

## PRESCRIBING INFORMATION

### AVANDIA<sup>®</sup>

brand of

rosiglitazone maleate tablets

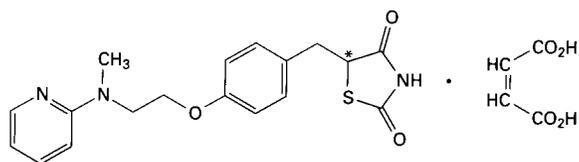
### DESCRIPTION

Avandia (rosiglitazone maleate) is an oral antidiabetic agent which acts primarily by increasing insulin sensitivity. *Avandia* is used in the management of type 2 diabetes mellitus (also known as non-insulin-dependent diabetes mellitus [NIDDM] or adult-onset diabetes). *Avandia* improves glycemic control while reducing circulating insulin levels.

Pharmacological studies in animal models indicate that rosiglitazone improves sensitivity to insulin in muscle and adipose tissue and inhibits hepatic gluconeogenesis.

Rosiglitazone maleate is not chemically or functionally related to the sulfonylureas, the biguanides, or the alpha-glucosidase inhibitors.

Chemically, rosiglitazone maleate is (±)-5-[[4-[2-(methyl-2-pyridinylamino)ethoxy]phenyl]methyl]-2,4-thiazolidinedione, (Z)-2-butenedioate (1:1) with a molecular weight of 473.52 (357.44 free base). The molecule has a single chiral center and is present as a racemate. Due to rapid interconversion, the enantiomers are functionally indistinguishable. The structural formula is:



rosiglitazone maleate

The molecular formula is  $C_{18}H_{19}N_3O_3S \cdot C_4H_4O_4$ . Rosiglitazone maleate is a white to off-white solid with a melting point range of 122° to 123°C. The pKa values of rosiglitazone maleate are 6.8 and 6.1. It is readily soluble in ethanol and a buffered aqueous solution with pH of 2.3; solubility decreases with increasing pH in the physiological range.

Each pentagonal film-coated Tiltab<sup>®</sup> tablet contains rosiglitazone maleate equivalent to rosiglitazone, 2 mg, 4 mg, or 8 mg, for oral administration. Inactive ingredients are: hydroxypropyl methylcellulose, lactose monohydrate, magnesium stearate, microcrystalline cellulose, polyethylene glycol 3000, sodium starch glycolate, titanium dioxide, triacetin, and one or more of the following: synthetic red and yellow iron oxides and talc.

## **CLINICAL PHARMACOLOGY**

### **Mechanism of Action**

Rosiglitazone, a member of the thiazolidinedione class of antidiabetic agents, improves glycemic control by improving insulin sensitivity. Rosiglitazone is a highly selective and potent agonist for the peroxisome proliferator-activated receptor-gamma (PPAR $\gamma$ ). In humans, PPAR receptors are found in key target tissues for insulin action such as adipose tissue, skeletal muscle, and liver. Activation of PPAR $\gamma$  nuclear receptors regulates the transcription of insulin-responsive genes involved in the control of glucose production, transport, and utilization. In addition, PPAR $\gamma$ -responsive genes also participate in the regulation of fatty acid metabolism.

Insulin resistance is a common feature characterizing the pathogenesis of type 2 diabetes. The antidiabetic activity of rosiglitazone has been demonstrated in animal models of type 2 diabetes in which hyperglycemia and/or impaired glucose tolerance is a consequence of insulin resistance in target tissues. Rosiglitazone reduces blood glucose concentrations and reduces hyperinsulinemia in the ob/ob obese mouse, db/db diabetic mouse, and fa/fa fatty Zucker rat.

In animal models, rosiglitazone's antidiabetic activity was shown to be mediated by increased sensitivity to insulin's action in the liver, muscle, and adipose tissues. The expression of the insulin-regulated glucose transporter GLUT-4 was increased in adipose tissue. Rosiglitazone did not induce hypoglycemia in animal models of type 2 diabetes and/or impaired glucose tolerance.

### **Pharmacokinetics and Drug Metabolism**

Maximum plasma concentration ( $C_{max}$ ) and the area under the curve (AUC) of rosiglitazone increase in a dose-proportional manner over the therapeutic dose range (Table 1). The elimination half-life is 3 to 4 hours and is independent of dose.

**Table 1. Mean (SD) Pharmacokinetic Parameters for Rosiglitazone Following Single Oral Doses (N=32)**

<b>Parameter</b>	<b>1 mg Fasting</b>	<b>2 mg Fasting</b>	<b>8 mg Fasting</b>	<b>8 mg Fed</b>
AUC <sub>0-inf</sub> [ng.hr./mL]	358 (112)	733 (184)	2971 (730)	2890 (795)
C <sub>max</sub> [ng/mL]	76 (13)	156 (42)	598 (117)	432 (92)
Half-life [hr.]	3.16 (0.72)	3.15 (0.39)	3.37 (0.63)	3.59 (0.70)
CL/F* [L/hr.]	3.03 (0.87)	2.89 (0.71)	2.85 (0.69)	2.97 (0.81)

\*CL/F = Oral Clearance.

### **Absorption**

The absolute bioavailability of rosiglitazone is 99%. Peak plasma concentrations are observed about 1 hour after dosing. Administration of rosiglitazone with food resulted in no change in overall exposure (AUC), but there was an approximately 28% decrease in C<sub>max</sub> and a delay in T<sub>max</sub> (1.75 hours). These changes are not likely to be clinically significant; therefore, Avandia (rosiglitazone maleate) may be administered with or without food.

### **Distribution**

The mean (CV%) oral volume of distribution (V<sub>ss</sub>/F) of rosiglitazone is approximately 17.6 (30%) liters, based on a population pharmacokinetic analysis. Rosiglitazone is approximately 99.8% bound to plasma proteins, primarily albumin.

### **Metabolism**

Rosiglitazone is extensively metabolized with no unchanged drug excreted in the urine. The major routes of metabolism were N-demethylation and hydroxylation, followed by conjugation with sulfate and glucuronic acid. All the circulating metabolites are considerably less potent than parent and, therefore, are not expected to contribute to the insulin-sensitizing activity of rosiglitazone.

*In vitro* data demonstrate that rosiglitazone is predominantly metabolized by Cytochrome P<sub>450</sub> (CYP) isoenzyme 2C8, with CYP2C9 contributing as a minor pathway.

### **Excretion**

Following oral or intravenous administration of [<sup>14</sup>C]rosiglitazone maleate, approximately 64% and 23% of the dose was eliminated in the urine and in the feces, respectively. The plasma half-life of [<sup>14</sup>C]related material ranged from 103 to 158 hours.

### **Population Pharmacokinetics in Patients with Type 2 Diabetes**

Population pharmacokinetic analyses from three large clinical trials including 642 men and 405 women with type 2 diabetes (aged 35 to 80 years) showed that the pharmacokinetics of rosiglitazone are not influenced by age, race, smoking, or alcohol consumption. Both oral clearance (CL/F) and oral steady-state volume of distribution (V<sub>ss</sub>/F) were shown to increase with increases in body weight. Over the weight range observed in these analyses (50 to 150 kg), the range of predicted CL/F and V<sub>ss</sub>/F values varied by <1.7-fold and <2.3-fold, respectively. Additionally, rosiglitazone CL/F was shown to be influenced by both weight and gender, being lower (about 15%) in female patients.

### **Special Populations**

**Age:** Results of the population pharmacokinetic analysis (n=716 <65 years; n=331 ≥65 years) showed that age does not significantly affect the pharmacokinetics of rosiglitazone.

**Gender:** Results of the population pharmacokinetics analysis showed that the mean oral clearance of rosiglitazone in female patients (n=405) was approximately 6% lower compared to male patients of the same body weight (n=642).

As monotherapy and in combination with metformin, *Avandia* improved glycemic control in both males and females. In metformin combination studies, efficacy was demonstrated with no gender differences in glycemic response.

In monotherapy studies, a greater therapeutic response was observed in females; however, in more obese patients, gender differences were less evident. For a given body mass index (BMI), females tend to have a greater fat mass than males. Since the molecular target PPAR $\gamma$  is expressed in adipose tissues, this differentiating characteristic may account, at least in part, for the greater response to *Avandia* in females. Since therapy should be individualized, no dose adjustments are necessary based on gender alone.

**Hepatic Impairment:** Unbound oral clearance of rosiglitazone was significantly lower in patients with moderate to severe liver disease (Child-Pugh Class B/C) compared to healthy subjects. As a result, unbound C<sub>max</sub> and AUC<sub>0-inf</sub> were increased 2- and 3-fold, respectively. Elimination half-life for rosiglitazone was about 2 hours longer in patients with liver disease, compared to healthy subjects.

Therapy with *Avandia* (rosiglitazone maleate) should not be initiated if the patient exhibits clinical evidence of active liver disease or increased serum transaminase levels (ALT >2.5X upper limit of normal) at baseline (see PRECAUTIONS, *Hepatic Effects*).

**Renal Impairment:** There are no clinically relevant differences in the pharmacokinetics of rosiglitazone in patients with mild to severe renal impairment or in hemodialysis-dependent patients compared to subjects with normal renal function. No dosage adjustment is therefore required in such patients receiving *Avandia*. Since metformin is contraindicated in patients with renal impairment, co-administration of metformin with *Avandia* is contraindicated in these patients.

**Race:** Results of a population pharmacokinetic analysis including subjects of Caucasian, black, and other ethnic origins indicate that race has no influence on the pharmacokinetics of rosiglitazone.

**Pediatric Use:** The safety and effectiveness of *Avandia* in pediatric patients have not been established.

### **Clinical Studies**

In clinical studies, treatment with *Avandia* resulted in an improvement in glycemic control, as measured by fasting plasma glucose (FPG) and hemoglobin A1c (HbA1c), with a concurrent reduction in insulin and C-peptide. Postprandial glucose and insulin were also reduced. This is consistent with the mechanism of action of *Avandia* as an insulin sensitizer. The improvement in glycemic control was durable, with maintenance of effect for 52 weeks. The maximum recommended daily dose is 8 mg. Dose-ranging studies suggested that no additional benefit was obtained with a total daily dose of 12 mg.

The addition of *Avandia* to either metformin or a sulfonylurea resulted in significant reductions in hyperglycemia compared to any of these agents alone. These results are consistent with an additive effect on glycemic control when *Avandia* is used as combination therapy.

Patients with lipid abnormalities were not excluded from clinical trials of *Avandia*. In all 26-week controlled trials, across the recommended dose range, *Avandia* as monotherapy was associated with increases in total cholesterol, LDL, and HDL and decreases in free fatty acids. These changes were statistically significantly different from placebo or glyburide controls (Table 2).

Increases in LDL occurred primarily during the first 1 to 2 months of therapy with *Avandia* and LDL levels remained elevated above baseline throughout the trials. In contrast, HDL continued to rise over time. As a result, the LDL/HDL ratio peaked after 2 months of therapy and then appeared to decrease over time. Because of the temporal nature of lipid changes, the 52-week glyburide-controlled study is most pertinent to assess long-term effects on lipids. At baseline, week 26, and week 52, mean LDL/HDL ratios were 3.1, 3.2, and 3.0, respectively, for *Avandia* 4 mg twice daily. The corresponding values for glyburide were 3.2, 3.1, and 2.9. The differences in change from baseline between *Avandia* and glyburide at week 52 were statistically significant.

The pattern of LDL and HDL changes following therapy with *Avandia* in combination with other hypoglycemic agents were generally similar to those seen with *Avandia* in monotherapy.

The changes in triglycerides during therapy with *Avandia* (rosiglitazone maleate) were variable and were generally not statistically different from placebo or glyburide controls.

**Table 2. Summary of Mean Lipid Changes in 26-Week Placebo-Controlled and 52-Week Glyburide-Controlled Monotherapy Studies**

	Placebo-controlled Studies Week 26			Glyburide-controlled Study Week 26 and Week 52			
	Placebo	<i>Avandia</i>		Glyburide titration		<i>Avandia</i> 8 mg	
		4 mg daily*	8 mg daily*	Wk 26	Wk 52	Wk 26	Wk 52
<b>Free Fatty Acids</b>							
N	207	428	436	181	168	166	145
Baseline (mean)	18.1	17.5	17.9	26.4	26.4	26.9	26.6
% Change from baseline (mean)	+0.2%	-7.8%	-14.7%	-2.4%	-4.7%	-20.8%	-21.5%
<b>LDL</b>							
N	190	400	374	175	160	161	133
Baseline (mean)	123.7	126.8	125.3	142.7	141.9	142.1	142.1
% Change from baseline (mean)	+4.8%	+14.1%	+18.6%	-0.9%	-0.5%	+11.9%	+12.1%
<b>HDL</b>							
N	208	429	436	184	170	170	145
Baseline (mean)	44.1	44.4	43.0	47.2	47.7	48.4	48.3
% Change from baseline (mean)	+8.0%	+11.4%	+14.2%	+4.3%	+8.7%	+14.0%	+18.5%

\*Once daily and twice daily dosing groups were combined.

### Monotherapy

A total of 2315 patients with type 2 diabetes, previously treated with diet alone or antidiabetic medication(s), were treated with *Avandia* as monotherapy in six double-blind studies, which included two 26-week placebo-controlled studies, one 52-week glyburide-controlled study, and three placebo-controlled dose-ranging studies of 8 to 12 weeks duration. Previous antidiabetic medication(s) were withdrawn and patients entered a 2 to 4 week placebo run-in period prior to randomization.

Two 26-week, double-blind, placebo-controlled trials, in patients with type 2 diabetes with inadequate glycemic control (mean baseline FPG approximately 228 mg/dL and mean baseline HbA1c 8.9%), were conducted. Treatment with *Avandia* produced statistically significant improvements in FPG and HbA1c compared to baseline and relative to placebo (Table 3).

**Table 3. Glycemic Parameters in Two 26-Week Placebo-Controlled Trials**

	Placebo	<i>Avandia</i> 2 mg twice daily	<i>Avandia</i> 4 mg twice daily
<b>STUDY A</b>			
<b>N</b>	158	166	169
<b>FPG (mg/dL)</b>			
Baseline (mean)	229	227	220
Change from baseline (mean)	19	-38	-54
Difference from placebo (adjusted mean)		-58*	-76*
<b>Responders (<sup>≥</sup>30 mg/dL decrease from baseline)</b>	16 %	54%	64%
<b>HbA1c (%)</b>			
Baseline (mean)	9.0	9.0	8.8
Change from baseline (mean)	0.9	-0.3	-0.6
Difference from placebo (adjusted mean)		-1.2*	-1.5*
<b>Responders (<sup>≥</sup>0.7% decrease from baseline)</b>	6%	40%	42%

	<b>Placebo</b>	<b>Avandia 4 mg once daily</b>	<b>Avandia 2 mg twice daily</b>	<b>Avandia 8 mg once daily</b>	<b>Avandia 4 mg twice daily</b>
<b>STUDY B</b>					
<b>N</b>	173	180	186	181	187
<b>FPG (mg/dL)</b>					
Baseline (mean)	225	229	225	228	228
Change from baseline (mean)	8	-25	-35	-42	-55
Difference from placebo (adjusted mean)	-	-31*	-43*	-49*	-62*
<b>Responders (<sup>≥</sup>30 mg/dL decrease from baseline)</b>	19%	45%	54%	58%	70%
<b>HbA1c (%)</b>					
Baseline (mean)	8.9	8.9	8.9	8.9	9.0
Change from baseline (mean)	0.8	0.0	-0.1	-0.3	-0.7
Difference from placebo (adjusted mean)	-	-0.8*	-0.9*	-1.1*	-1.5*
<b>Responders (<sup>≥</sup> 0.7% decrease from baseline)</b>	9%	28%	29%	39%	54%

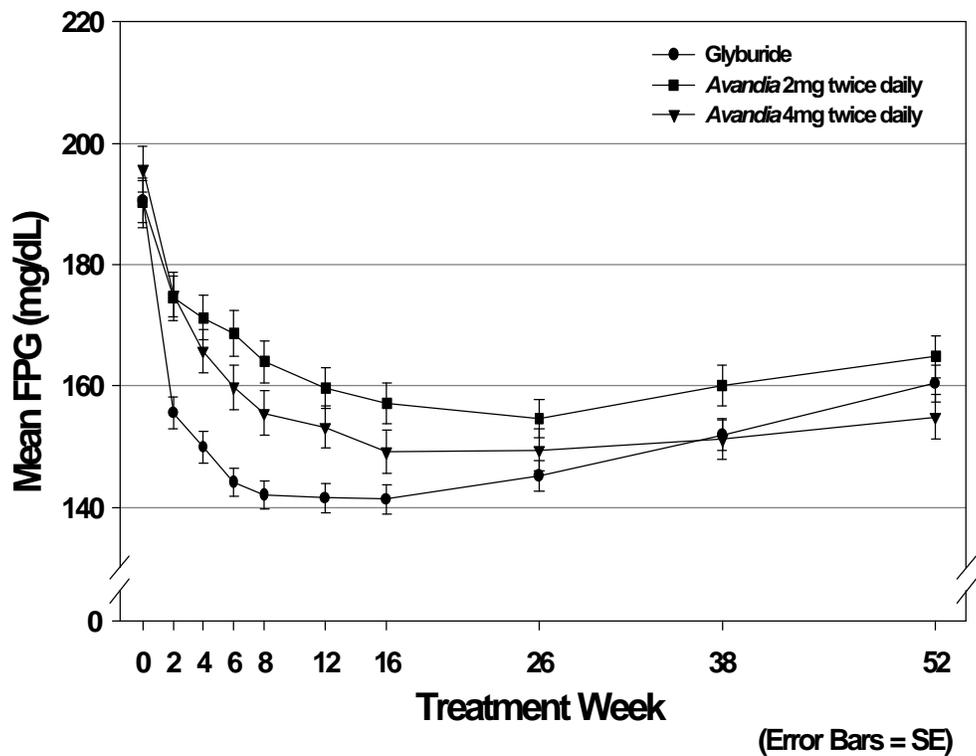
\* <0.0001 compared to placebo.

When administered at the same total daily dose, *Avandia* was generally more effective in reducing FPG and HbA1c when administered in divided doses twice daily compared to once daily doses. However, for HbA1c, the difference between the 4 mg once daily and 2 mg twice daily doses was not statistically significant.

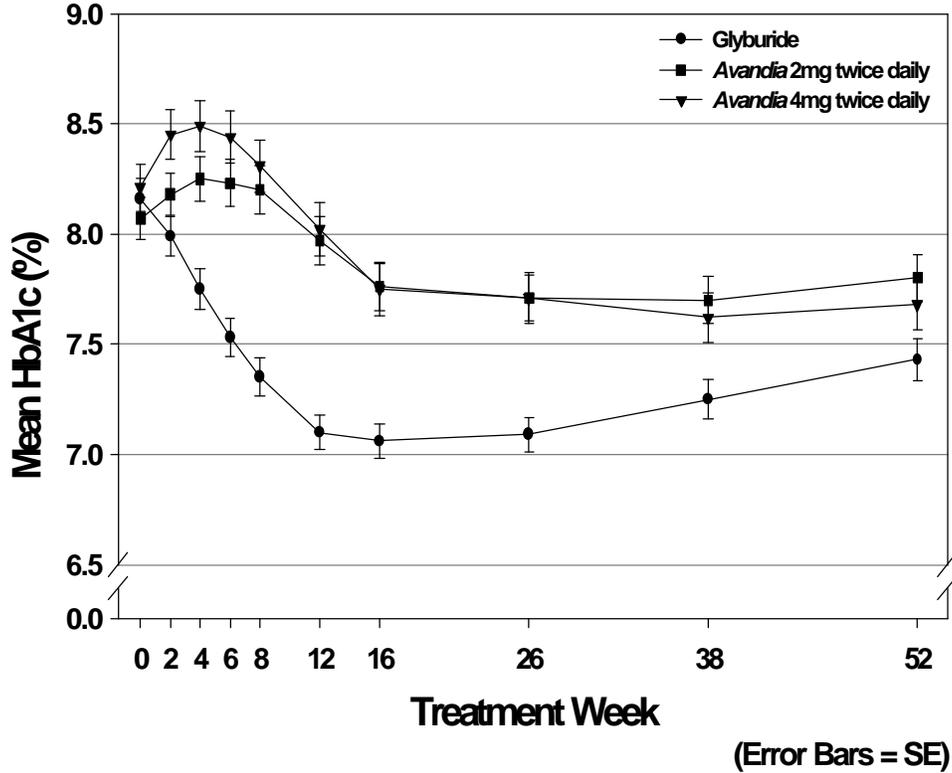
Long-term maintenance of effect was evaluated in a 52-week, double-blind, glyburide-controlled trial in patients with type 2 diabetes. Patients were randomized to treatment with *Avandia* (rosiglitazone maleate) 2 mg twice daily (N=195) or *Avandia* 4 mg twice daily (N=189) or glyburide (N=202) for 52 weeks. Patients receiving glyburide were given an initial dosage of either 2.5 mg/day or 5.0 mg/day. The dosage was then titrated in 2.5 mg/day increments over the next 12 weeks, to a maximum dosage of 15.0 mg/day in order to optimize glycemic control. Thereafter the glyburide dose was kept constant.

The median titrated dose of glyburide was 7.5 mg. All treatments resulted in a statistically significant improvement in glycemic control from baseline (Figures 1 and 2). At the end of week 52, the reduction from baseline in FPG and HbA1c was  $-40.8$  mg/dL and  $-0.53\%$  with *Avandia* 4 mg twice daily;  $-25.4$  mg/dL and  $-0.27\%$  with *Avandia* 2 mg twice daily; and  $-30.0$  mg/dL and  $-0.72\%$  with glyburide. For HbA1c, the difference between *Avandia* 4 mg twice daily and glyburide was not statistically significant at week 52. The initial fall in FPG with glyburide was greater than with *Avandia*; however, this effect was less durable over time. The improvement in glycemic control seen with *Avandia* 4 mg twice daily at week 26 was maintained through week 52 of the study.

**Figure 1. Mean FPG Over Time in a 52-Week Glyburide-Controlled Study**



**Figure 2. Mean HbA1c Over Time in a 52-Week Glyburide-Controlled Study**



Hypoglycemia was reported in 12.1% of glyburide-treated patients versus 0.5% (2 mg twice daily) and 1.6% (4 mg twice daily) of patients treated with *Avandia*. The improvements in glycemetic control were associated with a mean weight gain of 1.75 kg and 2.95 kg for patients treated with 2 mg and 4 mg twice daily of *Avandia*, respectively, versus 1.9 kg in glyburide-treated patients. In patients treated with *Avandia*, C-peptide, insulin, pro-insulin, and pro-insulin split products were significantly reduced in a dose-ordered fashion, compared to an increase in the glyburide-treated patients.

**Combination with Metformin**

A total of 670 patients with type 2 diabetes participated in two 26-week, randomized, double-blind, placebo/active-controlled studies designed to assess the efficacy of *Avandia* (rosiglitazone maleate) in combination with metformin. *Avandia*, administered in either once daily or twice daily dosing regimens, was added to the therapy of patients who were inadequately controlled on a maximum dose (2.5 grams/day) of metformin.

In one study, patients inadequately controlled on 2.5 grams/day of metformin (mean baseline FPG 216 mg/dL and mean baseline HbA1c 8.8%) were randomized to receive *Avandia* 4 mg once daily, *Avandia* 8 mg once daily, or placebo in addition to metformin.

A statistically significant improvement in FPG and HbA1c was observed in patients treated with the combinations of metformin and *Avandia* 4 mg once daily and *Avandia* 8 mg once daily, versus patients continued on metformin alone (Table 4).

**Table 4. Glycemic Parameters in a 26-Week Combination Study**

	<b>Metformin</b>	<b><i>Avandia</i> 4 mg once daily +metformin</b>	<b><i>Avandia</i> 8 mg once daily +metformin</b>
<b>N</b>	113	116	110
<b>FPG (mg/dL)</b>			
Baseline (mean)	214	215	220
Change from baseline (mean)	6	-33	-48
Difference from placebo (adjusted mean)		-40*	-53*
<b>Responders</b> ( <sup>≥</sup> 30 mg/dL decrease from baseline)	20%	45%	61%
<b>HbA1c (%)</b>			
Baseline (mean)	8.6	8.9	8.9
Change from baseline (mean)	0.5	-0.6	-0.8
Difference from placebo (adjusted mean)		-1.0*	-1.2*
<b>Responders</b> ( <sup>≥</sup> 0.7% decrease from baseline)	11%	45%	52%

\* <0.0001 compared to metformin.

In a second 26-week study, patients with type 2 diabetes inadequately controlled on 2.5 grams/day of metformin who were randomized to receive the combination of *Avandia* 4 mg twice daily and metformin (N=105) showed a statistically significant improvement in glycemic control with a mean treatment effect for FPG of -56 mg/dL and a mean treatment effect for HbA1c of -0.8% over metformin alone. The combination of metformin and *Avandia* resulted in lower levels of FPG and HbA1c than either agent alone.

Patients who were inadequately controlled on a maximum dose (2.5 grams/day) of metformin and who were switched to monotherapy with *Avandia* (rosiglitazone maleate) demonstrated loss of glycemic control, as evidenced by increases in FPG and HbA1c. In this group, increases in LDL and VLDL were also seen.

### Combination with a Sulfonylurea

A total of 1216 patients with type 2 diabetes participated in three 26-week randomized, double-blind, placebo/active-controlled studies designed to assess the efficacy and safety of *Avandia* in combination with a sulfonylurea. *Avandia* 2 mg or 4 mg daily, was administered either once daily or in divided doses twice daily, to patients inadequately controlled on a sulfonylurea.

In the two placebo-controlled studies, patients inadequately controlled on sulfonylureas that were randomized to single dose or divided doses of *Avandia* 4 mg daily plus a sulfonylurea showed significantly reduced FPG and HbA1c compared to sulfonylurea plus placebo (Table 5).

**Table 5. Glycemic Parameters in Two 26-Week Combination Studies**

	Sulfonylurea	<i>Avandia</i> 2 mg twice daily + sulfonylurea
<b>Study C (patients on prior sulfonylurea monotherapy)</b>		
<b>N</b>	192	183
<b>FPG (mg/dL)</b>		
Baseline (mean)	207	205
Change from baseline (mean)	+6	-38
Difference from placebo (adjusted mean)	-	-44*
<b>Responders (<math>\geq 30</math> mg/dL decrease from baseline)</b>	21%	56%
<b>HbA1c (%)</b>		
Baseline (mean)	9.2	9.2
Change from baseline (mean)	+0.2	-0.9
Difference from placebo (adjusted mean)	-	-1.0*
<b>Study D (patients on prior single or multiple therapies)</b>		
<b>N</b>	115	116
<b>FPG (mg/dL)</b>		
Baseline (mean)	209	214
Change from baseline (mean)	+23	-25
Difference from placebo (adjusted mean)	-	-47*
<b>Responders (<math>\geq 30</math> mg/dL decrease from baseline)</b>	13%	46%
<b>HbA1c (%)</b>		
Baseline (mean)	8.9	9.1
Change from baseline (mean)	+0.6	-0.3
Difference from placebo (adjusted mean)	-	-0.9*

\* $\leq 0.0001$  compared to sulfonylurea plus placebo

In the third study, including patients on prior single or multiple therapies, in patients inadequately controlled on the maximal dose of glyburide (20 mg daily), *Avandia* 2 mg twice daily plus sulfonylurea significantly reduced FPG (n=98, mean change from baseline of -31 mg/dL) and HbA1c (mean change from baseline of -0.5%) compared to sulfonylurea plus placebo (n=99, mean change from baseline of FPG of +24 mg/dL and of HbA1c of +0.9%). The combination of sulfonylurea and *Avandia* resulted in lower levels of FPG and HbA1c than either agent alone. Patients who were switched from

maximal dose of glyburide to 2 mg twice daily *Avandia* monotherapy demonstrated loss of glycemic control, as evidenced by increases in FPG and HbA1c.

## INDICATIONS AND USAGE

*Avandia* is indicated as an adjunct to diet and exercise to improve glycemic control in patients with type 2 diabetes mellitus. *Avandia* is indicated as monotherapy. *Avandia* is also indicated for use in combination with a sulfonylurea or metformin when diet, exercise and a single agent do not result in adequate glycemic control. For patients inadequately controlled with a maximum dose of a sulfonylurea or metformin, *Avandia* should be added to, rather than substituted for, a sulfonylurea or metformin.

Management of type 2 diabetes should include diet control. Caloric restriction, weight loss, and exercise are essential for the proper treatment of the diabetic patient because they help improve insulin sensitivity. This is important not only in the primary treatment of type 2 diabetes, but also in maintaining the efficacy of drug therapy. Prior to initiation of therapy with *Avandia* (rosiglitazone maleate), secondary causes of poor glycemic control, e.g., infection, should be investigated and treated.

## CONTRAINDICATIONS

*Avandia* is contraindicated in patients with known hypersensitivity to this product or any of its components.

## WARNINGS

**Cardiac Failure and Other Cardiac Effects:** *Avandia*, like other thiazolidinediones, alone or in combination with other antidiabetic agents, can cause fluid retention, which may exacerbate or lead to heart failure. Patients should be observed for signs and symptoms of heart failure. *Avandia* should be discontinued if any deterioration in cardiac status occurs.

Patients with New York Heart Association (NYHA) Class 3 and 4 cardiac status were not studied during the clinical trials. *Avandia* is not recommended in patients with NYHA Class 3 and 4 cardiac status.

In two 26-week U.S. trials involving 611 patients with type 2 diabetes, *Avandia* plus insulin therapy was compared with insulin therapy alone. These trials included patients with long-standing diabetes and a high prevalence of pre-existing medical conditions, including peripheral neuropathy (34%), retinopathy (19%), ischemic heart disease (14%), vascular disease (9%), and congestive heart failure (2.5%). In these clinical studies an increased incidence of cardiac failure and other cardiovascular adverse events were seen in patients on *Avandia* and insulin combination therapy compared to insulin and placebo. Patients who experienced heart failure were on average older, had a longer duration of diabetes, and were mostly on the higher 8 mg daily dose of *Avandia*. In this population, however, it was not possible to determine specific risk factors that could be used to identify all patients at risk of heart failure on combination therapy. Three of 10 who

developed cardiac failure on combination therapy during the double blind part of the studies had no known prior evidence of congestive heart failure, or pre-existing cardiac condition. **The use of Avandia in combination therapy with insulin is not currently indicated. (See ADVERSE REACTIONS).**

## PRECAUTIONS

### General

Due to its mechanism of action, *Avandia* is active only in the presence of insulin. Therefore, *Avandia* should not be used in patients with type 1 diabetes or for the treatment of diabetic ketoacidosis.

**Hypoglycemia:** Patients receiving *Avandia* in combination with other hypoglycemic agents may be at risk for hypoglycemia, and a reduction in the dose of the concomitant agent may be necessary.

**Edema:** *Avandia* should be used with caution in patients with edema. In a clinical study in healthy volunteers who received *Avandia* 8 mg once daily for 8 weeks, there was a statistically significant increase in median plasma volume compared to placebo.

Since thiazolidinediones, including rosiglitazone, can cause fluid retention, which can exacerbate or lead to congestive heart failure, *Avandia* should be used with caution in patients at risk for heart failure. Patients should be monitored for signs and symptoms of heart failure (See WARNINGS, *Cardiac Failure and Other Cardiac Effects* and PRECAUTIONS, *Information for Patients*).

In controlled clinical trials of patients with type 2 diabetes, mild to moderate edema was reported in patients treated with *Avandia*, and may be dose related. Patients with ongoing edema are more likely to have adverse events associated with edema if started on combination therapy with insulin and *Avandia*. (See ADVERSE REACTIONS).

**Weight Gain:** Dose-related weight gain was seen with *Avandia* alone and in combination with other hypoglycemic agents (Table 6). The mechanism of weight gain is unclear but probably involves a combination of fluid retention and fat accumulation.

**Table 6. Weight Changes (kg) from Baseline During Clinical Trials with *Avandia***

Monotherapy	Duration	Control Group		<i>Avandia</i> 4 mg	<i>Avandia</i> 8 mg
			Median (25 <sup>th</sup> , 75 <sup>th</sup> percentile)	Median (25 <sup>th</sup> , 75 <sup>th</sup> percentile)	Median (25 <sup>th</sup> , 75 <sup>th</sup> percentile)
	26 weeks	placebo	-0.9 (-2.8, 0.9)	1.0 (-0.9, 3.6)	3.1 (1.1, 5.8)
	52 weeks	sulfonylurea	2.0 (0, 4.0)	2.0 (-0.6, 4.0)	2.6 (0, 5.3)
Combination therapy					

sulfonylurea	26 weeks	sulfonylurea	0 (-1.3, 1.2)	1.8 (0, 3.1)	--
metformin	26 weeks	metformin	-1.4 (-3.2, 0.2)	0.8 (-1.0, 2.6)	2.1 (0, 4.3)
insulin	26 weeks	insulin	0.9 (-0.5, 2.7)	4.1 (1.4, 6.3)	5.4 (3.4, 7.3)

**Hematologic:** Across all controlled clinical studies, decreases in hemoglobin and hematocrit (mean decreases in individual studies  $\leq 1.0$  gram/dL and  $\leq 3.3\%$ , respectively) were observed for *Avandia* alone and in combination with other hypoglycemic agents. The changes occurred primarily during the first 3 months following initiation of *Avandia* therapy or following an increase in *Avandia* dose. White blood cell counts also decreased slightly in patients treated with *Avandia*. The observed changes may be related to the increased plasma volume observed with treatment with *Avandia* and may be dose related. (See ADVERSE REACTIONS, Laboratory Abnormalities).

**Ovulation:** Therapy with *Avandia*, like other thiazolidinediones, may result in ovulation in some premenopausal anovulatory women. As a result, these patients may be at an increased risk for pregnancy while taking *Avandia*. (See PRECAUTIONS, Pregnancy, Pregnancy Category C.) Thus, adequate contraception in premenopausal women should be recommended. This possible effect has not been specifically investigated in clinical studies so the frequency of this occurrence is not known.

Although hormonal imbalance has been seen in preclinical studies (see Carcinogenesis, Mutagenesis, Impairment of Fertility), the clinical significance of this finding is not known. If unexpected menstrual dysfunction occurs, the benefits of continued therapy with *Avandia* should be reviewed.

**Hepatic Effects:** Another drug of the thiazolidinedione class, troglitazone, was associated with idiosyncratic hepatotoxicity, and very rare cases of liver failure, liver transplants, and death were reported during clinical use. In pre-approval controlled clinical trials in patients with type 2 diabetes, troglitazone was more frequently associated with clinically significant elevations in liver enzymes (ALT  $>3X$  upper limit of normal) compared to placebo. Very rare cases of reversible jaundice were also reported.

In pre-approval clinical studies in 4598 patients treated with *Avandia*, encompassing approximately 3600 patient years of exposure, there was no signal of drug-induced hepatotoxicity or elevation of ALT levels. In the pre-approval controlled trials, 0.2% of patients treated with *Avandia* had elevations in ALT  $>3X$  the upper limit of normal compared to 0.2% on placebo and 0.5% on active comparators. The ALT elevations in patients treated with *Avandia* were reversible and were not clearly causally related to therapy with *Avandia* (rosiglitazone maleate).

In postmarketing experience with *Avandia*, reports of hepatitis and of hepatic enzyme elevations to three or more times the upper limit of normal have been received. Very rarely, these reports have involved hepatic failure with and without fatal outcome,

although causality has not been established. Rosiglitazone is structurally related to troglitazone, a thiazolidinedione no longer marketed in the United States, which was associated with idiosyncratic hepatotoxicity and rare cases of liver failure, liver transplants, and death during clinical use. Pending the availability of the results of additional large, long-term controlled clinical trials and additional postmarketing safety data, it is recommended that patients treated with *Avandia* undergo periodic monitoring of liver enzymes.

Liver enzymes should be checked prior to the initiation of therapy with *Avandia* in all patients. Therapy with *Avandia* should not be initiated in patients with increased baseline liver enzyme levels (ALT > 2.5X upper limit of normal). In patients with normal baseline liver enzymes, following initiation of therapy with *Avandia*, it is recommended that liver enzymes be monitored every 2 months for the first 12 months, and periodically thereafter. Patients with mildly elevated liver enzymes (ALT levels  $\leq$  2.5X upper limit of normal) at baseline or during therapy with *Avandia* should be evaluated to determine the cause of the liver enzyme elevation. Initiation of, or continuation of, therapy with *Avandia* in patients with mild liver enzyme elevations should proceed with caution and include close clinical follow-up, including more frequent liver enzyme monitoring, to determine if the liver enzyme elevations resolve or worsen. If at any time ALT levels increase to > 3X the upper limit of normal in patients on therapy with *Avandia*, liver enzyme levels should be rechecked as soon as possible. If ALT levels remain > 3X the upper limit of normal, therapy with *Avandia* should be discontinued.

There are no data available from clinical trials to evaluate the safety of *Avandia* in patients who experienced liver abnormalities, hepatic dysfunction, or jaundice while on troglitazone. *Avandia* (rosiglitazone maleate) should not be used in patients who experienced jaundice while taking troglitazone.

If any patient develops symptoms suggesting hepatic dysfunction, which may include unexplained nausea, vomiting, abdominal pain, fatigue, anorexia and/or dark urine, liver enzymes should be checked. The decision whether to continue the patient on therapy with *Avandia* should be guided by clinical judgment pending laboratory evaluations. If jaundice is observed, drug therapy should be discontinued.

### **Laboratory Tests**

Periodic fasting blood glucose and HbA1c measurements should be performed to monitor therapeutic response.

Liver enzyme monitoring is recommended prior to initiation of therapy with *Avandia* in all patients and periodically thereafter (See PRECAUTIONS, *Hepatic Effects* and ADVERSE REACTIONS, Serum Transaminase Levels).

### **Information for Patients**

Patients should be informed of the following:

Management of type 2 diabetes should include diet control. Caloric restriction, weight loss, and exercise are essential for the proper treatment of the diabetic patient because they help improve insulin sensitivity. This is important not only in the primary treatment of type 2 diabetes, but in maintaining the efficacy of drug therapy.

It is important to adhere to dietary instructions and to regularly have blood glucose and glycosylated hemoglobin tested. Patients should be advised that it can take 2 weeks to see a reduction in blood glucose and 2 to 3 months to see full effect. Patients should be informed that blood will be drawn to check their liver function prior to the start of therapy and every 2 months for the first 12 months, and periodically thereafter. Patients with unexplained symptoms of nausea, vomiting, abdominal pain, fatigue, anorexia, or dark urine should immediately report these symptoms to their physician. Patients who experience an unusually rapid increase in weight or edema or who develop shortness of breath or other symptoms of heart failure while on *Avandia* should immediately report these symptoms to their physician.

*Avandia* can be taken with or without meals.

When using *Avandia* in combination with other hypoglycemic agents, the risk of hypoglycemia, its symptoms and treatment, and conditions that predispose to its development should be explained to patients and their family members.

Therapy with *Avandia*, like other thiazolidinediones, may result in ovulation in some premenopausal anovulatory women. As a result, these patients may be at an increased risk for pregnancy while taking *Avandia*. (See PRECAUTIONS, Pregnancy, Pregnancy Category C.) Thus, adequate contraception in premenopausal women should be recommended. This possible effect has not been specifically investigated in clinical studies so the frequency of this occurrence is not known.

### **Drug Interactions**

#### ***Drugs Metabolized by Cytochrome P<sub>450</sub>***

*In vitro* drug metabolism studies suggest that rosiglitazone does not inhibit any of the major P<sub>450</sub> enzymes at clinically relevant concentrations. *In vitro* data demonstrate that rosiglitazone is predominantly metabolized by CYP2C8, and to a lesser extent, 2C9.

*Avandia* (4 mg twice daily) was shown to have no clinically relevant effect on the pharmacokinetics of nifedipine and oral contraceptives (ethinylestradiol and norethindrone), which are predominantly metabolized by CYP3A4.

*Glyburide*: *Avandia* (2 mg twice daily) taken concomitantly with glyburide (3.75 to 10 mg/day) for 7 days did not alter the mean steady-state 24-hour plasma glucose concentrations in diabetic patients stabilized on glyburide therapy.

*Metformin*: Concurrent administration of *Avandia* (2 mg twice daily) and metformin (500 mg twice daily) in healthy volunteers for 4 days had no effect on the steady-state pharmacokinetics of either metformin or rosiglitazone.

*Acarbose*: Coadministration of acarbose (100 mg three times daily) for 7 days in healthy volunteers had no clinically relevant effect on the pharmacokinetics of a single oral dose of *Avandia*.

*Digoxin*: Repeat oral dosing of *Avandia* (8 mg once daily) for 14 days did not alter the steady-state pharmacokinetics of digoxin (0.375 mg once daily) in healthy volunteers.

*Warfarin*: Repeat dosing with *Avandia* had no clinically relevant effect on the steady-state pharmacokinetics of warfarin enantiomers.

*Ethanol*: A single administration of a moderate amount of alcohol did not increase the risk of acute hypoglycemia in type 2 diabetes mellitus patients treated with *Avandia* (rosiglitazone maleate).

*Ranitidine*: Pretreatment with ranitidine (150 mg twice daily for 4 days) did not alter the pharmacokinetics of either single oral or intravenous doses of rosiglitazone in healthy volunteers. These results suggest that the absorption of oral rosiglitazone is not altered in conditions accompanied by increases in gastrointestinal pH.

### **Carcinogenesis, Mutagenesis, Impairment of Fertility**

*Carcinogenesis*: A 2-year carcinogenicity study was conducted in Charles River CD-1 mice at doses of 0.4, 1.5, and 6 mg/kg/day in the diet (highest dose equivalent to approximately 12 times human AUC at the maximum recommended human daily dose). Sprague-Dawley rats were dosed for 2 years by oral gavage at doses of 0.05, 0.3, and 2 mg/kg/day (highest dose equivalent to approximately 10 and 20 times human AUC at the maximum recommended human daily dose for male and female rats, respectively).

Rosiglitazone was not carcinogenic in the mouse. There was an increase in incidence of adipose hyperplasia in the mouse at doses  $\geq 1.5$  mg/kg/day (approximately 2 times human AUC at the maximum recommended human daily dose). In rats, there was a significant increase in the incidence of benign adipose tissue tumors (lipomas) at doses  $\geq 0.3$  mg/kg/day (approximately 2 times human AUC at the maximum recommended human daily dose). These proliferative changes in both species are considered due to the persistent pharmacological overstimulation of adipose tissue.

*Mutagenesis*: Rosiglitazone was not mutagenic or clastogenic in the *in vitro* bacterial assays for gene mutation, the *in vitro* chromosome aberration test in human lymphocytes, the *in vivo* mouse micronucleus test, and the *in vivo/in vitro* rat UDS assay. There was a small (about 2-fold) increase in mutation in the *in vitro* mouse lymphoma assay in the presence of metabolic activation.

*Impairment of Fertility:* Rosiglitazone had no effects on mating or fertility of male rats given up to 40 mg/kg/day (approximately 116 times human AUC at the maximum recommended human daily dose). Rosiglitazone altered estrous cyclicity (2 mg/kg/day) and reduced fertility (40 mg/kg/day) of female rats in association with lower plasma levels of progesterone and estradiol (approximately 20 and 200 times human AUC at the maximum recommended human daily dose, respectively). No such effects were noted at 0.2 mg/kg/day (approximately 3 times human AUC at the maximum recommended human daily dose). In monkeys, rosiglitazone (0.6 and 4.6 mg/kg/day; approximately 3 and 15 times human AUC at the maximum recommended human daily dose, respectively) diminished the follicular phase rise in serum estradiol with consequential reduction in the luteinizing hormone surge, lower luteal phase progesterone levels, and amenorrhea. The mechanism for these effects appears to be direct inhibition of ovarian steroidogenesis.

### **Animal Toxicology**

Heart weights were increased in mice (3 mg/kg/day), rats (5 mg/kg/day), and dogs (2 mg/kg/day) with rosiglitazone treatments (approximately 5, 22, and 2 times human AUC at the maximum recommended human daily dose, respectively). Morphometric measurement indicated that there was hypertrophy in cardiac ventricular tissues, which may be due to increased heart work as a result of plasma volume expansion.

### **Pregnancy**

#### **Pregnancy Category C**

There was no effect on implantation or the embryo with rosiglitazone treatment during early pregnancy in rats, but treatment during mid-late gestation was associated with fetal death and growth retardation in both rats and rabbits. Teratogenicity was not observed at doses up to 3 mg/kg in rats and 100 mg/kg in rabbits (approximately 20 and 75 times human AUC at the maximum recommended human daily dose, respectively). Rosiglitazone caused placental pathology in rats (3 mg/kg/day). Treatment of rats during gestation through lactation reduced litter size, neonatal viability, and postnatal growth, with growth retardation reversible after puberty. For effects on the placenta, embryo/fetus, and offspring, the no-effect dose was 0.2 mg/kg/day in rats and 15 mg/kg/day in rabbits. These no-effect levels are approximately 4 times human AUC at the maximum recommended human daily dose.

There are no adequate and well-controlled studies in pregnant women. Avandia (rosiglitazone maleate) should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus.

Because current information strongly suggests that abnormal blood glucose levels during pregnancy are associated with a higher incidence of congenital anomalies as well as increased neonatal morbidity and mortality, most experts recommend that insulin monotherapy be used during pregnancy to maintain blood glucose levels as close to normal as possible.

**Labor and Delivery**

The effect of rosiglitazone on labor and delivery in humans is not known.

**Nursing Mothers**

Drug related material was detected in milk from lactating rats. It is not known whether *Avandia* is excreted in human milk. Because many drugs are excreted in human milk, *Avandia* should not be administered to a nursing woman.

**ADVERSE REACTIONS**

In clinical trials, approximately 4600 patients with type 2 diabetes have been treated with *Avandia*; 3300 patients were treated for 6 months or longer and 2000 patients were treated for 12 months or longer.

**Trials of *Avandia* as Monotherapy and In Combination with Other Hypoglycemic Agents**

The incidence and types of adverse events reported in clinical trials of *Avandia* as monotherapy are shown in Table 7.

**Table 7. Adverse Events (<sup>≥</sup>5% in Any Treatment Group) Reported by Patients in Double-blind Clinical Trials with *Avandia* as Monotherapy**

	<i>Avandia</i> Monotherapy N = 2526	Placebo N = 601	Metformin N = 225	Sulfonylureas* N = 626
<b>Preferred Term</b>	%	%	%	%
Upper respiratory tract infection	9.9	8.7	8.9	7.3
Injury	7.6	4.3	7.6	6.1
Headache	5.9	5.0	8.9	5.4
Back pain	4.0	3.8	4.0	5.0
Hyperglycemia	3.9	5.7	4.4	8.1
Fatigue	3.6	5.0	4.0	1.9
Sinusitis	3.2	4.5	5.3	3.0
Diarrhea	2.3	3.3	15.6	3.0
Hypoglycemia	0.6	0.2	1.3	5.9

\*Includes patients receiving glyburide (N=514), gliclazide (N=91) or glipizide (N=21).

There were a small number of patients treated with *Avandia* who had adverse events of anemia and edema. Overall, these events were generally mild to moderate in severity and usually did not require discontinuation of treatment with *Avandia*.

In double-blind studies, anemia was reported in 1.9% of patients receiving *Avandia* compared to 0.7% on placebo, 0.6% on sulfonylureas and 2.2% on metformin. Edema was reported in 4.8% of patients receiving *Avandia* compared to 1.3% on placebo, 1.0% on sulfonylureas, and 2.2% on metformin. Overall, the types of adverse experiences reported when *Avandia* was used in combination with a sulfonylurea or metformin were similar to those during monotherapy with *Avandia*. Reports of anemia (7.1%) were greater in patients treated with a combination of *Avandia* and metformin compared to monotherapy with *Avandia* or in combination with a sulfonylurea.

Lower pre-treatment hemoglobin/hematocrit levels in patients enrolled in the metformin combination clinical trials may have contributed to the higher reporting rate of anemia in these studies (see Laboratory Abnormalities, Hematologic).

In 26-week double-blind studies, edema was reported with higher frequency in the *Avandia* plus insulin combination trials (insulin, 5.4%; and *Avandia* in combination with insulin, 14.7%). Reports of new onset or exacerbation of congestive heart failure occurred at rates of 1% for insulin alone, and 2% (4 mg) and 3% (8 mg) for insulin in combination with *Avandia*. (See WARNINGS, *Cardiac Failure and Other Cardiac Effects*)

In postmarketing experience with *Avandia*, adverse events potentially related to volume expansion (e.g. congestive heart failure, pulmonary edema, and pleural effusions) have been reported.

### **Laboratory Abnormalities**

**Hematologic:** Decreases in mean hemoglobin and hematocrit occurred in a dose-related fashion in patients treated with *Avandia* (mean decreases in individual studies up to 1.0 gram/dL hemoglobin and up to 3.3% hematocrit). The time course and magnitude of decreases were similar in patients treated with a combination of *Avandia* and other hypoglycemic agents or *Avandia* monotherapy. Pre-treatment levels of hemoglobin and hematocrit were lower in patients in metformin combination studies and may have contributed to the higher reporting rate of anemia. White blood cell counts also decreased slightly in patients treated with *Avandia*. Decreases in hematologic parameters may be related to increased plasma volume observed with treatment with *Avandia*.

**Lipids:** Changes in serum lipids have been observed following treatment with *Avandia* (see CLINICAL PHARMACOLOGY, Pharmacodynamics and Clinical Effects).

**Serum Transaminase Levels:** In clinical studies in 4598 patients treated with *Avandia* (rosiglitazone maleate) encompassing approximately 3600 patient years of exposure, there was no evidence of drug-induced hepatotoxicity or elevated ALT levels.

In controlled trials, 0.2% of patients treated with *Avandia* had reversible elevations in ALT >3X the upper limit of normal compared to 0.2% on placebo and 0.5% on active comparators. Hyperbilirubinemia was found in 0.3% of patients treated with *Avandia* compared with 0.9% treated with placebo and 1% in patients treated with active comparators.

In the clinical program including long-term, open-label experience, the rate per 100 patient years exposure of ALT increase to >3X the upper limit of normal was 0.35 for patients treated with *Avandia*, 0.59 for placebo-treated patients, and 0.78 for patients treated with active comparator agents.

In pre-approval clinical trials, there were no cases of idiosyncratic drug reactions leading to hepatic failure. In postmarketing experience with *Avandia* (rosiglitazone maleate), reports of hepatic enzyme elevations three or more times the upper limit of normal and hepatitis have been received. (See PRECAUTIONS, *Hepatic Effects*).

### **DOSAGE AND ADMINISTRATION**

The management of antidiabetic therapy should be individualized. *Avandia* may be administered either at a starting dose of 4 mg as a single daily dose or divided and administered in the morning and evening. For patients who respond inadequately following 8 to 12 weeks of treatment, as determined by reduction in FPG, the dose may be increased to 8 mg daily as indicated below. Reductions in glycemic parameters by dose

and regimen are described under CLINICAL PHARMACOLOGY, Clinical Studies. *Avandia* may be taken with or without food.

### **Monotherapy**

The usual starting dose of *Avandia* is 4 mg administered either as a single dose once daily or in divided doses twice daily. In clinical trials, the 4 mg twice daily regimen resulted in the greatest reduction in FPG and HbA1c.

### **Combination Therapy with a Sulfonylurea or Metformin**

When *Avandia* is added to existing therapy, the current dose of sulfonylurea or metformin can be continued upon initiation of *Avandia* therapy.

#### ***Sulfonylurea:***

When used in combination with sulfonylurea, the recommended dose of *Avandia* is 4 mg administered as either a single dose once daily or in divided doses twice daily. If patients report hypoglycemia, the dose of the sulfonylurea should be decreased.

#### ***Metformin:***

The usual starting dose of *Avandia* in combination with metformin is 4 mg administered as either a single dose once daily or in divided doses twice daily. It is unlikely that the dose of metformin will require adjustment due to hypoglycemia during combination therapy with *Avandia*.

### **Maximum Recommended Dose:**

The dose of *Avandia* should not exceed 8 mg daily, as a single dose or divided twice daily. The 8 mg daily dose has been shown to be safe and effective in clinical studies as monotherapy and in combination with metformin. Doses of *Avandia* greater than 4 mg daily in combination with a sulfonylurea have not been studied in adequate and well-controlled clinical trials.

*Avandia* may be taken with or without food.

No dosage adjustments are required for the elderly.

No dosage adjustment is necessary when *Avandia* is used as monotherapy in patients with renal impairment. Since metformin is contraindicated in such patients, concomitant administration of metformin and *Avandia* is also contraindicated in patients with renal impairment.

Therapy with *Avandia* should not be initiated if the patient exhibits clinical evidence of active liver disease or increased serum transaminase levels (ALT >2.5X the upper limit of normal at start of therapy) (See PRECAUTIONS, *Hepatic Effects* and CLINICAL PHARMACOLOGY, Hepatic Impairment). Liver enzyme monitoring is recommended in

all patients prior to initiation of therapy with *Avandia* and periodically thereafter (See PRECAUTIONS, *Hepatic Effects*).

There are no data on the use of *Avandia* in patients under 18 years of age; therefore, use of *Avandia* in pediatric patients is not recommended.

### **OVERDOSAGE**

Limited data are available with regard to overdosage in humans. In clinical studies in volunteers, *Avandia* (rosiglitazone maleate) has been administered at single oral doses of up to 20 mg and was well-tolerated. In the event of an overdose, appropriate supportive treatment should be initiated as dictated by the patient's clinical status.

### **HOW SUPPLIED**

**Tablets:** Each pentagonal film-coated Tiltab<sup>®</sup> tablet contains rosiglitazone as the maleate as follows: 2 mg—pink, debossed with SB on one side and 2 on the other; 4 mg—orange, debossed with SB on one side and 4 on the other; 8 mg—red-brown, debossed with SB on one side and 8 on the other.

2 mg bottles of 30: NDC 0029-3158-13  
2 mg bottles of 60: NDC 0029-3158-18  
2 mg bottles of 100: NDC 0029-3158-20  
2 mg bottles of 500: NDC 0029-3158-25  
2 mg SUP 100s: NDC 0029-3158-21

4 mg bottles of 30: NDC 0029-3159-13  
4 mg bottles of 60: NDC 0029-3159-18  
4 mg bottles of 100: NDC 0029-3159-20  
4 mg bottles of 500: NDC 0029-3159-25  
4 mg SUP 100s: NDC 0029-3159-21

8 mg bottles of 30: NDC 0029-3160-13  
8 mg bottles of 100: NDC 0029-3160-20  
8 mg bottles of 500: NDC 0029-3160-25  
8 mg SUP 100s: NDC 0029-3160-21

### **STORAGE**

Store at 25°C (77°F); excursions 15°-30°C (59°-86°F). Dispense in a tight, light-resistant container.

DATE OF ISSUANCE FEB. 2001

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**SmithKline Beecham Pharmaceuticals**  
Philadelphia, PA 19101

R<sub>x</sub> only