# EMPOLI®
**(Empagliflozin)**

## 1. NAME OF THE PRODUCT
**EMPOLI®** (Empagliflozin) Tablets 10mg
**EMPOLI®** (Empagliflozin) Tablets 25mg

## 2. QUALITATIVE AND QUANTITATIVE COMPOSITION
**EMPOLI® Tablets 10mg**
Each film coated tablet contains:
Empagliflozin MS……....10mg

**EMPOLI® Tablets 25mg**
Each film coated tablet contains:
Empagliflozin MS……....25mg

## 3. PHARMACEUTICAL FORM
Film coated tablet

**Appearance:**
**EMPOLI® Tablets 10mg:** Light yellow to dark yellow, round shaped film coated tablet, plain on both sides.
**EMPOLI® Tablets 25mg:** Yellow to dark yellow, oval shaped film coated tablet, plain on one side and break line on the other side.

## 4. CLINICAL PARTICULARS
### 4.1. THERAPEUTIC INDICATIONS:
**Type 2 diabetes mellitus:**
**EMPOLI®** is indicated in adults and children aged 10 years and above for the treatment of insufficiently controlled type 2 diabetes mellitus as an adjunct to diet and exercise.

- as monotherapy when metformin is considered inappropriate due to intolerance
- in addition to other medicinal products for the treatment of diabetes

### 4.2. POSOLOGY AND METHOD OF ADMINISTRATION:
**Posology:**
**Type 2 diabetes mellitus:** The recommended starting dose is 10mg **EMPOLI®** once daily for monotherapy and add-on combination therapy with other medicinal products for the treatment of diabetes. In patients tolerating **EMPOLI®** 10mg once daily who have an eGFR ≥60ml/min/1.73m$^2$ and need tighter glycaemic control, the dose can be increased to 25mg once daily. The maximum daily dose is 25mg.

**All indications:** When **EMPOLI**® is used in combination with a sulphonylurea, a lower dose of the sulphonylurea may be considered to reduce the risk of hypoglycemia. If a dose is missed, it should be taken as soon as the patient remembers; however, a double dose should not be taken on the same day.

**Special Population:**
***Renal impairment:*** Due to limited experience, it is not recommended to initiate treatment with **EMPOLI**® in patients with an eGFR < 20ml/min/1.73m$^2$.
***Hepatic impairment:*** No dose adjustment is required for patients with hepatic impairment. **EMPOLI**® exposure is increased in patients with severe hepatic impairment. Therapeutic experience in patients with severe hepatic impairment is limited and therefore not recommended for use in this population.
**Elderly:** No dose adjustment is recommended based on age. In patients 75 years and older, an increased risk for volume depletion should be taken into account.
**Paediatric population:** The recommended starting dose is 10mg **EMPOLI**® once daily. In patients tolerating **EMPOLI**® 10mg once daily and requiring additional glycaemic control, the dose can be increased to 25mg once daily.

**Method of administration:**
The tablets can be taken with or without food, swallowed whole with water.

## 4.3. CONTRAINDICATIONS:
Hypersensitivity to the active substance or to any of the excipients.

## 4.4. SPECIAL WARNINGS AND PRECAUTIONS FOR USE:
**General:** Empagliflozin should not be used in patients with type 1 diabetes mellitus.
**Ketoacidosis:** Cases of ketoacidosis, including life-threatening and fatal cases, have been reported in patients with diabetes mellitus treated with SGLT2 inhibitors, including empagliflozin. In a number of cases, the presentation of the condition was atypical with only moderately increased blood glucose values, below 14mmol/l (250mg/dl). It is not known if ketoacidosis is more likely to occur with higher doses of empagliflozin. Although ketoacidosis is less likely to occur in patients without diabetes mellitus, cases have also been reported in these patients. The risk of ketoacidosis must be considered in the event of non-specific symptoms such as nausea, vomiting, anorexia, abdominal pain, excessive thirst, difficulty breathing, confusion, unusual fatigue or sleepiness. Patients should be assessed for ketoacidosis immediately if these symptoms occur, regardless of blood glucose level. In patients where ketoacidosis is suspected or diagnosed, treatment with empagliflozin should be discontinued immediately. Treatment should be interrupted in patients who are hospitalized for major surgical procedures or acute serious medical illnesses. Monitoring of

ketones is recommended in these patients. Measurement of blood ketone levels is preferred to urine. Treatment with empagliflozin may be restarted when the ketone values are normal and the patient's condition has stabilized. Before initiating empagliflozin, factors in the patient history that may predispose to ketoacidosis should be considered. Patients who may be at higher risk of ketoacidosis include patients with a low beta-cell function reserve (e.g. type 2 diabetes patients with low C-peptide or latent autoimmune diabetes in adults (LADA) or patients with a history of pancreatitis), patients with conditions that lead to restricted food intake or severe dehydration, patients for whom insulin doses are reduced and patients with increased insulin requirements due to acute medical illness, surgery or alcohol abuse. SGLT2 inhibitors should be used with caution in these patients. Restarting SGLT2 inhibitor treatment in patients with previous ketoacidosis while on SGLT2 inhibitor treatment is not recommended, unless another clear precipitating factor is identified and resolved. Empagliflozin should not be used in patients with type 1 diabetes.

**Renal impairment:** Due to limited experience, it is not recommended to initiate treatment with empagliflozin in patients with an eGFR < 20ml/min/1.73m$^2$. In patients with an eGFR < 60ml/min/1.73m$^2$ the daily dose of empagliflozin is 10mg. The glucose lowering efficacy of empagliflozin is dependent on renal function, and is reduced in patients with an eGFR < 45ml/min/1.73m$^2$ and is likely absent in patients with an eGFR < 30ml/min/1.73m$^2$.

***Monitoring of renal function:*** Assessment of renal function is recommended as follows:

- Prior to empagliflozin initiation and periodically during treatment, i.e. at least yearly.
- Prior to initiation of any concomitant medicinal product that may have a negative impact on renal function.

**Risk for volume depletion:** Based on the mode of action of SGLT2 inhibitors, osmotic diuresis accompanying glucosuria may lead to a modest decrease in blood pressure. Therefore, caution should be exercised in patients for whom an empagliflozin induced drop in blood pressure could pose a risk, such as patients with known cardiovascular disease, patients on anti-hypertensive therapy with a history of hypotension or patients aged 75 years and older. In case of conditions that may lead to fluid loss (e.g. gastrointestinal illness), careful monitoring of volume status (e.g. physical examination, blood pressure measurements, laboratory tests including haematocrit) and electrolytes is recommended for patients receiving empagliflozin. Temporary interruption of treatment with empagliflozin should be considered until the fluid loss is corrected.

**Elderly:** The effect of empagliflozin on urinary glucose excretion is associated with osmotic diuresis, which could affect the hydration status. Patients aged 75 years and older may be at an increased risk of volume depletion. A higher

number of these patients treated with empagliflozin had adverse reactions related to volume depletion as compared to placebo. Therefore, special attention should be given to their volume intake in case of co-administered medicinal products which may lead to volume depletion (e.g. diuretics, ACE inhibitors).

**Complicated urinary tract infections:** Cases of complicated urinary tract infections including pyelonephritis and urosepsis have been reported in patients treated with empagliflozin. Temporary interruption of empagliflozin should be considered in patients with complicated urinary tract infections.

**Necrotizing fasciitis of the perineum (Fournier's gangrene):** Cases of necrotizing fasciitis of the perineum, (also known as Fournier's gangrene), have been reported in female and male patients with diabetes mellitus taking SGLT2 inhibitors. This is a rare but serious and potentially life-threatening event that requires urgent surgical intervention and antibiotic treatment. Patients should be advised to seek medical attention if they experience a combination of symptoms of pain, tenderness, erythema, or swelling in the genital or perineal area, with fever or malaise. Be aware that either uro-genital infection or perineal abscess may precede necrotizing fasciitis. If Fournier´s gangrene is suspected, empagliflozin should be discontinued and prompt treatment (including antibiotics and surgical debridement) should be instituted.

**Lower limb amputations:** An increase in cases of lower limb amputation (primarily of the toe) has been observed in long-term clinical studies with another SGLT2 inhibitor. It is unknown whether this constitutes a class effect. Like for all diabetic patients it is important to counsel patients on routine preventative foot-care.

**Hepatic injury:** Cases of hepatic injury have been reported with empagliflozin in clinical trials. A causal relationship between empagliflozin and hepatic injury has not been established.

**Elevated haematocrit:** Haematocrit increase was observed with empagliflozin treatment.

**Chronic kidney disease:** Patients with albuminuria may benefit more from treatment with empagliflozin.

**Infiltrative disease or Takotsubo cardiomyopathy:** Patients with infiltrative disease or with Takotsubo cardiomyopathy have not been specifically studied. Therefore, efficacy in these patients has not been established.

**Urine laboratory assessments:** Due to its mechanism of action, patients taking empagliflozin will test positive for glucose in their urine.

**Interference with 1,5-anhydroglucitol (1,5-AG) assay:** Monitoring glycaemic control with 1,5-AG assay is not recommended as measurements of 1,5-AG are unreliable in assessing glycaemic control in patients taking SGLT2 inhibitors. Use of alternative methods to monitor glycaemic control is advised.

**Lactose:** The tablets contain lactose. Patients with rare hereditary problems of galactose intolerance, total lactase deficiency, or glucose-galactose malabsorption should not take this medicinal product.
**Sodium:** Each tablet contains less than 1 mmol sodium (23mg), that is to say essentially 'sodium free'.

## 4.5. INTERACTION WITH OTHER MEDICINAL PRODUCTS AND OTHER FORM OF INTERACTIONS:

**Pharmacodynamic interactions:**

***Diuretics:*** Empagliflozin may add to the diuretic effect of thiazide and loop diuretics and may increase the risk of dehydration and hypotension.

***Insulin and insulin secretagogues:*** Insulin and insulin secretagogues, such as sulphonylureas, may increase the risk of hypoglycemia. Therefore, a lower dose of insulin or an insulin secretagogue may be required to reduce the risk of hypoglycemia when used in combination with empagliflozin.

**Pharmacokinetic interactions:**

***Effects of other medicinal products on empagliflozin:***

Co-administration of empagliflozin with probenecid, an inhibitor of UGT enzymes and OAT3, resulted in a 26% increase in peak empagliflozin plasma concentrations ($C_{max}$) and a 53% increase in area under the concentration-time curve (AUC). These changes were not considered to be clinically meaningful.

The effect of UGT induction (e.g. induction by rifampicin or phenytoin) on empagliflozin has not been studied. Co-treatment with known inducers of UGT enzymes is not recommended due to a potential risk of decreased efficacy. If an inducer of these UGT enzymes must be co-administered, monitoring of glycemic control to assess response to empagliflozin is appropriate.

An interaction study with gemfibrozil, an in vitro inhibitor of OAT3 and OATP1B1/1B3 transporters, showed that empagliflozin $C_{max}$ increased by 15% and AUC increased by 59% following co-administration. These changes were not considered to be clinically meaningful.

Inhibition of OATP1B1/1B3 transporters by co-administration with rifampicin resulted in a 75% increase in $C_{max}$ and a 35% increase in AUC of empagliflozin. These changes were not considered to be clinically meaningful.

Empagliflozin exposure was similar with and without co-administration with verapamil, a P-gp inhibitor, indicating that inhibition of P-gp does not have any clinically relevant effect on empagliflozin.

Interaction studies suggest that the pharmacokinetics of empagliflozin were not influenced by co-administration with metformin, glimepiride, pioglitazone, sitagliptin, linagliptin, warfarin, verapamil, ramipril, simvastatin, torasemide and hydrochlorothiazide.

***Effects of empagliflozin on other medicinal products:***

Empagliflozin may increase renal lithium excretion and the blood lithium levels may be decreased. Serum concentration of lithium should be monitored more frequently after empagliflozin initiation and dose changes. Please refer the patient to the lithium prescribing doctor in order to monitor serum concentration of lithium.

Empagliflozin does not inhibit, inactivate, or induce CYP450 isoforms. Empagliflozin does not inhibit UGT1A1, UGT1A3, UGT1A8, UGT1A9, or UGT2B7. Drug-drug interactions involving the major CYP450 and UGT isoforms with empagliflozin and concomitantly administered substrates of these enzymes are therefore considered unlikely.

Empagliflozin does not inhibit P-gp at therapeutic doses. Co-administration of digoxin, a P-gp substrate, with empagliflozin resulted in a 6% increase in AUC and 14% increase in $C_{max}$ of digoxin. These changes were not considered to be clinically meaningful.

Empagliflozin does not inhibit human uptake transporters such as OAT3, OATP1B1, and OATP1B3 in vitro at clinically relevant plasma concentrations and, as such, drug-drug interactions with substrates of these uptake transporters are considered unlikely.

**Paediatric population:** Interaction studies have only been performed in adults.

## 4.6. FERTILITY, PREGNANCY AND LACTATION:

**Fertility:** No studies on the effect on human fertility have been conducted for empagliflozin. Animal studies do not indicate direct or indirect harmful effects with respect to fertility.

**Pregnancy:** As a precautionary measure, it is preferable to avoid the use of empagliflozin during pregnancy.

**Breast-feeding:** Empagliflozin should not be used during breast-feeding.

## 4.7. EFFECTS ON ABILITY TO DRIVE AND USE MACHINES:

Empagliflozin has minor influence on the ability to drive and use machines. Patients should be advised to take precautions to avoid hypoglycemia while driving and using machines, in particular when empagliflozin is used in combination with a sulphonylurea and/or insulin.

## 4.8. UNDESIRABLE EFFECTS:

The adverse reactions are listed by absolute frequency. Frequencies are defined as very common (≥1/10), common (≥1/100 to <1/10), uncommon (≥1/1 000 to <1/100), rare (≥1/10 000 to <1/1 000), or very rare (<1/10 000), and not known (cannot be estimated from the available data).

**Infections and infestations:**

***Common:*** Vaginal moniliasis, vulvovaginitis, balanitis and other genital infection, Urinary tract infection (including pyelonephritis and urosepsis)

***Rare:*** Necrotizing fasciitis of the perineum (Fournier´s gangrene)*
**Metabolism and nutrition disorders:**
***Very Common:*** Hypoglycaemia (when used with sulphonylurea or insulin)
***Common:*** Thirst
***Uncommon:*** Ketoacidosis*
**Gastrointestinal disorders:**
***Common:*** Constipation
**Skin and subcutaneous tissue disorders:**
***Common:*** Pruritus (generalized), rash
***Uncommon:*** Urticaria, angioedema
**Vascular disorders**
***Very Common:*** Volume depletion
**Renal and urinary disorders:**
***Common:*** Increased urination
***Uncommon:*** Dysuria
***Very Rare:*** Tubulo-interstitial nephritis
**Investigations:**
***Common:*** Serum lipids increased
***Uncommon:*** Blood creatinine increased/ glomerular filtration rate decreased, haematocrit increased

### 4.9. OVERDOSE:

**Symptoms:** Single doses of up to 800mg empagliflozin and multiple daily doses of up to 100mg empagliflozin in patients with type 2 diabetes did not show any toxicity. Empagliflozin increased urine glucose excretion leading to an increase in urine volume. The observed increase in urine volume was not dose-dependent and is not clinically meaningful. There is no experience with doses above 800mg in humans.

**Therapy:** In the event of an overdose, treatment should be initiated as appropriate to the patient‘s clinical status. The removal of empagliflozin by haemodialysis has not been studied.

## 5. PHARMACOLOGICAL PROPERTIES

### 5.1. PHARMACODYNAMIC PROPERTIES:

**Pharmacotherapeutic group:** Drugs used in diabetes, Sodium-glucose co-transporter 2 (SGLT2) inhibitors.

**ATC code:** A10BK03

**Mechanism of action:**

Empagliflozin is a reversible, highly potent (IC50 of 1.3nmol) and selective competitive inhibitor of sodium-glucose co-transporter 2 (SGLT2). Empagliflozin does not inhibit other glucose transporters important for glucose transport into peripheral tissues and is 5000 times more selective for SGLT2 versus SGLT1, the major transporter responsible for glucose absorption in the

gut. SGLT2 is highly expressed in the kidney, whereas expression in other tissues is absent or very low. It is responsible, as the predominant transporter, for the reabsorption of glucose from the glomerular filtrate back into the circulation. In patients with type 2 diabetes and hyperglycaemia a higher amount of glucose is filtered and reabsorbed.

Empagliflozin improves glycaemic control in patients with type 2 diabetes by reducing renal glucose reabsorption. The amount of glucose removed by the kidney through this glucuretic mechanism is dependent on blood glucose concentration and GFR. Inhibition of SGLT2 in patients with type 2 diabetes and hyperglycaemia leads to excess glucose excretion in the urine. In addition, initiation of empagliflozin increases excretion of sodium resulting in osmotic diuresis and reduced intravascular volume.

In patients with type 2 diabetes, urinary glucose excretion increased immediately following the first dose of empagliflozin and is continuous over the 24-hour dosing interval. Increased urinary glucose excretion was maintained at the end of the 4-week treatment period, averaging approximately 78g/day. Increased urinary glucose excretion resulted in an immediate reduction in plasma glucose levels in patients with type 2 diabetes.

Empagliflozin improves both fasting and post-prandial plasma glucose levels. The mechanism of action of empagliflozin is independent of beta cell function and insulin pathway and this contribute to a low risk of hypoglycaemia. Improvement of surrogate markers of beta cell function including Homeostasis Model Assessment-β (HOMA-β) was noted. In addition, urinary glucose excretion triggers calorie loss, associated with body fat loss and body weight reduction. The glucosuria observed with empagliflozin is accompanied by diuresis which may contribute to sustained and moderate reduction of blood pressure.

Empagliflozin also reduces sodium reabsorption and increases the delivery of sodium to the distal tubule. This may influence several physiological functions including, but not restricted to: increasing tubuloglomerular feedback and reducing intraglomerular pressure, lowering both pre- and afterload of the heart, downregulating of sympathetic activity and reducing left ventricular wall stress as evidenced by lower NT-proBNP values which may have beneficial effects on cardiac remodeling, filling pressures and diastolic function as well as preserving kidney structure and function. Other effects such as an increase in haematocrit, a reduction in body weight and blood pressure may further contribute to the beneficial cardiac and renal effects.

## 5.2. PHARMACOKINETICS PROPERTIES:

**Absorption:** After oral administration, empagliflozin was rapidly absorbed with peak plasma concentrations occurring at a median $t_{max}$ of 1.5 hours post-dose. Thereafter, plasma concentrations declined in a biphasic manner with a rapid distribution phase and a relatively slow terminal phase. The steady state mean

plasma AUC and $C_{max}$ were 1870nmol.h/l and 259nmol/l with empagliflozin 10mg and 4740nmol.h/l and 687nmol/l with empagliflozin 25mg once daily. Systemic exposure of empagliflozin increased in a dose proportional manner. The single-dose and steady-state pharmacokinetic parameters of empagliflozin were similar suggesting linear pharmacokinetics with respect to time. There were no clinically relevant differences in empagliflozin pharmacokinetics between healthy volunteers and patients with type 2 diabetes. Administration of empagliflozin 25mg after intake of a high-fat and high calorie meal resulted in slightly lower exposure; AUC decreased by approximately 16% and $C_{max}$ by approximately 37% compared to fasted condition. The observed effect of food on empagliflozin pharmacokinetics was not considered clinically relevant and empagliflozin may be administered with or without food.

**Distribution:** The apparent steady-state volume of distribution was estimated to be 73.8L based on the population pharmacokinetic analysis. Following administration of an oral [$^{14}$C]- empagliflozin solution to healthy volunteers, the red blood cell partitioning was approximately 37% and plasma protein binding was 86%.

**Metabolism:** No major metabolites of empagliflozin were detected in human plasma and the most abundant metabolites were three glucuronide conjugates (2-, 3-, and 6-O glucuronide). Systemic exposure of each metabolite was less than 10% of total drug related material. In vitro studies suggested that the primary route of metabolism of empagliflozin in humans is glucuronidation by the uridine 5'-diphosphoglucuronosyltransferases UGT2B7, UGT1A3, UGT1A8, and UGT1A.

**Elimination:** Based on the population pharmacokinetic analysis, the apparent terminal elimination half-life of empagliflozin was estimated to be 12.4 hours and apparent oral clearance was 10.6 l/hour.

## 5.3. PRECLINICAL SAFETY DATA:

Non-clinical data reveal no special hazard for humans based on conventional studies of safety pharmacology, genotoxicity, fertility and early embryonic development.

In long term toxicity studies in rodents and dogs, signs of toxicity were observed at exposures greater than or equal to 10-times the clinical dose of empagliflozin. Most toxicity was consistent with secondary pharmacology related to urinary glucose loss and electrolyte imbalances including decreased body weight and body fat, increased food consumption, diarrhoea, dehydration, decreased serum glucose and increases in other serum parameters reflective of increased protein metabolism and gluconeogenesis, urinary changes such as polyuria and glucosuria, and microscopic changes including mineralization in kidney and some soft and vascular tissues. Microscopic evidence of the effects of exaggerated pharmacology on the kidney observed in some species included tubular dilatation, and tubular and pelvic mineralization at approximately 4-

times the clinical AUC exposure of empagliflozin associated with the 25mg dose.

Empagliflozin is not genotoxic.

In a 2-year carcinogenicity study, empagliflozin did not increase the incidence of tumors in female rats up to the highest dose of 700mg/kg/day, which corresponds to approximately 72-times the maximal clinical AUC exposure to empagliflozin. In male rats, treatment-related benign vascular proliferative lesions (hemangiomas) of the mesenteric lymph node were observed at the highest dose, but not at 300mg/kg/day, which corresponds to approximately 26-times the maximal clinical exposure to empagliflozin. Interstitial cell tumors in the testes were observed with a higher incidence in rats at 300mg/kg/day and above, but not at 100mg/kg/day which corresponds to approximately 18-times the maximal clinical exposure to empagliflozin. Both tumors are common in rats and are unlikely to be relevant to humans.

Empagliflozin did not increase the incidence of tumors in female mice at doses up to 1000mg/kg/day, which corresponds to approximately 62-times the maximal clinical exposure to empagliflozin. Empagliflozin induced renal tumors in male mice at 1000mg/kg/day, but not at 300mg/kg/day, which corresponds to approximately 11- times the maximal clinical exposure to empagliflozin. The mode of action for these tumors is dependent on the natural predisposition of the male mouse to renal pathology and a metabolic pathway not reflective of humans. The male mouse renal tumors are considered not relevant to humans.

At exposures sufficiently in excess of exposure in humans after therapeutic doses, empagliflozin had no adverse effects on fertility or early embryonic development. Empagliflozin administered during the period of organogenesis was not teratogenic. Only at maternally toxic doses, empagliflozin also caused bent limb bones in the rat and increased embryofetal loss in the rabbit.

In pre- and postnatal toxicity studies in rats, reduced weight gain of offspring was observed at maternal exposures approximately 4-times the maximal clinical exposure to empagliflozin. No such effect was seen at systemic exposure equal to the maximal clinical exposure to empagliflozin. The relevance of this finding to humans is unclear.

In a juvenile toxicity study in the rat, when empagliflozin was administered from postnatal day 21 until postnatal day 90, non-adverse, minimal to mild renal tubular and pelvic dilation in juvenile rats was seen only at 100mg/kg/day, which approximates 11-times the maximum clinical dose of 25mg. These findings were absent after a 13 weeks drug-free recovery period.

# 6. PHARMACEUTICAL PARTICULARS

## 6.1. LIST OF EXCIPIENTS:

**EMPOLI® Tablets 10mg:**

- Lactose Monohydrate
- Microcrystalline Cellulose

- Hydroxypropyl Cellulose
- Croscarmellose Sodium
- Silicon Dioxide
- Magnesium Stearate
- Purified Water
- Sheffcoat White
- Yellow Iron Oxide Color

**EMPOLI® Tablets 25mg:**

- Lactose Monohydrate
- Microcrystalline Cellulose
- Hydroxypropyl Cellulose
- Croscarmellose Sodium
- Silicon Dioxide
- Magnesium Stearate
- Purified Water
- Sheffcoat White
- Yellow Iron Oxide Color

**6.2. INCOMPATIBILITIES:**

Not applicable

**6.3. SHELF LIFE:**

See expiry on the pack.

**6.4. SPECIAL PRECAUTIONS FOR STORAGE:**

Avoid exposure to heat light and humidity. Store between 15 to 30°C.
Improper storage may deteriorate the medicine.
Keep out of reach of children.

**6.5. NATURE AND CONTENTS OF CONTAINER:**

**EMPOLI® Tablets 10mg:** Alu/Alu Blister, pack size is 14's.
**EMPOLI® Tablets 25mg:** Alu/Alu Blister, pack size is 14's.

**6.6. SPECIAL PRECAUTIONS FOR DISPOSAL OF A USED PRODUCT:**

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

**6.7. DRUG PRODUCT SPECIFICATIONS:**

**EMPOLI® Tablets 10mg:** Innovator's Specs.
**EMPOLI® Tablets 25mg:** Innovator's Specs.

## 7. REGISTRATION / MARKETING AUTHORISATION HOLDER

Manufactured by:
**SAMI Pharmaceuticals (Pvt.) Ltd.**
F-95, Off Hub River Road, S.I.T.E., Karachi-Pakistan
www.samipharma.com
Mfg Lic. No. 000072

## 8. REGISTRATION / MARKETING AUTHORISATION NUMBER(S)

**EMPOLI® Tablets 10mg:** 098702
**EMPOLI® Tablets 25mg:** 098701

## 9. DATE OF FIRST AUTHORISATION / RENEWAL OF THE AUTHORISATION

**EMPOLI® Tablets 10mg:** 10th October, 2019
**EMPOLI® Tablets 25mg:** 10th October, 2019

## 10. DATE OF REVISION OF THE TEXT

# اِمپولی ٹیبلٹ

## (امپیگلیفلوزِن)

### ہدایات:

خوراک ڈاکٹر کی ہدایت کے مطابق استعمال کریں۔

صرف رجسٹرڈ ڈاکٹر کے نسخے کے مطابق فروخت کریں۔

بچوں کی پہنچ سے دور رکھیں۔

دوا کو گرمی، روشنی اور نمی سے محفوظ ۱۵ سے ۳۰ ڈگری سینٹی گریڈ کے درمیان میں رکھیں ورنہ دوا خراب ہو جائیگی۔