
SITAXA

1. Generic Name

Sitagliptin Tablets I.P.

2. Qualitative and quantitative Composition:

SITAGLIPTIN TABLETS I.P. 25 mg

Each Film-Coated Tablet Contains:

Each Film Coated Tablet Contains:

Sitagliptin phosphate monohydrate I.P. equivalent to Sitagliptin.... 25 mg

Excipients..... q.s.

Colours: Red oxide of iron, yellow oxide of iron and Titanium dioxide I.P.

SITAGLIPTIN TABLETS I.P.50 mg

Each Film Coated Tablet Contains:

Sitagliptin phosphate monohydrate I.P. equivalent to Sitagliptin.... 50 mg

Excipients..... q.s.

Colours: Red oxide of iron, yellow oxide of iron and Titanium dioxide I.P.

SITAGLIPTIN TABLETS I.P. 100 mg

Each Film Coated Tablet Contains:

Sitagliptin phosphate monohydrate I.P. equivalent to Sitagliptin.... 100 mg

Excipients..... q.s.

Colours: Red oxide of iron, yellow Oxide of iron and Titanium dioxide I.P.

Excipients are Microcrystalline cellulose, Dibasic calcium phosphate anhydrous, Croscarmellose sodium, Sodium stearyl fumarate ,Polyvinyl alcohol (partially hydrolyzed), Macrogol/PEG, Titanium dioxide, Talc, Red oxide of iron, yellow Oxide of iron.

3. Dosage form and strength

Dosage form: Film-Coated Tablet

Strength: Sitagliptin Phosphate monohydrate 25, 50 and 100 mg Tablets

4. Clinical particulars

4.1 Therapeutic indication

As adjunct to diet and exercise to improve glycaemia control in patients with type- II diabetes.

4.2 Posology and method of administration

Posology

Dose: As directed by the Physician.

The dose is 100 mg sitagliptin once daily. When used in combination with metformin and/or a PPAR γ agonist, the dose of metformin and/or PPAR γ agonist should be maintained, and sitagliptin administered concomitantly.

When sitagliptin 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 of sitagliptin is missed, it should be taken as soon as the patient remembers. A double dose should not be taken on the same day.

Special populations

Renal impairment

When considering the use of sitagliptin in combination with another anti-diabetic medicinal product, its conditions for use in patients with renal impairment should be checked.

For patients with mild renal impairment (glomerular filtration rate [GFR] ≥ 60 to < 90 mL/min), no dose adjustment is required.

For patients with moderate renal impairment (GFR ≥ 45 to < 60 mL/min), no dosage adjustment is required.

For patients with moderate renal impairment (GFR ≥ 30 to < 45 mL/min), the dose of Sitagliptin is 50 mg once daily.

For patients with severe renal impairment (GFR ≥ 15 to < 30 mL/min) or with end-stage renal disease (ESRD) (GFR < 15 mL/min), including those requiring haemodialysis or peritoneal dialysis, the dose of Sitagliptin is 25 mg once daily. Treatment may be administered without regard to the timing of dialysis.

Because there is a dosage adjustment based upon renal function, assessment of renal function is recommended prior to initiation of Sitagliptin and periodically thereafter.

Hepatic impairment

No dose adjustment is necessary for patients with mild to moderate hepatic impairment. Sitagliptin has not been studied in patients with severe hepatic impairment and care should be exercised.

However, because sitagliptin is primarily renally eliminated, severe hepatic impairment is not expected to affect the pharmacokinetics of sitagliptin.

Elderly

No dose adjustment is necessary based on age.

Paediatric population

Sitagliptin should not be used in children and adolescents 10 to 17 years of age because of insufficient efficacy. Currently available data are described in sections 4.8, 5.1, and 5.2. Sitagliptin has not been studied in paediatric patients under 10 years of age.

Method of administration

Sitagliptin can be taken with or without food.

4.3 Contraindications

Hypersensitivity to the active substance or to any of the excipients.

4.4 Special warnings and precautions for use

General

Sitagliptin should not be used in patients with type 1 diabetes or for the treatment of diabetic ketoacidosis.

Acute pancreatitis

Use of DPP-4 inhibitors has been associated with a risk of developing acute pancreatitis. Patients should be informed of the characteristic symptom of acute pancreatitis: persistent, severe abdominal pain. Resolution of pancreatitis has been observed after discontinuation of sitagliptin (with or without supportive treatment), but very rare cases of necrotising or haemorrhagic pancreatitis and/or death have been reported. If pancreatitis is suspected, Sitagliptin and other potentially suspect medicinal products should be discontinued; if acute pancreatitis is confirmed, Sitagliptin should not be restarted. Caution should be exercised in patients with a history of pancreatitis.

Hypoglycaemia when used in combination with other anti-hyperglycaemic medicinal products

In clinical trials of Sitagliptin as monotherapy and as part of combination therapy with medicinal products not known to cause hypoglycaemia (i.e. metformin and/or a PPAR γ agonist), rates of hypoglycaemia reported with sitagliptin were similar to rates in patients taking placebo. Hypoglycaemia has been observed when sitagliptin was used in combination with insulin or a sulphonylurea. Therefore, to reduce the risk of hypoglycaemia, a lower dose of sulphonylurea or insulin may be considered.

Renal impairment

Sitagliptin is renally excreted. To achieve plasma concentrations of sitagliptin similar to those in patients with normal renal function, lower dosages are recommended in patients with GFR < 45 mL/min, as well as in ESRD patients requiring haemodialysis or peritoneal dialysis.

When considering the use of sitagliptin in combination with another anti-diabetic medicinal product, its conditions for use in patients with renal impairment should be checked.

Hypersensitivity reactions

Post-marketing reports of serious hypersensitivity reactions in patients treated with sitagliptin have been reported. These reactions include anaphylaxis, angioedema, and exfoliative skin conditions including Stevens-Johnson syndrome. Onset of these reactions occurred within the first 3 months after initiation of treatment with sitagliptin, with some reports occurring after the first dose. If a hypersensitivity reaction is suspected, Sitagliptin should be discontinued, other potential causes of the event should be assessed, and alternative treatment for diabetes should be instituted.

Bullous pemphigoid

There have been post-marketing reports of bullous pemphigoid in patients taking DPP-4 inhibitors including sitagliptin. If bullous pemphigoid is suspected, Sitagliptin should be discontinued.

4.5 Drugs interactions

Effects of other medicinal products on sitagliptin

Clinical data described below suggest that the risk for clinically meaningful interactions by co-administered medicinal products is low.

In reported *in vitro* studies indicated that the primary enzyme responsible for the limited metabolism of sitagliptin is CYP3A4, with contribution from CYP2C8. In patients with normal renal function, metabolism, including via CYP3A4, plays only a small role in the clearance of sitagliptin. Metabolism may play a more significant role in the elimination of sitagliptin in the setting of severe renal impairment or end-stage renal disease (ESRD). For this reason, it is possible that potent CYP3A4 inhibitors (i.e. ketoconazole, itraconazole, ritonavir, clarithromycin) could alter the pharmacokinetics of sitagliptin in patients with severe renal impairment or ESRD. The effect of potent CYP3A4 inhibitors in the setting of renal impairment has not been assessed in a clinical study.

In reported *in vitro* transport studies showed that sitagliptin is a substrate for p-glycoprotein and organic anion transporter-3 (OAT3). OAT3 mediated transport of sitagliptin was inhibited *in vitro* by probenecid, although the risk of clinically meaningful interactions is considered to be low. Concomitant administration of OAT3 inhibitors has not been evaluated *in vivo*.

Metformin: Co-administration of multiple twice-daily doses of 1,000 mg metformin with 50 mg sitagliptin did not meaningfully alter the pharmacokinetics of sitagliptin in patients with type 2 diabetes.

Ciclosporin: A study was conducted to assess the effect of ciclosporin, a potent inhibitor of p-glycoprotein, on the pharmacokinetics of sitagliptin. Co-administration of a single 100 mg oral dose of sitagliptin and a single 600 mg oral dose of ciclosporin increased the AUC and C_{max} of sitagliptin by approximately 29 % and 68 %, respectively. These changes in sitagliptin pharmacokinetics were not considered to be clinically meaningful. The renal clearance of sitagliptin was not meaningfully altered. Therefore, meaningful interactions would not be expected with other p-glycoprotein inhibitors.

Effects of sitagliptin on other medicinal products

Digoxin: Sitagliptin had a small effect on plasma digoxin concentrations. Following administration of 0.25 mg digoxin concomitantly with 100 mg of sitagliptin daily for 10 days, the plasma AUC of digoxin was increased on average by 11 %, and the plasma C_{max} on average by 18 %. No dose adjustment of digoxin is recommended. However, patients at risk of digoxin toxicity should be monitored for this when sitagliptin and digoxin are administered concomitantly.

In reported *in vitro* data suggest that sitagliptin does not inhibit nor induce CYP450 isoenzymes. In clinical studies, sitagliptin did not meaningfully alter the pharmacokinetics of metformin, glyburide, simvastatin, rosiglitazone, warfarin, or oral contraceptives, providing *in vivo* evidence of a low propensity for causing interactions with substrates of CYP3A4, CYP2C8, CYP2C9, and organic cationic transporter (OCT). Sitagliptin may be a mild inhibitor of p-glycoprotein *in vivo*.

4.6 Use in special populations (such as pregnant women, lactating women, paediatric patients, geriatric patients etc.)

Pregnancy

There are no adequate data from the use of sitagliptin in pregnant women. Studies in animals have shown reproductive toxicity at high doses. The potential risk for humans is unknown. Due to lack of human data, SITAXA should not be used during pregnancy.

Breast-feeding

It is unknown whether sitagliptin is excreted in human breast milk. Animal studies have shown excretion of sitagliptin in breast milk. SITAXA should not be used during breast-feeding.

Fertility

Reported animal data do not suggest an effect of treatment with sitagliptin on male and female fertility. Human data are lacking.

4.7 Effects on ability to drive and use machines

Sitagliptin has no or negligible influence on the ability to drive and use machines. However, when driving or using machines, it should be taken into account that dizziness and somnolence have been reported.

In addition, patients should be alerted to the risk of hypoglycaemia when Sitagliptin is used in combination with a sulphonylurea or with insulin.

4.8 Undesirable effects

Summary of the safety profile

Serious adverse reactions including pancreatitis and hypersensitivity reactions have been reported. Hypoglycaemia has been reported in combination with sulphonylurea (4.7 %-13.8 %) and insulin (9.6 %).

Sitagliptin

Tabulated list of adverse reactions

Adverse reactions are listed below (Table 1) by system organ class and frequency. Frequencies are defined as: 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).

The frequency of adverse reactions identified from placebo-controlled clinical studies of Sitagliptin monotherapy and post-marketing experience

Adverse reaction	Frequency of adverse reaction
Blood and lymphatic system disorders	
thrombocytopenia	Rare
Immune system disorders	
hypersensitivity reactions including anaphylactic responses ^{*,†}	Frequency not known
Metabolism and nutrition disorders	
hypoglycaemia [†]	Common
Nervous system disorders	

headache	Common
dizziness	Uncommon
Respiratory, thoracic and mediastinal disorders	
interstitial lung disease*	Frequency not known
Gastrointestinal disorders	
constipation	Uncommon
vomiting*	Frequency not known
acute pancreatitis*,†,‡	Frequency not known
fatal and non-fatal haemorrhagic and necrotizing pancreatitis*,†	Frequency not known
Skin and subcutaneous tissue disorders	
pruritus*	Uncommon
angioedema*,†	Frequency not known
rash*,†	Frequency not known
urticaria*,†	Frequency not known
cutaneous vasculitis*,†	Frequency not known
exfoliative skin conditions including Stevens-Johnson syndrome*,†	Frequency not known
bullous pemphigoid*	Frequency not known
Musculoskeletal and connective tissue disorders	
arthralgia*	Frequency not known
myalgia*	Frequency not known
pain in extremity*	Frequency not known
back pain*	Frequency not known

arthropathy*	Frequency not known
Renal and urinary disorders	
impaired renal function*	Frequency not known
acute renal failure*	Frequency not known

Adverse reactions were identified through post-marketing surveillance.

† See section 4.4.

‡ See TECOS Cardiovascular Safety Study below.

Description of selected adverse reactions:

In addition to the drug-related adverse experiences described above, adverse experiences reported regardless of causal relationship to medication and occurring in at least 5 % and more commonly in patients treated with sitagliptin included upper respiratory tract infection and nasopharyngitis. Additional adverse experiences reported regardless of causal relationship to medication that occurred more frequently in patients treated with sitagliptin (not reaching the 5 % level, but occurring with an incidence of > 0.5 % higher with sitagliptin than that in the control group) included osteoarthritis and pain in extremity.

Some adverse reactions were observed more frequently in studies of combination use of sitagliptin with other anti-diabetic medicinal products than in studies of sitagliptin monotherapy. These included hypoglycaemia (frequency very common with the combination of sulphonylurea and metformin), influenza (common with insulin (with or without metformin)), nausea and vomiting (common with metformin), flatulence (common with metformin or pioglitazone), constipation (common with the combination of sulphonylurea and metformin), peripheral oedema (common with pioglitazone or the combination of pioglitazone and metformin), somnolence and diarrhoea (uncommon with metformin), and dry mouth (uncommon with insulin (with or without metformin)).

Paediatric population

In clinical trials with sitagliptin in paediatric patients with type 2 diabetes mellitus aged 10 to 17 years, the profile of adverse reactions was comparable to that observed in adults.

TECOS Cardiovascular Safety Study

The Trial Evaluating Cardiovascular Outcomes with Sitagliptin (TECOS) included 7,332 patients treated with sitagliptin, 100 mg daily (or 50 mg daily if the baseline eGFR was ≥ 30 and < 50 mL/min/1.73 m²), and 7,339 patients treated with placebo in the intention-to-treat population. Both treatments were added to usual care targeting regional standards for HbA1c and CV risk factors. The overall incidence of serious adverse events in patients receiving sitagliptin was similar to that in patients receiving placebo.

In the intention-to-treat population, among patients who were using insulin and/or a sulphonylurea at baseline, the incidence of severe hypoglycaemia was 2.7 % in sitagliptin-treated patients and 2.5 % in placebo-treated patients; among patients who were not using insulin and/or a sulphonylurea at baseline, the incidence of severe hypoglycaemia was 1.0 % in sitagliptin-treated patients and 0.7 % in placebo-treated patients. The incidence of adjudication-confirmed pancreatitis events was 0.3 % in sitagliptin-treated patients and 0.2 % in placebo-treated patients.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are requested to report any suspected adverse reactions via any point of contact of Torrent Pharma available at: http://www.torrentpharma.com/index.php/site/info/adverse_event_reporting.

By reporting side effects, you can help provide more information on the safety of this medicine.

4.9 Overdose

During controlled clinical trials in healthy subjects, single doses of up to 800 mg sitagliptin were administered. Minimal increases in QTc, not considered to be clinically relevant, were observed in one study at a dose of 800 mg sitagliptin. There is no experience with doses above 800 mg in clinical studies. In Phase I multiple-dose studies, there were no dose-related clinical adverse reactions observed with sitagliptin with doses of up to 600 mg per day for periods of up to 10 days and 400 mg per day for periods of up to 28 days.

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

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

5 Pharmacological properties

5.1 Mechanism of Action

Sitagliptin phosphate is an orally-active, potent, and highly selective inhibitor of the dipeptidyl peptidase 4 (DPP-4) enzyme for the treatment of type 2 diabetes. The DPP-4 inhibitors are a class of agents that act as incretin enhancers. By inhibiting the DPP-4 enzyme, sitagliptin increases the levels of two known active incretin hormones, glucagon-like peptide-1 (GLP-1) and glucose-dependent insulinotropic polypeptide (GIP). The incretins are part of an endogenous system involved in the physiologic regulation of glucose homeostasis. When blood glucose concentrations are normal or elevated, GLP-1 and GIP increase insulin synthesis and release from pancreatic beta cells. GLP-1 also lowers glucagon secretion from pancreatic alpha cells, leading to reduced hepatic glucose production. When blood glucose levels are low, insulin release is not enhanced and glucagon secretion is not suppressed. Sitagliptin is a potent and highly selective inhibitor of the enzyme DPP-4 and does not inhibit the closely-related enzymes DPP-8 or DPP-9 at therapeutic concentrations. Sitagliptin differs in chemical structure and pharmacological action from GLP-1 analogues, insulin, sulphonylureas or meglitinides, biguanides, peroxisome proliferator-activated receptor gamma (PPAR γ) agonists, alpha-glucosidase inhibitors, and amylin analogues.

In a two-day study in healthy subjects, sitagliptin alone increased active GLP-1 concentrations, whereas metformin alone increased active and total GLP-1 concentrations to similar extents. Co-administration of sitagliptin and metformin had an additive effect on active GLP-1 concentrations. Sitagliptin, but not metformin, increased active GIP concentrations.

5.2 Pharmacodynamic properties

Pharmacotherapeutic group: Drugs used in diabetes, Dipeptidyl peptidase 4 (DPP-4) inhibitors, ATC code: A10BH01.

Clinical efficacy and safety

Overall, sitagliptin improved glycaemic control when used as monotherapy or in combination treatment in adult patients with type 2 diabetes (see Table 2).

Two studies were conducted to evaluate the efficacy and safety of sitagliptin monotherapy. Treatment with sitagliptin at 100 mg once daily as monotherapy provided significant improvements in HbA1c, fasting plasma glucose (FPG), and 2-hour post-prandial glucose (2-hour PPG), compared to placebo in two studies, one of 18- and one of 24-weeks duration. Improvement of surrogate markers of beta cell function, including HOMA- β (Homeostasis Model Assessment- β), proinsulin to insulin ratio, and measures of beta cell responsiveness from the frequently-sampled meal tolerance test were observed. The observed incidence of hypoglycaemia in patients treated with sitagliptin was similar to placebo. Body weight did not increase from baseline with sitagliptin therapy in either study, compared to a small reduction in patients given placebo.

Sitagliptin 100 mg once daily provided significant improvements in glycaemic parameters compared with placebo in two 24-week studies of sitagliptin as add-on therapy, one in combination with metformin and one in combination with pioglitazone. Change from baseline in body weight was similar for patients treated with sitagliptin relative to placebo. In these studies there was a similar incidence of hypoglycaemia reported for patients treated with sitagliptin or placebo.

A 24-week placebo-controlled reported study was designed to evaluate the efficacy and safety of sitagliptin (100 mg once daily) added to glimepiride alone or glimepiride in combination with metformin. The addition of sitagliptin to either glimepiride alone or to glimepiride and metformin provided significant improvements in glycaemic parameters. Patients treated with sitagliptin had a modest increase in body weight compared to those given placebo.

A 26-week placebo-controlled reported study was designed to evaluate the efficacy and safety of sitagliptin (100 mg once daily) added to the combination of pioglitazone and metformin. The addition of sitagliptin to pioglitazone and metformin provided significant improvements in glycaemic parameters. Change from baseline in body weight was similar for patients treated with sitagliptin relative to placebo. The incidence of hypoglycaemia was also similar in patients treated with sitagliptin or placebo.

A 24-week placebo-controlled reported study was designed to evaluate the efficacy and safety of sitagliptin (100 mg once daily) added to insulin (at a stable dose for at least 10 weeks) with or without metformin (at least 1,500 mg). In patients taking pre-mixed insulin, the mean daily dose was 70.9 U/day. In patients taking non-pre-mixed (intermediate/long-acting) insulin, the mean daily dose was 44.3 U/day. The addition of sitagliptin to insulin provided significant improvements in glycaemic parameters. There was no meaningful change from baseline in body weight in either group.

In a 24-week placebo-controlled reported factorial study of initial therapy, sitagliptin 50 mg twice daily in combination with metformin (500 mg or 1,000 mg twice daily) provided significant improvements in glycaemic parameters compared with either monotherapy. The decrease in body weight with the combination of sitagliptin and metformin was similar to that observed with metformin alone or placebo; there was no change from baseline for patients on sitagliptin alone. The incidence of hypoglycaemia was similar across treatment groups.

A 24-week active (metformin)-controlled reported study was designed to evaluate the efficacy and safety of sitagliptin 100 mg once daily (N=528) compared to metformin (N=522) in patients with inadequate glycaemic control on diet and exercise and who were not on anti-hyperglycaemic therapy (off therapy for at least 4 months). The mean dose of metformin was

approximately 1,900 mg per day. The reduction in HbA1c from mean baseline values of 7.2 % was -0.43 % for sitagliptin and -0.57 % for metformin (Per Protocol Analysis). The overall incidence of gastrointestinal adverse reactions considered as drug-related in patients treated with sitagliptin was 2.7 % compared with 12.6 % in patients treated with metformin. The incidence of hypoglycaemia was not significantly different between the treatment groups (sitagliptin, 1.3 %; metformin, 1.9 %). Body weight decreased from baseline in both groups (sitagliptin, -0.6 kg; metformin -1.9 kg).

In a reported study comparing the efficacy and safety of the addition of sitagliptin 100 mg once daily or glipizide (a sulphonylurea) in patients with inadequate glycaemic control on metformin monotherapy, sitagliptin was similar to glipizide in reducing HbA1c. The mean glipizide dose used in the comparator group was 10 mg per day with approximately 40 % of patients requiring a glipizide dose of ≤ 5 mg/day throughout the study. However, more patients in the sitagliptin group discontinued due to lack of efficacy than in the glipizide group. Patients treated with sitagliptin exhibited a significant mean decrease from baseline in body weight compared to a significant weight gain in patients administered glipizide (-1.5 vs. +1.1 kg). In this study, the proinsulin to insulin ratio, a marker of efficiency of insulin synthesis and release, improved with sitagliptin and deteriorated with glipizide treatment. The incidence of hypoglycaemia in the sitagliptin group (4.9 %) was significantly lower than that in the glipizide group (32.0 %).

A 24-week placebo-controlled reported study involving 660 patients was designed to evaluate the insulin-sparing efficacy and safety of sitagliptin (100 mg once daily) added to insulin glargine with or without metformin (at least 1,500 mg) during intensification of insulin therapy. Baseline HbA1c was 8.74 % and baseline insulin dose was 37 IU/day. Patients were instructed to titrate their insulin glargine dose based on fingerstick fasting glucose values. At Week 24, the increase in daily insulin dose was 19 IU/day in patients treated with sitagliptin and 24 IU/day in patients treated with placebo. The reduction in HbA1c in patients treated with sitagliptin and insulin (with or without metformin) was -1.31 % compared to -0.87 % in patients treated with placebo and insulin (with or without metformin), a difference of -0.45 % [95 % CI: -0.60, -0.29]. The incidence of hypoglycaemia was 25.2 % in patients treated with sitagliptin and insulin (with or without metformin) and 36.8 % in patients treated with placebo and insulin (with or without metformin). The difference was mainly due to a higher percentage of patients in the placebo group experiencing 3 or more episodes of hypoglycaemia (9.4 vs. 19.1 %). There was no difference in the incidence of severe hypoglycaemia.

A reported study comparing sitagliptin at 25 or 50 mg once daily to glipizide at 2.5 to 20 mg/day was conducted in patients with moderate to severe renal impairment. This study involved 423 patients with chronic renal impairment (estimated glomerular filtration rate < 50 mL/min). After 54 weeks, the mean reduction from baseline in HbA1c was -0.76 % with sitagliptin and -0.64 % with glipizide (Per-Protocol Analysis). In this study, the efficacy and safety profile of sitagliptin at 25 or 50 mg once daily was generally similar to that observed in other monotherapy studies in patients with normal renal function. The incidence of hypoglycaemia in the sitagliptin group (6.2 %) was significantly lower than that in the glipizide group (17.0 %). There was also a significant difference between groups with respect to change from baseline body weight (sitagliptin -0.6 kg; glipizide +1.2 kg).

Another reported study comparing sitagliptin at 25 mg once daily to glipizide at 2.5 to 20 mg/day was conducted in 129 patients with ESRD who were on dialysis. After 54 weeks, the mean reduction from baseline in HbA1c was -0.72 % with sitagliptin and -0.87 % with glipizide. In this study, the efficacy and safety profile of sitagliptin at 25 mg once daily was generally similar to that observed in other monotherapy studies in patients with normal renal function. The

incidence of hypoglycaemia was not significantly different between the treatment groups (sitagliptin, 6.3 %; glipizide, 10.8 %).

In another reported study involving 91 patients with type 2 diabetes and chronic renal impairment (creatinine clearance < 50 mL/min), the safety and tolerability of treatment with sitagliptin at 25 or 50 mg once daily were generally similar to placebo. In addition, after 12 weeks, the mean reductions in HbA1c (sitagliptin -0.59 %; placebo -0.18 %) and FPG (sitagliptin -25.5 mg/dL; placebo -3.0 mg/dL) were generally similar to those observed in other monotherapy studies in patients with normal renal function (see section 5.2).

The TECOS was a randomised study in 14,671 patients in the intention-to-treat population with an HbA1c of ≥ 6.5 to 8.0 % with established CV disease who received sitagliptin (7,332) 100 mg daily (or 50 mg daily if the baseline eGFR was ≥ 30 and < 50 mL/min/1.73 m²) or placebo (7,339) added to usual care targeting regional standards for HbA1c and CV risk factors. Patients with an eGFR < 30 mL/min/1.73 m² were not to be enrolled in the study. The study population included 2,004 patients ≥ 75 years of age and 3,324 patients with renal impairment (eGFR < 60 mL/min/1.73 m²).

Over the course of the study, the overall estimated mean (SD) difference in HbA1c between the sitagliptin and placebo groups was 0.29 % (0.01), 95 % CI (-0.32, -0.27); $p < 0.001$.

The primary cardiovascular endpoint was a composite of the first occurrence of cardiovascular death, nonfatal myocardial infarction, nonfatal stroke, or hospitalisation for unstable angina. Secondary cardiovascular endpoints included the first occurrence of cardiovascular death, nonfatal myocardial infarction, or nonfatal stroke; first occurrence of the individual components of the primary composite; all-cause mortality; and hospital admissions for congestive heart failure.

After a median follow up of 3 years, sitagliptin, when added to usual care, did not increase the risk of major adverse cardiovascular events or the risk of hospitalisation for heart failure compared to usual care without sitagliptin in patients with type 2 diabetes.

Paediatric population

A 54-week, double-blind reported study was conducted to evaluate the efficacy and safety of sitagliptin 100 mg once daily in paediatric patients (10 to 17 years of age) with type 2 diabetes who were not on anti hyperglycaemic therapy for at least 12 weeks (with HbA1c 6.5% to 10%) or were on a stable dose of insulin for at least 12 weeks (with HbA1c 7% to 10%). Patients were randomised to sitagliptin 100 mg once daily or placebo for 20 weeks.

Mean baseline HbA1c was 7.5%. Treatment with sitagliptin 100 mg did not provide significant improvement in HbA1c at 20 weeks. The reduction in HbA1c in patients treated with sitagliptin (N=95) was 0.0% compared to 0.2% in patients treated with placebo (N=95), a difference of -0.2% (95% CI: -0.7, 0.3).

5.3 Pharmacokinetic properties

Sitagliptin

Absorption

Following oral administration of a 100-mg dose to healthy subjects, sitagliptin was rapidly absorbed, with peak plasma concentrations (median T_{max}) occurring 1 to 4 hours post-dose, mean plasma AUC of sitagliptin was 8.52 Mm.hr, C_{max} was 950 nM. The absolute bioavailability of sitagliptin is approximately 87 %. Since co-administration of a high-fat meal with sitagliptin had no effect on the pharmacokinetics, sitagliptin may be administered with or without food.

Plasma AUC of sitagliptin increased in a dose-proportional manner. Dose-proportionality was not established for C_{max} and C_{24hr} (C_{max} increased in a greater than dose-proportional manner and C_{24hr} increased in a less than dose-proportional manner).

Distribution

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

Biotransformation

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

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

In vitro data showed that sitagliptin is not an inhibitor of CYP isoenzymes CYP3A4, 2C8, 2C9, 2D6, 1A2, 2C19 or 2B6, and is not an inducer of CYP3A4 and CYP1A2.

Elimination

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

Elimination of sitagliptin occurs primarily via renal excretion and involves active tubular secretion. Sitagliptin is a substrate for human organic anion transporter-3 (hOAT-3), which may be involved in the renal elimination of sitagliptin. The clinical relevance of hOAT-3 in sitagliptin transport has not been established. Sitagliptin is also a substrate of p-glycoprotein, which may also be involved in mediating the renal elimination of sitagliptin. However, ciclosporin, a p-glycoprotein inhibitor, did not reduce the renal clearance of sitagliptin. Sitagliptin is not a substrate for OCT2 or OAT1 or PEPT1/2 transporters. *In vitro*, sitagliptin did not inhibit OAT3 ($IC_{50}=160 \mu M$) or p-glycoprotein (up to 250 μM) mediated transport at therapeutically relevant plasma concentrations. In a clinical study sitagliptin had a small effect on plasma digoxin concentrations indicating that sitagliptin may be a mild inhibitor of p-glycoprotein.

Characteristics in patients

The pharmacokinetics of sitagliptin were generally similar in healthy subjects and in patients with type 2 diabetes.

Renal impairment

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

Compared to normal healthy control subjects, plasma AUC of sitagliptin was increased by approximately 1.2-fold and 1.6-fold in patients with mild renal impairment (GFR \geq 60 to $<$ 90 mL/min) and patients with moderate renal impairment (GFR \geq 45 to $<$ 60 mL/min), respectively. Because increases of this magnitude are not clinically relevant, dosage adjustment in these patients is not necessary.

Plasma AUC of sitagliptin was increased approximately 2-fold in patients with moderate renal impairment (GFR \geq 30 to $<$ 45 mL/min), and approximately 4-fold in patients with severe renal impairment (GFR $<$ 30 mL/min), including patients with ESRD on haemodialysis. Sitagliptin was modestly removed by haemodialysis (13.5 % over a 3- to 4-hour haemodialysis session starting 4 hours post-dose).

Hepatic impairment

No dose adjustment for sitagliptin is necessary for patients with mild or moderate hepatic impairment (Child-Pugh score \leq 9). There is no clinical experience in patients with severe hepatic impairment (Child-Pugh score $>$ 9). However, because sitagliptin is primarily renally eliminated, severe hepatic impairment is not expected to affect the pharmacokinetics of sitagliptin.

Elderly

No dose adjustment is required based on age. Age did not have a clinically meaningful impact on the pharmacokinetics of sitagliptin based on a population pharmacokinetic analysis of Phase I and Phase II data. Elderly subjects (65 to 80 years) had approximately 19 % higher plasma concentrations of sitagliptin compared to younger subjects.

Paediatric population

The pharmacokinetics of sitagliptin (single dose of 50 mg, 100 mg or 200 mg) were investigated in paediatric patients (10 to 17 years of age) with type 2 diabetes. In this population, the dose adjusted AUC of sitagliptin in plasma was approximately 18 % lower compared to adult patients with type 2 diabetes for a 100 mg dose. No studies with sitagliptin have been performed in paediatric patients $<$ 10 years of age.

Other patient characteristics

No dose adjustment is necessary based on gender, race, or body mass index (BMI). These characteristics had no clinically meaningful effect on the pharmacokinetics of sitagliptin based on a composite analysis of Phase I pharmacokinetic data and on a population pharmacokinetic analysis of Phase I and Phase II data.

6 Nonclinical properties

6.1 Animal Toxicology or Pharmacology

Sitagliptin

Renal and liver toxicity were observed in rodents at systemic exposure values 58 times the human exposure level, while the no-effect level was found at 19 times the human exposure level. Incisor teeth abnormalities were observed in rats at exposure levels 67 times the clinical exposure level; the no-effect level for this finding was 58-fold based on the 14-week rat study. The relevance of these findings for humans is unknown. Transient treatment-related physical signs, some of which suggest neural toxicity, such as open-mouth breathing, salivation, white foamy emesis, ataxia, trembling, decreased activity, and/or hunched posture were observed in dogs at exposure levels approximately 23 times the clinical exposure level. In addition, very slight to slight skeletal muscle degeneration was also observed histologically at doses resulting in systemic exposure

levels of approximately 23 times the human exposure level. A no-effect level for these findings was found at an exposure 6-fold the clinical exposure level.

Sitagliptin has not been demonstrated to be genotoxic in preclinical studies. Sitagliptin was not carcinogenic in mice. In rats, there was an increased incidence of hepatic adenomas and carcinomas at systemic exposure levels 58 times the human exposure level. Since hepatotoxicity has been shown to correlate with induction of hepatic neoplasia in rats, this increased incidence of hepatic tumours in rats was likely secondary to chronic hepatic toxicity at this high dose. Because of the high safety margin (19-fold at this no-effect level), these neoplastic changes are not considered relevant for the situation in humans.

No treatment related effects on fertility were observed in male and female rats given sitagliptin prior to and throughout mating.

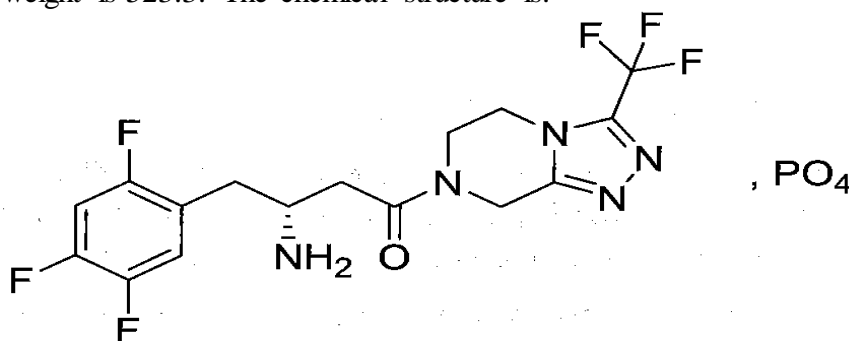
In a pre-/post-natal development study performed in rats sitagliptin showed no adverse effects.

Reproductive toxicity studies showed a slight treatment-related increased incidence of foetal rib malformations (absent, hypoplastic and wavy ribs) in the offspring of rats at systemic exposure levels more than 29 times the human exposure levels. Maternal toxicity was seen in rabbits at more than 29 times the human exposure levels. Because of the high safety margins, these findings do not suggest a relevant risk for human reproduction. Sitagliptin is secreted in considerable amounts into the milk of lactating rats (milk/plasma ratio: 4:1).

7 Description

Sitagliptin phosphate monohydrate:

Sitagliptin Phosphate is (3R)-3-amino-1-[3-(trifluoromethyl)-5,6-dihydro[1,2,4]triazolo[4,3- α]pyrazine-7(8H)-yl]-4-(2,4,5-trifluorophenyl)butan-1-one phosphate monohydrate. The empirical formula of Sitagliptin phosphate monohydrate is $C_{16}H_{18}F_6N_5O_5P \cdot H_2O$. The molecular weight is 523.3. The chemical structure is:



Sitagliptin phosphate monohydrate is a white or almost white powder.

It is Soluble in water; very slightly soluble in ethanol; practically insoluble in heptane.

Product Description:

SITAXA 25 :Pink colored, round shaped, biconvex, film coated tablets, plain on both sides.

SITAXA 50: Light beige colored, round shaped, biconvex, film coated tablets, plain on both sides.

SITAXA 100: Beige colored, round shaped, biconvex, film coated tablets, plain on both sides.

Excipients are Microcrystalline cellulose, Dibasic calcium phosphate anhydrous, Croscarmellose sodium, Sodium stearyl fumarate, Polyvinyl alcohol (partially hydrolyzed), Macrogol/PEG, Titanium dioxide, Talc, Red oxide of iron, yellow Oxide of iron.

8 Pharmaceutical particulars

8.1 Incompatibilities

Not applicable

8.2 Shelf-life

Do not use later than date of expiry.

8.3 Packaging information

SITAXA 25, 50 and 100 Tablets is available blister pack of 15 tablets

8.4 Storage and handing instructions

STORE AT A TEMPERATURE NOT EXCEEDING 30° C,
PROTECTED FROM MOISTURE.

9 Patient Counselling Information

Package leaflet: Information for the user

SITAXA

Sitagliptin Tablets I.P.

- 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 is in this leaflet

9.1 What Sitagliptin and what it is used for

9.2 What you need to know before you take Sitagliptin

9.3 How to take Sitagliptin

9.4 Possible side effects

9.5 How to store Sitagliptin

9.6 Contents of the pack and other information

9.1 What SITAXA is and what it is used for

SITAXA contains medicines called sitagliptin.

- SITAXA contains the active substance sitagliptin which is a member of a class of medicines called DPP-4 inhibitors (dipeptidyl peptidase-4 inhibitors) that lowers blood sugar levels in adult patients with type 2 diabetes mellitus.
- This medicine helps to increase the levels of insulin produced after a meal and decreases the amount of sugar made by the body.

- Your doctor has prescribed this medicine to help lower your blood sugar, which is too high because of your type 2 diabetes. This medicine can be used alone or in combination with certain other medicines (insulin, metformin, sulphonylureas, or glitazones) that lower blood sugar, which you may already be taking for your diabetes together with a food and exercise plan.

9.2 What you need to know before you take SITAXA

Do not take SITAXA:

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

Do not take SITAXA if the above apply to you and talk with your doctor about other ways of managing your diabetes. If you are not sure, talk to your doctor, pharmacist or nurse before taking Sitagliptin.

Warnings and precautions

Cases of inflammation of the pancreas (pancreatitis) have been reported in patients receiving SITAXA.

If you encounter blistering of the skin it may be a sign for a condition called bullous pemphigoid.

Your doctor may ask you to stop SITAXA.

Tell your doctor if you have or have had:

- a disease of the pancreas (such as pancreatitis)
- gallstones, alcohol dependence or very high levels of triglycerides (a form of fat) in your blood.

These medical conditions can increase your chance of getting pancreatitis.

- type 1 diabetes
- diabetic ketoacidosis (a complication of diabetes with high blood sugar, rapid weight loss,
- nausea or vomiting)
- any past or present kidney problems
- an allergic reaction to SITAXA

This medicine is unlikely to cause low blood sugar because it does not work when your blood sugar is low. However, when this medicine is used in combination with a sulphonylurea medicine or with insulin, low blood sugar (hypoglycaemia) can occur. Your doctor may reduce the dose of your sulphonylurea or insulin medicine.

Children and adolescents

Children and adolescents below 18 years should not use this medicine. It is not effective in children and adolescents between the ages of 10 and 17 years. It is not known if this medicine is safe and effective when used in children younger than 10 years.

Other medicines and SITAXA

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

In particular, tell your doctor if you are taking digoxin (a medicine used to treat irregular heartbeat and other heart problems). The level of digoxin in your blood may need to be checked if taking with SITAXA.

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 not take this medicine during pregnancy.

It is not known if this medicine passes into breast milk. You should not take this medicine if you are breast-feeding or plan to breast-feed.

Driving and using machines

This medicine has no or negligible influence on the ability to drive and use machines.

However, dizziness and drowsiness have been reported, which may affect your ability to drive or use machines.

Taking this medicine in combination with medicines called sulphonylureas or with insulin can cause hypoglycaemia, which may affect your ability to drive and use machines or work without safe foothold.

9.3 How to take SITAXA

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

The usual recommended dose is:

- one 100 mg film-coated tablet
- once a day
- by mouth

If you have kidney problems, your doctor may prescribe lower doses (such as 25 mg or 50 mg).

You can take this medicine with or without food and drink.

Your doctor may prescribe this medicine alone or with certain other medicines that lower blood sugar.

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

If you take more SITAXA than you should

If you take more than the prescribed dosage of this medicine, contact your doctor immediately.

If you forget to take SITAXA

If you miss a dose, take it as soon as you remember. If you do not remember until it is time for your next dose, skip the missed dose and go back to your regular schedule. Do not take a double dose of this medicine.

If you stop taking SITAXA

Continue to take this medicine as long as your doctor prescribes it so you can continue to help control your blood sugar. You should not stop taking this medicine without talking to your doctor first.

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

9.4 Possible side effects

Like all medicines, this medicine can cause side effects, although not everybody gets them.

STOP taking SITAXA and contact a doctor immediately if you notice any of the following serious side effects:

- Severe and persistent pain in the abdomen (stomach area) which might reach through to your back with or without nausea and vomiting, as these could be signs of an inflamed pancreas (pancreatitis).

If you have a serious allergic reaction (frequency not known), including rash, hives, blisters on the skin/peeling skin and swelling of the face, lips, tongue, and throat that may cause difficulty in breathing or swallowing, stop taking this medicine and call your doctor right away. Your doctor may prescribe a medicine to treat your allergic reaction and a different medicine for your diabetes.

Some patients taking metformin have experienced the following side effects after starting sitagliptin:

Common (may affect up to 1 in 10 people): low blood sugar, nausea, flatulence, vomiting

Uncommon (may affect up to 1 in 100 people): stomachache, diarrhoea, constipation, drowsiness.

Some patients have experienced diarrhoea, nausea, flatulence, constipation, stomachache or vomiting when starting the combination of Sitagliptin and metformin together (frequency is common).

Some patients have experienced the following side effects while taking this medicine with a sulphonylurea such as glimepiride:

Very common (may affect more than 1 in 10 people): low blood sugar

Common: constipation

Some patients have experienced the following side effects while taking this medicine in combination with pioglitazone:

Common: swelling of the hands or legs

Some patients have experienced the following side effects while taking this medicine in combination with insulin:

Very common: low blood sugar

Uncommon: dry mouth, headache

Some patients have experienced the following side effects during clinical studies while taking sitagliptin alone (one of the medicines in Sitagliptin and metformin) or during post-approval use of Sitagliptin and metformin or sitagliptin alone or with other diabetes medicines:

Common: low blood sugar, headache, upper respiratory infection, stuffy or runny nose and sore throat, osteoarthritis, arm or leg pain

Uncommon: dizziness, constipation, itching

Rare: reduced number of platelets

Frequency not known: kidney problems (sometimes requiring dialysis), vomiting, joint pain, muscle pain, back pain, interstitial lung disease, bullous pemphigoid (a type of skin blister).

9.5 How to store SITAXA

STORE AT A TEMPERATURE NOT EXCEEDING 30° C, PROTECTED FROM MOISTURE.

9.6 Contents of the pack and other information

What SITAXA contains

- The active substances are Sitagliptin.
- **Excipients of SITAXA 25/50/500mg are** Microcrystalline cellulose, Dibasic calcium phosphate anhydrous, Croscarmellose sodium, Sodium stearyl fumarate ,Polyvinyl alcohol (partially hydrolyzed), Macrogol/PEG, Titanium dioxide, Talc, Red oxide of iron, yellow Oxide of iron.

What SITAXA looks like and contents of the pack

SITAXA 25, 50 and 100 Tablets is available blister pack of 15 tablets.

10 Details of manufacturer

Torrent Pharmaceuticals Ltd.
32 No, Middle Camp, NH-10,
East District, Gangtok, Sikkim-737 135.

11 Details of permission or licence number with date

M/563/2010 dated 02.03.2022

12. Date of revision

MAR 2022

MARKETED BY



TORRENT PHARMACEUTICALS LTD.

IN/SITAGLIPTIN 25/ 50/ 100 mg /MAR-22/01/PI