

For the use only of registered medical practitioners or a hospital or a laboratory

Teneligliptin Tablets 20 mg

GLIZ™ TG

Composition:

Each film coated tablet contains:

Teneligliptin Hydrobromide Hydrate

Equivalent to Teneligliptin 20 mg

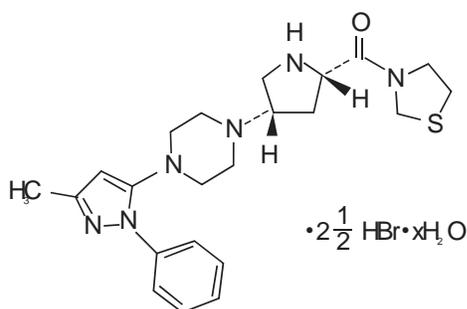
Excipients q.s.

Colours: Ferric Oxide Yellow USP-NF and Titanium Dioxide I.P.

DESCRIPTION

Teneligliptin is a DPP-4 inhibitor for treatment of type 2 diabetes mellitus (T2DM). It is chemically known as {(2S,4S)-4-[4-(3-Methyl-1-phenyl-1H-pyrazol-5-yl)piperazin-1-yl]pyrrolidin-2-yl}(1,3-thiazolidin-3-yl)methanonehydrobromide hydrate

Its structural formula is as follows:



It has the molecular formula $\text{C}_{22}\text{H}_{30}\text{N}_6\text{O}_5 \cdot 2\frac{1}{2}\text{HBr} \cdot x\text{H}_2\text{O}$. It is a white color powder. It is readily soluble in water, sparingly soluble in methanol, slightly insoluble in ethanol (99.5) and insoluble in acetonitrile.

DOSAGE FORM

Film-coated Tablet

CLINICAL PHARMACOLOGY

Mechanism of Action

The glucagon-like peptide-1 (GLP-1) is secreted from alimentary canal in response to meal that promotes insulin secretion from pancreas and regulates blood sugar post meal by controlling glucagon secretion. Teneligliptin exhibits a hypoglycemic effect by controlling the decomposition of GLP-1 by inhibiting dipeptidyl peptidase-4 (DPP-4) activity and thereby increasing blood concentration of active GLP-1.

DPP-4 inhibitory action and GLP-1 degradation inhibitory action

1. Teneligliptin inhibits concentration-dependent human plasma DPP-4 activity, and its IC_{50} value (95% confidence interval) was 1.75 (1.62 - 1.89) nmol/L (in vitro).
2. Teneligliptin concentration-dependently suppressed the degradation of GLP-1 in rat plasma, with IC_{50} values and its 95% CI being 2.92 nM [2.21, 3.87] (in vitro).
3. In the glucose tolerance test using Zucker Fatty rat, an obesity model showing insulin resistance and abnormal glucose tolerance, teneligliptin increased plasma active GLP-1 concentration and plasma insulin concentration by its single dose administration.
4. In patients having type 2 diabetes mellitus, the administration of 20 mg teneligliptin once daily inhibited the plasma DPP-4 activity and increased the plasma active GLP-1 concentration.

Glucose tolerance improvement action

1. In the glucose tolerance test using Zucker Fatty rat, an obesity model showing insulin resistance and abnormal glucose tolerance, teneligliptin controlled an increase in the blood sugar level by its single-dose administration
2. In patients having type 2 diabetes mellitus, the administration of 20 mg teneligliptin once daily improved the blood sugar after breakfast, lunch, and dinner and the fasting blood sugar

Clinical Study

In a double-blind, randomized, comparative study of 16 week treatment duration Tenelegliptin Tablets were compared with Placebo Tablets in the treatment of patients with type 2 diabetes mellitus inadequately controlled on diet and exercise alone. A total of 237 subjects (age of 48.9-49.6 years) were enrolled in the study and randomized to treatment with 158 patients in the Tenelegliptin Tablets group, and 79 patients Placebo Tablets group. All subjects were Asian (Indian) and 60.8% were male and 39.2% were female. There was a statistically significant difference ($p < 0.05$) for the primary end point, mean change in HbA1c from baseline to end of treatment in both ITT (change in HbA1c: 0.555) and PP (change in HbA1c: 0.642) population. There was also statistical significant difference ($p < 0.05$) for proportion of patients with HbA1c below 7% between Tenelegliptin and Placebo tablets in both PP (43.6%) and ITT (43.4%) population.

Pharmacokinetics

Plasma concentration:

(1) Single-dose administration:

The plasma concentration changes and the pharmacokinetic parameters of tenelegliptin after a single oral dose of 20 mg and 40 mg of tenelegliptin given empty stomach to the healthy adults are shown below.

Table 1: Pharmacokinetic parameters at the time of single - dose oral drug administration in healthy adults

Strengths	C _{max} (ng/mL)	AUC _{0-inf} (ng.hr/mL)	t _{max} (hr)	T _{1/2} (hr)
20 mg	187.20 ± 44.70	2028.9 ± 459.5	1.8 (1.0-2.0)	24.2 ± 5.0
40 mg	382.40 ± 89.83	3705.0 ± 787.0	1.0 (0.5 3.0)	20.8 ± 3.2

n=6, Mean Value ± SD

tmax = Central value (minimum value - maximum value)

2) Repeated dose administration:

The pharmacokinetic parameters of tenelegliptin after a repeated dose of 20 mg of tenelegliptin once daily for seven days given 30 minutes before breakfast to the healthy adults are shown below. It was thought that the state of equilibrium will be attained within seven days

Table 2: Pharmacokinetic parameters at the time of repeated - dose oral drug administration in healthy adults

	Cmax (ng/mL)	AUC _{0-24 hr} (ng.hr/mL)	AUC _{0-inf} (ng.hr/mL)	t _{max} (hr)	t _{1/2} (hr)
After first dose	160.60± 47.26	1057.2± 283.9	1627.9± 427.8	1.0 (0.4-2.0)	25.8± 4.9
7 days after administration	220.14± 59.86	1514.6± 370.5	2641.4± 594.7	1.0 (1.0-1.0)	30.2± 6.9

n=7, Mean Value ± SD

tmax = Central value (minimum value - maximum value)

(3) Food effect:

Cmax decreased after a single dose of 20 mg of tenelegliptin given post meal to the healthy adults as compared to empty stomach and tmax prolonged from 1.1 hr to 2.6 hr; however, no difference observed in AUC

Table 3: Pharmacokinetic parameters at the time of fasting and after food intake in healthy adults

	Cmax (ng/mL)	AUC _{0-24 hr} (ng.hr/mL)	AUC _{0-inf} (ng.hr/mL)	t _{max} (hr)	t _{1/2} (hr)
Empty Stomach	232. 2 (236.2± 43.77)	1855.5 (1861.1± 148.1)	2090.3 (2094.6± 138.5)	1.1± 0.4	26.5 (27.8± 9.3)
Post Meal	184.9 (187.5± 33.55)	1806 (1814.6± 183.3)	2044.0 (2056.1± 230.9)	2.6± 1.1	26.9 (28.3± 9.5)

n=14, Geometric mean (Arithmetic mean value ± Standard Deviation)

tmax = Arithmetic mean value ± Standard Deviation

Rate of protein binding:

The protein binding ratio was 77.6 to 82.2% when the [14C] label teneligliptin (20, 100, and 500 ng/mL) was added to the human plasma (in vitro).

Metabolism:

1) Following a single oral administration of 20 mg [14C] label teneligliptin to the healthy adults, the unaltered substance and the metabolites M1, M2, M3, M4, and M5 were observed in the blood plasma. Furthermore, the ratio of AUC_{0-∞} of teneligliptin, M1, M2, M3, M4, and M5 with respect to AUC_{0-∞} calculated from the plasma radioactive concentration up to 72 hours after administration was 71.1%, 14.7%, 1.3%, 1.3%, 0.3%, and 1.1%.

Mainly, CYP3A4 and flavin-containing monooxygenases (FMO1 and FMO3) participate in the metabolism of teneligliptin. Furthermore, although teneligliptin showed a weak inhibitory action towards CYP2D6, CYP3A4, and FMO (IC₅₀ value: 489.4, 197.5, and 467.2 μmol/L), it did not show inhibitory action towards CYP1A2, CYP2A6, CYP2B6, CYP2C8, CYP2C8/9, CYP2C19, and CYP2E1, and CYP1A2 and CYP3A4 were not introduced (in vitro).

Excretion:

1) When a single oral dose of 20 mg and 40 mg teneligliptin was given to the healthy adults on empty stomach, about 21.0 to 22.1% of dose was excreted as unaltered substance in urine, and the renal clearance was 37 to 39 mL/hr/kg.

2) When a single oral dose of 20 mg [14C] label teneligliptin was given to the healthy adults, 45.4% of dosage radioactivity was excreted in urine and 46.5% was excreted in feces up to 216 hours after administration. Furthermore, with respect to the dosage up to 120 hours after administration, the accumulated urinary excretion rate of unaltered substance, M1, M2, and M3 was 14.8%, 17.7%, 1.4%, and 1.9%, respectively and the accumulated feces excretion rate of unaltered substance, M1, M3, M4, and M5 was 26.1%, 4.0%, 1.6%, 0.3%, and 1.3%, respectively.

3) Teneligliptin is a substrate of P-glycoprotein that inhibited the transportation of digoxin up to 42.5% through P-glycoprotein in the concentration of 99 μmol/L. Furthermore, teneligliptin showed a weak inhibitory action towards the organic anion transporter OAT 3 appeared in kidney, (IC₅₀ value: 99.2 μmol/L); however, it did not show inhibitory action towards OAT 1 and organic cation transporter OCT2 (in vitro).

Renal dysfunction:

When a single oral dose of 20 mg teneligliptin was given to the renal dysfunction patients, no remarkable change was observed in C_{max} and t_{1/2} of teneligliptin depending on the extent/degree of renal dysfunction. On the other hand, in the mild renal dysfunction patient (C_{cr} ≥50 to ≥80 mL/min), moderate renal dysfunction patient (C_{cr} ≥30 to ≥50 mL/min), and severe renal dysfunction patient (C_{cr} <30 mL/min), the AUC_{0-∞} was found to be about 1.25 times, 1.68 times, and 1.49 times, respectively, as compared to the healthy adults, and AUC_{0-43hr} of terminal renal failure affected individual was about 1.16 times as compared to the healthy adults. Furthermore, 15.6% of teneligliptin dose was removed due to hemodialysis.

Liver dysfunction:

When a single oral dose of 20 mg teneligliptin was given to the hepatic dysfunction patients, the C_{max} of teneligliptin was found to be about 1.25 times and 1.38 times and AUC_{0-∞} was about 1.46 times and 1.59 times, respectively, in mild hepatic dysfunction patient (total score 5~6 by Child-Pugh classification) and moderate hepatic dysfunction patient (total score 7~9 by Child-Pugh classification) as compared to the healthy adults. There is no clinical experience in high degree hepatic dysfunction patient (total score more than 9 by Child-Pugh classification).

Pharmacokinetics in Elderly Patient:

When a single oral dose of 20 mg teneligliptin was given to the healthy elderly patients (≥65 years old ≤75 years old, 12 patients) and non-elderly patients (≥45 years old ≤65 years old, 12 patients) on empty stomach, the ratio (90% confidence interval) of geometric minimum mean-square value of elderly patient with C_{max}, AUC_{0-∞}, and t_{1/2} of non-elderly patient was almost similar, 1.006 (0.871- 1.163), 1.090 (0.975 - 1.218), and 1.054 (0.911-1.219), respectively.

INDICATIONS AND USAGE

For the treatment of Type 2 Diabetes Mellitus as a monotherapy adjunct to diet and exercise.

DOSAGE AND ADMINISTRATION

The usual adult dosage is 20 mg of teneligliptin administered orally once daily. If efficacy is insufficient, the dose may be increased up to 40 mg once daily while closely monitoring the clinical course.

Teneligliptin tablets are to be administered orally without regard to meal. Do not crush or chew tablets.

Special Populations

Pediatric Use

The safety of this product in low birth weight baby, newborn baby, infant, or little child has not been established. (No usage experience).

Geriatric Use

In general, elderly patients often have physiological hypofunction; and therefore, teneligliptin should be administered carefully.

Renal impairment

As determined from the pharmacokinetic characteristics of teneligliptin, the extent of increase in the exposure level of teneligliptin in patients with renal impairment will not pose any significant safety risk. Thus no dose adjustment is proposed in renal impaired patients.

Hepatic impairment

As determined from the pharmacokinetic characteristics of teneligliptin, the extent of increase in the exposure level of teneligliptin in patients with mild to moderate hepatic impairment will not pose any significant safety risk. Thus no dose adjustment is proposed in mild to moderate hepatic impaired patients. There was no clinical experience in severe degree hepatic dysfunction patient.

CONTRAINDICATIONS

Teneligliptin Tablets are contraindicated in patients with:

L Hypersensitivity to the drug or any of its components

L Severe ketosis, diabetic coma or pre-coma and also for immediate remedy in type 1 diabetes of hyperglycemias with infusion and insulin

L Severe trauma, before and after surgery and when the blood glucose level is controlled with insulin injection

WARNINGS & PRECAUTIONS

1 Careful Administration (this medicine should be carefully administered in the following patients):

1) Patient with severe hepatic dysfunction (as there is no usage experience and safety has not been established).

2) Acute pancreatitis has been observed in studies done outside Japan and since acute pancreatitis is also reported with similar molecules, it should not be used in patients with history of acute pancreatitis. In case a patient develops acute pancreatitis the drug should be withdrawn and immediate physician consultation should be done.

3) Patient with heart failure (NYHA class III~IV) (as there is no usage experience and safety has not been established.)

4) Co-administration of sulfonylurea medication or insulin formulation (Risk of hypoglycemia may increase).

5) Hypoglycemia may occur in patients with:

L Adrenal insufficiency

L Malnutrition, starved state, irregular dietary intake, insufficient dietary intake or hyposthenia

L Vigorous muscular movement

L Patient with excessive alcohol consumption

6) Patient with history of abdominal surgery or intestinal obstruction (intestinal obstruction might occur).

7) QT prolongation may occur in patients having arrhythmia such as severe bradycardia or having its history, patient having heart disease such as congestive heart failure, and patient having hypokalemia

2. Important Precautions:

1. The points regarding hypoglycemia and its coping strategy should be sufficiently explained to the patient when using this product. Particularly, when co-administered with sulfonylurea or insulin formulation, there is a possibility of higher risk of hypoglycemia. In order to reduce the risk of hypoglycemia caused by sulfonylurea or insulin formulation, consider decreasing the dose of sulfonylurea or insulin formulation when given in combination with teneligliptin.

2. Consider its application only to the patient diagnosed with Type 2 diabetes mellitus (T2DM). In addition to T2DM, pay attention to diseases having symptoms (such as renal glycosuria, thyroid dysfunction) similar to diabetes, such as abnormal glucose tolerance/positive urine sugar.

3. Consider the application of this product: in patients who have not sufficiently responded to diet and exercise therapy, which is a basic treatment for diabetes.

4. During administration of this product, regularly check the blood sugar, check the effect of the drug. In case, the drug effect is insufficient even after taking this product for 3 months, then change to other treatment.

5. During continuous administration, there are cases that do not need medication, cases where dose has to be reduced, and cases where there is no effect or inadequate response due to complications of patient's infestation and infections; and therefore, pay attention to dietary intake, blood sugar level, and presence of infections, as well as, always take care of selection of drugs, dosage, and whether to continue the drug.

6. Since there is a possibility that adverse reactions, such as QT prolongation, might occur, it is desirable to avoid the medication in the patients having QT prolongation or its history (such as hereditary QT prolongation syndrome) or the patients having history of Torsade's de pointes.

7. Since there is a risk of hypoglycemia, attention should be paid while administration of this drug to the patients who are engaged in car driving or working at heights.

8. In regards to the co-administration of this drug and insulin formulation, the efficacy and the safety have not been studied.

9. This drug and GLP-1 receptor agonist both have GLP-1 receptor mediated anti-hyperglycemic effect. No clinical trial results are available regarding concomitant use of both drugs; also, effectiveness and safety have not been confirmed.

(3) Other Precautions

1) In clinical trials done outside Japan, QT prolongation has been reported when 160 mg of this product was administered once daily. (Approved dose of this product: The usual dosage is 20 mg of teneligliptin once daily, and the maximum dose is 40 mg once daily). When a repeated oral dose of 40 mg or 160 mg teneligliptin once daily to the healthy adults for four days, the maximum mean value (and 90% confidence interval upper limit) of placebo-corrected QTcI (QTc corrected per individual) interval change was 3.9 (7.6) msec at 3 hours after dosing completion in 40 mg group and 9.3 (13.0) msec at 1.5 hours after dosing completion in 160 mg group).

2) In 52-week repeated oral administration toxicity test using cynomolgus monkey, the cutaneous symptoms, such as superficial abrasion, scab, or ulcer, were observed on the tail, extremities, and auricles with the dose of 75mg/kg/ day. AUC_{0-24hr} in this case reached to around 45 times when 40 mg/day was administered to humans. Note that the same toxicity findings have not been reported in other animal species (rats, mice, and rabbits) and humans.

3) There have been postmarketing reports of severe and disabling arthralgia in patients taking DPP-4 inhibitors. The time to onset of symptoms following initiation of drug therapy varied from one day to years. Patients experienced relief of symptoms upon discontinuation of the medication. A subset of patients experienced a recurrence of symptoms when restarting the same drug or a different DPP-4 inhibitor. Consider DPP-4 inhibitors as a possible cause for severe joint pain and discontinue drug if appropriate.

Use during Pregnancy, Delivery, or Lactation

The safety of this product in pregnant women has not been established. Teneligliptin should be used in pregnant women or in women who may possibly be pregnant only if the expected therapeutic benefits outweigh the possible risks associated with treatment. (The safety of this product in pregnant women has not been established. Furthermore, the transfer to embryo in animal studies (rats) has been reported.)

Breast-feeding must be discontinued during administration of this product in lactating women (transfer to milk in animal studies (rats) has been reported.)

CARCINOGENESIS, MUTAGENESIS, AND IMPAIRMENT OF FERTILITY

Teneligliptin was non carcinogenic in rats and mice carcinogenicity assays. In 104-Week oral carcinogenicity assay in rats, the NOAEL was 75 mg/kg/day in males and 100 mg/kg/day in females [18 and 24 times, respectively the maximum clinical daily dose (40 mg/day) on a mg/m² basis] for neoplastic changes. In a 26-Week oral carcinogenicity assay in CB6F1-TgrasH2 mice, the NOAEL was 600 mg/kg/day (73 times the maximum clinical daily dose on a mg/m² basis) for neoplastic changes.

Teneligliptin was not genotoxic in various in vitro (bacterial reverse mutation tests, unscheduled DNA synthesis test in liver cells and chromosomal aberration test with cultured mammalian cells) and in vivo (bone marrow micronucleus tests in rats) genotoxicity assays. Teneligliptin showed effects on fertility of both male (low epididymal weight, low number of sperms in the epididymal tail, and high percentage of abnormal sperms) and female (low number of implantation and live fetuses and high rate of early embryonic death) rats. In male and female rats the NOAEL was 70 and 100 mg/kg/day (17 and 24 times, respectively the maximum clinical daily dose on a mg/m² basis), respectively for reproductive function, and early embryogenesis. Teneligliptin did not show teratogenic effects in rats and rabbits. The NOAEL of 30 mg/kg/day (7 and 15 times, respectively the maximum clinical daily dose on a mg/m² basis) was determined for embryo-fetal development in

both rats and rabbits. In pre- and post-natal developmental study in rats, except for a decrease in food consumption (maternal animals) and body weight gain (F1 pups) no other effects were noted at the highest 100 mg/kg/day. The NOAEL was 30 mg/kg/day (7 times the maximum clinical daily dose on a mg/m² basis).

DRUG INTERACTIONS

Table 4: Precautions for Coadministration with certain drugs

Drug name and other details	Clinical symptoms and treatment methods	Mechanism and Risk factors
Medicines for diabetic disease: - Drugs for diabetes Sulfonylurea fast-acting insulin secretagogue α -glucosidase inhibitor Biguanide drugs Thiazolidinediones GLP-1 analog preparation SGLT2 inhibitor Insulin preparation	Since hypoglycemia might occur, these drugs should be administered while carefully monitoring the patient's condition. Particularly, when co-administered with sulfonylurea or insulin formulation, there is a possibility of higher risk of hypoglycemia. In order to reduce the risk of hypoglycemia caused by sulfonylurea or insulin formulation, consider decreasing the quantity of sulfonylurea or insulin formulation. When hypoglycemia is observed, usually, cane sugar should be given, and when co-administered with α -glucosidase inhibitor, glucose should be given	Hypoglycemic action is increased.
Drugs increasing hypoglycemic action β -blocking agents Salicylic acid drugs Monoamine oxidase inhibitor	Since the blood sugar may further decrease, these drugs should be administered while carefully observing the patient's condition in addition to blood sugar level.	Hypoglycemic action is increased.
Drugs decreasing hypoglycemic action -Adrenaline -Adrenocortical hormone -Thyroid hormone	Since the blood sugar may increase, these drugs should be administered while carefully observing the patient's condition in addition to blood sugar level.	Hypoglycemic action is decreased.
Drugs known to cause QT prolongation -Class IA anti arrhythmic drugs: Quinidine sulfate hydrate, procainamide hydrochloride -Class III antiarrhythmic drugs: amiodarone hydrochloride, sotalol hydrochloride	QT prolongation might occur.	QT prolongation is seen with single administration of these drugs.

(1) Glimepiride combination:

When a repeated dose of 1 mg glimepiride for four days and a single combined dose (2nd day of glimepiride administration) of 40 mg teneligliptin were administered to the healthy adults (16), the ratio (90% confidence interval) of C_{max} of teneligliptin and AUC_{0-∞} geometric mean value was 0.971 (0.866- 1.088) and 0.926 (0.894 - 0.959) with respect to single-dose administration of teneligliptin alone. Furthermore, when a repeated-dose of 40 mg teneligliptin for seven days and a single combined dose (7th day of teneligliptin administration) of 1 mg glimepiride were administered to the healthy adults, the ratio (90% confidence interval) of C_{max} of glimepiride and AUC_{0-∞} geometric mean value was 1.016 (0.932 - 1.106) and 1.023 (0.978 -1.071) with respect to single-dose administration of glimepiride alone).

(2) Pioglitazone combination:

When a repeated dose of 30 mg pioglitazone for nine days and a single combined dose (7th day of pioglitazone administration) of 40 mg teneligliptin were administered to the healthy adults, the ratio (90% confidence interval) of C_{max} of teneligliptin and AUC_{0-∞} geometric mean value was 1.117 (0.984 -1.266) and 1.005 (0.967 - 1.045) with respect to single-dose administration of teneligliptin alone, and the C_{max} of teneligliptin increased 11.7% due to co-administration. Furthermore, when a repeated-dose of 40 mg teneligliptin for nine days and a single combined dose (7th day of teneligliptin administration) of 30 mg pioglitazone were administered to the healthy adults, the ratio (90% confidence interval) of C_{max} of pioglitazone and AUC_{0-∞} geometric mean value was 1.004 (0.917 - 1.100) and 1.134 (1.060 - 1.213) with respect to single-dose administration of pioglitazone alone. Similarly, the ratio (90% confidence interval) of C_{max} of active metabolites (M-III and M-IV) of pioglitazone and AUC_{0-∞} geometric mean value was 1.041 (0.975 -1.113) and 1.116 (1.056 - 1.180) in M-III and 1.028 (0.963 - 1.096) and 1.088 (1.032 - 1.147) in M-IV).

(3) Metformin combination:

When a repeated dose of 40 mg teneligliptin once daily for eight days and a repeated combined dose (6 to 8th day of teneligliptin administration) of 850 mg metformin twice daily were administered to the healthy adults, the ratio (90% confidence interval) of C_{max} of teneligliptin and AUC_{0-24hr} geometric minimum mean-square value was 0.907 (0.853 - 0.965) and 1.042 (0.997 - 1.089) with respect to repeated-dose administration of teneligliptin only. Furthermore, when a repeated combined dose (4th to 8th day of metformin administration) of 850 mg metformin twice daily for eight days and 40 mg teneligliptin once daily was administered to the healthy adults, the ratio (90% confidence interval) of C_{max} of metformin and AUC_{0-12hr} geometric minimum mean-square value was 1.057 (0.974 - 1.148) and 1.209 (1.143 - 1.278) with respect to repeated-dose administration of metformin only, and the AUC_{0-12hr} of metformin increased 20.9% due to coadministration).

(4) Ketoconazole combination:

When a repeated dose of 400 mg ketoconazole for six days and a single combined dose (4th day of ketoconazole administration) of 20 mg teneligliptin were administered to the healthy adults (14), the ratio (90% confidence interval) of C_{max} of teneligliptin and AUC_{0-∞} geometric minimum mean-square value was 1.37 (1.25 - 1.50) and 1.49 (1.39 - 1.60) with respect to single-dose administration of teneligliptin alone, and it increased to 37% and 49% due to co-administration.

EFFECTS ON ABILITY TO DRIVE AND USE MACHINES

No studies on the effects on the ability to drive and use machines have been performed. However, patients should be alerted to the risk of hypoglycaemia especially when Teneligliptin co-administered with sulphonylurea and/or insulin.

ADVERSE REACTIONS

The following adverse drug reactions have been identified in the clinical trials on Teneligliptin.

In clinical trials conducted in Japan, 232 adverse reactions to this drug (including abnormal laboratory tests) were reported in 156 patients (9.5%) of total 1645 patients. The most frequently observed adverse reactions were hypoglycemia in 43 patients (2.6%) and constipation in 14 patients (0.9%).

Patients with Inadequate Glycemic Control on Diet and Exercise Alone

In a clinical study conducted in 237 Indian patients with Type 2 Diabetes Mellitus inadequately controlled on diet and exercise alone. A total of 158 patients were exposed to Teneligliptin Tablets for a mean duration of 106.7 days. Adverse events considered to be related to study medication were reported for 6/158 (3.8%) of patients in the Teneligliptin group. The most frequent individual adverse event was dizziness in Teneligliptin group (5/158) 3.2%, followed by headache in (5/158) 3.2%, diarrhea in (4/158) 2.5% and pyrexia in (4/158) 2.5%. An AE (cancer right pyriform fossa) leading to early

termination from the study was reported for 1/158(0.6%) of patients in the Teneagliptin group, this was unrelated to study drug. No SAE related to the study drug was reported during the study. Most of the adverse events were mild in severity.

(1) Significant adverse reactions:

a) Hypoglycemia: Hypoglycemia may occur when co-administered with other drugs for diabetes (in combination with glimepiride: 8.9%, in combination with pioglitazone: 1.5%, in combination with glinides: 3.8%, in combination with biguanide: 1.1%, and in combination with α -glucosidase inhibitor: 1.3%). Particularly, a severe hypoglycemia is noted when co-administered with other DPP-4 inhibitors, sulfonylurea, and also the cases with loss of consciousness are reported; and therefore, consider decreasing the quantity of sulfonylurea when co-administered with sulfonylurea. Furthermore, hypoglycemia (1.1%) is also reported when not co-administered with other drugs for diabetes. In case hypoglycemia is observed, appropriate measures must be taken such as intake of carbohydrate containing food.

b) Intestinal Obstruction (0.1%): Intestinal obstruction may occur; and therefore, the patient should be carefully monitored. If any abnormal findings, such as severe constipation, abdominal swelling, continuous abdominal pain, and vomiting, are observed, administration should be discontinued and appropriate measures must be taken.

c) Liver dysfunction (unknown frequency): Liver dysfunction occurs with increase in AST (SGOT), ALT (SGPT); and therefore, appropriate measures such as performing sufficient monitoring of these parameters should be taken. Discontinue teneagliptin if abnormalities are observed.

d) Interstitial pneumonia (frequency unknown): Interstitial pneumonia may occur. If coughing, breathing difficulty, onset of fever, and abnormal chest sounds (crepitation) are noticed, the examinations such as chest X-ray, chest CT, and serum maker should be carried out. In case interstitial pneumonia is suspected, the appropriate measures like discontinuation of administration and administration of adrenocortical hormone should be taken

Other adverse reactions/side effects:

If adverse reactions are observed, the drug administration should be discontinued and appropriate measures should be taken.

Table 5: Other Adverse reactions

Incidence/Types	0.1% ~ 1%	< 0.1%
Digestive system	Constipation, abdominal swelling, abdominal discomfort, nausea, stomach ache, flatulence, stomatitis, gastric polyp, colon polyp, duodenal ulcer, reflux esophagitis, diarrhea, anorexia, increased amylase, increased lipase, acute pancreatitis	
Liver	Increased AST (GOT), increased A L T (GPT), and increased γ -GTP	Rise in AI-P
Kidney and urinary system	Albuminuria, positive ketone body in urine	
Skin	Eczema, Wet rash, pruritus, allergic dermatitis	
Others	Increased CK (CPK), increased serum potassium, fatigue, allergic rhinitis, and increased serum uric acid	

OVERDOSAGE

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.

STORAGE: Store below 25OC away from direct sunlight, heat and moisture.

Keep all medicines out of reach of children.

PRESENTATION

10 Tablets in Alu-Alu blister pack.

Manufactured in India by:
Windlas Biotech Private Limited
(Plant-2), Khasra No. 141 to 143 & 145,
Mohabewal Indl. Area, Dehradun - 248 110 (U.K.)
R.O.: 40/1, Mohabewal Indl. Area, Dehradun.



Marketed by:
Makers Laboratories Ltd.
Regd. Off.: 54-D, Kandivli Ind. Estate,
Mumbai - 400 067

TM : Trademark