

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use KAZANO safely and effectively. See full prescribing information for KAZANO.

KAZANO (alogliptin and metformin HCl) tablets for oral administration

Initial U.S. Approval: 2013

WARNING: LACTIC ACIDOSIS

See full prescribing information for complete boxed warning

- Lactic acidosis can occur due to metformin accumulation. The risk increases with conditions such as sepsis, dehydration, excess alcohol intake, hepatic impairment, renal impairment, and acute congestive heart failure. (5.1)
- Symptoms include malaise, myalgias, respiratory distress, increasing somnolence, and nonspecific abdominal distress. Laboratory abnormalities include low pH, increased anion gap and elevated blood lactate. (5.1)
- If acidosis is suspected, discontinue KAZANO and hospitalize the patient immediately. (5.1)

INDICATIONS AND USAGE

KAZANO is a dipeptidyl-peptidase-4 (DPP-4) inhibitor and a biguanide combination product indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus. (1.1)

Important Limitation of Use: Not for treatment of type 1 diabetes or diabetic ketoacidosis. (1.2)

DOSAGE AND ADMINISTRATION

- Individualize the starting dose of KAZANO based on the patient's current regimen. (2.1)
- KAZANO should be taken twice daily with food. (2.1)
- May adjust the dosing based on effectiveness and tolerability, while not exceeding the maximum recommended daily dose of 25 mg alogliptin and 2000 mg metformin HCl. (2.1)

DOSAGE FORMS AND STRENGTHS

Tablets: 12.5 mg alogliptin and 500 mg metformin HCl, 12.5 mg alogliptin and 1000 mg metformin HCl. (3)

CONTRAINDICATIONS

- Renal impairment. (4, 5.5)
- Metabolic acidosis, including diabetic ketoacidosis. (4, 5.1)
- History of a serious hypersensitivity reaction to alogliptin or metformin, components of KAZANO, such as anaphylaxis, angioedema or severe cutaneous adverse reactions. (4)

WARNINGS AND PRECAUTIONS

- Lactic acidosis: Warn against excessive alcohol intake. KAZANO is not recommended in hepatic impairment and is contraindicated in renal impairment. Ensure normal renal function before initiating and at least annually thereafter. (5.1)

- Acute pancreatitis: There have been postmarketing reports of acute pancreatitis. If pancreatitis is suspected, promptly discontinue KAZANO. (5.2)
- Hypersensitivity: There have been postmarketing reports of serious hypersensitivity reactions in patients treated with alogliptin such as anaphylaxis, angioedema and severe cutaneous adverse reactions. In such cases, promptly discontinue KAZANO, assess for other potential causes, institute appropriate monitoring and treatment, and initiate alternative treatment for diabetes. (5.3)
- Hepatic effects: Postmarketing reports of hepatic failure, sometimes fatal. Causality cannot be excluded. If liver injury is detected, promptly interrupt KAZANO and assess patient for probable cause, then treat cause if possible, to resolution or stabilization. Do not restart KAZANO if liver injury is confirmed and no alternative etiology can be found. (5.4)
- Temporarily discontinue in patients undergoing radiologic studies with intravascular administration of iodinated contrast materials or any surgical procedures necessitating restricted intake of food and fluids. (5.5)
- Vitamin B12 deficiency: Metformin may lower Vitamin B12 levels. Monitor hematologic parameters annually. (5.8)
- Hypoglycemia: When used with an insulin secretagogue (e.g., sulfonyleurea) or with insulin, a lower dose of the insulin secretagogue or insulin may be required to reduce the risk of hypoglycemia. (5.9)
- Macrovascular outcomes: There have been no clinical studies establishing conclusive evidence of macrovascular risk reduction with KAZANO or any other antidiabetic drug. (5.10)

ADVERSE REACTIONS

Common adverse reactions reported in $\geq 4\%$ of patients treated with coadministration of alogliptin with metformin were: upper respiratory tract infection, nasopharyngitis, diarrhea, hypertension, headache, back pain and urinary tract infection. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Takeda Pharmaceuticals at 1-877-TAKEDA-7 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DRUG INTERACTIONS

Cationic drugs eliminated by renal tubular secretion: Use with caution. (7.2)

USE IN SPECIFIC POPULATIONS

- Pregnancy Category B: There are no adequate and well-controlled studies in pregnant women. (8.1)
- Pediatrics: Safety and effectiveness of KAZANO in patients below the age of 18 have not been established. (8.4)
- Geriatric Use: Caution should be used when prescribing KAZANO to elderly patients because reduced renal functions are associated with increasing age. (8.5)

See 17 for PATIENT COUNSELING INFORMATION and Medication Guide

Revised: 01/2013

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FULL PRESCRIBING INFORMATION

WARNING: LACTIC ACIDOSIS

- Lactic acidosis is a rare, but serious complication that can occur due to metformin accumulation. The risk increases with conditions such as sepsis, dehydration, excess alcohol intake, hepatic impairment, renal impairment, and acute congestive heart failure [see *Warnings and Precautions (5.1)*].
- The onset is often subtle, accompanied only by nonspecific symptoms such as malaise, myalgias, respiratory distress, increasing somnolence, and nonspecific abdominal distress. Laboratory abnormalities include low pH, increased anion gap and elevated blood lactate. [see *Warnings and Precautions (5.1)*]
- If acidosis is suspected, KAZANO (alogliptin and metformin HCl) should be discontinued and the patient hospitalized immediately. [see *Warnings and Precautions (5.1)*]

1 INDICATIONS AND USAGE

1.1 Monotherapy and Combination Therapy

KAZANO is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus in multiple clinical settings when treatment with both alogliptin and metformin is appropriate [see *Clinical Studies (14)*].

1.2 Limitation of Use

KAZANO should not be used in patients with type 1 diabetes mellitus or for the treatment of diabetic ketoacidosis, as it would not be effective in these settings.

2 DOSAGE AND ADMINISTRATION

2.1 Recommendations for All Patients

- Health care providers should individualize the starting dose of KAZANO based on the patient's current regimen.
- KAZANO should be taken twice daily with food with gradual dose escalation to reduce the gastrointestinal (GI) side effects due to metformin. KAZANO tablets must not be split before swallowing.
- Dosing may be adjusted based on effectiveness and tolerability while not exceeding the maximum recommended daily dose of 25 mg alogliptin and 2000 mg metformin HCl.
- The following doses are available:
 - 12.5 mg alogliptin and 500 mg metformin HCl
 - 12.5 mg alogliptin and 1000 mg metformin HCl

22 3 DOSAGE FORMS AND STRENGTHS

- 23 • 12.5 mg/500 mg tablets are pale yellow, oblong, film-coated tablets with “12.5/500”
24 debossed on one side and “322M” debossed on the other side
- 25 • 12.5 mg/1000 mg tablets are pale yellow, oblong, film-coated tablets with
26 “12.5/1000” debossed on one side and “322M” debossed on the other side

27 4 CONTRAINDICATIONS

28 KAZANO is contraindicated in patients with:

- 29 • Renal impairment (e.g., serum creatinine levels ≥ 1.5 mg/dL for men, ≥ 1.4 mg/dL for
30 women or abnormal creatinine clearance) which may also result from conditions
31 such as cardiovascular collapse (shock), acute myocardial infarction, and septicemia
32 [*see Warnings and Precautions (5.5)*].
- 33 • Acute or chronic metabolic acidosis, including diabetic ketoacidosis. Diabetic
34 ketoacidosis should be treated with insulin.
- 35 • History of a serious hypersensitivity reaction to alogliptin or metformin, components
36 of KAZANO, such as anaphylaxis, angioedema or severe cutaneous adverse
37 reactions.

38 5 WARNINGS AND PRECAUTIONS

39 5.1 Lactic Acidosis

40 Lactic acidosis is a rare, but serious, metabolic complication that can occur due to
41 metformin accumulation during treatment with KAZANO and is fatal in approximately
42 50% of cases. Lactic acidosis may also occur in association with a number of
43 pathophysiologic conditions, including diabetes mellitus, and whenever there is
44 significant tissue hypoperfusion and hypoxemia. Lactic acidosis is characterized by
45 elevated blood lactate levels (>5 mmol/L), decreased blood pH, electrolyte disturbances
46 with an increased anion gap, and an increased lactate/pyruvate ratio. When metformin
47 is implicated as the cause of lactic acidosis, metformin plasma levels >5 mcg/mL are
48 generally found.

49 The reported incidence of lactic acidosis in patients receiving metformin HCl is very low
50 (approximately 0.03 cases/1000 patient years, with approximately 0.015 fatal
51 cases/1000 patient years). In more than 20,000 patient years exposure to metformin in
52 clinical trials, there were no reports of lactic acidosis. Reported cases have occurred
53 primarily in diabetic patients with significant renal impairment, including both intrinsic
54 renal disease and renal hypoperfusion, often in the setting of multiple concomitant
55 medical/surgical problems and multiple concomitant medications. Patients with
56 congestive heart failure requiring pharmacologic management, particularly when
57 accompanied by hypoperfusion and hypoxemia due to unstable or acute failure, are at
58 increased risk of lactic acidosis. The risk of lactic acidosis increases with the degree of
59 renal dysfunction and the patient's age. The risk of lactic acidosis may, therefore, be
60 significantly decreased by regular monitoring of renal function in patients taking
61 metformin. In particular, treatment of the elderly should be accompanied by careful
62 monitoring of renal function. Metformin treatment should not be initiated in any patients

63 unless measurement of creatinine clearance demonstrates that renal function is not
64 reduced, as these patients are more susceptible to developing lactic acidosis. In
65 addition, metformin should be promptly withheld in the presence of any condition
66 associated with hypoxemia, dehydration, or sepsis. Because impaired hepatic function
67 may significantly limit the ability to clear lactate, metformin should generally be avoided
68 in patients with clinical or laboratory evidence of hepatic impairment. Patients should be
69 cautioned against excessive alcohol intake when taking metformin, because alcohol
70 potentiates the effects of metformin on lactate metabolism. In addition, metformin
71 should be temporarily discontinued prior to any intravascular radiocontrast study and for
72 any surgical procedure necessitating restricted intake of food or fluids. Use of
73 topiramate, a carbonic anhydrase inhibitor, in epilepsy and migraine prophylaxis may
74 frequently cause dose-dependent metabolic acidosis (In controlled trials, 32% and 67%
75 for adjunctive treatment in adults and pediatric patients, respectively, and 15 to 25% for
76 monotherapy of epilepsy, with decrease in serum bicarbonate to less than 20 mEq/L;
77 3% and 11% for adjunctive treatment in adults and pediatric patients, respectively, and 1
78 to 7% for monotherapy of epilepsy, with decrease in serum bicarbonate to less than 17
79 mEq/L) and may exacerbate the risk of metformin-induced lactic acidosis [see *Drug*
80 *Interactions (7.1) and Clinical Pharmacology (12.3)*].

81 The onset of lactic acidosis often is subtle, and accompanied only by nonspecific
82 symptoms such as malaise, myalgias, respiratory distress, increasing somnolence, and
83 nonspecific abdominal distress. There may be associated hypothermia, hypotension,
84 and resistant bradyarrhythmias with more marked acidosis.

85 Patients should be educated to promptly report these symptoms should they occur. If
86 present, KAZANO should be withdrawn until lactic acidosis is ruled out. Serum
87 electrolytes, ketones, blood glucose, blood pH, lactate levels, and blood metformin
88 levels may be useful. Once a patient is stabilized on any dose level of metformin,
89 gastrointestinal symptoms, which are common during initiation of therapy, are unlikely to
90 recur. Later occurrence of gastrointestinal symptoms could be due to lactic acidosis or
91 other serious disease.

92 Levels of fasting venous plasma lactate above the upper limit of normal but less than
93 5 mmol/L in patients taking metformin do not necessarily indicate impending lactic
94 acidosis and may be explainable by other mechanisms, such as poorly controlled
95 diabetes or obesity, vigorous physical activity, or technical problems in sample handling.

96 Lactic acidosis should be suspected in any diabetic patient with metabolic acidosis
97 lacking evidence of ketoacidosis (ketonuria and ketonemia).

98 Lactic acidosis is a medical emergency that must be treated in a hospital setting. In a
99 patient with lactic acidosis who is taking metformin, the drug should be discontinued
100 immediately and general supportive measures promptly instituted. Because metformin
101 is dialyzable (with a clearance of up to 170 mL/min under good hemodynamic
102 conditions), prompt hemodialysis is recommended to correct the acidosis and remove
103 the accumulated metformin. Such management often results in prompt reversal of
104 symptoms and recovery [see *Contraindications (4)*].

105

106 **5.2 Pancreatitis**

107 There have been postmarketing reports of acute pancreatitis in patients taking
108 alogliptin. After initiation of KAZANO, patients should be observed carefully for signs
109 and symptoms of pancreatitis. If pancreatitis is suspected, alogliptin should promptly be
110 discontinued and appropriate management should be initiated. It is unknown whether
111 patients with a history of pancreatitis are at increased risk for the development of
112 pancreatitis while using KAZANO.

113 **5.3 Hypersensitivity Reactions**

114 There have been postmarketing reports of serious hypersensitivity reactions in patients
115 treated with alogliptin. These reactions include anaphylaxis, angioedema, and severe
116 cutaneous adverse reactions including Stevens-Johnson syndrome. If a serious
117 hypersensitivity reaction is suspected, discontinue KAZANO, assess for other potential
118 causes for the event, and institute alternative treatment for diabetes [see *Adverse*
119 *Reactions (6.3)*]. Use caution in patients with a history of angioedema to another DPP-4
120 inhibitor because it is unknown whether such patients will be predisposed to
121 angioedema with KAZANO.

122 **5.4 Hepatic Effects**

123 There have been postmarketing reports of fatal and non-fatal hepatic failure in patients
124 taking alogliptin, although the reports contain insufficient information necessary to
125 establish the probable cause [see *Adverse Reactions (6.3)*]. In randomized controlled
126 studies, serum alanine aminotransferase (ALT) elevations greater than three times the
127 upper limit of normal (ULN) were observed: 1.3% in alogliptin-treated patients and 1.5%
128 in all comparator-treated patients.

129 Patients with type 2 diabetes may have fatty liver disease which may cause liver test
130 abnormalities, and they may also have other forms of liver disease, many of which can
131 be treated or managed. Therefore, obtaining a liver test panel and assessing the patient
132 before initiating KAZANO therapy is recommended. Because impaired hepatic function
133 has been associated with some cases of lactic acidosis with use of metformin, KAZANO
134 should generally be avoided in patients with clinical or laboratory evidence of hepatic
135 disease.

136 Measure liver tests promptly in patients who report symptoms that may indicate liver
137 injury, including fatigue, anorexia, right upper abdominal discomfort, dark urine or
138 jaundice. In this clinical context, if the patient is found to have clinically significant liver
139 enzyme elevations and if abnormal liver tests persist or worsen, KAZANO should be
140 interrupted and investigation done to establish the probable cause. KAZANO should
141 not be restarted in these patients without another explanation for the liver test
142 abnormalities.

143

144

145 5.5 Monitoring of Renal Function

146 Metformin is substantially excreted by the kidney, and the risk of metformin
147 accumulation and lactic acidosis increases with the degree of impairment. Therefore,
148 KAZANO is contraindicated in patients with renal impairment.

149 Before initiation of KAZANO therapy and at least annually thereafter, renal function
150 should be assessed and verified as normal. In patients in whom development of renal
151 dysfunction is anticipated, renal function should be assessed more frequently and
152 KAZANO discontinued if evidence of renal impairment is present. Metformin treatment
153 should not be initiated in patients ≥ 80 years of age unless measurement of creatinine
154 clearance demonstrates that renal function is not reduced, as these patients are more
155 susceptible to developing lactic acidosis.

**156 Use of concomitant medications that may affect renal function or metformin
157 disposition**

158 Concomitant medication(s) that may affect renal function or result in significant
159 hemodynamic change or may interfere with the disposition of metformin, such as
160 cationic drugs that are eliminated by renal tubular secretion [*see Drug Interactions*
161 (7.2)], should be used with caution.

162 Radiological studies and surgical procedures:

163 Radiologic studies involving the use of intravascular iodinated contrast materials (for
164 example, intravenous urogram, intravenous cholangiography, angiography, and
165 computed tomography) can lead to acute alteration of renal function and have been
166 associated with lactic acidosis in patients receiving metformin. Therefore, in patients in
167 whom any such study is planned, KAZANO should be temporarily discontinued at the
168 time of or prior to the procedure, and withheld for 48 hours subsequent to the procedure
169 and reinstated only after renal function has been re-evaluated and found to be normal.

170 KAZANO therapy should be temporarily suspended for any surgical procedure (except
171 minor procedures not associated with restricted intake of food and fluids) and should not
172 be restarted until the patient's oral intake has resumed and renal function has been
173 evaluated as normal.

174 5.6 Hypoxic States

175 Cardiovascular collapse (shock) from whatever cause, acute congestive heart failure,
176 acute myocardial infarction and other conditions characterized by hypoxemia have been
177 associated with lactic acidosis and may also cause prerenal azotemia. When such
178 events occur in patients on KAZANO therapy, the drug should be promptly
179 discontinued.

180 5.7 Alcohol Intake

181 Alcohol is known to potentiate the effect of metformin on lactate metabolism. Patients,
182 therefore, should be warned against excessive alcohol intake while receiving KAZANO.

183 5.8 Vitamin B12 Levels

184 In controlled, 29-week clinical trials of immediate release metformin, a decrease to
185 subnormal levels of previously normal serum Vitamin B12 levels, without clinical
186 manifestations, was observed in approximately 7% of patients. Such decrease, possibly
187 due to interference with B12 absorption from the B12-intrinsic factor complex is,
188 however, very rarely associated with anemia and appears to be rapidly reversible with
189 discontinuation of metformin or Vitamin B12 supplementation. Measurement of
190 hematologic parameters on an annual basis is advised in patients on KAZANO and any
191 apparent abnormalities should be appropriately investigated and managed. Certain
192 individuals (those with inadequate Vitamin B12 or calcium intake or absorption) appear
193 to be predisposed to developing subnormal Vitamin B12 levels. In these patients,
194 routine serum Vitamin B12 measurements at two- to three-year intervals may be useful.

195 **5.9 Use with Medications Known to Cause Hypoglycemia**

196 **Alogliptin**

197 Insulin and insulin secretagogues, such as sulfonylureas, are known to cause
198 hypoglycemia. Therefore, a lower dose of insulin or insulin secretagogue may be
199 required to reduce the risk of hypoglycemia when used in combination with KAZANO.

200 **Metformin hydrochloride**

201 Hypoglycemia does not occur in patients receiving metformin alone under usual
202 circumstances of use, but could occur when caloric intake is deficient, when strenuous
203 exercise is not compensated by caloric supplementation, or during concomitant use with
204 other glucose-lowering agents (such as sulfonylureas and insulin) or ethanol. Elderly,
205 debilitated, or malnourished patients and those with adrenal or pituitary insufficiency or
206 alcohol intoxication are particularly susceptible to hypoglycemic effects. Hypoglycemia
207 may be difficult to recognize in the elderly, and in people who are taking β -adrenergic
208 blocking drugs.

209 **5.10 Macrovascular Outcomes**

210 There have been no clinical studies establishing conclusive evidence of macrovascular
211 risk reduction with KAZANO or any other antidiabetic drug.

212 **6 ADVERSE REACTIONS**

213 **6.1 Clinical Studies Experience**

214 Because clinical trials are conducted under widely varying conditions, adverse reaction
215 rates observed in the clinical trials of a drug cannot be directly compared to rates in the
216 clinical trials of another drug and may not reflect the rates observed in practice.

217

218 **Alogliptin and Metformin hydrochloride**

219 Over 2700 patients with type 2 diabetes have received alogliptin coadministered with
 220 metformin in four large randomized, double-blind controlled clinical trials. The mean
 221 exposure to KAZANO was 58 weeks with more than 1400 subjects treated for more
 222 than one year. These included two 26-week placebo controlled studies, one 52-week
 223 active control study and an interim analysis of a 104-week active control study. In the
 224 KAZANO arm, the mean duration of diabetes was approximately 6 years, the mean
 225 body mass index (BMI) was 31 kg/m² (56% of patients had a BMI ≥30 kg/m²), and the
 226 mean age was 55 years (18% of patients ≥65 years of age).

227 In a pooled analysis of these four controlled clinical studies, the overall incidence of
 228 adverse reactions was 74% in patients treated with KAZANO compared to 76% treated
 229 with placebo. Overall discontinuation of therapy due to adverse events was 6.2% with
 230 KAZANO compared to 1.9% in placebo, 6.4% in metformin, and 5.0% in alogliptin.

231 Adverse reactions reported in ≥4% of patients treated with KAZANO and more
 232 frequently than in patients who received alogliptin, metformin or placebo are
 233 summarized in *Table 1*.

234

Table 1. Adverse Reactions Reported in ≥4% of Patients Treated with KAZANO and More Frequently Than in Patients Receiving Either Alogliptin, Metformin or Placebo

Number of Patients (%)				
	KAZANO*	Alogliptin [†]	Metformin [‡]	Placebo
	N=2794	N=222	N=1592	N=106
Upper respiratory tract infection	224 (8.0)	6 (2.7)	105 (6.6)	3 (2.8)
Nasopharyngitis	191 (6.8)	7 (3.2)	93 (5.8)	2 (1.9)
Diarrhea	155 (5.5)	4 (1.8)	105 (6.6)	3 (2.8)
Hypertension	154 (5.5)	5 (2.3)	96 (6.0)	6 (5.7)
Headache	149 (5.3)	11 (5.0)	74 (4.6)	3 (2.8)
Back pain	119 (4.3)	1 (0.5)	72 (4.5)	1 (0.9)
Urinary tract infection	116 (4.2)	4 (1.8)	59 (3.7)	2 (1.9)

*KAZANO – includes data pooled for patients receiving alogliptin 25 and 12.5 mg combined with various dose of metformin

[†] Alogliptin – includes data pooled for patients receiving alogliptin 25 and 12.5 mg

[‡]Metformin – includes data pooled for patients receiving various doses of metformin

235 **Hypoglycemia**

236 In a 26-week, double-blind, active-controlled study, of alogliptin in combination with
 237 metformin, the number of patients reporting hypoglycemia was 1.9% in the alogliptin
 238 12.5 mg with metformin HCl 500 mg, 5.3% in the alogliptin 12.5 mg with metformin HCl

239 1000 mg, 1.8% in the metformin HCl 500 mg, and 6.3% in the metformin HCl 1000 mg
240 treatment groups.

241 In a 26-week placebo-controlled study of alogliptin 25 mg administered once daily as
242 add-on to metformin regimen, the number of patients reporting hypoglycemic events
243 was 0.9% in the alogliptin with metformin and 2.9% in the placebo treatment groups.

244 In a 52-week, active-controlled, double-blind study of alogliptin once daily as add-on
245 therapy to the combination of pioglitazone 30 mg and metformin compared to the
246 titration of pioglitazone 30 mg to 45 mg and metformin, the number of patients reporting
247 hypoglycemia was 4.5% in the alogliptin 25 mg with pioglitazone 30 mg and metformin
248 group versus 1.5% in the pioglitazone 45 mg with metformin group.

249 In an interim analysis conducted in a 104-week, double-blind, active controlled study, of
250 alogliptin 25 mg in combination with metformin, the number of patients reporting
251 hypoglycemia was 1.4% in the alogliptin 25 mg with metformin group versus 23.8% in
252 the glipizide with metformin group.

253 **Alogliptin**

254 Approximately 8500 patients with type 2 diabetes have been treated with alogliptin in 14
255 randomized, double-blind, controlled clinical trials with approximately 2900 subjects
256 randomized to placebo and approximately 2200 to an active comparator. The mean
257 exposure to alogliptin was 40 weeks with more than 2400 subjects treated for more than
258 one year. Among these patients, 63% had a history of hypertension, 51% had a history
259 of dyslipidemia, 25% had a history of myocardial infarction, 8% had a history of unstable
260 angina, and 7% had a history of congestive heart failure. The mean duration of diabetes
261 was 7 years, the mean body mass index (BMI) was 31 kg/m² (51% of patients had a
262 BMI ≥30 kg/m²), and the mean age was 57 years (24% of patients ≥65 years of age).

263 Two placebo-controlled monotherapy trials of 12 and 26 weeks of duration were
264 conducted in patients treated with alogliptin 12.5 mg daily, alogliptin 25 mg daily and
265 placebo. Four placebo-controlled add-on combination therapy trials of 26 weeks
266 duration were also conducted: with metformin, with a sulfonylurea, with a
267 thiazolidinedione, and with insulin.

268 Five placebo-controlled trials of 16 weeks up through two years in duration were
269 conducted in combination with metformin, in combination with pioglitazone and with
270 pioglitazone added to a background of metformin therapy.

271 Three active-controlled trials of 52 weeks in duration were conducted in patients treated
272 with pioglitazone and metformin, in combination with metformin and as monotherapy
273 compared to glipizide.

274 In a pooled analysis of these 14 controlled clinical trials, the overall incidence of adverse
275 events was 66% in patients treated with alogliptin 25 mg compared to 62% with placebo
276 and 70% with active comparator. Overall discontinuation of therapy due to adverse
277 events was 4.7% with alogliptin 25 mg compared to 4.5% with placebo or 6.2% with
278 active comparator.

279 Adverse reactions reported in $\geq 4\%$ of patients treated with alogliptin 25 mg and more
 280 frequently than in patients who received placebo are summarized in *Table 2*.

Table 2. Adverse Reactions Reported in $\geq 4\%$ Patients Treated with Alogliptin 25 mg and More Frequently Than in Patients Given Placebo in Pooled Studies			
	Number of Patients (%)		
	Alogliptin 25 mg	Placebo	Active Comparator
	N=5902	N=2926	N=2257
Nasopharyngitis	257 (4.4)	89 (3.0)	113 (5.0)
Headache	247 (4.2)	72 (2.5)	121 (5.4)
Upper respiratory tract infection	247 (4.2)	61 (2.1)	113 (5.0)

281 **Pancreatitis**

282 In the clinical trial program, pancreatitis was reported in 11 of 5902 (0.2%) patients
 283 receiving alogliptin 25 mg daily compared to 5 of 5183 (<0.1%) patients receiving all
 284 comparators.

285 **Hypersensitivity Reactions**

286 In a pooled analysis, the overall incidence of hypersensitivity reactions was 0.6% with
 287 alogliptin 25 mg compared to 0.8% with all comparators. A single event of serum
 288 sickness was reported in a patient treated with alogliptin 25 mg.

289 **Hypoglycemia**

290 Hypoglycemic events were documented based upon a blood glucose value and/or
 291 clinical signs and symptoms of hypoglycemia.

292 In the monotherapy study, the incidence of hypoglycemia was 1.5% in patients treated
 293 with alogliptin compared to 1.6% with placebo. The use of alogliptin as add-on therapy
 294 to glyburide or insulin did not increase the incidence of hypoglycemia compared to
 295 placebo. In a monotherapy study comparing alogliptin to a sulfonylurea in elderly
 296 patients, the incidence of hypoglycemia was 5.4% with alogliptin as compared to 26%
 297 with glipizide.

298

299 **Metformin hydrochloride**

Table 3. Most Common Adverse Reactions (≥5%) in a Placebo-Controlled Clinical Study of Metformin Monotherapy*		
Adverse Reaction	Metformin Monotherapy (n=141)	Placebo (n=145)
	% of Patients	
Diarrhea	53.2	11.7
Nausea/Vomiting	25.5	8.3
Flatulence	12.1	5.5
Asthenia	9.2	5.5
Indigestion	7.1	4.1
Abdominal Discomfort	6.4	4.8
Headache	5.7	4.8

*Reactions that were more common in metformin than placebo-treated patients

300

301 **6.2 Laboratory Abnormalities**302 **Alogliptin and Metformin hydrochloride**

303 No clinically meaningful differences were observed among treatment groups regarding
304 hematology, serum chemistry, or urinalysis results.

305 **Alogliptin**

306 No clinically meaningful changes in hematology, serum chemistry, or urinalysis were
307 observed in patients treated with alogliptin.

308 **Metformin hydrochloride**

309 Metformin may lower serum Vitamin B12 concentrations. Measurement of hematologic
310 parameters on an annual basis is advised in patients on KAZANO and any apparent
311 abnormalities should be appropriately investigated and managed [see *Warnings and*
312 *Precautions (5.8)*].

313 **6.3 Postmarketing Experience**314 **Alogliptin**

315 The following adverse reactions have been identified during the postmarketing use of
316 alogliptin outside the United States. Because these reactions are reported voluntarily
317 from a population of uncertain size, it is not always possible to reliably estimate their
318 frequency or establish a causal relationship to drug exposure.

319 Hypersensitivity reactions including anaphylaxis, angioedema, rash, urticaria, and
320 severe cutaneous adverse reactions including Stevens-Johnson syndrome; hepatic
321 enzyme elevations; fulminant hepatic failure; and acute pancreatitis.

322 7 DRUG INTERACTIONS

323 **Alogliptin**

324 Alogliptin is primarily renally excreted and CYP-related metabolism is negligible. No
325 drug-drug interactions were observed with the CYP-substrates or inhibitors tested, or
326 with renally excreted drugs [see *Clinical Pharmacology (12.3)*].

327 **Metformin hydrochloride**

328 **7.1 Carbonic Anhydrase Inhibitors**

329 Topiramate or other carbonic anhydrase inhibitors (e.g., zonisamide, acetazolamide or
330 dichlorphenamide) frequently decrease serum bicarbonate and induce non-anion gap,
331 hyperchloremic metabolic acidosis. Concomitant use of these drugs may induce
332 metabolic acidosis. Use these drugs with caution in patients treated with metformin, as
333 the risk of lactic acidosis may increase.

334 **7.2 Cationic Drugs**

335 Cationic drugs (e.g., amiloride, digoxin, morphine, procainamide, quinidine, quinine,
336 ranitidine, triamterene, trimethoprim, or vancomycin) that are eliminated by renal tubular
337 secretion theoretically have the potential for interaction with metformin by competing for
338 common renal tubular transport systems. Although such interactions remain theoretical
339 (except for cimetidine), careful patient monitoring and dose adjustment of KAZANO
340 and/or the interfering drug is recommended in patients who are taking cationic
341 medications that are excreted via the proximal renal tubular secretory system.

342 **7.3 The Use of Metformin with Other Drugs**

343 Certain drugs tend to produce hyperglycemia and may lead to loss of glycemic control.
344 These drugs include the thiazides and other diuretics, corticosteroids, phenothiazines,
345 thyroid products, estrogens, oral contraceptives, phenytoin, nicotinic acid,
346 sympathomimetics, calcium channel blocking drugs, and isoniazid. When such drugs
347 are administered to a patient receiving KAZANO the patient should be closely observed
348 for loss of blood glucose control. When such drugs are withdrawn from a patient
349 receiving KAZANO, the patient should be observed closely for hypoglycemia.

350 8 USE IN SPECIFIC POPULATIONS

351 **8.1 Pregnancy**

352 **Pregnancy Category B**

353 **Alogliptin and Metformin hydrochloride**

354 There are no adequate and well-controlled studies in pregnant women with KAZANO or
355 its individual components. Based on animal data, KAZANO is not predicted to increase
356 the risk of developmental abnormalities. Because animal reproduction studies are not
357 always predictive of human risk and exposure, KAZANO, like other antidiabetic
358 medications, should be used during pregnancy only if clearly needed.

359 No treatment-related fetal abnormalities occurred following concomitant administration
360 of 100 mg/kg alogliptin with 150 mg/kg metformin to pregnant rats, or approximately 28-
361 and 2-times the clinical dose of alogliptin (25 mg) and metformin (2000 mg),
362 respectively (based on AUC).

363 Alogliptin

364 Alogliptin administered to pregnant rabbits and rats during the period of organogenesis
365 was not teratogenic at doses of up to 200 and 500 mg/kg, or 149-times and 180-times,
366 respectively, the clinical dose based on plasma drug exposure (AUC).

367 Doses of alogliptin up to 250 mg/kg (approximately 95-times clinical exposure based on
368 AUC) given to pregnant rats from gestation day 6 to lactation day 20 did not harm the
369 developing embryo or adversely affect growth and development of offspring.

370 Placental transfer of alogliptin into the fetus was observed following oral dosing to
371 pregnant rats.

372 Metformin hydrochloride

373 Metformin was not teratogenic in rats and rabbits at doses up to 600 mg/kg, which
374 represents an exposure of about 2 and 6 times the MRHD dose of 2000 mg based on
375 body surface area comparisons for rats and rabbits, respectively. Metformin HCl should
376 not be used during pregnancy unless clearly needed.

377 8.3 Nursing Mothers

378 No studies have been conducted with the combined components of KAZANO. In studies
379 performed with the individual components, both alogliptin and metformin are secreted in
380 the milk of lactating rats. It is not known whether alogliptin and/or metformin are
381 secreted in human milk. Because many drugs are excreted in human milk, caution
382 should be exercised when KAZANO is administered to a nursing woman.

383 8.4 Pediatric Use

384 Safety and effectiveness of KAZANO in pediatric patients have not been established.

385 8.5 Geriatric Use**386 Alogliptin and Metformin hydrochloride**

387 Elderly patients are more likely to have decreased renal function. Because metformin is
388 contraindicated in patients with renal impairment, carefully monitor renal function in the
389 elderly and use KAZANO with caution as age increases [*see Warnings and Precautions*
390 (5.5) and *Clinical Pharmacology* (12.3)].

391 Of the total number of patients (N = 2095) in clinical safety and efficacy studies, 343
392 (16.4%) patients were 65 years and older and 37 (1.8%) patients were 75 years and
393 older. No overall differences in safety or effectiveness were observed between these
394 patients and younger patients. While this and other reported clinical experiences have
395 not identified differences in responses between the elderly and younger patients,
396 greater sensitivity of some older individuals cannot be excluded.

397 Alogliptin

398 Of the total number of patients (N=8507) in clinical safety and efficacy studies treated
399 with alogliptin, 2064 (24.3%) patients were 65 years and older and 341 (4%) patients
400 were 75 years and older. No overall differences in safety or effectiveness were
401 observed between patients 65 years and over and younger patients.

402 Metformin hydrochloride

403 Controlled studies of metformin did not include sufficient numbers of subjects age 65
404 and over to determine whether they respond differently from younger patients. Other
405 reported clinical experience has not identified differences in responses between the
406 elderly and younger patients.

407 Metformin should only be used in patients with normal renal function. The initial and
408 maintenance dosing of metformin should be conservative in patients with advanced
409 age, due to the potential for decreased renal function in this population [see
410 *Contraindications (4), Warnings and Precautions (5.5), Clinical Pharmacology (12.3)*].

411 10 OVERDOSAGE**412 Alogliptin**

413 The highest doses of alogliptin administered in clinical trials were single doses of 800
414 mg to healthy subjects and doses of 400 mg once daily for 14 days to patients with type
415 2 diabetes (equivalent to 32 times and 16 times the recommended clinical dose,
416 respectively). No dose-limiting adverse events were observed at these doses.

417 In the event of an overdose, it is reasonable to institute the necessary clinical monitoring
418 and supportive therapy as dictated by the patient's clinical status. Per clinical judgment,
419 it may be reasonable to initiate removal of unabsorbed material from the gastrointestinal
420 tract.

421 Alogliptin is minimally dialyzable; over a 3-hour hemodialysis session, approximately 7%
422 of the drug was removed. Therefore, hemodialysis is unlikely to be beneficial in an
423 overdose situation. It is not known if alogliptin is dialyzable by peritoneal dialysis.

424 Metformin hydrochloride

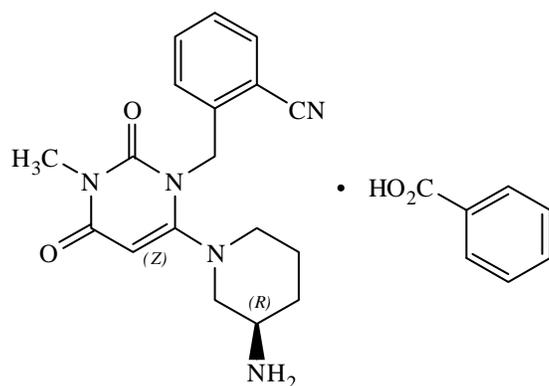
425 Overdose of metformin has occurred, including ingestion of amounts greater than 50
426 grams. Hypoglycemia was reported in approximately 10% of cases, but no causal
427 association with metformin has been established. Lactic acidosis has been reported in
428 approximately 32% of metformin overdose cases [see *Warnings and Precautions (5.1)*].
429 Metformin is dialyzable with a clearance of up to 170 mL/min under good hemodynamic
430 conditions. Therefore, hemodialysis may be useful for removal of accumulated drug
431 from patients in whom metformin overdosage is suspected.

432 11 DESCRIPTION

433 KAZANO tablets contain 2 oral antihyperglycemic drugs used in the management of
434 type 2 diabetes: alogliptin and metformin hydrochloride.

435 Alogliptin

436 Alogliptin is a selective, orally bioavailable inhibitor of the enzymatic activity of dipeptidyl
437 peptidase-4 (DPP-4). Chemically, alogliptin is prepared as a benzoate salt, which is
438 identified as 2-({6-[(3R)-3-aminopiperidin-1-yl]-3-methyl-2,4-dioxo-3,4-dihydropyrimidin-
439 1(2H)-yl}methyl)benzotrile monobenzoate. It has a molecular formula of
440 $C_{18}H_{21}N_5O_2 \cdot C_7H_6O_2$ and a molecular weight of 461.51 daltons; the structural formula is:

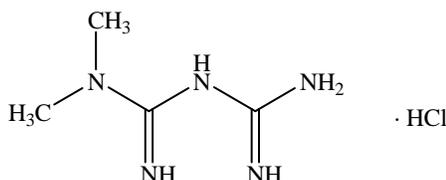


441

442 Alogliptin benzoate is a white to off-white, crystalline powder, containing one
 443 asymmetric carbon in the aminopiperidine moiety. It is soluble in dimethylsulfoxide,
 444 sparingly soluble in water and methanol, slightly soluble in ethanol, and very slightly
 445 soluble in octanol and isopropyl acetate.

446 **Metformin hydrochloride**

447 Metformin hydrochloride (*N,N*-dimethylimidodicarbonimidic diamide hydrochloride) is
 448 not chemically or pharmacologically related to any other classes of oral
 449 antihyperglycemic agents. Metformin hydrochloride is a white to off-white crystalline
 450 compound with a molecular formula of $C_4H_{11}N_5 \cdot HCl$ and a molecular weight of 165.63.
 451 Metformin hydrochloride is freely soluble in water and is practically insoluble in acetone,
 452 ether, and chloroform. The pKa of metformin is 12.4. The pH of a 1% aqueous solution
 453 of metformin hydrochloride is 6.68. The structural formula is as shown:



454

455 KAZANO is available as a tablet for oral administration containing 17 mg alogliptin
 456 benzoate equivalent to 12.5 mg alogliptin and:

- 457 • 500 mg metformin hydrochloride (12.5 mg/500 mg) or
- 458 • 1000 mg metformin hydrochloride (12.5 mg/1000 mg).

459 KAZANO tablets contain the following inactive ingredients: mannitol, microcrystalline
 460 cellulose, povidone, crospovidone, and magnesium stearate; the tablets are film-coated
 461 with hypromellose 2910, talc, titanium dioxide, and ferric oxide yellow.

462 **12 CLINICAL PHARMACOLOGY**

463 **12.1 Mechanism of Action**

464 **Alogliptin and Metformin hydrochloride**

465 KAZANO combines 2 antihyperglycemic agents with complementary and distinct
 466 mechanisms of action to improve glycemic control in patients with type 2 diabetes:

467 alogliptin, a selective inhibitor of DPP-4, and metformin HCl, a member of the biguanide
468 class.

469 **Alogliptin**

470 Increased concentrations of the incretin hormones such as glucagon-like peptide-1
471 (GLP-1) and glucose-dependent insulintropic polypeptide (GIP) are released into the
472 bloodstream from the small intestine in response to meals. These hormones cause
473 insulin release from the pancreatic beta cells in a glucose-dependent manner but are
474 inactivated by the DPP-4 enzyme within minutes. GLP-1 also lowers glucagon secretion
475 from pancreatic alpha cells, reducing hepatic glucose production. In patients with type 2
476 diabetes, concentrations of GLP-1 are reduced but the insulin response to GLP-1 is
477 preserved. Alogliptin is a DPP-4 inhibitor that slows the inactivation of the incretin
478 hormones, thereby increasing their bloodstream concentrations and reducing fasting
479 and postprandial glucose concentrations in a glucose-dependent manner in patients
480 with type 2 diabetes mellitus. Alogliptin selectively binds to and inhibits DPP-4 but not
481 DPP-8 or DPP-9 activity in vitro at concentrations approximating therapeutic exposures.

482 **Metformin hydrochloride**

483 Metformin is a biguanide that improves glucose tolerance in patients with type 2
484 diabetes, lowering both basal and postprandial plasma glucose. Metformin decreases
485 hepatic glucose production, decreases intestinal absorption of glucose, and improves
486 insulin sensitivity by increasing peripheral glucose uptake and utilization. Metformin
487 does not produce hypoglycemia in patients with type 2 diabetes or in healthy subjects
488 except in special circumstances [*see Warnings and Precautions (5.9)*] and does not
489 cause hyperinsulinemia. With metformin therapy, insulin secretion remains unchanged
490 while fasting insulin levels and day-long plasma insulin response may actually
491 decrease.

492 **12.2 Pharmacodynamics**

493 **Alogliptin**

494 Single-dose administration of alogliptin to healthy subjects resulted in a peak inhibition
495 of DPP-4 within 2 to 3 hours after dosing. The peak inhibition of DPP-4 exceeded
496 93% across doses of 12.5 mg to 800 mg. Inhibition of DPP-4 remained above 80% at
497 24 hours for doses greater than or equal to 25 mg. Peak and total exposure over 24
498 hours to active GLP-1 were 3- to 4-fold greater with alogliptin (at doses of 25 - 200 mg)
499 than placebo. In a 16-week, double-blind, placebo-controlled study, alogliptin 25 mg
500 demonstrated decreases in postprandial glucagon while increasing postprandial active
501 GLP-1 levels compared to placebo over an 8-hour period following a standardized meal.
502 It is unclear how these findings relate to changes in overall glycemic control in patients
503 with type 2 diabetes mellitus. In this study, alogliptin 25 mg demonstrated decreases in
504 2-hour postprandial glucose compared to placebo (-30 mg/dL versus 17 mg/dL,
505 respectively).

506 Multiple-dose administration of alogliptin to patients with type 2 diabetes also resulted in
507 a peak inhibition of DPP-4 within 1 to 2 hours and exceeded 93% across all doses (25
508 mg, 100 mg, and 400 mg) after a single dose and after 14 days of once-daily dosing. At

509 these doses of alogliptin, inhibition of DPP-4 remained above 81% at 24 hours after 14
510 days of dosing.

511 **12.3 Pharmacokinetics**

512 **Absorption and Bioavailability**

513 ***Alogliptin and Metformin hydrochloride***

514 In bioequivalence studies of KAZANO, the area under the curve (AUC) and maximum
515 concentration (C_{max}) of both the alogliptin and the metformin component following a
516 single dose of the combination tablet were bioequivalent to the alogliptin 12.5 mg
517 concomitantly administered with metformin HCl 500 or 1000 mg tablets under fasted
518 conditions in healthy subjects. Administration of KAZANO with food resulted in no
519 change in total exposure (AUC) of alogliptin and metformin. Mean peak plasma
520 concentrations of alogliptin and metformin were decreased by 13% and 28%,
521 respectively, when administered with food. There was no change in time to peak plasma
522 concentrations (T_{max}) for alogliptin under fed conditions, however, there was a delayed
523 T_{max} for metformin of 1.5 hr. These changes are not likely to be clinically significant.

524 ***Alogliptin***

525 The absolute bioavailability of alogliptin is approximately 100%. Administration of
526 alogliptin with a high-fat meal resulted in no change in total and peak exposure to
527 alogliptin. Alogliptin may therefore be administered with or without food.

528 ***Metformin hydrochloride***

529 The absolute bioavailability of metformin following administration of a 500-mg metformin
530 HCl tablet given under fasting conditions is approximately 50 to 60%. Studies using
531 single oral doses of metformin HCl tablets 500 mg to 1500 mg, and 850 mg to 2550 mg,
532 indicate that there is a lack of dose proportionality with increasing doses, which is due to
533 decreased absorption rather than an alteration in elimination. Food decreases the
534 extent of and slightly delays the absorption of metformin, as shown by approximately a
535 40% lower mean peak plasma concentration (C_{max}), a 25% lower area under the plasma
536 concentration versus time curve (AUC), and a 35-minute prolongation of time to peak
537 plasma concentration (T_{max}) following administration of a single 850-mg tablet of
538 metformin HCl with food, compared to the same tablet strength administered fasting.
539 The clinical relevance of these decreases is unknown.

540 **Distribution**

541 ***Alogliptin***

542 Following a single, 12.5 mg intravenous dose of alogliptin to healthy subjects, the
543 volume of distribution during the terminal phase was 417 L, indicating that the drug is
544 well distributed into tissues.

545 Alogliptin is 20% bound to plasma proteins.

546 ***Metformin hydrochloride***

547 The apparent volume of distribution (V/F) of metformin following single oral doses of
548 immediate release metformin HCl tablets 850 mg averaged 654 ± 358 L. Metformin is
549 negligibly bound to plasma proteins. Metformin partitions into erythrocytes, most likely
550 as a function of time. At usual clinical doses and dosing schedules of metformin, steady-

551 state plasma concentrations of metformin are reached within 24 to 48 hours and are
552 generally <1 mcg/mL. During controlled clinical trials, which served as the basis for
553 approval for metformin, maximum metformin plasma levels did not exceed 5 mcg/mL,
554 even at maximum doses.

555 **Metabolism**

556 ***Alogliptin***

557 Alogliptin does not undergo extensive metabolism and 60% to 71% of the dose is
558 excreted as unchanged drug in the urine.

559 Two minor metabolites were detected following administration of an oral dose of [¹⁴C]
560 alogliptin, *N*-demethylated, M-I (<1% of the parent compound), and *N*-acetylated
561 alogliptin, M-II (<6% of the parent compound). M-I is an active metabolite and is an
562 inhibitor of DPP-4 similar to the parent molecule; M-II does not display any inhibitory
563 activity towards DPP-4 or other DPP-related enzymes. *In vitro* data indicate that
564 CYP2D6 and CYP3A4 contribute to the limited metabolism of alogliptin.

565 Alogliptin exists predominantly as the (*R*)-enantiomer (>99%) and undergoes little or no
566 chiral conversion *in vivo* to the (*S*)-enantiomer. The (*S*)-enantiomer is not detectable at
567 the 25 mg dose.

568 ***Metformin hydrochloride***

569 Intravenous single-dose studies in healthy subjects demonstrate that metformin is
570 excreted unchanged in the urine and does not undergo hepatic metabolism (no
571 metabolites have been identified in humans) nor biliary excretion.

572 **Excretion and Elimination**

573 ***Alogliptin***

574 The primary route of elimination of [¹⁴C] alogliptin-derived radioactivity occurred via
575 renal excretion (76%) with 13% recovered in the feces, achieving a total recovery of
576 89% of the administered radioactive dose. The renal clearance of alogliptin (9.6 L/hr)
577 indicates some active renal tubular secretion and systemic clearance was 14.0 L/hr.

578 ***Metformin hydrochloride***

579 Renal clearance is approximately 3.5 times greater than creatinine clearance, which
580 indicates that tubular secretion is the major route of metformin elimination. Following
581 oral administration, approximately 90% of the absorbed drug is eliminated via the renal
582 route within the first 24 hours, with a plasma elimination half-life of approximately 6.2
583 hours. In blood, the elimination half-life is approximately 17.6 hours, suggesting that the
584 erythrocyte mass may be a compartment of distribution.

585 **Special Populations**

586 **Renal Impairment**

587 ***Alogliptin and Metformin hydrochloride***

588 Use of KAZANO in patients with renal impairment increases the risk for lactic acidosis.
589 Because KAZANO contains metformin, KAZANO is contraindicated in patients with
590 renal impairment [see *Contraindications (4) and Warnings and Precautions (5.5)*].

591 Hepatic Impairment

592 KAZANO is not recommended in patients with hepatic impairment. KAZANO contains
593 metformin and use of metformin in patients with hepatic impairment has been
594 associated with some cases of lactic acidosis [see *Warnings and Precautions (5.4)*].

595 Alogliptin

596 Total exposure to alogliptin was approximately 10% lower and peak exposure was
597 approximately 8% lower in patients with moderate hepatic impairment (Child-Pugh
598 Grade B) compared to healthy subjects. The magnitude of these reductions is not
599 considered to be clinically meaningful. Patients with severe hepatic impairment (Child-
600 Pugh Grade C) have not been studied.

601 Metformin hydrochloride

602 No pharmacokinetic studies of metformin have been conducted in subjects with hepatic
603 impairment.

604 Gender**605 Alogliptin**

606 No dose adjustment is necessary based on gender. Gender did not have any clinically
607 meaningful effect on the pharmacokinetics of alogliptin.

608 Metformin hydrochloride

609 Metformin pharmacokinetic parameters did not differ significantly between normal
610 subjects and patients with type 2 diabetes when analyzed according to gender.
611 Similarly, in controlled clinical studies in patients with type 2 diabetes, the
612 antihyperglycemic effect of metformin hydrochloride tablets was comparable in males
613 and females.

614 Geriatric

615 KAZANO contains metformin which is contraindicated in patients with renal impairment
616 [see *Warnings and Precautions (5.5)*]. Due to declining renal function in the elderly,
617 measurement of creatinine clearance should be obtained prior to initiation of therapy.
618 Do not use KAZANO if renal function is not within normal range.

619 Alogliptin

620 No dose adjustment is necessary based on age. Age did not have any clinically
621 meaningful effect on the pharmacokinetics of alogliptin.

622 Metformin hydrochloride

623 Limited data from controlled pharmacokinetic studies of metformin in healthy elderly
624 subjects suggest that total plasma clearance of metformin is decreased, the half-life is
625 prolonged, and C_{max} is increased, compared to healthy young subjects. From these
626 data, it appears that the change in metformin pharmacokinetics with aging is primarily
627 accounted for by a change in renal function.

628 Pediatrics

629 Studies characterizing the pharmacokinetics of alogliptin in pediatric patients have not
630 been performed.

631 **Race**

632 ***Alogliptin***

633 No dose adjustment of alogliptin is necessary based on race. Race (White, Black and
634 Asian) did not have any clinically meaningful effect on the pharmacokinetics of
635 alogliptin.

636 ***Metformin hydrochloride***

637 No studies of metformin pharmacokinetic parameters according to race have been
638 performed. In controlled clinical studies of metformin in patients with type 2 diabetes,
639 the antihyperglycemic effect was comparable in Whites (n=249), Blacks (n=51), and
640 Hispanics (n=24).

641 **Drug Interactions**

642 ***Alogliptin and Metformin hydrochloride***

643 Administration of alogliptin 100 mg once daily with metformin HCl 1000 mg twice daily
644 for 6 days had no meaningful effect on the pharmacokinetics of alogliptin or metformin.

645 Specific pharmacokinetic drug interaction studies with KAZANO have not been
646 performed, although such studies have been conducted with the individual components
647 of KAZANO (alogliptin and metformin).

648 ***Alogliptin***

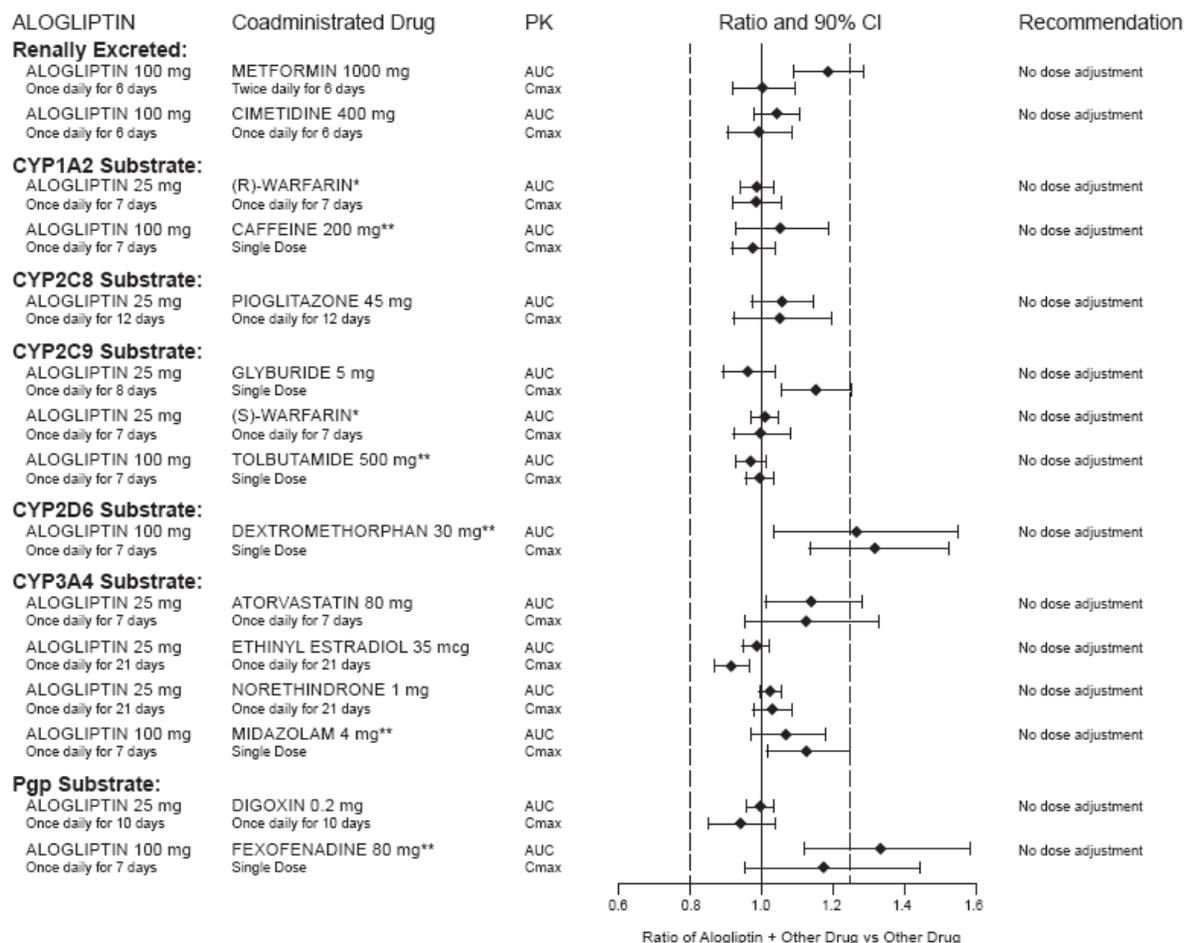
649 ***In Vitro Assessment of Drug Interactions***

650 *In vitro* studies indicate that alogliptin is neither an inducer of CYP1A2, CYP2B6,
651 CYP2C9, CYP2C19, and CYP3A4, nor an inhibitor of CYP1A2, CYP2C8, CYP2C9,
652 CYP2C19, CYP3A4 and CYP2D6 at clinically relevant concentrations.

653 ***In Vivo Assessment of Drug Interactions***

654 **Effects of Alogliptin on the Pharmacokinetics of Other Drugs**

655
656 In clinical studies, alogliptin did not meaningfully increase the systemic exposure to the
657 following drugs that are metabolized by CYP isozymes or excreted unchanged in urine
658 (*Figure 1*). No dose adjustment of alogliptin is recommended based on results of the
659 described pharmacokinetic studies.

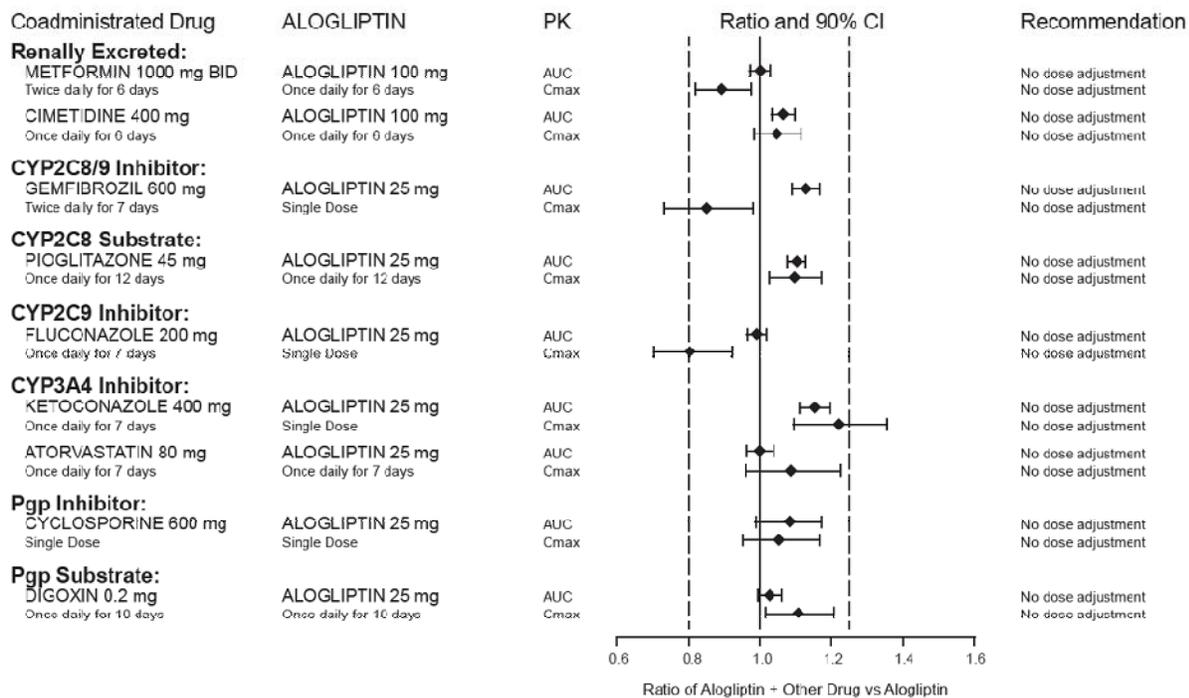
660 **Figure 1. Effect of Alogliptin on the Pharmacokinetic Exposure to Other Drugs**

661
 662 *warfarin was given once daily at a stable dose in the range of 1 mg to 10 mg. Alogliptin had no significant
 663 effect on the prothrombin time (PT) or International Normalized Ratio (INR).
 664 **caffeine (1A2 substrate), tolbutamide (2C9 substrate), dextromethorphan (2D6 substrate), midazolam
 665 (3A4 substrate), and fexofenadine (P-gp substrate) were administered as a cocktail.
 666

667 **Effects of Other Drugs on the Pharmacokinetics of Alogliptin**

668 There are no clinically meaningful changes in the pharmacokinetics of alogliptin when
 669 alogliptin is administered concomitantly with the drugs described below (*Figure 2*).
 670

671 **Figure 2. Effect of Other Drugs on the Pharmacokinetic Exposure of Alogliptin**



672

673

674

675 **Metformin hydrochloride**

676 Pharmacokinetic drug interaction studies have been performed on metformin (*Tables 4*
677 *and 5*).

Table 4. Effect of Coadministered Drug on Plasma Metformin Systemic Exposure				
Coadministered Drug	Dose of Coadministered Drug*	Dose of Metformin HCl*	Geometric Mean Ratio (ratio with/without coadministered drug) No effect = 1.00	
			AUC[†]	C_{max}
No dosing adjustments required for the following:				
Glyburide	5 mg	500 mg [‡]	0.98 [§]	0.99 [§]
Furosemide	40 mg	850 mg	1.09 [§]	1.22 [§]
Nifedipine	10 mg	850 mg	1.16	1.21
Propranolol	40 mg	850 mg	0.90	0.94
Ibuprofen	400 mg	850 mg	1.05 [§]	1.07 [§]
Cationic drugs eliminated by renal tubular secretion may reduce metformin elimination: use with caution [see Warnings and Precautions (5) and Drug Interactions (7)]				
Cimetidine	400 mg	850 mg	1.40	1.61
Carbonic anhydrase inhibitors may cause metabolic acidosis: use with caution [see Warnings and Precautions (5) and Drug Interactions (7)]				
Topiramate	100 mg [¶]	500 mg [¶]	1.25 [¶]	1.17
*All metformin and coadministered drugs were given as single doses				
[†] AUC = AUC _{0-∞}				
[‡] metformin hydrochloride extended-release tablets 500 mg				
[§] Ratio of arithmetic means				
[¶] At steady state with topiramate 100 mg every 12 hours and metformin 500 mg every 12 hours; AUC = AUC _{0-12h}				

678

679

Table 5. Effect of Metformin on Coadministered Drug Systemic Exposure				
Coadministered Drug	Dose of Coadministered Drug*	Dose of Metformin HCl*	Geometric Mean Ratio (ratio with/without coadministered drug) No effect = 1.00	
			AUC[†]	C_{max}
No dosing adjustments required for the following:				
Glyburide	5 mg	500 mg [‡]	0.78 [§]	0.63 [§]
Furosemide	40 mg	850 mg	0.87 [§]	0.69 [§]
Nifedipine	10 mg	850 mg	1.10 [‡]	1.08
Propranolol	40 mg	850 mg	1.01 [‡]	0.94
Ibuprofen	400 mg	850 mg	0.97 [¶]	1.01 [¶]
Cimetidine	400 mg	850 mg	0.95 [‡]	1.01
*All metformin and coadministered drugs were given as single doses				
[†] AUC = AUC _{0-∞}				
[‡] AUC _{0-24 hr} reported				
[§] Ratio of arithmetic means, p-value of difference <0.05				
[¶] Ratio of arithmetic means				

680 **13 NONCLINICAL TOXICOLOGY**681 **13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility**682 **Alogliptin and Metformin hydrochloride**

683 No carcinogenicity, mutagenicity, or impairment of fertility studies have been conducted
684 with KAZANO. The following data are based on findings in studies performed with
685 alogliptin or metformin individually.

686 **Alogliptin**

687 Rats were administered oral doses of 75, 400, and 800 mg/kg alogliptin for 2 years. No
688 drug-related tumors were observed up to 75 mg/kg or approximately 32 times the
689 maximum recommended clinical dose of 25 mg, based on AUC exposure. At higher
690 doses (approximately 308 times the maximum recommended clinical dose of 25 mg), a
691 combination of thyroid C-cell adenomas and carcinomas increased in male but not
692 female rats. No drug-related tumors were observed in mice after administration of 50,
693 150, or 300 mg/kg alogliptin for 2 years, or up to approximately 51-times the maximum
694 recommended clinical dose of 25 mg, based on AUC exposure.

695 Alogliptin was not mutagenic or clastogenic, with and without metabolic activation, in the
696 Ames test with *S. typhimurium* and *E. coli* or the cytogenetic assay in mouse lymphoma
697 cells. Alogliptin was negative in the *in vivo* mouse micronucleus study.

698 In a fertility study in rats, alogliptin had no adverse effects on early embryonic
699 development, mating, or fertility, at doses up to 500 mg/kg, or approximately 172-times
700 the clinical dose based on plasma drug exposure (AUC).

701

702 **Metformin hydrochloride**

703 Long-term carcinogenicity studies have been performed in rats (dosing duration of 104
704 weeks) and mice (dosing duration of 91 weeks) at doses up to and including 900 mg/kg
705 and 1500 mg/kg, respectively. These doses are both approximately four times the
706 maximum recommended human daily dose of 2000 mg based on body surface area
707 comparisons. No evidence of carcinogenicity with metformin was found in either male or
708 female mice. Similarly, there was no tumorigenic potential observed with metformin in
709 male rats. There was an increased incidence of benign stromal uterine polyps in female
710 rats treated with 900 mg/kg.

711 There was no evidence of a mutagenic potential of metformin in the following *in vitro*
712 tests: Ames test (*S. typhimurium*), gene mutation test (mouse lymphoma cells), or
713 chromosomal aberrations test (human lymphocytes). Results in the *in vivo* mouse
714 micronucleus test were also negative.

715 Fertility of male or female rats was unaffected by metformin when administered at doses
716 as high as 600 mg/kg, which is approximately three times the maximum recommended
717 human daily dose based on body surface area comparisons.

718 **14 CLINICAL STUDIES**

719 The coadministration of alogliptin and metformin has been studied in patients with type
720 2 diabetes inadequately controlled on either diet and exercise alone, on metformin
721 alone or metformin in combination with a thiazolidinedione.

722 There have been no clinical efficacy studies conducted with KAZANO; however
723 bioequivalence of KAZANO with coadministered alogliptin and metformin tablets was
724 demonstrated, and efficacy of the combination of alogliptin and metformin has been
725 demonstrated in three Phase 3 efficacy studies.

726 A total of 4716 patients with type 2 diabetes were randomized in 4 double-blind,
727 placebo- or active-controlled clinical safety and efficacy studies conducted to evaluate
728 the effects of KAZANO on glycemic control. The racial distribution of patients exposed
729 to study medication was 65% White, 20% Asian, 8% Black, and 7% other racial groups.
730 The ethnic distribution was 23% Hispanic. Patients had an overall mean age of
731 approximately 55 years (range 21 to 80 years). In patients with type 2 diabetes,
732 treatment with KAZANO produced clinically meaningful and statistically significant
733 improvements in A1C versus comparator. As is typical for trials of agents to treat type 2
734 diabetes, the mean reduction in A1C with KAZANO appears to be related to the degree
735 of A1C elevation at baseline.

736 **Alogliptin and Metformin Coadministration in Patients with Type 2 Diabetes** 737 **Inadequately Controlled on Diet and Exercise**

738 In a 26-week, double-blind, placebo-controlled study, a total of 784 patients
739 inadequately controlled on diet and exercise alone (mean baseline A1C=8.4%) were
740 randomized to 1 of 7 treatment groups: placebo; metformin HCl 500 mg or metformin
741 HCl 1000 mg twice daily, alogliptin 12.5 mg twice daily, or alogliptin 25 mg daily;
742 alogliptin 12.5 mg in combination with metformin HCl 500 mg or metformin HCl 1000 mg

743 twice daily. Both coadministration treatment arms (alogliptin 12.5 mg + metformin HCl
744 500 mg and alogliptin 12.5 mg + metformin HCl 1000 mg) resulted in significant
745 improvements in A1C (*Figure 3*) and FPG when compared with their respective
746 individual alogliptin and metformin component regimens (*Table 6*). Coadministration
747 treatment arms demonstrated improvements in 2-hour postprandial glucose (PPG)
748 compared to alogliptin alone or metformin alone (*Table 6*). A total of 12% of patients
749 receiving alogliptin 12.5 mg + metformin HCl 500 mg, 3% of patients receiving alogliptin
750 12.5 mg + metformin HCl 1000 mg, 17% of patients receiving alogliptin 12.5 mg, 23% of
751 patients receiving metformin HCl 500 mg, 11% of patients receiving metformin HCl 1000
752 mg and 39% of patients receiving placebo required glycemic rescue.

753 Improvements in A1C were not affected by gender, age, race, or baseline BMI. The
754 mean decrease in body weight was similar between metformin alone and alogliptin
755 when coadministered with metformin. Lipid effects were neutral.

756

757

Table 6. Glycemic Parameters at Week 26 for Alogliptin and Metformin Alone and in Combination in Patients with Type 2 Diabetes						
	Placebo	Alogliptin 12.5 mg twice daily	Metformin HCl 500 mg twice daily	Metformin HCl 1000 mg twice daily	Alogliptin 12.5 mg + Metformin HCl 500 mg twice daily	Alogliptin 12.5 mg + Metformin HCl 1000 mg twice daily
A1C (%)*	N=102	N=104	N=103	N=108	N=102	N=111
Baseline (mean)	8.5	8.4	8.5	8.4	8.5	8.4
Change from baseline (adjusted mean [†])	0.1	-0.6	-0.7	-1.1	-1.2	-1.6
Difference from metformin (adjusted mean [†] with 95% confidence interval)	-	-	-	-	-0.6 [‡] (-0.9, -0.3)	-0.4 [‡] (-0.7, -0.2)
Difference from alogliptin (adjusted mean [†] with 95% confidence interval)	-	-	-	-	-0.7 [‡] (-1.0, -0.4)	-1.0 [‡] (-1.3, -0.7)
% Patients (n/N) achieving A1C <7% [§]	4% (4/102)	20% (21/104)	27% (28/103)	34% (37/108)	47% [‡] (48/102)	59% [‡] (66/111)
FPG (mg/dL)*	N=105	N=106	N=106	N=110	N=106	N=112
Baseline (mean)	187	177	180	181	176	185
Change from baseline (adjusted mean [†])	12	-10	-12	-32	-32	-46
Difference from metformin (adjusted mean [†] with 95% confidence interval)	-	-	-	-	-20 [‡] (-33, -8)	-14 [‡] (-26, -2)
Difference from alogliptin (adjusted mean [†] with 95% confidence interval)	-	-	-	-	-22 [‡] (-35, -10)	-36 [‡] (-49, -24)
2-Hour PPG (mg/dL)[¶]	N=26	N=34	N=28	N=37	N=31	N=37
Baseline (mean)	263	272	247	266	261	268
Change from baseline (adjusted mean [†])	-21	-43	-49	-54	-68	-86 [‡]
Difference from metformin (adjusted mean [†] with 95% confidence interval)	-	-	-	-	-19 (-49, 11)	-32 [‡] (-58, -5)
Difference from alogliptin (adjusted mean [†] with 95% confidence interval)	-	-	-	-	-25 (-53, 3)	-43 [‡] (-70, -16)

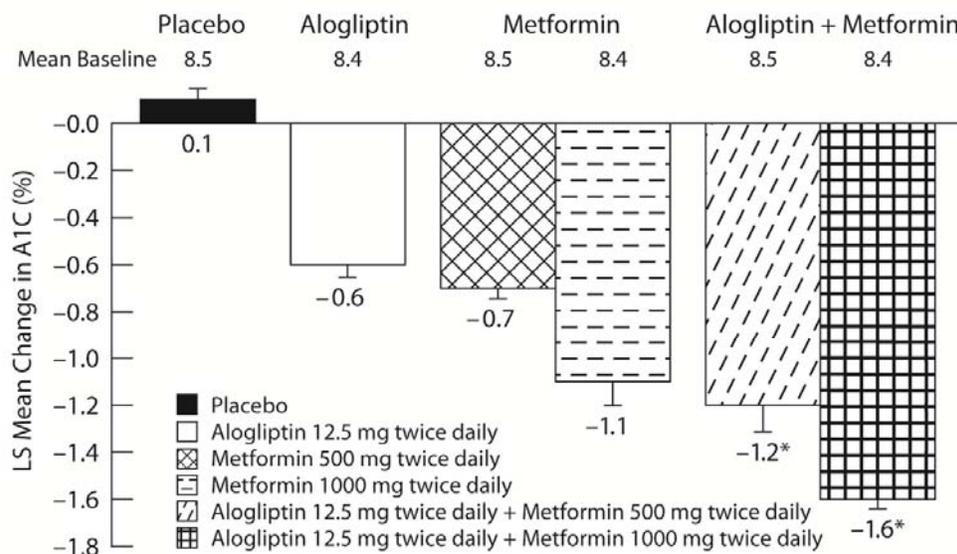
*Intent-to-treat population using last observation on study prior to discontinuation of double-blind study medication or sulfonylurea rescue therapy for patients needing rescue.

[†]Least squares means adjusted for treatment, geographic region and baseline value.

[‡]p<0.05 when compared to metformin and alogliptin alone

[§]Compared using logistic regression.

[¶]Intent to treat population using data available at Week 26

758
759**Figure 3. Change From Baseline A1C at Week 26 with Alogliptin and Metformin Alone and Alogliptin in Combination with Metformin**

Intent-to-treat population using last observation on study prior to discontinuation of double-blind study medication or sulfonylurea rescue therapy for patients needing rescue.

*P<0.001 when compared to metformin and alogliptin alone.

760

761 **Alogliptin and Metformin Coadministration in Patients with Type 2 Diabetes** 762 **Inadequately Controlled on Metformin Alone**

763 In a 26-week double-blind, placebo-controlled study, a total of 527 patients already on
764 metformin (mean baseline A1C=8%) were randomized to receive alogliptin 12.5 mg,
765 alogliptin 25 mg, or placebo once daily. Patients were maintained on a stable dose of
766 metformin HCl (median daily dose=1700 mg) during the treatment period. Alogliptin 25
767 mg in combination with metformin resulted in statistically significant improvements from
768 baseline in A1C and FPG at Week 26, when compared to placebo (*Table 7*). A total of
769 8% of patients receiving alogliptin 25 mg and 24% of patients receiving placebo
770 required glycemic rescue. Improvements in A1C were not affected by gender, age, race,
771 baseline BMI, or baseline metformin dose.

772 The mean decrease in body weight was similar between alogliptin 25 mg and placebo
773 when given in combination with metformin. Lipid effects were also neutral.

774

775

Table 7. Glycemic Parameters at Week 26 in a Placebo-Controlled Study of Alogliptin as Add-on Therapy to Metformin*		
	Alogliptin 25 mg + Metformin	Placebo + Metformin
A1C (%)	N=203	N=103
Baseline (mean)	7.9	8.0
Change from baseline (adjusted mean [†])	-0.6	-0.1
Difference from placebo (adjusted mean [†] with 95% confidence interval)	-0.5 [‡] (-0.7, -0.3)	—
% of patients (n/N) achieving A1C ≤7% [‡]	44% (92/207) [‡]	18% (19/104)
FPG (mg/dL)	N=204	N=104
Baseline (mean)	172	180
Change from baseline (adjusted mean [†])	-17	0
Difference from placebo (adjusted mean [†] with 95% confidence interval)	-17 [‡] (-26, -9)	—

*Intent-to-treat population using last observation on study.

[†]Least squares means adjusted for treatment, baseline value, geographic region, and baseline metformin dose.

[‡]p<0.001 compared to placebo.

776 **Alogliptin Add-on Therapy in Patients with Type 2 Diabetes Inadequately** 777 **Controlled on the Combination of Metformin and Pioglitazone**

778 In a 52-week, active-comparator study, a total of 803 patients inadequately controlled
779 (mean baseline A1C=8.2%) on a current regimen of pioglitazone 30 mg and metformin
780 were randomized to either receive the addition of once daily alogliptin 25 mg or the
781 titration of pioglitazone 30 mg to 45 mg following a 4-week single-blind, placebo run-in
782 period. Patients were maintained on a stable dose of metformin HCl (median daily
783 dose=1700 mg). Patients who failed to meet pre-specified hyperglycemic goals during
784 the 52-week treatment period received glycemic rescue therapy.

785 In combination with pioglitazone and metformin, alogliptin 25 mg was shown to be
786 statistically superior in lowering A1C and FPG compared with the titration of
787 pioglitazone from 30 to 45 mg at Week 26 and at Week 52 (*Table 8*). A total of 11% of
788 patients in the alogliptin 25 mg in combination with pioglitazone 30 mg and metformin
789 treatment group and 22% of patients in the up titration of pioglitazone in combination
790 with metformin treatment group required glycemic rescue. Improvements in A1C were
791 not affected by gender, age, race, or baseline BMI.

792 The mean increase in body weight was similar in both treatment arms. Lipid effects
793 were neutral.

794

Table 8. Glycemic Parameters at Week 52 in an Active-Controlled Study of Alogliptin as Add-on Combination Therapy to Metformin and Pioglitazone*		
	Alogliptin 25 mg + Pioglitazone 30 mg + Metformin	Pioglitazone 45 mg + Metformin
A1C (%)	N=397	N=394
Baseline (mean)	8.2	8.1
Change from Baseline (adjusted mean [†])	-0.7	-0.3
Difference from Pioglitazone 45 mg + Metformin* (adjusted mean [†] with 95% confidence interval)	-0.4 [‡] (-0.5, -0.3)	—
% of Patients (n/N) achieving A1C ≤7%	33% (134/404) [§]	21% (85/399)
FPG (mg/dL)[‡]	N=399	N=396
Baseline (mean)	162	162
Change from Baseline (adjusted mean [†])	-15	-4
Difference from Pioglitazone 45 mg + Metformin (adjusted mean [†] with 95% confidence interval)	-11 [§] (-16, -6)	—

* Intent-to-treat population using last observation on study.

[†] Least squares means adjusted for treatment, baseline value, geographic region, and baseline metformin dose.

[‡] Non-inferior and statistically superior to metformin plus pioglitazone at the 0.025 1-sided significance level.

[§]p<0.001 compared to pioglitazone 45 mg + metformin.

795 **16 HOW SUPPLIED/STORAGE AND HANDLING**

796 KAZANO tablets are available in the following strengths and packages:

797 12.5 mg/500 mg tablet: pale yellow, oblong, film-coated tablets with “12.5/500”
798 debossed on one side and “322M” debossed on the other side, available in:

799 NDC 64764-335-60 Bottles of 60 tablets

800 NDC 64764-335-80 Bottles of 180 tablets

801 NDC 64764-335-77 Bottles of 500 tablets

802 12.5 mg/1000 mg tablet: pale yellow, oblong, film-coated tablets with “12.5/1000”

803 debossed on one side and “322M” debossed on the other side, available in:

804	NDC 64764-337-60	Bottles of 60 tablets
805	NDC 64764-337-80	Bottles of 180 tablets
806	NDC 64764-337-77	Bottles of 500 tablets

807 **Storage**

808 Store at 25°C (77°F); excursions permitted to 15° to 30°C (59° to 86°F) [see USP
809 Controlled Room Temperature]. Keep container tightly closed.

810 **17 PATIENT COUNSELING INFORMATION**

811 See FDA-Approved Patient Labeling (Medication Guide).

812 **17.1 Instructions**

- 813 • Inform patients of the potential risks and benefits of KAZANO.
- 814 • The risks of lactic acidosis, its symptoms, and conditions that predispose to its
815 development, as noted in *Warnings and Precautions (5.1)*, should be explained to
816 patients. Patients should be advised to discontinue KAZANO immediately and to
817 promptly notify their health practitioner if unexplained hyperventilation, myalgias,
818 malaise, unusual somnolence, or other nonspecific symptoms occur. Once a patient
819 is stabilized on any dose level of KAZANO, gastrointestinal symptoms, which are
820 common during initiation of metformin therapy, are unlikely to recur. Later
821 occurrence of gastrointestinal symptoms could be due to lactic acidosis or other
822 serious disease.
- 823 • Patients should be informed that acute pancreatitis has been reported during use of
824 alogliptin. Patients should be informed that persistent, severe abdominal pain,
825 sometimes radiating to the back, which may or may not be accompanied by
826 vomiting, is the hallmark symptom of acute pancreatitis. Patients should be
827 instructed to promptly discontinue KAZANO and contact their physician if persistent
828 severe abdominal pain occurs.
- 829
- 830 • Patients should be informed that allergic reactions have been reported during use of
831 alogliptin and metformin. If symptoms of allergic reactions (including skin rash,
832 hives, and swelling of the face, lips, tongue, and throat that may cause difficulty in
833 breathing or swallowing) occur, patients should be instructed to discontinue
834 KAZANO and seek medical advice promptly.
- 835
- 836 • Patients should be informed that postmarketing reports of liver injury, sometimes
837 fatal, have been reported during use of alogliptin. If signs or symptoms of liver injury
838 occur, patients should be instructed to discontinue KAZANO and seek medical
839 advice promptly.
- 840
- 841
- 842 • Patients should be informed about the importance of regular testing of renal function
843 and hematological parameters when receiving treatment with KAZANO.

- 844 • Patients should be counseled against excessive alcohol intake, either acute or
845 chronic, while receiving KAZANO.
- 846 • Inform patients that hypoglycemia can occur, particularly when an insulin
847 secretagogue or insulin is used in combination with KAZANO. Explain the risks,
848 symptoms, and appropriate management of hypoglycemia.
- 849 • Instruct patients to take KAZANO only as prescribed twice daily. KAZANO should be
850 taken with food. If a dose is missed, advise patients not to double their next dose.
- 851 • Patients should be informed that the tablets must never be split.

852 Instruct patients to read the Medication Guide before starting KAZANO therapy and to
853 reread each time the prescription is refilled. Instruct patients to inform their healthcare
854 provider if an unusual symptom develops or if a symptom persists or worsens.

855 **Distributed by:**
856 **Takeda Pharmaceuticals America, Inc.**
857 Deerfield, IL 60015

858 Revised: January 2013
859

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866 **MEDICATION GUIDE**

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MEDICATION GUIDE
KAZANO (Kah-ZAHN-oh)
(alogliptin and metformin HCl)
tablets

Read this Medication Guide carefully before you start taking KAZANO and each time you get a refill. There may be new information. This information does not take the place of talking with your doctor about your medical condition or treatment. If you have any questions about KAZANO, ask your doctor or pharmacist.

What is the most important information I should know about KAZANO?

KAZANO can cause serious side effects, including:

1. **Lactic Acidosis.** Metformin, one of the medicines in KAZANO can cause a rare, but serious condition called lactic acidosis (a buildup of an acid in the blood) that can cause death. Lactic acidosis is a medical emergency and must be treated in the hospital.

Stop taking KAZANO and call your doctor right away if you get any of the following symptoms of lactic acidosis:

- feel very weak or tired
- have unusual (not normal) muscle pain
- have trouble breathing
- have unusual sleepiness or sleep longer than usual
- have unexplained stomach or intestinal problems with nausea and vomiting, or diarrhea
- feel cold, especially in your arms and legs
- feel dizzy or lightheaded
- have a slow or irregular heartbeat

You have a higher chance for getting lactic acidosis with KAZANO if you:

- have kidney problems. People whose kidneys are not working properly should not take KAZANO.
 - have liver problems
 - have congestive heart failure that requires treatment with medicines
 - drink a lot of alcohol (very often or short-term “binge” drinking)
 - get dehydrated (lose a large amount of body fluids). This can happen if you are sick with a fever, vomiting, or diarrhea. Dehydration can also happen when you sweat a lot with activity or exercise and do not drink enough fluids.
 - have certain x-ray tests with injectable dyes or contrast agents
 - have surgery
 - have a heart attack, severe infection, or stroke
2. **Inflammation of the pancreas (pancreatitis).** Alogliptin, one of the medicines in KAZANO, may cause pancreatitis which may be severe.

Certain medical conditions make you more likely to get pancreatitis.

Before you start taking KAZANO:

Tell your doctor if you have ever had:

- pancreatitis
- stones in your gallbladder (gallstones)
- a history of alcoholism
- kidney problems
- liver problems

Stop taking KAZANO and call your doctor right away if you have pain in your stomach area (abdomen) that is severe and will not go away. The pain may be felt going from your abdomen through to your back. The pain may happen with or without vomiting. These may be symptoms of pancreatitis.

What is KAZANO?

- KAZANO contains 2 prescription diabetes medicines, alogliptin (NESINA) and metformin hydrochloride.
- KAZANO is a prescription medicine used with diet and exercise to improve blood sugar (glucose) control in adults with type 2 diabetes.
- KAZANO is not for people with type 1 diabetes.
- KAZANO is not for people with diabetic ketoacidosis (increased ketones in blood or urine).

It is not known if KAZANO is safe and effective in children under the age of 18.

Who should not take KAZANO?

Do not take KAZANO if you:

- have kidney problems
- have a condition called metabolic acidosis or have had diabetic ketoacidosis (increased ketones in your blood or urine)
- are going to get an injection of dye or contrast agents for an x-ray procedure, KAZANO will need to be stopped for a short time. Talk to your doctor about when you should stop KAZANO and when you should start KAZANO again.
- are allergic to alogliptin (NESINA) or metformin or any of the ingredients in KAZANO or have had a serious allergic (hypersensitivity) reaction to alogliptin or metformin. See the end of this Medication Guide for a complete list of the ingredients in KAZANO.

Symptoms of a serious allergic reaction to KAZANO may include:

- swelling of your face, lips, throat, and other areas on your skin
- difficulty with swallowing or breathing
- raised, red areas on your skin (hives)
- skin rash, itching, flaking, or peeling

If you have any of these symptoms, stop taking KAZANO and contact your doctor right away or go to the nearest hospital emergency room.

What should I tell my doctor before and during treatment with KAZANO?

Before you take KAZANO, tell your doctor if you:

- have or have had inflammation of your pancreas (pancreatitis)
- have kidney or liver problems
- have heart problems, including congestive heart failure
- are older than 80 years, you should not take KAZANO unless your kidneys have been checked and they are normal
- drink alcohol very often, or drink a lot of alcohol in short-term “binge” drinking
- have other medical conditions
- are pregnant or plan to become pregnant. It is not known if KAZANO will harm your unborn baby. Talk with your doctor about the best way to control your blood sugar while you are pregnant or if you plan to become pregnant.
- are breast-feeding or plan to breast-feed. It is not known whether KAZANO passes into your breast milk. Talk with your doctor about the best way to feed your baby if you are taking KAZANO.

Tell your doctor about all the medicines you take, including prescription and nonprescription medicines, vitamins, and herbal supplements. Know the medicines you take. Keep a list of them and show it to your doctor and pharmacist before you start any new medicine

KAZANO may affect the way other medicines work, and other medicines may affect how KAZANO works. Contact your doctor before you start or stop other types of medicines.

How should I take KAZANO?

- Take KAZANO exactly as your doctor tells you to take it.
- Take KAZANO 2 times each day.
- Take KAZANO with food to lower your chances of having an upset stomach.
- Do not break or cut KAZANO tablets before swallowing.
- Your doctor may need to change your dose of KAZANO to control your blood glucose. Do not change your dose unless told to do so by your doctor.
- 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 take the next dose at your regular schedule. Do not take 2 doses of KAZANO at the same time.
- If you take too much KAZANO, call your doctor or go to the nearest hospital emergency room right away.
- If your body is under stress, such as from fever, infection, accident, or surgery, the dose of your diabetes medicines may need to be changed. Call your doctor right away.

- Stay on your diet and exercise programs and check your blood sugar as your doctor tells you to.
- Your doctor may do certain blood tests before you start KAZANO and during treatment as needed. Your doctor may ask you to stop taking KAZANO based on the results of your blood tests due to how well your kidneys are working.
- Your doctor will check your diabetes with regular blood tests, including your blood sugar levels and your hemoglobin A1C.

What are the possible side effects of KAZANO?

KAZANO can cause serious side effects, including:

- See “**What is the most important information I should know about KAZANO?**”

- **Allergic (hypersensitivity) reactions**, such as:
 - swelling of your face, lips, throat, and other areas on your skin
 - difficulty swallowing or breathing
 - raised, red areas on your skin (hives)
 - skin rash, itching, flaking or peeling

If you have these symptoms, stop taking KAZANO and contact your doctor right away.

- **Liver problems.** Call your doctor right away if you have symptoms, such as:
 - nausea or vomiting
 - stomach pain
 - unusual or unexplained tiredness
 - loss of appetite
 - dark urine
 - yellowing of your skin or the whites of your eyes
- **Low blood sugar (hypoglycemia).** If you take KAZANO with another medicine that can cause low blood sugar, such as a sulfonylurea or insulin, your risk of getting low blood sugar is higher. The dose of your sulfonylurea medicine or insulin may need to be lowered while you take KAZANO. If you have symptoms of low blood sugar, you should check your blood sugar and treat if low, and then call your doctor. Signs and symptoms of low blood sugar may include:

• shaking or feeling jittery	• headache
• sweating	• change in mood
• fast heartbeat	• confusion
• change in vision	• dizziness
• hunger	

The most common side effects of KAZANO include:

- cold-like symptoms (upper respiratory tract infection)
- stuffy or runny nose and sore throat

- diarrhea
- increase in blood pressure
- headache
- back pain
- urinary tract infection

Taking KAZANO with food can help lessen the common stomach side effects of metformin that usually happen at the beginning of treatment. If you have unexplained stomach problems, tell your doctor. Stomach problems that start later, during treatment may be a sign of something more serious.

Tell your doctor if you have any side effect that bothers you or that does not go away.

These are not all the possible side effects of KAZANO. For more information, ask your doctor or pharmacist.

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

How should I store KAZANO?

- Store KAZANO at room temperature between 68°F to 77°F (20°C to 25°C).
- Keep the container of KAZANO tightly closed.

Keep KAZANO and all medicines out of the reach of children.

General information about the safe and effective use of KAZANO

Medicines are sometimes prescribed for purposes other than those listed in the Medication Guide. Do not take KAZANO for a condition for which it was not prescribed. Do not give KAZANO to other people, even if they have the same symptoms you have. It may harm them.

This Medication Guide summarizes the most important information about KAZANO. If you would like more information, talk with your doctor. You can ask your doctor or pharmacist for information about KAZANO that is written for health professionals.

For more information go to www.kazano.com or call 1-877-TAKEDA-7 (1-877-825-3327).

What are the ingredients in KAZANO?

Active ingredients: alogliptin and metformin hydrochloride

Inactive ingredients: mannitol, microcrystalline cellulose, povidone, crospovidone, and magnesium stearate; the tablets are film-coated with hypromellose 2910, talc, titanium dioxide, and ferric oxide yellow.

This Medication Guide has been approved by the U.S. Food and Drug Administration.

Distributed by:

Takeda Pharmaceuticals America, Inc.

Deerfield, IL 60015

Revised: January 2013

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