

# Summary of Product Characteristics

## 1 NAME OF THE MEDICINAL PRODUCT

Diaclide MR 60 mg modified-release tablets

## 2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet contains 60 mg of gliclazide.

For the full list of excipients, see section 6.1.

## 3 PHARMACEUTICAL FORM

Modified-release tablet

A white to offwhite, oblong biconvex tablet, debossed with M on left side of the breakline on one side and GL on left side of the breakline, 60 on the right side of the breakline on another side.

The tablet can be divided into equal doses.

## 4 CLINICAL PARTICULARS

### 4.1 Therapeutic indications

Diaclide MR is indicated for non insulin-dependent diabetes (type 2) in adults when dietary measures, physical exercise and weight loss alone are not sufficient to control blood glucose.

### 4.2 Posology and method of administration

#### Posology

The daily dose of Diaclide MR may vary from one half to 2 tablets per day, *i.e.* from 30 to 120 mg taken orally in a single intake at breakfast time.

It is recommended to swallow the dose without crushing or chewing.

If a dose is forgotten, there must be no increase in the dose taken the next day.

As with any hypoglycaemic agent, the dose should be adjusted according to the individual patient's metabolic response (blood glucose, HbA1c).

#### Initial dose

The recommended starting dose is 30 mg daily (half a tablet of Diaclide MR). If blood glucose is effectively controlled, this dose may be used for maintenance treatment.

If blood glucose is not adequately controlled, the dose may be increased to 60, 90 or 120 mg daily, in successive steps. The interval between each dose increment should be at least 1 month except in patients whose blood glucose has not reduced after two weeks of treatment. In such cases, the dose may be increased at the end of the second week of treatment.

The maximum recommended daily dose is 120 mg.

One gliclazide 60 mg modified release tablet is equivalent to two gliclazide 30 mg modified release tablets. The breakability of Diaclide MR enables flexibility of dosing to be achieved.

Switching from gliclazide 80 mg tablets to gliclazide 60 mg modified release tablets:

One tablet of gliclazide 80 mg is comparable to 30 mg of the modified release formulation (i.e. half a tablet of Diaclide MR). Consequently the switch can be performed with careful blood monitoring.

Switching from another oral antidiabetic agent to gliclazide 60 mg modified release tablets:

Diaclide MR can be used to replace other oral antidiabetic agents.

The dosage and the half-life of the previous antidiabetic agent should be taken into account when switching to Diaclide MR.

A transitional period is not generally necessary. A starting dose of 30 mg should be used and this should be adjusted to suit the patient's blood glucose response, as described above.

When switching from a hypoglycaemic sulfonylurea with a prolonged half-life, a treatment free period of a few days may be necessary to avoid an additive effect of the two products, which might cause hypoglycaemia. The procedure described for initiating treatment should also be used when switching to treatment with Diaclide MR, i.e. a starting dose of 30 mg/day, followed by a stepwise increase in dose, depending on the metabolic response.

Combination treatment with other antidiabetic agents:

Diaclide MR can be given in combination with biguanides, alpha glucosidase inhibitors or insulin.

In patients not adequately controlled with gliclazide 60 mg modified release tablets, concomitant insulin therapy can be initiated under close medical supervision.

Special populations

*Elderly*

Diaclide MR should be prescribed using the same dosing regimen recommended for patients under 65 years of age.

*Renal impairment*

In patients with mild to moderate renal insufficiency, the same dosing regimen can be used as in patients with normal renal function with careful patient monitoring. These data have been confirmed in clinical trials.

*Patients at risk of hypoglycaemia:*

- undernourished or malnourished,
- severe or poorly compensated endocrine disorders (hypopituitarism, hypothyroidism, adrenocorticotrophic insufficiency),
- withdrawal of prolonged and/or high dose corticosteroid therapy,
- severe vascular disease (severe coronary heart disease, severe carotid impairment, diffuse vascular disease);

It is recommended that the minimum daily starting dose of 30 mg is used.

*Paediatric population*

The safety and efficacy of gliclazide modified release tablets in children and adolescents have not been established. No data are available.

Method of administration

For oral use.

### **4.3 Contraindications**

- Hypersensitivity to the active substance, other sulfonylurea and sulfonamides or to any of the excipients listed in section 6.1
- Type 1 diabetes
- Diabetic pre-coma and coma, diabetic keto-acidosis
- Severe renal or hepatic insufficiency: in these cases the use of insulin is recommended
- Treatment with miconazole (see section 4.5)
- Breast-feeding (see section 4.6).

#### 4.4 Special warnings and precautions for use

##### Hypoglycaemia:

This treatment should be prescribed only if the patient is likely to have a regular food intake (including breakfast). It is important to have a regular carbohydrate intake due to the increased risk of hypoglycaemia if a meal is taken late, if an inadequate amount of food is consumed or if the food is low in carbohydrate. Hypoglycaemia is more likely to occur during low-calorie diets, following prolonged or strenuous exercise, alcohol intake or if a combination of hypoglycaemic agents is being used.

Hypoglycaemia may occur following administration of sulfonylurea (see section 4.8.). Some cases may be severe and prolonged. Hospitalisation may be necessary and glucose administration may need to be continued for several days.

Careful selection of patients, of the dose used, and clear patient directions are necessary to reduce the risk of hypoglycaemic episodes.

Factors which increase the risk of hypoglycaemia:

- patient refuses or (particularly in elderly subjects) is unable to co-operate
- malnutrition, irregular mealtimes, skipping meals, periods of fasting or dietary changes
- imbalance between physical exercise and carbohydrate intake
- renal insufficiency
- severe hepatic insufficiency
- overdose of Diaclide MR
- certain endocrine disorders: thyroid disorders, hypopituitarism and adrenal insufficiency
- concomitant administration of certain other medicinal products (see section 4.5)

##### Renal and hepatic insufficiency:

The pharmacokinetics and/or pharmacodynamics of gliclazide may be altered in patients with hepatic insufficiency or severe renal failure. A hypoglycaemic episode occurring in these patients may be prolonged, so appropriate management should be initiated.

##### Patient information:

The risks of hypoglycaemia, together with its symptoms (see section 4.8), treatment, and conditions that predispose to its development, should be explained to the patient and to family members.

The patient should be informed of the importance of following dietary advice, of taking regular exercise, and of regular monitoring of blood glucose levels.

##### Poor blood glucose control:

Blood glucose control in a patient receiving antidiabetic treatment may be affected by any of the following: St John's wort (*Hypericum perforatum*) preparations (see section 4.5), fever, trauma, infection or surgical intervention. In some cases, it may be necessary to administer insulin.

The hypoglycaemic efficacy of any oral antidiabetic agent, including gliclazide, is attenuated over time in many patients: this may be due to progression in the severity of the diabetes, or to a reduced response to treatment. This phenomenon is known as secondary failure which is distinct from primary failure, when an active substance is ineffective as first-line treatment. Adequate dose adjustment and dietary compliance should be considered before classifying the patient as secondary failure.

##### Dysglycaemia

Disturbances in blood glucose, including hypoglycaemia and hyperglycaemia have been reported, in diabetic patients receiving concomitant treatment with fluoroquinolones, especially in elderly patients. Indeed, careful monitoring of blood glucose is recommended in all patients receiving at the same time gliclazide modified release tablets and a fluoroquinolone.

Laboratory tests:

Measurement of glycated haemoglobin levels (or fasting venous plasma glucose) is recommended in assessing blood glucose control. Blood glucose self-monitoring may also be useful.

Treatment of patients with G6PD-deficiency with sulfonylurea agents can lead to haemolytic anaemia. Since gliclazide belongs to the chemical class of sulfonylurea drugs, caution should be used in patients with G6PD-deficiency and a non-sulfonylurea alternative should be considered.

Porphyric patients:

Cases of acute porphyria have been described with some other sulfonylurea drugs, in patients who have porphyria.

**4.5 Interaction with other medicinal products and other forms of interaction**

The following products are likely to increase the risk of hypoglycaemia

*Contra-indicated combination*

- **Miconazole** (systemic route, oromucosal gel): increases the hypoglycaemic effect with possible onset of hypoglycaemic symptoms, or even coma.

*Combinations which are not recommended*

- **Phenylbutazone** (systemic route): increases the hypoglycaemic effect of sulfonylurea (displaces their binding to plasma proteins and/or reduces their elimination).

It is preferable to use a different anti-inflammatory agent, or else to warn the patient and emphasise the importance of self-monitoring. Where necessary, adjust the dose during and after treatment with the anti-inflammatory agent.

- **Alcohol:** increases the hypoglycaemic reaction (by inhibiting compensatory reactions) that can lead to the onset of hypoglycaemic coma.

Alcohol or medicinal products containing alcohol should be avoided.

*Combinations requiring precautions for use*

Potential of the blood glucose lowering effect and thus, in some instances, hypoglycaemia may occur when one of the following drugs is taken:

- Other antidiabetic agents (insulins, acarbose, metformin, thiazolidinediones, dipeptidyl peptidase-4 inhibitors, GLP-1 receptor agonists), beta-blockers, fluconazole, angiotensin converting enzyme inhibitors (captopril, enalapril), H<sub>2</sub>-receptor antagonists, MAOIs, sulfonamides, clarithromycin and nonsteroidal anti-inflammatory agents.

The following products may cause an increase in blood glucose levels

*Combination which is not recommended*

- **Danazol:** diabetogenic effect of danazol.

If the use of this active substance cannot be avoided, warn the patient and emphasise the importance of urine and blood glucose monitoring. It may be necessary to adjust the dose of the antidiabetic agent during and after treatment with danazol.

*Combinations requiring precautions during use*

- **Chlorpromazine** (neuroleptic agent): high doses (> 100 mg per day of chlorpromazine) increase blood glucose levels (reduced insulin release).

Warn the patient and emphasise the importance of blood glucose monitoring. It may be necessary to adjust the dose of the antidiabetic active substance during and after treatment with the neuroleptic agent.

- **Glucocorticoids** (systemic and local route: intra-articular, cutaneous and rectal preparations) **and tetracosactrin**: increase in blood glucose levels with possible ketosis (reduced tolerance to carbohydrates due to glucocorticoids).

Warn the patient and emphasise the importance of blood glucose monitoring, particularly at the start of treatment. It may be necessary to adjust the dose of the antidiabetic active substance during and after treatment with glucocorticoids.

- **Ritodrine, salbutamol, terbutaline** (I.V.): increased blood glucose levels due to beta-2 agonist effects.

Emphasise the importance of monitoring blood glucose levels. If necessary, switch to insulin.

- **St John's wort (*Hypericum perforatum*) preparations:**

Gliclazide exposure is decreased by St John's wort – *Hypericum perforatum*. Emphasize the importance of blood glucose levels monitoring.

The following products may cause dysglycaemia

*Combinations requiring precautions during use*

- **Fluoroquinolones**: in case of a concomitant use of gliclazide modified release tablets and a fluoroquinolone, the patient should be warned of the risk of dysglycaemia, and the importance of blood glucose monitoring should be emphasized.

Combination which must be taken into account

- **Anticoagulant therapy** (e.g. warfarin ...): Sulfonylureas may lead to potentiation of anticoagulation during concurrent treatment.

Adjustment of the anticoagulant may be necessary.

#### **4.6 Fertility, pregnancy and lactation**

##### Pregnancy

There is no or limited amount of data (less than 300 pregnancy outcomes) from the use of gliclazide in pregnant women, even though there are few data with other sulfonylurea.

In animal studies, gliclazide is not teratogenic (see section 5.3).

As a precautionary measure, it is preferable to avoid the use of gliclazide during pregnancy.

Control of diabetes should be obtained before the time of conception to reduce the risk of congenital abnormalities linked to uncontrolled diabetes.

Oral hypoglycaemic agents are not suitable; insulin is the drug of first choice for treatment of diabetes during pregnancy. It is recommended that oral hypoglycaemic therapy is changed to insulin before a pregnancy is attempted, or as soon as pregnancy is discovered.

##### Breast-feeding

It is unknown whether gliclazide or its metabolites are excreted in human milk. Given the risk of neonatal hypoglycaemia, the product is therefore contra-indicated in breast-feeding mother. A risk to the newborns/infants cannot be excluded.

##### Fertility

No effect on fertility or reproductive performance was noted in male and female rats (see section 5.3).

#### **4.7 Effects on ability to drive and use machines**

Gliclazide modified release tablets have no or negligible influence on the ability to drive and use machines. However, patients should be made aware of the symptoms of hypoglycaemia and should be careful if driving or operating machinery, especially at the beginning of treatment.

#### **4.8 Undesirable effects**

Based on the experience with gliclazide, the following undesirable effects have been reported.

The most frequent adverse reaction with gliclazide is hypoglycaemia

As for other sulfonylureas, treatment with Diaclide MR can cause hypoglycaemia, if meal times are irregular and, in particular, if meals are skipped. Possible symptoms of hypoglycaemia are: headache, intense hunger, nausea, vomiting, lassitude, sleep disorders, agitation, aggression, poor concentration, reduced awareness and slowed reactions, depression, confusion, visual and speech disorders, aphasia, tremor, paresis, sensory disorders, dizziness, feeling of powerlessness, loss of self-control, delirium, convulsions, shallow respiration, bradycardia, drowsiness and loss of consciousness, possibly resulting in coma and lethal outcome.

In addition, signs of adrenergic counter-regulation may be observed: sweating, clammy skin, anxiety, tachycardia, hypertension, palpitations, angina pectoris and cardiac arrhythmia.

Usually, symptoms disappear after intake of carbohydrates (sugar). However, artificial sweeteners have no effect. Experience with other sulfonylurea shows that hypoglycaemia can recur even when measures prove effective initially.

If a hypoglycaemic episode is severe or prolonged, and even if it is temporarily controlled by intake of sugar, immediate medical treatment or even hospitalisation is required.

#### Other undesirable effects:

*Gastrointestinal disorders:* abdominal pain, nausea, vomiting, dyspepsia, diarrhoea, and constipation have been reported. If these should occur they can be avoided or minimised if gliclazide is taken with breakfast.

The following undesirable effects have been more rarely reported:

*Skin and subcutaneous tissue disorders:* rash, pruritus, urticaria, angioedema, erythema, maculopapular rashes, bullous reactions (such as Stevens-Johnson syndrome and toxic epidermal necrolysis and autoimmune bullous disorders), and exceptionally, drug rash with eosinophilia and systemic symptoms (DRESS).

*Blood and lymphatic system disorders:* Changes in haematology are rare. They may include anaemia, leucopenia, thrombocytopenia, granulocytopenia. These are in general reversible upon discontinuation of medication.

*Hepatobiliary disorders:* raised hepatic enzyme levels (AST, ALT, alkaline phosphatase), hepatitis (isolated reports). Discontinue treatment if cholestatic jaundice appears.

These symptoms usually disappear after discontinuation of treatment.

*Eye disorders:* Transient visual disturbances may occur especially on initiation of treatment, due to changes in blood glucose levels.

*Class attribution effects:* As for other sulfonylureas, the following adverse events have been observed: cases of erythrocytopenia, agranulocytosis, haemolytic anaemia, pancytopenia, allergic vasculitis, hyponatraemia, elevated liver enzyme levels and even impairment of liver function (e.g. with cholestasis and jaundice) and hepatitis which regressed after withdrawal of the sulfonylurea or led to life-threatening liver failure in isolated cases.

#### Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via HPRA Pharmacovigilance. Website: [www.hpra.ie](http://www.hpra.ie).

## **4.9 Overdose**

An overdose of sulfonylurea may cause hypoglycaemia.

Moderate symptoms of hypoglycaemia, without any loss of consciousness or neurological signs, must be corrected by carbohydrate intake, dose adjustment and/or change of diet. Strict monitoring should be continued until the doctor is sure that the patient is out of danger.

Severe hypoglycaemic reactions, with coma, convulsions or other neurological disorders are possible and must be treated as a medical emergency, requiring immediate hospitalisation.

If hypoglycaemic coma is diagnosed or suspected, the patient should be given a rapid I.V. injection of 50 mL of concentrated glucose solution (20 to 30 %). This should be followed by continuous infusion of a more dilute glucose solution (10 %) at a rate that will maintain blood glucose levels above 1 g/L. Patients should be monitored closely and, depending on the patient's condition after this time, the doctor will decide if further monitoring is necessary.

Dialysis is of no benefit to patients due to the strong binding of gliclazide to proteins.

## 5 PHARMACOLOGICAL PROPERTIES

### 5.1 Pharmacodynamic properties

Pharmacotherapeutic group: blood glucose lowering drugs, excl. insulins, sulfonamides, urea derivatives, ATC code: A10BB09

#### Mechanism of action

Gliclazide is a hypoglycaemic sulfonyleurea oral anti-diabetic active substance differing from other related compounds by an N-containing heterocyclic ring with an endocyclic bond.

Gliclazide reduces blood glucose levels by stimulating insulin secretion from the  $\beta$ -cells of the islets of Langerhans. Increase in postprandial insulin and C-peptide secretion persists after two years of treatment.

In addition to these metabolic properties, gliclazide has haemovascular properties.

#### Pharmacodynamic effects

##### Effects on insulin release

In type 2 diabetics, gliclazide restores the first peak of insulin secretion in response to glucose and increases the second phase of insulin secretion. A significant increase in insulin response is seen in response to stimulation induced by a meal or glucose.

##### Haemovascular properties:

Gliclazide decreases microthrombosis by two mechanisms which may be involved in complications of diabetes:

- a partial inhibition of platelet aggregation and adhesion, with a decrease in the markers of platelet activation (beta thromboglobulin, thromboxane B<sub>2</sub>).
- an action on the vascular endothelium fibrinolytic activity with an increase in tPA activity.

### 5.2 Pharmacokinetic properties

#### Absorption

Plasma levels increase progressively during the first 6 hours, reaching a plateau which is maintained from the sixth to the twelfth hour after administration.

Intra-individual variability is low.

Gliclazide is completely absorbed. Food intake does not affect the rate or degree of absorption.

#### Distribution

Plasma protein binding is approximately 95%. The volume of distribution is around 30 litres.

A single daily intake of gliclazide modified release tablets maintains effective gliclazide plasma concentrations over 24 hours.

#### Biotransformation

Gliclazide is mainly metabolised in the liver and excreted in the urine: less than 1% of the unchanged form is found in the urine. No active metabolites have been detected in plasma.

#### Elimination

The elimination half-life of gliclazide varies between 12 and 20 hours.

#### Linearity/non-linearity

The relationship between the dose administered ranging up to 120 mg and the area under the concentration time curve is linear.

#### Special populations

##### *Elderly*

No clinically significant changes in pharmacokinetic parameters have been observed in elderly patients.

### **5.3 Preclinical safety data**

Preclinical data reveal no special hazards for humans based on conventional studies of repeated dose toxicity and genotoxicity. Long term carcinogenicity studies have not been done. No teratogenic changes have been shown in animal studies, but lower foetal body weight was observed in animals receiving doses 25 fold higher than the maximum recommended dose in humans. Fertility and reproductive performance were unaffected after gliclazide administration in animal studies.

## **6 PHARMACEUTICAL PARTICULARS**

### **6.1 List of excipients**

Hypromellose  
Cellulose, microcrystalline  
Magnesium stearate

### **6.2 Incompatibilities**

Not applicable.

### **6.3 Shelf life**

Blisters: 3 years  
Bottles: 3 years  
In use for bottles: Use within 100 days of opening

### **6.4 Special precautions for storage**

This medicinal product does not require any special storage conditions.

### **6.5 Nature and contents of container**

Clear PVC/PE/PVdC blister packs in cardboard cartons containing 10, 30, 30x1 (unit dose), 60, 90, 90x1 (unit dose) tablets. HDPE bottle with opaque polypropylene (PP) cap with desiccant containing silica gel or desiccant containing silica gel and absorbent cotton containing 30, 60, 90, 100 tablets.  
Not all pack sizes may be marketed.

### **6.6 Special precautions for disposal**

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



**7 MARKETING AUTHORISATION HOLDER**

McDermott Laboratories Ltd., T/A Gerard Laboratories  
35/36 Baldoyle Industrial Estate  
Grange Road  
Dublin 13  
Ireland

**8 MARKETING AUTHORISATION NUMBER**

PA0577/030/003

**9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION**

Date of first authorisation: 13<sup>th</sup> February 2015.  
Date of last renewal: 23<sup>rd</sup> December 2019.

**10 DATE OF REVISION OF THE TEXT**

December 2022