

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use JARDIANCE safely and effectively. See full prescribing information for JARDIANCE.

JARDIANCE® (empagliflozin tablets), for oral use

Initial U.S. Approval: 2014

RECENT MAJOR CHANGES

Indications and Usage (1) 2/2022

INDICATIONS AND USAGE

JARDIANCE is a sodium-glucose co-transporter 2 (SGLT2) inhibitor indicated:

- To reduce the risk of cardiovascular death and hospitalization for heart failure in adults with heart failure. (1)
- To reduce the risk of cardiovascular death in adults with type 2 diabetes mellitus and established cardiovascular disease. (1)
- As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus. (1)

Limitations of Use:

- Not recommended in patients with type 1 diabetes mellitus. It may increase the risk of diabetic ketoacidosis in these patients. (1)
- Not recommended for use to improve glycemic control in adults with type 2 diabetes mellitus with an eGFR less than 30 mL/min/1.73 m² (1)

DOSAGE AND ADMINISTRATION

- Assess volume status and correct volume depletion before initiating (2.1)
- Recommended dose is 10 mg once daily in the morning, taken with or without food (2.2)
- For additional glycemic control, dose may be increased to 25 mg in patients tolerating JARDIANCE (2.2)

DOSAGE FORMS AND STRENGTHS

Tablets: 10 mg, 25 mg (3)

CONTRAINDICATIONS

- Hypersensitivity to empagliflozin or any of the excipients in JARDIANCE (4)
- Patients on dialysis (4)

WARNINGS AND PRECAUTIONS

- **Ketoacidosis:** Assess patients who present with signs and symptoms of metabolic acidosis for ketoacidosis, regardless of blood glucose level. If suspected, discontinue JARDIANCE, evaluate and treat promptly. Before initiating JARDIANCE, consider risk factors for ketoacidosis. Patients on JARDIANCE may require monitoring and temporary

discontinuation of therapy in clinical situations known to predispose to ketoacidosis. (5.1)

- **Volume Depletion:** Before initiating JARDIANCE, assess volume status and renal function in patients with impaired renal function, elderly patients, or patients on loop diuretics. Monitor for signs and symptoms during therapy. (5.2, 6.1)
- **Urosepsis and Pyelonephritis:** Evaluate patients for signs and symptoms of urinary tract infections and treat promptly, if indicated (5.3)
- **Hypoglycemia:** Consider lowering the dose of insulin secretagogue or insulin to reduce the risk of hypoglycemia when initiating JARDIANCE (5.4)
- **Necrotizing Fasciitis of the Perineum (Fournier's Gangrene):** Serious, life-threatening cases have occurred in both females and males. Assess patients presenting with pain or tenderness, erythema, or swelling in the genital or perineal area, along with fever or malaise. If suspected, institute prompt treatment. (5.5)
- **Genital Mycotic Infections:** Monitor and treat as appropriate (5.6)
- **Hypersensitivity Reactions:** Serious hypersensitivity reactions (e.g., angioedema) have occurred with JARDIANCE. If hypersensitivity reactions occur, discontinue JARDIANCE, treat promptly, and monitor until signs and symptoms resolve. (5.7)

ADVERSE REACTIONS

Most common adverse reactions (5% or greater incidence) were urinary tract infections and female genital mycotic infections (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Boehringer Ingelheim Pharmaceuticals, Inc. at 1-800-542-6257 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DRUG INTERACTIONS

See full prescribing information for information on drug interactions and interference of JARDIANCE with laboratory tests. (7)

USE IN SPECIFIC POPULATIONS

- **Pregnancy:** Advise females of the potential risk to a fetus especially during the second and third trimesters (8.1)
- **Lactation:** Not recommended when breastfeeding (8.2)
- **Geriatric Patients:** Higher incidence of adverse reactions related to volume depletion and reduced renal function (5.2, 8.5, 8.6)
- **Renal Impairment:** Higher incidence of adverse reactions related to reduced renal function (2.2, 5.2, 8.6)

See 17 for PATIENT COUNSELING INFORMATION and Medication Guide.

Revised: 10/2022

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FULL PRESCRIBING INFORMATION

1 INDICATIONS AND USAGE

JARDIANCE is indicated:

- to reduce the risk of cardiovascular death and hospitalization for heart failure in adults with heart failure.
- to reduce the risk of cardiovascular death in adults with type 2 diabetes mellitus and established cardiovascular disease.
- as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

Limitations of Use

JARDIANCE is not recommended in patients with type 1 diabetes mellitus. It may increase the risk of diabetic ketoacidosis in these patients [see *Warnings and Precautions (5.1)*].

JARDIANCE is not recommended for use to improve glycemic control in adults with type 2 diabetes mellitus with an eGFR less than 30 mL/min/1.73 m². JARDIANCE is likely to be ineffective in this setting based upon its mechanism of action.

2 DOSAGE AND ADMINISTRATION

2.1 Prior to Initiation of JARDIANCE

- Assess renal function before initiating JARDIANCE and as clinically indicated [see *Warnings and Precautions (5.2)*].
- In patients with volume depletion, correct this condition before initiating JARDIANCE [see *Warnings and Precautions (5.2)*, *Use in Specific Populations (8.5, 8.6)*].

2.2 Recommended Dosage

- The recommended dose of JARDIANCE is 10 mg once daily in the morning, taken with or without food.
- For additional glycemic control, the dose may be increased to 25 mg in patients tolerating JARDIANCE.
- Use for glycemic control is not recommended in patients with an eGFR less than 30 mL/min/1.73 m².
- Data are insufficient to provide a dosing recommendation in patients;
 - who have type 2 diabetes and established cardiovascular disease with an eGFR less than 30 mL/min/1.73 m², or
 - who have heart failure with an eGFR less than 20 mL/min/1.73 m² [see *Warnings and Precautions (5.2) and Use in Specific Populations (8.6)*].
- JARDIANCE is contraindicated in patients on dialysis [see *Contraindications (4)*].

3 DOSAGE FORMS AND STRENGTHS

JARDIANCE tablets available as:

- 10 mg pale yellow, round, biconvex and bevel-edged, film-coated tablets debossed with “S 10” on one side and the Boehringer Ingelheim company symbol on the other side.
- 25 mg pale yellow, oval, biconvex, film-coated tablets debossed with “S 25” on one side and the Boehringer Ingelheim company symbol on the other side.

4 CONTRAINDICATIONS

- Hypersensitivity to empagliflozin or any of the excipients in JARDIANCE, reactions such as angioedema have occurred [see *Warnings and Precautions (5.7)*].
- Patients on dialysis [see *Use in Specific Populations (8.6)*].

5 WARNINGS AND PRECAUTIONS

5.1 Ketoacidosis

Reports of ketoacidosis, a serious life-threatening condition requiring urgent hospitalization have been identified in clinical trials and postmarketing surveillance in patients with type 1 and type 2 diabetes mellitus receiving sodium glucose co-transporter-2 (SGLT2) inhibitors, including JARDIANCE. Fatal cases of ketoacidosis have been reported in patients taking JARDIANCE. In placebo-controlled trials of patients with type 1 diabetes, the risk of ketoacidosis was increased in patients who received SGLT2 inhibitors compared to patients who received placebo. JARDIANCE is not indicated for the treatment of patients with type 1 diabetes mellitus [see *Indications and Usage (1)*].

Patients treated with JARDIANCE 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 JARDIANCE may be present even if blood glucose levels are less than 250 mg/dL. If ketoacidosis is suspected, JARDIANCE should be discontinued, patient should be evaluated, and prompt treatment should be instituted. Treatment of ketoacidosis may require insulin, fluid and carbohydrate replacement.

In many of the postmarketing reports, and particularly in patients with type 1 diabetes, the presence of ketoacidosis was not immediately recognized and institution of treatment was delayed because presenting blood glucose levels were below those typically expected for diabetic ketoacidosis (often less than 250 mg/dL). Signs and symptoms at presentation were consistent with dehydration and severe metabolic acidosis and included nausea, vomiting, abdominal pain, generalized malaise, and shortness of breath. In some but not all cases, factors predisposing to ketoacidosis such as insulin dose reduction, acute febrile illness, reduced caloric intake, surgery, pancreatic disorders suggesting insulin deficiency (e.g., type 1 diabetes, history of pancreatitis or pancreatic surgery), and alcohol abuse were identified.

Before initiating JARDIANCE, 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 JARDIANCE for at least 3 days prior to surgery [see *Clinical Pharmacology (12.2, 12.3)*].

Consider monitoring for ketoacidosis and temporarily discontinuing JARDIANCE 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 JARDIANCE.

Educate patients on the signs and symptoms of ketoacidosis and instruct patients to discontinue JARDIANCE and seek medical attention immediately if signs and symptoms occur.

5.2 Volume Depletion

JARDIANCE can cause intravascular volume depletion which may sometimes manifest as symptomatic hypotension or acute transient changes in creatinine [see *Adverse Reactions (6.1)*]. There have been post-marketing reports of acute kidney injury, some requiring hospitalization and dialysis, in patients with type 2 diabetes mellitus receiving SGLT2 inhibitors, including JARDIANCE. Patients with impaired renal function (eGFR less than 60 mL/min/1.73 m²), elderly patients, or patients on loop diuretics may be at increased risk for volume depletion or hypotension. Before initiating JARDIANCE 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 JARDIANCE. Monitor for signs and symptoms of volume depletion, and renal function after initiating therapy.

5.3 Urosepsis and Pyelonephritis

There have been reports of serious urinary tract infections including urosepsis and pyelonephritis requiring hospitalization in patients receiving SGLT2 inhibitors, including JARDIANCE. 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 [see *Adverse Reactions (6)*].

5.4 Hypoglycemia with Concomitant Use with Insulin and Insulin Secretagogues

Insulin and insulin secretagogues are known to cause hypoglycemia. The risk of hypoglycemia is increased when JARDIANCE is used in combination with insulin secretagogues (e.g., sulfonylurea) or insulin [see *Adverse Reactions (6.1)*]. Therefore, a lower dose of the insulin secretagogue or insulin may be required to reduce the risk of hypoglycemia when used in combination with JARDIANCE.

5.5 Necrotizing Fasciitis of the Perineum (Fournier's Gangrene)

Reports of necrotizing fasciitis of the perineum (Fournier's gangrene), a rare but serious and life-threatening necrotizing infection requiring urgent surgical intervention, have been identified in patients with diabetes mellitus receiving SGLT2 inhibitors, including JARDIANCE. Cases have been reported in both females and males. Serious outcomes have included hospitalization, multiple surgeries, and death.

Patients treated with JARDIANCE 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 JARDIANCE, closely monitor blood glucose levels, and provide appropriate alternative therapy for glycemic control.

5.6 Genital Mycotic Infections

JARDIANCE increases the risk for genital mycotic infections [see *Adverse Reactions (6.1)*]. Patients with a history of chronic or recurrent genital mycotic infections were more likely to develop genital mycotic infections. Monitor and treat as appropriate.

5.7 Hypersensitivity Reactions

There have been postmarketing reports of serious hypersensitivity reactions (e.g., angioedema) in patients treated with JARDIANCE. If a hypersensitivity reaction occurs, discontinue JARDIANCE; treat promptly per standard of care, and monitor until signs and symptoms resolve. JARDIANCE is contraindicated in patients with hypersensitivity to empagliflozin or any of the excipients in JARDIANCE [see *Contraindications (4)*].

6 ADVERSE REACTIONS

The following important adverse reactions are described below and elsewhere in the labeling:

- Ketoacidosis [see *Warnings and Precautions (5.1)*]
- Volume Depletion [see *Warnings and Precautions (5.2)*]
- Urosepsis and Pyelonephritis [see *Warnings and Precautions (5.3)*]
- Hypoglycemia with Concomitant Use with Insulin and Insulin Secretagogues [see *Warnings and Precautions (5.4)*]
- Necrotizing Fasciitis of the Perineum (Fournier's Gangrene) [see *Warnings and Precautions (5.5)*]
- Genital Mycotic Infections [see *Warnings and Precautions (5.6)*]
- Hypersensitivity Reactions [see *Warnings and Precautions (5.7)*]

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

JARDIANCE has been evaluated in clinical trials in patients with type 2 diabetes mellitus and in patients with heart failure. The overall safety profile of JARDIANCE was generally consistent across the studied indications.

Clinical Trials in Patients with Type 2 Diabetes Mellitus

The data in Table 1 are derived from a pool of four 24-week placebo-controlled trials and 18-week data from a placebo-controlled trial with insulin in patients with type 2 diabetes. JARDIANCE was used as monotherapy in one trial and as add-on therapy in four trials [see *Clinical Studies (14)*].

These data reflect exposure of 1976 patients to JARDIANCE with a mean exposure duration of approximately 23 weeks. Patients received placebo (N=995), JARDIANCE 10 mg (N=999), or JARDIANCE 25 mg (N=977) once daily. The mean age of the population was 56 years and 3% were older than 75 years of age. More than half (55%) of the population was male; 46% were White, 50% were Asian, and 3% were Black or African American. At baseline, 57% of the population had diabetes more than 5 years and had a mean hemoglobin A1c (HbA1c) of 8%. Established microvascular complications of diabetes at baseline included diabetic nephropathy (7%), retinopathy (8%), or neuropathy (16%). Baseline renal function was normal or mildly impaired in 91% of patients and moderately impaired in 9% of patients (mean eGFR 86.8 mL/min/1.73 m²).

Table 1 shows common adverse reactions (excluding hypoglycemia) associated with the use of JARDIANCE. The adverse reactions were not present at baseline, occurred more commonly on JARDIANCE than on placebo and occurred in greater than or equal to 2% of patients treated with JARDIANCE 10 mg or JARDIANCE 25 mg.

Table 1 Adverse Reactions Reported in ≥2% of Patients Treated with JARDIANCE and Greater than Placebo in Pooled Placebo-Controlled Clinical Studies of JARDIANCE Monotherapy or Combination Therapy

| Adverse Reactions | Placebo (%) N=995 | JARDIANCE 10 mg (%) N=999 | JARDIANCE 25 mg (%) N=977 |
|------------------------------------------------|----------------------|------------------------------|------------------------------|
| Urinary tract infection ^a | 7.6 | 9.3 | 7.6 |
| Female genital mycotic infections ^b | 1.5 | 5.4 | 6.4 |
| Upper respiratory tract infection | 3.8 | 3.1 | 4.0 |
| Increased urination ^c | 1.0 | 3.4 | 3.2 |
| Dyslipidemia | 3.4 | 3.9 | 2.9 |
| Arthralgia | 2.2 | 2.4 | 2.3 |
| Male genital mycotic infections ^d | 0.4 | 3.1 | 1.6 |
| Nausea | 1.4 | 2.3 | 1.1 |

^aPredefined adverse event grouping, including, but not limited to, urinary tract infection, asymptomatic bacteriuria, cystitis

^bFemale genital mycotic infections include the following adverse reactions: vulvovaginal mycotic infection, vaginal infection, vulvitis, vulvovaginal candidiasis, genital infection, genital candidiasis, genital infection fungal, genitourinary tract infection, vulvovaginitis, cervicitis, urogenital infection fungal, vaginitis bacterial. Percentages calculated with the number of female subjects in each group as denominator: placebo (N=481), JARDIANCE 10 mg (N=443), JARDIANCE 25 mg (N=420).

^cPredefined adverse event grouping, including, but not limited to, polyuria, pollakiuria, and nocturia

^dMale genital mycotic infections include the following adverse reactions: balanoposthitis, balanitis, genital infections fungal, genitourinary tract infection, balanitis candida, scrotal abscess, penile infection. Percentages calculated with the number of male subjects in each group as denominator: placebo (N=514), JARDIANCE 10 mg (N=556), JARDIANCE 25 mg (N=557).

Thirst (including polydipsia) was reported in 0%, 1.7%, and 1.5% for placebo, JARDIANCE 10 mg, and JARDIANCE 25 mg, respectively.

Volume Depletion

JARDIANCE causes an osmotic diuresis, which may lead to intravascular volume contraction and adverse reactions related to volume depletion. In the pool of five placebo-controlled clinical trials, adverse reactions related to volume depletion (e.g., blood pressure (ambulatory) decreased, blood pressure systolic decreased, dehydration, hypotension, hypovolemia, orthostatic hypotension, and syncope) were reported by 0.3%, 0.5%, and 0.3% of patients treated with placebo, JARDIANCE 10 mg, and JARDIANCE 25 mg, respectively. JARDIANCE may increase the risk of hypotension in patients at risk for volume contraction [see *Use in Specific Populations* (8.5, 8.6)].

Increased Urination

In the pool of five placebo-controlled clinical trials, adverse reactions of increased urination (e.g., polyuria, pollakiuria, and nocturia) occurred more frequently on JARDIANCE than on placebo (see Table 1). Specifically, nocturia was reported by 0.4%, 0.3%, and 0.8% of patients treated with placebo, JARDIANCE 10 mg, and JARDIANCE 25 mg, respectively.

Hypoglycemia

The incidence of hypoglycemia by study is shown in Table 2. The incidence of hypoglycemia increased when JARDIANCE was administered with insulin or sulfonylurea.

Table 2 Incidence of Overall^a and Severe^b Hypoglycemic Events in Placebo-Controlled Clinical Studies^c

| Monotherapy (24 weeks) | Placebo (n=229) | JARDIANCE 10 mg (n=224) | JARDIANCE 25 mg (n=223) |
|---------------------------------------------------------------------------------------|----------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------|
| Overall (%) | 0.4 | 0.4 | 0.4 |
| Severe (%) | 0 | 0 | 0 |
| In Combination with Metformin (24 weeks) | Placebo + Metformin (n=206) | JARDIANCE 10 mg + Metformin (n=217) | JARDIANCE 25 mg + Metformin (n=214) |
| Overall (%) | 0.5 | 1.8 | 1.4 |
| Severe (%) | 0 | 0 | 0 |
| In Combination with Metformin + Sulfonylurea (24 weeks) | Placebo (n=225) | JARDIANCE 10 mg + Metformin + Sulfonylurea (n=224) | JARDIANCE 25 mg + Metformin + Sulfonylurea (n=217) |
| Overall (%) | 8.4 | 16.1 | 11.5 |
| Severe (%) | 0 | 0 | 0 |
| In Combination with Pioglitazone +/- Metformin (24 weeks) | Placebo (n=165) | JARDIANCE 10 mg + Pioglitazone +/- Metformin (n=165) | JARDIANCE 25 mg + Pioglitazone +/- Metformin (n=168) |
| Overall (%) | 1.8 | 1.2 | 2.4 |
| Severe (%) | 0 | 0 | 0 |
| In Combination with Basal Insulin +/- Metformin (18 weeks^d) | Placebo (n=170) | JARDIANCE 10 mg (n=169) | JARDIANCE 25 mg (n=155) |
| Overall (%) | 20.6 | 19.5 | 28.4 |
| Severe (%) | 0 | 0 | 1.3 |
| In Combination with MDI Insulin +/-Metformin (18 weeks^d) | Placebo (n=188) | JARDIANCE 10 mg (n=186) | JARDIANCE 25 mg (n=189) |
| Overall (%) | 37.2 | 39.8 | 41.3 |
| Severe (%) | 0.5 | 0.5 | 0.5 |

^aOverall hypoglycemic events: plasma or capillary glucose of less than or equal to 70 mg/dL

^bSevere hypoglycemic events: requiring assistance regardless of blood glucose

^cTreated set (patients who had received at least one dose of study drug)

^dInsulin dose could not be adjusted during the initial 18-week treatment period

Genital Mycotic Infections

In the pool of five placebo-controlled clinical trials, the incidence of genital mycotic infections (e.g., vaginal mycotic infection, vaginal infection, genital infection fungal, vulvovaginal candidiasis, and vulvitis) was increased in patients treated with JARDIANCE compared to placebo, occurring in 0.9%, 4.1%, and 3.7% of patients randomized to placebo, JARDIANCE 10 mg, and JARDIANCE 25 mg, respectively. Discontinuation from study due to genital infection occurred in 0% of placebo-treated patients and 0.2% of patients treated with either JARDIANCE 10 mg or 25 mg.

Genital mycotic infections occurred more frequently in female than male patients (see Table 1).

Phimosis occurred more frequently in male patients treated with JARDIANCE 10 mg (less than 0.1%) and JARDIANCE 25 mg (0.1%) than placebo (0%).

Urinary Tract Infections

In the pool of five placebo-controlled clinical trials, the incidence of urinary tract infections (e.g., urinary tract infection, asymptomatic bacteriuria, and cystitis) was increased in patients treated with JARDIANCE compared

to placebo (see Table 1). Patients with a history of chronic or recurrent urinary tract infections were more likely to experience a urinary tract infection. The rate of treatment discontinuation due to urinary tract infections was 0.1%, 0.2%, and 0.1% for placebo, JARDIANCE 10 mg, and JARDIANCE 25 mg, respectively.

Urinary tract infections occurred more frequently in female patients. The incidence of urinary tract infections in female patients randomized to placebo, JARDIANCE 10 mg, and JARDIANCE 25 mg was 16.6%, 18.4%, and 17.0%, respectively. The incidence of urinary tract infections in male patients randomized to placebo, JARDIANCE 10 mg, and JARDIANCE 25 mg was 3.2%, 3.6%, and 4.1%, respectively [see *Use in Specific Populations (8.5)*].

Clinical Trials in Patients with Heart Failure

The EMPEROR-Reduced study included 3730 patients with heart failure and left ventricular ejection fraction (LVEF) $\leq 40\%$ followed for a median of 16 months, and EMPEROR-Preserved included 5988 patients with heart failure and LVEF $>40\%$ followed for a median of 26 months. In both studies, patients were randomized to JARDIANCE 10 mg or placebo. The safety profile in patients with heart failure was generally consistent with that observed in patients with type 2 diabetes mellitus.

Laboratory Tests

Increases in Serum Creatinine and Decreases in eGFR

Initiation of JARDIANCE causes an increase in serum creatinine and decrease in eGFR within weeks of starting therapy and then these changes stabilize. In a study of patients with moderate renal impairment, larger mean changes were observed. In a long-term cardiovascular outcomes trial, the increase in serum creatinine and decrease in eGFR generally did not exceed 0.1 mg/dL and -9.0 mL/min/1.73 m², respectively, at Week 4, and reversed after treatment discontinuation, suggesting acute hemodynamic changes may play a role in the renal function changes observed with JARDIANCE.

Increase in Low-Density Lipoprotein Cholesterol (LDL-C)

Dose-related increases in low-density lipoprotein cholesterol (LDL-C) were observed in patients treated with JARDIANCE. LDL-C increased by 2.3%, 4.6%, and 6.5% in patients treated with placebo, JARDIANCE 10 mg, and JARDIANCE 25 mg, respectively. The range of mean baseline LDL-C levels was 90.3 to 90.6 mg/dL across treatment groups.

Increase in Hematocrit

In a pool of four placebo-controlled studies, median hematocrit decreased by 1.3% in placebo and increased by 2.8% in JARDIANCE 10 mg and 2.8% in JARDIANCE 25 mg treated patients. At the end of treatment, 0.6%, 2.7%, and 3.5% of patients with hematocrits initially within the reference range had values above the upper limit of the reference range with placebo, JARDIANCE 10 mg, and JARDIANCE 25 mg, respectively.

6.2 Postmarketing Experience

Additional adverse reactions have been identified during postapproval use of JARDIANCE. Because these reactions are reported voluntarily from a population of uncertain size, it is generally not possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

Gastrointestinal Disorders: Constipation

Infections: Necrotizing fasciitis of the perineum (Fournier's gangrene), urosepsis and pyelonephritis

Metabolism and Nutrition Disorders: Ketoacidosis

Renal and Urinary Disorders: Acute kidney injury

Skin and Subcutaneous Tissue Disorders: Angioedema, skin reactions (e.g., rash, urticaria)

7 DRUG INTERACTIONS

Table 3 Clinically Relevant Interactions with JARDIANCE

| Diuretics | |
|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <i>Clinical Impact</i> | Coadministration of empagliflozin with diuretics resulted in increased urine volume and frequency of voids, which might enhance the potential for volume depletion. |
| <i>Intervention</i> | Before initiating JARDIANCE, assess volume status and renal function. In patients with volume depletion, correct this condition before initiating JARDIANCE. Monitor for signs and symptoms of volume depletion, and renal function after initiating therapy. |
| Insulin or Insulin Secretagogues | |
| <i>Clinical Impact</i> | The risk of hypoglycemia is increased when JARDIANCE is used in combination with insulin secretagogues (e.g., sulfonylurea) or insulin. |
| <i>Intervention</i> | Coadministration of JARDIANCE with an insulin secretagogue (e.g., sulfonylurea) or insulin may require lower doses of the insulin secretagogue or insulin to reduce the risk of hypoglycemia. |
| Lithium | |
| <i>Clinical Impact</i> | Concomitant use of an SGLT2 inhibitor with lithium may decrease serum lithium concentrations. |
| <i>Intervention</i> | Monitor serum lithium concentration more frequently during JARDIANCE initiation and dosage changes. |
| Positive Urine Glucose Test | |
| <i>Clinical Impact</i> | SGLT2 inhibitors increase urinary glucose excretion and will lead to positive urine glucose tests. |
| <i>Intervention</i> | Monitoring glycemic control with urine glucose tests is not recommended in patients taking SGLT2 inhibitors. Use alternative methods to monitor glycemic control. |
| Interference with 1,5-anhydroglucitol (1,5-AG) Assay | |
| <i>Clinical Impact</i> | Measurements of 1,5-AG are unreliable in assessing glycemic control in patients taking SGLT2 inhibitors. |
| <i>Intervention</i> | Monitoring glycemic control with 1,5-AG assay is not recommended. Use alternative methods to monitor glycemic control. |

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Risk Summary

Based on animal data showing adverse renal effects, JARDIANCE is not recommended during the second and third trimesters of pregnancy.

The limited available data with JARDIANCE in pregnant women are not sufficient to determine a drug-associated risk for major birth defects and miscarriage. There are risks to the mother and fetus associated with poorly controlled diabetes in pregnancy [*see Clinical Considerations*].

In animal studies, adverse renal changes were observed in rats when empagliflozin was administered during a period of renal development corresponding to the late second and third trimesters of human pregnancy. Doses approximately 13-times the maximum clinical dose caused renal pelvic and tubule dilatations that were reversible [*see Data*].

The estimated background risk of major birth defects is 6% to 10% in women with pre-gestational diabetes with a HbA1c >7 and has been reported to be as high as 20% to 25% in women with HbA1c >10. The estimated

background risk of miscarriage for the indicated population is unknown. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% to 4% and 15% to 20%, respectively.

Clinical Considerations

Disease-associated maternal and/or embryo/fetal risk: Poorly controlled diabetes in pregnancy increases the maternal risk for diabetic ketoacidosis, pre-eclampsia, spontaneous abortions, preterm delivery, and delivery complications. Poorly controlled diabetes increases the fetal risk for major birth defects, stillbirth, and macrosomia related morbidity.

Data

Animal Data

Empagliflozin dosed directly to juvenile rats from postnatal day (PND) 21 until PND 90 at doses of 1, 10, 30, and 100 mg/kg/day caused increased kidney weights and renal tubular and pelvic dilatation at 100 mg/kg/day, which approximates 13-times the maximum clinical dose of 25 mg, based on AUC. These findings were not observed after a 13-week, drug-free recovery period. These outcomes occurred with drug exposure during periods of renal development in rats that correspond to the late second and third trimester of human renal development.

In embryo-fetal development studies in rats and rabbits, empagliflozin was administered for intervals coinciding with the first trimester period of organogenesis in humans. Doses up to 300 mg/kg/day, which approximates 48-times (rats) and 128-times (rabbits) the maximum clinical dose of 25 mg (based on AUC), did not result in adverse developmental effects. In rats, at higher doses of empagliflozin causing maternal toxicity, malformations of limb bones increased in fetuses at 700 mg/kg/day or 154-times the 25 mg maximum clinical dose. Empagliflozin crosses the placenta and reaches fetal tissues in rats. In the rabbit, higher doses of empagliflozin resulted in maternal and fetal toxicity at 700 mg/kg/day, or 139-times the 25 mg maximum clinical dose.

In pre- and postnatal development studies in pregnant rats, empagliflozin was administered from gestation day 6 through to lactation day 20 (weaning) at up to 100 mg/kg/day (approximately 16-times the 25 mg maximum clinical dose) without maternal toxicity. Reduced body weight was observed in the offspring at greater than or equal to 30 mg/kg/day (approximately 4-times the 25 mg maximum clinical dose).

8.2 Lactation

Risk Summary

There is limited information regarding the presence of JARDIANCE in human milk, the effects of JARDIANCE on the breastfed infant or the effects on milk production. Empagliflozin is present in the milk of lactating rats [see *Data*]. Since human kidney maturation occurs *in utero* and during the first 2 years of life when lactational exposure may occur, there may be risk to the developing human kidney.

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 JARDIANCE is not recommended while breastfeeding.

Data

Empagliflozin was present at a low level in rat fetal tissues after a single oral dose to the dams at gestation day 18. In rat milk, the mean milk to plasma ratio ranged from 0.634 to 5, and was greater than one from 2 to 24 hours post-dose. The mean maximal milk to plasma ratio of 5 occurred at 8 hours post-dose, suggesting accumulation of empagliflozin in the milk. Juvenile rats directly exposed to empagliflozin showed a risk to the developing kidney (renal pelvic and tubular dilatations) during maturation.

8.4 Pediatric Use

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

8.5 Geriatric Use

In glycemic control studies in patients with type 2 diabetes mellitus, a total of 2721 (32%) patients treated with JARDIANCE were 65 years of age and older, and 491 (6%) were 75 years of age and older. JARDIANCE is expected to have diminished glycemic efficacy in elderly patients with renal impairment [see *Use in Specific Populations (8.6)*]. The risk of volume depletion-related adverse reactions increased in patients who were 75 years of age and older to 2.1%, 2.3%, and 4.4% for placebo, JARDIANCE 10 mg, and JARDIANCE 25 mg. The risk of urinary tract infections increased in patients who were 75 years of age and older to 10.5%, 15.7%, and 15.1% in patients randomized to placebo, JARDIANCE 10 mg, and JARDIANCE 25 mg, respectively [see *Warnings and Precautions (5.2)* and *Adverse Reactions (6.1)*].

In heart failure studies, EMPEROR-Reduced included 1188 (64%) patients treated with JARDIANCE 65 years of age and older, and 503 (27%) patients 75 years of age and older. EMPEROR-Preserved included 2402 (80%) patients treated with JARDIANCE 65 years of age and older, and 1281 (43%) patients 75 years of age and older. Safety and efficacy were similar for patients 65 years and younger and those older than 65 years.

8.6 Renal Impairment

The efficacy and safety of JARDIANCE for glycemic control were evaluated in a study of patients with type 2 diabetes mellitus with mild and moderate renal impairment (eGFR 30 to less than 90 mL/min/1.73 m²) [see *Clinical Studies (14)*]. In this study, 195 patients exposed to JARDIANCE had an eGFR between 60 and 90 mL/min/1.73 m², 91 patients exposed to JARDIANCE had an eGFR between 45 and 60 mL/min/1.73 m², and 97 patients exposed to JARDIANCE had an eGFR between 30 and 45 mL/min/1.73 m². The glucose lowering benefit of JARDIANCE 25 mg decreased in patients with worsening renal function. The risks of renal impairment, volume depletion adverse reactions and urinary tract infection-related adverse reactions increased with worsening renal function [see *Warnings and Precautions (5.2)*]. Use of JARDIANCE for glycemic control in patients without established cardiovascular disease or cardiovascular risk factors is not recommended when eGFR is less than 30 mL/min/1.73 m².

In a large cardiovascular outcomes study of patients with type 2 diabetes and established cardiovascular disease, there were 1819 patients with eGFR below 60 mL/min/1.73 m². The cardiovascular death findings in this subgroup were consistent with the overall findings [see *Clinical Studies (14)*].

Studies of patients with heart failure [see *Clinical Studies (14)*] enrolled patients with eGFR equal to or above 20 mL/min/1.73 m². No dose adjustment is recommended for these patients. There are insufficient data to support a dosing recommendation in patients with eGFR below 20 mL/min/1.73 m².

Efficacy and safety studies with JARDIANCE did not enroll patients with an eGFR less than 20 mL/min/1.73 m². JARDIANCE is contraindicated in patients on dialysis [see *Contraindications (4)*].

8.7 Hepatic Impairment

JARDIANCE may be used in patients with hepatic impairment [see *Clinical Pharmacology (12.3)*].

10 OVERDOSAGE

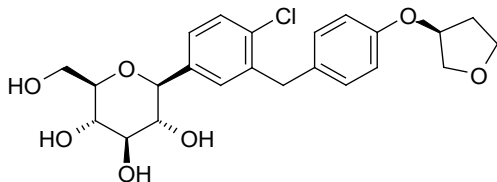
In the event of an overdose with JARDIANCE, contact the Poison Control Center. Removal of empagliflozin by hemodialysis has not been studied.

11 DESCRIPTION

JARDIANCE tablets for oral use contain empagliflozin, an inhibitor of the sodium-glucose co-transporter 2 (SGLT2).

The chemical name of empagliflozin is D-Glucitol,1,5-anhydro-1-C-[4-chloro-3-[[4-[[[(3S)-tetrahydro-3-furanyl]oxy]phenyl]methyl]phenyl]-, (1S).

Its molecular formula is $C_{23}H_{27}ClO_7$ and the molecular weight is 450.91. The structural formula is:



Empagliflozin is a white to yellowish, non-hygroscopic powder. It is very slightly soluble in water, sparingly soluble in methanol, slightly soluble in ethanol and acetonitrile, soluble in 50% acetonitrile/water, and practically insoluble in toluene.

Each film-coated tablet of JARDIANCE contains 10 mg or 25 mg of empagliflozin (free base) and the following inactive ingredients: lactose monohydrate, microcrystalline cellulose, hydroxypropyl cellulose, croscarmellose sodium, colloidal silicon dioxide and magnesium stearate. In addition, the film coating contains the following inactive ingredients: hypromellose, titanium dioxide, talc, polyethylene glycol, and yellow ferric oxide.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

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.

Empagliflozin also reduces sodium reabsorption and increases the delivery of sodium to the distal tubule. This may influence several physiological functions such as lowering both pre-and afterload of the heart and downregulating sympathetic activity.

12.2 Pharmacodynamics

Urinary Glucose Excretion

In patients with type 2 diabetes, urinary glucose excretion increased immediately following a dose of empagliflozin and was maintained at the end of a 4-week treatment period averaging at approximately 64 grams per day with 10 mg empagliflozin and 78 grams per day with 25 mg empagliflozin once daily [see *Clinical Studies (14)*]. Data from single oral doses of empagliflozin in healthy subjects indicate that, on average, the elevation in urinary glucose excretion approaches baseline by about 3 days for the 10 mg and 25 mg doses.

Urinary Volume

In a 5-day study, mean 24-hour urine volume increase from baseline was 341 mL on Day 1 and 135 mL on Day 5 of empagliflozin 25 mg once daily treatment.

Cardiac Electrophysiology

In a randomized, placebo-controlled, active-comparator, crossover study, 30 healthy subjects were administered a single oral dose of empagliflozin 25 mg, empagliflozin 200 mg (8 times the maximum dose), moxifloxacin, and placebo. No increase in QTc was observed with either 25 mg or 200 mg empagliflozin.

12.3 Pharmacokinetics

Absorption

The pharmacokinetics of empagliflozin has been characterized in healthy volunteers and patients with type 2 diabetes and no clinically relevant differences were noted between the two populations. After oral administration, peak plasma concentrations of empagliflozin were reached at 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 1870 nmol·h/L and 259 nmol/L, respectively, with 10 mg empagliflozin once daily treatment, and 4740 nmol·h/L and 687 nmol/L, respectively, with 25 mg empagliflozin once daily treatment. Systemic exposure of empagliflozin increased in a dose-proportional manner in the therapeutic dose range. The single-dose and steady-state pharmacokinetic parameters of empagliflozin were similar, suggesting linear pharmacokinetics with respect to time.

Administration of 25 mg empagliflozin after intake of a high-fat and high-calorie meal resulted in slightly lower exposure; AUC decreased by approximately 16% and C_{max} decreased 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 73.8 L based on a population pharmacokinetic analysis. Following administration of an oral [14 C]-empagliflozin solution to healthy subjects, the red blood cell partitioning was approximately 36.8% and plasma protein binding was 86.2%.

Elimination

The apparent terminal elimination half-life of empagliflozin was estimated to be 12.4 h and apparent oral clearance was 10.6 L/h based on the population pharmacokinetic analysis. Following once-daily dosing, up to 22% accumulation, with respect to plasma AUC, was observed at steady-state, which was consistent with empagliflozin half-life.

Metabolism

No major metabolites of empagliflozin were detected in human plasma and the most abundant metabolites were three glucuronide conjugates (2-O-, 3-O-, 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'-diphospho-glucuronosyltransferases UGT2B7, UGT1A3, UGT1A8, and UGT1A9.

Excretion

Following administration of an oral [14 C]-empagliflozin solution to healthy subjects, approximately 95.6% of the drug-related radioactivity was eliminated in feces (41.2%) or urine (54.4%). 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.

Specific Populations

Renal Impairment

In patients with type 2 diabetes mellitus with mild (eGFR: 60 to less than 90 mL/min/1.73 m²), moderate (eGFR: 30 to less than 60 mL/min/1.73 m²), and severe (eGFR: less than 30 mL/min/1.73 m²) renal impairment

and patients on dialysis due to kidney failure, AUC of empagliflozin increased by approximately 18%, 20%, 66%, and 48%, respectively, compared to subjects with normal renal function. Peak plasma levels of empagliflozin were similar in patients with moderate renal impairment and patients on dialysis due to kidney failure compared to subjects with normal renal function. Peak plasma levels of empagliflozin were roughly 20% higher in patients with mild and severe renal impairment as compared to subjects with normal renal function. Population pharmacokinetic analysis showed that the apparent oral clearance of empagliflozin decreased, with a decrease in eGFR leading to an increase in drug exposure. However, the fraction of empagliflozin that was excreted unchanged in urine, and urinary glucose excretion, declined with decrease in eGFR.

Hepatic Impairment

In patients with mild, moderate, and severe hepatic impairment according to the Child-Pugh classification, AUC of empagliflozin increased by approximately 23%, 47%, and 75%, and C_{max} increased by approximately 4%, 23%, and 48%, respectively, compared to subjects with normal hepatic function.

Effects of Age, Body Mass Index, Gender, and Race

Based on the population PK analysis, age, body mass index (BMI), gender and race (Asians versus primarily Whites) do not have a clinically meaningful effect on pharmacokinetics of empagliflozin [see *Use in Specific Populations (8.5)*].

Drug Interactions

In vitro Assessment of Drug Interactions

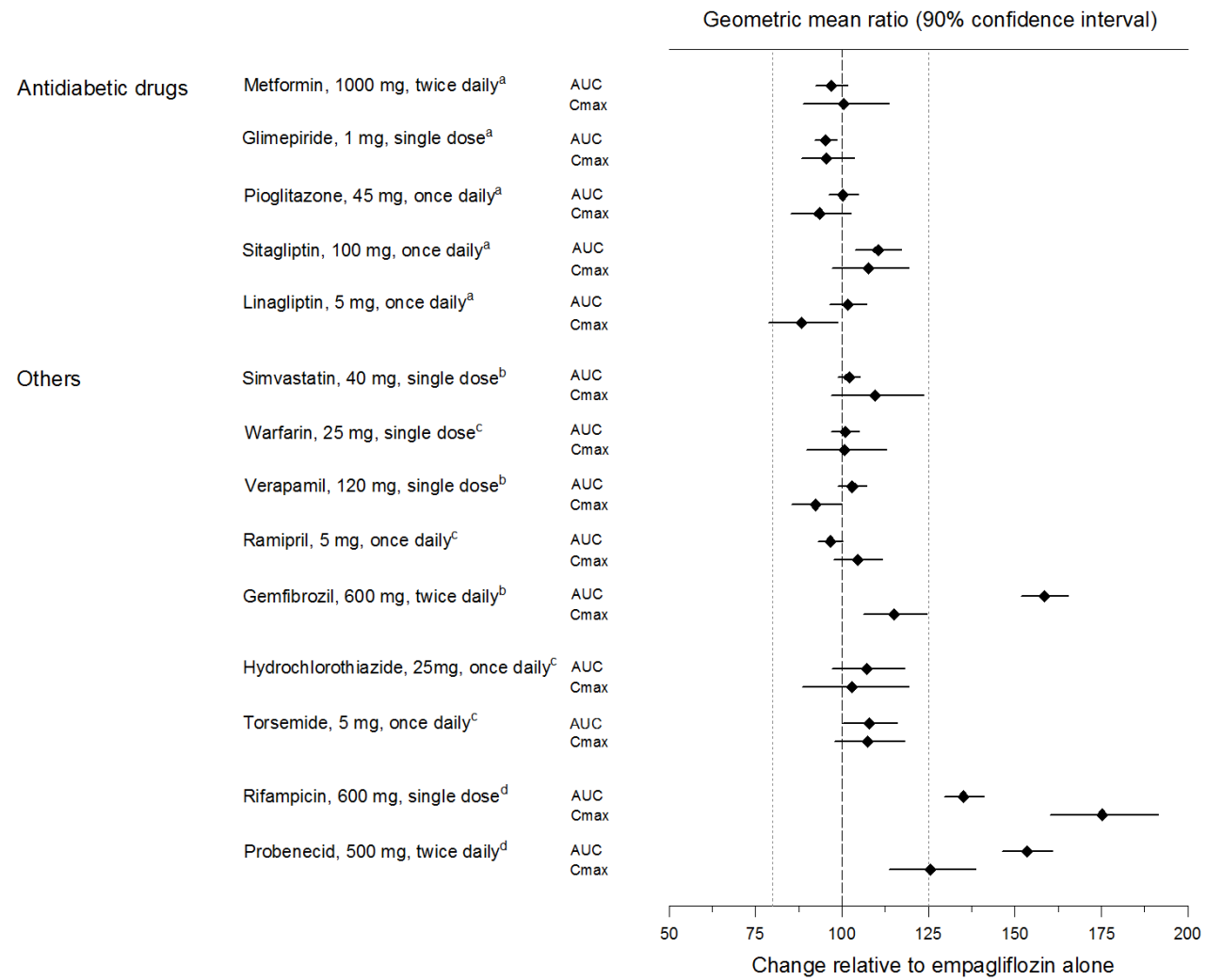
Empagliflozin does not inhibit, inactivate, or induce CYP450 isoforms. *In vitro* data suggest that the primary route of metabolism of empagliflozin in humans is glucuronidation by the uridine 5'-diphospho-glucuronosyltransferases UGT1A3, UGT1A8, UGT1A9, and UGT2B7. Empagliflozin does not inhibit UGT1A1, UGT1A3, UGT1A8, UGT1A9, or UGT2B7. Therefore, no effect of empagliflozin is anticipated on concomitantly administered drugs that are substrates of the major CYP450 isoforms or UGT1A1, UGT1A3, UGT1A8, UGT1A9, or UGT2B7. The effect of UGT induction (e.g., induction by rifampicin or any other UGT enzyme inducer) on empagliflozin exposure has not been evaluated.

Empagliflozin is a substrate for P-glycoprotein (P-gp) and breast cancer resistance protein (BCRP), but it does not inhibit these efflux transporters at therapeutic doses. Based on *in vitro* studies, empagliflozin is considered unlikely to cause interactions with drugs that are P-gp substrates. Empagliflozin is a substrate of the human uptake transporters OAT3, OATP1B1, and OATP1B3, but not OAT1 and OCT2. Empagliflozin does not inhibit any of these human uptake transporters at clinically relevant plasma concentrations and, therefore, no effect of empagliflozin is anticipated on concomitantly administered drugs that are substrates of these uptake transporters.

In vivo Assessment of Drug Interactions

Empagliflozin pharmacokinetics were similar with and without coadministration of metformin, glimepiride, pioglitazone, sitagliptin, linagliptin, warfarin, verapamil, ramipril, and simvastatin in healthy volunteers and with or without coadministration of hydrochlorothiazide and torsemide in patients with type 2 diabetes (see Figure 1). In subjects with normal renal function, coadministration of empagliflozin with probenecid resulted in a 30% decrease in the fraction of empagliflozin excreted in urine without any effect on 24-hour urinary glucose excretion. The relevance of this observation to patients with renal impairment is unknown.

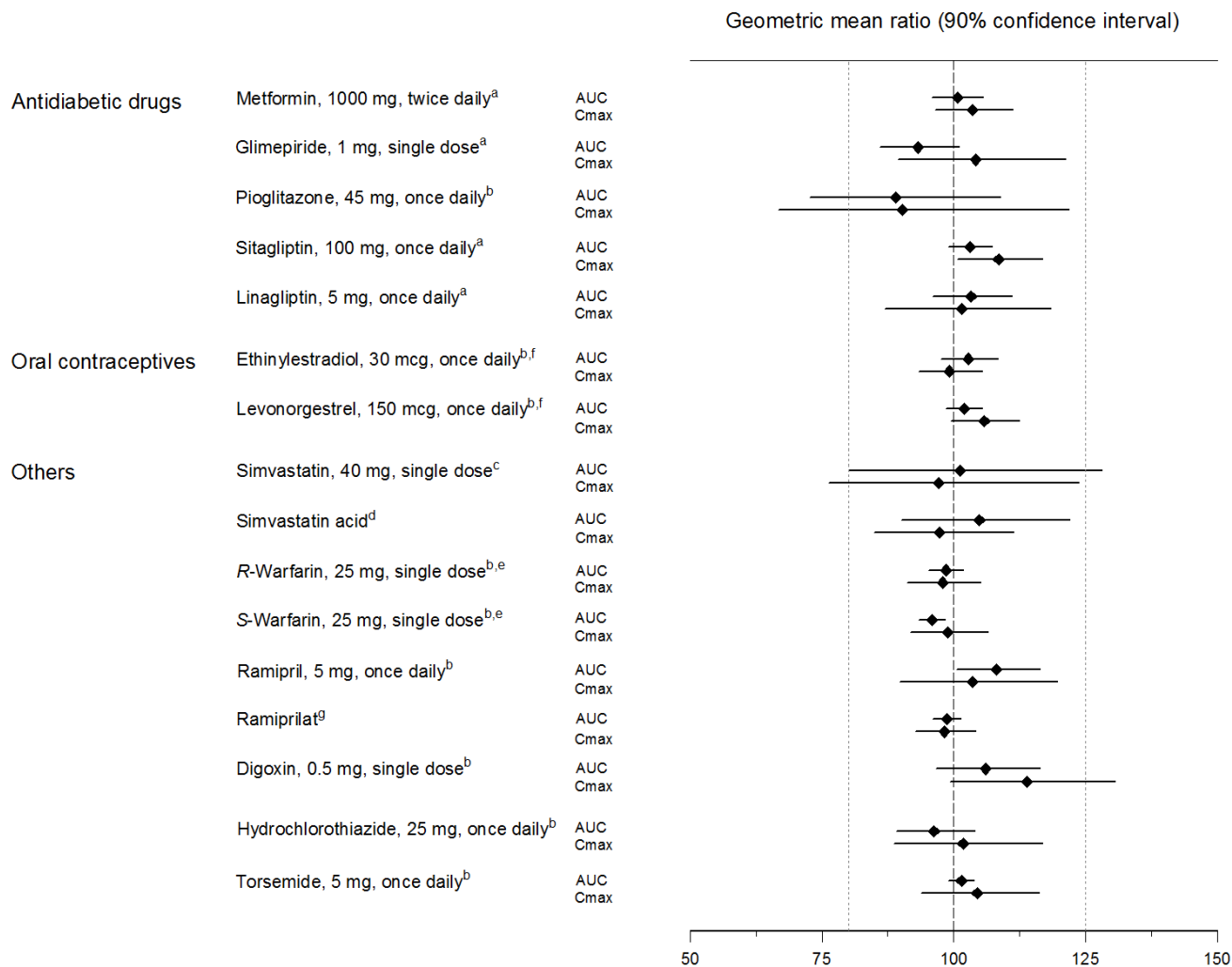
Figure 1 Effect of Various Medications on the Pharmacokinetics of Empagliflozin as Displayed as 90% Confidence Interval of Geometric Mean AUC and C_{max} Ratios [reference lines indicate 100% (80% - 125%)]



^aempagliflozin, 50 mg, once daily; ^bempagliflozin, 25 mg, single dose; ^cempagliflozin, 25 mg, once daily; ^dempagliflozin, 10 mg, single dose

Empagliflozin had no clinically relevant effect on the pharmacokinetics of metformin, glimepiride, pioglitazone, sitagliptin, linagliptin, warfarin, digoxin, ramipril, simvastatin, hydrochlorothiazide, torsemide, and oral contraceptives when coadministered in healthy volunteers (see Figure 2).

Figure 2 Effect of Empagliflozin on the Pharmacokinetics of Various Medications as Displayed as 90% Confidence Interval of Geometric Mean AUC and C_{max} Ratios [reference lines indicate 100% (80% - 125%)]



^aempagliflozin, 50 mg, once daily; ^bempagliflozin, 25 mg, once daily; ^cempagliflozin, 25 mg, single dose; ^dadministered as simvastatin; ^eadministered as warfarin racemic mixture; ^fadministered as Microgynon[®]; ^gadministered as ramipril

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis

Carcinogenesis was evaluated in 2-year studies conducted in CD-1 mice and Wistar rats. Empagliflozin did not increase the incidence of tumors in female rats dosed at 100, 300, or 700 mg/kg/day (up to 72 times the exposure from the maximum clinical dose of 25 mg). In male rats, hemangiomas of the mesenteric lymph node were increased significantly at 700 mg/kg/day or approximately 42 times the exposure from a 25 mg clinical dose. Empagliflozin did not increase the incidence of tumors in female mice dosed at 100, 300, or 1000 mg/kg/day (up to 62 times the exposure from a 25 mg clinical dose). Renal tubule adenomas and carcinomas were observed in male mice at 1000 mg/kg/day, which is approximately 45 times the exposure of the maximum

clinical dose of 25 mg. These tumors may be associated with a metabolic pathway predominantly present in the male mouse kidney.

Mutagenesis

Empagliflozin was not mutagenic or clastogenic with or without metabolic activation in the *in vitro* Ames bacterial mutagenicity assay, the *in vitro* L5178Y tk[±] mouse lymphoma cell assay, and an *in vivo* micronucleus assay in rats.

Impairment of Fertility

Empagliflozin had no effects on mating, fertility or early embryonic development in treated male or female rats up to the high dose of 700 mg/kg/day (approximately 155 times the 25 mg clinical dose in males and females, respectively).

14 CLINICAL STUDIES

Glycemic Control in Patients with Type 2 Diabetes Mellitus

JARDIANCE has been studied as monotherapy and in combination with metformin, sulfonylurea, pioglitazone, linagliptin, and insulin. JARDIANCE has also been studied in patients with type 2 diabetes with mild or moderate renal impairment.

In patients with type 2 diabetes, treatment with JARDIANCE reduced hemoglobin A1c (HbA1c), compared to placebo. The reduction in HbA1c for JARDIANCE compared with placebo was observed across subgroups including gender, race, geographic region, baseline BMI and duration of disease.

Monotherapy

A total of 986 patients with type 2 diabetes participated in a double-blind, placebo-controlled study to evaluate the efficacy and safety of JARDIANCE monotherapy.

Treatment-naïve patients with inadequately controlled type 2 diabetes entered an open-label placebo run-in for 2 weeks. At the end of the run-in period, patients who remained inadequately controlled and had an HbA1c between 7% and 10% were randomized to placebo, JARDIANCE 10 mg, JARDIANCE 25 mg, or a reference comparator.

At Week 24, treatment with JARDIANCE 10 mg or 25 mg daily provided statistically significant reductions in HbA1c (p-value <0.0001), fasting plasma glucose (FPG), and body weight compared with placebo (see Table 4 and Figure 3).

Table 4 Results at Week 24 From a Placebo-Controlled Monotherapy Study of JARDIANCE

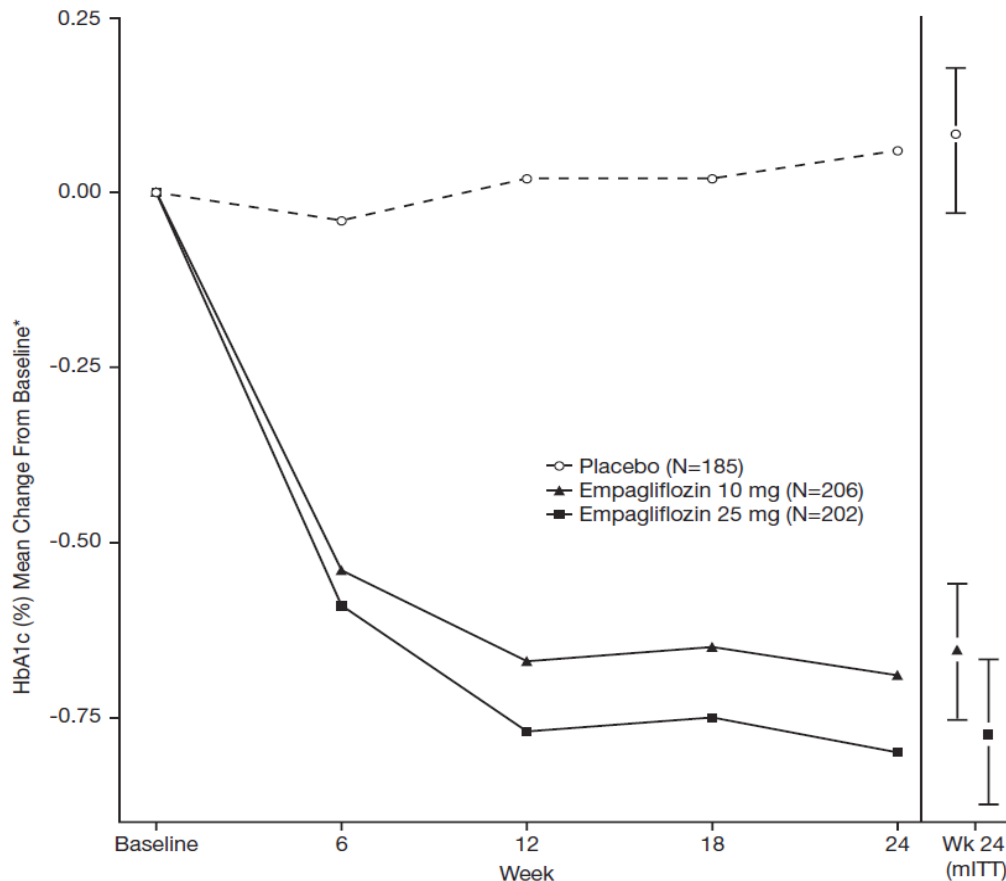
| | JARDIANCE 10 mg N=224 | JARDIANCE 25 mg N=224 | Placebo N=228 |
|----------------------------------------------------|--------------------------------------|--------------------------------------|--------------------------|
| HbA1c (%)^a | | | |
| Baseline (mean) | 7.9 | 7.9 | 7.9 |
| Change from baseline (adjusted mean) | -0.7 | -0.8 | 0.1 |
| Difference from placebo (adjusted mean) (97.5% CI) | -0.7 ^b (-0.9, -0.6) | -0.9 ^b (-1.0, -0.7) | -- |
| Patients [n (%)] achieving HbA1c <7% | 72 (35%) | 88 (44%) | 25 (12%) |
| FPG (mg/dL)^c | | | |
| Baseline (mean) | 153 | 153 | 155 |
| Change from baseline (adjusted mean) | -19 | -25 | 12 |
| Difference from placebo (adjusted mean) (95% CI) | -31 (-37, -26) | -36 (-42, -31) | -- |
| Body Weight | | | |
| Baseline (mean) in kg | 78 | 78 | 78 |
| % change from baseline (adjusted mean) | -2.8 | -3.2 | -0.4 |
| Difference from placebo (adjusted mean) (95% CI) | -2.5 ^b (-3.1, -1.9) | -2.8 ^b (-3.4, -2.2) | -- |

^aModified intent-to-treat population. Last observation on study (LOCF) was used to impute missing data at Week 24. At Week 24, 9.4%, 9.4%, and 30.7% was imputed for patients randomized to JARDIANCE 10 mg, JARDIANCE 25 mg, and placebo, respectively.

^bANCOVA derived p-value <0.0001 (HbA1c: ANCOVA model includes baseline HbA1c, treatment, renal function, and region. Body weight and FPG: same model used as for HbA1c but additionally including baseline body weight/baseline FPG, respectively.)

^cFPG (mg/dL); for JARDIANCE 10 mg, n=223, for JARDIANCE 25 mg, n=223, and for placebo, n=226

Figure 3 Adjusted Mean HbA1c Change at Each Time Point (Completers) and at Week 24 (mITT Population) - LOCF



*Mean change from baseline adjusted for baseline HbA1c, geographical region, and eGFR at baseline.

At Week 24, the systolic blood pressure was statistically significantly reduced compared to placebo by -2.6 mmHg (placebo-adjusted, p-value=0.0231) in patients randomized to 10 mg of JARDIANCE and by -3.4 mmHg (placebo-corrected, p-value=0.0028) in patients randomized to 25 mg of JARDIANCE.

Add-On Combination Therapy with Metformin

A total of 637 patients with type 2 diabetes participated in a double-blind, placebo-controlled study to evaluate the efficacy and safety of JARDIANCE in combination with metformin.

Patients with type 2 diabetes inadequately controlled on at least 1500 mg of metformin per day entered an open-label 2-week placebo run-in. At the end of the run-in period, patients who remained inadequately controlled and had an HbA1c between 7% and 10% were randomized to placebo, JARDIANCE 10 mg, or JARDIANCE 25 mg.

At Week 24, treatment with JARDIANCE 10 mg or 25 mg daily provided statistically significant reductions in HbA1c (p-value <0.0001), FPG, and body weight compared with placebo (see Table 5).

Table 5 Results at Week 24 From a Placebo-Controlled Study for JARDIANCE used in Combination with Metformin

| | JARDIANCE 10 mg + Metformin N=217 | JARDIANCE 25 mg + Metformin N=213 | Placebo + Metformin N=207 |
|--------------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|------------------------------------------|
| HbA1c (%)^a | | | |
| Baseline (mean) | 7.9 | 7.9 | 7.9 |
| Change from baseline (adjusted mean) | -0.7 | -0.8 | -0.1 |
| Difference from placebo + metformin (adjusted mean) (95% CI) | -0.6 ^b (-0.7, -0.4) | -0.6 ^b (-0.8, -0.5) | -- |
| Patients [n (%)] achieving HbA1c <7% | 75 (38%) | 74 (39%) | 23 (13%) |
| FPG (mg/dL)^c | | | |
| Baseline (mean) | 155 | 149 | 156 |
| Change from baseline (adjusted mean) | -20 | -22 | 6 |
| Difference from placebo + metformin (adjusted mean) | -26 | -29 | -- |
| Body Weight | | | |
| Baseline mean in kg | 82 | 82 | 80 |
| % change from baseline (adjusted mean) | -2.5 | -2.9 | -0.5 |
| Difference from placebo (adjusted mean) (95% CI) | -2.0 ^b (-2.6, -1.4) | -2.5 ^b (-3.1, -1.9) | -- |

^aModified intent-to-treat population. Last observation on study (LOCF) was used to impute missing data at Week 24. At Week 24, 9.7%, 14.1%, and 24.6% was imputed for patients randomized to JARDIANCE 10 mg, JARDIANCE 25 mg, and placebo, respectively.

^bANCOVA p-value <0.0001 (HbA1c: ANCOVA model includes baseline HbA1c, treatment, renal function, and region. Body weight and FPG: same model used as for HbA1c but additionally including baseline body weight/baseline FPG, respectively.)

^cFPG (mg/dL); for JARDIANCE 10 mg, n=216, for JARDIANCE 25 mg, n=213, and for placebo, n=207

At Week 24, the systolic blood pressure was statistically significantly reduced compared to placebo by -4.1 mmHg (placebo-corrected, p-value <0.0001) for JARDIANCE 10 mg and -4.8 mmHg (placebo-corrected, p-value <0.0001) for JARDIANCE 25 mg.

Initial Combination Therapy with Metformin

A total of 1364 patients with type 2 diabetes participated in a double-blind, randomized, active-controlled study to evaluate the efficacy and safety of JARDIANCE in combination with metformin as initial therapy compared to the corresponding individual components.

Treatment-naïve patients with inadequately controlled type 2 diabetes entered an open-label placebo run-in for 2 weeks. At the end of the run-in period, patients who remained inadequately controlled and had an HbA1c between 7% and 10.5% were randomized to one of 8 active-treatment arms: JARDIANCE 10 mg or 25 mg; metformin 1000 mg, or 2000 mg; JARDIANCE 10 mg in combination with 1000 mg or 2000 mg metformin; or JARDIANCE 25 mg in combination with 1000 mg or 2000 mg metformin.

At Week 24, initial therapy of JARDIANCE in combination with metformin provided statistically significant reductions in HbA1c (p-value <0.01) compared to the individual components (see Table 6).

Table 6 Glycemic Parameters at 24 Weeks in a Study Comparing JARDIANCE and Metformin to the Individual Components as Initial Therapy

| | JARDIANCE 10 mg + Metformin 1000 mg ^a N=161 | JARDIANCE 10 mg + Metformin 2000 mg ^a N=167 | JARDIANCE 25 mg + Metformin 1000 mg ^a N=165 | JARDIANCE 25 mg + Metformin 2000 mg ^a N=169 | JARDIANCE 10 mg N=169 | JARDIANCE 25 mg N=163 | Metformin 1000 mg ^a N=167 | Metformin 2000 mg ^a N=162 |
|-----------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------------|-----------------------------|-----------------------------|--------------------------------------------|--------------------------------------------|
| HbA1c (%) | | | | | | | | |
| Baseline (mean) | 8.7 | 8.7 | 8.8 | 8.7 | 8.6 | 8.9 | 8.7 | 8.6 |
| Change from baseline (adjusted mean) | -2.0 | -2.1 | -1.9 | -2.1 | -1.4 | -1.4 | -1.2 | -1.8 |
| Comparison vs JARDIANCE (adjusted mean) (95% CI) | -0.6 ^b (-0.9, -0.4) | -0.7 ^b (-1.0, -0.5) | -0.6 ^c (-0.8, -0.3) | -0.7 ^c (-1.0, -0.5) | -- | -- | -- | -- |
| Comparison vs metformin (adjusted mean) (95% CI) | -0.8 ^b (-1.0, -0.6) | -0.3 ^b (-0.6, -0.1) | -0.8 ^c (-1.0, -0.5) | -0.3 ^c (-0.6, -0.1) | -- | -- | -- | -- |

^aMetformin total daily dose, administered in two equally divided doses per day.

^bp-value ≤0.0062 (modified intent-to-treat population [observed case] MMRM model included treatment, renal function, region, visit, visit by treatment interaction, and baseline HbA1c).

^cp-value ≤0.0056 (modified intent-to-treat population [observed case] MMRM model included treatment, renal function, region, visit, visit by treatment interaction, and baseline HbA1c).

Add-On Combination Therapy with Metformin and Sulfonylurea

A total of 666 patients with type 2 diabetes participated in a double-blind, placebo-controlled study to evaluate the efficacy and safety of JARDIANCE in combination with metformin plus a sulfonylurea.

Patients with inadequately controlled type 2 diabetes on at least 1500 mg per day of metformin and on a sulfonylurea, entered a 2 week open-label placebo run-in. At the end of the run-in, patients who remained inadequately controlled and had an HbA1c between 7% and 10% were randomized to placebo, JARDIANCE 10 mg, or JARDIANCE 25 mg.

Treatment with JARDIANCE 10 mg or 25 mg daily provided statistically significant reductions in HbA1c (p-value <0.0001), FPG, and body weight compared with placebo (see Table 7).

Table 7 Results at Week 24 from a Placebo-Controlled Study for JARDIANCE in Combination with Metformin and Sulfonylurea

| | JARDIANCE 10 mg + Metformin + SU N=225 | JARDIANCE 25 mg + Metformin + SU N=216 | Placebo + Metformin + SU N=225 |
|--------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------|
| HbA1c (%)^a | | | |
| Baseline (mean) | 8.1 | 8.1 | 8.2 |
| Change from baseline (adjusted mean) | -0.8 | -0.8 | -0.2 |
| Difference from placebo (adjusted mean) (95% CI) | -0.6 ^b (-0.8, -0.5) | -0.6 ^b (-0.7, -0.4) | -- |
| Patients [n (%)] achieving HbA1c <7% | 55 (26%) | 65 (32%) | 20 (9%) |
| FPG (mg/dL)^c | | | |
| Baseline (mean) | 151 | 156 | 152 |
| Change from baseline (adjusted mean) | -23 | -23 | 6 |
| Difference from placebo (adjusted mean) | -29 | -29 | -- |
| Body Weight | | | |
| Baseline mean in kg | 77 | 78 | 76 |
| % change from baseline (adjusted mean) | -2.9 | -3.2 | -0.5 |
| Difference from placebo (adjusted mean) (95% CI) | -2.4 ^b (-3.0, -1.8) | -2.7 ^b (-3.3, -2.1) | -- |

^aModified intent-to-treat population. Last observation on study (LOCF) was used to impute missing data at Week 24. At Week 24, 17.8%, 16.7%, and 25.3% was imputed for patients randomized to JARDIANCE 10 mg, JARDIANCE 25 mg, and placebo, respectively.

^bANCOVA p-value <0.0001 (HbA1c: ANCOVA model includes baseline HbA1c, treatment, renal function, and region. Body weight and FPG: same model used as for HbA1c but additionally including baseline body weight/baseline FPG, respectively.)

^cFPG (mg/dL); for JARDIANCE 10 mg, n=225, for JARDIANCE 25 mg, n=215, for placebo, n=224

In Combination with Linagliptin as Add-On to Metformin Therapy

A total of 686 patients with type 2 diabetes participated in a double-blind, active-controlled study to evaluate the efficacy and safety of JARDIANCE 10 mg or 25 mg in combination with linagliptin 5 mg compared to the individual components.

Patients with type 2 diabetes inadequately controlled on at least 1500 mg of metformin per day entered a single-blind placebo run-in period for 2 weeks. At the end of the run-in period, patients who remained inadequately controlled and had an HbA1c between 7% and 10.5% were randomized 1:1:1:1:1 to one of 5 active-treatment arms of JARDIANCE 10 mg or 25 mg, linagliptin 5 mg, or linagliptin 5 mg in combination with 10 mg or 25 mg JARDIANCE as a fixed-dose combination tablet.

At Week 24, JARDIANCE 10 mg or 25 mg used in combination with linagliptin 5 mg provided statistically significant improvement in HbA1c (p-value <0.0001) and FPG (p-value <0.001) compared to the individual components in patients who had been inadequately controlled on metformin. Treatment with JARDIANCE/linagliptin 25 mg/5 mg or JARDIANCE/linagliptin 10 mg/5 mg daily also resulted in a statistically significant reduction in body weight compared to linagliptin 5 mg (p-value <0.0001). There was no statistically significant difference in body weight compared to JARDIANCE alone.

Active-Controlled Study versus Glimepiride in Combination with Metformin

The efficacy of JARDIANCE was evaluated in a double-blind, glimepiride-controlled, study in 1545 patients with type 2 diabetes with insufficient glycemic control despite metformin therapy.

Patients with inadequate glycemic control and an HbA1c between 7% and 10% after a 2-week run-in period were randomized to glimepiride or JARDIANCE 25 mg.

At Week 52, JARDIANCE 25 mg and glimepiride lowered HbA1c and FPG (see Table 8, Figure 4). The difference in observed effect size between JARDIANCE 25 mg and glimepiride excluded the pre-specified non-inferiority margin of 0.3%. The mean daily dose of glimepiride was 2.7 mg and the maximal approved dose in the United States is 8 mg per day.

Table 8 Results at Week 52 from an Active-Controlled Study Comparing JARDIANCE to Glimepiride as Add-On Therapy in Patients Inadequately Controlled on Metformin

| | JARDIANCE 25 mg + Metformin N=765 | Glimepiride + Metformin N=780 |
|--------------------------------------------------------|--------------------------------------------------|----------------------------------------------|
| HbA1c (%)^a | | |
| Baseline (mean) | 7.9 | 7.9 |
| Change from baseline (adjusted mean) | -0.7 | -0.7 |
| Difference from glimepiride (adjusted mean) (97.5% CI) | -0.07 ^b (-0.15, 0.01) | -- |
| FPG (mg/dL)^d | | |
| Baseline (mean) | 150 | 150 |
| Change from baseline (adjusted mean) | -19 | -9 |
| Difference from glimepiride (adjusted mean) | -11 | -- |
| Body Weight | | |
| Baseline mean in kg | 82.5 | 83 |
| % change from baseline (adjusted mean) | -3.9 | 2.0 |
| Difference from glimepiride (adjusted mean) (95% CI) | -5.9 ^c (-6.3, -5.5) | -- |

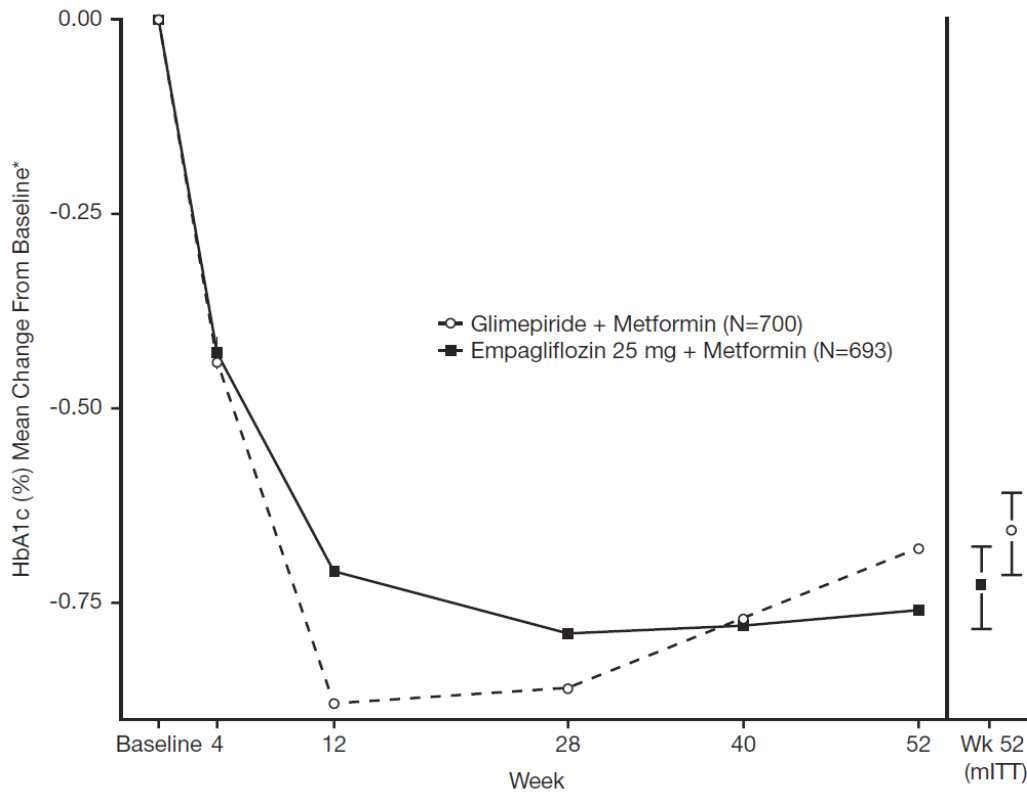
^aModified intent-to-treat population. Last observation on study (LOCF) was used to impute data missing at Week 52. At Week 52, data was imputed for 15.3% and 21.9% of patients randomized to JARDIANCE 25 mg and glimepiride, respectively.

^bNon-inferior, ANCOVA model p-value <0.0001 (HbA1c: ANCOVA model includes baseline HbA1c, treatment, renal function, and region)

^cANCOVA p-value <0.0001 (Body weight and FPG: same model used as for HbA1c but additionally including baseline body weight/baseline FPG, respectively.)

^dFPG (mg/dL); for JARDIANCE 25 mg, n=764, for glimepiride, n=779

Figure 4 Adjusted mean HbA1c Change at Each Time Point (Completers) and at Week 52 (mITT Population) - LOCF



*Mean change from baseline adjusted for baseline HbA1c, geographical region, and eGFR at baseline.

At Week 52, the adjusted mean change from baseline in systolic blood pressure was -3.6 mmHg, compared to 2.2 mmHg for glimepiride. The differences between treatment groups for systolic blood pressure was statistically significant (p-value <0.0001).

At Week 104, the adjusted mean change from baseline in HbA1c was -0.75% for JARDIANCE 25 mg and -0.66% for glimepiride. The adjusted mean treatment difference was -0.09% with a 97.5% confidence interval of (-0.32%, 0.15%), excluding the pre-specified non-inferiority margin of 0.3%. The mean daily dose of glimepiride was 2.7 mg and the maximal approved dose in the United States is 8 mg per day. The Week 104 analysis included data with and without concomitant glycemic rescue medication, as well as off-treatment data. Missing data for patients not providing any information at the visit were imputed based on the observed off-treatment data. In this multiple imputation analysis, 13.9% of the data were imputed for JARDIANCE 25 mg and 12.9% for glimepiride.

At Week 104, JARDIANCE 25 mg daily resulted in a statistically significant difference in change from baseline for body weight compared to glimepiride (-3.1 kg for JARDIANCE 25 mg vs. +1.3 kg for glimepiride; ANCOVA-LOCF, p-value <0.0001).

Add-On Combination Therapy with Pioglitazone with or without Metformin

A total of 498 patients with type 2 diabetes participated in a double-blind, placebo-controlled study to evaluate the efficacy and safety of JARDIANCE in combination with pioglitazone, with or without metformin.

Patients with inadequately controlled type 2 diabetes on metformin at a dose of at least 1500 mg per day and pioglitazone at a dose of at least 30 mg per day were placed into an open-label placebo run-in for 2 weeks. Patients with inadequate glycemic control and an HbA1c between 7% and 10% after the run-in period were randomized to placebo, JARDIANCE 10 mg, or JARDIANCE 25 mg.

Treatment with JARDIANCE 10 mg or 25 mg daily resulted in statistically significant reductions in HbA1c (p-value <0.0001), FPG, and body weight compared with placebo (see Table 9).

Table 9 Results of Placebo-Controlled Study for JARDIANCE in Combination Therapy with Pioglitazone

| | JARDIANCE 10 mg + Pioglitazone N=165 | JARDIANCE 25 mg + Pioglitazone N=168 | Placebo + Pioglitazone N=165 |
|-------------------------------------------------------------------|---------------------------------------------------------|---------------------------------------------------------|---------------------------------------------|
| HbA1c (%)^a | | | |
| Baseline (mean) | 8.1 | 8.1 | 8.2 |
| Change from baseline (adjusted mean) | -0.6 | -0.7 | -0.1 |
| Difference from placebo + pioglitazone (adjusted mean) (95% CI) | -0.5 ^b (-0.7, -0.3) | -0.6 ^b (-0.8, -0.4) | -- |
| Patients [n (%)] achieving HbA1c <7% | 36 (24%) | 48 (30%) | 12 (8%) |
| FPG (mg/dL)^c | | | |
| Baseline (mean) | 152 | 152 | 152 |
| Change from baseline (adjusted mean) | -17 | -22 | 7 |
| Difference from placebo + pioglitazone (adjusted mean) (97.5% CI) | -23 ^b (-31.8, -15.2) | -28 ^b (-36.7, -20.2) | -- |
| Body Weight | | | |
| Baseline mean in kg | 78 | 79 | 78 |
| % change from baseline (adjusted mean) | -2.0 | -1.8 | 0.6 |
| Difference from placebo (adjusted mean) (95% CI) | -2.6 ^b (-3.4, -1.8) | -2.4 ^b (-3.2, -1.6) | -- |

^aModified intent-to-treat population. Last observation on study (LOCF) was used to impute missing data at Week 24. At Week 24, 10.9%, 8.3%, and 20.6% was imputed for patients randomized to JARDIANCE 10 mg, JARDIANCE 25 mg, and placebo, respectively.

^bANCOVA p-value <0.0001 (HbA1c: ANCOVA model includes baseline HbA1c, treatment, renal function, and background medication. Body weight and FPG: same model used as for HbA1c but additionally including baseline body weight/baseline FPG, respectively.)

^cFPG (mg/dL); for JARDIANCE 10 mg, n=163

Add-On Combination with Insulin with or without Metformin and/or Sulfonylureas

A total of 494 patients with type 2 diabetes inadequately controlled on insulin, or insulin in combination with oral drugs participated in a double-blind, placebo-controlled study to evaluate the efficacy of JARDIANCE as add-on therapy to insulin over 78 weeks.

Patients entered a 2-week placebo run-in period on basal insulin (e.g., insulin glargine, insulin detemir, or NPH insulin) with or without metformin and/or sulfonylurea background therapy. Following the run-in period, patients with inadequate glycemic control were randomized to the addition of JARDIANCE 10 mg, JARDIANCE 25 mg, or placebo. Patients were maintained on a stable dose of insulin prior to enrollment, during the run-in period, and during the first 18 weeks of treatment. For the remaining 60 weeks, insulin could be adjusted. The mean total daily insulin dose at baseline for JARDIANCE 10 mg, 25 mg, and placebo was 45 IU, 48 IU, and 48 IU, respectively.

JARDIANCE used in combination with insulin (with or without metformin and/or sulfonylurea) provided statistically significant reductions in HbA1c and FPG compared to placebo after both 18 and 78 weeks of treatment (see Table 10). JARDIANCE 10 mg or 25 mg daily also resulted in statistically significantly greater percent body weight reduction compared to placebo.

Table 10 Results at Week 18 and 78 for a Placebo-Controlled Study for JARDIANCE in Combination with Insulin

| | 18 weeks (no insulin adjustment) | | | 78 weeks (adjustable insulin dose after 18 weeks) | | |
|-------------------------------------------------------------|------------------------------------------|------------------------------------------|-------------------------------|------------------------------------------------------|------------------------------------------|-------------------------------|
| | JARDIANCE 10 mg + Insulin N=169 | JARDIANCE 25 mg + Insulin N=155 | Placebo + Insulin N=170 | JARDIANCE 10 mg + Insulin N=169 | JARDIANCE 25 mg + Insulin N=155 | Placebo + Insulin N=170 |
| HbA1c (%)^a | | | | | | |
| Baseline (mean) | 8.3 | 8.3 | 8.2 | 8.3 | 8.3 | 8.2 |
| Change from baseline (adjusted mean) | -0.6 | -0.7 | 0 | -0.4 | -0.6 | 0.1 |
| Difference from placebo (adjusted mean) (97.5% CI) | -0.6 ^b (-0.8, -0.4) | -0.7 ^b (-0.9, -0.5) | -- | -0.5 ^b (-0.7, -0.3) | -0.7 ^b (-0.9, -0.5) | -- |
| Patients (%) achieving HbA1c <7% | 18.0 | 19.5 | 5.5 | 12.0 | 17.5 | 6.7 |
| FPG (mg/dL) | | | | | | |
| Baseline (mean) | 138 | 146 | 142 | 138 | 146 | 142 |
| Change from baseline (adjusted mean, SE) | -17.9 (3.2) | -19.1 (3.3) | 10.4 (3.1) | -10.1 (3.2) | -15.2 (3.4) | 2.8 (3.2) |
| Difference from placebo (adjusted mean) (95% CI) | -28.2 ^b (-37.0, -19.5) | -29.5 ^b (-38.4, -20.6) | -- | -12.9 ^c (-21.9, 3.9) | -17.9 ^b (-27.0, -8.8) | -- |
| Body Weight | | | | | | |
| Baseline mean in kg | 92 | 95 | 90 | 92 | 95 | 90 |
| % change from baseline (adjusted mean) | -1.8 | -1.4 | -0.1 | -2.4 | -2.4 | 0.7 |
| Difference from placebo (adjusted mean) (95% CI) | -1.7 ^d (-3.0, -0.5) | -1.3 ^c (-2.5, -0.0) | -- | -3.0 ^b (-4.4, -1.7) | -3.0 ^b (-4.4, -1.6) | -- |

^aModified intent-to-treat population. Last observation on study (LOCF) was used to impute missing data at Week 18 and 78. At Week 18, 21.3%, 30.3%, and 21.8% was imputed for patients randomized to JARDIANCE 10 mg, JARDIANCE 25 mg, and placebo, respectively. At Week 78, 32.5%, 38.1% and 42.4% was imputed for patients randomized to JARDIANCE 10 mg, JARDIANCE 25 mg, and placebo, respectively.

^bANCOVA p-value <0.0001 (HbA1c: ANCOVA model includes baseline HbA1c, treatment, and region; FPG: MMRM model includes baseline FPG, baseline HbA1c, treatment, region, visit and visit by treatment interaction. Body weight: MMRM model includes baseline body weight, baseline HbA1c, treatment, region, visit and visit by treatment interaction.

^cp-value=0.0049

^dp-value=0.0052

^ep-value=0.0463

Add-on Combination with MDI Insulin with or without Metformin

A total of 563 patients with type 2 diabetes inadequately controlled on multiple daily injections (MDI) of insulin (total daily dose >60 IU), alone or in combination with metformin, participated in a double-blind, placebo-controlled study to evaluate the efficacy of JARDIANCE as add-on therapy to MDI insulin over 18 weeks.

Patients entered a 2-week placebo run-in period on MDI insulin with or without metformin background therapy. Following the run-in period, patients with inadequate glycemic control were randomized to the addition of JARDIANCE 10 mg, JARDIANCE 25 mg, or placebo. Patients were maintained on a stable dose of insulin prior to enrollment, during the run-in period, and during the first 18 weeks of treatment. The mean total daily insulin dose at baseline for JARDIANCE 10 mg, JARDIANCE 25 mg, and placebo was 88.6 IU, 90.4 IU, and 89.9 IU, respectively.

JARDIANCE 10 mg or 25 mg daily used in combination with MDI insulin (with or without metformin) provided statistically significant reductions in HbA1c compared to placebo after 18 weeks of treatment (see Table 11).

Table 11 Results at Week 18 for a Placebo-Controlled Study for JARDIANCE in Combination with Insulin and with or without Metformin

| | JARDIANCE 10 mg + Insulin +/- Metformin N=186 | JARDIANCE 25 mg + Insulin +/- Metformin N=189 | Placebo + Insulin +/- Metformin N=188 |
|--------------------------------------------------|--------------------------------------------------------|--------------------------------------------------------|------------------------------------------------|
| HbA1c (%)^a | | | |
| Baseline (mean) | 8.4 | 8.3 | 8.3 |
| Change from baseline (adjusted mean) | -0.9 | -1.0 | -0.5 |
| Difference from placebo (adjusted mean) (95% CI) | -0.4 ^b (-0.6, -0.3) | -0.5 ^b (-0.7, -0.4) | -- |

^aModified intent-to-treat population. Last observation on study (LOCF) was used to impute missing data at Week 18. At Week 18, 23.7%, 22.8% and 23.4% was imputed for patients randomized to JARDIANCE 10 mg, JARDIANCE 25 mg, and placebo, respectively.

^bANCOVA p-value <0.0001 (HbA1c: ANCOVA model includes baseline HbA1c, treatment, renal function, geographical region, and background medication).

During an extension period with treatment for up to 52 weeks, insulin could be adjusted to achieve defined glucose target levels. The change from baseline in HbA1c was maintained from 18 to 52 weeks with both JARDIANCE 10 mg and 25 mg. After 52 weeks, JARDIANCE 10 mg or 25 mg daily resulted in statistically greater percent body weight reduction compared to placebo (p-value <0.0001). The mean change in body weight from baseline was -1.95 kg for JARDIANCE 10 mg, and -2.04 kg for JARDIANCE 25 mg.

Renal Impairment

A total of 738 patients with type 2 diabetes and a baseline eGFR less than 90 mL/min/1.73 m² participated in a randomized, double-blind, placebo-controlled, parallel-group study to evaluate the efficacy and safety of JARDIANCE in patients with type 2 diabetes and renal impairment. The trial population comprised of 290 patients with mild renal impairment (eGFR 60 to less than 90 mL/min/1.73 m²), 374 patients with moderate renal impairment (eGFR 30 to less than 60 mL/min/1.73 m²), and 74 with severe renal impairment (eGFR less than 30 mL/min/1.73 m²). A total of 194 patients with moderate renal impairment had a baseline eGFR of 30 to less than 45 mL/min/1.73 m² and 180 patients a baseline eGFR of 45 to less than 60 mL/min/1.73 m².

At Week 24, JARDIANCE 25 mg provided statistically significant reduction in HbA1c relative to placebo in patients with mild to moderate renal impairment (see Table 12). A statistically significant reduction relative to

placebo was also observed with JARDIANCE 25 mg in patients with either mild [-0.7 (95% CI: -0.9, -0.5)] or moderate [-0.4 (95% CI: -0.6, -0.3)] renal impairment and with JARDIANCE 10 mg in patients with mild [-0.5 (95% CI: -0.7, -0.3)] renal impairment.

The glucose lowering efficacy of JARDIANCE 25 mg decreased with decreasing level of renal function in the mild to moderate range. Least square mean HbA1c changes at 24 weeks were -0.6%, -0.5%, and -0.2% for those with a baseline eGFR of 60 to less than 90 mL/min/1.73 m², 45 to less than 60 mL/min/1.73 m², and 30 to less than 45 mL/min/1.73 m², respectively [see Dosage and Administration (2) and Use in Specific Populations (8.6)]. For placebo, least square mean HbA1c changes at 24 weeks were 0.1%, -0.1%, and 0.2% for patients with a baseline eGFR of 60 to less than 90 mL/min/1.73 m², 45 to less than 60 mL/min/1.73 m², and 30 to less than 45 mL/min/1.73 m², respectively.

Table 12 Results at Week 24 (LOCF) of Placebo-Controlled Study for JARDIANCE in Patients with Type 2 Diabetes and Renal Impairment

| | Mild and Moderate Impairment ^b |
|------------------------------------------------|-------------------------------------------|
| | JARDIANCE 25 mg |
| HbA1c | |
| Number of patients | n=284 |
| Comparison vs placebo (adjusted mean) (95% CI) | -0.5 ^a (-0.6, -0.4) |

^ap-value <0.0001 (HbA1c: ANCOVA model includes baseline HbA1c, treatment, renal function, and background medication)

^beGFR 30 to less than 90 mL/min/1.73 m² - Modified intent-to-treat population. Last observation on study (LOCF) was used to impute missing data at Week 24. At Week 24, 24.6% and 26.2% was imputed for patients randomized to JARDIANCE 25 mg and placebo, respectively.)

For patients with severe renal impairment, the analyses of changes in HbA1c and FPG showed no discernible treatment effect of JARDIANCE 25 mg compared to placebo [see Indications and Usage (1), Dosage and Administration (2.2) and Use in Specific Populations (8.6)].

Cardiovascular Outcomes in Patients with Type 2 Diabetes Mellitus and Atherosclerotic Cardiovascular Disease

The effect of JARDIANCE on cardiovascular risk in adult patients with type 2 diabetes and established, stable, atherosclerotic cardiovascular disease was evaluated in the EMPA-REG OUTCOME study, a multicenter, multinational, randomized, double-blind parallel group trial. The study compared the risk of experiencing a major adverse cardiovascular event (MACE) between JARDIANCE and placebo when these were added to and used concomitantly with standard of care treatments for diabetes and atherosclerotic cardiovascular disease. Coadministered antidiabetic medications were to be kept stable for the first 12 weeks of the trial. Thereafter, antidiabetic and atherosclerotic therapies could be adjusted, at the discretion of investigators, to ensure participants were treated according to the standard care for these diseases.

A total of 7020 patients were treated (JARDIANCE 10 mg = 2345; JARDIANCE 25 mg = 2342; placebo = 2333) and followed for a median of 3.1 years. Approximately 72% of the study population was Caucasian, 22% was Asian, and 5% was Black. The mean age was 63 years and approximately 72% were male.

All patients in the study had inadequately controlled type 2 diabetes mellitus at baseline (HbA1c greater than or equal to 7%). The mean HbA1c at baseline was 8.1% and 57% of participants had diabetes for more than 10 years. Approximately 31%, 22% and 20% reported a past history of neuropathy, retinopathy and nephropathy to investigators, respectively and the mean eGFR was 74 mL/min/1.73 m². At baseline, patients were treated with one (~30%) or more (~70%) antidiabetic medications including metformin (74%), insulin (48%), and sulfonylurea (43%).

All patients had established atherosclerotic cardiovascular disease at baseline including one (82%) or more (18%) of the following: a documented history of coronary artery disease (76%), stroke (23%) or peripheral artery disease (21%). At baseline, the mean systolic blood pressure was 136 mmHg, the mean diastolic blood pressure was 76 mmHg, the mean LDL was 86 mg/dL, the mean HDL was 44 mg/dL, and the mean urinary albumin to creatinine ratio (UACR) was 175 mg/g. At baseline, approximately 81% of patients were treated with renin angiotensin system inhibitors, 65% with beta-blockers, 43% with diuretics, 77% with statins, and 86% with antiplatelet agents (mostly aspirin).

The primary endpoint in EMPA-REG OUTCOME was the time to first occurrence of a Major Adverse Cardiac Event (MACE). A major adverse cardiac event was defined as occurrence of either a cardiovascular death or a non-fatal myocardial infarction (MI) or a non-fatal stroke. The statistical analysis plan had pre-specified that the 10 and 25 mg doses would be combined. A Cox proportional hazards model was used to test for non-inferiority against the pre-specified risk margin of 1.3 for the hazard ratio of MACE and superiority on MACE if non-inferiority was demonstrated. Type-1 error was controlled across multiples tests using a hierarchical testing strategy.

JARDIANCE significantly reduced the risk of first occurrence of primary composite endpoint of cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke (HR: 0.86; 95% CI: 0.74, 0.99). The treatment effect was due to a significant reduction in the risk of cardiovascular death in subjects randomized to empagliflozin (HR: 0.62; 95% CI: 0.49, 0.77), with no change in the risk of non-fatal myocardial infarction or non-fatal stroke (see Table 13 and Figures 5 and 6). Results for the 10 mg and 25 mg empagliflozin doses were consistent with results for the combined dose groups.

Table 13 Treatment Effect for the Primary Composite Endpoint and its Components^a

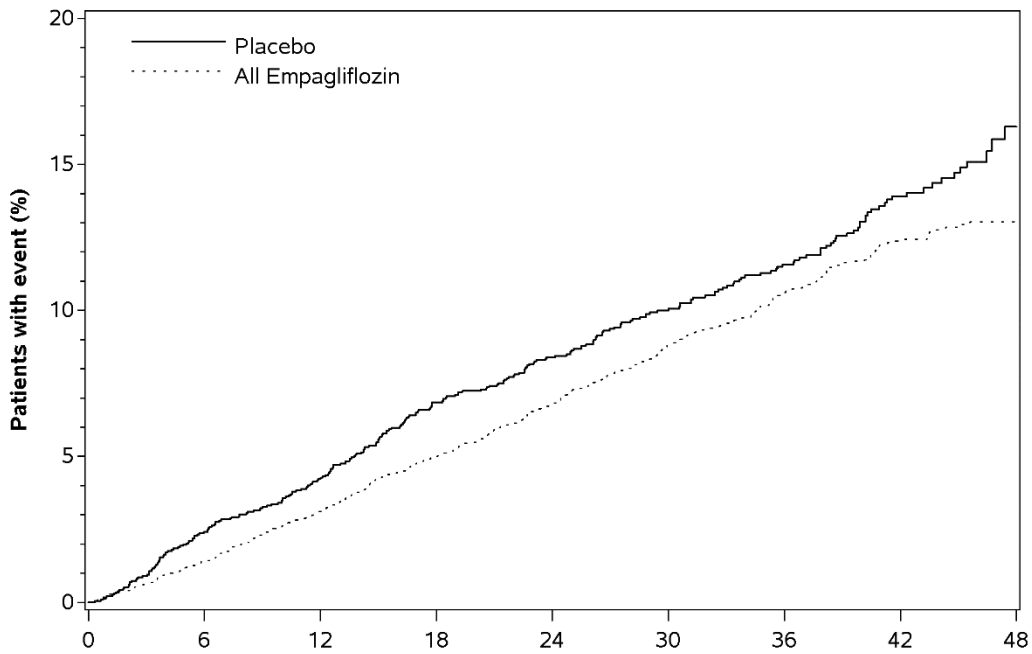
| | Placebo N=2333 | JARDIANCE N=4687 | Hazard ratio vs placebo (95% CI) |
|------------------------------------------------------------------------------------------------------------------------------|---------------------------|-----------------------------|-------------------------------------------------|
| Composite of cardiovascular death, non-fatal myocardial infarction, non-fatal stroke (time to first occurrence) ^b | 282 (12.1%) | 490 (10.5%) | 0.86 (0.74, 0.99) |
| Non-fatal myocardial infarction ^c | 121 (5.2%) | 213 (4.5%) | 0.87 (0.70, 1.09) |
| Non-fatal stroke ^c | 60 (2.6%) | 150 (3.2%) | 1.24 (0.92, 1.67) |
| Cardiovascular death ^c | 137 (5.9%) | 172 (3.7%) | 0.62 (0.49, 0.77) |

^aTreated set (patients who had received at least one dose of study drug)

^bp-value for superiority (2-sided) 0.04

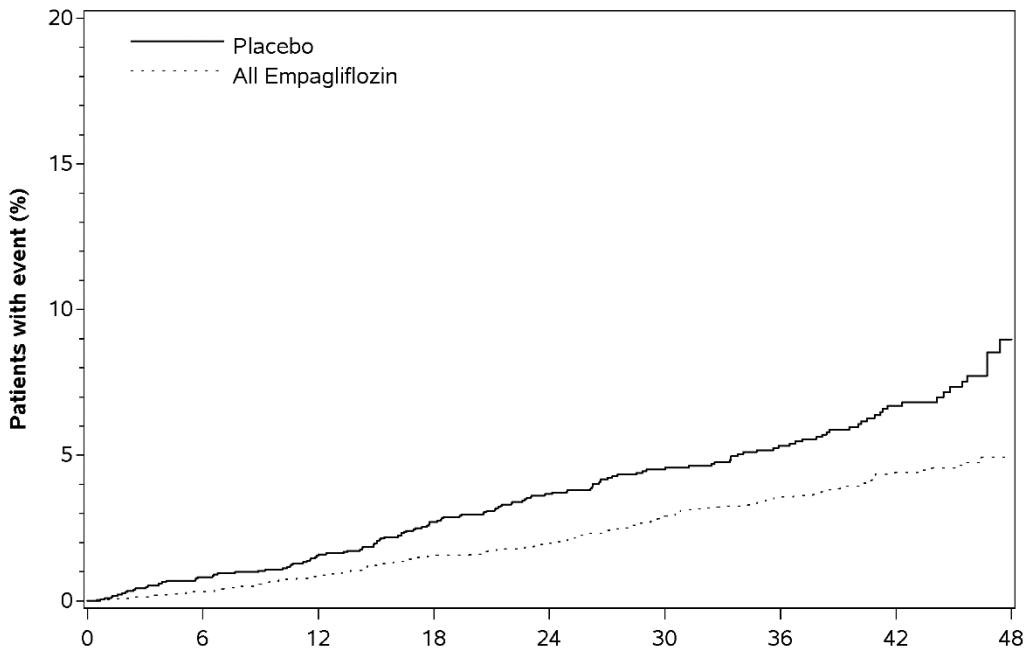
^cTotal number of events

Figure 5 Estimated Cumulative Incidence of First MACE



| | Subjects at risk | | | | | | | | |
|-------------------|------------------|------|------|------|------|------|------|------|-----|
| | Month | | | | | | | | |
| Placebo | 2333 | 2256 | 2194 | 2112 | 1875 | 1380 | 1161 | 741 | 166 |
| All Empagliflozin | 4687 | 4580 | 4455 | 4328 | 3851 | 2821 | 2359 | 1534 | 370 |

Figure 6 Estimated Cumulative Incidence of Cardiovascular Death



| | Subjects at risk | | | | | | | | |
|-------------------|------------------|------|------|------|------|------|------|------|-----|
| | Month | | | | | | | | |
| Placebo | 2333 | 2303 | 2280 | 2243 | 2012 | 1503 | 1281 | 825 | 177 |
| All Empagliflozin | 4687 | 4651 | 4608 | 4556 | 4128 | 3079 | 2617 | 1722 | 414 |

The efficacy of JARDIANCE on cardiovascular death was generally consistent across major demographic and disease subgroups.

Vital status was obtained for 99.2% of subjects in the trial. A total of 463 deaths were recorded during the EMPA-REG OUTCOME trial. Most of these deaths were categorized as cardiovascular deaths. The non-cardiovascular deaths were only a small proportion of deaths and were balanced between the treatment groups (2.1% in patients treated with JARDIANCE, and 2.4% of patients treated with placebo).

Heart Failure

EMPEROR-Reduced (NCT03057977) was a double-blind study conducted in patients with chronic heart failure (New York Heart Association [NYHA] functional class II-IV) with left ventricular ejection fraction (LVEF) $\leq 40\%$ to evaluate the efficacy and safety of JARDIANCE as adjunct to standard of care heart failure therapy.

Of 3730 patients, 1863 were randomized to JARDIANCE 10 mg and 1867 to placebo and were followed for a median of 16 months. The mean age of the study population was 67 years (range: 25 to 94 years) and 76% were men, 24% were women, and 27% were 75 years of age or older. Approximately 71% of the study population were White, 18% Asian and 7% Black or African American. At baseline, 50% of the patients had type 2 diabetes mellitus.

At randomization, 75% of patients were NYHA class II, 24% were class III and 0.5% were class IV. The mean LVEF was 28%. At baseline, the mean eGFR was 62 mL/min/1.73 m² and the median urinary albumin to creatinine ratio (UACR) was 22 mg/g. Approximately half of the patients (52%) had eGFR equal to or above 60 mL/min/1.73 m², 24% had eGFR 45 to less than 60 mL/min/1.73 m², 19% had eGFR 30 to less than 45 mL/min/1.73 m² and 5% had eGFR 20 to less than 30 mL/min/1.73 m².

At baseline, 88% of patients were treated with angiotensin-converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARB), or angiotensin receptor-neprilysin inhibitors (ARNI), 95% with beta-blockers, 71% with mineralocorticoid receptor antagonists (MRA), and 95% with diuretics.

The primary endpoint was the time to first event of either cardiovascular death (CV) or hospitalization for heart failure (HHF). First and recurrent HHF was assessed as a key secondary endpoint.

JARDIANCE was superior in reducing the risk of the primary composite endpoint of cardiovascular death or hospitalization for heart failure compared with placebo, mostly through a reduction in hospitalization for heart failure. JARDIANCE reduced the risk of first and recurrent HHF (see Table 14 and Figures 7 and 8).

Table 14 Treatment Effect for the Primary Composite Endpoint, its Components, and Key Secondary Endpoints

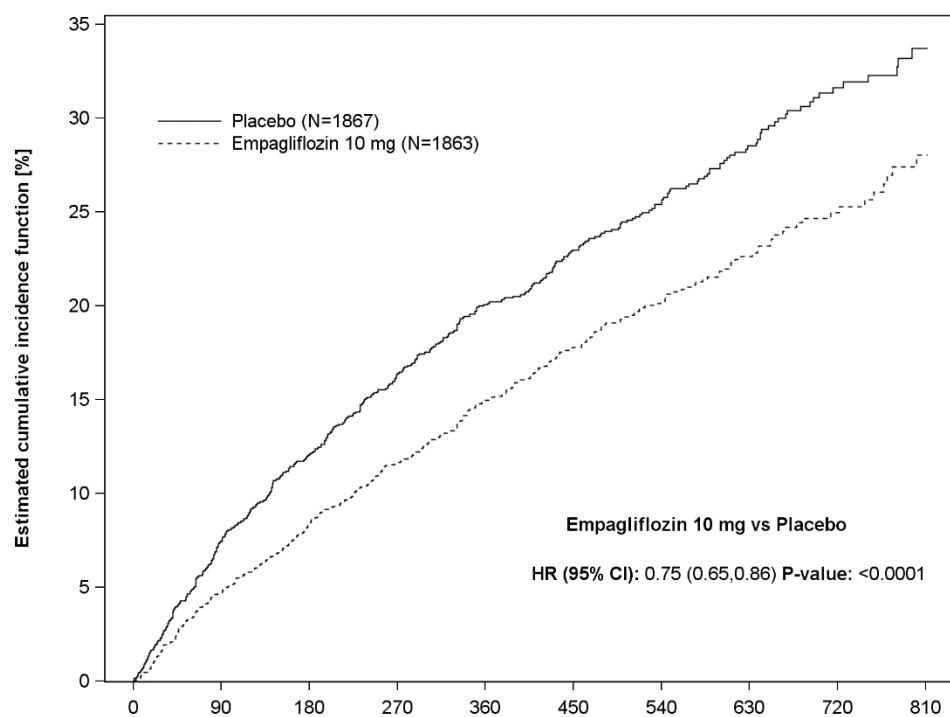
| | Placebo N=1867 | JARDIANCE 10 mg N=1863 | Hazard ratio vs placebo (95% CI) | p-value |
|--------------------------------------|-------------------|---------------------------|-------------------------------------|---------|
| Number of Patients (%) | | | | |
| CV death or HHF ^a | 462 (24.7%) | 361 (19.4%) | 0.75 (0.65, 0.86) | <0.0001 |
| CV death ^{a,b} | 202 (10.8%) | 187 (10.0%) | 0.92 (0.75, 1.12) | |
| HHF ^a | 342 (18.3%) | 246 (13.2%) | 0.69 (0.59, 0.81) | |
| Number of Events | | | | |
| First and recurrent HHF ^c | 553 | 388 | 0.70 (0.58, 0.85) | 0.0003 |

^aTime to first event

^bIncludes deaths following hospitalization

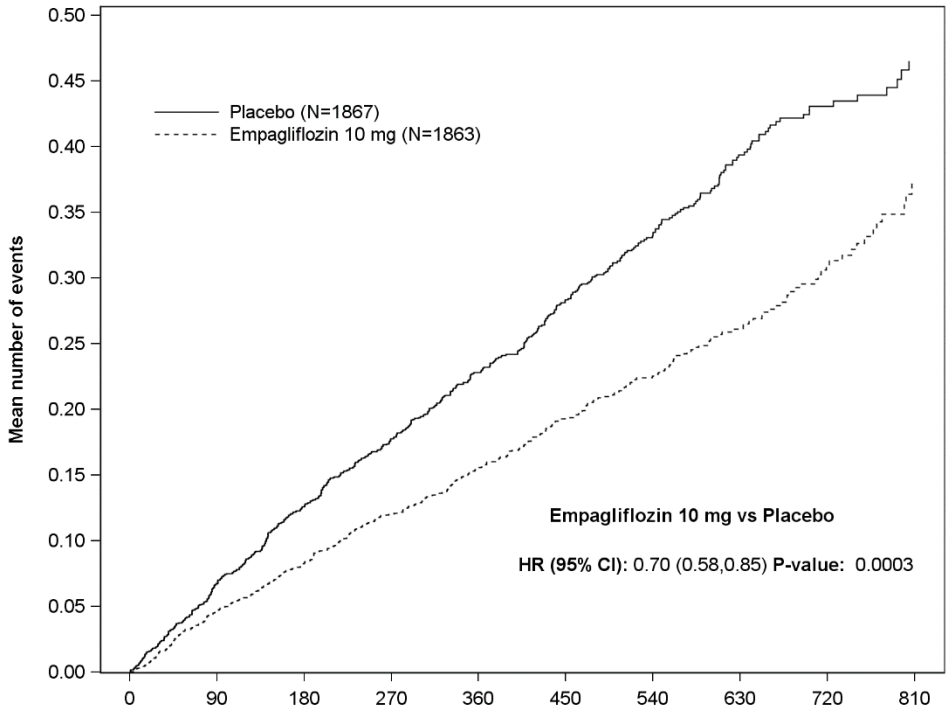
^cJoint frailty model accounting for CV death

Figure 7 Time to First Occurrence of the Primary Composite Endpoint of Cardiovascular Death or Hospitalization for Heart Failure



| Patients at risk | Days since randomization | | | | | | | | | |
|---------------------|--------------------------|------|------|------|------|-----|-----|-----|-----|-----|
| | 0 | 90 | 180 | 270 | 360 | 450 | 540 | 630 | 720 | 810 |
| Placebo | 1867 | 1715 | 1612 | 1345 | 1108 | 854 | 611 | 410 | 224 | 109 |
| Empagliflozin 10 mg | 1863 | 1763 | 1677 | 1424 | 1172 | 909 | 645 | 423 | 231 | 101 |

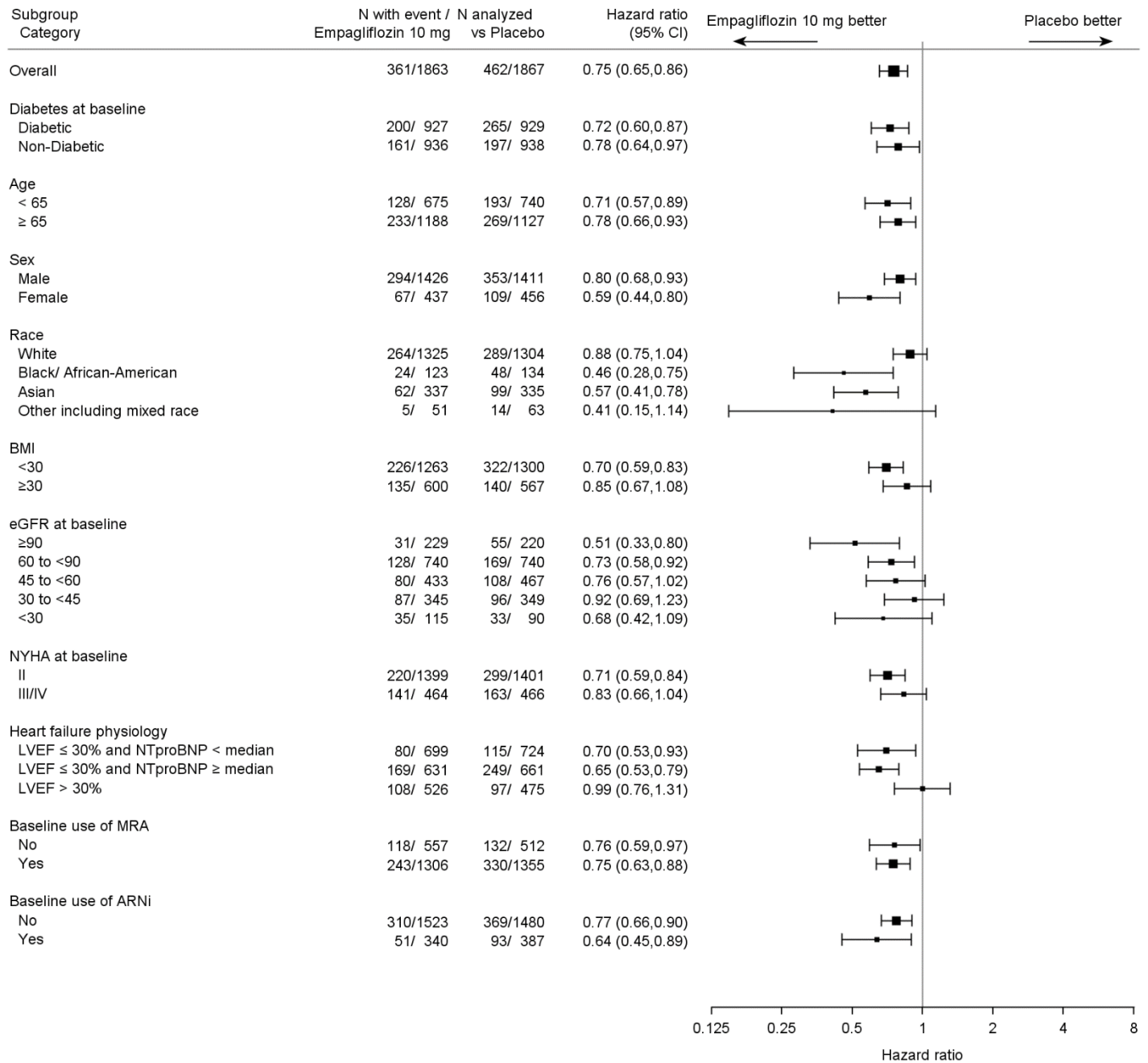
Figure 8 Time to Event of Hospitalization for Heart Failure (First and Recurrent)



| Patients at risk | Days since randomization | | | | | | | | | |
|---------------------|--------------------------|------|------|------|------|------|-----|-----|-----|-----|
| | 0 | 90 | 180 | 270 | 360 | 450 | 540 | 630 | 720 | 810 |
| Placebo | 1867 | 1820 | 1762 | 1526 | 1285 | 1017 | 732 | 497 | 275 | 135 |
| Empagliflozin 10 mg | 1863 | 1826 | 1768 | 1532 | 1283 | 1008 | 732 | 495 | 272 | 118 |

The results of the primary composite were generally consistent across the pre-specified subgroups (see Figure 9).

Figure 9 Treatment Effects for the Primary Composite Endpoint (Cardiovascular Death and Hospitalization for Heart Failure) Subgroup Analysis (EMPEROR-Reduced)



LVEF >30%: Includes both above and below the median NT-proBNP. To be eligible for inclusion, patients with an LVEF >30% were required to meet a higher NT-proBNP threshold than those with LVEF ≤30%, unless they additionally had a history of HHF within the past 12 months.

EMPEROR-Preserved (NCT03057951) was a double-blind study conducted in patients with chronic heart failure NYHA Class II-IV with LVEF >40% to evaluate the efficacy and safety of JARDIANCE as adjunct to standard of care therapy.

Of 5988 patients, 2997 were randomized to JARDIANCE 10 mg and 2991 to placebo and were followed for a median of 26 months. The mean age of the study population was 72 years (range: 22 to 100 years) and 55% were men, 45% were women, and 43% were 75 years of age or older. Approximately 76% of the study population were White, 14% Asian and 4% Black or African American.

At randomization, 82% of patients were NYHA class II, 18% were class III and 0.3% were class IV. The *EMPEROR-Preserved* study population included patients with a LVEF <50% (33.1%), with a LVEF 50 to <60% (34.4%) and a LVEF ≥60% (32.5%). At baseline, the mean eGFR was 61 mL/min/1.73 m² and the median urinary albumin to creatinine ratio (UACR) was 21 mg/g. Approximately half of the patients (50%) had eGFR equal to or above 60 mL/min/1.73 m², 26% had eGFR 45 to less than 60 mL/min/1.73 m², 19% had eGFR 30 to less than 45 mL/min/1.73 m², and 5% had eGFR 20 to less than 30 mL/min/1.73 m².

At baseline, 81% of patients were treated with ACE inhibitors, ARBs, or ARNI, 86% with beta-blockers, 38% with MRAs, and 86% with diuretics.

The primary endpoint was the time to first event of either CV death or HHF. First and recurrent HHF was assessed as a key secondary endpoint.

JARDIANCE was superior in reducing the risk of the primary composite endpoint compared with placebo, mostly through a reduction in hospitalization for heart failure. JARDIANCE reduced the risk of first and recurrent HHF (see Table 15 and Figures 10 and 11).

Table 15 Treatment Effect for the Primary Composite Endpoint, its Components, and Key Secondary Endpoints

| | Placebo N=2991 | JARDIANCE 10 mg N=2997 | Hazard ratio vs placebo (95% CI) | p-value |
|--------------------------------------|-------------------|---------------------------|-------------------------------------|---------|
| Number of Patients (%) | | | | |
| CV death or HHF ^a | 511 (17.1%) | 415 (13.8%) | 0.79 (0.69, 0.90) | 0.0003 |
| CV death ^{a,b} | 244 (8.2%) | 219 (7.3%) | 0.91 (0.76, 1.09) | |
| HHF ^a | 352 (11.8%) | 259 (8.6%) | 0.71 (0.60, 0.83) | |
| Number of Events | | | | |
| First and recurrent HHF ^c | 541 | 407 | 0.73 (0.61, 0.88) | 0.0009 |

^aTime to first event

^bIncludes deaths following hospitalization

^cJoint frailty model accounting for CV death

Figure 10 Time to First Occurrence of the Primary Composite Endpoint of Cardiovascular Death or Hospitalization for Heart Failure

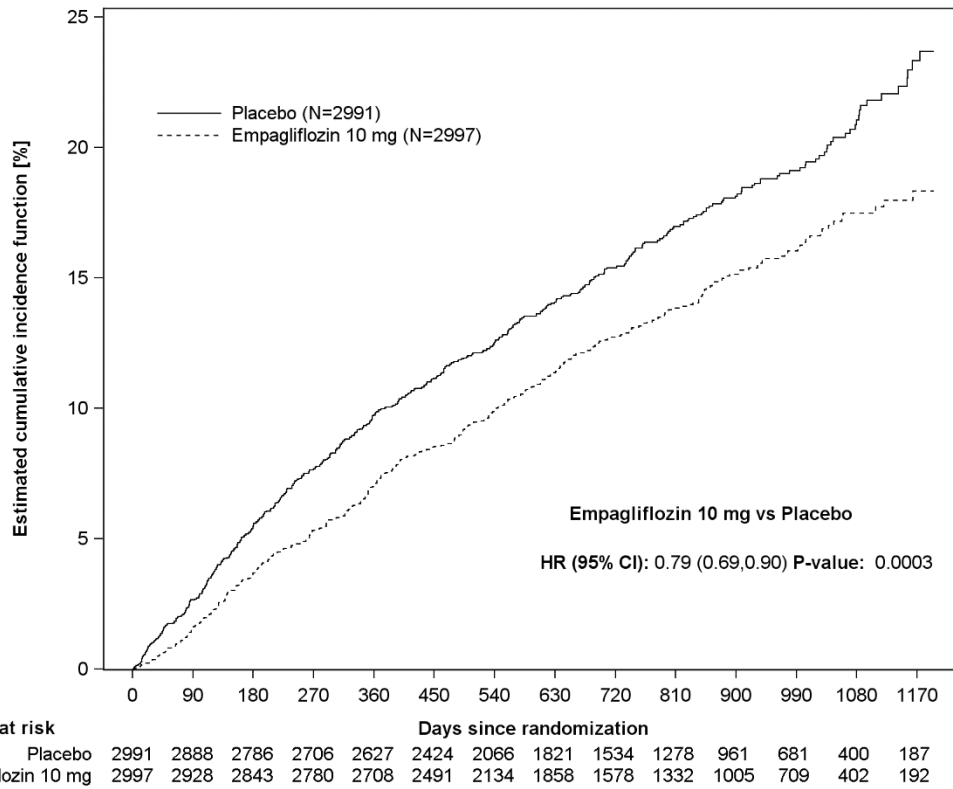
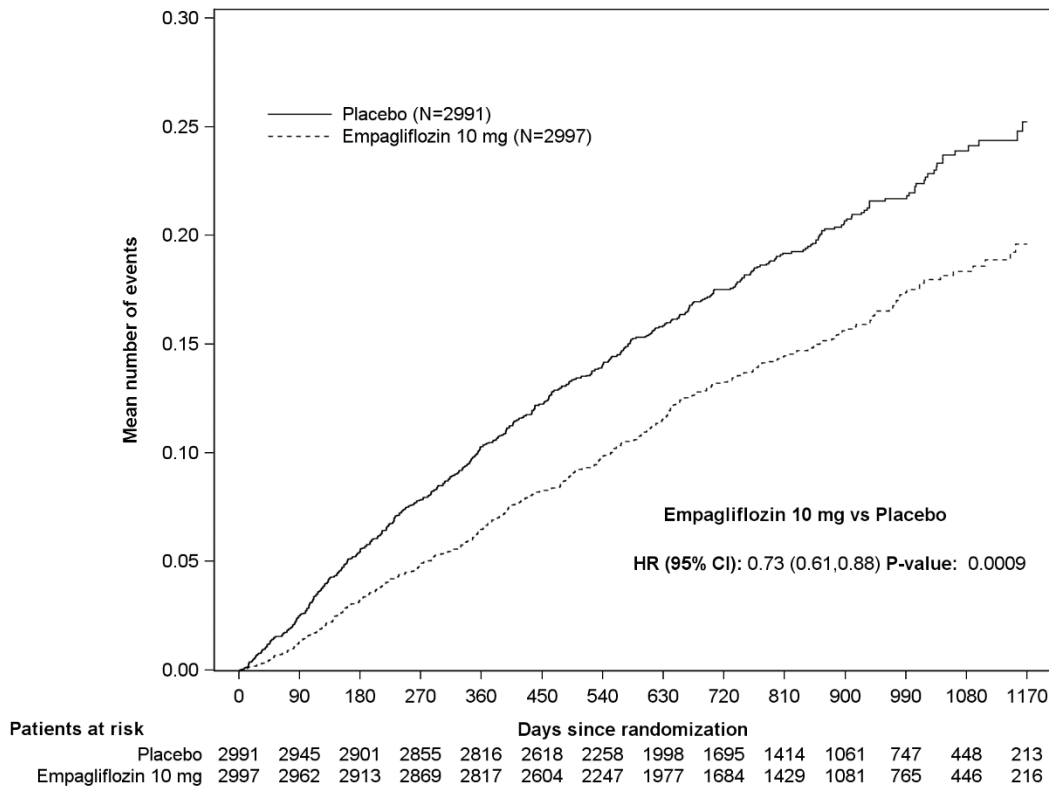
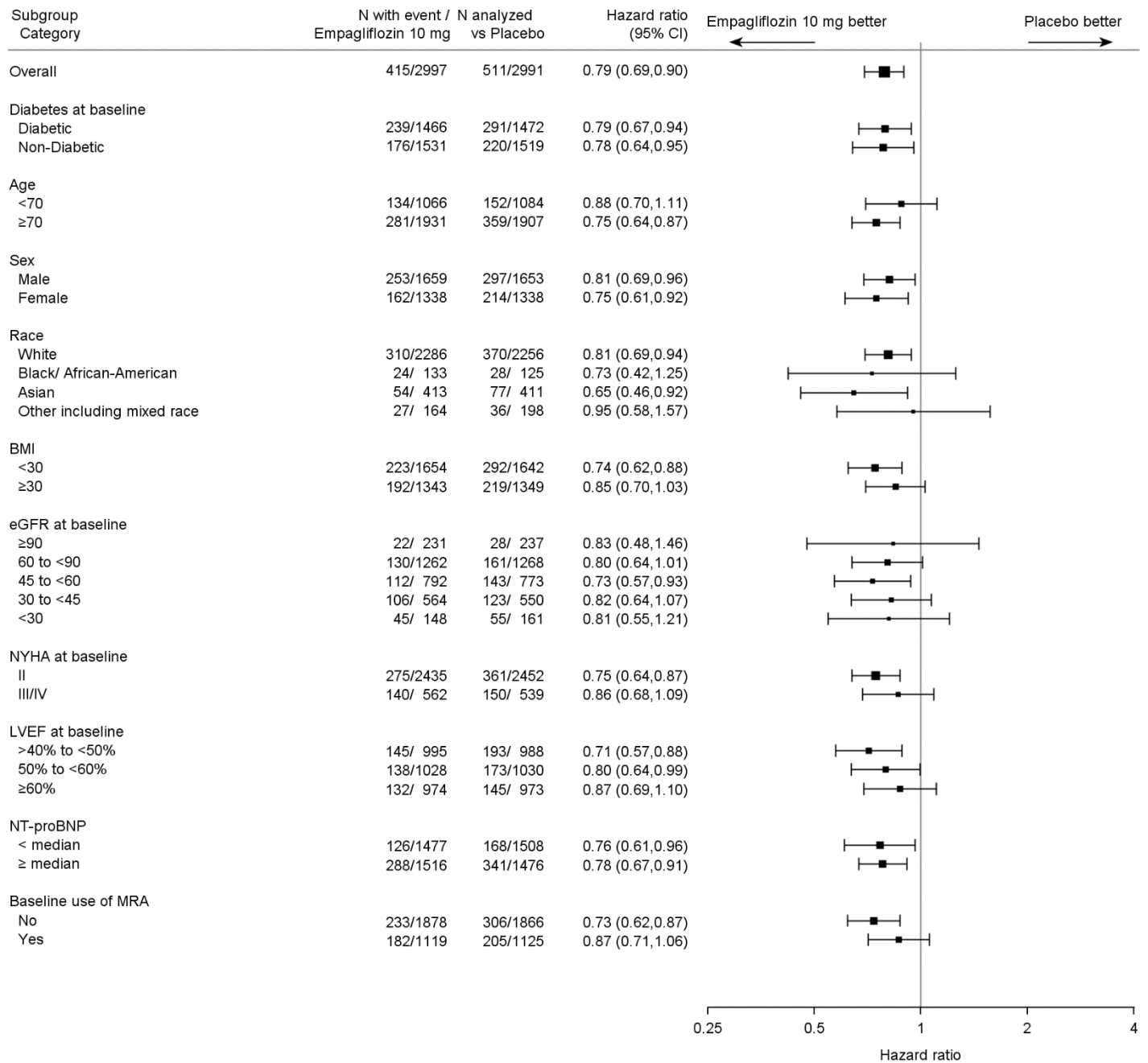


Figure 11 Time to Event of Hospitalization for Heart Failure (First and Recurrent)



The results of the primary composite endpoint were consistent across the pre-specified subgroups (see Figure 12).

Figure 12 Treatment Effects for the Primary Composite Endpoint (Cardiovascular Death or Hospitalization for Heart Failure) Subgroup Analysis (EMPEROR-Preserved)



16 HOW SUPPLIED/STORAGE AND HANDLING

JARDIANCE tablets are available as follows:

10 mg tablets: pale yellow, round, biconvex, and bevel-edged film-coated tablets debossed with “S 10” on one side and the Boehringer Ingelheim company symbol on the other side.

Bottles of 30 (NDC 0597-0152-30)

Bottles of 90 (NDC 0597-0152-90)

Cartons containing 3 blister cards of 10 tablets each (3 x 10) (NDC 0597-0152-37), institutional pack.

25 mg tablets: pale yellow, oval, biconvex film-coated tablets, debossed with “S 25” on one side and the Boehringer Ingelheim company symbol on the other side.

Bottles of 30 (NDC 0597-0153-30)

Bottles of 90 (NDC 0597-0153-90)

Cartons containing 3 blister cards of 10 tablets each (3 x 10) (NDC 0597-0153-37), institutional pack.

Dispense in a well-closed container as defined in the USP.

Storage

Store at 20°C to 25°C (68°F to 77°F); excursions permitted to 15°C to 30°C (59°F to 86°F) [see USP Controlled Room Temperature].

17 PATIENT COUNSELING INFORMATION

Advise the patient to read the FDA-approved patient labeling (Medication Guide).

Ketoacidosis

Inform patients that ketoacidosis is a serious life-threatening condition and that cases of ketoacidosis have been reported during use of JARDIANCE, sometimes associated with illness or surgery among other risk factors. Instruct patients to check ketones (when possible) if symptoms consistent with ketoacidosis occur even if blood glucose is not elevated. If symptoms of ketoacidosis (including nausea, vomiting, abdominal pain, tiredness, and labored breathing) occur, instruct patients to discontinue JARDIANCE and seek medical attention immediately [see *Warnings and Precautions (5.1)*].

Volume Depletion

Inform patients that symptomatic hypotension may occur with JARDIANCE and advise them to contact their healthcare provider if they experience such symptoms [see *Warnings and Precautions (5.2)*]. Inform patients that dehydration may increase the risk for hypotension, and to maintain adequate fluid intake.

Serious Urinary Tract Infections

Inform patients of the potential for urinary tract infections, which may be serious. Provide them with information on the symptoms of urinary tract infections. Advise them to seek medical advice if such symptoms occur [see *Warnings and Precautions (5.3)*].

Hypoglycemia with Concomitant Use with Insulin and Insulin Secretagogues

Inform patients that the incidence of hypoglycemia is increased when JARDIANCE is used in combination with insulin secretagogues (e.g., sulfonylurea) or insulin and that a lower dose of the insulin secretagogue or insulin may be required to reduce the risk of hypoglycemia [see *Warnings and Precautions (5.4)*].

Necrotizing Fasciitis of the Perineum (Fournier’s Gangrene)

Inform patients that necrotizing infections of the perineum (Fournier’s gangrene) have occurred with JARDIANCE. Counsel patients to promptly seek medical attention if they develop pain or tenderness, redness, or swelling of the genitals or the area from the genitals back to the rectum, along with a fever above 100.4°F or malaise [*see Warnings and Precautions (5.5)*].

Genital Mycotic Infections in Females (e.g., Vulvovaginitis)

Inform female patients that vaginal yeast infections may occur and provide them with information on the signs and symptoms of vaginal yeast infections. Advise them of treatment options and when to seek medical advice [*see Warnings and Precautions (5.6)*].

Genital Mycotic Infections in Males (e.g., Balanitis or Balanoposthitis)

Inform male patients that yeast infection of the penis (e.g., balanitis or balanoposthitis) may occur, especially in uncircumcised males and patients with chronic and recurrent infections. Provide them with information on the signs and symptoms of balanitis and balanoposthitis (rash or redness of the glans or foreskin of the penis). Advise them of treatment options and when to seek medical advice [*see Warnings and Precautions (5.6)*].

Hypersensitivity Reactions

Inform patients that serious hypersensitivity reactions, such as urticaria and angioedema, have been reported with JARDIANCE. Advise patients to report immediately any skin reaction or angioedema, and to discontinue drug until they have consulted prescribing healthcare provider [*see Warnings and Precautions (5.7)*].

Laboratory Tests

Inform patients that elevated glucose in urinalysis is expected when taking JARDIANCE.

Pregnancy

Advise pregnant patients, and patients of reproductive potential, of the potential risk to a fetus with treatment with JARDIANCE [*see Use in Specific Populations (8.1)*]. Instruct patients to report pregnancies to their healthcare provider as soon as possible.

Lactation

Advise patients that breastfeeding is not recommended during treatment with JARDIANCE [*see Use in Specific Populations (8.2)*].

Missed Dose

Instruct patients to take JARDIANCE only as prescribed. If a dose is missed, it should be taken as soon as the patient remembers. Advise patients not to double their next dose.

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MEDICATION GUIDE
JARDIANCE® (jar DEE ans)
(empagliflozin tablets)
for oral use

What is the most important information I should know about JARDIANCE?

JARDIANCE can cause serious side effects, including:

- **Ketoacidosis (increased ketones in your blood or urine).** Ketoacidosis has happened in people who have **type 1 diabetes or type 2 diabetes**, during treatment with JARDIANCE. Ketoacidosis has also happened in people with diabetes who were sick or who had surgery during treatment with JARDIANCE. Ketoacidosis is a serious condition, which needs to be treated in a hospital. Ketoacidosis may lead to death. **Ketoacidosis can happen with JARDIANCE even if your blood sugar is less than 250 mg/dL. Stop taking JARDIANCE and call your healthcare provider right away or go to the nearest hospital emergency room if you get any of the following symptoms:**

- nausea
- vomiting
- stomach-area (abdominal) pain
- tiredness
- trouble breathing

If you get any of these symptoms during treatment with JARDIANCE, if possible, check for ketones in your urine, even if your blood sugar is less than 250 mg/dL.

- **Dehydration.** JARDIANCE can cause some people to become dehydrated (the loss of body water and salt). Dehydration may cause you to feel dizzy, faint, light-headed, or weak, especially when you stand up (orthostatic hypotension). There have been reports of sudden worsening of kidney function in people who are taking JARDIANCE.

You may be at higher risk of dehydration if you:

- take medicines to lower your blood pressure, including diuretics (water pills)
- are on low sodium (salt) diet
- have kidney problems
- are 65 years of age or older

Talk to your healthcare provider about what you can do to prevent dehydration including how much fluid you should drink on a daily basis.

Talk to your healthcare provider right away if you reduce the amount of food or liquid you drink, for example if you are sick or cannot eat, or start to lose liquids from your body, for example from vomiting, diarrhea or being in the sun too long.

What is JARDIANCE?

JARDIANCE is a prescription medicine used to:

- reduce the risk of cardiovascular death and hospitalization for heart failure in adults with heart failure, when the heart cannot pump enough blood to the rest of your body.
- reduce the risk of cardiovascular death in adults with type 2 diabetes and who also have known cardiovascular disease.
- lower blood sugar along with diet and exercise in adults with type 2 diabetes.

JARDIANCE is not for people with type 1 diabetes. It may increase their risk of diabetic ketoacidosis (increased ketones in blood or urine).

JARDIANCE is not for use to lower blood sugar in adults with type 2 diabetes who have severe kidney problems, because it may not work.

It is not known if JARDIANCE is safe and effective in children.

Who should not take JARDIANCE?

Do not take JARDIANCE if you:

- are allergic to empagliflozin or any of the ingredients in JARDIANCE. See the end of this Medication Guide for a complete list of ingredients in JARDIANCE. Symptoms of a serious allergic reaction to JARDIANCE may include:
 - swelling of your face, lips, throat and other areas of your skin
 - difficulty with swallowing or breathing
 - raised, red areas on your skin (hives)

If you have any of these symptoms, stop taking JARDIANCE and call your healthcare provider right away or go to the nearest hospital emergency room.

- are on dialysis.

What should I tell my healthcare provider before taking JARDIANCE?

Before taking JARDIANCE, tell your healthcare provider about all of your medical conditions, including if you:

- have kidney problems.
- have liver problems.
- have a history of infection of the vagina or penis.
- have a history of urinary tract infections or problems with urination.
- are going to have surgery. Your healthcare provider may stop your JARDIANCE before you have surgery. Talk to your healthcare provider if you are having surgery about when to stop taking JARDIANCE and when to start it again.
- are eating less, or there is a change in your diet.
- have or have had problems with your pancreas, including pancreatitis or surgery on your pancreas.
- drink alcohol very often or drink a lot of alcohol in the short term (“binge” drinking).
- have type 1 diabetes. JARDIANCE should not be used to treat people with type 1 diabetes.
- are pregnant or plan to become pregnant. JARDIANCE may harm your unborn baby. If you become pregnant while taking JARDIANCE, tell your healthcare provider as soon as possible. Talk with your healthcare provider about the best way to control your blood sugar while you are pregnant.
- are breastfeeding or plan to breastfeed. JARDIANCE may pass into your breast milk and may harm your baby. Talk with your healthcare provider about the best way to feed your baby if you are taking JARDIANCE. Do not breastfeed while taking JARDIANCE.

Tell your healthcare provider about all the medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements.

JARDIANCE may affect the way other medicines work, and other medicines may affect how JARDIANCE works. Know the medicines you take. Keep a list of them to show your healthcare provider and pharmacist when you get a new medicine.

How should I take JARDIANCE?

- Take JARDIANCE exactly as your healthcare provider tells you to take it.
- Take JARDIANCE by mouth 1 time in the morning each day, with or without food.
- Your healthcare provider may change your dose if needed.
- If you miss a dose, take it as soon as you remember. If you do not remember until it is time for your next dose, skip the missed dose and go back to your regular schedule. Do not take two doses of JARDIANCE at the same time. Talk with your healthcare provider if you have questions about a missed dose.
- Your healthcare provider may tell you to take JARDIANCE along with other diabetes medicines. Low blood sugar can happen more often when JARDIANCE is taken with certain other diabetes medicines. See **“What are the possible side effects of JARDIANCE?”**
- If you take too much JARDIANCE, call your healthcare provider or go to the nearest hospital emergency room right away.
- When taking JARDIANCE, you may have sugar in your urine, which will show up on a urine test.
- Your healthcare provider may do blood tests to check how well your kidneys are working before and during your treatment with JARDIANCE.

What are the possible side effects of JARDIANCE?

JARDIANCE may cause serious side effects, including:

- See **“What is the most important information I should know about JARDIANCE?”**
- **Serious urinary tract infections.** Serious urinary tract infections that may lead to hospitalization have happened in people who are taking JARDIANCE. Tell your healthcare provider if you have any signs or symptoms of a urinary tract infection such as a burning feeling when passing urine, a need to urinate often, the need to urinate right away, pain in the lower part of your stomach (pelvis), or blood in the urine. Sometimes people also may have a fever, back pain, nausea or vomiting.
- **Low blood sugar (hypoglycemia).** If you take JARDIANCE with another medicine that can cause low blood sugar, such as a sulfonylurea or insulin, your risk of getting low blood sugar is higher. The dose of your sulfonylurea medicine or insulin may need to be lowered while you take JARDIANCE. Signs and symptoms of low blood sugar may include:
 - headache
 - drowsiness
 - weakness
 - irritability
 - hunger
 - fast heartbeat
 - confusion
 - shaking or feeling jittery
 - dizziness
 - sweating
- **A rare but serious bacterial infection that causes damage to the tissue under the skin (necrotizing fasciitis) in the area between and around the anus and genitals (perineum).** Necrotizing fasciitis of the perineum has happened in women and men who take JARDIANCE. Necrotizing fasciitis of the perineum may lead to

hospitalization, may require multiple surgeries, and may lead to death. **Seek medical attention immediately if you have a fever or you are feeling very weak, tired or uncomfortable (malaise), and you develop any of the following symptoms in the area between and around your anus and genitals:**

- pain or tenderness
- swelling
- redness of skin (erythema)

• **Vaginal yeast infection.** Symptoms of a vaginal yeast infection include:

- vaginal odor
- white or yellowish vaginal discharge (discharge may be lumpy or look like cottage cheese)
- vaginal itching

• **Yeast infection of the penis (balanitis or balanoposthitis).** Swelling of an uncircumcised penis may develop that makes it difficult to pull back the skin around the tip of the penis. Other symptoms of yeast infection of the penis include:

- redness, itching, or swelling of the penis
- rash of the penis
- foul smelling discharge from the penis
- pain in the skin around the penis

Talk to your healthcare provider about what to do if you get symptoms of a yeast infection of the vagina or penis. Your healthcare provider may suggest you use an over-the-counter antifungal medicine. Talk to your healthcare provider right away if you use an over-the-counter antifungal medication and your symptoms do not go away.

• **Allergic (hypersensitivity) reactions.** Serious allergic reactions have happened in people who are taking JARDIANCE. Symptoms may include:

- swelling of your face, lips, throat and other areas of your skin
- difficulty with swallowing or breathing.
- raised, red areas on your skin (hives)

If you have any of these symptoms, stop taking JARDIANCE and call your healthcare provider right away or go to the nearest hospital emergency room.

The most common side effects of JARDIANCE include:

- urinary tract infections
- yeast infections in females

These are not all the possible side effects of JARDIANCE. For more information, ask your healthcare provider or pharmacist.

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

How should I store JARDIANCE?

- Store JARDIANCE at room temperature between 68°F to 77°F (20°C to 25°C).
- **Keep JARDIANCE and all medicines out of the reach of children.**

General information about the safe and effective use of JARDIANCE.

Medicines are sometimes prescribed for purposes other than those listed in a Medication Guide. Do not use JARDIANCE for a condition for which it is not prescribed. Do not give JARDIANCE to other people, even if they have the same symptoms you have. It may harm them.

You can ask your pharmacist or healthcare provider for information about JARDIANCE that is written for health professionals.

What are the ingredients in JARDIANCE?

Active Ingredient: empagliflozin

Inactive Ingredients: lactose monohydrate, microcrystalline cellulose, hydroxypropyl cellulose, croscarmellose sodium, colloidal silicon dioxide and magnesium stearate. In addition, the film coating contains the following inactive ingredients: hypromellose, titanium dioxide, talc, polyethylene glycol, and yellow ferric oxide.

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For more information about JARDIANCE, including current prescribing information and Medication Guide, go to www.jardiance.com, scan the code, or call Boehringer Ingelheim Pharmaceuticals, Inc. at 1-800-542-6257.



This MEDICATION GUIDE has been approved by the U.S. Food and Drug Administration.

Revised: October 2022