

SUMMARY OF PRODUCT CHARACTERISTICS

1. Name of the medicinal product

Strength : 50

INN Name: GLIPINN 50 (Sitagliptin Tablets USP 50 mg)

2. Qualitative and quantitative composition

Each film coated tablet contains :

Sitagliptin Phosphate Monohydrate USP

Equivalent to Sitagliptin 50 mg

Excipients q.s

3. Pharmaceutical form :

Dosage Form : Tablet

Description :

White coloured, round shaped, biconvex, film coated tablet plain on both sides.

4. Clinical Particulars

4.1 Therapeutic indications

For adult patients with type 2 diabetes mellitus, Sitagliptin Tablet is indicated to improve glycaemic control:

as monotherapy:

- in patients inadequately controlled by diet and exercise alone and for whom metformin is inappropriate due to contraindications or intolerance.

as dual oral therapy in combination with:

- metformin when diet and exercise plus metformin alone do not provide adequate glycaemic control.
- a sulphonylurea when diet and exercise plus maximal tolerated dose of a sulphonylurea alone do not provide adequate glycaemic control and when metformin is inappropriate due to contraindications or intolerance.

- a peroxisome proliferator-activated receptor gamma (PPAR γ) agonist (i.e. a thiazolidinedione) when use of a PPAR γ agonist is appropriate and when diet and exercise plus the PPAR γ agonist alone do not provide adequate glycaemic control.

as triple oral therapy in combination with:

- a sulphonylurea and metformin when diet and exercise plus dual therapy with these medicinal products do not provide adequate glycaemic control.
- a PPAR γ agonist and metformin when use of a PPAR γ agonist is appropriate and when diet and exercise plus dual therapy with these medicinal products do not provide adequate glycaemic control.

Sitagliptin Tablet is also indicated as add-on to insulin (with or without metformin) when diet and exercise plus stable dose of insulin do not provide adequate glycaemic control.

4.2 Posology and method of administration

Posology

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 Tablet administered concomitantly.

When Sitagliptin Tablet 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 Tablet 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 Tablet 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 Tablet 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 Tablet and periodically thereafter.

Hepatic impairment

No dose adjustment is necessary for patients with mild to moderate hepatic impairment. Sitagliptin Tablet 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.

4.3 Method of administration

Method of administration

Sitagliptin Tablet can be taken with or without food.

4.4 Contraindications

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

4.5 Special warning & precautions for use

General

Sitagliptin Tablet 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 Tablet and

other potentially suspect medicinal products should be discontinued; if acute pancreatitis is confirmed, Sitagliptin Tablet 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

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 some reports occurring after the first dose. If a hypersensitivity reaction is suspected, Sitagliptin Tablet should be discontinued. Other potential causes for the event should be assessed, and alternative treatment for diabetes initiated.

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 Tablet should be discontinued.

4.6 Interaction with other medicinal products and other forms of interactions

Effects of other medicinal products on sitagliptin

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.

4.7 Pregnancy and lactation

Pregnancy

There are no adequate data from the use of sitagliptin in pregnant women. Due to lack of human data, Sitagliptin Tablet should not be used during pregnancy.

Breast-feeding

It is unknown whether sitagliptin is excreted in human breast milk. Sitagliptin Tablet should not be used during breast-feeding.

Fertility

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

4.8 Effects on ability to drive and use machine

Sitagliptin Tablet 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 Tablet is used in combination with a sulphonylurea or with insulin.

4.9 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 %).

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).

Table 1. 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

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.

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)).

4.10 Overdose

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 Pharmacodynamic Properties

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

Mechanism of action

Sitagliptin Tablet is a member of a class of oral anti-hyperglycaemic agents called dipeptidyl peptidase 4 (DPP-4) inhibitors. The improvement in glycaemic control observed with this medicinal product may be mediated by enhancing the levels of active incretin hormones. Incretin hormones, including glucagon-like peptide-1 (GLP-1) and glucose-dependent insulintropic polypeptide (GIP), are released by the intestine throughout the day, and levels are increased in response to a meal. 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 by intracellular signaling pathways involving cyclic AMP. Treatment with GLP-1 or with DPP-4 inhibitors in animal models of type 2 diabetes has been demonstrated to improve beta cell responsiveness to glucose and stimulate insulin biosynthesis and release. With higher insulin levels, tissue glucose uptake is enhanced. In addition, GLP-1 lowers glucagon secretion from pancreatic alpha cells. Decreased glucagon concentrations, along with higher insulin levels, lead to reduced hepatic glucose production, resulting in a decrease in blood glucose levels. The effects of GLP-1 and GIP are glucose-dependent such that when blood glucose concentrations are low, stimulation of insulin release and suppression of glucagon secretion by GLP-1 are not observed. For both GLP-1 and GIP, stimulation of insulin release is enhanced as glucose rises above normal concentrations. Further, GLP-1 does not impair the normal glucagon response to hypoglycaemia. The activity of GLP-1 and GIP is limited by the DPP-4 enzyme, which rapidly hydrolyzes the incretin hormones to produce inactive products. Sitagliptin prevents the hydrolysis of incretin hormones by DPP-4, thereby increasing plasma concentrations of the active forms of GLP-1 and GIP. By enhancing active incretin levels, sitagliptin increases insulin release and decreases glucagon levels in a glucose-dependent manner. In patients with type 2 diabetes with hyperglycaemia, these changes in insulin and glucagon levels lead to lower haemoglobin A_{1c} (HbA_{1c}) and lower fasting and postprandial glucose concentrations. The glucose-dependent mechanism of sitagliptin is distinct from the mechanism of sulphonylureas, which increase insulin secretion even when glucose levels are low and can lead to hypoglycaemia in patients with type 2 diabetes and in normal subjects. 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.

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.

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 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 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 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 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.

Table 2. HbA_{1c} results in placebo-controlled monotherapy and combination therapy studies*

Study	Mean baseline HbA_{1c} (%)	Mean change from baseline HbA_{1c} (%)[†]	Placebo-corrected mean change in HbA_{1c} (%)[†] (95 % CI)
Monotherapy Studies			
Sitagliptin 100 mg once daily [§] (N=193)	8.0	-0.5	-0.6 [‡] (-0.8, -0.4)
Sitagliptin 100 mg once daily [¶] (N=229)	8.0	-0.6	-0.8 [‡] (-1.0, -0.6)
Combination Therapy Studies			

Sitagliptin 100 mg once daily added to ongoing metformin therapy [%] (N=453)	8.0	-0.7	-0.7 [‡] (-0.8, -0.5)
Sitagliptin 100 mg once daily added to ongoing pioglitazone therapy [%] (N=163)	8.1	-0.9	-0.7 [‡] (-0.9, -0.5)
Sitagliptin 100 mg once daily added to ongoing glimepiride therapy [%] (N=102)	8.4	-0.3	-0.6 [‡] (-0.8, -0.3)
Sitagliptin 100 mg once daily added to ongoing glimepiride + metformin therapy [%] (N=115)	8.3	-0.6	-0.9 [‡] (-1.1, -0.7)
Sitagliptin 100 mg once daily added to ongoing pioglitazone + metformin therapy [#] (N=152)	8.8	-1.2	-0.7 [‡] (-1.0, -0.5)
Initial therapy (twice daily) [%] : Sitagliptin 50 mg + metformin 500 mg (N=183)	8.8	-1.4	-1.6 [‡] (-1.8, -1.3)
Initial therapy (twice daily) [%] : Sitagliptin 50 mg + metformin 1,000 mg (N=178)	8.8	-1.9	-2.1 [‡] (-2.3, -1.8)
Sitagliptin 100 mg once daily added to ongoing insulin (+/- metformin) therapy [%] (N=305)	8.7	-0.6 [¶]	-0.6 ^{‡,¶} (-0.7, -0.4)

* All Patients Treated Population (an intention-to-treat analysis).

† Least squares means adjusted for prior antihyperglycaemic therapy status and baseline value.

‡ p<0.001 compared to placebo or placebo + combination treatment.

§ HbA_{1c} (%) at week 18.

% HbA_{1c} (%) at week 24.

HbA_{1c} (%) at week 26.

¶ Least squares mean adjusted for metformin use at Visit 1 (yes/no), insulin use at Visit 1 (pre-mixed vs. non-pre-mixed [intermediate- or long-acting]), and baseline value. Treatment by stratum (metformin and insulin use) interactions were not significant ($p > 0.10$).

A 24-week active (metformin)-controlled 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 HbA_{1c} 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 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 HbA_{1c}. 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 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 HbA_{1c} 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 HbA_{1c} 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 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 HbA_{1c} 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 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 HbA_{1c} 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 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 HbA_{1c} (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.

The TECOS was a randomised study in 14,671 patients in the intention-to-treat population with an HbA_{1c} 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 HbA_{1c} 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 HbA_{1c} 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 .

Table 3. Rates of Composite Cardiovascular Outcomes and Key Secondary Outcomes

	Sitagliptin 100 mg		Placebo		Hazard Ratio (95% CI)	p-value [†]
	N (%)	Incidence rate per 100 patient-years*	N (%)	Incidence rate per 100 patient-years*		
Analysis in the Intention-to-Treat Population						
Number of patients	7,332		7,339			
Primary Composite Endpoint (Cardiovascular death, nonfatal myocardial infarction, nonfatal stroke, or hospitalisation for unstable angina)	839 (11.4)	4.1	851 (11.6)	4.2	0.98 (0.89–1.08)	<0.001
Secondary Composite Endpoint (Cardiovascular death, nonfatal myocardial infarction, or nonfatal stroke)	745 (10.2)	3.6	746 (10.2)	3.6	0.99 (0.89–1.10)	<0.001
Secondary Outcome						
Cardiovascular death	380 (5.2)	1.7	366 (5.0)	1.7	1.03 (0.89–1.19)	0.711
All myocardial infarction (fatal and non-fatal)	300 (4.1)	1.4	316 (4.3)	1.5	0.95 (0.81–1.11)	0.487

All stroke (fatal and non-fatal)	178 (2.4)	0.8	183 (2.5)	0.9	0.97 (0.79– 1.19)	0.760
Hospitalisation for unstable angina	116 (1.6)	0.5	129 (1.8)	0.6	0.90 (0.70– 1.16)	0.419
Death from any cause	547 (7.5)	2.5	537 (7.3)	2.5	1.01 (0.90– 1.14)	0.875
Hospitalisation for heart failure [‡]	228 (3.1)	1.1	229 (3.1)	1.1	1.00 (0.83– 1.20)	0.983

* Incidence rate per 100 patient-years is calculated as $100 \times$ (total number of patients with ≥ 1 event during eligible exposure period per total patient-years of follow-up).

[†] Based on a Cox model stratified by region. For composite endpoints, the p-values correspond to a test of non-inferiority seeking to show that the hazard ratio is less than 1.3. For all other endpoints, the p-values correspond to a test of differences in hazard rates.

[‡] The analysis of hospitalisation for heart failure was adjusted for a history of heart failure at baseline.

Paediatric population

A 54-week, double-blind 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).

5.2 Pharmacokinetic Properties

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 $\mu\text{M}\cdot\text{hr}$, 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 Tablet 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 $C_{24\text{hr}}$ (C_{\max} increased in a greater than dose-proportional manner and $C_{24\text{hr}}$ 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 isozymes 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.

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 in patients with ESRD on haemodialysis. Sitagliptin was modestly removed by haemodialysis (13.5 % over a 3- to 4-hour haemodialysis session starting 4 hours postdose). 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 .

Hepatic impairment

No dose adjustment for Sitagliptin Tablet 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. This is not considered to be a clinically meaningful difference compared to adult patients based on the flat PK/PD relationship between the dose of 50 mg and 100 mg. No studies with sitagliptin have been performed in paediatric patients with age $<$ 10 years.

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.

5.3 Preclinical safety data

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 adverse effects upon fertility were observed in male and female rats given sitagliptin prior to and throughout mating.

In a pre-/postnatal 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).

6. Pharmaceutical Particulars

6.1 List of Excipients

Anhydrous Dibasic Calcium Phosphate USP.

Crosscarmellose Sodium USP.

Microcrystalline Cellulose USP.

Sodium Stearyl Fumarate USP

Purified water USP

Sheffcoat PVA White (5Y00122) IH

Composition of Sheffcoat PVA white (5Y00122)

Ingredient	E#	CI#	CAS#
Polyvinyl Alcohol	E1203	---	9002-89-5
Polyethylene Glycol	E1521	---	25322-68-3
Talc	E553(b)	77019	14807-96-6
Titanium Dioxide	E171	77891	13463-67-7

6.2 Incompatibilities

Not Applicable

6.3 Shelf life

The shelf life of the medicinal product as package for sale

36 Months.

6.4 Special precaution for storage

Store below 30°C. Protect from light.

6.5 Nature and contents of container

Alu-PVC blister of 10 Tablets.

6.6 Special precautions for disposal and other handling

No special requirement.

7. Marketing Authorization Holder

Pinnacle Life Science Pvt. Ltd.

Mahendra Industrial Estate, Ground Floor

Plot no .109-D, Rd no 29

Sion (East), Mumbai 400 022, INDIA

8. Marketing Authorization Number :

08467/09677/NMR/2022

9. Manufacturer Name :

Pinnacle Life Science Pvt. Ltd.

Khasra No. 1328-1330, Village Manpura, Tehsil-Baddi,
Distt. Solan, Himachal Pradesh (H.P.) - 174101, India.

10. Date of first authorization/ renewal of the authorization

Mar 15, 2023

11. Date of the revision of the text
