

VEXAZONE

1. Product Name

Vexazone, 15 mg, 30 mg & 45 mg, tablets.

2. Qualitative and Quantitative Composition

Each tablet contains 15 mg, 30 mg or 45 mg of pioglitazone as pioglitazone hydrochloride.

Excipient with known effect: sugars as lactose

For the full list of excipients, see section 6.1.

3. Pharmaceutical Form

Vexazone 15 mg: white to off-white, round, biconvex, uncoated tablet debossed "PG" over "15" on one side and "G" on the other side.

Vexazone 30 mg: white to off-white, round, biconvex, uncoated tablet debossed "PG" over "30" on one side and "G" on the other side.

Vexazone 45 mg: white to off-white, round, biconvex, uncoated tablet debossed "PG" over "45" on one side and "G" on the other side.

Do not halve the tablets. Dose equivalence when a tablet is divided has not been established.

4. Clinical Particulars

4.1 *Therapeutic indications*

Vexazone is indicated for the treatment of type 2 diabetes mellitus inadequately controlled by diet. Vexazone is effective as a single agent and may also be used in combination with sulfonylureas, metformin or insulin when diet plus the single agent does not result in adequate glycaemic control.

4.2 *Dose and method of administration*

Dose

After initiation of Vexazone or with dose increase, patients should be carefully monitored for adverse events related to fluid retention (see section 4.4).

Monotherapy

The recommended dosage of Vexazone is 15 mg or 30 mg once daily, increasing after four weeks, if greater therapeutic effect is needed, to 45 mg once daily.

Combination therapy

The recommended dose of Vexazone is 30 mg once daily in combination with sulfonylureas, insulin or metformin. It may be possible to achieve metabolic control at a reduced dose of the sulfonylurea, insulin or metformin. If there is a particular risk of hypoglycaemia, Vexazone can be introduced at a dose of 15 mg. For patients already on insulin, Vexazone should be introduced at a dose of 15 mg once daily. Dosage can then be increased cautiously.

Maximum recommended dose

The dose should not exceed 45 mg/day since doses higher than 45 mg/day have not been studied in clinical trials.

Special populations

Female patients

Oedema has been reported more often in women. Dosage should start at 15 mg and be increased cautiously, paying attention to the development of oedema.

Patients with renal insufficiency

Dose adjustment in patients with renal insufficiency is not recommended (see section 5.2). No information is available for patients on dialysis therefore Vexazone should not be used in such patients.

Patients with hepatic impairment

The intrinsic clearance of pioglitazone may be reduced in patients with hepatic disease. Dosage should start at 15 mg and be increased cautiously. Vexazone therapy should not be initiated in patients with increased baseline liver enzyme levels (ALT >2.5 times the upper limit of normal).

Method of administration

Vexazone should be taken once daily with or without food. Do not halve the tablets. Dose equivalence when a tablet is divided has not been established.

4.3 Contraindications

Vexazone is contraindicated in patients with known hypersensitivity or allergy to pioglitazone or any of the tablet excipients (see section 6.1).

Vexazone is not recommended in patients with symptomatic heart failure. Initiation of Vexazone (like other thiazolidinediones) is contraindicated in patients with NYHA Class II, III or IV heart failure (see section 4.4).

Because of its mechanism of action, Vexazone is only active in the presence of insulin. Therefore, Vexazone should not be used in type 1 diabetes or for the treatment of diabetic ketoacidosis.

4.4 Special warnings and precautions for use

Hypoglycaemia

Patients receiving pioglitazone in combination with insulin or oral hypoglycaemic agents may be at risk for hypoglycaemia. A reduction in the dose of the concomitant agent may be necessary.

Cardiac

Pioglitazone should not be prescribed to lower the risk of cardiovascular disease such as myocardial infarction and stroke or to lower cardiovascular mortality.

Pioglitazone, like other thiazolidinediones, can cause or exacerbate congestive heart failure (CHF) in some patients. In post-marketing experience with pioglitazone, CHF has been reported in patients both with and without pre-existing cardiac disease. After initiation of pioglitazone, and after dose

increases, observe patients carefully for signs and symptoms of heart failure (including excessive, rapid weight gain, dyspnoea, and/or oedema). If these signs and symptoms develop, pioglitazone should be discontinued. The patient's heart failure should be evaluated and managed according to the current standards of care.

Patients with New York Heart Association (NYHA) Class III and IV cardiac status were excluded from initial clinical trials. Therefore, pioglitazone is not indicated in patients with NYHA Class III or IV cardiac status.

Pioglitazone should be initiated at the lowest approved dose in patients with type 2 diabetes and systolic heart failure (NYHA Class I). If subsequent dose escalation is necessary, the dose should be increased gradually only after several months of treatment with careful monitoring for weight gain, oedema or congestive heart failure exacerbation.

In one 16-week U.S. double-blind, placebo-controlled clinical trial involving 566 patients with type 2 diabetes, pioglitazone at doses of 15 mg and 30 mg in combination with insulin were compared to insulin therapy alone. This trial included patients with long-standing diabetes and a high prevalence of pre-existing medical conditions as follows: arterial hypertension (57.2%), peripheral neuropathy (22.6%), coronary heart disease (19.6%), retinopathy (13.1%), myocardial infarction (8.8%), vascular disease (6.4%), angina pectoris (4.4%), stroke and/or transient ischaemic attack (4.1%), and congestive heart failure (2.3%).

In this study two of the 191 patients receiving 15 mg pioglitazone plus insulin (1.1%) and two of the 188 patients receiving 30 mg pioglitazone plus insulin (1.1%) developed congestive heart failure compared with none of the 187 patients on insulin therapy alone. All four of these patients had previous histories of cardiovascular conditions including coronary artery disease, previous CABG procedures, and myocardial infarction. Analysis of data from this study did not identify specific factors that predict increased risk of congestive heart failure on combination therapy with insulin.

A 24-week post-marketing safety study was performed to compare pioglitazone (n=262) to glibenclamide (n=256) in uncontrolled diabetic patients (mean HbA_{1c} 8.8% at baseline) with NYHA Class II and III heart failure and ejection fraction less than 40% (mean EF 30% at baseline). Overnight hospitalisation for congestive heart failure was reported in 9.9% of patients on pioglitazone compared to 4.7% of patients on glyburide with a treatment difference observed from 6 weeks. This adverse event associated with pioglitazone was more marked in patients using insulin at baseline and in patients over 64 years of age. No difference in cardiovascular mortality between the treatment groups was observed.

A cardiovascular outcome study of pioglitazone has been performed in patients with type 2 diabetes mellitus and pre-existing major macrovascular disease (PROactive). Pioglitazone or placebo was added to existing antidiabetic and cardiovascular therapy for up to 3.5 years. This study showed the expected increase in reports of serious heart failure (an average of 16 per 1000 treated patients); however, this did not lead to an increase in mortality in this study.

Oedema

As thiazolidinediones can cause fluid retention, pioglitazone should be used with caution in patients with oedema. In placebo controlled clinical trials oedema was reported more frequently in patients treated with pioglitazone than in placebo treated patients.

Weight gain

Dose related weight gain was seen with pioglitazone alone and in combination with other hypoglycaemic agents (table 1). The mechanism of weight gain is unclear but probably involves a combination of fluid retention and fat accumulation.

Table 1: Weight changes (kg) from baseline during double-blind clinical trials with pioglitazone

		Control group (placebo)	Pioglitazone 15mg	Pioglitazone 30mg	Pioglitazone 45mg
		Median (25 th /75 th percentile)			
Monotherapy		-1.4 (-2.7/0.0) n=256 ^{a,b,c}	0.9 (-0.5/3.4) n=79 ^a	1.0 (-0.9/3.4) n=188 ^{a,c}	2.6 (0.2/5.4) n=79 ^c
Combination therapy	Sulfonylurea ^d	-0.5 (-1.8/0.7) n=187	1.0 (0.2/3.2) 3.0 n=183	2.7 (1.1/4.5) n=186	N/A
	Metformin ^e	-1.4 (-3.2/0.3) n=160	N/A	1.4 (-0.9/3.0) n=167	N/A
	Insulin ^f	0.2 (-1.4/1.4) n=182	2.3 (0.5/4.3) n=190	3.6 (1.4/5.9) n=188	N/A

^a Study PNFP-001

^b Study PNFP-012

^c Study PNFP-026

^d Study PNFP-010

^e Study PNFP-027

^f Study PNFP-014

Hepatic impairment

In clinical trials worldwide, over 4500 patients have been treated with pioglitazone. There was no evidence of drug-induced hepatotoxicity.

Therapy should not be initiated if the patient exhibits clinical evidence of active liver disease or increased transaminase levels (ALT > 2.5 times the upper limit of normal) at the start of therapy. Existing pioglitazone therapy should be discontinued if ALT levels are persistently higher than 3x the upper limit of normal, and symptoms suggesting hepatic dysfunction should cause the liver enzymes to be checked. Pending results of laboratory investigations, the decision as to whether pioglitazone therapy should continue must be based on clinical judgement; in the presence of jaundice, drug therapy should be discontinued.

Liver function tests should be performed at baseline and every two months for the first twelve months and periodically thereafter, and if a patient develops symptoms suggestive of hepatic dysfunction, liver enzyme levels should be checked.

Bone fracture

An increased incidence in bone fractures in women was seen in a pooled analysis of adverse event reports of bone fracture from randomised, controlled, double blind clinical trials in over 8100 pioglitazone and 7400 comparator (excluding thiazolidinediones) treated patients, on treatment for up to 3.5 years. Fractures were observed in 2.6% of women taking pioglitazone compared to 1.7% of women treated with a comparator. No increase in fracture rates was observed in men treated with pioglitazone (1.3%) versus comparator (1.5%). The fracture incidence calculated was 1.9 fractures per 100 patient years in women treated with pioglitazone and 1.1 fractures per 100 patient years in women treated with a comparator. The observed excess risk of fractures for women in this dataset on pioglitazone is therefore 0.8 fractures per 100 patient years of use.

In the 3.5 year cardiovascular risk PROactive study, 44/870 (5.1%; 1.0 fractures per 100 patient years) of pioglitazone-treated female patients experienced fractures compared to 23/905 (2.5%; 0.5 fractures per 100 patient years) of female patients treated with comparator. This difference was noted after the first year of treatment and remained during the course of the study. No increase in fracture rates was observed in men treated with pioglitazone (1.7%) versus comparator (2.1%).

The risk of fractures should be considered in the long term care of women treated with pioglitazone.

Ovulation

In premenopausal anovulatory patients with insulin resistance, treatment with thiazolidinediones, including pioglitazone, may result in resumption of ovulation. These patients may be at risk of pregnancy.

Patients with polycystic ovarian syndrome may resume ovulation after pioglitazone treatment, as a consequence of enhanced insulin action. Patients should therefore be aware of the risk of pregnancy; if the patient wishes to become pregnant or if pregnancy occurs, the treatment should be discontinued.

Bladder cancer

Pioglitazone should be avoided in patients with bladder cancer or history of bladder cancer. The risk of bladder cancer should be considered in the care of all patients treated with pioglitazone. Risk factors for bladder cancer should be assessed before initiating pioglitazone treatment (risks include age, smoking history, exposure to occupational chemicals, or chemotherapeutic agents e.g. cyclophosphamide or prior radiation treatment in the pelvic region). Patients should be advised to promptly seek medical attention if macroscopic haematuria or other symptoms such as urinary urgency develop during treatment.

Some epidemiological studies suggested a small increased risk of bladder cancer in diabetic patients treated with pioglitazone, although other large, long-term observational studies did not.

An increased incidence of bladder cancer was observed in subjects receiving pioglitazone in the PROactive study. In the pioglitazone arm there were 14 cases (0.5%) and in the placebo arm there were 5 cases (0.2%); the point estimate for the hazard ratio (HR) was 2.7 (95% confidence interval [CI] 0.99-7.6). After excluding patients in whom exposure to the study drug was less than one year at the time of diagnosis of bladder cancer, there were six cases (0.2%) in the pioglitazone arm and two cases (0.1%) in the placebo arm.

Paediatric use

Safety and effectiveness in paediatric patients have not been established.

Elderly use

Approximately 500 patients in placebo-controlled clinical trials of pioglitazone were 65 and over. No significant differences in safety and efficacy were observed between these patients and younger patients.

Interference with laboratory tests

Haematologic

Pioglitazone may cause decreases in haemoglobin and haematocrit. Across all clinical studies, mean haemoglobin values declined by 2% to 4% in patients treated with pioglitazone. These changes generally occurred within the first 4 to 12 weeks of therapy and remained relatively stable thereafter. These changes may be related to increased plasma volume associated with pioglitazone therapy and have not been associated with any significant haematologic clinical effects.

Serum transaminase levels

During placebo-controlled clinical trials in the U.S., a total of 4 of 1526 (0.26%) patients treated with pioglitazone and 2 of 793 (0.25%) placebo-treated patients had ALT values \geq 3 times the upper limit of normal. During all clinical studies in the U.S., 11 of 2561 (0.43%) patients treated with pioglitazone had ALT values \geq 3 times the upper limit of normal. All patients with follow-up values had reversible elevations in ALT. In the population of patients treated with pioglitazone, mean values for bilirubin, AST, ALT, alkaline phosphatase, and GGT were decreased at the final visit compared with baseline. Less than 0.12% of patients treated with pioglitazone were withdrawn from clinical trials in the U.S. due to abnormal liver function tests. In pre-approval clinical trials, there were no cases of idiosyncratic drug reactions leading to hepatic failure (see hepatic impairment).

CPK levels

During required laboratory testing in clinical trials, sporadic, transient elevations in creatine phosphokinase levels (CPK) were observed. A single, isolated elevation to greater than 10 times the upper limit of normal (values of 2150 to 8610 IU/L) was noted in 7 patients. Five of these patients continued to receive pioglitazone and the other two patients had completed receiving study medication at the time of the elevated value. These elevations resolved without any apparent clinical sequelae. The relationship of these events to pioglitazone therapy is unknown.

4.5 Interaction with other medicines and other forms of interaction

The cytochrome P450 isoforms CYP2C8 and CYP3A4 are partially responsible for the metabolism of pioglitazone. Interactions with substances metabolised by these enzymes e.g. oral contraceptives, cyclosporine, calcium channel blockers, and HMG CoA reductase inhibitors are not to be expected. Inhibitors of CYP2C8 (such as gemfibrozil) may increase the AUC of pioglitazone, a decrease in the AUC of pioglitazone may occur when administered in combination with CYP2C8 inducers (such as rifampicin).

Gemfibrozil: Co-administration of pioglitazone and gemfibrozil is reported to result in a 3-fold increase in the AUC of pioglitazone. Since there is a potential for dose-related adverse events with pioglitazone, a decrease in the dose of pioglitazone may be needed when gemfibrozil is concomitantly administered.

Rifampicin: Co-administration of pioglitazone and rifampicin is reported to result in a 54% decrease in the AUC of pioglitazone. The dose of pioglitazone may need to be increased based on clinical response when rifampicin is concomitantly administered.

Oral contraceptives: Administration of a similar thiazolidinedione with an oral contraceptive containing ethinylestradiol and norethindrone reduced the plasma concentrations of both hormones by approximately 30%. This could result in loss of contraception. Therefore, a higher dose of oral contraceptive or an alternative method of contraception should be considered.

Glipizide: Co-administration of pioglitazone and glipizide does not alter the steady state pharmacokinetics of glipizide.

Digoxin: Co-administration of pioglitazone with digoxin does not alter the steady-state pharmacokinetics of digoxin.

Warfarin: Co-administration of pioglitazone with warfarin does not alter the steady-state pharmacokinetics of warfarin. In addition, pioglitazone has no clinically significant effect on prothrombin time when administered to patients receiving chronic warfarin therapy.

Metformin: Co-administration of pioglitazone with metformin does not alter the steady-state pharmacokinetics of metformin.

4.6 Fertility, pregnancy and lactation

Pregnancy

Category B3

A study in pregnant rats showed that pioglitazone and its metabolites cross the placenta. Pioglitazone was not teratogenic in rats or rabbits at oral doses up to 80 and 160 mg/kg/day respectively. Systemic exposure (plasma AUC_{0-24h}) to total active compounds at the highest dose was about 12 times (rats) and 7 times (rabbits) greater than in humans at the maximum recommended dose. Embryotoxicity (increased post-implantation loss) was observed in both animal species, and foetotoxic effects (reduced foetal weight and retarded development) were seen in rats. Administration of pioglitazone during the period of organogenesis also caused suppression of postnatal growth in rats. Administration of pioglitazone to rats throughout gestation and lactation caused retardation in postnatal growth and development, and impaired fertility of the offspring. The no-effect dose for retardation of postnatal growth and development in rats was 3 mg/kg/day and

systemic exposure to total active compounds at this dose was similar to that in humans. There are no adequate and well controlled studies in pregnant women. Pioglitazone should be used during pregnancy only if the potential benefits justify the potential risk to the foetus.

Breast-feeding

Pioglitazone is secreted in the milk of lactating rats. It is not known whether pioglitazone is secreted in human milk. In reproductive studies in rats, oral administration of pioglitazone during late gestation and lactation caused adverse effects on postnatal survival, growth, development and fertility of the offspring. The no-effect dose on retardation of postnatal growth and development was 3 mg/kg/day and systemic exposure to total active compounds at this dose was similar to that in humans. Pioglitazone should not be administered to lactating women. Breastfeeding should be discontinued if the use of this product is considered essential.

Fertility

No adverse effects on fertility were observed in male and female rats at oral doses up to 40 mg/kg/day. Systemic exposure (plasma AUC_{0-24h}) to total active compounds at the highest dose was about 7 times greater than that in humans at the maximum recommended dose (see section 4.4).

4.7 Effects on ability to drive and use machines

The effect of pioglitazone on the ability to drive and use machinery has not been studied but based on its pharmacodynamic properties, Pioglitazone monotherapy is unlikely to affect this ability. When driving vehicles or operating machinery it should be taken into account that the hypoglycaemic effects of sulfonylureas and insulin may be exacerbated upon combination therapy with pioglitazone.

4.8 Undesirable effects

Adverse events identified from clinical trials

The overall incidence and types of adverse events reported in placebo controlled clinical trials of pioglitazone monotherapy are shown in table 2. In pooled, double blind, placebo controlled trials in 862 patients taking pioglitazone and 431 patients taking placebo, withdrawal due to adverse events occurred in 3.6% of pioglitazone patients and in 4.6% of patients on placebo. Table 2 shows the 12 week cumulative incidence at >2% of patients with pioglitazone when this was in excess of placebo.

Table 2: 12 week cumulative incidence of adverse events at >2% of pioglitazone-treated patients

	Placebo (N=431)	Pioglitazone (N=862)
Upper respiratory tract infection	7.2	8.7
Headache	6.5	7.0
Sinusitis	2.9	3.6
Myalgia	2.3	3.2
Oedema	0.6	3.2
Back pain	2.3	3.1
Urinary tract infection	1.6	2.7
Pharyngitis	0.3	2.7
Tooth disorder	1.5	2.6
Fatigue	2.4	2.5
Accidental injury	1.5	2.2
Cramps legs	1.1	2.1
Vision abnormal	1.4	2.1

Table 3: Adverse events by frequency: events occurring at ≥5% in pioglitazone dual therapy*

	PIO ^a + SU ^b or Met ^c (n=1479)	Placebo + SU ^b or Met ^c (n=1292)	PIO ^a + Insulin (n=631)	Placebo + Insulin (n=446)
Oedema	7.0	2.6	15.8	7.8
Hypoglycaemia	5.9	7.7	30.6	29.4
Upper respiratory tract infection	7.5	6.2	8.9	8.1
Headache	4.2	3.1	5.1	3.8
Weight increased	5.5	0.9	7.8	1.3
Arthralgia	3.1	3.1	5.4	2.9
Back pain	3.7	3.9	5.9	3.4
Diarrhoea	2.5	6.5	4.6	5.4

* Integrated Safety Summary: all completed double-blind studies available in the TGRD clinical trials database as of August 2008

^aPIO = pioglitazone

^bSU = sulfonylurea

^cMet = Metformin

In the PROactive study, which involved a high risk population of patients with pre-existing macrovascular disease, treatment emergent adverse events that occurred more often in the pioglitazone group compared to placebo group were oedema (26.4% and 15.1% respectively), hypoglycaemia (27.2% and 18.8% respectively) and cardiac failure, including serious and non-serious cases (12.6% and 8.7% respectively).

Cardiovascular system

In insulin combination studies a small number of patients with previously existing cardiac disease developed congestive heart failure when treated with pioglitazone. The incidence of congestive heart failure is increased in patients with uncontrolled diabetes, NYHA Class II or III cardiac status and ejection fraction less than 40% when treated with pioglitazone (see section 4.4).

In one 16-week clinical trial of insulin plus pioglitazone combination therapy, more patients developed congestive heart failure on combination therapy (1.1%) compared to none on insulin alone (see section 4.4).

In the PROactive study, the rate of serious heart failure was higher for patients treated with pioglitazone (5.7%) than for patients treated with placebo (4.1%) and the incidence of death subsequent to a report of serious heart failure was 1.5% in patients treated with pioglitazone and 1.4% in placebo-treated patients. In patients treated with an insulin-containing regimen at baseline, the incidence of serious heart failure was 6.3% with pioglitazone and 5.2% with placebo. For those patients treated with a sulfonylurea-containing regimen at baseline, the incidence of serious heart failure was 5.8% with pioglitazone and 4.4% with placebo.

Hypoglycaemia

Although pioglitazone does not change the safety profile of sulfonylureas and insulin, the combination may increase the risk of developing hypoglycaemic symptoms.

Oedema

In combination therapy studies, oedema was reported for 7.2% of patients treated with pioglitazone and sulfonylureas compared to 2.1% of patients on sulfonylureas alone. In combination therapy studies with metformin, oedema was reported in 6.0% of patients on combination therapy compared to 2.5% of patients on metformin alone. In combination therapy studies with insulin, oedema was reported in 15.8% of patients on combination therapy compared to 7.8% of patients on insulin alone (see section 4.4). Most of these events were considered mild or moderate in intensity.

Weight gain

In all clinical trials, weight increased proportionately as the HbA_{1c} decreased suggesting that weight gain was associated with improved glycaemic control. Occasional transient increases in creatinine phosphokinase were noticed in patients taking pioglitazone.

Bladder Cancer

An increased incidence of bladder cancer was observed in subjects receiving pioglitazone in the PROactive study. In the pioglitazone arm there were 14 cases (0.5%) and in the placebo arm there were 5 cases (0.2%); the point estimate for the HR was 2.7 (95% CI 0.99-7.6). After excluding patients in whom exposure to study drug was less than one year at the time of diagnosis of bladder cancer, there were six (0.2%) cases in the pioglitazone arm and two (0.1%) cases in the placebo arm (see section 4.4).

Bone fracture

A pooled analysis was conducted of adverse event reports of bone fractures from randomised, comparator controlled (excluding thiazolidinediones), double blind clinical trials in over 8100 patients in the pioglitazone-treated groups and 7400 in the comparator-treated groups of up to 3.5 years duration. A higher rate of fractures was observed in women taking pioglitazone (2.6%) versus comparator (1.7%). No increase in fracture rates was observed in men treated with pioglitazone (1.3%) versus comparator (1.5%) (see section 4.4).

In the 3.5 year PROactive study, 44/870 (5.1%) of pioglitazone-treated female patients experienced fractures compared to 23/905 (2.5%) of female patients treated with comparator. No increase in fracture rates was observed in men treated with pioglitazone (1.7%) versus comparator (2.1%).

Adverse events identified from spontaneous post-marketing surveillance

Cardiovascular system

Cardiac failure: In post-marketing experience with pioglitazone, congestive heart failure has been reported very rarely (0.9/10 000 patient years) in patients both with and without pre-existing cardiac disease. In clinical trials, heart failure was reported more frequently when pioglitazone was used in combination with insulin or in patients with a history of cardiac failure (see sections 4.3 and 4.4).

Hepatic system

Hepatocellular Dysfunction: In post-marketing experience with pioglitazone, reports of hepatitis and hepatic enzyme elevations to 3 or more times the upper limit of normal have been received. Very rarely, these have involved hepatic failure with and without fatal outcome, although causality has not been established.

Eye disorders

Very rarely, post-marketing reports of new onset or worsening (diabetic) macular oedema with decreased visual acuity have been reported with the use of thiazolidinediones, including pioglitazone. It is unknown whether or not there is a causal relationship between pioglitazone and macular oedema. Physicians should consider the possibility of macular oedema if a patient reports decreased visual acuity.

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicine is important. It allows continued monitoring of the benefit/risk balance of the medicine. Healthcare professionals are asked to report any suspected adverse reactions <https://nzphvc.otago.ac.nz/reporting/>.

4.9 Overdose

During clinical trials, one case of overdose with pioglitazone was reported. A patient took 120 mg/day for four days, then 180 mg/day for seven days. The patient did not report any clinical symptoms.

Hypoglycaemia would not be expected with pioglitazone alone but may occur in combination with sulfonylureas or insulin. Symptomatic and general supportive measures should be taken in case of overdose.

For further advice on management of overdose please contact the National Poisons Information Centre (0800 POISON or 0800 764 766).

5. Pharmacological Properties

5.1 *Pharmacodynamic properties*

Pharmacotherapeutic group: Blood glucose lowering drugs, excluding insulins, ATC code: A10BG03

Pharmacodynamic effects

Pioglitazone is an oral antidiabetic agent that acts primarily by decreasing insulin resistance. Pharmacological studies indicate that pioglitazone improves sensitivity to insulin in muscle and adipose tissue and inhibits hepatic gluconeogenesis. Pioglitazone improves glycaemic control while reducing circulating insulin levels.

Fasting and postprandial glycaemic control are improved in patients with type 2 diabetes mellitus. The decreased insulin resistance produced by pioglitazone results in lower blood glucose concentrations, lower plasma insulin levels and lower HbA_{1c} values.

Mechanism of action

Pioglitazone is a thiazolidinedione antidiabetic agent that depends on the presence of insulin for its unique mechanism of action. Pioglitazone decreases insulin resistance in the periphery and in the liver resulting in increased insulin-dependent glucose disposal and decreased hepatic glucose output. Unlike sulfonylureas, pioglitazone is not an insulin secretagogue. Pioglitazone is a potent and highly selective agonist for peroxisome proliferator-activated receptor-gamma (PPAR γ). PPAR receptors are found in tissues important for insulin action such as adipose tissue, skeletal muscle and liver. Activation of PPAR γ nuclear receptors modulates the transcription of a number of insulin responsive genes involved in the control of glucose and lipid metabolism.

In animal models of diabetes, pioglitazone reduces the hyperglycaemia, hyperinsulinaemia and hypertriglyceridaemia characteristic of insulin-resistant states such as type 2 diabetes. The metabolic changes produced by pioglitazone result in increased responsiveness of insulin-dependent tissues and are observed in numerous animal models of insulin resistance.

Since pioglitazone enhances the effects of circulating insulin (by decreasing insulin resistance), it does not lower blood glucose in animal models that lack endogenous insulin.

Clinical efficacy and safety

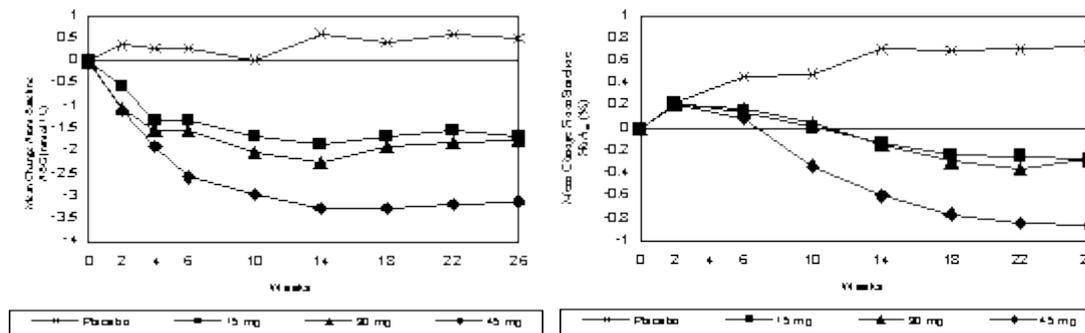
Clinical studies demonstrate that pioglitazone improves insulin sensitivity in insulin-resistant patients. Pioglitazone enhances cellular responsiveness to insulin, increases insulin-dependent glucose disposal, improves hepatic sensitivity to glucose and thus improves dysfunctional glucose homeostasis.

Monotherapy

Three randomised, double blind, placebo-controlled trials of 16 to 26 weeks were conducted to study the use of pioglitazone as monotherapy in patients with type 2 diabetes. These studies examined pioglitazone doses from 7.5 to 45 mg/day in 865 patients.

In a 26-week dose-ranging study, 408 patients with type 2 diabetes were randomised to receive 7.5, 15, 30 or 45 mg of pioglitazone, or placebo. Compared with placebo, treatment with 15 to 45 mg of pioglitazone resulted in significant improvements in HbA_{1c} and fasting blood glucose (FBG) (see Figure 1).

Figure 1 Mean change from baseline for FBG and HbA_{1c} in a 26-week placebo-controlled dose-ranging study



The study population included patients not previously treated with antidiabetic medication (naive; 31%) and patients who were receiving antidiabetic medication at the time of study enrolment (previously treated; 69%). The data for the naive and previously treated patient subsets are shown in Table 4. This run-in period was associated with little change in HbA_{1c} and FBG values from screening to baseline for the naive patients. However, for the previously-treated group, washout from previous antidiabetic medication resulted in deterioration of glycaemic control and increases in HbA_{1c} and FBG. With pioglitazone, while most patients in the previously-treated group had a decrease from baseline in HbA_{1c} and FBG in many cases the values did not return to screening levels by the end of the study. The study design did not permit the evaluation of patients who switched directly to pioglitazone from another antidiabetic agent.

Table 4 Glycaemic parameters in a 26-week placebo-controlled dose-ranging study

	Placebo	Pioglitazone 15 mg once daily	Pioglitazone 30 mg once daily	Pioglitazone 45 mg once daily
Naive to therapy				
HbA_{1c} (%)	N=25	N=26	N=26	N=21
Screening (mean)	9.3	10.0	9.5	9.8
Baseline (mean)	9.0	9.9	9.3	10.0
Change from baseline (adjusted mean ⁺)	0.6	-0.8	-0.6	-1.9
Difference from placebo (adjusted mean ⁺)		-1.4	-1.3	-2.6
FBG (mmol/L)	N=25	N=26	N=26	N=21
Screening (mean)	12.39	13.61	13.28	13.28
Baseline (mean)	12.72	13.94	12.5	13.06
Change from baseline (adjusted mean ⁺)	0.89	-2.06	-2.28	-3.56
Difference from placebo (adjusted mean ⁺)		-2.89	-3.11	-4.44
Previously treated				
HbA_{1c} (%)	N=54	N=53	N=59	N=55
Screening (mean)	9.3	9.0	9.1	9.0
Baseline (mean)	10.9	10.4	10.4	10.6
Change from baseline (adjusted mean ⁺)	0.8	-0.1	-0.0	-0.6
Difference from placebo (adjusted mean ⁺)		-1.0	-0.9	-1.4
FBG (mmol/L)	N=54	N=53	N=58	N=56
Screening (mean)	12.33	11.61	12.78	11.94
Baseline (mean)	15.83	15.28	15.89	16.22
Change from baseline (adjusted mean ⁺)	0.22	-1.78	-1.50	-3.06

Table 4 Glycaemic parameters in a 26-week placebo-controlled dose-ranging study

	Placebo	Pioglitazone 15 mg once daily	Pioglitazone 30 mg once daily	Pioglitazone 45 mg once daily
Difference from placebo (adjusted mean ⁺)		-2.00	-1.72	-3.28

⁺Adjusted for baseline, pooled centre

Pioglitazone has been shown to reduce total plasma triglycerides and free fatty acids and to increase HDL-cholesterol levels. LDL-cholesterol levels remain unchanged. In a 26-week, placebo-controlled, dose-ranging study, mean triglyceride levels decreased in the 15 mg, 30 mg and 45 mg pioglitazone dose groups compared to a mean increase in the placebo group. Mean HDL levels increased to a greater extent in the pioglitazone-treated patients than in the placebo-treated patients. There were no consistent differences for LDL and total cholesterol in pioglitazone-treated patients compared with placebo (table 5).

Table 5 Lipids in a 26-week placebo-controlled dose-ranging study

	Placebo	Pioglitazone 15 mg once daily	Pioglitazone 30 mg once daily	Pioglitazone 45 mg once daily
Triglycerides (mmol/L)	N=79	N=79	N=84	N=77
Baseline (mean)	2.97	3.20	2.95	2.93
Percent change from baseline (mean)	4.8%	-9.0%	-9.6%	-9.3%
HDL cholesterol (mmol/L)	N=79	N=79	N=83	N=77
Baseline (mean)	1.08	1.04	1.06	1.05
Percent change from baseline (mean)	8.1%	14.1%	12.2%	19.1%
LDL cholesterol (mmol/L)	N=65	N=63	N=74	N=62
Baseline (mean)	3.59	3.41	3.51	3.28
Percent change from baseline (mean)	4.8%	7.2%	5.2%	6.0%
Total cholesterol (mmol/L)	N=79	N=79	N=84	N=77
Baseline (mean)	5.81	5.69	5.76	5.53
Percent change from baseline (mean)	4.4%	4.6%	3.3%	6.4%

In a separate 24-week study, 260 patients with type 2 diabetes were randomised to one of two forced-titration pioglitazone treatment arms (final doses 30 or 45 mg), or a mock titration placebo arm. In one pioglitazone treatment group, patients received an initial dose of 7.5 mg once daily. After four weeks, the dose was increased to 15 mg once daily and after another four weeks, the dose was increased to 30 mg once daily for the remainder of the study (16 weeks). In the second pioglitazone treatment group, patients received an initial dose of 15 mg once daily and were titrated to 30 mg once daily and 45 mg once daily in a similar manner. Treatment with pioglitazone, as described, produced statistically significant improvements in HbA_{1c} and FBG at endpoint compared with placebo (see table 6).

Table 6 Glycaemic parameters in a 24-week placebo-controlled forced-titration study

	Placebo	Pioglitazone 30 mg ⁺ once daily	Pioglitazone 45 mg ⁺ once daily
Total population			

Table 6 Glycaemic parameters in a 24-week placebo-controlled forced-titration study

	Placebo	Pioglitazone 30 mg ⁺ once daily	Pioglitazone 45 mg ⁺ once daily
HbA_{1c} (%)	N=83	N=85	N=85
Baseline (mean)	10.8	10.3	10.8
Change from baseline (adjusted mean ⁺⁺)	0.9	-0.6	-0.6
Difference from placebo (adjusted mean ⁺⁺)		-1.5*	-1.5*
FBG (mmol/L)	N=78	N=82	N=85
Baseline (mean)	15.50	14.89	15.61
Change from baseline (adjusted mean ⁺⁺)	1.00	-2.44	-2.77
Difference from placebo (adjusted mean ⁺⁺)		-3.44*	-3.77*

⁺Final dose in forced titration

⁺⁺Adjusted for baseline, pooled centre, and pooled centre by treatment interaction

* p < 0.05 vs. placebo

For patients who had not been previously treated with antidiabetic medication (24%), mean values at screening were 10.1% for HbA_{1c} and 13.22 mmol/L for FBG. At baseline, mean HbA_{1c} was 10.2% and mean FBG was 13.5 mmol/L. Compared with placebo, treatment with pioglitazone titrated to a final dose of 30 mg and 45 mg resulted in reductions from baseline in mean HbA_{1c} of 2.3% and 2.6% and mean FBG of 3.5 mmol/L and 5.28 mmol/L, respectively. For patients who had been previously treated with antidiabetic medication (76%), this medication was discontinued at screening. Mean values at screening were 9.4% for HbA_{1c} and 12 mmol/L for FBG. At baseline, mean HbA_{1c} was 10.7% and mean FBG was 16.11 mmol/L. Compared with placebo, treatment with pioglitazone titrated to a final dose of 30 mg and 45 mg resulted in reductions from baseline in mean HbA_{1c} of 1.3% and 1.4% and mean FBG of 3.06 mmol/L and 3.33 mmol/L, respectively. For many previously-treated patients, HbA_{1c} and FBG had not returned to screening levels by the end of the study.

In a 16 week study, 197 patients with type 2 diabetes were randomised to treatment with 30 mg pioglitazone or placebo once daily. Compared with placebo, treatment with pioglitazone resulted in significant reductions in HbA_{1c} and FBG (see table 7).

Table 7 Glycaemic parameters in a 16-week placebo-controlled study

	Placebo	Pioglitazone 30 mg once daily
Total population		
HbA_{1c} (%)	N=93	N=100
Baseline (mean)	10.3	10.5
Change from baseline (adjusted mean ⁺)	0.8	-0.6
Difference from placebo (adjusted mean ⁺)		-1.4*
FBG (mmol/L)	N=91	N=99
Baseline (mean)	15.00	15.17
Change from baseline (adjusted mean ⁺)	0.44	-2.78
Difference from placebo (adjusted mean ⁺)		-3.22*

⁺Adjusted for baseline, pooled centre, and pooled centre by treatment interaction

* p < 0.05 vs. placebo

For patients who had not been previously treated with antidiabetic medication (40%), mean values at screening were 10.3% for HbA_{1c} and 13.33 mmol/L for FBG. At baseline, mean HbA_{1c} was 10.4% and mean FBG was 14.11 mmol/L. Compared with placebo, treatment with pioglitazone 30 mg

resulted in reductions from baseline in mean HbA_{1c} of 1.0% and mean FBG of 3.44 mmol/L. For patients who had been previously treated with antidiabetic medication (60%), this medication was discontinued at screening. Mean values at screening were 9.4% for HbA_{1c} and 12 mmol/L for FBG. At baseline, mean HbA_{1c} was 10.6% and mean FBG was 15.94 mmol/L. Compared with placebo, treatment with pioglitazone 30 mg resulted in reductions from baseline in mean HbA_{1c} of 1.3% and mean FBG of 2.56 mmol/L. For many previously-treated patients, HbA_{1c} and FBG had not returned to screening levels by the end of the study.

Dual therapy

Three 16-week, randomised, double-blind, placebo-controlled clinical studies were conducted to evaluate the effects of pioglitazone on glycaemic control in patients with type 2 diabetes who were inadequately controlled (HbA_{1c} ≥ 8%) despite sulfonylurea, metformin or insulin therapy. Previous diabetes treatment may have been monotherapy or combination therapy.

In one combination study, 560 patients on a sulfonylurea either alone or combined with another antidiabetic agent, were randomised to receive pioglitazone 15 mg, pioglitazone 30 mg or placebo in addition to their sulfonylurea regimen. Any other antidiabetic agent was withdrawn. Compared with placebo, the addition of pioglitazone to the sulfonylurea significantly reduced the mean HbA_{1c} 0.9% and 1.3% for the 15 and 30 mg doses, respectively. In addition, compared with placebo, pioglitazone decreased FBG by 2.17 mmol/L (15 mg dose) and 3.22 mmol/L (30 mg dose). The therapeutic effect of pioglitazone in combination with a sulfonylurea was observed in patients regardless of whether the patients were receiving low, medium, or high doses of sulfonylurea (< 50%, 50%, or > 50% of the recommended maximum daily dose).

In a second combination study, 328 patients with type 2 diabetes on metformin either alone or combined with another antidiabetic agent, were randomised to receive either pioglitazone 30 mg or placebo in addition to their metformin. Any other antidiabetic agent was withdrawn. Compared with placebo, the addition of pioglitazone to metformin significantly reduced the mean HbA_{1c} 0.8% and FBG 2.11 mmol/L. The therapeutic effect of pioglitazone in combination with metformin was observed in patients regardless of whether the patients were receiving lower or higher doses of metformin (< 2000 mg per day or ≥ 2000 mg per day).

In a third combination study, 566 patients with type 2 diabetes receiving a median of 60.5 units/day insulin, either alone or combined with another antidiabetic agent, were randomised to receive either pioglitazone 15 mg, pioglitazone 30 mg or placebo in addition to their insulin. Any other antidiabetic agent was discontinued. Compared with treatment with placebo, treatment with pioglitazone in addition to insulin significantly reduced both HbA_{1c} 0.7% (15 mg dose) and 1.00% (30 mg dose) and FBG 1.94 mmol/L (15 mg dose) and 2.72 mmol/L (30 mg dose). The therapeutic effect of pioglitazone in combination with insulin was observed in patients regardless of whether the patients were receiving lower or higher doses of insulin (< 60.5 units per day or ≥ 60.5 units per day).

5.2 Pharmacokinetic properties

Absorption

Following oral administration, in the fasting state, pioglitazone is first measurable in serum within 30 minutes, with peak concentrations observed within 2 hours. Steady state is achieved after 4-7 days of dosing. Food slightly delays the time to peak serum concentration to 3 to 4 hours, but does not alter the extent of absorption. The absolute bioavailability following oral administration is approximately 83%.

Distribution

The mean apparent volume of distribution (Vd/F) of pioglitazone following intravenous administration is 0.25 L/kg of body weight.

Protein binding

Pioglitazone is extensively bound to plasma protein (> 99 %), principally to serum albumin. The free fraction is less than 2% and independent of concentration in the range of 34-2000 ng/mL (which includes the therapeutic concentration range).

Biotransformation

Pioglitazone undergoes extensive hepatic metabolism by hydroxylation of aliphatic methylene groups. This is predominantly via cytochrome P450 2C8 and 3A4. Three of the six metabolites formed are active. The major circulating metabolite is M-IV (1-hydroxyethyl pioglitazone), which accounts for most of the drug-related material in human plasma and probably accounts for much of the therapeutic efficacy.

Pioglitazone did not inhibit P450 activity when incubated with human P450 liver microsomes.

Elimination

Following oral administration of radiolabelled pioglitazone to humans, recovered label was mainly in faeces (55%) and a lesser amount in urine (45%). In animals, only a small amount of unchanged pioglitazone can be detected in either urine or faeces. The mean plasma elimination half-life of unchanged pioglitazone in man is 5 - 6 hours and for its total active metabolites 16 - 23 hours.

Special populations

Renal insufficiency

In patients with renal impairment, plasma concentrations of pioglitazone and its metabolites are lower than those seen in subjects with normal renal function, but with similar oral clearance of parent drug. Thus free (unbound) pioglitazone concentration remains unchanged. Dose adjustment in patients with renal dysfunction is not recommended (see section 4.2). No information is available for patients on dialysis therefore pioglitazone should not be used in such patients.

Hepatic insufficiency

In subjects with impaired hepatic function, total plasma concentration of pioglitazone is unchanged, but with an increased volume of distribution. Intrinsic clearance is therefore reduced, coupled with a higher unbound fraction of pioglitazone. Pioglitazone therapy should not be initiated in patients with increased baseline liver enzyme levels (ALT >2.5 times the upper limit of normal).

Elderly

No clinically significant differences between elderly and young subjects were observed.

Paediatric

Pharmacokinetic data in the paediatric population is not available.

Gender

The mean C_{max} and AUC values were increased 20% to 60% in females. As monotherapy and in combination with sulfonylurea, metformin or insulin, pioglitazone improved glycaemic control in both males and females. In controlled clinical trials, haemoglobin A1c (HbA1c) decreases from baseline were generally greater for females than for males (average mean difference in HbA1c 0.5%). See section 4.2.

5.3 Preclinical safety data

Genotoxicity

No data available

Carcinogenicity

A two-year carcinogenicity study in mice showed no drug-related increases in tumour incidences at oral doses up to 91 mg/kg/day. Rats dosed orally with pioglitazone at 0.9-57 mg/kg/day for two years

showed increased incidences of subcutaneous benign adipose tissue tumours (lipomas) and urinary bladder transitional cell tumours. Systemic exposure (plasma AUC_{0-24h}) to total active compounds at the highest dose in both studies was 8 times greater than that in humans at the maximum recommended dose. The no-effect doses were not established for either tumour site. Subcutaneous benign adipose tissue tumours (lipomas) have been observed in rats treated with other thiazolidinedione drugs, and are probably related to the pharmacodynamic activity of this drug class.

Pioglitazone was not mutagenic in a battery of tests for gene mutation in bacteria and mammalian cells *in vitro*, in assays for chromosomal damage *in vitro* and *in vivo*, and in an assay for DNA damage (unscheduled DNA synthesis in rat hepatocytes *in vitro*).

6. Pharmaceutical Particulars

6.1 *List of excipients*

Vexazone tablets also contain

- lactose monohydrate
- croscarmellose sodium
- hypromellose
- polysorbate 80
- magnesium stearate
- colloidal silicon dioxide.

Contains sugars as lactose.

6.2 *Incompatibilities*

Not applicable.

6.3 *Shelf life*

3 years.

6.4 *Special precautions for storage*

15 mg, 30 mg and 45 mg bottles: Store at or below 25°C.

15 mg and 30 mg blister: Store below 25°C in original container. Protect from light and moisture.

45 mg blister: Store at or below 25°C. Protect from moisture.

6.5 *Nature and contents of container*

Blister pack. Pack sizes of 28, 90 and 250 tablets.

HDPE bottle with PP cap. Pack size of 90 tablets.

Not all pack types and sizes may be marketed.

6.6 *Special precautions for disposal*

Not applicable.

7. Medicines Schedule

Prescription Medicine

8. Sponsor Details

Viatris Ltd
PO Box 11-183
Ellerslie
AUCKLAND
www.viatris.co.nz
Telephone 0800 168 169

9. Date of First Approval

2 September 2010

10. Date of Revision of the Text

29 September 2022

Summary table of changes

Section	Summary of new information
Header	Header size increase Updated logo
2	Addition of excipient with known effect
4.2, 4.4, 4.5, 4.7, 4.7, 4.8, 5.3	Minor editorial change
4.4	Correction of Table 1
4.6	Relocation of fertility data from section 5.3
4.8	Updated notes to table 3 Addition of Bladder Cancer section
5.3	Addition of Genotoxicity section
6.1	Addition of allergen information
8	Updated sponsor detail