

SUMMARY OF PRODUCT CHARACTERISTICS

1. NAME OF THE MEDICINAL PRODUCT:

DAPAGOOD M 1000

2. Qualitative and quantitative composition

Each tablet contains:

Dapagliflozin Propanediol monohydrate

Equivalent to Dapagliflozin 10 mg

Metformin Hydrochloride USP 1000 mg

(Extended Release)

Excipients of known effect:

Each Tablet Contains 20 mg of Lactose

For a full list of excipients see section 6.1.

3. PHARMACEUTICAL FORM

Tablets

Yellow & white colour, Caplet shaped bilayer uncoated tablets scored on one side and other side plain

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

DAPAGOOD M 1000 is indicated in adults for the treatment of type 2 diabetes mellitus as an adjunct to diet and exercise:

- in patients insufficiently controlled on their maximally tolerated dose of metformin alone
- in combination with other medicinal products for the treatment of diabetes in patients insufficiently controlled with metformin and these medicinal products
- in patients already being treated with the combination of dapagliflozin and metformin as separate tablets.

4.2 Posology and method of administration

Posology

DAPAGOOD M 1000 Tablet SR can be taken with or without food at any time of day but you should try to take it at the same time every day. The dose will be decided by your doctor. Don't stop taking it without asking your doctor. If you do, your blood sugar levels may increase and put you at risk of serious complications like kidney damage and blindness. This medicine is only part of a treatment program that should include a healthy diet, regular exercise, and weight reduction as advised by your doctor.

Method of administration

DAPAGOOD M 1000 should be given twice daily with meals to reduce the gastrointestinal adverse reactions associated with metformin.

4.3 Contraindications

DAPAGOOD M 1000 is contraindicated in patients with:

- hypersensitivity to the active substances or to any of the excipients.;
- any type of acute metabolic acidosis (such as lactic acidosis, diabetic ketoacidosis);
- diabetic pre-coma;
- severe renal failure (GFR < 30 mL/min);
- acute conditions with the potential to alter renal function such as:
 - dehydration,
 - severe infection,
 - shock;
- acute or chronic disease which may cause tissue hypoxia such as:
 - cardiac or respiratory failure
 - recent myocardial infarction
 - shock
- hepatic impairment
- acute alcohol intoxication, alcoholism

4.4 Special warnings and precautions for use

Lactic acidosis

Lactic acidosis, a very rare but serious metabolic complication, most often occurs at acute worsening of renal function or cardiorespiratory illness or sepsis. Metformin accumulation occurs at acute worsening of renal function and increases the risk of lactic acidosis.

In case of dehydration (severe diarrhoea or vomiting, fever or reduced fluid intake), DAPAGOOD M 1000 should be temporarily discontinued and contact with a health care professional is recommended.

Medicinal products that can acutely impair renal function (such as antihypertensives, diuretics and non-steroidal anti-inflammatory drugs [NSAIDs]) should be initiated with caution in metformin-treated patients. Other risk factors for lactic acidosis are excessive alcohol intake, hepatic insufficiency, inadequately controlled diabetes, ketosis, prolonged fasting and any conditions associated with hypoxia, as well as concomitant use of medicinal products that may cause lactic acidosis.

Patients and/or care-givers should be informed on the risk of lactic acidosis. Lactic acidosis is characterised by acidotic dyspnoea, abdominal pain, muscle cramps, asthenia and hypothermia followed by coma. In case of suspected symptoms, the patient should stop taking DAPAGOOD M 1000 and seek immediate medical attention. Diagnostic laboratory findings are decreased blood pH (< 7.35), increased plasma lactate levels above 5 mmol/L, and an increased anion gap and lactate/pyruvate ratio.

Renal function

The glycaemic efficacy of dapagliflozin is dependent on renal function, and efficacy is reduced in patients who have moderate renal impairment and is likely absent in patients with severe renal impairment. DAPAGOOD M 1000 should

not be initiated in patients with GFR < 60 mL/min and should be discontinued at GFR persistently below 45 mL/min.

Metformin is excreted by the kidney, and moderate to severe renal insufficiency increases the risk of lactic acidosis.

Monitoring of renal function: Renal function should be assessed:

- Before initiation of treatment and regularly thereafter.
- For renal function with GFR levels < 60 mL/min and in elderly patients, at least 2 to 4 times per year.
- Prior to initiation of concomitant medicinal products that may reduce renal function and periodically thereafter.
- If renal function falls persistently below GFR 45 mL/min, treatment should be discontinued.
- Metformin is contraindicated in patients with GFR of < 30 mL/min and should be temporarily discontinued in the presence of conditions that alter renal function.

Decreased renal function in elderly patients is frequent and asymptomatic. Special caution should be exercised in situations where renal function may become impaired, for example when initiating anti-hypertensive or diuretic therapy or when starting treatment with a NSAID.

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 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 this medicinal product is recommended for patients who develop volume depletion until the depletion is corrected.

Diabetic ketoacidosis

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

The risk of diabetic ketoacidosis must be considered in the event of non-specific symptoms such as nausea, vomiting, anorexia, abdominal pain, excessive thirst, difficulty breathing, confusion, unusual fatigue or sleepiness. Patients should be assessed for ketoacidosis immediately if these symptoms occur, regardless of blood glucose level. In patients where DKA is suspected or diagnosed, treatment with dapagliflozin should be discontinued immediately. Treatment should be interrupted in patients who are hospitalised for major surgical procedures or

acute serious medical illnesses. Monitoring of ketones is recommended in these patients. Measurement of 6 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 stabilised.

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

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

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

The safety and efficacy of DAPAGOOD M 1000 in patients with type 1 diabetes have not been established and DAPAGOOD M 1000 should not be used for treatment of patients with type 1 diabetes. In type 1 diabetes mellitus studies, DKA was reported with common frequency.

Necrotising fasciitis of the perineum (Fournier's gangrene)

Post-marketing cases of necrotising 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 necrotising fasciitis. If Fournier's gangrene is suspected, DAPAGOOD M 1000 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 treatment 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

There is no experience in clinical studies with dapagliflozin in NYHA class IV.

Lower limb amputations

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

Urine laboratory assessments

Due to its mechanism of action, patients taking this medicinal product will test positive for glucose in their urine. Administration of iodinated contrast agents

Intravascular administration of iodinated contrast agents may lead to contrast induced nephropathy, resulting in metformin accumulation and increased risk of lactic acidosis. DAPAGOOD M 1000 should be discontinued prior to, or at the time of, the imaging procedure and not restarted until at least 48 hours after, provided that renal function has been re-evaluated and found to be stable.

Surgery

DAPAGOOD M 1000 must be discontinued at the time of surgery with general, spinal or epidural anaesthesia. Therapy may be restarted no earlier than 48 hours following surgery or resumption of oral nutrition and provided that renal function has been re-evaluated and found to be stable.

Change in clinical status of patients with previously controlled type 2 diabetes

As this medicinal product contains metformin, a patient with type 2 diabetes previously well-controlled on it 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, treatment must be stopped immediately and other appropriate corrective measures initiated.

4.5 Interaction with other medicinal products and other forms of interaction

Coadministration of multiple doses of dapagliflozin and metformin does not meaningfully alter the pharmacokinetics of either dapagliflozin or metformin in healthy subjects.

No interaction studies have been performed for DAPAGOOD M. The following statements reflect the information available on the individual active substances.

Dapagliflozin

Pharmacodynamic interactions

Diuretics This medicinal product 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 hypoglycaemia. Therefore, a lower dose of insulin or an insulin secretagogue may be required to reduce the risk of hypoglycaemia when used in combination with dapagliflozin .

Pharmacokinetic interactions

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

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

Effect of other medicinal products on dapagliflozin

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

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

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

Effect of dapagliflozin on other medicinal products

In interaction studies conducted in healthy subjects, using mainly a single-dose design, dapagliflozin did not alter the pharmacokinetics of pioglitazone, sitagliptin, glimepiride, hydrochlorothiazide, bumetanide, valsartan, digoxin (a P-gp substrate) or warfarin (S-warfarin, a CYP2C9 substrate), or the anti-coagulatory 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. Metformin

Concomitant use not recommended

Cationic substances that are eliminated by renal tubular secretion (e.g. cimetidine) may interact with metformin by competing for common renal tubular transport systems. A study conducted in seven normal healthy volunteers showed that cimetidine, administered as 400 mg twice daily, increased metformin systemic exposure (AUC) by 50% and C_{max} by 81%. Therefore, close monitoring of glycaemic control, dose adjustment within the recommended posology and changes in diabetic treatment should be considered when cationic medicinal products that are eliminated by renal tubular secretion are coadministered.

Alcohol

Alcohol intoxication is associated with an increased risk of lactic acidosis, particularly in the case of fasting, malnutrition or hepatic impairment due to the metformin active substance of this medicinal product. Consumption of alcohol and medicinal products containing alcohol should be avoided.

Iodinated contrast agents

Intravascular administration of iodinated contrast agents may lead to contrast induced nephropathy, resulting in metformin accumulation and increased risk of lactic acidosis. DAPAGOOD M 1000 must be discontinued prior to, or at the time of the imaging procedure and not restarted until at least 48 hours after, provided that renal function has been re-evaluated and found to be stable.

Combination requiring precautions for use

Glucocorticoids (given by systemic and local routes), beta-2 agonists, and diuretics have intrinsic hyperglycaemic activity. The patient should be informed and more frequent blood glucose monitoring performed, especially at the beginning of treatment with such medicinal products. If necessary, the dose of the glucose-lowering medicinal product should be adjusted during therapy with the other medicinal product and on its discontinuation. 9 Some medicinal products can adversely affect renal function which may increase the risk of lactic acidosis, e.g. NSAIDs, including selective cyclo-oxygenase (COX) II inhibitors, ACE inhibitors, angiotensin II receptor antagonists and diuretics, especially loop diuretics. When starting or using such products in combination with metformin, close monitoring of renal function is necessary.

Insulin and insulin secretagogues

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

4.6 Fertility, pregnancy and lactation

Pregnancy

There are no data from the use of DAPAGOOD M 1000 or dapagliflozin in pregnant women. Studies in rats treated with dapagliflozin 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 this medicinal product is not recommended during the second and third trimesters of pregnancy. A limited amount of data from the use of metformin in pregnant women does not indicate an increased risk of congenital malformations. Animal studies with metformin do not indicate harmful effects with respect to pregnancy, embryonic or foetal development, parturition or postnatal development.

When the patient plans to become pregnant, and during pregnancy, it is recommended that diabetes is not treated with this medicinal product, but insulin be used to maintain blood glucose levels as close to normal as possible, to reduce the risk of malformations of the foetus associated with abnormal blood glucose levels.

Breast-feeding

It is unknown whether this medicinal product or 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. Metformin is excreted in human milk in small amounts. A risk to the newborns/infants cannot be excluded.

This medicinal product should not be used while breast-feeding.

Fertility

The effect of this medicinal product or dapagliflozin on fertility in humans has not been studied. In male and female rats, dapagliflozin showed no effects on fertility at any dose tested. For metformin, studies in animals have not shown reproductive toxicity.

4.7 Effects on ability to drive and use machines

DAPAGOOD M 1000 has no or negligible influence on the ability to drive and use machines. Patients should be alerted to the risk of hypoglycaemia when this medicinal product is used in combination with other glucose-lowering medicinal products known to cause hypoglycaemia.

4.8 Undesirable effects

DAPAGOOD M 1000 has been demonstrated to be bioequivalent with coadministered dapagliflozin and metformin. There have been no therapeutic clinical trials conducted with DAPAGOOD M 1000 tablets.

Dapagliflozin plus metformin

Summary of the safety profile

In an analysis of 5 placebo-controlled dapagliflozin add-on to metformin studies, the safety results were similar to that of the pre-specified pooled analysis of 13 placebo-controlled dapagliflozin studies (see Dapagliflozin, Summary of the safety profile below). No additional adverse reactions were identified for the dapagliflozin plus metformin group compared with those reported for the individual 10 components. In the separate dapagliflozin add-on to metformin pooled analysis, 623 subjects were treated with dapagliflozin 10 mg as add-on to metformin and 523 were treated with placebo plus metformin.

Dapagliflozin

Summary of the safety profile

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, 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.

Reporting of suspected adverse reactions:

Reporting suspected adverse reactions after authorisation of the medicinal

product is important as it allows continued monitoring of the benefit–risk balance of the medicinal product. Healthcare professionals are requested to report any suspected adverse reactions to the marketing authorisation holder or, where applicable, via the national reporting system.

4.9 Overdose

Removal of dapagliflozin by haemodialysis has not been studied. The most effective method to remove metformin and lactate is haemodialysis.

Dapagliflozin

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.

Metformin

High overdose or concomitant risks of metformin may lead to lactic acidosis. Lactic acidosis is a medical emergency and must be treated in hospital.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Drugs used in diabetes, Combinations of oral blood glucose-lowering drugs, ATC code: A10BD15

Mechanism of action

DAPAGOOD M 1000 combines two anti-hyperglycaemic medicinal products with different and complementary mechanisms of action to improve glycaemic control in patients with type 2 diabetes: dapagliflozin, a SGLT2 inhibitor, and metformin hydrochloride, a member of the biguanide class.

Dapagliflozin

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

The SGLT2 is selectively expressed in the kidney with no expression detected in more than 70 other tissues including liver, skeletal muscle, adipose tissue, breast, bladder and brain. SGLT2 is the predominant transporter responsible for reabsorption of glucose from the glomerular filtrate back into the circulation. Despite the presence of hyperglycaemia in type 2 diabetes, reabsorption of

filtered glucose continues. Dapagliflozin improves both fasting and post-prandial plasma glucose levels by reducing renal glucose reabsorption leading to urinary glucose excretion. This glucose excretion (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. 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.

Metformin

Metformin is a biguanide with anti-hyperglycaemic effects, lowering both basal and postprandial plasma glucose. It does not stimulate insulin secretion and therefore does not produce hypoglycaemia.

Metformin may act via three mechanisms:

- by reduction of hepatic glucose production by inhibiting gluconeogenesis and glycogenolysis;
- by modestly increasing insulin sensitivity, improving peripheral glucose uptake and utilisation in muscle;
- by delaying intestinal glucose absorption.

Metformin stimulates intracellular glycogen synthesis by acting on glycogen synthase. Metformin increases the transport capacity of specific types of membrane glucose transporters (GLUT-1 and GLUT-4).

Pharmacodynamic effects

Dapagliflozin

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.

Metformin

In humans, independently of its action on glycaemia, metformin has favourable effects on lipid metabolism. This has been shown at therapeutic doses in controlled, medium-term or long-term clinical studies: metformin reduces total cholesterol, LDL cholesterol and triglyceride levels.

In clinical studies, use of metformin was associated with either a stable body weight or modest weight loss.

5.2 Pharmacokinetic properties

DAPAGOOD M 1000 combination tablets are considered to be bioequivalent to coadministration of corresponding doses of dapagliflozin and metformin hydrochloride administered together as individual tablets.

Dapagliflozin

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_t 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%. 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 present in the liver and kidney, and CYP-mediated metabolism was a minor clearance pathway in humans.

Elimination

The mean plasma terminal half-life (t_{1/2}) for dapagliflozin was 12.9 hours following a single oral dose of dapagliflozin 10 mg to healthy subjects. The mean total systemic clearance of dapagliflozin administered intravenously was 207 mL/min. Dapagliflozin and related metabolites are primarily eliminated via urinary excretion with less than 2% as unchanged dapagliflozin. After administration of a 50 mg [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.

Metformin

Absorption

After an oral dose of metformin, t_{max} is reached in 2.5 h. Absolute bioavailability of a 500 mg or 850 mg metformin tablet is approximately 50-60% in healthy subjects. After an oral dose, the non-absorbed fraction recovered in faeces was 20-30%.

After oral administration, metformin absorption is saturable and incomplete. It is assumed that the pharmacokinetics of metformin absorption is non-linear. At the usual metformin doses and dosing schedules, steady-state plasma concentrations are reached within 24-48 hours and are generally less than 1 µg/mL. In controlled clinical trials, maximum metformin plasma levels (C_{max}) did not exceed 5 µg/mL, even at maximum doses.

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 Vd ranged between 63-276 l.

Biotransformation

Metformin is excreted unchanged in the urine. No metabolites have been identified in humans. Elimination

Renal clearance of metformin is > 400 mL/min, indicating that metformin is eliminated by glomerular filtration and tubular secretion. Following an oral dose, the apparent terminal elimination half-life is approximately 6.5 hours.

Special populations

Renal impairment

In patients with decreased renal function (based on measured creatinine clearance), the plasma and blood half-life of metformin is prolonged and the renal clearance is decreased in proportion to the decrease in creatinine clearance, leading to increased levels of metformin in plasma.

5.3 Preclinical safety data

Not applicable

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

HPMC(K4M)

HPMC (K 100)

Sodium CMC

PVPK-30

Isopropyl alcohol

Magnesium stearate

MCCP Plain

Lactose monohydrate

Quinoline yellow lake

PVPK-30

MCCP pH102

Low substituted HPC (LH-11)

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

36 months

6.4 Special precautions for storage

Store below 30°C. Protect from light and moisture.

6.5 Nature and contents of container

10 tablets are packed in ALU-ALU blister, such 3 blisters are packed in one carton with insert coded with batch number, manufacturing date and expiry date.

7. MARKETING AUTHORISATION HOLDER AND MANUFACTURING SITE ADDRESS:

MARKETING AUTHORISATION HOLDER:

ZAIN PHARMA LIMITED

Plot No: 209/13741, Colchester Park,
Go-Down No.1, 2, 3, Off Mombasa Road,
Behind Nice And Lovely House,
P.O. Box: 100167-00101, Nairobi, Kenya

Manufacturer:

ZAIN PHARMA LIMITED

Plot No: 209/13741, Colchester Park,
Go-Down No.1, 2, 3, Off Mombasa Road,
Behind Nice And Lovely House,
P.O. Box: 100167-00101, Nairobi, Kenya

8. MARKETING AUTHORIZATION NUMBER

H2026/CTD11595/25252

9. DATE OF FIRST REGISTRATION/ RENEWAL OF THE REGISTRATION

18/02/2026

10. DATE OF REVISION OF THE TEXT

18/02/2026