (diuretic).
- if you are taking other medicines that lower the amount of sugar in your blood such as insulin or a “sulphonylurea” medicine. Your doctor may want to lower the dose of these other medicines, to prevent you from getting low blood sugar levels (hypoglycaemia).

Pregnancy and breast-feeding

If you are pregnant or breast-feeding, think you may be pregnant or are planning to have a baby, ask your doctor or pharmacist for advice before taking this medicine. You should stop taking this medicine if you become pregnant, since it is not recommended during the second and third trimesters of pregnancy. Talk to your doctor about the best way to control your blood sugar while you are pregnant. Talk to your doctor if you would like to or are breast-feeding before taking this medicine. Do not use Dapagliflozin if you are breast-feeding. It is not known if this medicine passes into human breast milk.

Driving and using machines

Dapagliflozin has no or negligible influence on the ability to drive and use machines. Taking this medicine with other medicines called sulphonylureas or with insulin can cause too low blood sugar levels (hypoglycaemia), which may cause symptoms such as shaking, sweating and change in vision, and may affect your ability to drive and use machines. Do not drive or use any tools or machines, if you feel dizzy taking Dapagliflozin.

How to Take Dapagliflozin Tablet

Always take this medicine exactly as your doctor has told you. Check with your doctor, pharmacist, or nurse if you are not sure.

- Your doctor will prescribe the dosage that is right for you.

Taking this medicine

- Swallow the tablet whole with half a glass of water.
- You can take your tablet with or without food.
- You can take the tablet at any time of the day. However, try to take it at the same time each day. This will help you to remember to take it. Your doctor may prescribe Dapagliflozin together with other medicine(s). Remember to take these other medicine(s) as your doctor has told you. This will help get the best results for your health. Diet and exercise can help your body use its blood sugar better. If you have diabetes, it is important to stay on any diet and exercise program recommended by your doctor while taking Dapagliflozin.

If you take more Dapagliflozin tablets than you should, talk to a doctor or go to a hospital immediately. Take the medicine pack with you.

Do not stop taking Dapagliflozin without talking to your doctor first. If you have diabetes, your blood sugar may increase without this medicine.

If you have any further questions on the use of this medicine, ask your doctor, pharmacist or nurse. Always take this medicine exactly as your doctor has told you. Check with your doctor or pharmacist if you are not sure.

Possible side effects

Like all medicines, this medicine can cause side effects, although not everybody gets them. Contact a doctor or the nearest hospital straight away if you have any of the following side effects:

- angioedema, seen very rarely (may affect up to 1 in 10,000 people).

These are signs of angioedema:

- swelling of the face, tongue or throat
- difficulties swallowing
- hives and breathing problems

- diabetic ketoacidosis - this is rare in patients with type 2 diabetes (may affect up to 1 in 1,000 people).

These are the signs of diabetic ketoacidosis:

- increased levels of “ketone bodies” in your urine or blood
- feeling sick or being sick
- stomach pain
- excessive thirst
- fast and deep breathing
- confusion
- unusual sleepiness or tiredness
- a sweet smell to your breath, a sweet or metallic taste in your mouth or a different odour to your urine or sweat
- rapid weight loss.

This may occur regardless of blood sugar level. Your doctor may decide to temporarily or permanently stop your treatment with Dapagliflozin.

- necrotising fasciitis of the perineum or Fournier’s gangrene, a serious soft tissue infection of the genitals or the area between the genitals and the anus, seen very rarely. Stop taking Dapagliflozin and see a doctor as soon as possible if you notice any of the following serious side effects:

- urinary tract infection, seen commonly (may affect up to 1 in 10 people).

These are signs of a severe infection of the urinary tract:

- fever and/or chills
- burning sensation when passing water (urinating)
- pain in your back or side.

Although uncommon, if you see blood in your urine, tell your doctor immediately. Contact your doctor as soon as possible if you have any of the following side effects:

- low blood sugar levels (hypoglycaemia), seen very commonly (may affect more than 1 in 10 people) in patients with diabetes taking this medicine with a sulphonylurea or insulin.

These are the signs of low blood sugar:

- shaking, sweating, feeling very anxious, fast heartbeat
- feeling hungry, headache, change in vision
- a change in your mood or feeling confused.

Your doctor will tell you how to treat low blood sugar levels and what to do if you get any of the signs above.

Other side effects when taking Dapagliflozin:

Common

- genital infection (thrush) of your penis or vagina (signs may include irritation, itching, unusual discharge or odour)
- back pain
- passing more water (urine) than usual or needing to pass water more often
- changes in the amount of cholesterol or fats in your blood (shown in tests)
- increases in the amount of red blood cells in your blood (shown in tests)
- decreases in creatinine renal clearance (shown in tests) in the beginning of treatment
- dizziness
- rash

Uncommon (may affect up to 1 in 100 people)

- loss of too much fluid from your body (dehydration, signs may include very dry or sticky mouth, passing little or no urine or fast heartbeat)
- thirst
- constipation
- awakening from sleep at night to pass urine
- dry mouth
- weight decreased
- increases in creatinine (shown in laboratory blood tests) in the beginning of treatment
- increases in urea (shown in laboratory blood tests).

How should I store Dapagliflozin Tablets?

Keep this medicine out of the sight and reach of children.

Do not store above 30°C, to be protected light and moisture.

Do not use this medicine after the expiry date, which is stated on the carton and the container after expiry. The expiry date refers to the last day of that month.

Do not throw away any medicines via wastewater or household waste. Ask your pharmacist how to throw away medicines you no longer use. These measures will help to protect the environment.

Any other information

Keep this medicine out of the sight and reach of children.

10. DETAILS OF MANUFACTURER

Refer Pack for manufacturer details.

® Regd. Trade Mark of Abbott Healthcare Pvt. Ltd.

11. DETAILS OF PERMISSION OR LICENCE NUMBER WITH DATE

Refer Pack for Permission/License details.

11. DATE OF REVISION

Version 1.0, dated 13/05/2024

For Product Complaints/Adverse events or Queries please write to
webmasterindia@abbott.com