Starlix®

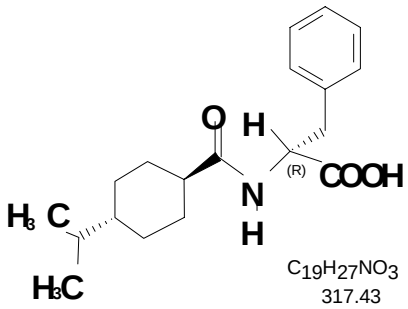
(nateglinide) tablets

"Rx only"

DESCRIPTION

Starlix (nateglinide) is an oral antidiabetic agent used in the management of Type 2 diabetes mellitus (also known as non-insulin dependent diabetes mellitus (NIDDM) or adult-onset diabetes). Starlix, (-)-N-[(trans-4-isopropylcyclohexane)carbonyl]-D-phenylalanine, is structurally unrelated to the oral sulfonylurea insulin secretagogues.

The structural formula is as shown:



Nateglinide is a white powder with a molecular weight of 317.43. It is freely soluble in methanol, ethanol, and chloroform, soluble in ether, sparingly soluble in acetonitrile and octanol, and practically insoluble in water. Starlix biconvex tablets contain 60mg, or 120 mg, of nateglinide for oral administration.

Inactive ingredients: colloidal silicon dioxide, croscarmellose sodium, hydroxypropyl methylcellulose, iron oxides (red or yellow), lactose monohydrate, magnesium stearate, microcrystalline cellulose, polyethylene glycol, povidone, talc, and titanium dioxide .

CLINICAL PHARMACOLOGY

Mechanism of Action

Nateglinide is an amino-acid derivative that lowers blood glucose levels by stimulating insulin secretion from the pancreas. This action is dependent upon functioning beta-cells in the pancreatic islets. Nateglinide interacts with the ATP-sensitive potassium ($K+_{ATP}$) channel on pancreatic beta-cells. The subsequent depolarization of the beta cell opens the calcium channel, producing calcium influx and insulin secretion. The extent of insulin release is glucose dependent and diminishes at low glucose levels. Nateglinide is highly tissue selective with low affinity for heart and skeletal muscle.

Pharmacokinetics

Absorption

Following oral administration immediately prior to a meal, nateglinide is rapidly absorbed with mean peak plasma drug concentrations (C_{max}) generally occurring within 1 hour (T_{max}) after dosing. When administered to patients with Type 2 diabetes over the dosage range 60 to 240 mg three times a day for one week, nateglinide demonstrated linear pharmacokinetics for both AUC (area under the time/plasma concentration curve) and C_{max}. T_{max} was also found to be independent of dose in this patient population. Absolute bioavailability is estimated to be approximately 73%. When given with or after meals, the extent of nateglinide absorption (AUC) remains unaffected. However, there is a delay in the rate of absorption characterized by a decrease in C_{max} and a delay in time to peak plasma concentration (T_{max}). Plasma profiles are characterized by multiple plasma concentration peaks when nateglinide is administered under fasting conditions. This effect is diminished when nateglinide is taken prior to a meal.

Distribution

Based on data following intravenous (IV) administration of nateglinide, the steady state volume of distribution of nateglinide is estimated to be approximately 10 liters in healthy subjects. Nateglinide is extensively bound (98%) to serum proteins, primarily serum albumin, and to a lesser extent $_1$ acid glycoprotein. The extent of serum protein binding is independent of drug concentration over the test range of 0.1-10 μg/mL.

Metabolism

Nateglinide is metabolized by the mixed-function oxidase system prior to elimination. The major routes of metabolism are hydroxylation followed by glucuronide conjugation. The major metabolites are less potent antidiabetic agents than nateglinide. The isoprene minor metabolite possesses potency similar to that of the parent compound nateglinide.

In vitro data demonstrate that nateglinide is predominantly metabolized by cytochrome P_{450} isoenzymes CYP2C9 (70%) andCYP3A4 (30%).

Excretion

Nateglinide and its metabolites are rapidly and completely eliminated following oral administration. Within 6 hours after dosing, approximately 75% of the administered ^{14}C-nateglinide was recovered in the urine. Eighty-three percent of the ^{14}C-nateglinide was excreted in the urine with an additional 10% eliminated in the feces. Approximately 16% of the ^{14}C-nateglinide was excreted in the urine as parent compound. In all studies of healthy volunteers and patients with Type 2 diabetes, nateglinide plasma concentrations declined rapidly with an average elimination half-life of approximately1.5 hours. Consistent with this short elimination half-life, there was no apparent accumulation of nateglinide upon multiple dosing of up to 240 mg three times daily for 7 days.

Special Populations

Geriatric: Age did not influence the pharmacokinetic properties of nateglinide. Therefore no dose adjustments are necessary for elderly patients.

Gender: No clinically significant differences in nateglinide pharmacokinetics were observed between men and women. Therefore, no dose adjustment based on gender is necessary.

Race: Results of a population pharmacokinetic analysis including subjects of Caucasian, black, and other ethnic origins suggest that race has little influence on the pharmacokinetics of nateglinide.

Renal Impairment: Compared to healthy matched subjects, patients withType 2 diabetes and moderate to severe renal insufficiency (CrCl 15 - 50 mL/min) not on dialysis displayed similar apparent clearance, AUC and Cmax. Patients with Type 2 diabetes and renal failure on dialysis exhibited reduced overall drug exposure. However, hemodialysis patients also experienced reductions in plasma protein binding compared to the matched healthy volunteers.

Hepatic Impairment: The peak and total exposure of nateglinide in non-diabetic subjects with mild hepatic insufficiency were increased by 30% compared to matched healthy subjects. Starlix should be used with caution in patients with chronic liver disease. (See PRECAUTIONS, Hepatic Impairment)

Pharmacodynamics

Starlix is rapidly absorbed and stimulates pancreatic insulin secretion within 20 minutes of oral administration. When Starlix is dosed three times daily before meals there is a rapid rise in plasma insulin, with peak levels approximately 1 hour after dosing and a fall to baseline by 4 hours after dosing.

In a double-blind, controlled clinical trial in which Starlix was administered before each of three meals, plasma glucose levels were determined over a 12-hour, daytime period after 7 weeks of treatment. Starlix was administered 10 minutes before meals. The meals were based on standard diabetic weight maintenance menus with the total caloric content based on each subject's height. Starlix produced statistically significant decreases in fasting and post-prandial glycemia compared to placebo.

Clinical Studies

A total of 3164 patients were randomized in eight double-blind, placebo- or active-controlled studies eight to 24 weeks in duration to evaluate the safety and efficacy of Starlix. 3118 patients had efficacy values beyond baseline. In these studies Starlix was administered up to 30 minutes before each of three main meals daily.

Starlix Monotherapy Compared to Placebo

In a randomized, double-blind, placebo-controlled, 24-week study, patients with Type 2 diabetes with HbA_{1C} ≥6.8% on diet alone were randomized to receive either Starlix (60 mg or 120 mg three times daily before meals) or placebo. Baseline HbA_{1C} ranged from 7.9% to 8.1% and 77.8% of patients were previously untreated with oral antidiabetic therapy. Patients

previously treated with antidiabetic medications were required to discontinue that medication for at least 2 months before randomization. The addition of Starlix before meals resulted in statistically significant reductions in mean HbA_{1C} and mean fasting plasma glucose (FPG) compared to placebo (See Table 1). The reductions in HbA_{1C} and FPG were similar for patients naïve to, and those previously exposed to, antidiabetic medications.

In this study, one episode of severe hypoglycemia (plasma glucose <36 mg/dL) was reported in a patient treated with Starlix 120 mg three times daily before meals. No patients experienced hypoglycemia that required third party assistance. Patients treated with Starlix had statistically significant mean increases in weight compared to placebo (Table 1).

In another randomized, double-blind, 24-week, active- and placebo-controlled study, patients with Type 2 diabetes were randomized to receive Starlix (120 mg three times daily before meals), metformin 500 mg (three times daily), a combination of Starlix 120 mg (three times daily before meals) and metformin 500 mg (three times daily), or placebo. Baseline HbA_{1C} ranged from 8.3% to 8.4%. Fifty-seven percent of patients were previously untreated with oral antidiabetic therapy. Starlix monotherapy resulted in significant reductions in mean HbA_{1C} and mean FPG compared to placebo that were similar to the results of the study reported above (See Table 2).

Table 1 Endpoint results for a 24-week, fixed dose study of Starlix monotherapy

	Placebo	**Starlix 60 mg** three times daily before meals	**Starlix 120 mg** three times daily before meals
HbA_{1c} (%)	*N=168*	*N=167*	*N=168*
Baseline (mean)	8.0	7.9	8.1
Change from baseline (mean)	+0.2	-0.3	-0.5
Difference from placebo (mean)		-0.5 [a]	-0.7[a]
FPG (mg/dL)	*N=172*	*N=171*	*N=169*
Baseline (mean)	167.9	161.0	166.5
Change from baseline (mean)	+9.1	+0.4	-4.5
Difference from placebo (mean)		-8.7 [a]	-13.6 [a]
Weight (kg)	*N=170*	*N=169*	*N=166*
Baseline (mean)	85.8	83.7	86.3
Change from baseline (mean)	-0.7	+0.3	+0.9
Difference from placebo (mean)		+1.0 [a]	+1.6[a]

[a] p-value ≤ 0.004.

Starlix Monotherapy Compared to Other Oral Antidiabetic Agents

Glyburide

In a 24-week, double-blind, active-controlled trial, patients with Type 2 diabetes who had been on a sulfonylurea for ≥ 3 months and who had a baseline HbA_{1C} ≥6.5% were randomized to receive Starlix (60 mg or 120 mg three times daily before meals) or glyburide 10 mg once daily. Patients randomized to Starlix had significant increases in mean HbA_{1C} and mean FPG at endpoint compared to patients randomized to glyburide.

Metformin

In another randomized, double-blind, 24-week, active- and placebo-controlled study, patients with Type 2 diabetes were randomized to receive Starlix (120 mg three times daily before meals), metformin 500 mg (three times daily), a combination of Starlix 120 mg (three times daily before meals) and metformin 500 mg (three times daily), or placebo. Baseline HbA_{1C} ranged from 8.3% to 8.4%. Fifty-seven percent of patients were previously untreated with oral antidiabetic therapy. The reductions in mean HbA_{1C} and mean FPG at endpoint with metformin monotherapy were significantly greater than the reductions in these variables with Starlix monotherapy. (See Table 2). Relative to placebo, Starlix monotherapy was associated with significant increases in mean weight whereas metformin monotherapy was associated with significant decreases in mean weight. Among the subset of patients naïve to antidiabetic therapy, the reductions in mean HbA_{1C} and mean FPG for Starlix monotherapy were similar to those for metformin monotherapy (See Table 2). Among the subset of patients previously treated with other antidiabetic agents, primarily glyburide, HbA_{1C} in the Starlix monotherapy group increased slightly from baseline, whereas HbA_{1C} was reduced in the metformin monotherapy group (See Table 2).

Starlix Combination Therapy

Metformin

In another randomized, double-blind, 24-week, active- and placebo-controlled study, patients with Type 2 diabetes were randomized to receive Starlix (120 mg three times daily before meals), metformin 500 mg (three times daily), a combination of Starlix 120 mg (three times daily before meals) and metformin 500 mg (three times daily), or placebo. Baseline HbA_{1C} ranged from 8.3% to 8.4%. Fifty-seven percent of patients were previously untreated with oral antidiabetic therapy. Patients previousily treated with antidiabetic medications were required to discontinue medication for at least 2 months before randomization. The combination of Starlix and metformin resulted in statistically significantly greater reductions in HbA_{1C} and FPG compared to either Starlix or metformin monotherapy (Table 2). Starlix, alone or in combination with metformin, significantly reduced the prandial glucose elevation from pre-meal to 2-hours post-meal compared to placebo and metformin alone.

In this study, one episode of severe hypoglycemia (plasma glucose ≤ 36 mg/dL) was reported in a patient receiving the combination of Starlix and metformin and four episodes of severe hypoglycemia were reported in a single patient in the metformin treatment arm. No patient experienced an episode of hypoglycemia that required third party assistance. Compared to placebo, Starlix monotherapy was associated with a statistically significant increase in weight, while no significant change in weight was observed with combined Starlix and metformin therapy (See Table 2).

In another 24-week, double-blind, placebo-controlled trial, patients with Type 2 diabetes with $HbA_{1C} \geq 6.8\%$ after treatment with metformin (≥ 1500 mg daily for ≥ 1 month) were first entered into a four week run-in period of metformin monotherapy (2000 mg daily) and then randomized to receive Starlix (60 or 120 mg three times daily before meals) or placebo in addition to metformin. Combination therapy with Starlix and metformin was associated with statistically significantly greater reductions in HbA_{1C} compared to metformin monotherapy (-0.4% and –0.6% for Starlix 60 mg and Starlix 120 mg plus metformin, respectively).

Table 2 Endpoint results for 24-week study of Starlix monotherapy and combination with metformin

	Placebo	**Starlix 120 mg three times daily before meals**	**Metformin 500 mg three times daily**	**Starlix 120 mg before meals plus Metformin***
HbA_{1c} (%)				
All	*N=160*	*N=171*	*N=172*	*N=162*
Baseline (mean)	8.3	8.3	8.4	8.4
Change from baseline (mean)	+0.4	-0.4 [bc]	-0.8 [c]	-1.5
Difference from placebo		-0.8 [a]	-1.2 [a]	-1.9 [a]
Naïve	*N=98*	*N=99*	*N=98*	*N=81*
Baseline (mean)	8.2	8.1	8.3	8.2
Change from baseline (mean)	+0.3	-0.7 [c]	-0.8 [c]	-1.6
Difference from placebo		*-1.0* [a]	*-1.1* [a]	*-1.9* [a]
Non-naïve	*N=62*	*N=72*	*N=74*	*N=81*
Baseline (mean)	8.3	8.5	8.7	8.7
Change from baseline (mean)	+0.6	+0.004 [bc]	-0.8 [c]	-1.4
Difference from placebo		-0.6 [a]	-1.4 [a]	-2.0 [a]
FPG (mg/dL)				
All	*N=166*	*N=173*	*N=174*	*N=167*
Baseline (mean)	194.0	196.5	196.0	197.7
Change from baseline (mean)	+8.0	-13.1 [bc]	-30.0 [c]	-44.9
Difference from placebo		-21.1 [a]	-38.0 [a]	-52.9 [a]
Weight (kg)				
All	*N=160*	*N=169*	*N=169*	*N=160*
Baseline (mean)	85.0	85.0	86.0	87.4
Change from baseline (mean)	-0.4	+0.9 [bc]	-0.1	+0.2

Difference from placebo	+1.3 [a]	+0.3	+0.6

[a] p-value ≤ 0.05 vs. placebo.
[b] p-value ≤ 0.03 vs. metformin.
[c] p-value ≤ 0.05 vs. combination.
* Metformin was administered three times daily

Glyburide

In a 12-week study of patients with type 2 diabetes inadequately controlled on glyburide 10 mg once daily, the addition of Starlix (60 mg or 120 mg three times daily before meals) did not produce any additional benefit.

INDICATIONS AND USAGE

Starlix is indicated as monotherapy to lower blood glucose in patients with Type 2 diabetes (non-insulin dependent diabetes mellitus, NIDDM) whose hyperglycemia cannot be adequately controlled by diet and physical exercise and who have not been chronically treated with other anti-diabetic agents.

Starlix is also indicated for use in combination with metformin. In patients whose hyperglycemia is inadequately controlled with metformin, Starlix may be added to, but not substituted for, metformin.

Patients whose hyperglycemia is not adequately controlled with glyburide or other insulin secretagogues should not be switched to Starlix, nor should Starlix be added to their treatment regimen.

CONTRAINDICATIONS

Starlix is contraindicated in patients with:

1. Known hypersensitivity to the drug or its inactive ingredients.
2. Type 1 diabetes.
3. Diabetic ketoacidosis. This condition should be treated with insulin.

PRECAUTIONS

Hypoglycemia: All oral blood glucose lowering drugs that are absorbed systemically are capable of producing hypoglycemia. The frequency of hypoglycemia is related to the severity of the diabetes, the level of glycemic control, and other patient characteristics. Geriatric patients, malnourished patients, and those with adrenal or pituitary insufficiency are more susceptible to the glucose lowering effect of these treatments. The risk of hypoglycemia may be increased by strenuous physical exercise, ingestion of alcohol, insufficient caloric intake on an acute or chronic basis, or combinations with other oral antidiabetic agents. Hypoglycemia may be difficult to recognize in patients with autonomic neuropathy and/or those who use beta-blockers. Starlix should be administered prior to meals to reduce the risk

of hypoglycemia. Patients who skip meals should also skip their scheduled dose of Starlix to reduce the risk of hypoglycemia.

Hepatic impairment: Starlix should be used with caution in patients with moderate to severe liver disease because such patients have not been studied.

Loss of glycemic control

Transient loss of glycemic control may occur with fever, infection, trauma, or surgery. Insulin therapy may be needed instead of Starlix therapy at such times. Secondary failure, or reduced effectiveness of Starlix over a period of time, may occur.

Information for Patients

Patients should be informed of the potential risks and benefits of Starlix and of alternative modes of therapy. The risks and management of hypoglycemia should be explained. Patients should be instructed to take Starlix 1 to 30 minutes before ingesting a meal, but to skip their scheduled dose if they skip the meal so that the risk of hypoglycemia will be reduced. Drug interactions should be discussed with patients. Patients should be informed of potential drug-drug interactions with Starlix.

Laboratory Tests

Response to therapies should be periodically assessed with glucose values and HbA_{1c} levels.

Drug Interactions

In vitro drug metabolism studies indicate that Starlix is predominantly metabolized by the cytochrome p450 isozyme CYP2C9 (70%) and to a lesser extent CYP3A4 (30%). Starlix is a potential inhibitor of the CYP2C9 isoenzyme *in vivo* as indicated by its ability to inhibit the *in vitro* metabolism of tolbutamide. Inhibition of CYP 3A4 metabolic reactions was not detected in *in vitro* experiments.

Glyburide: In a randomized, multiple-dose crossover study, patients with type 2 diabetes were administered 120 mg Starlix three times a day before meals for 1 day in combination with glyburide 10 mg daily. There were no clinically relevant alterations in the pharmacokinetics of either agent.

Metformin: When Starlix 120 mg three times daily before meals was administered in combination with metformin 500 mg three times daily to patients with type 2 diabetes, there were no clinically relevant changes in the pharmacokinetics of either agent.

Digoxin: When Starlix 120 mg before meals was administered in combination with a single 1 mg dose of digoxin to healthy volunteers there were no clinically relevant changes in the pharmacokinetics of either agent.

Warfarin: When healthy subjects were administered Starlix 120 mg three times daily before meals for four days in combination with a single dose of warfarin 30 mg on day 2, there were no alterations in the pharmacokinetics of either agent. Prothrombin time was not affected.

Diclofenac: Administration of morning and lunch doses of Starlix 120 mg in combination with a single 75 mg dose of diclofenac in healthy volunteers resulted in no significant changes to the pharmacokinetics of either agent.

Nateglinide is highly bound to plasma proteins (98 %), mainly albumin. *In vitro* displacement studies with highly protein-bound drugs such as furosemide, propranolol, captopril, nicardipine, pravastatin, glyburide, warfarin, phenytoin, acetylsalicylic acid, tolbutamide, and metformin showed no influence on the extent of nateglinide protein binding. Similarly, Nateglinide had no influence on the serum protein binding of propranolol, glyburide, nicardipine, warfarin, phenytoin, acetylsalicylic acid, and tolbutamide *in vitro*. However, prudent evaluation of individual cases is warranted in the clinical setting.

Certain drugs, including nonsteroidal anti-inflammatory agents (NSAIDs), salicylates, monoamine oxidase inhibitors, and non-selective beta-adrenergic-blocking agents may potentiate the hypoglycemic action of Starlix and other oral antidiabetic drugs.

Certain drugs including thiazides, corticosteroids, thyroid products, and sympathomimetics may reduce the hypoglycemic action of Starlix and other oral antidiabetic drugs.

When these drugs are administered to or withdrawn from patients receiving Starlix, the patient should be observed closely for changes in glycemic control.

Drug/Food Interactions

The pharmacokinetics of nateglinide were not affected by the composition of a meal (high protein, fat, or carbohydrate). However, peak plasma levels were significantly reduced when Starlix was administered 10 minutes prior to a liquid meal. Starlix did not have any effect on gastric emptying in healthy subjects as assessed by acetaminophen testing.

Carcinogenesis/Mutagenesis/Impairment of Fertility

Carcinogenicity: A two-year carcinogenicity study in Sprague Dawley rats was performed with oral doses of nateglinide up to 900 mg/kg/day, which produced AUC exposures in male and female rats approximately 30 and 40 times the human therapeutic exposure respectively with a recommended Starlix dose of 120 mg, three times daily before meals. A two-year carcinogenicity study in B6C3F1 mice was performed with oral doses of nateglinide up to 400 mg/kg/day, which produced AUC exposures in male and female mice approximately 10 and 30 times the human therapeutic exposure with a recommended Starlix dose of 120 mg, three times daily before meals. No evidence of a tumorigenic response was found in either rats or mice.

Mutagenesis: Nateglinide was not genotoxic in the in vitro Ames test, mouse lymphoma assay, chromosome aberration assay in Chinese hamster lung cells, or in the in vivo mouse micronucleus test.

Impairment of Fertility: Fertility was unaffected by administration of nateglinide to rats at doses up to 600 mg/kg (approximately 16 times the human therapeutic exposure with a recommended Starlix dose of 120 mg three times daily before meals.)

Pregnancy

Pregnancy Category C

Nateglinide was not teratogenic in rats at doses up to 1000 mg/kg (approximately 60 times the human therapeutic exposure with a recommended Starlix dose of 120 mg, three times daily before meals). In the rabbit, embryonic development was adversely affected and the incidence of gallbladder agenesis or small gallbladder was increased at a dose of 500 mg/kg (approximately 40 times the human therapeutic exposure with a recommended Starlix dose of 120 mg, three times daily before meals). There are no adequate and well-controlled studies in pregnant women. Starlix should not be used during pregnancy.

Labor and Delivery

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

Nursing Mothers

Studies in lactating rats showed that nateglinide is excreted in the milk; the $AUC_{0\text{-}48h}$ ratio in milk to plasma was approximately 1:4. During the peri-and postnatal period body weights were lower in offspring of rats administered nateglinide at 1000 mg/kg (approximately 60 times the human therapeutic exposure with a recommended Starlix dose of 120 mg, three times daily before meals). It is not known whether Starlix is excreted in human milk. Because many drugs are excreted in human milk, Starlix should not be administered to a nursing woman.

Pediatric Use

The safety and effectiveness of Starlix in pediatric patients have not been established.

Geriatric Use

No differences were observed in safety or efficacy of Starlix between patients age 65 and over, and those under age 65. However, greater sensitivity of some older individuals to Starlix therapy cannot be ruled out.

ADVERSE REACTIONS

In clinical trials, approximately 2400 patients with Type 2 diabetes were treated with Starlix. Of these, approximately 1200 patients were treated for 6 months or longer and approximately 190 patients for one year or longer.

Hypoglycemia was relatively uncommon in all treatment arms of the clinical trials. Only 0.3% of Starlix patients discontinued due to hypoglycemia. Gastrointestinal symptoms, especially diarrhea and nausea, were no more common in patients using the combination of Starlix and metformin than in patients receiving metformin alone. The following table lists events that occurred more frequently in Starlix patients than placebo patients in controlled clinical trials.

Common Adverse Events (≥ 2% in Starlix patients) in Starlix

Monotherapy Trials* *(% of patients)*

	Placebo ***n=458***	***Starlix*** ***n=1441***
Preferred term		
Upper Respiratory Infection	*8.1*	*10.5*
Back pain	*3.7*	*4.0*
Flu symptoms	*2.6*	*3.6*
Dizziness	*2.2*	*3.6*
Arthropathy	*2.2*	*3.3*
Diarrhea	*3.1*	*3.2*
Accidental trauma	*1.7*	*2.9*
Bronchitis	*2.6*	*2.7*
Coughing	*2.2*	*2.4*
Hypoglycemia	*0.4*	*2.4*

Laboratory Abnormalities

Uric acid: There were increases in mean uric acid levels for patients treated with Starlix alone, Starlix in combination with metformin, metformin alone, and glyburide alone. The respective differences from placebo were 0.29 mg/dL, 0.45 mg/dL, 0.28 mg/dL, and 0.19 mg/dL. The clinical significance of these findings is unknown.

OVERDOSAGE

In a clinical study in patients with Type 2 diabetes, Starlix was administered in increasing doses up to 720 mg a day for 7 days and there were no clinically significant adverse events reported. There have been no instances of overdose with Starlix in clinical trials. However, an overdose may result in an exaggerated glucose-lowering effect with the development of hypoglycemic symptoms. Hypoglycemic symptoms without loss of consciousness or neurological findings should be treated with oral glucose and adjustments in dosage and/or meal patterns. Severe hypoglycemic reactions with coma, seizure, or other neurological symptoms should be treated with intravenous glucose. As nateglinide is highly protein bound, dialysis is not an efficient means of removing it from the blood.

DOSAGE AND ADMINISTRATION

Starlix should be taken 1 to 30 minutes prior to meals.

Monotherapy and Combination with metformin

The recommended starting and maintenance dose of Starlix, alone or in combination with metformin, is 120 mg three times daily before meals.

The 60 mg dose of Starlix, either alone or in combination with metformin, may be used in patients who are near goal HbA_{1C} when treatment is initiated.

Dosage in geriatric patients

No special dose adjustments are usually necessary. However, greater sensitivity of some individuals to Starlix therapy cannot be ruled out.

Dosage in renal and hepatic impairment

No dosage adjustment is necessary in patients with mild to severe renal insufficiency or in patients with mild hepatic insufficiency. Dosing of patients with moderate to severe hepatic dysfunction has not been studied. Therefore, Starlix should be used with caution in patients with moderate to severe liver disease (See PRECAUTIONS, Hepatic Impairment).

HOW SUPPLIED

Starlix Tablets, 60 mg

Pink, round, tablet with "STARLIX" debossed on one side and "60" on the other.

Bottles of 100…….. NDC 0078-0351-05

Bottles of 500…….. NDC 0078-0351-08

Starlix Tablets, 120 mg

Yellow, ovaloid, tablet with "STARLIX" debossed on one side and "120" on the other.

Bottles of 100…….. NDC 0078-0352-05

Bottles of 500…….. NDC 0078-0352-08

Storage

Store at 25° C (77° F), excursions permitted to 15-30° C (59-86° F).

Dispense in a tight container, USP.