HIGHLIGHTS OF PRESCRIBING INFORMATION

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

AMARYL® (glimepiride) tablets, for oral use

Initial U.S. Approval: 1995

INDICATIONS AND USAGE

AMARYL is a sulfonylurea indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus (1).

Limitations of Use:

- Not for treating type 1 diabetes mellitus or diabetic ketoacidosis (1).

DOSEAGE AND ADMINISTRATION

Recommended starting dose is 1 mg or 2 mg once daily. Increase in 1 or 2 mg increments no more frequently than every 1–2 weeks based on glycemic response. Maximum recommended dose is 8 mg once daily (2.1)

Administer with breakfast or first meal of the day. (2.1)

Use 1 mg starting dose and titrate slowly in patients at increased risk for hypoglycemia (e.g., elderly, patients with renal impairment). (2.1)

DOSEAGE FORMS AND STRENGTHS

Tablets (scored): 1 mg, 2 mg, 4 mg (3)

CONTRAINDICATIONS

- Hypersensitivity to glimepiride or any of the product’s ingredients (4)
- Hypersensitivity to sulfonamide derivatives (4)

WARNINGS AND PRECAUTIONS

- Hypoglycemia: May be severe. Ensure proper patient selection, dosing, and instructions, particularly in at-risk populations (e.g., elderly, renally impaired) and when used with other anti-diabetic medications (5.1).
- Hypersensitivity Reactions: Postmarketing reports include anaphylaxis, angioedema and Stevens-Johnson Syndrome. If a reaction is suspected, promptly discontinue AMARYL, assess for other potential causes for the reaction, and institute alternative treatment for diabetes. (5.2)
- Hemolytic Anemia: Can occur if glucose-6-phosphate dehydrogenase (G6PD) deficient. Consider a non-sulfonylurea alternative. (5.3)
- Potential Increased Risk of Cardiovascular Mortality with Sulfonilureas: Inform patient of risks, benefits and treatment alternatives. (5.4)
- Macrosascular Outcomes: No clinical studies establishing conclusive evidence of macrosvascular risk reduction with AMARYL or any other anti-diabetic drug (5.5).

ADVERSE REACTIONS

Common adverse reactions in clinical trials (≥5% and more common than with placebo) include hypoglycemia, headache, nausea, and dizziness (6.1).

To report SUSPECTED ADVERSE REACTIONS, contact sanofi-aventis U.S. LLC at 1-800-633-1610 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DRUG INTERACTIONS

- Certain medications may affect glucose metabolism, requiring AMARYL dose adjustment and close monitoring of blood glucose. (7.1)
- Miconazole: Severe hypoglycemia can occur when AMARYL and oral miconazole are used concomitantly. (7.2)
- Cytochrome P450 2C9 interactions: Inhibitors and inducers of cytochrome P450 2C9 may affect glycemic control by altering glimepiride plasma concentrations. (7.3)
- Colesevelam: Concomitant use may reduce glimepiride absorption. AMARYL should be administered at least 4 hours prior to colesevelam. (2.1, 7.4)

USE IN SPECIFIC POPULATIONS

- Pediatric Patients: Not recommended because of adverse effects on body weight and hypoglycemia. (8.4)
- Geriatric or Renally Impaired Patients: At risk for hypoglycemia with AMARYL. Use caution in dose selection and titration, and monitor closely. (8.5, 8.6)

See 17 for PATIENT COUNSELING INFORMATION

Revised: 12/2018
Patients must be educated to recognize and manage hypoglycemia. Use caution when initiating and increasing AMARYL doses in patients who may be predisposed to hypoglycemia (e.g., the elderly, patients with renal impairment, patients on other anti-diabetic medications), Debilitated or malnourished patients, and those with adrenal, pituitary, or hepatic impairment are particularly susceptible to the hypoglycemic action of glucose-lowering medications. Hypoglycemia is also more likely to occur when caloric intake is deficient, after severe or prolonged exercise, or when alcohol is ingested. Early warning symptoms of hypoglycemia may be different or less pronounced in patients with autonomic neuropathy, the elderly, and in patients who are taking beta-adrenergic blocking medications or other sympatholytic agents. These situations may result in severe hypoglycemia before the patient is aware of the hypoglycemia.

5.2 Hypersensitivities Reactions

There have been postmarketing reports of hypersensitivity reactions in patients treated with AMARYL, including serious reactions such as anaphylaxis, angioedema, and Stevens-Johnson Syndrome [see Adverse Reactions (6.2)]. If a hypersensitivity reaction is suspected, promptly discontinue AMARYL and assess for other potential causes for the reaction, and institute alternative treatment for diabetes.

5.3 Hemolytic Anemia

Sulfonlureas can cause hemolytic anemia in patients with glucose-6-phosphate dehydrogenase (G6PD) deficiency. Because AMARYL is a sulfonlurea, use caution in patients with G6PD deficiency and consider the use of a non-sulfonlurea alternative. There are also postmarketing reports of hemolytic anemia in patients receiving AMARYL who did not have known G6PD deficiency [see Adverse Reactions (6.2)].

5.4 Increased Risk of Cardiovascular Mortality with Sulfonlureas

The administration of oral hypoglycemic drugs has been reported to be associated with increased cardiovascular mortality as compared to treatment with diet alone or diet plus insulin. This warning is based on the study conducted by the University Group Diabetes Program (UGDP), a long-term, prospective clinical trial designed to evaluate the effectiveness of glucose-lowering drugs in preventing or delaying vascular complications in patients with non-insulin-dependent diabetes. The study involved 823 patients who were randomly assigned to one of four treatment groups.

UGDP reported that patients treated for 5 to 8 years with diet plus a fixed dose of tolbutamide (1.5 grams per day) had a rate of cardiovascular mortality approximately 2 and a half times that of patients treated with diet alone. A significant increase in total mortality was not observed, but the use of tolbutamide was discontinued based on the increase in cardiovascular mortality, thus limiting the opportunity for the study to show an increase in overall mortality. Despite controversy regarding the interpretation of these results, the findings of the UGDP study provide an adequate basis for this warning. The patient should be informed of the potential risks and advantages of AMARYL and of alternative modes of therapy. Although only one drug in the sulfonylurea class (tolbutamide) was included in this study, it is prudent from a safety standpoint to consider that this warning may also apply to other oral hypoglycemic drugs in this class, in view of their close similarities in mode of action and chemical structure.

5.5 Macrovascular Outcomes

There have been no clinical studies establishing conclusive evidence of macrovascular risk reduction with AMARYL or any other anti-diabetic drug.

6 ADVERSE REACTIONS

The following serious adverse reactions are discussed in more detail below and elsewhere in the labeling:

• Hypoglycemia [see Warnings and Precautions (5.1)]
• Hemolytic anemia [see Warnings and Precautions (5.3)]

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 or other sympatholytic agents. These situations may result in severe hypoglycemia before the patient is aware of the hypoglycemia.

6.2 Postmarketing Experience

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

• Serious hypersensitivity reactions, including anaphylaxis, angioedema, and Stevens-Johnson Syndrome [see Warnings and Precautions (5.2)].
• Hemolytic anemia in patients with and without G6PD deficiency [see Warnings and Precautions (5.3)].
• Impairment of liver function (e.g., with cholestatic jaundice), as well as hepatitis, which may progress to failure liver death.
• Porphyria cutanea tarda, phototoxicity reactions and allergic vasculitis
• Leukopenia, agranulocytosis, aplastic anemia, and pancytopenia
• Trombocytopenia (including severe cases with platelet count less than 10,000/μL) and thrombocytopenic purpura
• Hepatic porphyria reactions and disulfiram-like reactions
• Hypogonadism and syndrome of inappropriate antidiuretic hormone secretion (SIADH), most often in patients who are on other medications or who have medical conditions known to cause hypogonadism or increase release of antidiuretic hormone
• Dysgeusia

7 DRUG INTERACTIONS

7.1 Drugs Affecting Glucose Metabolism

A number of medications affect glucose metabolism and may require AMARYL dose adjustment and particularly close monitoring for hypoglycemia or worsening glycometric control.

The following are examples of medications that may increase the glucose-lowering effect of sulfonylureas including AMARYL, increasing the susceptibility to and/or intensity of hypoglycemia: oral anti-infective agents, antihistamines, antipsychotics, beta-blockers, clonidine, and reserpine. Use in pregnancy over decades have not identified any drug associated risks for major birth defects, miscarriage, or adverse maternal outcomes. However, sulfonylureas (including glimepiride) cross the placenta and have been associated with neonatal adverse reactions such as hypoglycemia. Therefore, AMARYL should be discontinued at least two weeks before expected delivery [see Clinical Considerations].
**Risk Summary**

In clinical trials of AMARYL, 1053 of 3491 patients (30%) were ≥65 years of age. No overall differences in safety or effectiveness were observed between these patients and younger patients, but greater sensitivity of some older individuals cannot be ruled out. There were no significant differences in glimepiride pharmacokinetics between patients with type 2 diabetes (male=7; female=23) between ages 10 and 17 years. The mean (± SD) AUC (0–last) max (3.1±1.7 hours) for glimepiride were comparable to historical data from adults [AUC (0–last) max (3.1±1.7 hours)].

**Clinical Considerations**

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.

**Fetal/neonatal adverse reactions**

Neonates of women with gestational diabetes who are treated with sulfonylureas during pregnancy may be at increased risk for neonatal intensive care admission and may develop respiratory distress, hypoglycemia, birth injury, and be large for gestational age. Prolonged severe hypoglycemia, lasting 4–10 days, has been reported in neonates born to mothers receiving a sulfonylurea at the time of delivery and has been reported with the use of agents with a prolonged half-life. Observe newborns for symptoms of hypoglycemia and respiratory distress and manage accordingly.

Dose adjustments during pregnancy and the postpartum period

Due to reports of prolonged severe hypoglycemia in neonates born to mothers receiving a sulfonylurea at the time of delivery, AMARYL should be discontinued at least two weeks before expected delivery (see Fetal/Neonatal Adverse Reactions).

**Data**

In animal studies, there was no increase in congenital anomalies, but an increase in fetal deaths occurred in rats and rabbits at glimepiride doses 50 times (rats) and 0.1 times (rabbits) the maximum recommended human dose (based on body surface area). This fetotoxicity was observed only at doses inducing maternal hypoglycemia and is believed to be directly related to the pharmacologic (hypo-glycemic) action of glimepiride, as has been similarly noted with other sulfonylureas.

**8.2 Lactation**

Breastfed infants of lactating women using AMARYL should be monitored for symptoms of hypoglycemia (see Clinical Considerations). It is not known whether glimepiride is excreted in human milk and there are no data on the effects of glimepiride on milk production. Glimepiride is present in rat milk (see Data). The developmental and health benefits of breastfeeding should be considered along with the mother’s clinical need for AMARYL and any potential adverse effects on the breastfed child from AMARYL or from the underlying maternal condition.

**Clinical Considerations**

Breastfeeding should be reviewed for all patients treated with sulfonylureas. In clinical trials of AMARYL, 1053 of 3491 patients (30%) were ≥65 years of age. No overall differences in safety or effectiveness were observed between these patients and younger patients, but greater sensitivity of some older individuals cannot be ruled out. There were no significant differences in glimepiride pharmacokinetics between patients with type 2 diabetes (male=7; female=23) between ages 10 and 17 years. The mean (± SD) AUC (0–last) max (3.1±1.7 hours) for glimepiride were comparable to historical data from adults [AUC (0–last) max (3.1±1.7 hours)].

**8.4 Pediatric Use**

The pharmacokinetics, efficacy and safety of AMARYL have been evaluated in pediatric patients with type 2 diabetes as described below. AMARYL is not recommended in pediatric patients because of its adverse effects on body weight and hypoglycemia.

The pharmacokinetics of a 1 mg single dose of AMARYL was evaluated in 30 patients with type 2 diabetes (male:7; female:23) between ages 10 and 17 years. The mean (± SD) AUC (0–last) max (3.1±1.7 hours) for glimepiride were comparable to historical data from adults [AUC (0–last) max (3.1±1.7 hours)]. The safety and efficacy of AMARYL in pediatric patients was evaluated in a single-blind, 24-week trial that randomized 272 patients (8–17 years of age) with type 2 diabetes to AMARYL (n=135) or metformin (n=137). Both treatment-naive patients (those treated with only diet and exercise for at least 2 weeks prior to randomization) and previously treated patients (those previously treated or currently treated with other oral antidiabetic medications for at least 3 months) were eligible to participate. Patients who were receiving oral antidiabetic agents at the time of study entry discontinued these medications before randomization without a washout period. AMARYL was initiated at 1 mg, and then titrated up to 2, 4, or 8 mg (mean last dose 4 mg) through Week 12, targeting a self-monitored fasting finger-stick blood glucose <126 mg/dL. Metformin was initiated at 500 mg twice daily and titrated at Week 12 up to 1000 mg twice daily (mean last dose 1365 mg).

After 24 weeks, the overall mean treatment difference in HbA1c between AMARYL and metformin was 0.2%, favoring metformin (95% confidence interval -0.3% to +0.6%). Based on these results, the trial did not meet its primary objective of showing a similar reduction in HbA1c with AMARYL compared to metformin.

**Table 2: Change from Baseline in HbA1c and Body Weight in Pediatric Patients Taking AMARYL or Metformin**

<table>
<thead>
<tr>
<th></th>
<th>Metformin</th>
<th>AMARYL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment-Naive Patients</td>
<td>N=69</td>
<td>N=72</td>
</tr>
<tr>
<td>HbA1c (%)</td>
<td>Baseline (mean) 8.2</td>
<td>8.3</td>
</tr>
<tr>
<td></td>
<td>Change from baseline (adjusted LS mean) -1.2</td>
<td>-1.0</td>
</tr>
</tbody>
</table>

*Intent-to-treat population using last-observation-carried-forward for missing data (AMARYL, n=127; metformin, n=126)
†adjusted for baseline HbA1c and Tanner Stage
‡Difference is AMARYL – metformin with positive differences favoring metformin

The profile of adverse reactions in pediatric patients treated with AMARYL was similar to that observed in adults [see Adverse Reactions (6)].

Hypoglycemic events observed by blood glucose values <36 mg/dL were observed in 4% of pediatric patients treated with AMARYL and in 1% of pediatric patients treated with metformin. One patient in each treatment group experienced a severe hypoglycemic episode (severity was determined by the investigator based on observed signs and symptoms).

**8.5 Geriatric Use**

In clinical trials of AMARYL, 1053 of 3491 patients (30%) were >65 years of age. No overall differences in safety or effectiveness were observed between these patients and younger patients, but greater sensitivity of some older individuals cannot be ruled out. There were no significant differences in glimepiride pharmacokinetics between patients with type 2 diabetes (male=7; female=23) between ages 10 and 17 years. The mean (± SD) AUC (0–last) max (3.1±1.7 hours) for glimepiride were comparable to historical data from adults [AUC (0–last) max (3.1±1.7 hours)].

**10. OVERDOSAGE**

An overdose of AMARYL, as with other sulfonylureas, can produce severe hypoglycemia. Mild episodes of hypoglycemia can be treated with oral glucose. Severe hypoglycemic reactions constitute medical emergencies requiring immediate treatment. Severe hypoglycemia with coma, seizure, or neurological impairment can be treated with glucagon or intravenous glucose. Continued observation and additional carbohydrate intake may be necessary because hypoglycemia may recur after apparent clinical recovery [see Warnings and Precautions (5.1)].

**11. DESCRIPTION**

AMARYL is an oral sulfonylurea that contains the active ingredient glimepiride. Chemically, glimepiride is identified as 1-[2-(3-ethyl-4-methyl-2-oxo-3-pyrroline-1-carboxamido)ethyl]phenylsulfonil]-5-(trans-4-methylcyclohexyl)urea ([C₉H₁₄NO₄S] with a molecular weight of 490.82. Glimepiride is a white to yellowish-white, crystalline, odorless to practically odorless powder and is practically insoluble in water.

The structural formula is:
12.2 Pharmacodynamics
In healthy subjects, the time to reach maximal effect (minimum blood glucose concentrations) was approximately 2–3 hours after single oral doses of AMARYL. The effects of AMARYL on HbA1c, fasting plasma glucose, and postprandial glucose have been assessed in clinical trials [see Clinical Studies (14)].

12.3 Pharmacokinetics
Absorption
Studies with single oral doses of glimepiride in healthy subjects and with multiple oral doses in patients with type 2 diabetes showed peak drug concentrations (C_{max}) 2 to 3 hours post dose. When glimepiride was given with meals, the mean C_max and AUC (area under the curve) were decreased by 8% and 9%, respectively.

Glimepiride does not accumulate in serum following multiple dosing. The pharmacokinetics of glimepiride does not differ between healthy subjects and patients with type 2 diabetes. Clearance of glimepiride after oral administration does not change over the 1 mg to 8 mg dose range, indicating linear pharmacokinetics. In subjects, the intravariability and interindividual variability of glimepiride plasma glucose, and postprandial glucose have been assessed in clinical trials [see Clinical Studies (14)].

13. ADVERSE REACTIONS

13.1 Carcinogenesis, Mutagenesis, and Impairment of Fertility
Studies in rats of dose up to 5000 parts per million (ppm) in complete feed (approximately 340 times the maximum recommended human dose, based on surface area) for 30 months showed no evidence of carcinogenesis. In mice, administration of glimepiride for 24 months resulted in an increase in benign pancreatic adenoma formation that was dose-related and was thought to be the result of chronic pancreatic stimulation. No adrenocortical formation in mice was observed at a dose of 320 ppm in complete feed, or 46–54 mg/kg body weight/day. This is at least 28 times the maximum human recommended dose of 8 mg once daily based on surface area.

Glimepiride was non-mutagenic in a battery of in vitro and in vivo mutagenicity studies (Ames test, somatic cell mutation, chromosomal aberration, unscheduled DNA synthesis, and mouse micronucleus test).

There was no effect of glimepiride on male mouse fertility in animals exposed up to 2500 mg/kg body weight. In a 14-day period followed by randomization into 1 of 4 treatment groups: placebo (n=74), AMARYL 1 mg (n=78), AMARYL 4 mg (n=76), and AMARYL 8 mg (n=76). All patients randomized to AMARYL started 1 mg daily. Patients randomized to AMARYL 4 mg or 8 mg had blinded, forced titration of the AMARYL dose at weekly intervals, first to 4 mg and then to 8 mg, as long as the dose was well-tolerated, until the randomized dose was reached. Patients randomized to the 4 mg dose reached the assigned dose at Week 2. Patients randomized to the 8 mg dose reached the assigned dose at Week 3. Once the randomized dose level was reached, patients were to be maintained at that dose until Week 14. Approximately 66% of the placebo-treated patients completed the trial compared to 81% of patients with 8 mg once daily. Approximately 71% of patients treated with glimepiride 1 mg and 92% of patients treated with glimepiride 4 mg or 8 mg. Compared to placebo, treatment with AMARYL 1 mg, 4 mg, and 8 mg daily provided statistically significant improvements in HbA1c compared to placebo (Table 3).

Table 3: 14-Week Monotherapy Trial Comparing AMARYL to Placebo in Patients Previously Treated With Sulfonylurea Therapy*

| Table 3: 14-Week Monotherapy Trial Comparing AMARYL to Placebo in Patients Previously Treated With Sulfonylurea Therapy* |
|---|---|---|---|
| Placebo (N=74) | AMARYL 1 mg (N=78) | AMARYL 4 mg (N=76) | AMARYL 8 mg (N=76) |
| HbA1c (%) | | | |
| Baseline (mean) | 8.0 | 7.9 | 7.9 | 8.0 |
| Change from Baseline (adjusted mean²) | 1.5 | 0.3 | -0.3 | -0.4 |
| Difference from Placebo (adjusted mean²) | | | | |
| 95% confidence interval | -1.20 (<1.5, -0.8) | -1.80 (<2.1, -1.4) | -1.80 (<2.2, -1.5) |
| Mean Baseline Weight (kg) | | | |
| Baseline (mean) | 85.7 | 84.3 | 86.1 | 85.5 |
| Change from Baseline (adjusted mean²) | -2.3 | 0.2 | 0.5 | 1.0 |
| Difference from Placebo (adjusted mean²) | | | | |
| 95% confidence interval | 2.00 (1.4, 2.7) | 2.80 (2.1, 3.5) | 3.20 (2.8, 4.0) |

*Intention-to-treat population using last observation on study
†Least squares mean adjusted for baseline value
‡p<0.001
A total of 249 patients who were treatment-naive or who had received limited treatment with antidiabetic therapy in the past were randomized to receive 22 weeks of treatment with either AMARYL (n=123) or placebo (n=126) in a multicenter, randomized, double-blind, placebo-controlled, dose-titration trial. The starting dose of AMARYL was 1 mg daily and was titrated upward or downward at 2-week intervals to a goal FPG of 90–150 mg/dL. Blood glucose levels for both FPG and PPG were analyzed in the laboratory. Following 10 weeks of dose adjustment, patients were maintained at their optimal dose (1, 2, 3, 4, 6, or 8 mg) for the remaining 12 weeks of the trial. Treatment with AMARYL provided statistically significant improvements in HbA1c and FPG compared to placebo (Table 4).

Table 4: 22-Week Monotherapy Trial Comparing AMARYL to Placebo in Patients Who Were Treatment-Naive or Who Had No Recent Treatment with Antidiabetic Therapy

<table>
<thead>
<tr>
<th></th>
<th>Placebo (N=126)</th>
<th>AMARYL (N=123)</th>
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<tbody>
<tr>
<td><strong>HbA1c (%)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline (mean)</td>
<td>9.1</td>
<td>9.3</td>
</tr>
<tr>
<td>Change from Baseline (adjusted mean†)</td>
<td>-1.1‡</td>
<td>-2.2‡</td>
</tr>
<tr>
<td>Difference from Placebo (adjusted mean†) 95% confidence interval</td>
<td>(-1.5, -0.8)</td>
<td></td>
</tr>
<tr>
<td><strong>Body Weight (kg)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline (mean)</td>
<td>86.5</td>
<td>87.1</td>
</tr>
<tr>
<td>Change from Baseline (adjusted mean†)</td>
<td>-0.9</td>
<td>1.8</td>
</tr>
<tr>
<td>Difference from Placebo (adjusted mean†) 95% confidence interval</td>
<td>(1.9, 3.6)</td>
<td></td>
</tr>
</tbody>
</table>

*Intent-to-treat population using last observation on study
†Least squares mean adjusted for baseline value
‡p≤0.0001

16 HOW SUPPLIED/STORAGE AND HANDLING
AMARYL tablets are available in the following strengths and package sizes:
- 1 mg (pink, flat-faced, oblong with notched sides at double bisect, imprinted with “AMARYL” on one side) in bottles of 100 (NDC 0039-0221-10)
- 2 mg (green, flat-faced, oblong with notched sides at double bisect, imprinted with “AMARYL” on one side) in bottles of 100 (NDC 0039-0222-10)
- 4 mg (blue, flat-faced, oblong with notched sides at double bisect, imprinted with “AMARYL” on one side) in bottles of 100 (NDC 0039-0223-10)

Store at 25°C (77°F); excursions permitted to 20°C–25°C (68°F–77°F) (see USP Controlled Room Temperature). Dispense in well-closed containers with safety closures.

17 PATIENT COUNSELING INFORMATION

Hypoglycemia
Explain the symptoms and treatment of hypoglycemia as well as conditions that predispose to hypoglycemia. Inform patients that their ability to concentrate and react may be impaired as a result of hypoglycemia and that this may present a risk in situations where these abilities are especially important, such as driving or operating other machinery [see Warnings and Precautions (5.1)].

Hypersensitivity Reactions
Inform patients that hypersensitivity reactions may occur with AMARYL and that if a reaction occurs to seek medical treatment and discontinue AMARYL [see Warnings and Precautions (5.2)].

Pregnancy
Advise females of reproductive potential to inform their prescriber of a known or suspected pregnancy [see Use in Specific Populations (8.1)].

Lactation
Advise breastfeeding women taking AMARYL to monitor breastfed infants for signs of hypoglycemia (e.g., jitteriness, cyanosis, apnea, hypothermia, excessive sleepiness, poor feeding, seizures) [see Use in Specific Populations (8.2)].

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GLI-FPLR-SL-DEC18 Rx Only