

**PRODUCT MONOGRAPH
INCLUDING PATIENT MEDICATION INFORMATION**

PrINVOKAMET[®]

canagliflozin and metformin hydrochloride tablets
(canagliflozin (as anhydrous canagliflozin) and metformin hydrochloride)

50 mg/500 mg, 50 mg/850 mg, 50 mg/1000 mg, 150 mg/500 mg, 150 mg/850 mg and 150
mg/1000 mg

ATC Code: A10BD16

Combinations of oral blood glucose lowering drugs excl. insulins

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Pr INVOKAMET®

canagliflozin and metformin hydrochloride tablets

PART I: HEALTH PROFESSIONAL INFORMATION

Note: for additional information on canagliflozin and metformin hydrochloride, consult the individual Product Monographs.

SUMMARY PRODUCT INFORMATION

Route of Administration	Dosage Form / Strength	Clinically Relevant Nonmedicinal Ingredients
Oral	Tablets Canagliflozin (on anhydrous basis) / metformin HCl 50 mg/500 mg, 50 mg/850 mg, 50 mg/1000 mg, 150 mg/500 mg, 150 mg/850 mg, 150 mg/1000 mg	For a complete listing see DOSAGE FORMS, COMPOSITION AND PACKAGING section.

INDICATIONS AND CLINICAL USE

INVOKAMET® is indicated to improve glycemic control as an adjunct to diet and exercise in adult patients with type 2 diabetes mellitus inadequately controlled on:

- metformin
- a sulfonylurea in combination with metformin
- pioglitazone in combination with metformin
- insulin in combination with metformin

Or in patients already being treated and achieving glycemic control with:

- metformin and canagliflozin as separate tablets
- a sulfonylurea in combination with metformin and canagliflozin as separate tablets
- pioglitazone in combination with metformin and canagliflozin as separate tablets
- insulin in combination with metformin and canagliflozin as separate tablets

Geriatrics

Patients 65 years and older had a higher incidence of adverse reactions related to reduced intravascular volume with canagliflozin, including hypotension, postural dizziness, orthostatic hypotension, syncope, and dehydration. Reactions were more common in patients over 75 years of age and with the 300 mg daily dose (see **WARNINGS AND PRECAUTIONS, ADVERSE REACTIONS** and **DOSAGE AND ADMINISTRATION**). Smaller reductions in HbA1C with canagliflozin relative to placebo were seen in patients 65 years and older, compared to younger

patients (see **WARNINGS AND PRECAUTIONS, Special Populations**). Treatment with INVOKAMET[®] can reduce renal function. Metformin is eliminated by the kidney, and the risk of serious adverse reactions to the drug is greater in patients with impaired renal function. INVOKAMET[®] should be used with caution as age increases. The dosage of INVOKAMET[®] should be adjusted based on renal function. Regular assessment of renal function is necessary (see **WARNINGS AND PRECAUTIONS, DOSAGE AND ADMINISTRATION** and **ACTION AND CLINICAL PHARMACOLOGY, Pharmacokinetics**).

Pediatrics

The safety and efficacy of INVOKAMET[®] in pediatric patients under 18 years of age have not been established. Therefore, INVOKAMET[®] should not be used in this population.

CONTRAINDICATIONS

- Known hypersensitivity to canagliflozin or metformin or to any ingredient in the formulation or component of the container. For a complete listing, see **DOSAGE FORMS, COMPOSITION AND PACKAGING**.
- In patients with serum creatinine levels above the upper limit of normal range or when renal function is not known, renal disease or renal dysfunction, e.g., as suggested by serum creatinine levels ≥ 136 $\mu\text{mol/L}$ (males), ≥ 124 $\mu\text{mol/L}$ (females), or abnormal creatinine clearance (<60 mL/min), which may result from conditions such as cardiovascular collapse (shock), acute myocardial infarction, and septicemia (see **WARNINGS AND PRECAUTIONS**).
- Acute or chronic metabolic acidosis, including diabetic ketoacidosis, with or without coma, history of ketoacidosis with or without coma, history of lactic acidosis, irrespective of precipitating factors (see **WARNINGS AND PRECAUTIONS**).
- Unstable and/or insulin-dependent (Type I) diabetes mellitus.
- Excessive alcohol intake, acute or chronic.
- Severe hepatic dysfunction, since severe hepatic dysfunction has been associated with some cases of lactic acidosis, INVOKAMET[®] (canagliflozin/metformin hydrochloride) should not be used in patients with clinical or laboratory evidence of hepatic disease (see **WARNINGS AND PRECAUTIONS, Hepatic**).
- Cardiovascular collapse and in disease states associated with hypoxemia such as cardiorespiratory insufficiency, which are often associated with hyperlactacidemia.
- Stress conditions, such as severe infections, trauma or surgery and the recovery phase thereafter.
- Severe dehydration.

- During pregnancy and breastfeeding (see **WARNINGS AND PRECAUTIONS, Special Populations**).
- Period around administration of iodinated contrast materials, because the use of such products may result in acute alteration of renal function (see **WARNINGS AND PRECAUTIONS, Renal**).

WARNINGS AND PRECAUTIONS

Serious Warnings and Precautions

Lactic Acidosis

- Lactic acidosis is a rare, but serious, metabolic complication that can occur due to metformin accumulation during treatment with INVOKAMET[®] (canagliflozin/metformin hydrochloride) (see **Endocrine and Metabolism, Lactic Acidosis**).
- Patients should be cautioned against excessive alcohol intake, either acute or chronic, when taking INVOKAMET[®] since alcohol intake potentiates the effect of metformin on lactate metabolism (see **Endocrine and Metabolism, Lactic Acidosis**).

Diabetic Ketoacidosis

- Clinical trial and post-market cases of diabetic ketoacidosis (DKA), a serious life-threatening condition requiring urgent hospitalization, have been reported in patients with type 2 diabetes mellitus (T2DM) treated with canagliflozin and other sodium-glucose co-transporter 2 (SGLT2) inhibitors. Some cases of DKA have been fatal. A number of cases have been atypical with blood glucose values below 13.9 mmol/L (250 mg/dL) (see ADVERSE REACTIONS).
- Patients should be assessed for diabetic ketoacidosis immediately if non-specific symptoms such as difficulty breathing, nausea, vomiting, abdominal pain, confusion, anorexia, excessive thirst and unusual fatigue or sleepiness occur, regardless of blood glucose level. If DKA is suspected or diagnosed, INVOKAMET[®] should be **discontinued immediately**.
- INVOKAMET[®] should not be used for the treatment of DKA or in patients with a history of DKA.
- INVOKAMET[®] is not indicated, and should not be used, in patients with type 1 diabetes.

Cardiovascular

Canagliflozin

Reduced Intravascular Volume

Due to its mechanism of action, canagliflozin increases urinary glucose excretion (UGE) and induces an osmotic diuresis, which may reduce intravascular volume. Patients most susceptible

to adverse reactions related to reduced intravascular volume (e.g., postural dizziness, orthostatic hypotension, hypotension or renal failure) include patients with moderate renal impairment, elderly patients, patients on loop diuretics or medications that interfere with the renin-angiotensin-aldosterone system (e.g., angiotensin-converting-enzyme [ACE] inhibitors, angiotensin receptor blockers [ARBs]), and patients with low systolic blood pressure (see **ADVERSE REACTIONS, DRUG INTERACTIONS** and **DOSAGE AND ADMINISTRATION**). Before initiating INVOKAMET[®] in patients with one or more of these characteristics, volume status should be assessed and any volume depletion corrected. Caution should also be exercised in other patients for whom a drop in blood pressure could pose a risk, such as patients with known cardiovascular disease. Monitor for signs and symptoms after initiating therapy. Patients should be advised to report symptoms of reduced intravascular volume.

In placebo-controlled clinical studies of canagliflozin, increases in adverse reactions related to reduced intravascular volume were seen more commonly with the 300 mg canagliflozin dose and occurred most frequently in the first three months (see **ADVERSE REACTIONS**).

INVOKAMET[®] is not recommended for use in patients receiving loop diuretics (see **ADVERSE REACTIONS** and **DOSAGE AND ADMINISTRATION**) or who are volume depleted.

In case of intercurrent conditions that may lead to volume depletion (such as a gastrointestinal illness), careful monitoring of volume status (e.g., physical examination, blood pressure measurements, laboratory tests including renal function tests), and serum electrolytes is recommended. In the case of volume depletion, temporary interruption of treatment with INVOKAMET[®] may be considered until the condition is corrected, and more frequent glucose monitoring may be considered.

Metformin

Hypoxic States

Cardiovascular collapse (shock) from whatever cause (e.g., acute congestive heart failure, acute myocardial infarction and other conditions characterized by hypoxemia) have been associated with lactic acidosis and may also cause prerenal azotemia. When such events occur in patients on INVOKAMET[®] therapy, the drug should be promptly discontinued.

Endocrine and Metabolism

Canagliflozin

Diabetic ketoacidosis

Clinical trial and post-market cases of DKA, a serious life-threatening condition requiring urgent hospitalization, have been reported in patients with type 2 diabetes mellitus treated with SGLT2 inhibitors, including canagliflozin. Some cases of DKA have been fatal. In a number of reported cases, the presentation of the condition was atypical with blood glucose values below 13.9 mmol/L (250 mg/dL) (see **ADVERSE REACTIONS**).

INVOKAMET[®] should not be used in patients with type 1 diabetes. The diagnosis of T2DM should therefore be confirmed before initiating INVOKAMET[®].

INVOKAMET[®] is not indicated and should not be used for the treatment of DKA or in patients with a history of DKA.

DKA must be considered in the event of non-specific symptoms such as difficulty breathing, nausea, vomiting, abdominal pain, confusion, anorexia, excessive thirst and unusual fatigue or sleepiness.

If these symptoms occur, regardless of blood glucose level, patients should discontinue INVOKAMET[®] treatment and be assessed for diabetic ketoacidosis immediately.

SGLT2 inhibitors have been shown to increase blood ketones in clinical trial subjects. Conditions that can precipitate DKA while taking INVOKAMET[®] include a very low carbohydrate diet (as the combination may further increase ketone body production), dehydration, high alcohol consumption and a low beta-cell function reserve. These patients should be monitored closely. Caution should also be taken when reducing the insulin dose in patients requiring insulin (see **DOSAGE AND ADMINISTRATION**).

Consider interrupting treatment with INVOKAMET[®] in T2DM patients who are hospitalized for major surgical procedures, serious infections or acute serious medical illnesses.

Hypoglycemia in Add-on Therapy with other Antihyperglycemic Agents

When canagliflozin was used as add-on therapy with insulin or an insulin secretagogue (e.g., sulfonylurea), the incidence of hypoglycemia was increased over that of placebo. Therefore, to lower the risk of hypoglycemia, a dose reduction of insulin or an insulin secretagogue may be considered (see **ADVERSE REACTIONS** and **DOSAGE AND ADMINISTRATION**).

Increases in Low-Density Lipoprotein (LDL-C)

Dose-related increases in LDL-C are seen with canagliflozin treatment (see **ADVERSE REACTIONS**). LDL-C levels should be monitored.

Hyperkalemia

Canagliflozin can lead to hyperkalemia. Patients with moderate renal impairment who are taking medications that interfere with potassium excretion, such as potassium-sparing diuretics, or medications that interfere with the renin-angiotensin-aldosterone system are more likely to develop hyperkalemia (see **ADVERSE REACTIONS** and **DOSAGE AND ADMINISTRATION**). Serum potassium levels should be monitored periodically after initiating INVOKAMET[®] in patients with impaired renal function and in patients predisposed to hyperkalemia due to medications or other medical conditions (see **Monitoring and Laboratory Tests**).

Metformin

Hypoglycemia: Hypoglycemia does not occur in patients receiving metformin alone under usual circumstances of use, but could occur when caloric intake is deficient, when strenuous exercise is not compensated by caloric supplementation, or during concomitant use with other glucose lower agents or ethanol.

Elderly, debilitated, or malnourished patients and those with adrenal or pituitary insufficiency or alcohol intoxication are particularly susceptible to hypoglycemic effects. Hypoglycemia may be difficult to recognize in the elderly, and in people who are taking β -adrenergic blocking drugs.

Lactic Acidosis: Lactic acidosis is a rare, but serious, metabolic complication that occurs due to metformin accumulation during treatment with INVOKAMET[®]. When it occurs, it is fatal in approximately 50% of cases. Lactic acidosis may also occur in association with a number of pathophysiologic conditions, including diabetes mellitus, and whenever there is significant tissue hypoperfusion and hypoxemia. Lactic acidosis is characterized by elevated blood lactate levels (> 5 mmol/L), decreased blood pH, electrolyte disturbances with an increased anion gap, and an increased lactate/pyruvate ratio. When metformin is implicated as the cause of lactic acidosis, metformin plasma levels >5 μ g/mL are generally found.

The reported incidence of lactic acidosis in patients receiving metformin HCl is very low (approximately 0.03 cases / 1000 patient-years, with approximately 0.015 fatal cases / 1000 patient-years) and occurs primarily in diabetic patients with significant renal insufficiency, including both intrinsic renal disease and renal hypoperfusion, often in the setting of multiple concomitant medical/surgical problems and multiple concomitant medications. Patients with congestive heart failure requiring pharmacologic management, in particular those with unstable or acute congestive heart failure who are at risk of hypoperfusion and hypoxemia, are at increased risk of lactic acidosis. In particular, treatment of the elderly should be accompanied by careful monitoring of renal function. INVOKAMET[®] treatment should not be initiated in patients ≥ 80 years of age, unless measurement of creatinine clearance demonstrates that renal function is not reduced, as the patients are more susceptible to developing lactic acidosis. The risk of lactic acidosis increases with the degree of renal dysfunction and the patient's age. The risk of lactic acidosis may, therefore, be significantly decreased by regular monitoring of renal function in patients taking metformin and by use of the minimum effective dose of metformin. In addition, INVOKAMET[®] should be promptly withheld in the presence of any condition associated with hypoxemia, dehydration or sepsis. Because impaired hepatic function may significantly limit the ability to clear lactate, INVOKAMET[®] should generally be avoided in patients with clinical or laboratory evidence of hepatic disease. Patients should be cautioned against excessive alcohol intake, either acute or chronic, when taking metformin (metformin HCl), since alcohol intake potentiates the effect of metformin HCl on lactate metabolism. In addition, INVOKAMET[®] should be temporarily discontinued prior to any intravascular radiocontrast study and for any surgical procedure.

The onset of lactic acidosis is often subtle, and accompanied only by nonspecific symptoms such as malaise, myalgia, respiratory distress, increasing somnolence and non-specific abdominal distress. There may be associated hypothermia, hypotension and resistance bradyarrhythmias with more marked acidosis. The patient and the patient's physician must be aware of the possible importance of such symptoms and the patient should be instructed to notify the physician

immediately if they occur. INVOKAMET[®] should be withdrawn until the situation is clarified. Serum electrolytes, ketones, blood glucose and, if indicated, blood pH, lactate levels and even blood metformin levels may be useful. Once a patient is stabilized on any dose level of metformin, gastrointestinal symptoms, which are common during initiation of therapy, are unlikely to be drug related. Later occurrence of gastrointestinal symptoms could be due to lactic acidosis or other serious disease. In patients taking metformin, levels of fasting venous plasma lactate above the upper limit of normal but less than 5 mmol/L, do not necessarily indicate impending lactic acidosis and may be explainable by other mechanisms, such as poorly controlled diabetes or obesity, vigorous physical activity or technical problems in sample handling. Lactic acidosis should be suspected in any diabetic patient with metabolic acidosis lacking evidence of ketoacidosis (ketonuria and ketonemia).

Lactic acidosis is a medical emergency that must be treated in a hospital setting. In a patient with lactic acidosis who is taking INVOKAMET[®], the drug should be discontinued immediately and general supportive measures should be promptly instituted. Because metformin HCl is dialysable (with clearance of up to 170 mL/min under good hemodynamic conditions), prompt hemodialysis is recommended to correct the acidosis and remove the accumulated metformin.

Physicians should instruct their patients to recognize the symptoms which could be signal onset of lactic acidosis. If acidosis of any kind develops, INVOKAMET[®] should be discontinued immediately and the patient should be immediately hospitalized.

Change in Clinical Status in Patients with Previously Controlled Type 2 Diabetes: A patient with type 2 diabetes previously well-controlled on INVOKAMET[®] who develops laboratory abnormalities or clinical illness (especially vague and poorly defined illness) should be evaluated promptly for evidence of ketoacidosis or lactic acidosis. Evaluation should include serum electrolytes and ketones, blood glucose and, if indicated, blood pH, lactate, pyruvate, and metformin levels. If acidosis of either form occurs, INVOKAMET[®] must be stopped immediately and other appropriate corrective measures initiated.

Loss of control of blood glucose: When a patient stabilized on any diabetic regimen is exposed to stress such as fever, trauma, infection, or surgery, a temporary loss of glycemic control may occur. At such times, it may be necessary to withhold INVOKAMET[®] and temporarily administer insulin. INVOKAMET[®] may be reinstituted after the acute episode is resolved.

Vitamin B₁₂ levels: In controlled clinical trials of metformin of 29-week duration, a decrease to subnormal levels of previously normal serum Vitamin B₁₂ levels, without clinical manifestations, was observed in approximately 7% of patients. Such decrease, possibly due to interference with B₁₂ absorption from the B₁₂-intrinsic factor complex, is, however, very rarely associated with anemia and appears to be rapidly reversible with discontinuation of metformin or Vitamin B₁₂ supplementation. Measurement of hematologic parameters on an annual basis is advised in patients on metformin and any apparent abnormalities should be appropriately investigated and managed (see **WARNINGS AND PRECAUTIONS, Monitoring and Laboratory Tests**). Certain individuals (those with inadequate Vitamin B₁₂ or calcium intake or absorption) appear to be predisposed to developing subnormal Vitamin B₁₂ levels.

Measurements of serum Vitamin B12 are advisable at least every one to two years in patients on long term INVOKAMET[®] therapy.

Genitourinary

Canagliflozin

Genital Mycotic Infections

Canagliflozin increases the risk of genital mycotic infections, consistent with the mechanism of increased urinary glucose. Patients with a history of genital mycotic infections and uncircumcised males were more likely to develop genital mycotic infections (see **ADVERSE REACTIONS**).

Urinary tract infections (including urosepsis and pyelonephritis)

Treatment with canagliflozin increases the risk for urinary tract infections (see **ADVERSE REACTIONS**). There have been post-marketing reports of serious urinary tract infections, including urosepsis and pyelonephritis, requiring hospitalization in patients treated with canagliflozin.

Hematologic

Canagliflozin

Elevated Hemoglobin and Hematocrit

Mean hemoglobin and hematocrit increased in patients administered canagliflozin, as did the frequency of patients with abnormally elevated values for hemoglobin/hematocrit (see **ADVERSE REACTIONS**). INVOKAMET[®] should be used with caution in patients with an elevated hematocrit.

Hepatic

Metformin

INVOKAMET[®] is contraindicated in patients with clinical or laboratory evidence of hepatic disease (see **CONTRAINDICATIONS**). Impaired hepatic function has been associated with some cases of lactic acidosis.

Immune

Hypersensitivity

Serious hypersensitivity reactions, including angioedema and anaphylaxis, have been reported post-market in patients treated with canagliflozin. If a hypersensitivity reaction is suspected, discontinue INVOKAMET[®], assess for other potential causes and initiate alternative treatment for diabetes (see **ADVERSE REACTIONS, Post-Market Adverse Drug Reactions**).

Musculoskeletal

Bone fractures: An increased risk of bone fractures, occurring as early as 12 weeks after treatment initiation, was observed in patients using canagliflozin. Consider factors that contribute to fracture risk prior to initiating canagliflozin.

Peri-Operative Considerations

Metformin

INVOKAMET[®] therapy should be temporarily discontinued for any surgical procedure (except minor procedures not associated with restricted intake of food and fluids). INVOKAMET[®] should be discontinued 2 days before surgical intervention and should not be restarted until the patient's oral intake has resumed and renal function has been evaluated as normal.

Renal

Impairment of renal function

Canagliflozin

Canagliflozin increases serum creatinine and decreases eGFR in a dose dependent fashion. In clinical trials, renal function abnormalities have occurred after initiating canagliflozin. Post-marketing cases of acute kidney injury, including acute renal failure and a decline in eGFR, shortly after initiation of canagliflozin treatment have been reported. Patients with hypovolemia may be more susceptible to these changes (see **WARNINGS AND PRECAUTIONS**, **Cardiovascular** and **ADVERSE REACTIONS**).

Renal function should be assessed prior to initiation of INVOKAMET[®] and regularly thereafter. More frequent renal function monitoring is recommended in patients whose eGFR decreases to < 60 mL/min/1.73 m² after initiating treatment.

Metformin

Metformin is excreted by the kidney, and the risk of metformin accumulation and lactic acidosis increases with the degree of impairment of renal function. Thus, patients with serum creatinine levels above the upper limit of the normal range for their age should not receive INVOKAMET[®]. Before initiation of INVOKAMET[®] therapy and every 6 months while on INVOKAMET[®] therapy, renal function should be assessed and verified as being within normal range.

Decreased renal function occurs more commonly in elderly patients and can be asymptomatic. In patients in whom development of renal dysfunction is anticipated, renal function should be assessed more frequently and INVOKAMET[®] discontinued if evidence of renal impairment is present.

Special caution should be exercised in situations where renal function may become impaired, for example when initiating antihypertensive therapy or diuretic therapy and when starting therapy with an NSAID.

Use of Concomitant Medications that May Affect Renal Function or Metformin

Disposition: Concomitant medication(s) that may affect renal function or result in a significant hemodynamic change or interfere with the disposition of metformin such as cationic drugs that are eliminated by renal tubular secretion should be used with caution (see **DRUG INTERACTIONS**).

Administration of Iodinated Contrast Agent: Intravascular contrast studies with iodinated materials can lead to acute alteration of renal function and have been associated with lactic acidosis in patients receiving metformin (see **CONTRAINDICATIONS**). Therefore, in patients in whom any such study is planned, INVOKAMET® should be temporarily discontinued at the time of or prior to the procedure, and withheld for 48 hours subsequent to the procedure and reinstituted only after renal function has been re-evaluated and found to be normal.

Use in renal impairment: INVOKAMET® is contraindicated in patients with serum creatinine levels above the upper limit of normal range, as suggested by serum creatinine levels ≥ 136 $\mu\text{mol/L}$ (males), ≥ 124 $\mu\text{mol/L}$ (females) or abnormal creatinine clearance (<60 mL/min).

Special Populations

Pregnant Women: INVOKAMET® is contraindicated in pregnancy (see **CONTRAINDICATIONS**). There are no adequate and well-controlled studies in pregnant women with INVOKAMET® or its individual components, therefore, the safety of INVOKAMET® in pregnant women is not known.

Canagliflozin

Based on results from rat studies, canagliflozin may affect renal development and maturation. In a juvenile rat study, increased kidney weights and renal pelvic and tubular dilatation were evident at greater than or equal to 0.5 times clinical exposure from a 300 mg dose (see **TOXICOLOGY**).

Metformin hydrochloride

Metformin was not teratogenic in rats and rabbits at doses up to 600 mg/kg/day, or about two times the maximum recommended human daily dose on a body surface area basis. Determination of fetal concentrations demonstrated a partial placental barrier to metformin. Because animal reproduction studies are not always predictive of human response, metformin is contraindicated during pregnancy (see **CONTRAINDICATIONS**).

Nursing Women: INVOKAMET® is contraindicated during nursing (see **CONTRAINDICATIONS**). No studies in lactating animals have been conducted with INVOKAMET® or its individual components.

Canagliflozin

It is not known if canagliflozin is excreted in human milk. Available pharmacodynamic/toxicological data in animals have shown excretion of canagliflozin in the milk of lactating rats reaching levels which are approximately 1.4 times higher than plasma systemic exposure. Data in juvenile rats directly exposed to canagliflozin showed risk to the developing kidney (renal pelvic and tubular dilatations) during maturation.

Metformin

Studies in lactating rats show that metformin is excreted into milk and reaches levels comparable to those in plasma. Metformin is excreted into human breast milk.

Pediatrics: Safety and effectiveness of INVOKAMET[®] in pediatric patients under 18 years of age have not been established. Therefore, INVOKAMET[®] should not be used in this population.

Geriatrics: Metformin is eliminated by the kidney. INVOKAMET[®] treatment is associated with reduced renal function and should be used with caution as age increases because elderly patients are more likely to have decreased renal function (see **WARNINGS AND PRECAUTIONS, Renal** and **DOSAGE AND ADMINISTRATION, Geriatrics**).

Canagliflozin

Two thousand thirty-four (2,034) patients 65 years and older, and 345 patients 75 years and older were exposed to canagliflozin in nine clinical studies of canagliflozin (see **CLINICAL TRIALS**).

Patients 65 years and older had a higher incidence of adverse reactions related to reduced intravascular volume with canagliflozin (such as hypotension, postural dizziness, orthostatic hypotension, syncope, and dehydration), particularly with the 300 mg daily dose, compared to younger patients; more prominent increase in the incidence was seen in patients who were 75 years and older (see **DOSAGE AND ADMINISTRATION** and **ADVERSE REACTIONS**). Smaller reductions in HbA1C with canagliflozin relative to placebo were seen in older (65 years and older; -0.61% with canagliflozin 100 mg and -0.74% with canagliflozin 300 mg relative to placebo) compared to younger patients (-0.72% with canagliflozin 100 mg and -0.87% with canagliflozin 300 mg relative to placebo).

Metformin hydrochloride

Controlled clinical studies of metformin did not include sufficient numbers of elderly patients to determine whether they respond differently from younger patients, although other reported clinical experience has not identified differences in responses between the elderly and younger patients. Metformin is known to be substantially excreted by the kidney and because the risk of serious adverse reactions to the drug is greater in patients with impaired renal function, metformin should only be used in patients with normal renal function (see **CONTRAINDICATIONS**). Because aging is associated with reduced renal function, INVOKAMET[®] should be used with caution as age increases.

Hepatic Impairment: INVOKAMET[®] is contraindicated in patients with clinical or laboratory evidence of hepatic disease. INVOKAMET[®] has not been studied in patients with hepatic impairment. Metformin use in patients with impaired hepatic function has been associated with some cases of lactic acidosis. Canagliflozin has not been studied in patients with severe hepatic impairment.

Monitoring and Laboratory Tests

Renal function

Renal function should be assessed prior to initiation of INVOKAMET[®] and regularly thereafter (see **DOSAGE AND ADMINISTRATION**). INVOKAMET[®] is contraindicated in patients with a serum creatinine level above the upper limit of normal range [serum creatinine levels $\geq 136 \mu\text{mol/L}$ (males) or $\geq 124 \mu\text{mol/L}$ females)], abnormal creatinine clearance ($<60 \text{ mL/min}$), or when renal function is not known (see **CONTRAINDICATIONS**).

Hyperkalemia

Monitor serum potassium levels periodically after initiating INVOKAMET[®] in patients with impaired renal function and in patients predisposed to hyperkalemia due to medications or other medical conditions.

Reduced intravascular volume

Before initiating INVOKAMET[®], assess volume status, particularly in patients with moderate renal impairment, the elderly, in patients with low systolic blood pressure, or if on a loop diuretic, angiotensin-converting enzyme inhibitor (ACEi), or angiotensin receptor blocker (ARB).

In patients with hypovolemia, the condition should be corrected prior to initiation of INVOKAMET[®] (see **DOSAGE AND ADMINISTRATION**). For patients receiving INVOKAMET[®], in case of intercurrent conditions that may lead to volume depletion (such as a gastrointestinal illness), careful monitoring of volume status (e.g., physical examination, blood pressure measurements, laboratory tests including renal function tests), and serum electrolytes is recommended.

LDL-cholesterol

LDL-C levels should be monitored during treatment with INVOKAMET[®] due to dose-dependent increases in LDL-C seen with therapy.

Digoxin levels

In patients taking digoxin and canagliflozin 300 mg once daily for seven days, there was an increase in the total exposure (AUC) and peak drug concentration (C_{max}) of digoxin (20% and 36%, respectively), therefore patients taking INVOKAMET[®] concomitantly with digoxin should be monitored appropriately.

Hematology

Initial and periodic monitoring of hematologic parameters (e.g., hemoglobin/hematocrit and red blood cell indices) should be performed regularly. While megaloblastic anemia has rarely been seen with metformin therapy, if this is suspected, Vitamin B12 deficiency should be excluded.

ADVERSE REACTIONS

Adverse Drug Reaction Overview

There have been no clinical studies conducted with INVOKAMET[®] (canagliflozin/metformin hydrochloride) tablets. INVOKAMET[®] tablets demonstrated comparable bioavailability of canagliflozin and metformin with co-administered tablets of canagliflozin and metformin in comparative bioavailability studies (see **ACTION AND CLINICAL PHARMACOLOGY, Pharmacokinetics**).

Canagliflozin

The safety of canagliflozin was evaluated in nine double-blind, controlled Phase 3 clinical studies involving 10,285 patients with type 2 diabetes, including 3,139 patients treated with canagliflozin 100 mg and 3,506 patients, treated with canagliflozin 300 mg.

The primary assessment of safety and tolerability was conducted in a pooled analysis (N=2313) of four 26-week placebo-controlled clinical studies (monotherapy and add-on therapy with metformin, metformin and sulfonylurea, and metformin and pioglitazone). The most commonly reported adverse reactions during treatment ($\geq 5\%$) were vulvovaginal candidiasis, urinary tract infection (UTI), and polyuria or pollakiuria. Adverse reactions leading to discontinuation of $\geq 0.5\%$ of all canagliflozin-treated patients in these studies were vulvovaginal candidiasis (0.7% of females) and balanitis or balanoposthitis (0.5% of males).

A total of 8 serious adverse drug reactions were reported in the primary placebo-controlled safety population, including 5 reports from patients taking canagliflozin 100 mg daily (2 urticaria, 2 UTI, and 1 nausea), 2 reports from patients taking canagliflozin 300 mg daily (1 UTI, 1 constipation) and 1 report from a patient in the placebo group (reduced intravascular volume). Of these serious adverse reactions, 2 led to discontinuation in the canagliflozin group (UTI and urticaria).

Metformin hydrochloride

Lactic acidosis: very rare ($<1/10,000$ and isolated reports) (see WARNINGS AND PRECAUTIONS, and OVERDOSAGE).

Gastrointestinal Reactions: very common ($>1/10$). Gastrointestinal symptoms (diarrhea, nausea, vomiting, abdominal bloating, flatulence, and anorexia) are the most common reactions to metformin and are approximately 30% more frequent in patients on metformin monotherapy than in placebo-treated patients, particularly during initiation of metformin therapy. These symptoms are generally transient and resolve spontaneously during continued treatment.

Because significant diarrhea and/or vomiting can cause dehydration and prerenal azotemia, metformin should be temporarily discontinued, under such circumstances.

For patients who have been stabilized on metformin, nonspecific gastrointestinal symptoms should not be attributed to therapy unless intercurrent illness or lactic acidosis have been excluded.

Special Senses: common ($\geq 1/100$): taste disturbance, i.e. metallic taste.

Dermatologic Reactions: very rare ($< 1/10,000$ and isolated reports): Reports of skin reactions such as erythema, pruritus, and urticaria are very rare.

Hematologic: During controlled clinical trials of 29 weeks duration, approximately 9% of patients on metformin monotherapy developed asymptomatic subnormal serum Vitamin B12 levels; serum folic acid levels did not decrease significantly. Five cases of megaloblastic anemia have been reported with metformin administration and no increased incidence of neuropathy has been observed. (See WARNINGS AND PRECAUTIONS, Endocrine and Metabolism).

Decrease of Vitamin B12 absorption with decrease of serum levels during long-term use of metformin is rare ($\geq 1/10,000$ and $< 1/1,000$). Consideration of such etiology is recommended if a patient presents with megaloblastic anemia.

Hepatic: very rare ($< 1/10,000$ and isolated reports). Liver function tests abnormalities or hepatitis resolving upon metformin discontinuation has been documented in isolated reports.

Canagliflozin and Metformin

The incidence and type of adverse reactions in 26-week placebo-controlled metformin add-on studies was similar to the adverse reactions in the four 26-week placebo-controlled clinical studies used for the primary assessment of safety and tolerability. There were no additional adverse reactions identified in the pooling of these three placebo-controlled studies that included metformin relative to the four placebo-controlled studies.

Clinical Trial Adverse Drug Reactions

Because clinical trials are conducted under very specific conditions the adverse reaction rates observed in the clinical trials may not reflect the rates observed in practice and should not be compared to the rates in the clinical trials of another drug. Adverse drug reaction information from clinical trials is useful for identifying drug-related adverse events and for approximating rates.

Table 1 to Table 4 include treatment-emergent adverse events (TEAEs) reported in $\geq 2\%$ of canagliflozin-treated patients.

Combination with Metformin (Studies DIA3006 and DIA3009)

The incidence of adverse events, reported regardless of causality in $\geq 2\%$ of patients treated with canagliflozin 100 mg or 300 mg and more frequently than in the placebo groups, in studies of canagliflozin as add-on combination therapy with metformin, is provided in Table 1. The core

assessment period was 26 weeks for the placebo- and active-controlled study versus sitagliptin (DIA3006) and 52 weeks for the active-controlled study versus glimepiride (DIA3009).

Table 1: Adverse events (regardless of causality) reported in $\geq 2\%$ of patients treated with canagliflozin and more frequently than in the placebo groups* in double-blind clinical trials of canagliflozin in add-on combination use with metformin, and compared to sitagliptin or placebo (Study DIA3006) or to glimepiride (Study DIA3009)

System Organ Class / Preferred Term	Study DIA3006 (26 weeks)				Study DIA3009 (52 weeks)		
	Placebo + Metformin n=183 n (%)	Canagliflozin 100 mg + Metformin n=368 n (%)	Canagliflozin 300 mg + Metformin N=367 n (%)	Sitagliptin 100 mg + Metformin n=366 n (%)	Canagliflozin 100 mg + Metformin n=483 n (%)	Canagliflozin 300 mg + Metformin n=485 n (%)	Glimepiride + Metformin n=482 n (%)
Gastrointestinal Disorders							
Diarrhea	12 (6.6)	12 (3.3)	18 (4.9)	16 (4.4)	24 (5.0)	33 (6.8)	29 (6.0)
Gastritis	3 (1.6)	3 (0.8)	8 (2.2)	3 (0.8)	2 (0.4)	5 (1.0)	7 (1.5)
Nausea	3 (1.6)	11 (3.0)	8 (2.2)	5 (1.4)	16 (3.3)	25 (5.2)	13 (2.7)
Toothache	2 (1.1)	3 (0.8)	8 (2.2)	4 (1.1)	8 (1.7)	7 (1.4)	6 (1.2)
Vomiting	1 (0.5)	8 (2.2)	1 (0.3)	3 (0.8)	9 (1.9)	7 (1.4)	8 (1.7)
General Disorders and Administration Site Conditions							
Fatigue	2 (1.1)	10 (2.7)	8 (2.2)	1 (0.3)	9 (1.9)	7 (1.4)	10 (2.1)
Pyrexia	3 (1.6)	4 (1.1)	5 (1.4)	3 (0.8)	11 (2.3)	9 (1.9)	7 (1.5)
Thirst	0	2 (0.5)	4 (1.1)	0	8 (1.7)	14 (2.9)	0
Infections and Infestations							
Bronchitis	2 (1.1)	2 (0.5)	5 (1.4)	9 (2.5)	11 (2.3)	9 (1.9)	10 (2.1)
Gastroenteritis	2 (1.1)	3 (0.8)	3 (0.8)	2 (0.5)	3 (0.6)	15 (3.1)	9 (1.9)
Influenza	5 (2.7)	6 (1.6)	4 (1.1)	8 (2.2)	17 (3.5)	17 (3.5)	8 (1.7)
Sinusitis	3 (1.6)	8 (2.2)	2 (0.5)	6 (1.6)	7 (1.4)	13 (2.7)	6 (1.2)
Urinary Tract Infection	4 (2.2)	19 (5.2)	13 (3.5)	12 (3.3)	27 (5.6)	24 (4.9)	18 (3.7)
Vaginal Infection	0	2 (0.5)	3 (0.8)	1 (0.3)	11 (2.3)	7 (1.4)	1 (0.2)
Vulvovaginal Mycotic Infection	0	10 (2.7)	7 (1.9)	1 (0.3)	6 (1.2)	14 (2.9)	4 (0.8)
Musculoskeletal and Connective Tissue Disorders							
Back Pain	6 (3.3)	8 (2.2)	12 (3.3)	4 (1.1)	29 (6.0)	18 (3.7)	20 (4.1)
Musculoskeletal Pain	1 (0.5)	3 (0.8)	6 (1.6)	5 (1.4)	9 (1.9)	10 (2.1)	9 (1.9)
Psychiatric Disorders							
Insomnia	0	3 (0.8)	0	1 (0.3)	7 (1.4)	10 (2.1)	6 (1.2)
Renal and Urinary Disorders							
Pollakiuria	1 (0.5)	21 (5.7)	10 (2.7)	2 (0.5)	12 (2.5)	12 (2.5)	1 (0.2)
Reproductive System and Breast Disorders							
Balanoposthitis	1 (0.5)	2 (0.5)	1 (0.3)	0	4 (0.8)	13 (2.7)	2 (0.4)
Vulvovaginal Pruritus	0	4 (1.1)	5 (1.4)	1 (0.3)	6 (1.2)	20 (4.1)	1 (0.2)

*In either study

Combination with a Metformin and a Sulfonylurea (Studies DIA3002 and DIA3015)

The incidence of adverse events, reported regardless of causality in $\geq 2\%$ of patients treated with canagliflozin 100 mg or 300 mg and more frequently than in the placebo groups, in studies of canagliflozin as add-on combination therapy with metformin and a sulfonylurea, is provided in Table 2. The core assessment period was 26 weeks for the placebo-controlled study (DIA3002) and 52 weeks for the active-controlled study with sitagliptin (DIA3015).

Table 2: Adverse events (regardless of causality) reported in $\geq 2\%$ of patients treated with canagliflozin and more frequently than in the placebo groups* in double-blind clinical trials of canagliflozin in add-on combination use with metformin and a sulfonylurea, and compared to placebo (Study DIA3002) or sitagliptin (Study DIA3015)

System Organ Class / Preferred Term	Study DIA3002 (26 weeks)			Study DIA3015 (52 weeks)	
	Placebo+ Metformin + Sulfonylurea n=156 n (%)	Canagliflozin 100 mg + Metformin + Sulfonylurea n=157 n (%)	Canagliflozin 300 mg + Metformin + Sulfonylurea N=156 n (%)	Canagliflozin 300 mg + Metformin + Sulfonylurea n=377 n (%)	Sitagliptin 100 mg+ Metformin + Sulfonylurea n=378 n (%)
Ear and Labyrinth Disorders					
Vertigo	1 (0.6)	1 (0.6)	1 (0.6)	14 (3.7)	11 (2.9)
Gastrointestinal Disorders					
Abdominal Pain	1 (0.6)	2 (1.3)	1 (0.6)	8 (2.1)	6 (1.6)
Abdominal Pain Upper	2 (1.3)	1 (0.6)	1 (0.6)	10 (2.7)	2 (0.5)
Constipation	0	4 (2.5)	5 (3.2)	9 (2.4)	3 (0.8)
Diarrhea	5 (3.2)	5 (3.2)	10 (6.4)	17 (4.5)	26 (6.9)
Nausea	1 (0.6)	2 (1.3)	4 (2.6)	9 (2.4)	11 (2.9)
Infections and Infestations					
Bronchitis	3 (1.9)	4 (2.5)	3 (1.9)	1 (0.3)	11 (2.9)
Influenza	7 (4.5)	2 (1.3)	3 (1.9)	22 (5.8)	15 (4.0)
Nasopharyngitis	4 (2.6)	6 (3.8)	8 (5.1)	33 (8.8)	38 (10.1)
Sinusitis	3 (1.9)	4 (2.5)	2 (1.3)	8 (2.1)	8 (2.1)
Tooth Abscess	0	4 (2.5)	1 (0.6)	0	2 (0.5)
Upper Respiratory Tract Infection	10 (6.4)	17 (10.8)	6 (3.8)	33 (8.8)	21 (5.6)
Urinary Tract Infection	8 (5.1)	9 (5.7)	8 (5.1)	15 (4.0)	19 (5.0)
Vulvovaginal Mycotic Infection	2 (1.3)	8 (5.1)	8 (5.1)	12 (3.2)	5 (1.3)
Metabolism and Nutrition Disorders					
Decreased Appetite	1 (0.6)	0	4 (2.6)	4 (1.1)	5 (1.3)
Hypoglycemia	6 (3.8)	11 (7.0)	9 (5.8)	66 (17.5)	75 (19.8)
Musculoskeletal and Connective Tissue Disorders					
Arthralgia	4 (2.6)	7 (4.5)	7 (4.5)	17 (4.5)	8 (2.1)
Back Pain	4 (2.6)	2 (1.3)	5 (3.2)	8 (2.1)	15 (4.0)
Musculoskeletal Pain	1 (0.6)	0	3 (1.9)	8 (2.1)	6 (1.6)
Nervous System Disorders					
Headache	4 (2.6)	5 (3.2)	2 (1.3)	29 (7.7)	27 (7.1)
Renal and Urinary Disorders					
Pollakiuria	1 (0.6)	4 (2.5)	3 (1.9)	6 (1.6)	5 (1.3)
Reproductive System and Breast Disorders					
Vulvovaginal Pruritus	0	1 (0.6)	3 (1.9)	15 (4.0)	1 (0.3)

*In either study

Combination with Metformin and Pioglitazone (Study DIA3012)

The incidence of adverse events, reported regardless of causality in $\geq 2\%$ of patients treated with canagliflozin 100 mg or 300 mg and more frequently than in the placebo group, in a study of canagliflozin as add-on combination therapy with metformin and pioglitazone, is provided in Table 3. The core assessment period was 26 weeks for this placebo-controlled study.

Table 3: Adverse events (regardless of causality) reported in $\geq 2\%$ of patients treated with canagliflozin and more frequently than in the placebo group in a double-blind clinical trial of canagliflozin in add-on combination use with metformin and pioglitazone, and compared to placebo (Study DIA3012)

System Organ Class / Preferred Term	Placebo + Metformin+ Pioglitazone n=115 n (%)	Canagliflozin 100 mg + Metformin + Pioglitazone n=113 n (%)	Canagliflozin 300 mg + Metformin + Pioglitazone n=114 n (%)
Gastrointestinal Disorders			
Gastritis	2 (1.7)	4 (3.5)	0
General Disorders And Administration Site Conditions			
Fatigue	2 (1.7)	1 (0.9)	4 (3.5)
Edema Peripheral	2 (1.7)	2 (1.8)	4 (3.5)
Thirst	0	5 (4.4)	4 (3.5)
Infections And Infestations			
Nasopharyngitis	6 (5.2)	6 (5.3)	11 (9.6)
Sinusitis	2 (1.7)	1 (0.9)	3 (2.6)
Upper Respiratory Tract Infection	7 (6.1)	9 (8.0)	5 (4.4)
Vulvovaginal Candidiasis	0	1 (0.9)	3 (2.6)
Vulvovaginal Mycotic Infection	0	3 (2.7)	6 (5.3)
Investigations			
Weight Decreased	1 (0.9)	1 (0.9)	3 (2.6)
Metabolism And Nutrition Disorders			
Hypoglycemia	2 (1.7)	1 (0.9)	6 (5.3)
Musculoskeletal And Connective Tissue Disorders			
Arthralgia	2 (1.7)	1 (0.9)	6 (5.3)
Back Pain	3 (2.6)	8 (7.1)	5 (4.4)
Pain in Extremity	1 (0.9)	4 (3.5)	3 (2.6)
Nervous System Disorders			
Dizziness	1 (0.9)	4 (3.5)	3 (2.6)
Headache	4 (3.5)	3 (2.7)	5 (4.4)
Renal And Urinary Disorders			
Pollakiuria	1 (0.9)	5 (4.4)	7 (6.1)
Reproductive System And Breast Disorders			
Balanitis	0	3 (2.7)	0
Respiratory, Thoracic and Mediastinal Disorders			
Oropharyngeal Pain	2 (1.7)	3 (2.7)	0
Vascular Disorders			
Hypotension	3 (2.6)	3 (2.7)	0

Combination with Insulin and Metformin (Study DIA3008 Insulin Substudy)

The incidence of adverse events, reported regardless of causality in $\geq 2\%$ of patients treated with canagliflozin 100 mg or 300 mg and more frequently than in the placebo group, in a study of

canagliflozin as add-on combination therapy with insulin and metformin is provided in Table 4. The core assessment period was 18 weeks for this placebo-controlled study.

Table 4: Adverse events (regardless of causality) reported in $\geq 2\%$ of patients treated with canagliflozin and more frequently than in the placebo group in a double-blind clinical trial of canagliflozin in add-on combination use with insulin and metformin, and compared to placebo (Study DIA3008 - Insulin Substudy)

System Organ Class / Preferred Term	Placebo + Insulin + Metformin n=244 n (%)	Canagliflozin 100 mg + Insulin + Metformin n=241 n (%)	Canagliflozin 300 mg + Insulin + Metformin n=246 n (%)
Gastrointestinal disorders			
Constipation	2 (0.8)	1 (0.4)	8 (3.3)
Diarrhea	7 (2.9)	4 (1.7)	14 (5.7)
Dyspepsia	0	2 (0.8)	5 (2.0)
Nausea	5 (2.0)	5 (2.1)	8 (3.3)
General disorders and administration site conditions			
Fatigue	4 (1.6)	6 (2.5)	8 (3.3)
Thirst	0	2 (0.8)	10 (4.1)
Infections and infestations			
Bronchitis	5 (2.0)	7 (2.9)	3 (1.2)
Nasopharyngitis	22 (9.0)	22 (9.1)	13 (5.3)
Urinary tract infection	4 (1.6)	3 (1.2)	10 (4.1)
Vulvovaginal mycotic infection	2 (0.8)	4 (1.7)	5 (2.0)
Metabolism and nutrition disorders			
Hypoglycemia	21 (8.6)	23 (9.5)	23 (9.3)
Musculoskeletal and connective tissue disorders			
Arthralgia	3 (1.2)	8 (3.3)	4 (1.6)
Back pain	5 (2.0)	3 (1.2)	13 (5.3)
Pain in extremity	4 (1.6)	7 (2.9)	6 (2.4)
Nervous system disorders			
Dizziness	0	1 (0.4)	6 (2.4)
Headache	7 (2.9)	8 (3.3)	7 (2.8)
Renal and urinary disorders			
Pollakiuria	1 (0.4)	7 (2.9)	18 (7.3)
Reproductive system and breast disorders			
Balanitis	1 (0.4)	7 (2.9)	9 (3.7)
Vascular disorders			
Hypertension	3 (1.2)	8 (3.3)	1 (0.4)

Less Common Clinical Trial Adverse Drug Reactions (< 2%)¹

Metabolism and nutrition disorders: dehydration²

Nervous system disorders: dizziness postural², syncope²

Skin and subcutaneous tissue disorders: rash³, urticaria

Vascular disorders: hypotension², orthostatic hypotension²

Description of Selected Adverse Reactions

Reduced intravascular volume

In the pooled analysis of the four 26-week, placebo-controlled studies, the incidence of all adverse reactions related to reduced intravascular volume (e.g., postural dizziness, orthostatic hypotension, hypotension, dehydration, and syncope) was 1.2% for canagliflozin 100 mg, 1.3% for canagliflozin 300 mg, and 1.1% for placebo. The incidence of these adverse reactions with canagliflozin treatment in the two active-controlled studies was similar to comparators.

In the dedicated cardiovascular study, where patients were generally older with a higher prevalence of comorbidities, the incidences of adverse reactions related to reduced intravascular volume were 2.8% with canagliflozin 100 mg, 4.6% with canagliflozin 300 mg, and 1.9% with placebo.

To assess risk factors for these adverse reactions, a larger pooled analysis (N=9439) of patients from eight controlled Phase 3 studies including both doses of canagliflozin was conducted. In this pooled analysis, patients on loop diuretics, patients with moderate renal impairment (eGFR 30 to < 60 mL/min/1.73 m²), and patients ≥ 75 years of age had higher incidences of these reactions. For patients on loop diuretics, the incidences were 3.2% on canagliflozin 100 mg and 8.8% on canagliflozin 300 mg compared to 4.7% in the control group. For patients with a baseline eGFR < 60 mL/min/1.73 m², the incidences were 4.8% on canagliflozin 100 mg and 8.1% on canagliflozin 300 mg compared to 2.6% in the control group. In patients ≥ 75 years of age, the incidences were 4.9% on canagliflozin 100 mg and 8.7% on canagliflozin 300 mg compared to 2.6% in the control group (see **WARNINGS AND PRECAUTIONS, DOSING AND ADMINISTRATION** and **ACTION AND CLINICAL PHARMACOLOGY, Special Populations and Conditions**).

Diabetic ketoacidosis

Cases of DKA, a serious life-threatening condition requiring urgent hospitalization, have been reported in patients with type 2 diabetes mellitus treated with SGLT2 inhibitors, including canagliflozin. Some cases of DKA have been fatal. INVOKAMET[®] should not be used in patients with type 1 diabetes. In a number of reported cases, the presentation of the condition

¹ Adverse drug reactions (ADRs) were identified based on a comprehensive assessment of biological plausibility, mechanism of action, dose dependence in incidence rate, time of onset, seriousness and consistency of findings across four, 26-week placebo-controlled Phase 3 clinical studies. Additional supportive safety analyses were conducted on a large pooled dataset from eight active- and placebo-controlled Phase 3 clinical studies.

² Related to reduced intravascular volume (see **Adverse reactions related to reduced intravascular volume**).

³ Rash includes the terms: rash erythematous, rash generalized, rash macular, rash maculopapular, rash papular, rash pruritic, rash pustular, and rash vesicular

was atypical with blood glucose values below 13.9 mmol/L (250 mg/dL) (see **WARNINGS AND PRECAUTIONS, Endocrine and Metabolism**).

Hypoglycemia

In individual clinical trials (see **CLINICAL TRIALS**), episodes of hypoglycemia occurred at a higher rate when canagliflozin was co-administered with insulin or sulfonylurea (Table 5; see **WARNINGS AND PRECAUTIONS** and **DOSAGE AND ADMINISTRATION**).

Table 5: Incidence of Hypoglycemia¹ in Controlled Clinical Studies

Monotherapy (26 weeks)	Placebo (N=192)	Canagliflozin 100 mg (N=195)	Canagliflozin 300 mg (N=197)
Overall [N (%)]	5 (2.6)	7 (3.6)	6 (3.0)
In Combination with Metformin (26 weeks)	Placebo + Metformin (N=183)	Canagliflozin 100 mg + Metformin (N=368)	Canagliflozin 300 mg + Metformin (N=367)
Overall [N (%)]	3 (1.6)	16 (4.3)	17 (4.6)
Severe [N (%)] ²	0 (0)	1 (0.3)	1 (0.3)
In Combination with Metformin (52 weeks)	Glimepiride + Metformin (N=482)	Canagliflozin 100 mg + Metformin (N=483)	Canagliflozin 300 mg + Metformin (N=485)
Overall [N (%)]	165 (34.2)	27 (5.6)	24 (4.9)
Severe [N (%)] ²	15 (3.1)	2 (0.4)	3 (0.6)
In Combination with Metformin + Sulfonylurea (26 weeks)	Placebo + Metformin + Sulfonylurea (N=156)	Canagliflozin 100 mg + Metformin + Sulfonylurea (N=157)	Canagliflozin 300 mg + Metformin + Sulfonylurea (N=156)
Overall [N (%)]	24 (15.4)	43 (27.4)	47 (30.1)
Severe [N (%)] ²	1 (0.6)	1 (0.6)	0
In Combination with Metformin + Sulfonylurea (52 weeks)	Sitagliptin + Metformin + Sulfonylurea (N=378)		Canagliflozin 300 mg + Metformin + Sulfonylurea (N=377)
Overall [N (%)]	154 (40.7)		163 (43.2)
Severe [N (%)] ²	13 (3.4)		15 (4.0)
In Combination with Metformin + Pioglitazone (26 weeks)	Placebo + Metformin + Pioglitazone (N=115)	Canagliflozin 100 mg + Metformin + Pioglitazone (N=113)	Canagliflozin 300 mg + Metformin + Pioglitazone (N=114)
Overall [N (%)]	3 (2.6)	3 (2.7)	6 (5.3)
In Combination with Insulin (18 weeks)	Placebo + Insulin (N=565)	Canagliflozin 100 mg + Insulin (N=566)	Canagliflozin 300 mg + Insulin (N=587)
Overall [N (%)]	208 (36.8)	279 (49.3)	285 (48.6)
Severe [N (%)] ²	14 (2.5)	10 (1.8)	16 (2.7)

Table 5: Incidence of Hypoglycemia¹ in Controlled Clinical Studies

In Combination with Insulin and Metformin (18 weeks)³	Placebo + Metformin + Insulin (N=244)	Canagliflozin 100 mg + Metformin + Insulin (N=241)	Canagliflozin 300 mg + Metformin + Insulin (N=246)
Overall [N (%)]	101 (41.1)	107 (44.4)	113 (45.9)
Severe [N (%)] ²	9 (3.7)	4 (1.7)	4 (1.6)

¹ Number of patients experiencing at least one event of hypoglycemia based on either biochemically documented episodes (any glucose value ≤ 3.89 mmol/L) or severe hypoglycemic events in the intent-to-treat population.

² Severe episodes of hypoglycemia were defined as those where the patient: required the assistance of another person to recover; lost consciousness; or experienced a seizure (regardless of whether biochemical documentation of a low glucose value was obtained).

³ Subgroup of patients (N=731) from insulin substudy on canagliflozin in combination with metformin and insulin

Twice Daily Dosing

The incidence of hypoglycemia in a Phase 2 clinical study with twice daily dosing (canagliflozin 50 mg or 150 mg twice daily in combination with metformin) was reported in 4.3% and 3.2% of patients treated with canagliflozin 50 mg and 150 mg twice daily, respectively, compared to 3.2% in placebo-treated patients. There were no cases of severe hypoglycemia reported in the canagliflozin or placebo groups.

Genital mycotic infections

Vulvovaginal candidiasis (including vulvovaginitis and vulvovaginal mycotic infection) was reported in 10.4% and 11.4% of female patients treated with canagliflozin 100 mg and canagliflozin 300 mg, respectively, compared to 3.2% in placebo-treated female patients. Most reports of vulvovaginal candidiasis occurred during the first four months of treatment with canagliflozin. Among female patients taking canagliflozin, 2.3% experienced more than one infection. Overall, 0.7% of all female patients discontinued canagliflozin due to vulvovaginal candidiasis (see **WARNINGS AND PRECAUTIONS**).

Candidal balanitis or balanoposthitis was reported in 4.2% and 3.7% of male patients treated with canagliflozin 100 mg and canagliflozin 300 mg, respectively, compared to 0.6% in placebo-treated male patients. Among male patients taking canagliflozin, 0.9% had more than one infection. Overall, 0.5% of male patients discontinued canagliflozin due to candidial balanitis or balanoposthitis. Phimosis was reported in 0.3% of uncircumcised males in a pooled analysis of 8 controlled trials. In this pooled analysis, circumcision was also reported in 0.2% of male patients treated with canagliflozin (see **WARNINGS AND PRECAUTIONS**).

Urinary tract infections

Urinary tract infections were more frequently reported for canagliflozin 100 mg and 300 mg (5.9% versus 4.3%, respectively) compared to 4.0% with placebo. Most infections were mild to moderate with no increase in the occurrence of serious adverse events. Subjects responded to standard treatments while continuing canagliflozin treatment. The incidence of recurrent infections was not increased with canagliflozin.

Falls

In the pool of all Phase 3 studies, the incidence rate of AEs coded as related to a fall was 7.3, 8.0, and 11.8 per 1000 patient years of exposure to comparator, canagliflozin 100 mg, and canagliflozin 300 mg, respectively.

Bone fractures

In the pool of eight clinical trials with a longer mean duration of exposure to canagliflozin (68 weeks), the incidence rate of bone fracture was 14.2, 18.7, and 17.6 per 1000 patient years of exposure to comparator, canagliflozin 100 mg, and canagliflozin 300 mg, respectively, with the fracture imbalance observed within the first 26 weeks of therapy and not progressing thereafter.

Decreases in Bone Mineral Density: Bone mineral density (BMD) was measured by dual-energy X-ray absorptiometry in a clinical trial of 714 older adults (mean age 64 years). At 2 years, patients randomized to canagliflozin 100 mg and canagliflozin 300 mg had placebo-corrected declines in BMD at the total hip of 0.9% and 1.2%, respectively, and at the lumbar spine of 0.3% and 0.7%, respectively. Placebo-adjusted BMD declines were 0.1% at the femoral neck for both canagliflozin doses and 0.4% at the distal forearm for patients randomized to canagliflozin 300 mg. The placebo-adjusted change at the distal forearm for patients randomized to canagliflozin 100 mg was 0%.

Skin ulcers and peripheral ischemia

In the pool of 8 clinical studies with 78 weeks of mean duration of exposure, skin ulcers occurred in 0.7%, 1.1%, and 1.5% of patients and peripheral ischemia occurred in 0.1%, 0.4%, and 0.2% of patients receiving comparator, canagliflozin 100 mg, and canagliflozin 300 mg, respectively. An imbalance in these events generally were seen within the first 24 weeks of treatment and occurred in patients with known or at high risk for atherosclerotic disease, longer duration of diabetes, presence of diabetic complications, and diuretic use.

Amputations

In an ongoing cardiovascular study of 4327 patients with known or at high risk for cardiovascular disease, the incidence rates of lower limb amputation, primarily of the toe, were 7.3, 5.4 and 3.0 per 1000 patient years of exposure to canagliflozin 100 mg, canagliflozin 300 mg, and placebo, respectively, with the imbalance occurring as early as the first 26 weeks of therapy. In other type 2 diabetes studies with canagliflozin, which enrolled a general diabetes population of 8111 patients, no difference in lower limb amputation risk was observed relative to control.

Adverse reactions in specific populations***Elderly patients***

Compared to younger patients, patients 65 years and older had a higher incidence of adverse reactions related to reduced intravascular volume with canagliflozin, including hypotension, postural dizziness, orthostatic hypotension, syncope, and dehydration. In particular, in patients ≥ 75 years of age, adverse reactions related to reduced intravascular volume occurred with incidences of 4.9%, 8.7%, and 2.6% on canagliflozin 100 mg, canagliflozin 300 mg, and the control group, respectively. Decreases in eGFR (-3.6% and -5.2%) were reported with

canagliflozin 100 mg and 300 mg, respectively, compared to the control group (-3.0%) (see **WARNINGS AND PRECAUTIONS** and **DOSAGE AND ADMINISTRATION**).

Patients with an eGFR 45 to < 60 mL/min/1.73 m²

In an analysis of patients with a baseline eGFR 45 to < 60 mL/min/1.73 m², the incidences of adverse reactions related to reduced intravascular volume were 4.6% with canagliflozin 100 mg and 7.1% with canagliflozin 300 mg relative to 3.4% with placebo (see **WARNINGS AND PRECAUTIONS** and **DOSAGE AND ADMINISTRATION**). Serum creatinine levels increased by 4.9% and 7.3% for canagliflozin 100 mg and 300 mg, respectively, relative to 0.2% with placebo. Blood urea nitrogen (BUN) levels increased by 13.2% and 13.6% for canagliflozin 100 mg and 300 mg, respectively, relative to 0.7% with placebo. The proportion of patients with larger decreases in eGFR (> 30%) at any time during treatment was 6.1%, 10.4%, and 4.3% with canagliflozin 100 mg, canagliflozin 300 mg, and placebo, respectively. At study endpoint, 2.3% of patients treated with canagliflozin 100 mg, 4.3% with canagliflozin 300 mg, and 3.5% with placebo had such decreases (see **WARNINGS AND PRECAUTIONS**).

The incidences of elevated serum potassium (> 5.4 mEq/L and 15% above baseline) were 5.2% with canagliflozin 100 mg, 9.1% with canagliflozin 300 mg, and 5.5% with placebo. Rare, more severe elevations were seen in patients with moderate renal impairment who had prior elevated potassium concentrations and/or who were on multiple medications that reduce potassium excretion, such as potassium-sparing diuretics and angiotensin-converting-enzyme (ACE) inhibitors.

Serum phosphate levels increased by 3.3% and 4.2% for canagliflozin 100 mg and 300 mg, respectively, compared to 1.1% for placebo. The incidences of elevated serum phosphate (> 1.65 mmol/L and 25% above baseline) were 1.4% with canagliflozin 100 mg, 1.3% with canagliflozin 300 mg and 0.4% with placebo.

Cardiovascular safety

A prospective, pre-specified meta-analysis of independently adjudicated cardiovascular events from placebo-controlled Phase 2 and 3 clinical studies in 8492 patients with type 2 diabetes, including 4327 patients who are participating in an ongoing cardiovascular study (patients with cardiovascular disease or at high risk for cardiovascular disease) was conducted. The hazard ratio for the primary endpoint (time to event in composite of cardiovascular death, non-fatal stroke, non-fatal myocardial infarction, and unstable angina requiring hospitalization) for canagliflozin (both doses pooled) versus placebo was 0.89 (95% CI 0.681, 1.154). The hazard ratios for the 100 mg and 300 mg doses were similar. Therefore, there was no evidence of an increase in the primary endpoint with either canagliflozin 100 mg or canagliflozin 300 mg relative to placebo.

Clinical Chemistry and Hematology Findings

Laboratory values, described below, are derived from the pooled analysis of 26-week, placebo-controlled clinical studies unless otherwise noted.

Increases in serum potassium

Mean percent changes from baseline in blood potassium were 0.5% and 1.0% for canagliflozin 100 mg and 300 mg, respectively, compared to 0.6% for placebo. Episodes of elevated serum potassium (> 5.4 mEq/L and 15% above baseline) were seen in 4.4% of patients treated with canagliflozin 100 mg, 7.0% of patients treated with canagliflozin 300 mg, and 4.8% of patients treated with placebo.

In a trial in patients with moderate renal impairment (eGFR 30 to < 50 mL/min/1.73 m²), increases in serum potassium to > 5.4 mEq/L and 15% above baseline were seen in 16.1%, 12.4%, and 27.0% of patients treated with placebo, canagliflozin 100 mg, and canagliflozin 300 mg, respectively. Elevations to ≥ 6.5 mEq/L occurred in 1.1%, 2.2%, and 2.2% of patients treated with placebo, canagliflozin 100 mg, and canagliflozin 300 mg, respectively.

Increases in serum creatinine and blood urea nitrogen (BUN)

Mean percent changes from baseline in creatinine, with commensurate decreases in eGFR, were 2.8% and 4.0% for canagliflozin 100 mg and 300 mg, respectively, compared to 1.5% for placebo. Mean percent increases from baseline in BUN were 17.1% and 18.0% for canagliflozin 100 mg and 300 mg, respectively, compared to 2.7% for placebo. These changes were generally observed within six weeks of treatment initiation. Subsequently, serum creatinine concentrations gradually trended toward baseline and BUN levels remained stable.

The proportion of patients with larger decreases in eGFR ($> 30\%$) from baseline, occurring at any time during treatment, was 2.0% with canagliflozin 100 mg and 4.1% with canagliflozin 300 mg relative to 2.1% with placebo. At study end, decreases of $> 30\%$ from baseline were seen for 0.7% of subjects with canagliflozin 100 mg, 1.4% with canagliflozin 300 mg, and 0.5% with placebo (see **WARNINGS AND PRECAUTIONS**). After discontinuation of canagliflozin therapy, these changes in laboratory values improved or returned to baseline.

Lipid changes

Compared to placebo, mean increases from baseline in low density lipoprotein cholesterol (LDL-C) were 0.11 mmol/L (4.5%) and 0.21 mmol/L (8.0%) with canagliflozin 100 mg and canagliflozin 300 mg, respectively. Increases in total cholesterol of 0.12 mmol/L (2.5%) and 0.21 mmol/L (4.3%) were seen, relative to placebo, for canagliflozin 100 mg and canagliflozin 300 mg, respectively. Increases in non-HDL-C relative to placebo were 0.05 mmol/L (1.5%) and 0.13 mmol/L (3.6%) with canagliflozin 100 mg and 300 mg, respectively. Increases in high-density lipoprotein cholesterol (HDL-C) were 0.06 mmol/L (5.4%), and 0.07 mmol/L (6.3%) relative to placebo for canagliflozin 100 mg and canagliflozin 300 mg, respectively. The LDL-C/HDL-C ratios did not change with either canagliflozin dose compared to placebo.

Increases in hemoglobin

Mean hemoglobin concentration increased from baseline 4.7 g/L (3.5%) with canagliflozin 100 mg and 5.1 g/L (3.8%) with canagliflozin 300 mg, compared to a decrease of -1.8 g/L (-1.1%) with placebo. After 26 weeks of treatment, 0.8%, 4.0%, and 2.7% of patients treated with placebo, canagliflozin 100 mg, and canagliflozin 300 mg, respectively, had a hemoglobin level above the upper limit of normal.

Increases in serum phosphate

Dose-related increases in serum phosphate levels were observed with canagliflozin. In the pool of four placebo-controlled trials, the mean percent change in serum phosphate levels were 3.6% and 5.1% with canagliflozin 100 mg and canagliflozin 300 mg, respectively, compared to 1.5% with placebo. Episodes of elevated serum phosphate (> 1.65 mmol/L and 25% above baseline) were seen in 0.6% and 1.6% of patients treated with canagliflozin 100 mg and 300 mg, respectively, compared to 1.3% of patients treated with placebo.

Decreases in serum urate

Moderate decreases in the mean percent change from baseline in serum urate were observed in the canagliflozin 100 mg and 300 mg groups (-10.1% and -10.6%, respectively) compared with placebo, where a slight increase from baseline (1.9%) was observed. Decreases in serum urate in the canagliflozin groups were maximal or near maximal by Week 6 and maintained with dosing. A transient increase in urinary uric acid excretion was seen, which was not persistent.

Post-Market Adverse Drug Reactions

Because these reactions were reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

Canagliflozin

Metabolism and nutrition disorders: diabetic ketoacidosis

Immune system disorders: anaphylactic reaction

Skin and subcutaneous tissue disorders: angioedema

Renal and urinary disorders: acute kidney injury, including acute renal failure (with or without volume depletion).

Genitourinary: severe urinary tract infections; urosepsis and pyelonephritis

Musculoskeletal: bone fractures

Metformin hydrochloride

Gastrointestinal Disorders: Abdominal discomfort, abdominal distension, abdominal pain, abdominal pain upper, constipation, diarrhea, dry mouth, dyspepsia, flatulence, gastric disorder, gastric ulcer, gastrointestinal disorder, nausea, vomiting

Hepatobiliary Disorders: Liver function tests abnormalities or hepatitis resolving upon metformin discontinuation, autoimmune hepatitis, drug-induced liver injury, hepatitis

Investigations: Blood lactic acid increased

Metabolism and Nutrition Disorders: Lactic acidosis, decrease of Vitamin B12 absorption with decrease of serum levels during long-term use of metformin, weight decreased, decreased appetite

Skin and Subcutaneous Tissue Disorders: Erythema, pruritus, rash, skin lesion, urticarial

DRUG INTERACTIONS

Overview

Specific pharmacokinetic drug interactions studies with INVOKAMET[®] have not been performed, although such studies have been conducted with the individual canagliflozin and metformin components.

Co-administration of canagliflozin (300 mg once daily) and metformin (2000 mg once daily) had no clinically relevant effect on the pharmacokinetics of either canagliflozin or metformin.

Canagliflozin

***In vitro* assessment of interactions**

The metabolism of canagliflozin is primarily via glucuronide conjugation mediated by UDP glucuronosyl transferase 1A9 (UGT1A9) and 2B4 (UGT2B4).

Canagliflozin did not induce CYP450 enzyme expression (3A4, 2C9, 2C19, 2B6, and 1A2) in cultured human hepatocytes. Canagliflozin did not inhibit the CYP450 isoenzymes (1A2, 2A6, 2C19, 2D6, or 2E1) and weakly inhibited CYP2B6, CYP2C8, CYP2C9, and CYP3A4 based on *in vitro* studies with human hepatic microsomes. Canagliflozin is a weak inhibitor of P-gp.

Canagliflozin is also a substrate of drug transporters P-glycoprotein (P-gp), Breast Cancer Resistance Protein (BCRP) and Multi-Drug Resistance-Associated Protein 2 (MRP2).

***In vivo* assessment of interactions**

Specific clinical drug interaction studies were conducted to investigate the effects of co-administered drugs, inhibitors or inducers of the drug-metabolizing enzymes UGTs (1A9, 2B4), CYPs (3A4, 2C9) and transporters P-gp and MRP2 on canagliflozin pharmacokinetics. Clinical studies were also conducted to assess the inhibitory or induction effects of canagliflozin on the pharmacokinetics of the CYP (3A4, 2C9), P-gp, substrates and co-administered drugs (see **ACTION AND CLINICAL PHARMACOLOGY**).

Drug-Drug Interactions

Effects of other drugs on canagliflozin

In clinical studies, the effects of other drugs on canagliflozin were assessed. Cyclosporin (P-gp inhibitor), hydrochlorothiazide, oral contraceptives (ethinyl estradiol and levonorgestrel), metformin, and probenecid (UGT, MRP2, OATP, OAT1 and OAT3 inhibitor) had no clinically relevant effect on the pharmacokinetics of canagliflozin.

Table 6: Effect of Co-administered Drugs on Systemic Exposure of Canagliflozin

Co-administered Drug	Dose of Co-administered Drug ¹	Dose of Canagliflozin ¹	Geometric Mean Ratio (Ratio With/Without Co-administered Drug) No Effect = 1.0		Clinical Comment
			AUC ² (90% CI)	C _{max} (90% CI)	
Cyclosporin	400 mg	300 mg once daily for 8 days	1.23 (1.19; 1.27)	1.01 (0.91; 1.11)	No dosage adjustment for INVOKAMET [®] required
Ethinyl estradiol and levonorgestrel	0.03 mg ethinyl estradiol and 0.15 mg levonorgestrel	200 mg once daily for 6 days	0.91 (0.88; 0.94)	0.92 (0.84; 0.99)	No dosage adjustment for INVOKAMET [®] required
Hydrochlorothiazide	25 mg once daily for 35 days	300 mg once daily for 7 days	1.12 (1.08; 1.17)	1.15 (1.06; 1.25)	No dosage adjustment for INVOKAMET [®] required
Probenecid	500 mg twice daily for 3 days	300 mg once daily for 17 days	1.21 (1.16; 1.25)	1.13 (1.00; 1.28)	No dosage adjustment for INVOKAMET [®] required
Inducers of UGT enzymes / drug transporters					
Rifampin	600 mg once daily for 8 days	300 mg	0.49 (0.44; 0.54)	0.72 (0.61; 0.84)	Consider increasing the INVOKAMET [®] dose to 300 mg once daily if patients are currently tolerating INVOKAMET [®] 100 mg once daily (refer to DOSAGE AND ADMINISTRATION).
Phenytoin, phenobarbital, barbiturates, carbamazepine, ritonavir, efavirenz, or St. John's Wort	N/A ³				Consider increasing the INVOKAMET [®] dose to 300 mg once daily if patients are currently tolerating INVOKAMET [®] 100 mg once daily (refer to DOSAGE AND ADMINISTRATION).

¹ Single dose unless otherwise noted² AUC_{inf} for drugs given as a single dose and AUC_{24h} for drugs given as multiple doses.³ N/A = Not applicable**Effects of canagliflozin on other drugs**

Canagliflozin at steady-state had no clinically relevant effect on the pharmacokinetics of metformin, oral contraceptives (ethinyl estradiol and levonorgestrel-CYP3A4 substrates), glyburide (CYP2C9 substrate), simvastatin (CYP3A4 substrate), acetaminophen, hydrochlorothiazide, or warfarin (CYP2C9 substrate), in healthy subjects.

Inhibition of BCRP by canagliflozin cannot be excluded at an intestinal level and increased exposure may therefore occur for drugs transported by BCRP, e.g., certain statins like rosuvastatin and some anti-cancer agents.

Table 7: Effect of Canagliflozin on Systemic Exposure of Co-Administered Drugs

Co-Administered Drug	Dose of Co-Administered Drug ¹	Dose of Canagliflozin ¹	Geometric Mean Ratio (Ratio With/Without Co-Administered Drugs) No Effect = 1.0			Clinical Comment
				AUC ² (90% CI)	C _{max} (90% CI)	
Digoxin	0.5 mg once daily first day followed by 0.25 mg once daily for 6 days	300 mg once daily for 7 days	digoxin	1.20 (1.12; 1.28)	1.36 (1.21; 1.53)	Patients taking INVOKAMET® with concomitant digoxin should be monitored appropriately
Ethinyl estradiol and levonorgestrel	0.03 mg ethinyl estradiol and 0.15 mg levonorgestrel	200 mg once daily for 6 days	ethinyl estradiol	1.07 (0.99; 1.15)	1.22 (1.10; 1.35)	No dosage adjustment required for ethinyl estradiol and levonorgestrel
			levonorgestrel	1.06 (1.00; 1.13)	1.22 (1.11; 1.35)	
Glyburide	1.25 mg	200 mg once daily for 6 days	glyburide	1.02 (0.98; 1.07)	0.93 (0.85; 1.01)	No dosage adjustment required for glyburide
			3-cis-hydroxy-glyburide	1.01 (0.96; 1.07)	0.99 (0.91; 1.08)	
			4-trans-hydroxy-glyburide	1.03 (0.97; 1.09)	0.96 (0.88; 1.04)	
Hydrochlorothiazide	25 mg once daily for 35 days	300 mg once daily for 7 days	hydrochlorothiazide	0.99 (0.95; 1.04)	0.94 (0.87; 1.01)	No dosage adjustment required for hydrochlorothiazide
Acetaminophen	1000 mg	300 mg twice daily for 25 days	acetaminophen	1.06 ³ (0.98; 1.14)	1.00 (0.92; 1.09)	No dosage adjustment required for acetaminophen
Simvastatin	40 mg	300 mg once daily for 7 days	simvastatin	1.12 (0.94; 1.33)	1.09 (0.91; 1.31)	No dosage adjustment required for simvastatin
			simvastatin acid	1.18 (1.03; 1.35)	1.26 (1.10; 1.45)	
Warfarin	30 mg	300 mg once daily for 12 days	(R)-warfarin	1.01 (0.96; 1.06)	1.03 (0.94; 1.13)	No dosage adjustment required for warfarin
			(S)-warfarin	1.06 (1.00; 1.12)	1.01 (0.90; 1.13)	

¹ Single dose unless otherwise noted

² AUC_{inf} for drugs given as a single dose and AUC_{24h} for drugs given as multiple doses.

³ AUC_{0-12h}

Metformin hydrochloride

Glyburide: In a single-dose interaction study in type 2 diabetes patients, coadministration of metformin and glyburide did not result in any changes in either metformin pharmacokinetics or pharmacodynamics. Decreases in glyburide AUC and C_{max} were observed, but were highly variable. The single-dose nature of this study and the lack of correlation between glyburide blood levels and pharmacodynamic effects make the clinical significance of this interaction uncertain.

Furosemide: A single-dose, metformin-furosemide drug interaction study in healthy subjects demonstrated that pharmacokinetic parameters of both compounds were affected by coadministration. Furosemide increased the metformin plasma and blood C_{max} by 22% and blood AUC by 15%, without any significant change in metformin renal clearance. When administered with metformin, the C_{max} and AUC of furosemide were 31% and 12% smaller, respectively, than when administered alone, and the terminal half-life was decreased by 32%, without any significant change in furosemide renal clearance. No information is available about the interaction of metformin and furosemide when coadministered chronically.

Nifedipine: A single-dose, metformin-nifedipine drug interaction study in normal healthy volunteers demonstrated that coadministration of nifedipine increased plasma metformin C_{max} and AUC by 20% and 9%, respectively, and increased the amount excreted in the urine. T_{max} and half-life were unaffected. Nifedipine appears to enhance the absorption of metformin. Metformin had minimal effects on nifedipine.

Cationic drugs: Cationic drugs (e.g., amiloride, digoxin, morphine, procainamide, quinidine, quinine, ranitidine, triamterene, trimethoprim, or vancomycin) that are eliminated by renal tubular secretion, theoretically have the potential for interaction with metformin by competing for common renal tubular transport systems. Such an interaction has been observed between metformin and oral cimetidine in normal healthy volunteers in both single- and multiple-dose, metformin-cimetidine drug interaction studies, with a 60% increase in peak metformin plasma and whole blood concentrations and a 40% increase in plasma and whole blood metformin AUC.

There was no change in elimination half-life in the single-dose study. Metformin had no effect on cimetidine pharmacokinetics. Therefore, careful patient monitoring and dose adjustment of metformin or the interfering drug is recommended in patients who are taking cationic medications that are excreted via renal tubular secretion.

Anticoagulant: Elimination rate of the anticoagulant phenprocoumon has been reported to be increased by 20% when used concurrently with metformin. Therefore, patients receiving phenprocoumon or other antivitamin K anticoagulants should be monitored carefully when both types of drugs are used simultaneously. In such cases, an important increase of prothrombin time may occur upon cessation of INVOKAMET[®] therapy, with an increased risk of hemorrhage.

Other: Other drugs tend to produce hyperglycemia and may lead to loss of blood sugar control. These include the thiazides and other diuretics, corticosteroids, phenothiazines, thyroid products, estrogens, estrogen plus progestogen, oral contraceptives, phenytoin, nicotinic acid, sympathomimetics, calcium channel blocking drugs, isoniazid and beta-2-agonists. ACE

inhibitors may decrease the blood glucose levels. When such drugs are administered to a patient receiving metformin the patient should be closely observed to maintain adequate glycemic control.

Diuretics, especially loop diuretics, may increase the risk of lactic acidosis due to their potential to decrease renal function.

Pharmacodynamic Interactions

Diuretics: INVOKAMET[®] is not recommended for use in patients receiving loop diuretics. Canagliflozin may add to the effect of diuretics and may increase the risk of hypovolemia and hypotension (see **WARNINGS AND PRECAUTIONS** and **DOSAGE AND ADMINISTRATION**).

Drug-Food Interactions

Interactions with food have not been established.

Drug-Herb Interactions

St John's Wort (*Hypericum perforatum*) is a CYP3A4 inducer and co-administration with INVOKAMET[®] may result in loss of efficacy or reduced clinical response. Dosage adjustment may be required (see **DOSAGE AND ADMINISTRATION**).

Drug-Laboratory Interactions

Due to its mechanism of action, patients taking INVOKAMET[®] will test positive for glucose in their urine.

Increases in urinary glucose excretion with INVOKAMET[®] can falsely lower 1,5-anhydroglucitol (1,5 AG) levels and make measurements of 1,5 AG unreliable in assessing glycemic control. Therefore, 1,5-AG assays should not be used for assessment of glycemic control in patients on INVOKAMET[®]. For further detail, it may be advisable to contact the specific manufacturer of the 1,5-AG assay.

Metformin hydrochloride

Intravascular contrast studies with iodinated materials can lead to acute alteration of renal function and have been associated with lactic acidosis in patients receiving metformin (see **CONTRAINDICATIONS** and **WARNINGS AND PRECAUTIONS**).

Drug-Lifestyle Interactions

Effects on Ability to Drive and Use Machines

The effect of canagliflozin on the ability to drive and use machines has not been examined. However, patients should be alerted to the elevated risk of adverse reactions related to reduced intravascular volume, such as postural dizziness, and to the risk of hypoglycemia when

INVOKAMET[®] is used as add-on therapy with insulin or an insulin secretagogue (see **WARNINGS AND PRECAUTIONS**, **ADVERSE REACTIONS** and **DOSAGE AND ADMINISTRATION**).

Alcohol

Patients should be cautioned against excessive alcohol intake, either acute or chronic, when taking INVOKAMET[®], since alcohol intake potentiates the effect of metformin on lactate metabolism (see **CONTRAINDICATIONS**). The risk of lactic acidosis is increased in acute alcohol intoxication, particularly in case of fasting or malnutrition or hepatic insufficiency. INVOKAMET[®] is contraindicated in patients with clinical or laboratory evidence of hepatic disease (see **CONTRAINDICATIONS**). It is recommended that consumption of alcohol and alcohol-containing medicinal product be avoided.

DOSAGE AND ADMINISTRATION

Dosing Considerations

Concomitant Use with Insulin or an Insulin Secretagogue (e.g., Sulfonylurea)

When INVOKAMET[®] is used as add-on therapy with insulin or an insulin secretagogue (e.g., sulfonylurea), a lower dose of insulin or the insulin secretagogue may be considered to reduce the risk of hypoglycemia (see **WARNINGS AND PRECAUTIONS** and **ADVERSE REACTIONS**).

Concomitant Use with UDP-Glucuronosyl Transferase (UGT) Enzyme Inducers

If an inducer of UGTs and drug transport systems (e.g., rifampin, phenytoin, barbituates, phenobarbital, ritonavir, carbamazepine, efavirenz, St John's wort [*Hypericum perforatum*]) is co-administered with INVOKAMET[®], monitor A1C and consider increasing the dose to canagliflozin 150 mg twice daily in patients currently tolerating 50 mg canagliflozin twice daily who have an eGFR ≥ 60 mL/min/1.73 m² or CrCl ≥ 60 mL/min and require additional glycemic control. Consider another antihyperglycemic agent in patients with CrCl less than 60 mL/min.

Diuretics

INVOKAMET[®] is not recommended for use in patients on loop diuretics.

Recommended Dose and Dosage Adjustment

Recommended Adult Dose (18 years of age and older)

The dosage of INVOKAMET[®] (canagliflozin and metformin hydrochloride) should be individualized on the basis of both effectiveness and tolerability, while not exceeding the maximum recommended dose of 150 mg canagliflozin/1000 mg metformin hydrochloride twice daily. Dose escalation should be gradual to reduce the gastrointestinal side effects associated with metformin use.

INVOKAMET[®] should be taken orally twice a day with meals to reduce the risk of gastrointestinal side effects associated with metformin use. Tablets are to be swallowed whole.

The following dosage strengths are available:

- 50 mg canagliflozin/500 mg metformin hydrochloride
 - 50 mg canagliflozin/850 mg metformin hydrochloride
 - 50 mg canagliflozin/1000 mg metformin hydrochloride
 - 150 mg canagliflozin/500 mg metformin hydrochloride
 - 150 mg canagliflozin/850 mg metformin hydrochloride
 - 150 mg canagliflozin/1000 mg metformin hydrochloride
-
- In patients on metformin (alone or in combination with a sulfonylurea, pioglitazone, or insulin), switch to INVOKAMET[®] containing canagliflozin 50 mg with a similar total daily dose of metformin;
 - In patients already treated with canagliflozin and metformin (alone or in combination with a sulfonylurea, pioglitazone, or insulin), switch to INVOKAMET[®] containing the same total daily doses of each component.

In patients with evidence of reduced intravascular volume, this condition should be corrected prior to initiation of INVOKAMET[®].

For patients who are tolerating INVOKAMET[®] containing 50 mg canagliflozin taken twice daily who have an eGFR ≥ 60 mL/min/1.73 m², who need tighter glycemic control and who have a low risk of adverse reactions associated with reduced intravascular volume, the dose can be increased to INVOKAMET[®] containing 150 mg canagliflozin taken twice daily (see **WARNINGS AND PRECAUTIONS**).

Pediatrics (< 18 years of age)

The safety and efficacy of INVOKAMET[®] have not been established in pediatric patients. Therefore, INVOKAMET[®] should not be used in this population.

Elderly

Due to the potential for decreased renal function in elderly subjects, the dosage of INVOKAMET[®] should be adjusted based on renal function. Regular assessment of renal function is necessary (see **WARNINGS AND PRECAUTIONS**).

Renal function and risk of volume depletion should be taken into account (see **WARNINGS AND PRECAUTIONS** and **ADVERSE REACTIONS**). For those patients who are tolerating canagliflozin 50 mg twice daily and who need tighter glycemic control, the dose can be increased to canagliflozin 150 mg twice daily. See section below for dosing recommendations in renally impaired patients.

Renal Impairment

No dose adjustment is needed in patients with mild renal impairment (eGFR of 60 mL/min/1.73 m² to < 90 mL/min/1.73 m² or greater).

Hepatic Impairment

INVOKAMET[®] is contraindicated in patients with clinical or laboratory evidence of hepatic disease (see **CONTRAINDICATIONS**). Metformin use in patients with impaired hepatic function has been associated with some cases of lactic acidosis (see **WARNINGS AND PRECAUTIONS**).

Missed Dose

If a dose of INVOKAMET[®] is missed, it should be taken as soon as the patient remembers unless it is almost time for the next dose in which case patients should skip the missed dose and take the medicine at the next regularly scheduled time.

OVERDOSAGE

Canagliflozin

Single doses up to 1600 mg of canagliflozin in healthy subjects and canagliflozin 300 mg twice daily for 12 weeks in patients with type 2 diabetes were generally well-tolerated.

In the event of an overdose, contact the Poison Control Centre. It is also reasonable to employ the usual supportive measures, e.g., remove unabsorbed material from the gastrointestinal tract, employ clinical monitoring, and institute supportive treatment as dictated by the patient's clinical status. Canagliflozin was negligibly removed during a 4-hour hemodialysis session. Canagliflozin is not expected to be dialyzable by peritoneal dialysis.

Metformin

Available information concerning treatment of a massive overdose of metformin hydrochloride is very limited. It would be expected that adverse reactions of a more intense character including epigastric discomfort, nausea and vomiting followed by diarrhea, drowsiness, weakness, dizziness, malaise and headache might be seen. Should those symptoms persist, lactic acidosis should be excluded. The drug should be discontinued and proper supportive therapy instituted.

Overdose of metformin hydrochloride has occurred, including ingestion of amounts greater than 50 grams. Hypoglycemia was reported in approximately 10% of cases, but no causal association with metformin hydrochloride has been established. Lactic acidosis has been reported in approximately 32% of metformin overdose cases (see **WARNINGS AND PRECAUTIONS, Endocrine and Metabolism, Lactic Acidosis**). Metformin is dialyzable with a clearance of up to 170 mL/min under good hemodynamic conditions. Therefore, hemodialysis may be useful for removal of accumulated drug from patients in whom metformin overdose is suspected.

For management of a suspected drug overdose, contact your regional Poison Control Centre.

ACTION AND CLINICAL PHARMACOLOGY

Mechanism of Action

INVOKAMET®

INVOKAMET® (canagliflozin and metformin hydrochloride) combines two oral antihyperglycemic agents with complementary mechanisms of action to improve glycemic control in patients with type 2 diabetes: canagliflozin, a sodium-glucose co-transporter 2 (SGLT2) inhibitor, and metformin hydrochloride, a member of the biguanide class.

Canagliflozin

Sodium-glucose co-transporter 2 (SGLT2), expressed in the proximal renal tubules, is responsible for the majority of the reabsorption of filtered glucose from the tubular lumen. Patients with diabetes have been shown to have elevated renal glucose reabsorption which may contribute to persistent elevated glucose concentrations. Canagliflozin is an orally-active inhibitor of SGLT2. By inhibiting SGLT2, canagliflozin reduces reabsorption of filtered glucose and lowers the renal threshold for glucose (RT_G), and thereby increases urinary glucose excretion, which decreases elevated plasma glucose concentrations by an insulin-independent mechanism in patients with type 2 diabetes. The increased urinary glucose excretion with SGLT2 inhibition also translates to an osmotic diuresis, with the diuretic effect leading to a reduction in systolic blood pressure; the increase in urinary glucose excretion results in a loss of calories and therefore a reduction in body weight, as demonstrated in studies of patients with type 2 diabetes.

Canagliflozin's action to increase UGE directly lowering plasma glucose is independent of insulin. Improvement in homeostasis model assessment for beta-cell function (HOMA beta-cell) and improved beta-cell insulin secretion response to a mixed-meal challenge has been observed in clinical studies with canagliflozin.

In Phase 3 studies, pre-meal administration of canagliflozin 300 mg provided a greater reduction in post-meal glucose excursion than observed with the 100 mg dose. This effect at the 300 mg dose of canagliflozin may, in part, be due to local inhibition of intestinal SGLT1 (an important intestinal glucose co-transporter) related to transient high concentrations of canagliflozin in the intestinal lumen prior to drug absorption (canagliflozin is a low potency inhibitor of SGLT1). Studies have shown no glucose malabsorption with canagliflozin.

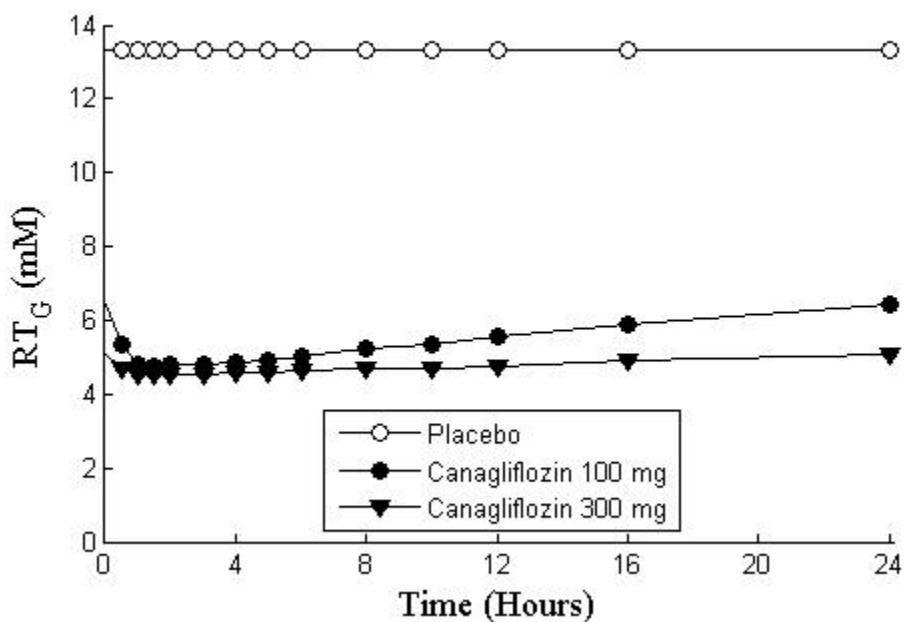
Metformin

Metformin is a biguanide derivative producing an antihyperglycemic effect which can only be observed in man or in the diabetic animal and only when there is insulin secretion. Metformin, at therapeutic doses, does not cause hypoglycemia when used alone in man or in the non-diabetic animal, except when using a near lethal dose. Metformin has no effects on the pancreatic beta cells. The mode of action of metformin is not fully understood. It has been postulated that metformin might potentiate the effect of insulin or that it might enhance the effect of insulin on the peripheral receptor site. This increased sensitivity seems to follow an increase in the number of insulin receptors on cell surface membranes.

Pharmacodynamics

Following single and multiple oral doses of canagliflozin to patients with type 2 diabetes, dose-dependent decreases in RT_G and increases in urinary glucose excretion were observed. From a starting value of RT_G of approximately 13 mmol/L, maximal suppression of 24-hour mean RT_G was seen with the 300 mg daily dose to approximately 4 to 5 mmol/L in patients with type 2 diabetes in Phase 1 studies (see model in Figure 1), suggesting a low risk for treatment-induced hypoglycemia. The reductions in RT_G led to increased UGE in subjects with type 2 diabetes treated with either 100 mg or 300 mg of canagliflozin ranging from 77 to 119 g/day across the Phase 1 studies; the UGE observed translates to a loss of 308 to 476 kcal/day. The reductions in RT_G and increases in UGE were sustained over a 26-week dosing period in patients with type 2 diabetes. Moderate increases (generally < 400-500 mL) in daily urine volume were seen that attenuated over several days of dosing. Urinary uric acid excretion was transiently increased by canagliflozin (increased by 19% compared to baseline on day 1 and then attenuating to 6% on day 2 and 1% on day 13). This was accompanied by a sustained reduction in serum uric acid concentration of approximately 20%.

Figure 1: Predicted (PK/PD Modelled) 24-Hour Profile for RT_G in Subjects with Type 2 Diabetes Treated with Canagliflozin 100 mg and 300 mg



In a single-dose study in patients with type 2 diabetes, treatment with 300 mg before a mixed meal delayed intestinal glucose absorption and reduced postprandial glucose through both renal and non-renal mechanisms.

Cardiac electrophysiology

In a randomized, double-blind, placebo-controlled, active-comparator, 4-way crossover study, 60 healthy subjects were administered a single oral dose of canagliflozin 300 mg, canagliflozin 1200 mg (4 times the maximum recommended dose), moxifloxacin, and placebo. No meaningful changes in QT_c interval were observed with either the recommended dose of 300 mg or the

1200 mg dose. At the 1200 mg dose, peak canagliflozin plasma concentrations were approximately 1.4 times the steady-state peak concentrations following a 300 mg once-daily dose.

Pharmacokinetics

Pharmacokinetics of canagliflozin were comparable between healthy volunteers and type 2 diabetic patients based on clinical trials and population pharmacokinetic data. After single-dose oral administration of 100 mg and 300 mg in healthy subjects, canagliflozin was rapidly absorbed, with peak plasma concentrations (median T_{max}) occurring 1 to 2 hours post-dose. Plasma C_{max} and AUC of canagliflozin increased in a dose-proportional manner from 50 mg to 300 mg. The apparent terminal half-life ($t_{1/2}$) (expressed as mean \pm standard deviation) was 10.6 ± 2.13 hours to 13.1 ± 3.28 hours for the 100 mg and 300 mg doses, respectively. Steady-state was reached after 4 to 5 days of once-daily dosing with canagliflozin 100 mg to 300 mg. Canagliflozin does not exhibit time-dependent pharmacokinetics, and accumulated in plasma up to 36% following multiple doses of 100 mg and 300 mg.

Table 8: Summary of Canagliflozin's Pharmacokinetic Parameters in Healthy Subjects and T2DM Patients at Steady State

	N	C_{max} (SD) (ng/mL)	$t_{1/2}$ (h)	AUC _{24h} (SD) (ng.h/mL)	Cl/F	Vd/F
Healthy Volunteers^a						
100 mg multiple oral doses qd	9	1,118 (143)	13.3 (4.8)	6,056 (959)	16.4 (2.16)	304 (79.7)
300 mg multiple oral doses qd	9	3,379 (728)	13.5 (3.2)	19,252 (5,348)	16.4 (3.60)	319 (104)
T2DM Patients^b						
100 mg multiple oral doses qd	8	1,227 (481)	13.7 (2.1)	8,225 (1,947)	13.0 (4.43)	250 (50.7)
300 mg multiple oral doses qd	10	4,678 (1,685)	14.9 (4.8)	30,995 (11,146)	11.3 (5.21)	226 (89.4)

^a From Study DIA1030

^b From Study DIA1023

The results of bioequivalence studies in healthy subjects demonstrated that INVOKAMET[®] 50 mg/500 mg, 50 mg/850 mg, 50 mg/1000 mg, 150 mg/500 mg, 150 mg/850 mg, and 150 mg/1000 mg combination tablets are bioequivalent to co-administration of corresponding doses of canagliflozin and metformin hydrochloride as individual tablets.

Administration of INVOKAMET[®] 150 mg/1000 mg fixed-dose combination with food resulted in no change in overall exposure of canagliflozin. There was no change in metformin AUC; however, mean peak plasma concentration of metformin was decreased by 16% when administered with food. A delayed time to peak plasma concentration was observed for both components (2 hours for canagliflozin and 1 hour for metformin) under fed conditions. These changes are not likely to be clinically significant. As metformin is recommended to be administered with a meal to reduce the incidence of gastrointestinal side effects, it is

recommended that INVOKAMET® be taken with a meal to reduce gastrointestinal intolerance associated with metformin.

The 24-h mean RTG at steady state was similar following once daily and twice daily dosing regimens at the same total daily dose of 100 mg or 300 mg. The mean systemic exposure (AUC) at steady state was similar following once daily and twice daily dosing regimens at the same total daily dose of 100 mg or 300 mg.

Absorption

Canagliflozin

The mean absolute oral bioavailability of canagliflozin is approximately 65%. Co-administration of a high-fat meal with canagliflozin had no effect on the pharmacokinetics of canagliflozin; therefore, canagliflozin may be taken with or without food (see **DOSAGE AND ADMINISTRATION**).

Metformin hydrochloride

Metformin absorption is relatively slow and may extend over 6 hours

Distribution

Canagliflozin

The mean steady-state volume of distribution of canagliflozin following a single intravenous infusion in healthy subjects was 119 L, suggesting extensive tissue distribution. Canagliflozin is extensively bound to proteins in plasma (99%), mainly to albumin. Protein binding is independent of canagliflozin plasma concentrations. Plasma protein binding is not meaningfully altered in patients with renal or hepatic impairment.

Metformin

Plasma protein binding is negligible. Metformin partitions into erythrocytes. The blood peak is lower than the plasma peak and appears at approximately the same time. The red blood cells most likely represent a secondary compartment of distribution. The mean V_d ranged between 63 – 276 liters.

Metabolism

Canagliflozin

O-glucuronidation is the major metabolic elimination pathway for canagliflozin, which is mainly glucuronidated by UGT1A9 and UGT2B4 to two inactive *O*-glucuronide metabolites. CYP3A4-mediated (oxidative) metabolism of canagliflozin is minimal (approximately 7%) in humans.

Metformin

Metformin is not metabolized. Its main sites of concentration are the intestinal mucosa and the salivary glands. The plasma concentration at steady-state ranges about 1 to 2 mcg/mL. Certain drugs may potentiate the effects of metformin (see **WARNINGS AND PRECAUTIONS** and **DRUG INTERACTIONS**).

Excretion

Canagliflozin

Following administration of a single oral [¹⁴C] canagliflozin dose to healthy subjects, 41.5%, 7.0%, and 3.2% of the administered radioactive dose was recovered in faeces as canagliflozin, a hydroxylated metabolite, and an *O*-glucuronide metabolite, respectively. Enterohepatic circulation of canagliflozin was negligible.

Approximately 33% of the administered radioactive dose was excreted in urine, mainly as *O*-glucuronide metabolites (30.5%). Less than 1% of the dose was excreted as unchanged canagliflozin in urine. Renal clearance for the 100 mg and 300 mg doses ranged from 1.30 to 1.55 mL/min.

Canagliflozin is a low-clearance drug, with a mean systemic clearance of approximately 192 mL/min in healthy subjects following intravenous administration.

Metformin

Metformin is excreted in urine at high renal clearance rate of about 450 mL/min. The initial elimination of metformin is rapid with a half-life varying between 1.7 and 3 hours. The terminal elimination phase accounting for about 4 to 5 % of the absorbed dose is slow with a half-life between 9 and 17 hours.

Special Populations and Conditions

Pediatrics (< 18 years of age):

INVOKAMET[®] is contraindicated in this patient population. Studies characterizing the pharmacokinetics of canagliflozin and metformin after administration of INVOKAMET[®] in pediatric patients have not been performed.

Geriatrics (≥ 65 years of age):

INVOKAMET[®]

Studies characterizing the pharmacokinetics of canagliflozin and metformin after administration of INVOKAMET[®] in geriatric patients have not been performed.

Canagliflozin

Age had no clinically meaningful effect on the pharmacokinetics of canagliflozin based on a population pharmacokinetic analysis. However, patients 65 years and older had a higher incidence of adverse reactions related to reduced intravascular volume with INVOKAMET[®] (see **WARNINGS AND PRECAUTIONS, ADVERSE REACTIONS and DOSAGE AND ADMINISTRATION**).

Metformin

Controlled clinical studies of metformin did not include sufficient numbers of elderly patients to determine whether they respond differently from younger patients.

Body Mass Index (BMI)/Weight, Gender and Race:

Canagliflozin

Body weight: For subjects with body weight <78.2 kg, the dose normalized exposures of canagliflozin increased by 33%, based on population pharmacokinetic analysis. These increases in exposures are not clinically meaningful and hence no dosage adjustment of canagliflozin is necessary based on body weight.

Gender: Dose normalized exposures of canagliflozin in females were 22% higher than males, based on population pharmacokinetic analysis. These increases in exposures are not clinically meaningful and hence no dosage adjustment of canagliflozin is necessary based on gender.

Race: Dose normalized exposures of canagliflozin were comparable in white and non-white subjects, Blacks, Asians, and other races. A population PK analysis of canagliflozin in 942 white subjects and 674 non-white subjects showed no significant impact of race on canagliflozin PK and hence no dosage adjustment of canagliflozin is necessary based on race.

Metformin

Controlled clinical studies of metformin did not include sufficient numbers of elderly patients to determine whether they respond differently from younger patients.

No studies of metformin pharmacokinetic parameters according to race have been performed.

Hepatic Insufficiency:

Canagliflozin

INVOKAMET® is contraindicated in patients with clinical or laboratory evidence of hepatic disease (see **CONTRAINDICATIONS**). Relative to subjects with normal hepatic function, the geometric mean ratios for C_{max} and AUC_{∞} of canagliflozin were 107% and 110%, respectively, in subjects with Child-Pugh class A (mild hepatic impairment) and 96% and 111%, respectively, in subjects with Child-Pugh class B (moderate hepatic impairment) following administration of a single 300 mg dose of canagliflozin.

These differences are not considered to be clinically meaningful. There is no clinical experience in patients with Child-Pugh class C (severe) hepatic impairment and therefore, canagliflozin is not recommended for use in this patient population.

Metformin

No pharmacokinetic studies of metformin have been conducted in patients with hepatic insufficiency

Renal Insufficiency:

Canagliflozin

A single-dose, open-label study evaluated the pharmacokinetics of canagliflozin 200 mg in subjects with varying degrees of renal impairment, classified using the Modification of Diet in

Renal Disease (MDRD)-eGFR formula, compared to healthy subjects. The study included 3 subjects with normal renal function (eGFR ≥ 90 mL/min/1.73 m²), 10 subjects with mild renal impairment (eGFR 60 to < 90 mL/min/1.73 m²), 9 subjects with moderate renal impairment (eGFR 30 to < 60 mL/min/1.73 m²), and 10 subjects with severe renal impairment (eGFR 15 to < 30 mL/min/1.73 m²) as well as 8 subjects with end stage renal disease (ESRD) on hemodialysis.

The C_{max} of canagliflozin was moderately increased by 13%, 29%, and 29% in subjects with mild, moderate, and severe renal failure, respectively, but not in subjects on hemodialysis. Compared to healthy subjects, plasma AUC of canagliflozin was increased by approximately 17%, 63%, and 50% in subjects with mild, moderate, and severe renal impairment, respectively, but was similar for ESRD subjects and healthy subjects. Increases in canagliflozin AUC of this magnitude are not considered clinically relevant, however, the pharmacodynamic response to canagliflozin declines with increasing severity of renal impairment (see **CONTRAINDICATIONS** and **WARNINGS AND PRECAUTIONS**). Canagliflozin was negligibly removed by hemodialysis.

Genetic polymorphism: Both UGT1A9 and UGT2B4 are subject to genetic polymorphism. In a pooled analysis of clinical data, increases in canagliflozin AUC of 26% were observed in UGT1A9*1/*3 carriers and 18% in UGT2B4*2/*2 carriers. These increases in canagliflozin exposure are not expected to be clinically relevant and no dosage adjustment is necessary based on UGT1A9 and UGT2B4 genetic polymorphisms. The effect of being homozygote (UGT1A9*3/*3, frequency $< 0.1\%$) is probably more marked, but has not been investigated.

STORAGE AND STABILITY

INVOKAMET[®] tablets should be stored at 15-30°C.

SPECIAL HANDLING INSTRUCTIONS

Keep INVOKAMET[®] out of the sight and reach of children.

DOSAGE FORMS, COMPOSITION AND PACKAGING

INVOKAMET[®] is supplied as film-coated, immediate-release tablets for oral administration. Each tablet strength contains canagliflozin drug substance as the hemihydrate equivalent to 50 mg or 150 mg of anhydrous canagliflozin, and metformin hydrochloride in quantities of 500 mg, 850 mg or 1000 mg tablet strengths are supplied in bottles of 60, inside cartons.

The available tablet strengths are listed below:

Strength	Description
50 mg + 500 mg	Capsule-shaped, white, film-coated tablets with “CM” on one side and “155” on the other side
50 mg + 850 mg	Capsule shaped, pink, film-coated tablets with “CM” on one side and “358” on the other side
50 mg + 1000 mg	Capsule shaped, beige, film-coated tablets with “CM” on one side and “551” on the other side
150 mg + 500 mg	Capsule shaped, yellow, film-coated tablets with “CM” on one side and “215” on the other side
150 mg + 850 mg	Capsule shaped, light yellow, film-coated tablets with “CM” on one side and “418” on the other side
150 mg + 1000 mg	Capsule shaped, purple, film-coated tablets with “CM” on one side and “611” on the other side

Composition

Each tablet contains the following non-medicinal ingredients:

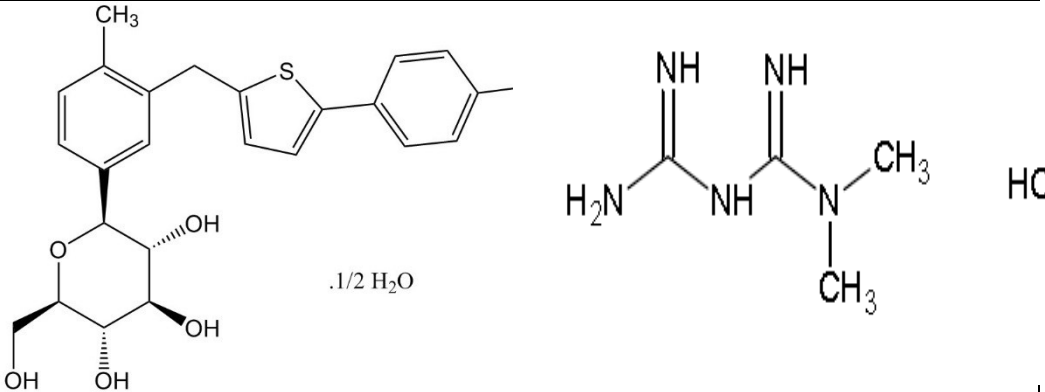
Core Tablet: croscarmellose sodium, hypromellose (2910), magnesium stearate, and microcrystalline cellulose.

Film Coat: iron oxide black (50 mg/850 mg and 150 mg/1000 mg tablets, iron oxide red (50 mg/850 mg, 50 mg/1000 mg, 150 mg/500 mg and 150/1000 mg tablets), iron oxide yellow (50 mg/1000 mg, 150 mg/500 mg, and 150 mg/850 mg tablets), macrogol (polyethylene glycol), polyvinyl alcohol (partially hydrolyzed), talc, and titanium dioxide.

PART II: SCIENTIFIC INFORMATION

PHARMACEUTICAL INFORMATION

Drug Substance: Canagliflozin plus metformin hydrochloride

Proper name:	Canagliflozin	Metformin hydrochloride
Chemical name:	(1 <i>S</i>)-1,5-anhydro-1-[3-[[5-(4-fluorophenyl)-2-thienyl]methyl]-4-methylphenyl]-D-glucitol hemihydrate	1,1-Dimethylbiguanide hydrochloride
Molecular formula:	C ₂₄ H ₂₅ FO ₅ S•1/2 H ₂ O	C ₄ H ₁₁ N ₅ •HCl
Molecular mass:	<ul style="list-style-type: none"> Hemihydrate: 453.53 Anhydrous: 444.52 	165.62
Structural formula:		
Physicochemical properties:	Canagliflozin is practically insoluble in aqueous media from pH 1.1 to 12.9. There is no detectable pK _a value for this substance.	Metformin hydrochloride is freely soluble in various aqueous media, irrespective of pH, and has low permeability.

CLINICAL TRIALS

There have been no clinical efficacy studies conducted with INVOKAMET[®], however, bioequivalence of INVOKAMET[®] to canagliflozin and metformin co-administered as individual tablets was demonstrated in healthy subjects (see **ACTION AND CLINICAL PHARMACOLOGY, Pharmacokinetics**). The co-administration of canagliflozin and metformin has been studied in patients with type 2 diabetes inadequately controlled on diet and exercise and as add-on therapy with other antihyperglycemic agents.

Canagliflozin

Five placebo- or active-controlled studies investigated canagliflozin as add-on therapy with other antihyperglycemic agents: two studies with metformin (26 and 52 weeks); two studies with metformin and sulfonylurea (26 and 52 weeks), and one study with metformin and pioglitazone (26 weeks). An ongoing dedicated cardiovascular study has been conducted in patients with type 2 diabetes; safety analyses were conducted that investigated canagliflozin as add-on therapy with a sulfonylurea and with insulin.

Study Demographics and Trial Design

Table 9: Summary of Patient Demographics for Clinical Trials in Specific Indication

Study #	Trial design	Dosage, route of administration and duration	Study subjects (n=number)	Mean age (Range)	Gender (% F/M)
Add-on Therapy with Metformin (\geq 1500 mg/day)					
DIA3006	Randomized, double-blind, active-controlled, parallel-group, multicentre	Canagliflozin 100 or 300 mg/day or Sitagliptin 100 mg/day or Placebo 26-week	Total: 1284 Canagliflozin 100 mg: 368 Canagliflozin 300 mg: 367 Sitagliptin 100 mg: 366 Placebo: 183	55.4 (21-79)	52.9/47.1
DIA3009	Randomized, double-blind, active-controlled, parallel-group, multicentre	Canagliflozin 100 or 300 mg/day or Glimepiride 1- 8 mg (titration protocol) 52-week	Total: 1450 Canagliflozin 100 mg: 483 Canagliflozin 300 mg: 485 Glimepiride: 482	56.2 (22-80)	47.9/52.1
Add-on Therapy with Metformin (\geq 1500 mg/day) and a Sulfonylurea (stable dose)					
DIA3002	Randomized, double-blind, placebo-controlled, parallel-group, multicentre	Canagliflozin 100 or 300 mg/day or Placebo 26-week	Total: 469 Canagliflozin 100 mg: 157 Canagliflozin 300 mg: 156 Placebo: 156	56.8 (27-79)	49.0/51.0

Table 9: Summary of Patient Demographics for Clinical Trials in Specific Indication

Study #	Trial design	Dosage, route of administration and duration	Study subjects (n=number)	Mean age (Range)	Gender (% F/M)
DIA3015	Randomized, double-blind, active-controlled, parallel-group, multicentre	Canagliflozin 300 mg/day or Sitagliptin 100 mg/day or Placebo 52-week	Total: 755 Canagliflozin 300 mg: 377 Sitagliptin 100 mg: 378	56.7 (21-91)	44.1/55.9
Add-on Therapy with Metformin (≥ 1500 mg/day) and Pioglitazone (30 or 45 mg/day)					
DIA3012	Randomized, double-blind, placebo-controlled, parallel-group, multicentre	Canagliflozin 100 or 300 mg/day or Placebo 26-week	Total: 342 Canagliflozin 100 mg: 113 Canagliflozin 300 mg: 114 Placebo: 115	57.4 (27-78)	36.8/63.2
Add-on to Insulin and Metformin					
DIA 3008 Insulin Substudy (subset)	Randomized, double-blind, placebo-controlled, parallel-group, multicentre	Canagliflozin 100 or 300 mg/day or Placebo 18 weeks	Total: 731 Canagliflozin 100 mg: 241 Canagliflozin 300 mg: 246 Placebo: 244	57.0 (21-91)	46.1/53.9

[†] AHA = antihyperglycemic agent

In the metformin add-on studies, a total of 5,031 patients with type 2 diabetes were randomized in six double-blind, controlled clinical efficacy and safety studies conducted to evaluate the effects of canagliflozin on glycemic control. The racial distribution was 71% White, 15% Asian, 5% Black, and 9% other groups. Approximately 20% of patients were Hispanic. Approximately 54% of patients were male. Patients had an overall mean age of 59.6 years (range 21 to 91 years), with 1036 patients 65 years of age and older and 121 patients 75 years of age and older,

In addition, an 18-week double-blind, placebo-controlled Phase 2 study with twice daily dosing (canagliflozin 50 mg or 150 mg in combination with metformin) was conducted in 279 patients in which 186 patients were treated with canagliflozin in combination with metformin.

Study Results

In patients with type 2 diabetes, treatment with canagliflozin produced statistically significant improvements in A1C, fasting plasma glucose (FPG), 2-hour postprandial glucose (PPG), and body weight, compared to placebo. Canagliflozin was effective in reducing A1C in a broad range of patients regardless of disease duration and concomitant use of antihyperglycemic agents. The durability of these reductions in A1C was demonstrated in two Phase 3 studies, with minimal attenuation of the glycemic response to canagliflozin over 52 weeks, in contrast to the deterioration of the glycemic response observed with comparators.

Statistically significant improvements in glycemic control relative to placebo were observed with canagliflozin when given as add-on therapy with metformin, add-on therapy with metformin and a sulfonylurea, add-on therapy with metformin and pioglitazone, or as add-on therapy with insulin and metformin).

In addition, significant improvements in A1C were observed with canagliflozin in older patients. Reductions in A1C were observed across subgroups including age, gender, race, baseline body mass index (BMI), and baseline beta-cell function. Greater reductions in A1C relative to placebo were observed in patients with higher baseline A1C or eGFR values.

Add-on Therapy

Add-on Therapy with Metformin (Study DIA3006)

A total of 1284 patients with inadequate glycemic control (A1C of $\geq 7\%$ to $\leq 10.5\%$) on metformin monotherapy (2,000 mg/day or at least 1,500 mg/day if higher dose not tolerated) participated in a randomized, double-blind, placebo- and active-controlled, parallel-group, 4-arm, multicentre clinical study to evaluate the efficacy of canagliflozin as add-on therapy with metformin over 26 weeks. The mean age was 55 years, 47% of patients were men, and the mean baseline eGFR was 89 mL/min/1.73 m². Patients already on metformin (N=1009) at screening with inadequate glycemic control completed a 2-week, single-blind, placebo run-in period. Other patients on metformin and another oral agent or a lower than required dose of metformin (N=275) were switched to a regimen of metformin monotherapy. After at least 8 weeks on a stable dose of metformin monotherapy, patients entered a 2-week, single-blind, placebo run-in period. Patients were randomized to the addition of canagliflozin 100 mg, canagliflozin 300 mg, sitagliptin 100 mg, or placebo, administered once daily.

As shown in Table 10, statistically significant ($p < 0.001$) reductions in A1C, FPG, PPG, and body weight relative to placebo were observed. In addition, a greater percentage of patients achieved an A1C $< 7.0\%$ compared to placebo. Statistically significant ($p < 0.001$) reductions in systolic blood pressure were observed with canagliflozin 100 mg and 300 mg relative to placebo of -5.4 mmHg and -6.6 mmHg, respectively.

Table 10: Results from Placebo-Controlled Clinical Study of Canagliflozin as Add-on Therapy with Metformin¹

Efficacy Parameter	Canagliflozin + Metformin 26 weeks		Placebo + Metformin (N=183)
	100 mg (N=368)	300 mg (N=367)	
A1C (%)			
Baseline (mean)	7.94	7.95	7.96
Change from baseline (adjusted mean)	-0.79	-0.94	-0.17
Difference from placebo (adjusted mean) (95% CI)	-0.62 ² (-0.76; -0.48)	-0.77 ² (-0.91; -0.64)	N/A ³
Percent of patients achieving A1C < 7%	45.5 ²	57.8 ²	29.8
Fasting Plasma Glucose (mmol/L)			
Baseline (mean)	9.36	9.59	9.12
Change from baseline (adjusted mean)	-1.52	-2.10	0.14
Difference from placebo (adjusted	-1.65 ²	-2.23 ²	N/A ³

Table 10: Results from Placebo-Controlled Clinical Study of Canagliflozin as Add-on Therapy with Metformin¹

Efficacy Parameter	Canagliflozin + Metformin 26 weeks		Placebo + Metformin (N=183)
	100 mg (N=368)	300 mg (N=367)	
mean) (95% CI)	(-1.99; -1.32)	(-2.57; -1.90)	
2-hour Postprandial Glucose (mmol/L)			
Baseline (mean)	14.30	14.54	13.81
Change from baseline (adjusted mean)	-2.66	-3.17	-0.55
Difference from placebo (adjusted mean) (95% CI)	-2.12 ² (-2.73; -1.51)	-2.62 ² (-3.24; -2.01)	N/A ³
Body Weight			
Baseline (mean) in kg	88.7	85.4	86.7
% change from baseline (adjusted mean)	-3.7	-4.2	-1.2
Difference from placebo (adjusted mean) (95% CI)	-2.5 ² (-3.1; -1.9)	-2.9 ² (-3.5; -2.3)	N/A ³

¹ Intent-to-treat population using last observation in study prior to glycemic rescue therapy

² p<0.001 compared to placebo

³ N/A = Not applicable

Active-Controlled Study versus Glimepiride as add-on therapy with Metformin (Study DIA3009)

A total of 1450 patients with inadequate glycemic control (A1C level of $\geq 7\%$ to $\leq 9.5\%$) on metformin monotherapy ($\geq 2,000$ mg/day or at least 1,500 mg/day if higher dose not tolerated) participated in a randomized, double-blind, active-controlled, parallel-group, 3-arm, multicentre clinical study to evaluate the efficacy of canagliflozin as add-on therapy with metformin over 52 weeks. The mean age was 56 years, 52% of patients were men, and the mean baseline eGFR was 90 mL/min/1.73 m². Patients on metformin (N=928) at a stable protocol-specified dose entered a 2-week, single-blind, placebo run-in period. Other patients (N=522) entered a metformin dose titration and dose stabilization/antihyperglycemic agent washout period, immediately followed by the 2-week run-in period. Following the run-in period, patients with inadequate glycemic control were randomized to the addition of canagliflozin 100 mg, canagliflozin 300 mg, or glimepiride (titration allowed throughout the 52-week study to 6 to 8 mg), administered once daily.

As shown in Table 11 and Figure 2, after 52 weeks, treatment with canagliflozin 100 mg provided similar reductions in A1C from baseline compared to glimepiride (with the upper bound of the 95% confidence interval around the between-group difference less than the pre-specified non-inferiority margin of 0.3%); canagliflozin 300 mg provided a superior ($p<0.05$) reduction from baseline in A1C compared to glimepiride (with the upper bound of the 95% confidence interval below 0). Statistically significant ($p<0.001$) reductions in body weight were observed with canagliflozin compared to glimepiride. Reductions in systolic blood pressure were observed with canagliflozin 100 mg and 300 mg relative to glimepiride of -3.5 mmHg and -4.8 mmHg, respectively. The incidence of hypoglycemia with canagliflozin was significantly lower ($p<0.001$) compared to glimepiride.

Table 11: Results from 52-Week Clinical Study Comparing Canagliflozin to Glimepiride as Add-on Therapy with Metformin¹

Efficacy Parameter	Canagliflozin + Metformin 52 Weeks		Glimepiride (titrated) + Metformin (N=482)
	100 mg (N=483)	300 mg (N=485)	
A1C (%)			
Baseline (mean)	7.78	7.79	7.83
Change from baseline (adjusted mean)	-0.82	-0.93	-0.81
Difference from glimepiride (adjusted mean) (95% CI)	-0.01 ² (-0.11; 0.09)	-0.12 ² (-0.22; -0.02)	N/A ³
Percent of patients achieving A1C < 7%	53.6	60.1	55.8
Fasting Plasma Glucose (mmol/L)			
Baseline (mean)	9.18	9.09	9.20
Change from baseline (adjusted mean)	-1.35	-1.52	-1.02
Difference from glimepiride (adjusted mean) (95% CI)	-0.33 (-0.56; -0.11)	-0.51 (-0.73; -0.28)	N/A ³
Body Weight			
Baseline (mean) in kg	86.8	86.6	86.6
% change from baseline (adjusted mean)	-4.2	-4.7	1.0
Difference from glimepiride (adjusted mean) (95% CI)	-5.2 ⁴ (-5.7; -4.7)	-5.7 ⁴ (-6.2; -5.1)	N/A ³

¹ Intent-to-treat population using last observation in study prior to glycemic rescue therapy

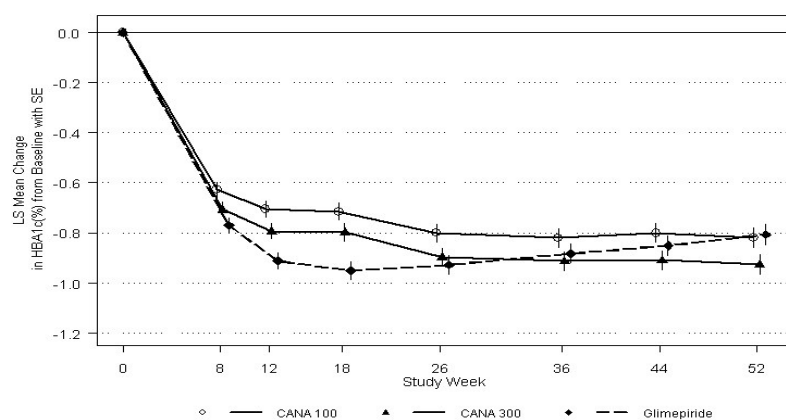
² Met pre-specified criteria for non-inferiority to glimepiride (with the upper bound of the 95% CI around the between-group difference less than the pre-specified non-inferiority margin of < 0.3%). In a pre-specified assessment, the upper bound of the 95% CI for canagliflozin 300 mg, but not for canagliflozin 100 mg was < 0, indicating a superior (p<0.05) reduction in A1C relative to glimepiride with canagliflozin 300 mg.

³ N/A = Not applicable

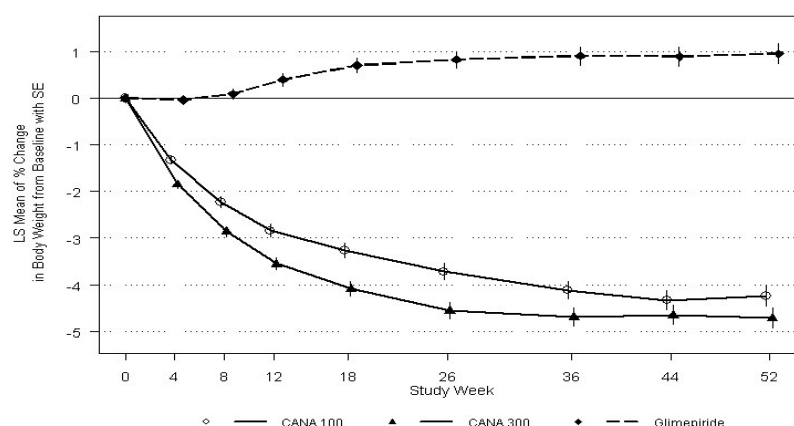
⁴ p<0.001

⁵ Includes only patients who had both baseline and post-baseline values

Figure 2: Mean Changes from Baseline for A1C (%) and Body Weight Over 52 Weeks in a Study Comparing Canagliflozin to Glimepiride as Add-on Therapy with Metformin



Note: LS Mean and SE in each post baseline visit are based on data with LOCF.



Note: LS Mean and SE in each post baseline visit are based on data with LOCF.

Add-on Therapy with Metformin and Sulfonyleurea (Study DIA3002)

A total of 469 patients with inadequate glycemic control (A1C level of $\geq 7\%$ to $\leq 10.5\%$) on the combination of metformin (2,000 mg/day or at least 1,500 mg/day if higher dose not tolerated) and sulfonyleurea (maximal or near-maximal effective dose) participated in a randomized, double-blind, placebo-controlled, parallel-group, 3-arm, multicentre clinical study to evaluate the efficacy of canagliflozin as add-on therapy with metformin and sulfonyleurea over 26 weeks. The mean age was 57 years, 51% of patients were men, and the mean baseline eGFR was 89 mL/min/1.73 m². Patients on near-maximal or maximal effective doses of metformin and sulfonyleurea (N=372) entered a 2-week, single-blind, placebo run-in period. Other patients (N=97) entered a metformin and sulfonyleurea dose titration and dose stabilization/antihyperglycemic agent washout period of up to 12 weeks, immediately followed by the 2-week run-in period. Following the run-in period, patients with inadequate glycemic control were randomized to the addition of canagliflozin 100 mg, canagliflozin 300 mg, or placebo administered once daily.

As shown in Table 12, statistically significant ($p < 0.001$) reductions in A1C, FPG, and body weight relative to placebo were observed. In addition, a greater percentage of patients achieved an A1C $< 7.0\%$ compared to placebo. Reductions in systolic blood pressure were observed with canagliflozin 100 mg and 300 mg relative to placebo of -2.2 mmHg and -1.6 mmHg, respectively. An increased incidence of hypoglycemia was observed in this study (see **WARNINGS AND PRECAUTIONS** and **ADVERSE REACTIONS**).

Table 12: Results from 26-Week Placebo-Controlled Clinical Study of Canagliflozin as Add-on Therapy with Metformin and Sulfonyleurea¹

Efficacy Parameter	Canagliflozin + Metformin and Sulfonyleurea 26 Weeks		Placebo + Metformin and Sulfonyleurea (N=156)
	100 mg (N=157)	300 mg (N=156)	
A1C (%)			
Baseline (mean)	8.13	8.13	8.12
Change from baseline (adjusted mean)	-0.85	-1.06	-0.13
Difference from placebo (adjusted mean) (95% CI)	-0.71 ² (-0.90; -0.52)	-0.92 ² (-1.11; -0.73)	N/A ³
Percent of patients achieving A1C < 7%	43.2 ²	56.6 ²	18.0
Fasting Plasma Glucose (mmol/L)			
Baseline (mean)	9.60	9.34	9.42
Change from baseline (adjusted mean)	-1.01	-1.69	0.23
Difference from placebo (adjusted mean) (95% CI)	-1.24 ² (-1.75; -0.73)	-1.92 ² (-2.43; -1.41)	N/A ³
Body Weight			
Baseline (mean) in kg	93.5	93.5	90.8
% change from baseline (adjusted mean)	-2.1	-2.6	-0.7
Difference from placebo (adjusted mean) (95% CI)	-1.4 ² (-2.1; -0.7)	-2.0 ² (-2.7; -1.3)	N/A ³

¹ Intent-to-treat population using last observation in study prior to glycemic rescue therapy

² $p < 0.001$ compared to placebo

³ N/A = Not applicable or not measured in this study

Active-Controlled Study versus Sitagliptin as Add-on Therapy with Metformin and Sulfonyleurea (Study DIA3015)

A total of 755 patients with inadequate glycemic control (A1C level of $\geq 7.0\%$ to $\leq 10.5\%$) on the combination of metformin (2,000 mg/day or at least 1,500 mg/day if higher dose not tolerated) and sulfonyleurea (near-maximal or maximal effective dose) participated in a double-blind, active-controlled, parallel-group, 2-arm, multicentre clinical study to evaluate the efficacy of canagliflozin 300 mg as add-on therapy with metformin and sulfonyleurea versus sitagliptin 100 mg as add-on therapy with metformin and sulfonyleurea over 52 weeks. The mean age was 57 years, 56% of patients were men, and the mean baseline eGFR was 88 mL/min/1.73 m². Patients on near-maximal or maximal effective doses of metformin and sulfonyleurea (N=716) entered a 2-week single-blind, placebo run-in period. Other patients (N=39) entered a metformin and sulfonyleurea dose titration and dose stabilization period of up to 12 weeks, immediately

followed by the 2-week run-in period. Following the run-in period, patients with inadequate glycemic control were randomized to the addition of canagliflozin 300 mg or sitagliptin 100 mg.

As shown in Table 13 and Figure 3, after 52 weeks, canagliflozin 300 mg provided a superior ($p < 0.05$) reduction in A1C compared to sitagliptin 100 mg (with the upper bound of the 95% confidence interval around the between-group difference below 0). In addition, a greater percent of patients achieved an A1C of $< 7.0\%$ with canagliflozin 300 mg relative to sitagliptin: 47.6% of patients receiving canagliflozin 300 mg and 35.3% of patients receiving sitagliptin. Patients treated with canagliflozin 300 mg exhibited a significant mean decrease in percent change from baseline body weight compared to patients administered sitagliptin 100 mg. A statistically significant ($p < 0.001$) reduction in systolic blood pressure was observed with canagliflozin 300 mg of -5.9 mmHg relative to sitagliptin. A similar increased incidence of hypoglycemia was observed with both canagliflozin 300 mg and sitagliptin in this study, consistent with the expected increase of hypoglycemia when agents not associated with hypoglycemia are added to sulfonylurea (see **WARNINGS AND PRECAUTIONS** and **ADVERSE REACTIONS**). The proportion of patients who met glycemic withdrawal criteria (based on FPG until Week 26 and A1C thereafter) was lower with canagliflozin 300 mg (10.6%) compared with sitagliptin 100 mg (22.5%).

Table 13: Results from 52-Week Clinical Study Comparing Canagliflozin to Sitagliptin as Add-on Therapy with Metformin and Sulfonyleurea¹

Efficacy Parameter	Canagliflozin 300 mg + Metformin and Sulfonyleurea (N=377)	Sitagliptin 100 mg + Metformin and Sulfonyleurea (N=378)
A1C (%)		
Baseline (mean)	8.12	8.13
Change from baseline (adjusted mean)	-1.03	-0.66
Difference from sitagliptin (adjusted mean) (95% CI)	-0.37 ² (-0.50; -0.25)	N/A ⁴
Percent of patients achieving A1C < 7%	47.6	35.3
Fasting Plasma Glucose (mmol/L)		
Baseline (mean)	9.42	9.09
Change from baseline (adjusted mean)	-1.66	-0.32
Difference from sitagliptin (adjusted mean) (95% CI)	-1.34 (-1.66; -1.01)	N/A ⁴
Body Weight		
Baseline (mean) in kg	87.6	89.6
% change from baseline (adjusted mean)	-2.5	0.3
Difference from sitagliptin (adjusted mean) (95% CI)	-2.8 ³ (-3.3; -2.2)	N/A ⁴

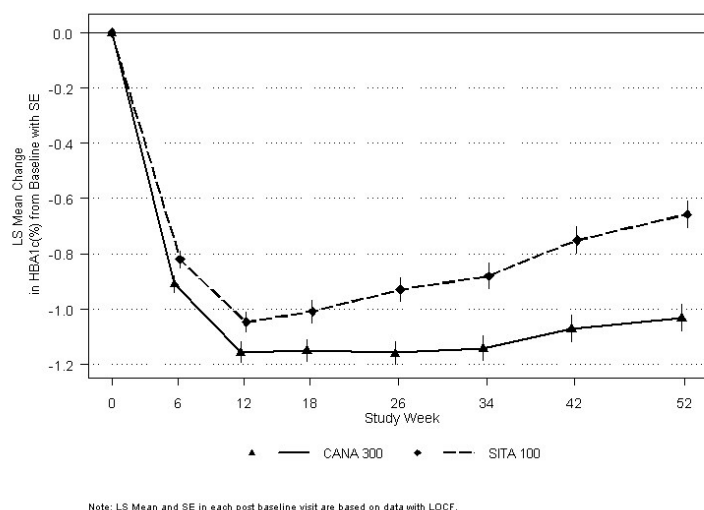
¹ Intent-to-treat population using last observation in study prior to glycemic rescue therapy

² Met pre-specified criteria for non-inferiority to sitagliptin (with the upper bound of the 95% CI around the between-group difference less than the pre-specified non-inferiority margin of < 0.3%); in a pre-specified assessment, the upper bound of the 95% CI for canagliflozin 300 mg was < 0, indicating a superior (p<0.05) reduction in A1C relative to sitagliptin with canagliflozin 300 mg.

³ p<0.001

⁴ N/A = Not applicable

Figure 3: Mean Change from Baseline for A1C (%) Over 52 Weeks in a Study Comparing Canagliflozin to Sitagliptin as Add-on Therapy with Metformin and Sulfonyleurea



Add-on Therapy with Metformin and Pioglitazone (Study DIA3012)

A total of 342 patients with inadequate glycemic control (A1C level of $\geq 7.0\%$ to $\leq 10.5\%$) on the combination of metformin (2,000 mg/day or at least 1,500 mg/day if higher dose not tolerated) and pioglitazone (30 or 45 mg/day) participated in a randomized, double-blind, placebo-controlled, parallel-group, 3-arm, multicentre clinical study to evaluate the efficacy of canagliflozin as add-on therapy with metformin and pioglitazone over 26 weeks. The mean age was 57 years, 63% of patients were men, and the mean baseline eGFR was 86 mL/min/1.73 m². Patients already on protocol-specified doses of metformin and pioglitazone (N=163) entered a 2-week, single-blind, placebo run-in period. Other patients (N=181) entered a metformin and pioglitazone dose titration and dose stabilization period for up to 12 weeks with at least 8 weeks on stable doses of metformin and pioglitazone, immediately followed by the 2-week run-in period. Following the run-in period, patients with inadequate glycemic control were randomized (N=344) to the addition of canagliflozin 100 mg, canagliflozin 300 mg, or placebo, administered once daily.

As shown in Table 14, statistically significant ($p < 0.001$) reductions in A1C, baseline FPG, and body weight relative to placebo were observed for canagliflozin at Week 26. In addition, a greater percent of patients achieved an A1C of $< 7.0\%$ compared to placebo. Statistically significant reductions in systolic blood pressure were observed with canagliflozin 100 mg and 300 mg relative to placebo of -4.1 mmHg ($p = 0.005$) and -3.5 mmHg ($p = 0.016$), respectively.

Table 14: Results from 26-Week Placebo-Controlled Clinical Study of Canagliflozin as Add-on Therapy with Metformin and Pioglitazone¹

Efficacy Parameter	Canagliflozin + Metformin and Pioglitazone 26 Weeks		Placebo + Metformin and Pioglitazone (N=115)
	100 mg (N=113)	300 mg (N=114)	
A1C (%)			
Baseline (mean)	7.99	7.84	8.00
Change from baseline (adjusted mean)	-0.89	-1.03	-0.26
Difference from placebo (adjusted mean) (95% CI)	-0.62 ² (-0.81; -0.44)	-0.76 ² (-0.95; -0.58)	N/A ³
Percent of patients achieving A1C < 7%	46.9 ²	64.3 ²	32.5
Fasting Plasma Glucose (mmol/L)			
Baseline (mean)	9.38	9.11	9.13
Change from baseline (adjusted mean)	-1.49	-1.84	0.14
Difference from placebo (adjusted mean) (95% CI)	-1.63 ² (-2.05; -1.21)	-1.98 ² (-2.41; -1.56)	N/A ³
Body Weight			
Baseline (mean) in kg	94.2	94.4	94
% change from baseline (adjusted mean)	-2.8	-3.8	-0.1
Difference from placebo (adjusted mean) (95% CI)	-2.7 ² (-3.6; -1.8)	-3.7 ² (-4.6; -2.8)	N/A ³

¹ Intent-to-treat population using last observation in study prior to glycemic rescue therapy

² p<0.001 compared to placebo

³ N/A = Not applicable or not measured in this study

Add-on Therapy with Insulin and Metformin (Derived from DIA3008 substudy)

A total of 1718 patients with inadequate glycemic control (A1C level of ≥ 7.0 to $\leq 10.5\%$) on insulin ≥ 30 units/day or insulin add-on therapy with other antihyperglycemic agents participated in a randomized, double-blind, placebo-controlled, parallel-group, 3-arm, multicentre substudy of a cardiovascular outcomes study; this substudy evaluated the efficacy of canagliflozin as add-on therapy with insulin over 18 weeks. The mean age was 63 years, 66% of patients were men, and the mean baseline eGFR was 75 mL/min/1.73 m². Patients on basal, bolus, or basal/bolus insulin, with the majority on a background basal/bolus insulin regimen, for at least 10 weeks entered a 2-week, single-blind, placebo run-in period. After the run-in period, patients with inadequate glycemic control were randomized to the addition of canagliflozin 100 mg, canagliflozin 300 mg, or placebo, administered once daily. The mean daily insulin dose at baseline was 83 units, which was similar across treatment groups.

A subgroup of 731 patients with inadequate glycemic control received canagliflozin in combination with metformin and ≥ 30 units/day of insulin over 18 weeks. As shown in Table 15, statistically significant (p<0.001) reductions in A1C, FPG, and body weight relative to placebo were observed for canagliflozin at Week 18 in patients on an insulin+metformin background. In addition, a greater percentage of patients achieved an A1C < 7.0% compared to placebo. Reductions in systolic blood pressure were observed with canagliflozin 100 mg and 300 mg relative to placebo of -2.9 mmHg (p=0.011) and -4.8 mmHg (p<0.001), respectively. An increased incidence of hypoglycemia was observed in this study (see **WARNINGS AND PRECAUTIONS, ADVERSE REACTIONS, and DOSAGE AND ADMINISTRATION**).

Table 15: Results from 18-Week Placebo-Controlled Clinical Study of Canagliflozin as Add-on Therapy with Insulin \geq 30 Units/Day (With Insulin and Metformin)¹

Efficacy Parameter	Canagliflozin + Insulin + Metformin 18 Weeks		Placebo + Insulin + Metformin (N=244)
	100 mg (N=241)	300 mg (N=246)	
A1C (%)			
Baseline (mean)	8.28	8.21	8.21
Change from baseline (adjusted mean)	-0.66	-0.77	0.01
Difference from placebo (adjusted mean) (95% CI)	-0.67 ² (-0.79; -0.55)	-0.78 ² (-0.90; -0.66)	N/A ³
Percent of patients achieving A1C < 7%	19.6 ²	26.7 ²	7.1
Fasting Plasma Glucose (mmol/L)			
Baseline	9.38	9.35	9.34
Change from baseline (adjusted mean)	-1.06	-1.48	0.09
Difference from placebo (adjusted mean) (95% CI)	-1.15 ² (-1.56; -0.73)	-1.57 ² (-1.98; -1.16)	N/A ³
Body Weight			
Baseline (mean) in kg	97.4	98.4	99.9
% change from baseline (adjusted mean)	-1.9	-2.7	0.0
Difference from placebo (adjusted mean) (95% CI)	-1.9 ² (-2.4; -1.5)	-2.7 ² (-3.2; -2.3)	N/A ³

¹ Intent-to-treat population using last observation in study prior to glycemic rescue therapy

² p < 0.001 compared to placebo

³ N/A = Not applicable

DETAILED PHARMACOLOGY

In Vitro Pharmacology Studies

Canagliflozin

In Chinese hamster ovary K1 (CHOK1) cells overexpressing either human SGLT1 (hSGLT1) or hSGLT2, canagliflozin was found to be a potent and selective inhibitor of SGLT2 with IC₅₀ values of 4.2 nM and 663 nM against hSGLT2 and hSGLT1, respectively. Similar IC₅₀ values of 3.7 nM and 555 nM were obtained for rat SGLT2 and SGLT1 expressed in CHOK1 cells, respectively.

In Vivo Pharmacology Studies

Canagliflozin

In diabetic mice, rats, and obese dogs, canagliflozin increased urinary glucose excretion (UGE) in a dose-related manner and also decreased plasma glucose. In the oral glucose tolerance test (OGTT), canagliflozin improved glucose tolerance in normal mice, Zucker diabetic Fatty (ZDF) rats, and obese dogs. Canagliflozin treatment (1 mg/kg single oral dose) markedly lowered the mean renal threshold of glucose (RT_G) in ZDF rats from 415 to 140 mg/dL (~23 to 8 mmol/L). Repeated daily treatment for 4 weeks with canagliflozin dose-dependently lowered fed and fasted blood glucose levels, lowered A1C, and improved beta-cell function as reflected by a

dose-dependent increase in plasma insulin levels in ZDF rats. In addition, repeated dosing of canagliflozin for up to 4 weeks in obese (*ob/ob*) and diet-induced obese mice reduced body weight and improved glucose handling during an OGTT.

Metformin hydrochloride

Metformin absorption is relatively slow and may extend over about 6 hours. Animal studies with metformin, labelled with ^{14}C have shown that the drug is neither concentrated by liver cells nor is it excreted in the bile; it is concentrated in the intestinal mucosa and salivary glands.

It has been shown that, following a 2 g dose of metformin, the blood level remains under 10 mcg/mL even at the peak, occurring 2 hours after absorption. During the experiments, metformin was shown to be devoid of any notable action in the body, apart from its specific metabolic activity.

In the healthy animal, metformin lowers blood sugar only at a nearly lethal dose. Different animal species are of unequal sensitivity. On the other hand, the animal with experimental diabetes, is sensitive to a much lower dosage, providing some insulin is still secreted.

The antihyperglycemic action of metformin is probably mediated through insulin. Metformin improves the coefficient of glucose assimilation (K), and the coefficient of insulin efficiency.

In the obese diabetic with hyperinsulinemia, metformin is reported to normalize insulin output. This normalizing effect is concurrent to that of glycemia.

Metformin has little effect on liver glycogen of the healthy animal. In low and average doses, no change occurs. In high doses nearing lethal levels, liver glycogen decreases. This lowering precedes the fall in blood sugar. This reaction represents a defense mechanism tending to mobilize body reserves in order to combat hypoglycemia.

In the diabetic animal with a low liver glycogen reserve, the opposite occurs and metformin builds up glycogen stores of the liver. In vitro, on muscular tissue isolated in Warburg's apparatus, metformin increases glucose uptake by the muscle. This action follows an aerobic pathway. Even in high concentration, contrary to phenethyl-biguanide, metformin apparently does not block respiration or change carbohydrate metabolism via the anaerobic pathway.

Metformin is eliminated in feces and urine. It is rapidly excreted by the kidneys in an unchanged form.

Renal clearance is 450 mL/minute; this appears to explain the absence of accumulation.

Metabolites of metformin have not been identified, neither by radio-active nor by chemical methods.

A single Rf spot is always present following radiochromatographic study of urine and always corresponds to that of pure metformin. Administration during 10 consecutive days has not shown any sign of accumulation.

Inhibition of glyconeogenesis has been observed in animals following its stimulation by fasting, cortisol, alcohol or other substrates such as alanine lactate or pyruvate. However, such an effect varies according to the type and dosage of the biguanide used, nutritional state of the animal species and design of experimental model.

This inhibition of glyconeogenesis is observed only in the presence of insulin and it does not appear to play an important role in man.

Inhibition of intestinal absorption of sugars, which is not related to a malabsorption phenomenon has been observed with biguanides under certain experimental conditions in animal and in man. In one study, a 20% retardation of galactose absorption was observed in man receiving metformin. However, such an effect of metformin could not be confirmed in another study in man.

Recent findings appear to indicate that most of the metabolic effects of the biguanides are exerted through a single mechanism, namely inhibition of fatty acid oxidation and of acetyl-CoA generation.

However, inhibition of insulin-stimulated lipogenesis which has also been observed appears to be due to the inhibition of acetyl-CoA carboxylase by the biguanides. Such an effect may explain, at least partly, the weight-reducing effect exerted by these drugs in obese diabetic patients.

TOXICOLOGY

Canagliflozin

Non-clinical data reveal no particular hazard for humans based on conventional studies of safety pharmacology, repeated dose toxicity, and genotoxicity. In a study in juvenile rats, dilatation of the renal pelvis and tubules was noticed beginning at the lowest dose tested, 4 mg/kg, an exposure greater than or equal to 0.5 times the maximum clinical dose of 300 mg, and the pelvic dilatation did not fully reverse within the approximately 1-month recovery period. Persistent renal findings in juvenile rats can most likely be attributed to reduced ability of the developing rat kidney to handle canagliflozin-increased urine volumes, as functional maturation of the rat kidney continues through 6 weeks of age.

Canagliflozin and Metformin Combination

No animal studies have been conducted with the combined products in INVOKAMET® to evaluate carcinogenesis, mutagenesis, or impairment of fertility.

Single and Repeat-Dose Toxicity

Canagliflozin

Canagliflozin has relatively low acute oral toxicity, with maximum non-lethal single doses of 2000 mg/kg in mice (both sexes) and male rats, and 1000 mg/kg in female rats.

Repeat-dose oral toxicity studies were conducted in mice, rats and dogs for up to 3, 6 and 12 months, respectively. Canagliflozin was generally well tolerated up to oral doses of 4 mg/kg/day in rats and 100 mg/kg/day in mice and dogs (up to approximately 0.5, 11, and 20 times the clinical dose of 300 mg based on AUC exposure for rats, mice and dogs, respectively). The major adverse effects, observed mainly in rats, were related to the pharmacologic mode of action of canagliflozin, and these included increased urinary glucose, increased urine volume, increased urinary excretion of electrolytes, decreased plasma glucose at high dose levels, and reduced body weight. The primary targets of toxicity were the kidney and bone. In the 3-month rat study, minimal mineralization of renal interstitium and/or pelvis were observed in some animals given doses of ≥ 4 mg/kg/day. In the 6-month rat study, renal tubular dilatation was seen at all doses (4, 20 and 100 mg/kg/day), and an increased incidence and severity of transitional epithelial hyperplasia in the renal pelvis was observed at 100 mg/kg/day. In dogs, treatment-related tubular regeneration/degeneration and tubular dilatation occurred only at the high dose of 200/100 mg/kg/day. Trabecular hyperostosis was observed in the repeat-dose studies in rats, but not in mice and dogs. In the 2-week rat study, canagliflozin at 150 mg/kg/day caused minimal to mild hyperostosis but in 3- and 6-month rat studies, hyperostosis was detected at 4 mg/kg/day, the lowest dose tested. A 1-month mechanistic rat study showed that hyperostosis occurred in young, actively growing animals (6 to 8 weeks old, as in the toxicity studies) but not in older (6 month old) animals where bone growth has substantially slowed.

Carcinogenicity

Canagliflozin

The carcinogenicity of canagliflozin was evaluated in 2-year studies in mice and rats at oral doses of 10, 30, or 100 mg/kg/day. Canagliflozin did not increase the incidence of tumors in male and female mice up to 100 mg/kg/day (up to 14 times the clinical dose of 300 mg based on AUC exposure).

The incidence of testicular Leydig cell tumors increased significantly in male rats at all doses tested (≥ 1.5 times the clinical dose of 300 mg based on AUC exposure). The Leydig cell tumors are associated with an increase in luteinizing hormone (LH), which is a known mechanism of Leydig cell tumor formation in rats. In a 12-week clinical study, unstimulated LH did not increase in males treated with canagliflozin.

The incidence of pheochromocytomas and renal tubular tumors increased significantly in male and female rats given high doses of 100 mg/kg/day (approximately 12 times the clinical dose of 300 mg based on AUC exposure). Canagliflozin-induced renal tubule tumors and pheochromocytomas in rats may be caused by carbohydrate malabsorption; mechanistic clinical

studies have not demonstrated carbohydrate malabsorption in humans at canagliflozin doses of up to 2 times the recommended clinical dose of 300 mg.

Metformin

Long-term carcinogenicity studies have been performed in rats (dosing duration of 104 weeks) and mice (dosing duration of 91 weeks) at doses up to and including 900 mg/kg/day and 1500 mg/kg/day, respectively. These doses are both approximately 4 times the maximum recommended human daily dose of 2000 mg based on body surface area comparisons. No evidence of carcinogenicity with metformin was found in either male or female mice. Similarly, there was no tumorigenic potential observed with metformin in male rats. There was, however, an increased incidence of benign stromal uterine polyps in female rats treated with 900 mg/kg/day.

Mutagenicity

Canagliflozin

Canagliflozin was not mutagenic with or without metabolic activation in the Ames assay. Canagliflozin was mutagenic in the *in vitro* mouse lymphoma assay with but not without metabolic activation. Canagliflozin was not mutagenic or clastogenic in an *in vivo* oral micronucleus assay in rats and an *in vivo* oral Comet assay in rats.

Metformin

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

Reproductive and Developmental Toxicity

Canagliflozin

In rat fertility studies, canagliflozin had no adverse effects on mating, fertility, or early embryonic development up to the highest dose of 100 mg/kg/day (up to 19 times the clinical dose of 300 mg based on AUC exposure), although there were slight sperm morphological changes at this dose level.

Canagliflozin was not teratogenic at any dose tested when administered orally to pregnant rats and rabbits during the period of organogenesis. In both rats and rabbits, a slight increase in the number of fetuses with reduced ossification, indicative of a slight developmental delay, was observed at the high doses (approximately 19 times the clinical dose of 300 mg based on AUC exposure) in the presence of maternal toxicity.

In a pre- and postnatal development study, canagliflozin administered orally to female rats from gestation Day 6 to lactation Day 20 resulted in decreased body weights in male and female offspring at maternally toxic doses of ≥ 30 mg/kg/day (≥ 5.9 times the clinical dose of 300 mg based on AUC exposure). Maternal toxicity was limited to decreased body weight gain.

In a juvenile toxicity study in which canagliflozin was dosed orally to young rats from postnatal day (PND) 21 until PND 90 at doses of 4, 20, 65, or 100 mg/kg, increased kidney weights and

a dose-related increase in the incidence and severity of renal pelvic and renal tubular dilatation were reported at all dose levels. Exposure at the lowest dose tested was approximately 0.5 times the maximum recommended clinical dose of 300 mg. The renal pelvic dilatations observed in juvenile animals did not fully reverse within the 1-month recovery period. Additionally, shortened ulna growth and delays in sexual maturation were observed in juvenile rats at doses that were greater than or equal to 3 times and 9 times the clinical dose of 300 mg based on AUC exposure, respectively.

Metformin

Fertility of male or female rats was unaffected by metformin when administered at doses as high as 600 mg/kg/day, which is approximately 3 times the maximum recommended human daily dose of 2000 mg based on body surface area comparisons.

Metformin was not teratogenic in rats and rabbits at doses up to 600 mg/kg/day. This represents an exposure of about 2 and 6 times the maximum recommended human daily dose of 2,000 mg based on body surface area comparisons for rats and rabbits, respectively. Determination of fetal concentrations demonstrated a partial placental barrier to metformin.

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READ THIS FOR SAFE AND EFFECTIVE USE OF YOUR MEDICINE
PATIENT MEDICATION INFORMATION

INVOKAMET®
canagliflozin and metformin hydrochloride tablets

Read this carefully before you start taking INVOKAMET® and each time you get a refill. This leaflet is a summary and will not tell you everything about this drug. Talk to your healthcare professional about your medical condition and treatment and ask if there is any new information about INVOKAMET®.

Serious Warnings and Precautions

- INVOKAMET® contains metformin and it can rarely cause a serious condition that can cause death called lactic acidosis.
- Alcohol may increase the risk of lactic acidosis. Do not drink a lot of alcohol while taking INVOKAMET®.
- Diabetic ketoacidosis (DKA) is a serious and life-threatening condition that requires urgent hospitalization. DKA has been reported in patients with type 2 diabetes mellitus (T2DM) with normal or high blood sugar levels, who are treated with canagliflozin and other sodium-glucose co-transporter 2 (SGLT2) inhibitors. Some cases of DKA have led to death.
- Seek medical attention right away and **stop taking INVOKAMET® immediately** if you have any of the following symptoms (even if your blood sugar levels are normal): difficulty breathing, nausea, vomiting, stomach pain, loss of appetite, confusion, feeling very thirsty, feeling unusually tired, a sweet smell to the breath, a sweet or metallic taste in the mouth, or a different odour to urine or sweat.
- INVOKAMET® should not be used in patients with type 1 diabetes
- INVOKAMET® should not be used in patients with DKA or a history of DKA

What is INVOKAMET® used for?

INVOKAMET® is used along with diet and exercise to improve blood sugar levels in adults with type 2 diabetes.

INVOKAMET® can be used:

- in patients who are not controlled on metformin alone or on a combination of metformin with:
 - a sulfonylurea
 - pioglitazone

- insulin
- in patients who are currently treated with combinations of separate tablets of metformin and canagliflozin (INVOKANA[®]), or a combination of metformin and canagliflozin (INVOKANA[®]) with:
 - a sulfonylurea
 - pioglitazone
 - insulin

How does INVOKAMET[®] work?

INVOKAMET[®] is a tablet containing two different medicines, canagliflozin and metformin.

Canagliflozin removes excess glucose from the body through the urine.

Metformin helps your body respond better to the insulin it makes naturally. It helps to lower the amount of sugar made by the liver and lower the amount of sugar moved from the gut into the blood.

What are the ingredients in INVOKAMET[®]?

Medicinal ingredients: anhydrous canagliflozin and metformin hydrochloride

Non-medicinal ingredients: croscarmellose sodium, hypromellose, iron oxide black (50/850 mg and 150/1000 mg tablets), iron oxide red (50 mg/850 mg, 50 mg/1000 mg, 150 mg/500 mg and 150 mg/1000 mg tablets), iron oxide yellow (50 mg/1000 mg, 150 mg/500 mg, and 150 mg/850 mg tablets), macrogol (polyethylene glycol), magnesium stearate, microcrystalline cellulose, polyvinyl alcohol (partially hydrolyzed), talc, and titanium dioxide

INVOKAMET[®] comes in the following dosage forms:

Tablets:

- 50 mg canagliflozin/500 mg metformin hydrochloride
- 50 mg canagliflozin /850 mg metformin hydrochloride
- 50 mg canagliflozin /1000 mg metformin hydrochloride
- 150 mg canagliflozin /500 mg metformin hydrochloride
- 150 mg canagliflozin /850 mg metformin hydrochloride
- 150 mg canagliflozin /1000 mg metformin hydrochloride

Do not use INVOKAMET[®] if you:

- are allergic (hypersensitive) to canagliflozin, metformin or any of the nonmedicinal ingredients in INVOKAMET[®].
- have kidney problems.
- have or have had a condition called metabolic acidosis, lactic acidosis or diabetic ketoacidosis (a complication of diabetes with high blood sugar, rapid weight loss, nausea, or vomiting). INVOKAMET should not be used to treat these conditions.
- have type 1 diabetes (your body does not produce any insulin). INVOKAMET[®] is not recommended for use in patients with type 1 diabetes.

- drink alcohol very often, or drink a lot of alcohol in a short-term “binge” drinking.
- have liver problems.
- have severe heart problems or heart failure.
- are under stress, have a serious infection, have recently had a trauma, are about to have surgery or are recovering from surgery.
- are severely dehydrated.
- need to have surgery or if you need an examination such as an X-ray or scan involving injection of dye or contrast agents into your bloodstream. INVOKAMET® will need to be stopped for a short time. Talk to your healthcare professional about when you should stop INVOKAMET® and when you should start INVOKAMET® again.
- are pregnant or are planning to become pregnant. INVOKAMET® should not be used during pregnancy.
- are breastfeeding. INVOKAMET® should not be used while breastfeeding.

To help avoid side effects and ensure proper use, talk to your healthcare professional before you take INVOKAMET®. Talk about any health conditions or problems you may have, including if you:

- have an increased chance of developing DKA, including if you:
 - are dehydrated or suffer from excessive vomiting, diarrhea, or sweating;
 - are on a very low carbohydrate diet;
 - drink a lot of alcohol;
 - have/have had problems with your pancreas, including pancreatitis or surgery on your pancreas;
 - are hospitalized for major surgery, serious infection or serious medical illnesses;
 - have a history of DKA.
- are taking a diuretic medicine also known as water pills (used to remove excess water from the body), such as furosemide; or taking medicines to lower your blood pressure such as angiotensin-converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARB); or have or have had low blood pressure. Taking INVOKAMET® with any of these medicines may increase the risk of becoming dehydrated and/or low blood pressure.
- are older than 65 years of age.
- are malnourished or have problems with your adrenal or pituitary glands (adrenal or pituitary insufficiency).
- have low B₁₂.
- have a history of yeast infections of the vagina or penis.
- are taking medicines to lower your blood sugar such as glyburide, glimepiride or glimepiride (sulfonylureas) or insulin. Taking INVOKAMET® with any of these medicines can increase the risk of having low blood sugar (hypoglycemia). Take precautions to avoid the potential for low blood sugar while driving or using heavy machinery.

Other warnings you should know about:

Stop taking INVOKAMET® and tell your healthcare professional if you get the following symptoms of lactic acidosis:

- You feel very weak and tired.
- You have unusual (not normal) muscle pain.
- You have trouble breathing or fast breathing.
- You have stomach pain with nausea and vomiting, or diarrhea.
- You feel cold, especially in your arms and legs.
- You feel dizzy or lightheaded.
- You feel unusual fatigue and drowsiness.
- You have a slow or irregular heartbeat.
- Your medical condition suddenly changes.
- You develop or experience a worsening of heart problems and particularly heart failure.

INVOKAMET® is not recommended for use in patients under 18 years of age.

INVOKAMET® will cause your urine to test positive for sugar (glucose).

Taking INVOKAMET® increases your risk of breaking a bone. Talk to your doctor about factors that may increase your risk of bone fracture.

While taking INVOKAMET® your healthcare professional may order blood tests to check your kidney function, blood fat levels (Low-Density Lipoprotein cholesterol or LDL-C), the amount of red blood cells in your blood (haematocrit), and potassium blood levels.

INVOKAMET® may cause dizziness or light-headedness. DO NOT drive or use machines until you know how the medicine affects you.

Tell your healthcare professional about all the medicines you take, including any drugs, vitamins, minerals, natural supplements or alternative medicines.

The following may interact with INVOKAMET®:

- digoxin, used to treat heart problems.
- furosemide or other diuretics (water pills), used to treat high blood pressure and other heart problems.
- insulin or a sulfonylurea (such as glimepiride, gliclazide, or glyburide), used to help control blood sugar.
- carbamazepine, phenytoin or phenobarbital, used to treat seizures.
- barbituates, used as sedatives and sleep-aids.
- efavirenz or ritonavir, used to treat HIV infection
- rifampin, an antibiotic used to treat bacterial infections such as Tuberculosis.
- St. John's wort, an herbal product used to treat depression.
- nifedipine, a Calcium Channel Blocker used to treat heart problems.
- Angiotensin-Converting Enzyme (ACE) inhibitors, Angiotensin Receptor Blockers (ARB) used to treat high blood pressure.
- phenprocoumon and other drugs used prevent blood clots and thin the blood.
- Birth control pills and other products containing estrogens.
- Alcohol.

How to take INVOKAMET®:

- Take the dose prescribed for you by your healthcare professional. Your healthcare professional will prescribe the strength that is right for you.
- Take INVOKAMET® twice a day with meals to lower your chance of having an upset stomach. Swallow the tablet whole.
- Your healthcare professional may prescribe INVOKAMET® together with another medicine to help control your blood sugar.
- Always take INVOKAMET® and all other medicines prescribed to you exactly as your healthcare professional has told you. Check with your doctor or pharmacist if you are not sure.

Overdose:

If you think you have taken too much INVOKAMET®, contact your healthcare professional, hospital emergency department or regional Poison Control Centre immediately, even if there are no symptoms.

Missed Dose:

- If you forget to take a dose of INVOKAMET®, take it as soon as you remember. However, if it is nearly time for the next dose, skip the missed dose.
- Do not take a double dose to make up for a forgotten dose.

What are possible side effects from using INVOKAMET®?

These are not all the possible side effects you may feel when taking INVOKAMET®. If you experience any side effects not listed here, contact your healthcare professional.

Side effects may include:

- Changes in urination:
 - urinating more often or in larger amounts
 - an urgent need to urinate
 - a need to urinate at night
- Constipation, excess gas, abdominal discomfort
- Nausea, vomiting, diarrhea, indigestion, loss of appetite
- Changes in taste or a metallic taste
- Feeling thirsty
- Rash, hives
- Headache
- Fatigue

Diabetic Ketoacidosis (DKA) is a serious medical condition with normal or high blood glucose levels. Get medical help right away if you have any of the symptoms in the table below under DKA, even if your blood glucose levels are normal.

Tell your doctor if you are hospitalized for major surgery, serious infection or serious medical illness.

Increased need for lower leg or toe amputation (removal) especially if you are at high risk of heart disease. Talk to your doctor if you experience symptoms including leg pain, poor circulation, bluish, cold skin, and poor hair and toe nail growth. Good foot care is recommended.

If you have a troublesome symptom or side effect that is not listed here or becomes bad enough to interfere with your daily activities, talk to your healthcare professional.

Serious side effects and what to do about them			
Symptom / effect	Talk to your healthcare professional		Stop taking drug and get immediate medical help
	Only if severe	In all cases	
VERY COMMON Vaginal yeast infection: vaginal odor, white or yellowish vaginal discharge, and/or itching		✓	
COMMON Yeast infection of the penis: rash or redness of the penis or foreskin		✓	
Urinary tract infection: burning sensation when urinating, cloudy or bloody urine, strong odor		✓	
Skin Ulcer (a break or sore on the skin with tissue breakdown) predominantly of the lower legs: It may start off red then get swollen and tender. Next, blisters can form with loss of skin layers. It can lead to an open round crater with a bad smell. Ulcers take a long time or may not heal.		✓	

Serious side effects and what to do about them			
Symptom / effect	Talk to your healthcare professional		Stop taking drug and get immediate medical help
	Only if severe	In all cases	
UNCOMMON Peripheral Ischemia (blocked or narrow blood vessels): Leg pain with walking that gets better with rest. Poor circulation, bluish, cold skin, and poor nail and hair growth. It can lead to Skin Ulcers and Lower Leg or Toe Amputation .		✓	
Low blood pressure: fainting, dizziness or light-headedness with standing		✓	
Dehydration (loss of needed fluids from the body): dry or sticky mouth, headache, dizziness or urinating less often than normal		✓	
Kidney problems: any change in the amount, frequency or colour (pale or dark) of urine		✓	
RARE Acute kidney infection: painful, urgent or frequent urination, lower back (flank) pain, fever or chills, cloudy or foul smelling urine, blood in your urine			✓
Severe infection that spreads from urinary tract throughout body (sepsis): fever or low body temperature, rapid breathing, chills, rapid heartbeat, pain with urination, difficulty urinating, frequent urination			✓

Serious side effects and what to do about them			
Symptom / effect	Talk to your healthcare professional		Stop taking drug and get immediate medical help
	Only if severe	In all cases	
Diabetic ketoacidosis (DKA): difficulty breathing, feeling very thirsty, vomiting, stomach pain, nausea, loss of appetite, confusion, and unusual tiredness, a sweet smell to the breath, a sweet or metallic taste in the mouth or a different odour to urine or sweat			✓
Severe low blood sugar: disorientation, loss of consciousness, seizure			✓
Lactic acidosis: feeling cold or uncomfortable, severe nausea with or without vomiting, stomach pain, unexplained weight loss, rapid breathing			✓
Angioedema and severe allergic reactions: rash, hives, swelling of the face, eyes, lips or throat, difficulty swallowing or breathing, wheezing, fever, stomach cramps, chest discomfort or tightness, unconsciousness			✓
VERY RARE Liver problems: yellowing of the skin or eyes, dark urine, abdominal pain, nausea, vomiting, loss of appetite		✓	

Reporting Side Effects

You can help improve the safe use of health products for Canadians by reporting serious and unexpected side effects to Health Canada. Your report may help to identify new side effects and change the product safety information.

3 ways to report:

- Online at MedEffect (www.healthcanada.gc.ca/medeffect);
- By calling 1-866-234-2345 (toll-free);
- By completing a Consumer Side Effect Reporting Form and sending it by:
 - Fax to 1-866-678-6789 (toll-free), or
 - Mail to: Canada Vigilance Program
Health Canada, Postal Locator 0701E
Ottawa, ON
K1A 0K9

Postage paid labels and the Consumer Side Effect Reporting Form are available at MedEffect (www.healthcanada.gc.ca/medeffect).

NOTE: Contact your healthcare professional if you need information about how to manage your side effects. The Canada Vigilance Program does not provide medical advice.

Storage:

- Store INVOKAMET® in the original container.
- Store at room temperature (15-30°C).
- Do not use INVOKAMET® after the expiry date which is stated on the label after EXP. The expiry date refers to the last day of that month.
- Do not throw away any medicines via wastewater or household waste. Ask your pharmacist how to throw away medicines you no longer use. These measures will help protect the environment.
- Keep out of reach and sight of children.

If you want more information about INVOKAMET®:

- Talk to your healthcare professional
- For questions or concerns, contact the manufacturer, Janssen Inc., at www.janssen.com/canada
- Find the full product monograph that is prepared for healthcare professionals and includes this Patient Medication Information by visiting the Health Canada website (www.healthcanada.gc.ca); the manufacturer's website www.janssen.com/canada, or by calling 1-800-567-3331 or 1-800-387-8781.

This leaflet was prepared by: Janssen Inc., Toronto, Ontario, M3C 1L9

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