120x320mm

Diajard Forte XR™

(Empagliflozin+Linagliptin+Metformin HCl)

Highnoon

COMPOSITION
Diajard Forte XR 5mg/2.5mg/1000mg Tablet:
Each Film-coated extended-release tablet contains:
Empagliflozin 5mg. Linagliptin 2.5mg.
(as immediate release coating)
Metformin HCl (as extended-release core) 1000mg

Diajard Forte XR 10mg/5mg/1000mg Tablet:
Each Film-coated extended-release tablet contains:
Empagliflozin 10mg. Linagliptin 5mg.
(as immediate release coating)
Metformin HCl (as extended-release core) 1000mg

Diajard Forte XR 12.5mg/2.5mg/1000mg Tablet:
Each Film-coated extended-release tablet contains:
Empagliflozin 12.5mg. Linagliptin 2.5mg.
(as immediate release coating)
Metformin HCl (as extended-release core) 1000mg

Diajard Forte XR 25mg/5mg/1000mg Tablet:
Each Film-coated extended-release tablet contains:
Empagliflozin 25mg. Linagliptin 5mg.
(as immediate release coating)
Metformin HCl (as extended-release core) 1000mg

DESCRIPTION
Tablets for oral use contain: empagliflozin, linagliptin, and metformin hydrochloride. Metformin is extended-release, empagliflozin and linagliptin are immediate-release drug substances. Empagliflozin is an inhibitor of the sodium-glucose co-transporter 2 (SGLT2). Linagliptin is an inhibitor of the dipeptidyl peptidase-4 (DPP-4) enzyme. Metformin hydrochloride is a biguanide.

MECHANISM OF ACTION
Empagliflozin
Empagliflozin is an inhibitor of the sodium-glucose co-transporter 2 (SGLT2), the predominant transporter responsible for reabsorption of glucose from the glomerular filtrate back into the circulation. By inhibiting SGLT2, empagliflozin reduces renal reabsorption of filtered glucose and lowers the renal threshold for glucose, and thereby increases urinary glucose excretion.

Linagliptin
Linagliptin is an inhibitor of DPP-4, an enzyme that degrades the incretin hormones glucagon-like peptide-1 (GLP-1) and glucose-dependent insulinotropic polypeptide (GIP). Thus, linagliptin increases the concentrations of active incretin hormones, stimulating the release of insulin in a glucose-dependent manner and decreasing the levels of glucagon in the circulation. Both incretin hormones are involved in the physiological regulation of glucose homeostasis. Incretin hormones are secreted at a low basal level throughout the day and levels rise immediately after meal intake. GLP-1 and GIP increase insulin biosynthesis and secretion from pancreatic beta cells in the presence of normal and elevated blood glucose levels. Furthermore, GLP-1 also reduces glucagon secretion from pancreatic alpha cells, resulting in a reduction in hepatic glucose output.

Metformin HCl
Metformin is an antihyperglycemic agent which improves glucose tolerance in patients with type 2 diabetes mellitus, lowering both basal and postprandial plasma glucose. Metformin decreases hepatic glucose production, decreases intestinal absorption of glucose, and improves insulin sensitivity by increasing peripheral glucose uptake and utilization. With metformin therapy, insulin secretion remains unchanged while fasting insulin levels and day-long plasma insulin response may decrease.

PHARMACOKINETICS
Empagliflozin
After oral administration, peak plasma concentrations of empagliflozin were reached at 1.5 hours post-dose. Plasma concentrations declined in a biphasic manner with a rapid distribution phase and a relatively slow terminal phase. Plasma protein binding was 86.2%. No major metabolites of empagliflozin were detected in human plasma and the most abundant metabolites were three glucuronide conjugates. The primary route of metabolism of empagliflozin in humans is glucuronidation by the uridine 5'-diphospho-glucuronosyltransferases UGT2B7, UGT1A3, UGT1A8, and UGT1A9. The apparent terminal elimination half-life of empagliflozin was estimated to be 12.4 hours. The majority of drug-related radioactivity recovered in feces was unchanged parent drug and approximately half of drug-related radioactivity excreted in urine was unchanged parent drug. It may be administered with or without food.

Linagliptin
Linagliptin has non-linear pharmacokinetic because of high-affinity saturable binding to dipeptidyl peptidase-4 (DPP-4) in plasma and tissue. It is rapidly absorbed from gastrointestinal tract, and peak plasma concentration occur with in about 1.5 hours. The absolute bioavailability is about 30%. The mean apparent volume of linagliptin after an intravenous dose is about 1110 litres indicating that linagliptin is extensively distributed to the tissues. Plasma protein binding of linagliptin is concentration dependent; at low concentration it is 99% bound, but at high concentrations when DPP-4 is fully saturated, 70 to 80% is bound to other plasma proteins and 20 to 30% is unbound. After multiple oral doses, linagliptin has an accumulation half-life of about 12 hours. Linagliptin is not extensively metabolised. It undergoes biphasic (or possible triphasic) elimination and at steady state has a terminal half-life of more than 100 hours. About 80% is eliminated in the faeces and 5% in the urine.

Metformin HCl
Metformin hydrochloride is slowly and incompletely absorbed from the gastrointestinal tract; the absolute bioavailability of a single 500mg dose is reported to be about 50 to 60%, although this is reduced somewhat if taken with food. Protein binding in plasma is negligible. Metformin is excreted unchanged in the urine. The plasma elimination half-life is reported to range from about 2 to 6 hours. Metformin crosses the placenta and is distributed into the breast milk in small amounts.

INDICATIONS
As an adjunct to diet and exercise to improve glycaemic control in adults with type 2 diabetes mellitus. However, It is not recommended in patients with type 1 diabetes mellitus as it may increase the risk of diabetic ketoacidosis in these patients. Empagliflozin is indicated to reduce the risk of cardiovascular death in adults with type 2 diabetes mellitus and established cardiovascular disease.

DOSAGE AND ADMINISTRATION
Prior to initiation, assessment of renal function is advised and in case of volume depletion, it needs to be rectified. In patients on metformin HCl, with or without linagliptin, switch to a similar total daily dose of metformin HCl and a total daily dose of empagliflozin 10mg and linagliptin 5mg; In patients on metformin HCl and any regimen containing empagliflozin, with or without linagliptin, switch to a similar total daily dose of metformin HCl, the same total daily dose of empagliflozin and linagliptin 5mg. Monitor effectiveness and tolerability, and adjust dosing as appropriate, not to exceed the maximum recommended daily dose of empagliflozin 25mg, linagliptin 5mg and metformin HCl 2000mg.

To be consumed orally, once daily with a meal in the morning.
The following can be taken as a single tablet once daily:
10mg/5mg/1000mg or 25mg/5mg/1000mg.
The following can be taken as two tablets together once daily:
5mg/2.5mg/1000mg or 12.5mg/2.5mg/1000mg.

Swallow tablets whole, do not split, crush, dissolve, or chew.
It is not recommended in patients with an eGFR less than 45 mL/min/1.73m² due to the metformin component.

CONTRAINDICATIONS
Severe renal impairment (eGFR less than 30mL/min/1.73m²), end-stage renal disease, or dialysis. Acute or chronic metabolic acidosis, including diabetic ketoacidosis. Hypersensitivity to empagliflozin, linagliptin, metformin or any of the excipients in it, reactions such as anaphylaxis, angioedema, exfoliative skin conditions, urticaria, or bronchial hyperreactivity have occurred.

ADVERSE EFFECTS
The following adverse reactions may be of importance:
Lactic acidosis, pancreatitis, ketoacidosis, volume depletion, urosepsis and pyelonephritis, hypoglycaemia with concomitant use with insulin and insulin secretagogues, necrotizing fasciitis of the perineum (fournier's gangrene), genital mycotic infections, hypersensitivity reactions including anaphylaxis, angioedema, and exfoliative skin conditions, urticaria, angioedema, localized skin exfoliation, vitamin b12 deficiency, severe and disabling arthralgia, bullous pemphigoid, heart failure, dyslipidaemia including Increase in Low-Density Lipoprotein Cholesterol (LDL-C), cough, nasopharyngitis, upper respiratory tract infection, bronchial hyperreactivity, asthenia, acute kidney injury, increased urination, urinary tract infection, urosepsis, headache, Increase in Serum Creatinine and decreases in eGFR, Increase in uric Acid mouth Ulceration, stomatitis, polydipsia, diarrhoea, constipation, nausea, vomiting, gastroenteritis, flatulence, abdominal discomfort, indigestion, increase in Lipase, increase in Amylase, cholestatic, hepatocellular, and mixed hepatocellular liver injury, increase in haematocrit.

DRUG INTERACTION
Carbonic Anhydrase Inhibitors: Topiramate or other carbonic anhydrase inhibitors (e.g., zonisamide, acetazolamide or dichlorphenamide) frequently causes a decrease in serum bicarbonate and induce non-anion gap, hyperchloremic metabolic acidosis. Concomitant use of these drugs with this combination (Empagliflozin/Linagliptin/Metformin HCl) may increase the risk of lactic acidosis.

Drugs that Reduce Metformin Clearance: Concomitant use of drugs that interfere with common renal tubular transport systems involved in the renal elimination of metformin (e.g., organic cationic transporter-2 [OCT2] / multidrug and toxin extrusion [MATE] inhibitors such as ranolazine, vandetanib, dolutegravir, and cimetidine) could increase systemic exposure to metformin and may increase the risk for lactic acidosis.

Alcohol: Alcohol is known to potentiate the effect of metformin on lactate metabolism.

Diuretics: Coadministration of empagliflozin with diuretics resulted in increased urine volume and frequency of voids, which might enhance the potential for volume depletion.

Insulin or Insulin Secretagogues: The risk of hypoglycaemia is increased when this combination (Empagliflozin/Linagliptin/Metformin HCl) is used in combination with an insulin secretagogue (e.g., sulfonylurea) or insulin.

Drugs Affecting Glycaemic Control: Certain drugs tend to produce hyperglycaemia and may lead to loss of glycaemic control. These drugs include the thiazides and other diuretics, corticosteroids, phenothiazines, thyroid products, oestrogens, oral contraceptives, phenytoin, nicotinic acid, sympathomimetics, calcium channel blocking drugs, and isoniazid.

Lithium: Concomitant use of an SGLT2 inhibitor with lithium may decrease serum lithium concentrations.

Inducers of P-glycoprotein or CYP3A4 Enzymes: Rifampin decreased linagliptin exposure, suggesting that the efficacy of linagliptin may be reduced when administered in combination with a strong P-gp or CYP3A4 inducer.

Positive Urine Glucose Test: SGLT2 inhibitors increase urinary glucose excretion and will lead to positive urine glucose tests. Interference with 1,5-anhydroglucitol (1,5-AG) Assay: Measurements of 1,5-AG are unreliable in assessing glycaemic control in patients taking SGLT2 inhibitors.

WARNINGS AND PRECAUTIONS
Lactic Acidosis: There have been cases of metformin-associated lactic acidosis, including fatal cases.

The concomitant use with specific drugs may increase the risk of metformin-associated lactic acidosis: those that impair renal function, result in significant hemodynamic change, interfere with acid-base balance or increase metformin accumulation.

There was a subtle onset and it were accompanied by nonspecific symptoms such as malaise, myalgias, abdominal pain, respiratory distress, or increased somnolence; however, hypothermia, hypotension, and resistant bradyarrhythmias have occurred with severe acidosis. Metformin-associated lactic acidosis was characterized by elevated blood lactate concentrations (>5 mmol/litre), anion gap acidosis (without evidence of ketonuria or ketonemia), and an increased lactate:pyruvate ratio; metformin plasma levels generally >5 mcg/mL. Metformin decreases liver uptake of lactate increasing lactate blood levels, which may increase the risk of lactic acidosis, especially in patients at risk. If metformin-associated lactic acidosis is suspected, general supportive measures should be instituted promptly in a hospital setting, along with immediate discontinuation of this combination (Empagliflozin/Linagliptin/Metformin HCl). In Patients consuming it and with a diagnosis or strong suspicion of lactic acidosis, prompt haemodialysis is recommended to correct the acidosis and remove accumulated metformin (metformin is dialyzable, with a clearance of up to 170 mL/minute under good hemodynamic conditions). Haemodialysis has often resulted in reversal of symptoms and recovery.

Renal Impairment: The metformin-associated lactic acidosis cases primarily occurred in patients with significant renal impairment. The risk of metformin accumulation and metformin-associated lactic acidosis increases with the severity of renal impairment. Before initiation, evaluation of glomerular filtration rate (eGFR) is suggested and at least an annual eGFR should be done. In patients at increased risk for the development of renal impairment (e.g., the elderly), renal function should be assessed more frequently.

Age 65 or Greater: The risk of metformin-associated lactic acidosis increases with the patient's age because elderly patients have a greater likelihood of having hepatic, renal, or cardiac impairment than younger patients. Assess renal function more frequently in elderly patients.

Radiological Studies with Contrast: Administration of intravascular iodinated contrast agents in metformin treated patients has led to an acute decrease in renal function and the occurrence of lactic acidosis. Stop this at the time of, or prior to, an iodinated contrast imaging procedure in patients with an eGFR less than 60mL/min/1.73m²; in patients with a history of hepatic impairment, alcoholism, or heart failure; or in patients who will be administered intra-arterial iodinated contrast. Re-evaluate eGFR 48 hours after the imaging procedure, and restart this combination (Empagliflozin/Linagliptin/Metformin HCl) if renal function is stable.

Surgery and Other Procedures: Withholding of food and fluids during surgical or other procedures may increase the risk for volume depletion, hypotension and renal impairment. This combination (Empagliflozin/Linagliptin/Metformin HCl) should be temporarily discontinued while patients have restricted food and fluid intake.

Hypoxic States: Cases of metformin-associated lactic acidosis occurred in the setting of acute congestive heart failure (particularly when accompanied by hypoperfusion and hypoxemia). Cardiovascular collapse (shock), acute myocardial infarction, sepsis, and other conditions associated with hypoxemia have been associated with lactic acidosis and may also cause prerenal azotaemia. When such events occur, discontinue this combination (Empagliflozin/Linagliptin/Metformin HCl).

120x320mm

Excessive Alcohol Intake: Alcohol potentiates the effect of metformin on lactate metabolism and this may increase the risk of metformin-associated lactic acidosis. Warn patients against excessive alcohol intake while receiving this combination (Empagliflozin/Linagliptin/Metformin HCl).

Hepatic Impairment: Patients with hepatic impairment have developed cases of metformin-associated lactic acidosis. This may be due to impaired lactate clearance resulting in higher lactate blood levels. Therefore, avoid use of this combination (Empagliflozin/Linagliptin/Metformin HCl) in patients with clinical or laboratory evidence of hepatic disease.

Pancreatitis Acute pancreatitis, including fatal pancreatitis: It has been reported in patients treated with linagliptin. If pancreatitis is suspected, promptly discontinue this combination (Empagliflozin/Linagliptin/Metformin HCl) and initiate appropriate management. It is unknown whether patients with a history of pancreatitis are at increased risk for the development of pancreatitis while using this drug.

Ketoacidosis Reports of ketoacidosis: A serious life-threatening condition requiring urgent hospitalization have been identified in patients with type 1 and type 2 diabetes mellitus receiving sodium glucose co-transporter-2 (SGLT2) inhibitors, including empagliflozin. Fatal cases of ketoacidosis have been reported in patients taking empagliflozin.

In patients with type 1 diabetes, the risk of ketoacidosis was seen to increase in patients who received SGLT2 inhibitors compared to patients who received placebo. This combination (Empagliflozin/Linagliptin/Metformin HCl) is not indicated for the treatment of patients with type 1 diabetes mellitus. Patients treated with this combination (Empagliflozin/Linagliptin/Metformin HCl) who present with signs and symptoms consistent with severe metabolic acidosis should be assessed for ketoacidosis regardless of presenting blood glucose levels, as ketoacidosis associated with this combination (Empagliflozin/Linagliptin/Metformin HCl) may be present even if blood glucose levels are less than 250 mg/dL. If ketoacidosis is suspected, this combination (Empagliflozin/Linagliptin/Metformin HCl) should be discontinued, patient should be evaluated, and prompt treatment should be instituted. Treatment of ketoacidosis may require insulin, fluid and carbohydrate replacement.

Before initiating this combination (Empagliflozin/Linagliptin/Metformin HCl), consider factors in the patient history that may predispose to ketoacidosis including pancreatic insulin deficiency from any cause, caloric restriction, and alcohol abuse. For patients who undergo scheduled surgery, consider temporarily discontinuing this combination (Empagliflozin/Linagliptin/Metformin HCl) for at least 3 days prior to surgery. Consider monitoring for ketoacidosis and temporarily discontinuing this combination (Empagliflozin/Linagliptin/Metformin HCl) in other clinical situations known to predispose to ketoacidosis (e.g., prolonged fasting due to acute illness or post-surgery). Ensure risk factors for ketoacidosis are resolved prior to restarting this combination (Empagliflozin/Linagliptin/Metformin HCl).

Volume Depletion: Empagliflozin can cause intravascular volume depletion which may sometimes manifest as symptomatic hypotension or acute transient changes in creatinine. There have been reports of acute kidney injury, some requiring hospitalization and dialysis, in patients with type 2 diabetes mellitus receiving SGLT2 inhibitors, including empagliflozin. Patients with impaired renal function (eGFR less than 60mL/min/1.73m²), elderly patients, or patients on loop diuretics may be at increased risk for volume depletion or hypotension. Before initiating this combination (Empagliflozin/Linagliptin/Metformin HCl) in patients with one or more of these characteristics, assess volume status and renal function. In patients with volume depletion, correct this condition before initiating this combination (Empagliflozin/Linagliptin/Metformin HCl). Monitor for signs and symptoms of volume depletion, and renal function after initiating therapy.

Urosepsis and Pyelonephritis: There have been reports of serious urinary tract infections including urosepsis and pyelonephritis requiring hospitalization in patients receiving SGLT2 inhibitors, including empagliflozin. Treatment with SGLT2 inhibitors increases the risk for urinary tract infections. Evaluate patients for signs and symptoms of urinary tract infections and treat promptly, if indicated.

Hypoglycaemia with Concomitant Use with Insulin and Insulin Secretagogues: Insulin and insulin secretagogues are known to cause hypoglycaemia. The risk of hypoglycaemia is increased when this combination (Empagliflozin/Linagliptin/Metformin HCl) is used in combination with an insulin secretagogue (e.g., sulfonylurea) or insulin. Therefore, a lower dose of the insulin secretagogue or insulin may be required to reduce the risk of hypoglycaemia when used in combination with this combination (Empagliflozin/Linagliptin/Metformin HCl).

Necrotizing Fasciitis of the Perineum (Fournier's Gangrene): Reports of necrotizing fasciitis of the perineum (Fournier's gangrene) have been identified in patients with diabetes mellitus receiving SGLT2 inhibitors, including empagliflozin. Cases have been reported in both females and males. Serious outcomes have included hospitalization, multiple surgeries, and death. Patients treated with this combination (Empagliflozin/Linagliptin/Metformin HCl) presenting with pain or tenderness, erythema, or swelling in the genital or perineal area, along with fever or malaise, should be assessed for necrotizing fasciitis. If suspected, start treatment immediately with broad-spectrum antibiotics and, if necessary, surgical debridement. Discontinue this combination (Empagliflozin/Linagliptin/Metformin HCl), closely monitor blood glucose levels, and provide appropriate alternative therapy for glycaemic control.

Genital Mycotic Infections: Empagliflozin increases the risk for genital mycotic infections. Patients with a history of chronic or recurrent genital mycotic infections were more likely to develop genital mycotic infections. Monitor and treat as appropriate.

Hypersensitivity Reactions: There have been reports of serious hypersensitivity reactions in patients treated with linagliptin. These reactions include anaphylaxis, angioedema, and exfoliative skin conditions. Onset of these reactions occurred predominantly within the first 3 months after initiation of treatment with linagliptin, with some reports occurring after the first dose. Angioedema has also been reported with other dipeptidyl peptidase-4 (DPP-4) inhibitors. Use caution in a patient with a history of angioedema to another DPP-4 inhibitor because it is unknown whether such patients will be predisposed to angioedema with this combination (Empagliflozin/Linagliptin/Metformin HCl). There have been reports of serious hypersensitivity reactions (e.g., angioedema) in patients treated with empagliflozin. If a hypersensitivity reaction occurs, discontinue this combination (Empagliflozin/Linagliptin/Metformin HCl), treat promptly per standard of care, and monitor until signs and symptoms resolve. this combination (Empagliflozin/Linagliptin/Metformin HCl) is contraindicated in patients with hypersensitivity to linagliptin, empagliflozin or any of the excipients in it.

Vitamin B12 Deficiency: In metformin studies a decrease to subnormal levels of previously normal serum vitamin B12 levels was observed. Such decrease, possibly due to interference with B12 absorption from the B12-intrinsic factor complex, may be associated with anaemia but appears to be rapidly reversible with discontinuation of metformin or vitamin B12 supplementation. Certain individuals (those with inadequate vitamin B12 or calcium intake or absorption) appear to be predisposed to developing subnormal vitamin B12 levels. Measure hematologic parameters on an annual basis and vitamin B12 at 2 to 3 year intervals in patients on this combination (Empagliflozin/Linagliptin/Metformin HCl) and manage any abnormalities.

Severe and Disabling Arthralgia: There have been reports of severe and disabling arthralgia in patients taking DPP-4 inhibitors. The time to onset of symptoms following initiation of drug therapy varied from one day to years. Patients experienced relief of symptoms upon discontinuation of the medication. Some patients experienced a recurrence of symptoms when restarting the same drug or a different DPP-4 inhibitor. Consider DPP-4 inhibitors as a possible cause for severe joint pain and discontinue drug if appropriate.

Bullous Pemphigoid: It has been reported in patients treated with linagliptin and patients were reported to be hospitalized due to bullous pemphigoid. Cases of bullous pemphigoid requiring hospitalization have been reported with DPP-4 inhibitor use. Patients typically recovered with topical or systemic immunosuppressive treatment and discontinuation of the DPP-4 inhibitor. Patients should report development of blisters or erosions while receiving this drug. If bullous pemphigoid is suspected, this combination (Empagliflozin/Linagliptin/Metformin HCl) should be discontinued and referral to a dermatologist should be considered for diagnosis and appropriate treatment.

Heart Failure: An association between DPP-4 inhibitor treatment and heart failure has been observed in cardiovascular. Consider the risks and benefits of this combination (Empagliflozin/Linagliptin/Metformin HCl) prior to initiating treatment in patients at risk for heart failure, such as those with a prior history of heart failure and a history of renal impairment, and observe these patients for signs and symptoms of heart failure during therapy. Advise patients of the characteristic symptoms of heart failure and to immediately report such symptoms. If heart failure develops, evaluate and manage according to current standards of care and consider discontinuation this drug.

USE IN SPECIAL POPULATION
Pregnancy
It is not recommended during the second and third trimesters of pregnancy. There is not significant data to determine a drug-associated risk for major birth defects and miscarriage. There are risks to the mother and foetus associated with poorly controlled diabetes in pregnancy. Studies suggest adverse renal changes in rats when administered during a period of renal development corresponding to the late second and third trimesters of human pregnancy. There has not been a clear association with metformin and major birth defects, miscarriage, or adverse maternal or foetal outcomes when metformin was used during pregnancy. However, this may not establish the absence of any metformin-associated risk.

Lactation
Because of the potential for serious adverse reactions in a breastfed infant, including the potential for empagliflozin to affect postnatal renal development, advise patients that use of it is not recommended while breastfeeding.

Females and Males of Reproductive Potential
Discuss the potential for unintended pregnancy with premenopausal women as therapy with metformin may result in ovulation in some anovulatory women.

Paediatric Use
Safety and effectiveness have not been established in paediatric patients.

Geriatric Use
Assess renal function more frequently in treated geriatric patients because there is a greater risk of empagliflozin-associated intravascular volume contraction and symptomatic hypotension in geriatric patients and there is a greater risk of metformin-associated lactic acidosis in geriatric patients. Patient may also be vulnerable to urinary tract infections.

The recommended dosage for the metformin component in geriatric patients should usually start at the lower end of the dosage range.

Hepatic Impairment
Use of metformin in patients with hepatic impairment has been associated with some cases of lactic acidosis. It is not recommended in patients with hepatic impairment.

OVERDOSAGE
Overdose of metformin HCl has occurred, including ingestion of amounts greater than 50 grams. Lactic acidosis has been reported in approximately 32% of metformin overdose.

Metformin is dialyzable with a clearance of up to 170mL/min under good hemodynamic conditions. Therefore, haemodialysis may be useful for removal of accumulated drug from patients in whom metformin overdosage is suspected.
Removal of empagliflozin by haemodialysis has not been studied, and removal of linagliptin by haemodialysis or peritoneal dialysis is unlikely.

DOSAGE & INSTRUCTIONS
To be sold and used on the prescription of a registered medical practitioner only. Keep out of reach of children. Do not store above 30ºC. Keep in a dry place. Protect from light.

PRESENTATION
Diajard Forte XR 5mg/2.5mg/1000mg Tablets:
Alu. Alu. Blister Pack of 2 x 7's.

Diajard Forte XR 10mg/5mg/1000mg Tablets:
Alu. Alu. Blister Pack of 2 x 7's.

Diajard Forte XR 12.5mg/2.5mg/1000mg Tablets:
Alu. Alu. Blister Pack of 2 x 7's.

Diajard Forte XR 25mg/5mg/1000mg Tablets:
Alu. Alu. Blister Pack of 2 x 7's.

ڈائیاجارڈ فورٹ ایکس آر™

(ایمپاگلیفلوزن + لینا گلپٹن + میٹ فارمن ہائیڈروکلورائیڈ)

خوراک و ہدایات:
صرف مستند ڈاکٹر کے نسخہ کے مطابق ہی دوا فروخت اور استعمال کی جائے۔
بچوں کی پہنچ سے دور رکھیں۔ 30°C سے زیادہ درجہ حرارت پر نہ رکھیں۔
خشک جگہ پر رکھیں۔ روشنی سے بچائیں۔

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