SUMMARY OF PRODUCT CHARACTERISTICS

1. Name of the medicinal product

Empadus 25 mg Tablet.

2. Qualitative and quantitative composition

Each tablet contains Empagliflozin 25 mg.

For the full list of excipients, see section 6.1.

3. Pharmaceutical form

Film-coated tablet.

A cream color, round, shallow bi-convex film coated tablet with dividing line in Alu-Alu blister.

4. Clinical particulars

4.1 Therapeutic indications

Empadus Tablet is indicated for:

- **Type 2 diabetes mellitus:** Empadus Tablet is indicated for the treatment of adults with insufficiently controlled type 2 diabetes mellitus as an adjunct to diet and exercise.
  - As monotherapy when metformin is considered inappropriate due to intolerance.
  - In addition to other medicinal products for the treatment of diabetes.
- **Heart failure:** Empadus Tablet is indicated in adults for the treatment of symptomatic chronic heart failure with reduced ejection fraction.

4.2 Posology and method of administration

Posology

- **Type 2 diabetes mellitus:** The recommended starting dose is 10 mg empagliflozin once daily for monotherapy and add-on combination therapy with other medicinal products for the treatment of diabetes. In patients tolerating empagliflozin 10 mg once daily who have an eGFR ≥60 ml/min/1.73 m^2 and need tighter glycaemic control, the dose can be increased to 25 mg once daily. The maximum daily dose is 25 mg.
- **Heart failure:** The recommended dose is 10 mg empagliflozin once daily.

All indications

When empagliflozin is used in combination with a sulphonylurea or with insulin, a lower dose of the sulphonylurea or insulin may be considered to reduce the risk of hypoglycaemia.

If a dose is missed, it should be taken as soon as the patient remembers; however, a double dose should not be taken on the same day.

Special populations

Renal impairment

In patients with type 2 diabetes mellitus, the glycaemic efficacy of empagliflozin is dependent on renal function. For cardiovascular risk reduction as add on to standard of care, a dose of 10 mg empagliflozin once daily should be used in patients with an eGFR below 60 ml/min/1.73 m2 (see Table 1). Because the glycaemic lowering efficacy of empagliflozin is reduced in patients with moderate renal impairment and likely absent in patients with severe renal impairment, if further glycaemic control is needed, the addition of other anti-hyperglycaemic agents should be considered. For dose adjustment recommendations according to eGFR or CrCL refer to Table 1.

Table 1: Dose adjustment recommendations

Indication	eGFR [ml/min/1.73 m^2] or CrCL [ml/min]	Total daily dose
Type 2 diabetes mellitus	≥60	Initiate with 10 mg empagliflozin. In patients tolerating 10 mg empagliflozin & requiring additional glycaemic control, the dose can be increased to 25 mg empagliflozin.
	45 to <60	Initiate with 10 mg empagliflozin.[a] Continue with 10 mg empagliflozin in patients already taking Jardiance.
	30 to <45[a]	Initiate with 10 mg empagliflozin. Continue with 10 mg empagliflozin in patients already taking Jardiance.
	<30	Empagliflozin is not recommended.
Heart failure (with or without type 2 diabetes mellitus)	≥20	Recommended daily dose is 10 mg empagliflozin.
	<20	Empagliflozin is not recommended.

[a] patients with type 2 diabetes mellitus and established cardiovascular disease

For treatment of heart failure in patients with or without type 2 diabetes mellitus, empagliflozin 10 mg may be initiated or continued down to an eGFR of 20 ml/min/1.73 m2 or CrCl of 20 ml/min.

Empagliflozin should not be used in patients with end stage renal disease (ESRD) or in patients on dialysis. There are insufficient data to support use in these patients.

Hepatic impairment

No dose adjustment is required for patients with hepatic impairment. Empagliflozin exposure is increased in patients with severe hepatic impairment. Therapeutic experience in patients with severe hepatic impairment is limited and therefore not recommended for use in this population.

Elderly

No dose adjustment is recommended based on age. In patients 75 years and older, an increased risk for volume depletion should be taken into account. In patients aged 85 years and older, initiation of empagliflozin therapy is not recommended due to the limited therapeutic experience.

Paediatric population

The safety and efficacy of empagliflozin in children and adolescents has not yet been established. No data are available.

Method of administration

Empadus Tablet is for oral administration. The tablets can be taken with or without food, swallowed whole with water.

4.3 Contraindications

Empadus Tablet is contraindicated in patient with:

- Hypersensitivity to the active substance or to any of the excipients of this medicine.

4.4 Special warnings and precautions for use

- **Ketoacidosis**

Rare cases of ketoacidosis, including life-threatening and fatal cases, have been reported in patients with diabetes mellitus treated with SGLT2 inhibitors, including empagliflozin. 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 ketoacidosis is more likely to occur with higher doses of empagliflozin.

The risk of 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 ketoacidosis is suspected or diagnosed, treatment with empagliflozin 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 blood ketone levels is preferred to urine. Treatment with empagliflozin may be restarted when the ketone values are normal and the patient's condition has stabilised.

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

Patients who may be at higher risk of ketoacidosis 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 ketoacidosis while on SGLT-2 inhibitor treatment is not recommended, unless another clear precipitating factor is identified and resolved.

Jardiance should not be used for treatment of patients with type 1 diabetes. Data from a clinical trial program in patients with type 1 diabetes showed increased ketoacidosis occurrence with common frequency in patients treated with empagliflozin 10 mg and 25 mg as an adjunct to insulin compared to placebo.

- **Renal impairment**

For the indication of type 2 diabetes mellitus, in patients with an eGFR below 60 ml/min/1.73 m2 or CrCl <60 ml/min the daily dose of empagliflozin is limited to 10 mg. Empagliflozin is not recommended when eGFR is below 30 ml/min/1.73 m2 or CrCl below 30 ml/min.

For the indication of heart failure, Jardiance is not recommended in patients with eGFR <20 ml/min/1.73 m2.

Empagliflozin should not be used in patients with ESRD or in patients on dialysis. There are insufficient data to support use in these patients.

Monitoring of renal function

Assessment of renal function is recommended as follows:

- Prior to empagliflozin initiation and periodically during treatment, i.e. at least yearly.
- Prior to initiation of any concomitant medicinal product that may have a negative impact on renal function.

- **Risk for volume depletion**

  Based on the mode of action of SGLT-2 inhibitors, osmotic diuresis accompanying glucosuria may lead to a modest decrease in blood pressure. Therefore, caution should be exercised in patients for whom an empagliflozin-induced drop in blood pressure could pose a risk, such as patients with known cardiovascular disease, patients on anti-hypertensive therapy with a history of hypotension or patients aged 75 years and older.

  In case of conditions that may lead to fluid loss (e.g. gastrointestinal illness), careful monitoring of volume status (e.g. physical examination, blood pressure measurements, laboratory tests including haematocrit) and electrolytes is recommended for patients receiving empagliflozin. Temporary interruption of treatment with empagliflozin should be considered until the fluid loss is corrected.

- **Elderly**

  The effect of empagliflozin on urinary glucose excretion is associated with osmotic diuresis, which could affect the hydration status. Patients aged 75 years and older may be at an increased risk of volume depletion. A higher number of these patients treated with empagliflozin had adverse reactions related to volume depletion as compared to placebo. Therefore, special attention should be given to their volume intake in case of co-administered medicinal products which may lead to volume depletion (e.g. diuretics, ACE inhibitors). Therapeutic experience in patients aged 85 years and older is limited. Initiation of empagliflozin therapy in this population is not recommended.

- **Complicated urinary tract infections**

  Cases of complicated urinary tract infections including pyelonephritis and urosepsis have been reported in patients treated with empagliflozin. Temporary interruption of empagliflozin should be considered in patients with complicated urinary tract infections.

- **Necrotising fasciitis of the perineum (Fournier's gangrene)**

  Cases of necrotising fasciitis of the perineum, (also known as Fournier's gangrene), have been reported in female and male patients with diabetes mellitus 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, Jardiance should be discontinued and prompt treatment (including antibiotics and surgical debridement) should be instituted.

- **Lower limb amputations**

  An increase in cases of lower limb amputation (primarily of the toe) has been observed in 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.

- **Hepatic injury**

  Cases of hepatic injury have been reported with empagliflozin in clinical trials. A causal relationship between empagliflozin and hepatic injury has not been established.

- **Elevated haematocrit**

  Haematocrit increase was observed with empagliflozin treatment.

- **Chronic kidney disease**

  There is experience with empagliflozin for the treatment of diabetes in patients with chronic kidney disease (eGFR ≥30 mL/min/1.73 m2) both with and without albuminuria. Patients with albuminuria may benefit more from treatment with empagliflozin.

- **Urine laboratory assessments**

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

- **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.

- **Lactose**

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

4.5 Interaction with other medicinal products and other forms of interaction

- **Pharmacodynamic interactions**

  Diuretics

  Empagliflozin 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, may increase the risk of 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 empagliflozin.

- **Pharmacokinetic interactions**

  Effects of other medicinal products on empagliflozin

  In vitro data suggest that the primary route of metabolism of empagliflozin in humans is glucuronidation by uridine 5'-diphosphoglucuronosyltransferases UGT1A3, UGT1A8, UGT1A9, and UGT2B7. Empagliflozin is a substrate of the human uptake transporters OAT3, OATP1B1, and OATP1B3, but not OAT1 and OCT2. Empagliflozin is a substrate of P-glycoprotein (P-gp) and breast cancer resistance protein (BCRP).

Co-administration of empagliflozin with probenecid, an inhibitor of UGT enzymes and OAT3, resulted in a 26% increase in peak empagliflozin plasma concentrations (Cmax) and a 53% increase in area under the concentration-time curve (AUC). These changes were not considered to be clinically meaningful.

The effect of UGT induction (e.g. induction by rifampicin or phenytoin) on empagliflozin has not been studied. Co-treatment with known inducers of UGT enzymes is not recommended due to a potential risk of decreased efficacy. If an inducer of these UGT enzymes must be co-administered, monitoring of glycaemic control to assess response to Jardiance is appropriate.

An interaction study with gemfibrozil, an in vitro inhibitor of OAT3 and OATP1B1/1B3 transporters, showed that empagliflozin Cmax increased by 15% and AUC increased by 59% following co-administration. These changes were not considered to be clinically meaningful.

Inhibition of OATP1B1/1B3 transporters by co-administration with rifampicin resulted in a 75% increase in Cmax and a 35% increase in AUC of empagliflozin. These changes were not considered to be clinically meaningful.

Empagliflozin exposure was similar with and without co-administration with verapamil, a P-gp inhibitor, indicating that inhibition of P-gp does not have any clinically relevant effect on empagliflozin.

Interaction studies suggest that the pharmacokinetics of empagliflozin were not influenced by co-administration with metformin, glimepiride, pioglitazone, sitagliptin, linagliptin, warfarin, verapamil, ramipril, simvastatin, torasemide and hydrochlorothiazide.

Effects of empagliflozin on other medicinal products

Based on in vitro studies, empagliflozin does not inhibit, inactivate, or induce CYP450 isoforms. Empagliflozin does not inhibit UGT1A1, UGT1A3, UGT1A8, UGT1A9, or

UGT2B7. Drug-drug interactions involving the major CYP450 and UGT isoforms with empagliflozin and concomitantly administered substrates of these enzymes are therefore considered unlikely.

Empagliflozin does not inhibit P-gp at therapeutic doses. Based on in vitro studies, empagliflozin is considered unlikely to cause interactions with active substances that are P-gp substrates. Co-administration of digoxin, a P-gp substrate, with empagliflozin resulted in a 6% increase in AUC and 14% increase in Cmax of digoxin. These changes were not considered to be clinically meaningful.

Empagliflozin does not inhibit human uptake transporters such as OAT3, OATP1B1, and OATP1B3 in vitro at clinically relevant plasma concentrations and, as such, drug-drug interactions with substrates of these uptake transporters are considered unlikely.

Interaction studies conducted in healthy volunteers suggest that empagliflozin had no clinically relevant effect on the pharmacokinetics of metformin, glimepiride, pioglitazone, sitagliptin, linagliptin, simvastatin, warfarin, ramipril, digoxin, diuretics and oral contraceptives.

4.6 Fertility, pregnancy and lactation

Pregnancy

There are no data from the use of empagliflozin in pregnant women. Animal studies show that empagliflozin crosses the placenta during late gestation to a very limited extent but do not indicate direct or indirect harmful effects with respect to early embryonic development. However, animal studies have shown adverse effects on postnatal development. As a precautionary measure, it is preferable to avoid the use of Jardiance during pregnancy.

Breast-feeding

No data in humans are available on excretion of empagliflozin into milk. Available toxicological data in animals have shown excretion of empagliflozin in milk. A risk to the newborns/infants cannot be excluded. Jardiance should not be used during breast-feeding.

Fertility

No studies on the effect on human fertility have been conducted for Jardiance. Animal studies do not indicate direct or indirect harmful effects with respect to fertility.

4.7 Effects on ability to drive and use machines

Jardiance has minor influence on the ability to drive and use machines. Patients should be advised to take precautions to avoid hypoglycaemia while driving and using machines, in particular when Jardiance is used in combination with a sulphonylurea and/or insulin.

4.8 Undesirable effects

Summary of the safety profile

Type 2 diabetes mellitus: A total of 15,582 patients with type 2 diabetes were included in clinical studies to evaluate the safety of empagliflozin, of which 10,004 patients received empagliflozin, either alone or in combination with metformin, a sulphonylurea, pioglitazone, DPP-4 inhibitors, or insulin.

In 6 placebo-controlled trials of 18 to 24 weeks duration, 3,534 patients were included of which 1,183 were treated with placebo and 2,351 with empagliflozin. The overall incidence of adverse events in patients treated with empagliflozin was similar to placebo. The most frequently reported adverse reaction was hypoglycaemia when used with sulphonylurea or insulin (see description of selected adverse reactions).

Heart failure: The EMPEROR-Reduced study included 3730 patients with heart failure and reduced ejection fraction treated with empagliflozin 10 mg or placebo. Approximately half of the patients had type 2 diabetes mellitus. The most frequent adverse reaction was volume depletion (empagliflozin 10 mg: 10.6%. placebo: 9.9%). Major hypoglycaemia (events requiring assistance) was observed only in patients with diabetes mellitus.

The overall safety profile of empagliflozin was generally consistent across the studied indications. No new adverse reactions were identified in the EMPEROR-Reduced heart failure study.

Tabulated list of adverse reactions

Adverse reactions classified by system organ class and MedDRA preferred terms reported in patients who received empagliflozin in placebo-controlled studies are presented in the table below (Table 2).

The adverse reactions are listed by absolute frequency. Frequencies are defined as very common (≥1/10), common (≥1/100 to <1/10), uncommon (≥1/1,000 to <1/100), rare (≥1/10,000 to <1/1,000), or very rare (<1/10,000), and not known (cannot be estimated from the available data).

Table 2: Tabulated list of adverse reactions (MedDRA) from reported placebo-controlled studies and from post-marketing experience.

System Organ Class	Frequency	Adverse reactions
Infections and infestations		
	Common	Vaginal moniliasis, vulvovaginitis, balanitis and other genital infection Urinary tract infection (including pyelonephritis and urosepsis)
	Rare	Necrotising fasciitis of the perineum (Fournier's gangrene)
Metabolism and nutrition disorders		
	Very common	Hypoglycaemia (when used with sulphonylurea or insulin)
	Common	Thirst
	Rare	Diabetic ketoacidosis
Gastrointestinal disorders		
	Common	Constipation
Skin and subcutaneous tissue disorders		
	Common	Pruritus (generalised), Rash
	Uncommon	Urticaria, Angioedema
Vascular disorders		
	Very common	Volume depletion
Renal and urinary disorders		
	Common	Increased urination

System Organ Class	Frequency	Adverse reactions
	Uncommon	Dysuria
Investigations		
	Common	Serum lipids increased
	Uncommon	Blood creatinine increased/ Glomerular filtration rate decreased, Haematocrit increased

Description of selected adverse reactions

Hypoglycaemia

The frequency of hypoglycaemia depended on the background therapy in the respective studies and was similar for empagliflozin and placebo as monotherapy, add-on to metformin, add-on to pioglitazone with or without metformin, as add-on to linagliptin and metformin, and as adjunct to standard care therapy and for the combination of empagliflozin with metformin in drug-naïve patients compared to those treated with empagliflozin and metformin as individual components. An increased frequency was noted when given as add-on to metformin and a sulphonylurea (empagliflozin 10 mg: 16.1%, empagliflozin 25 mg: 11.5%, placebo: 8.4%), add-on to basal insulin with or without metformin and with or without a sulphonylurea (empagliflozin 10 mg: 19.5%, empagliflozin 25 mg: 28.4%, placebo: 20.6% during initial 18 weeks treatment when insulin could not be adjusted; empagliflozin 10 mg and 25 mg: 36.1%, placebo 35.3% over the 78-week trial), and add-on to MDI insulin with or without metformin (empagliflozin 10 mg: 39.8%, empagliflozin 25 mg: 41.3%, placebo: 37.2% during initial 18 weeks treatment when insulin could not be adjusted; empagliflozin 10 mg: 51.1%, empagliflozin 25 mg: 57.7%, placebo: 58% over the 52-week trial).

In the EMPEROR-Reduced heart failure study, similar frequency of hypoglycaemia was noted when used add-on to sulphonylurea or insulin (empagliflozin 10 mg: 4.2%, placebo: 4.6%).

Major hypoglycaemia (events requiring assistance)

No increase in major hypoglycaemia was observed with empagliflozin compared to placebo as monotherapy, add-on to metformin, add-on to metformin and a sulphonylurea, add-on to pioglitazone with or without metformin, add-on to linagliptin and metformin, as adjunct to

standard care therapy and for the combination of empagliflozin with metformin in drug-naïve patients compared to those treated with empagliflozin and metformin as individual components. An increased frequency was noted when given as add-on to basal insulin with or without metformin and with or without a sulphonylurea (empagliflozin 10 mg: 0%, empagliflozin 25 mg: 1.3%, placebo: 0% during initial 18 weeks treatment when insulin could not be adjusted; empagliflozin 10 mg: 0%, empagliflozin 25 mg: 1.3%, placebo 0% over the 78-week trial), and add-on to MDI insulin with or without metformin (empagliflozin 10 mg: 0.5%, empagliflozin 25 mg: 0.5%, placebo: 0.5% during initial 18 weeks treatment when insulin could not be adjusted; empagliflozin 10 mg: 1.6%, empagliflozin 25 mg: 0.5%, placebo: 1.6% over the 52-week trial).

In the EMPEROR-Reduced heart failure study, major hypoglycaemia was observed only in patients with diabetes mellitus when used as add-on to sulphonylurea or insulin (empagliflozin 10 mg: 1.2%, placebo: 1.5%).

Vaginal moniliasis, vulvovaginitis, balanitis and other genital infection

Vaginal moniliasis, vulvovaginitis, balanitis and other genital infections were reported more frequently in patients treated with empagliflozin (empagliflozin 10 mg: 4.0%, empagliflozin 25 mg: 3.9%) compared to placebo (1.0%). These infections were reported more frequently in females treated with empagliflozin compared to placebo, and the difference in frequency was less pronounced in males. The genital tract infections were mild or moderate in intensity.

In the EMPEROR-Reduced heart failure study, the frequency of these infections was more pronounced in patients with diabetes mellitus (empagliflozin 10 mg: 1.9%; placebo: 0.4%) than in patients without diabetes mellitus (empagliflozin 10 mg: 1.4%; placebo: 0.9%) when treated with empagliflozin compared to placebo.

Increased urination

Increased urination (including the predefined terms pollakiuria, polyuria, and nocturia) was observed at higher frequencies in patients treated with empagliflozin (empagliflozin 10 mg: 3.5%, empagliflozin 25 mg: 3.3%) compared to placebo (1.4%). Increased urination was

mostly mild or moderate in intensity. The frequency of reported nocturia was similar for placebo and empagliflozin (<1%).

In the EMPEROR-Reduced heart failure study, increased urination was observed at similar frequencies in patients treated with empagliflozin and placebo (empagliflozin 10 mg: 0.7%, placebo 0.4%).

Urinary tract infection

The overall frequency of urinary tract infection reported as adverse event was similar in patients treated with empagliflozin 25 mg and placebo (7.0% and 7.2%) and higher in empagliflozin 10 mg (8.8%). Similar to placebo, urinary tract infection was reported more frequently for empagliflozin in patients with a history of chronic or recurrent urinary tract infections. The intensity (mild, moderate, severe) of urinary tract infection was similar in patients treated with empagliflozin and placebo. Urinary tract infection was reported more frequently in females treated with empagliflozin compared to placebo; there was no difference in males.

Volume depletion

The overall frequency of volume depletion (including the predefined terms blood pressure (ambulatory) decreased, blood pressure systolic decreased, dehydration, hypotension, hypovolaemia, orthostatic hypotension, and syncope) was similar in patients treated with empagliflozin (empagliflozin 10 mg: 0.6%, empagliflozin 25 mg: 0.4%) and placebo (0.3%). The frequency of volume depletion events was increased in patients 75 years and older treated with empagliflozin 10 mg (2.3%) or empagliflozin 25 mg (4.3%) compared to placebo (2.1%).

Blood creatinine increased/Glomerular filtration rate decreased

The overall frequency of patients with increased blood creatinine and decreased glomerular filtration rate were similar between empagliflozin and placebo (blood creatinine increased: empagliflozin 10 mg 0.6%, empagliflozin 25 mg 0.1%, placebo 0.5%; glomerular filtration rate decreased: empagliflozin 10 mg 0.1%, empagliflozin 25 mg 0%, placebo 0.3%).

Initial increases in creatinine and initial decreases in estimated glomerular filtration rates in patients treated with empagliflozin were generally transient during continuous treatment or reversible after drug discontinuation of treatment.

Consistently, in the EMPA-REG OUTCOME study, patients treated with empagliflozin experienced an initial fall in eGFR (mean: 3 ml/min/1.73 m2). Thereafter, eGFR was maintained during continued treatment. Mean eGFR returned to baseline after treatment discontinuation suggesting acute haemodynamic changes may play a role in these renal function changes.

Serum lipids increased

Mean percent increases from baseline for empagliflozin 10 mg and 25 mg versus placebo, respectively, were total cholesterol 4.9% and 5.7% versus 3.5%; HDL-cholesterol 3.3% and 3.6% versus 0.4 %; LDL-cholesterol 9.5% and 10.0% versus 7.5%; triglycerides 9.2% and 9.9% versus 10.5%.

Haematocrit increased

Mean changes from baseline in haematocrit were 3.4% and 3.6% for empagliflozin 10 mg and 25 mg, respectively, compared to 0.1% for placebo. In the EMPA-REG Outcome study, haematocrit values returned towards baseline values after a follow-up period of 30 days after treatment stop.

4.9 Overdose

Symptoms

In controlled clinical studies single doses of up to 800 mg empagliflozin in healthy volunteers and multiple daily doses of up to 100 mg empagliflozin in patients with type 2 diabetes did not show any toxicity. Empagliflozin increased urine glucose excretion leading to an increase in urine volume. The observed increase in urine volume was not dose-dependent and is not clinically meaningful. There is no experience with doses above 800 mg in humans.

Therapy

In the event of an overdose, treatment should be initiated as appropriate to the patient's clinical status. The removal of empagliflozin 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: A10BK03.

Mechanism of action

Empagliflozin is a reversible, highly potent (IC50 of 1.3 nmol) and selective competitive inhibitor of sodium-glucose co-transporter 2 (SGLT2). Empagliflozin does not inhibit other glucose transporters important for glucose transport into peripheral tissues and is 5000 times more selective for SGLT2 versus SGLT1, the major transporter responsible for glucose absorption in the gut. SGLT2 is highly expressed in the kidney, whereas expression in other tissues is absent or very low. It is responsible, as the predominant transporter, for the reabsorption of glucose from the glomerular filtrate back into the circulation. In patients with type 2 diabetes and hyperglycaemia a higher amount of glucose is filtered and reabsorbed.

Empagliflozin improves glycaemic control in patients with type 2 diabetes by reducing renal glucose reabsorption. The amount of glucose removed by the kidney through this glucuretic mechanism is dependent on blood glucose concentration and GFR. Inhibition of SGLT2 in patients with type 2 diabetes and hyperglycaemia leads to excess glucose excretion in the urine. In addition, initiation of empagliflozin increases excretion of sodium resulting in osmotic diuresis and reduced intravascular volume.

In patients with type 2 diabetes, urinary glucose excretion increased immediately following the first dose of empagliflozin and is continuous over the 24 hour dosing interval. Increased urinary glucose excretion was maintained at the end of the 4-week treatment period, averaging

approximately 78 g/day. Increased urinary glucose excretion resulted in an immediate reduction in plasma glucose levels in patients with type 2 diabetes.

Empagliflozin improves both fasting and post-prandial plasma glucose levels. The mechanism of action of empagliflozin is independent of beta cell function and insulin pathway and this contributes to a low risk of hypoglycaemia. Improvement of surrogate markers of beta cell function including Homeostasis Model Assessment-β (HOMA-β) was noted. In addition, urinary glucose excretion triggers calorie loss, associated with body fat loss and body weight reduction. The glucosuria observed with empagliflozin is accompanied by diuresis which may contribute to sustained and moderate reduction of blood pressure.

Empagliflozin also reduces sodium reabsorption and increases the delivery of sodium to the distal tubule. This may influence several physiological functions including, but not restricted to, increasing tubuloglomerular feedback and reducing intraglomerular pressure, lowering both pre- and afterload of the heart, and downregulating of sympathetic activity.

5.2 Pharmacokinetic properties

Absorption

The pharmacokinetics of empagliflozin have been extensively characterised in healthy volunteers and patients with type 2 diabetes. After oral administration, empagliflozin was rapidly absorbed with peak plasma concentrations occurring at a median tmax of 1.5 hours post-dose. Thereafter, plasma concentrations declined in a biphasic manner with a rapid distribution phase and a relatively slow terminal phase. The steady state mean plasma AUC and Cmax were 1870 nmol.h/l and 259 nmol/l with empagliflozin 10 mg and 4740 nmol.h/l and 687 nmol/l with empagliflozin 25 mg once daily. Systemic exposure of empagliflozin increased in a dose-proportional manner. The single-dose and steady-state pharmacokinetic parameters of empagliflozin were similar suggesting linear pharmacokinetics with respect to time. There were no clinically relevant differences in empagliflozin pharmacokinetics between healthy volunteers and patients with type 2 diabetes.

Administration of empagliflozin 25 mg after intake of a high-fat and high calorie meal resulted in slightly lower exposure; AUC decreased by approximately 16% and Cmax by approximately 37% compared to fasted condition. The observed effect of food on empagliflozin pharmacokinetics was not considered clinically relevant and empagliflozin may be administered with or without food.

Distribution

The apparent steady-state volume of distribution was estimated to be 73.8 l based on the population pharmacokinetic analysis. Following administration of an oral [14C]-empagliflozin solution to healthy volunteers, the red blood cell partitioning was approximately 37% and plasma protein binding was 86%.

Biotransformation

No major metabolites of empagliflozin were detected in human plasma and the most abundant metabolites were three glucuronide conjugates (2-, 3-, and 6-O glucuronide). Systemic exposure of each metabolite was less than 10% of total drug-related material. In vitro studies suggested that the primary route of metabolism of empagliflozin in humans is glucuronidation by the uridine 5'-diphospho-glucuronosyltransferases UGT2B7, UGT1A3, UGT1A8, and UGT1A9.

Elimination

Based on the population pharmacokinetic analysis, the apparent terminal elimination half-life of empagliflozin was estimated to be 12.4 hours and apparent oral clearance was 10.6 l/hour. The inter-subject and residual variabilities for empagliflozin oral clearance were 39.1% and 35.8%, respectively. With once-daily dosing, steady-state plasma concentrations of empagliflozin were reached by the fifth dose. Consistent with the half-life, up to 22% accumulation, with respect to plasma AUC, was observed at steady-state. Following administration of an oral [14C]-empagliflozin solution to healthy volunteers, approximately 96% of the drug-related radioactivity was eliminated in faeces (41%) or urine (54%). The majority of drug-related radioactivity recovered in faeces was unchanged parent drug and approximately half of drug related radioactivity excreted in urine was unchanged parent drug.

Special populations

- **Renal impairment:** In patients with mild, moderate or severe renal impairment (eGFR <30 - <90 ml/min/1.73 m2) and patients with kidney failure/end stage renal disease (ESRD), AUC of empagliflozin increased by approximately 18%, 20%, 66%, and 48%, respectively compared to subjects with normal renal function. Peak plasma levels of empagliflozin were similar in subjects with moderate renal impairment and kidney failure/ESRD compared to patients with normal renal function. Peak plasma levels of empagliflozin were roughly 20% higher in subjects with mild and severe renal impairment as compared to subjects with normal renal function. The population pharmacokinetic analysis showed that the apparent oral clearance of empagliflozin decreased with a decrease in eGFR leading to an increase in drug exposure.
- **Hepatic impairment:** In subjects with mild, moderate, and severe hepatic impairment according to the Child-Pugh classification, AUC of empagliflozin increased approximately by 23%, 47%, and 75% and Cmax by approximately 4%, 23%, and 48%, respectively, compared to subjects with normal hepatic function.
- **Body Mass Index:** Body mass index had no clinically relevant effect on the pharmacokinetics of empagliflozin based on the population pharmacokinetic analysis. In this analysis, AUC was estimated to be 5.82%, 10.4%, and 17.3% lower in subjects with BMI of 30, 35, and 45 kg/m2, respectively, compared to subjects with a body mass index of 25 kg/m2.
- **Gender:** Gender had no clinically relevant effect on the pharmacokinetics of empagliflozin based on the population pharmacokinetic analysis.
- **Race:** In the population pharmacokinetic analysis, AUC was estimated to be 13.5% higher in Asians with a body mass index of 25 kg/m2 compared to non-Asians with a body mass index of 25 kg/m2.
- **Elderly:** Age did not have a clinically meaningful impact on the pharmacokinetics of empagliflozin based on the population pharmacokinetic analysis.
- **Paediatric population:** A paediatric Phase 1 study examined the pharmacokinetics and pharmacodynamics of empagliflozin (5 mg, 10 mg and 25 mg) in children and adolescents ≥10 to <18 years of age with type 2 diabetes mellitus. The observed pharmacokinetic and pharmacodynamic responses were consistent with those found in adult subjects.

5.3 Preclinical safety data

Non-clinical data reveal no special hazard for humans based on conventional studies of safety pharmacology, genotoxicity, fertility and early embryonic development.

In long term toxicity studies in rodents and dogs, signs of toxicity were observed at exposures greater than or equal to 10-times the clinical dose of empagliflozin. Most toxicity was consistent with secondary pharmacology related to urinary glucose loss and electrolyte imbalances including decreased body weight and body fat, increased food consumption, diarrhoea, dehydration, decreased serum glucose and increases in other serum parameters reflective of increased protein metabolism and gluconeogenesis, urinary changes such as polyuria and glucosuria, and microscopic changes including mineralisation in kidney and some soft and vascular tissues. Microscopic evidence of the effects of exaggerated pharmacology on the kidney observed in some species included tubular dilatation, and tubular and pelvic mineralisation at approximately 4-times the clinical AUC exposure of empagliflozin associated with the 25 mg dose.

Empagliflozin is not genotoxic.

In a 2 year carcinogenicity study, empagliflozin did not increase the incidence of tumours in female rats up to the highest dose of 700 mg/kg/day, which corresponds to approximately 72-times the maximal clinical AUC exposure to empagliflozin. In male rats, treatment-related benign vascular proliferative lesions (haemangiomas) of the mesenteric lymph node were observed at the highest dose, but not at 300 mg/kg/day, which corresponds to approximately 26-times the maximal clinical exposure to empagliflozin. Interstitial cell tumours in the testes were observed with a higher incidence in rats at 300 mg/kg/day and above, but not at 100 mg/kg/day which corresponds to approximately 18-times the maximal clinical exposure to empagliflozin. Both tumours are common in rats and are unlikely to be relevant to humans.

Empagliflozin did not increase the incidence of tumours in female mice at doses up to 1000 mg/kg/day, which corresponds to approximately 62-times the maximal clinical exposure to empagliflozin. Empagliflozin induced renal tumours in male mice at 1000 mg/kg/day, but not at 300 mg/kg/day, which corresponds to approximately 11-times the maximal clinical

exposure to empagliflozin. The mode of action for these tumours is dependent on the natural predisposition of the male mouse to renal pathology and a metabolic pathway not reflective of humans. The male mouse renal tumours are considered not relevant to humans.

At exposures sufficiently in excess of exposure in humans after therapeutic doses, empagliflozin had no adverse effects on fertility or early embryonic development. Empagliflozin administered during the period of organogenesis was not teratogenic. Only at maternally toxic doses, empagliflozin also caused bent limb bones in the rat and increased embryofetal loss in the rabbit.

In pre- and postnatal toxicity studies in rats, reduced weight gain of offspring was observed at maternal exposures approximately 4-times the maximal clinical exposure to empagliflozin. No such effect was seen at systemic exposure equal to the maximal clinical exposure to empagliflozin. The relevance of this finding to humans is unclear.

In a juvenile toxicity study in the rat, when empagliflozin was administered from postnatal day 21 until postnatal day 90, non-adverse, minimal to mild renal tubular and pelvic dilation in juvenile rats was seen only at 100 mg/kg/day, which approximates 11-times the maximum clinical dose of 25 mg. These findings were absent after a 13 weeks drug-free recovery period.

6. Pharmaceutical particulars

6.1 List of excipients

Lactose Monohydrate, Microcrystalline Cellulose (Microcel MC- 102), Croscarmellose Sodium (Primellose), Colloidal Anhydrous Silica (Aerosil-200), Magnesium Stearate, Opadry Butterscotch OY-27302, Carnauba Wax, Purified Talc, Methylene Chloride and Methanol.

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

24 months.

6.4 Special precautions for storage

Keep out of the sight and reach of children. Store in a cool & dry place, protected for light. Do not store above 30°C.

6.5 Nature and contents of container

Empadus 25 mg Tablet is supplied in Alu-Alu blister. Each blister contains 14 tablets and each inner carton contains 01 blister as 1×14 No's pack size.

6.6 Special precautions for disposal and other handling

No special requirements. Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

7. Marketing authorization holder

OPSONIN PHARMA LIMITED

CORPORATE HEADQUARTER:

OPSONIN BUILDING

30 NEW ESKATON ROAD

DHAKA-1000, BANGLADESH

MANUFACTURING SITE:

RUPATALI, BARISHAL, BANGLADESH

8. Marketing authorization number(s)

D.A.R. No.: 025-1491-015.

9. Date of first authorization/renewal of the authorization

11 Feb' 2021.

10. Date of revision of the text

Not Applicable.

PATIENT LEAFLET: INFORMATION FOR THE USER
EMPADUS 25 MG TABLET

EMPAGLIFLOZIN

Read all of this leaflet carefully before you are given 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.
- ✓ If you get any side effects, talk to your doctor or pharmacist. This includes any possible side effects not listed in this leaflet.

What is in this leaflet?

1. What Empadus is used for

Type 2 diabetes mellitus

- Empadus is used to treat type 2 diabetes in adult patients (aged 18 years and older) that cannot be controlled by diet and exercise alone.
- Empadus can be used without other medicines in patients who cannot take metformin (another diabetes medicine).
- Empadus can also be used with other medicines for the treatment of diabetes. These may be medicines taken by mouth or given by injection such as insulin.

Empadus works by blocking the SGLT2 protein in your kidneys. This causes blood sugar (glucose) to be removed in your urine. Thereby Empadus lowers the amount of sugar in your blood.

This medicine can also help prevent heart disease in patients with type 2 diabetes mellitus.

It is important that you continue with your diet and exercise plan as told by your doctor, pharmacist or nurse.

Heart failure

- Empadus is used to treat heart failure in adult patients with symptoms due to impaired heart function. few moments each day to relax and gently unwind.

What is type 2 diabetes?

Type 2 diabetes is a disease that comes from both your genes and your lifestyle. If you have type 2 diabetes, your pancreas does not make enough insulin to control the level of glucose in your blood, and your body is unable to use its own insulin effectively. This results in high levels of glucose in your blood which can lead to medical problems like heart disease, kidney disease, blindness, and poor circulation in your limbs.

What is heart failure?

Heart failure occurs when the heart is too weak or stiff and cannot work properly. This can lead to serious medical problems and need for hospital care. The most common symptoms of heart failure are feeling breathless, feeling tired or very tired all the time, and ankle swelling.

Empadus helps protect your heart from getting weaker and improves your symptoms.

2. What you need to know before you take Empadus

Do not take Empadus

if you are allergic to empagliflozin or any of the other ingredients of this medicine.

Warnings and precautions

Contact a doctor or the nearest hospital straight away:

Ketoacidosis

- if you experience rapid weight loss, 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, contact a doctor or the nearest hospital straight away. These symptoms could be a sign of "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 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.

Talk to your doctor, pharmacist or nurse before taking this medicine, and during treatment:

- If you have "type 1 diabetes". This type usually starts when you are young and your body does not produce any insulin. You should not take Empadus to treat your type 1 diabetes.
- If you have serious kidney problems – your doctor may limit your dose to 25 mg once a day or ask you to take a different medicine.
- If you have serious liver problems – your doctor may ask you to take a different medicine.
- might be at risk of dehydration, for example:
    i. if you are being sick, have diarrhoea or fever, or if you are not able to eat or drink
    ii. if you are taking medicines that increase urine production [diuretics] or lower blood pressure
    iii. if you are 75 years old or older.

Possible signs are listed in 'dehydration'. Your doctor may ask you to stop taking Empadus until you recover to prevent loss of too much body fluid. Ask about ways to prevent dehydration.

- If you have a serious infection of the kidney or the urinary tract with fever. Your doctor may ask you to stop taking Empadus until you have recovered.

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.

Foot care

Like for all diabetic patients it is important to check your feet regularly and adhere to any other advice regarding foot care given by your health care professional.

Kidney function

Your kidneys should be checked before you start taking and whilst you are on this medicine.

Urine glucose

Because of how this medicine works, your urine will test positive for sugar while you are taking this medicine.

Children and adolescents

Empadus is not recommended for children and adolescents under 18 years, because it has not been studied in these patients.

Other medicines and Empadus

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

It is important to tell your doctor:

- If you are taking medicines that increase urine production (diuretics). Your doctor may ask you to stop taking Empadus. Possible signs of losing too much fluid from your body.
- 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 your blood sugar levels from getting too low (hypoglycaemia).
- If you are taking lithium because Empadus can lower the amount of lithium in your blood.

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. Do not use Empadus if you are pregnant. It is unknown if Empadus is harmful to the unborn child. Do not use Empadus if you are breast-feeding. It is not known if Empadus passes into human breast milk.

Driving and using machines

Empadus has minor influence on the ability to drive and use machines.Taking this medicine in combination with medicines called sulphonylureas or with insulin can cause blood sugar levels to drop too low (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 while taking Empadus.

Empadus contains lactose

Empadus contains lactose (milk sugar). If your doctor has told you that you have an intolerance to some sugars, contact your doctor before taking this medicine.

Empadus contains sodium

This medicine contains less than 1 mmol sodium (23 mg) per tablet, that is to say essentially 'sodium free'.

3. How to take Empadus

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

How much to take

- The recommended dose of Empadus is one 25 mg tablet once a day. If you have type 2 diabetes mellitus, your doctor will decide whether to increase your dose to 25 mg once a day, if needed to help to control your blood sugar.
- Your doctor may limit your dose to 25 mg once a day if you have a kidney problem.
- Your doctor will prescribe the strength that is right for you. Do not change your dose unless your doctor has told you to.

Taking this medicine

- Swallow the tablet whole with water
- You can take the 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.

If you have type 2 diabetes mellitus, your doctor may prescribe Empadus together with another diabetes medicine. Remember to take all medicines as directed by your doctor to achieve the best results for your health.

Appropriate diet and exercise help your body use its blood sugar better. It is important to stay on the diet and exercise program recommended by your doctor while taking Empadus.

If you take more Empadus than you should.

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

If you forget to take Empadus

What to do if you forget to take a tablet depends on how long it is until your next dose.

- If it is 12 hours or more until your next dose, take Empadus as soon as you remember. Then take your next dose at the usual time.
- If it is less than 12 hours until your next dose, skip the missed dose. Then take your next dose at the usual time.
- Do not take a double dose of Empadus to make up for a forgotten dose.

If you stop taking Empadus

Do not stop taking Empadus without first consulting your doctor. If you have type 2 diabetes mellitus, your blood sugar levels may increase when you stop taking Empadus.

If you have any further questions on the use of this medicine, ask your doctor, pharmacist or nurse.

4. 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:

Severe allergic reaction, seen uncommonly (may affect up to 1 in 100 people)

Possible signs of severe allergic reaction may include:

- swelling of the face, lips, mouth, tongue, or throat that may lead to difficulty breathing or swallowing)

Diabetic ketoacidosis, seen uncommonly (may affect up to 1 in 100 people)

These are the signs of diabetic ketoacidosis ('Warnings and precautions'):

- Increased levels of "ketone bodies" in your urine or blood
- rapid weight loss
- 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.

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

Contact your doctor as soon as possible if you notice the following side effects:

Low blood sugar (hypoglycaemia), seen very commonly (may affect more than 1 in 25 people)

If you take Empadus with another medicine that can cause low blood sugar, such as a sulphonylurea or insulin, your risk of getting low blood sugar is higher. The signs of low blood sugar may include:

- shaking, sweating, feeling very anxious or confused, fast heart beat
- excessive hunger, headache

Your doctor will tell you how to treat low blood sugar levels and what to do if you get any of the signs above. If you have symptoms of low blood sugar, eat glucose tablets, a high sugar snack or drink fruit juice. Measure your blood sugar if possible and rest.

Urinary tract infection, seen commonly (may affect up to 1 in 10 people)

The signs of urinary tract infection are:

- burning sensation when passing urine
- urine that appears cloudy
- pain in the pelvis, or mid-back pain (when kidneys are infected)

An urge to pass urine or more frequent urination may be due to the way Empadus works, but they can also be signs of urinary tract infection. If you note an increase in such symptoms, you should also contact your doctor.

Dehydration, seen very commonly (may affect more than 1 in 10 people)

The signs of dehydration are not specific, but may include:

- unusual thirst
- lightheadedness or dizziness upon standing
- fainting or loss of consciousness

Other side effects while taking Empadus:

Common

- genital yeast infection (thrush)
- passing more urine than usual or needing to pass urine more often
- itching
- rash or red skin – this may be itchy and include raised bumps, oozing fluid or blisters
- thirst
- blood tests may show an increase in blood fat (cholesterol) levels in your blood
- constipation

Uncommon

- hives
- straining or pain when emptying the bladder
- blood tests may show a decrease in kidney function (creatinine or urea)

- blood tests may show increases in the amount of red blood cells in your blood (haematocrit)

Rare

- 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

Very rare

- inflammation of the kidneys (tubulointerstitial nephritis)

Reporting of side effects

If you get any side effects, talk to your doctor, pharmacist or nurse. This includes any possible side effects not listed in this leaflet. You can also report side effects directly (see details below). By reporting side effects you can help provide more information on the safety of this medicine.

Yellow Card Scheme

Website: www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store.

5. How to store Empadus

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

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

This medicine does not require any special storage conditions.

Do not use this medicine if you notice that the packaging is damaged or shows signs of tampering.

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 protect the environment.

6. Contents of the pack and other information

What Mave SR Capsules contains:

- The active substance is Empagliflozin. Each tablet contains Empagliflozin 25 mg.
- The other ingredients is Lactose Monohydrate, Microcrystalline Cellulose (Microcel MC-102), Croscarmellose Sodium (Primellose), Colloidal Anhydrous Silica (Aerosil-200), Magnesium Stearate, Opadry Butterscotch OY-27302, Carnauba Wax, Purified Talc, Methylene Chloride & Methanol.

Contents of the pack:

This medicine is a white to almost white color, round shape film coated tablet with dividing line in Alu-Alu blister. Each tablet contains Empagliflozin 25 mg.

Empadus 25 mg Tablet is supplied in Alu-Alu blister. Each blister contains 14 tablets and each inner carton contains 01 blister as 1×14 No's pack size.

Marketing Authorization Holder and Manufacturer

OPSONIN PHARMA LIMITED

CORPORATE HEADQUARTER:

OPSONIN BUILDING

30 NEW ESKATON ROAD

DHAKA-2500, BANGLADESH.