

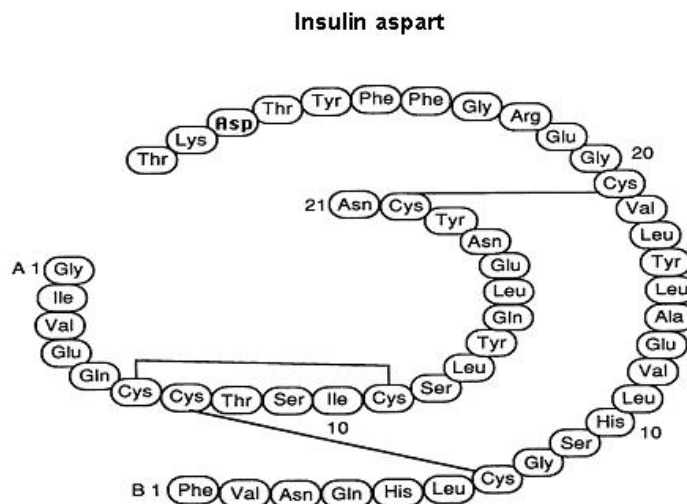
PRODUCT INFORMATION INSULIN ASPART

NovoRapid® 10mL Vial
NovoRapid® Penfill® 3mL
NovoRapid® FlexPen® 3mL
NovoMix® 30 Penfill® 3mL
NovoMix® 30 FlexPen® 3mL

NAME of the MEDICINE

Insulin aspart

Insulin aspart (rys) has the empirical formula $C_{256}H_{381}N_{65}O_{79}S_6$ and a molecular weight of 5825.8.



CAS No.: 116094-23-6

DESCRIPTION

Insulin aspart is a rapid-acting analogue of human insulin that rapidly lowers blood glucose. Insulin aspart is homologous with human insulin with the exception of a substitution of the amino acid proline by aspartic acid at position 28 on the B-chain. The unique structure of insulin aspart increases the rate of absorption from a subcutaneous injection site, giving a faster onset of action, an earlier peak effect and a shorter duration of action than soluble human insulin. Insulin aspart should be given immediately before a meal or, when necessary, after the start of a meal.

Insulin aspart is produced by recombinant DNA technology using *Saccharomyces cerevisiae*. One unit of insulin aspart corresponds to 6 nmol, 0.035 mg salt-free anhydrous insulin aspart.

NovoRapid® is a sterile, clear, colourless, aqueous, neutral solution of insulin aspart (B28 Asp) 100 U/mL. NovoRapid is a solution for injection.

NovoRapid also contains the following inactive ingredients: glycerol, phenol, meta-cresol, zinc chloride, dibasic sodium phosphate dihydrate, sodium chloride, sodium hydroxide, hydrochloric acid and water for injections.

NovoMix[®] 30 is a white suspension for subcutaneous injection consisting of 30% soluble insulin aspart and 70% protamine-crystallised insulin aspart. This is a biphasic insulin preparation (NovoMix 30) which produces insulin plasma profiles similar to premixed biphasic human insulin, apart from the initial faster absorption of the soluble component.

NovoMix 30 also contains the following inactive ingredients: protamine sulfate, glycerol, phenol, meta-cresol, zinc chloride, dibasic sodium phosphate dihydrate, sodium chloride, sodium hydroxide, hydrochloric acid and water for injections.

PHARMACOLOGY

Pharmacodynamics

Insulin lowers blood glucose levels by binding to insulin receptors to increase glucose uptake and inhibit hepatic glucose output.

As with all insulins in clinical practice, the duration of action of insulin aspart will vary according to the dose, injection site, blood flow, temperature and level of physical activity.

Insulin aspart is equipotent to soluble human insulin on a molar basis.

NovoRapid[®]

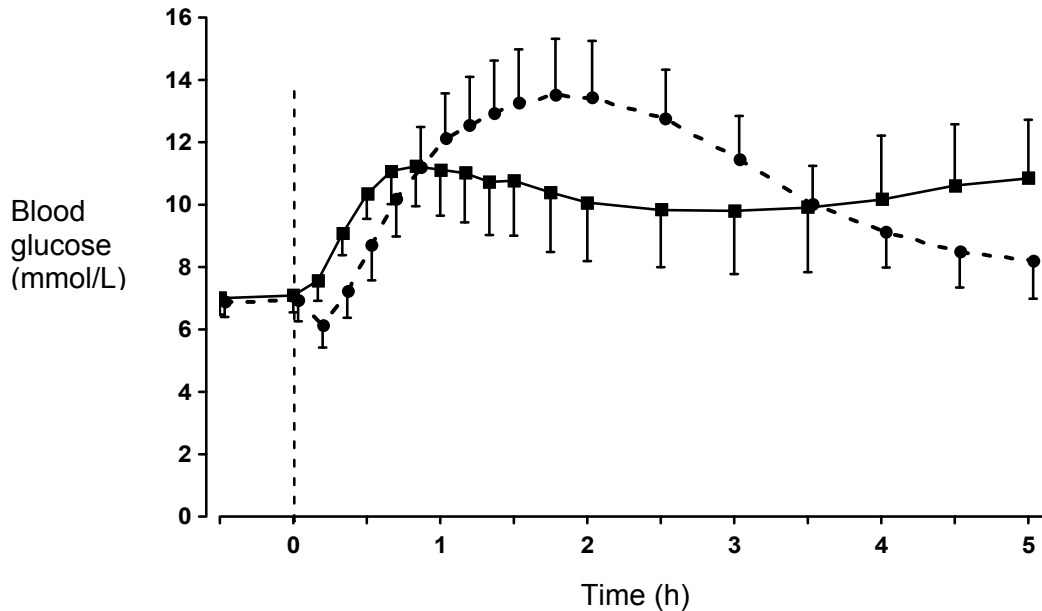
NovoRapid produces a more rapid and pronounced blood glucose lowering effect than soluble human insulin, due to the faster onset of action.

NovoRapid has a shorter duration of action compared to soluble human insulin after subcutaneous injection (Fig.1).

When administered immediately before a meal, the effect of NovoRapid more closely mimics normal physiological postprandial insulin release than soluble human insulin.

The onset of action of NovoRapid occurs within 10-20 minutes of subcutaneous injection. The maximum effect is exerted between 1 and 3 hours after injection. The duration of action is 3 to 5 hours. NovoRapid has a more predictable time to peak effect within subjects than soluble human insulin.

Fig. 1: Blood glucose concentrations* (mean \pm 2SEM) following a single pre-meal dose (0.15 U/kg) of NovoRapid injected immediately before a meal (solid curve) or soluble human insulin administered 30 minutes before a meal (dashed curve) in patients with type 1 diabetes mellitus.



* Data from Trial 024/UK, a randomised, double-blind, crossover trial involving 24 subjects.

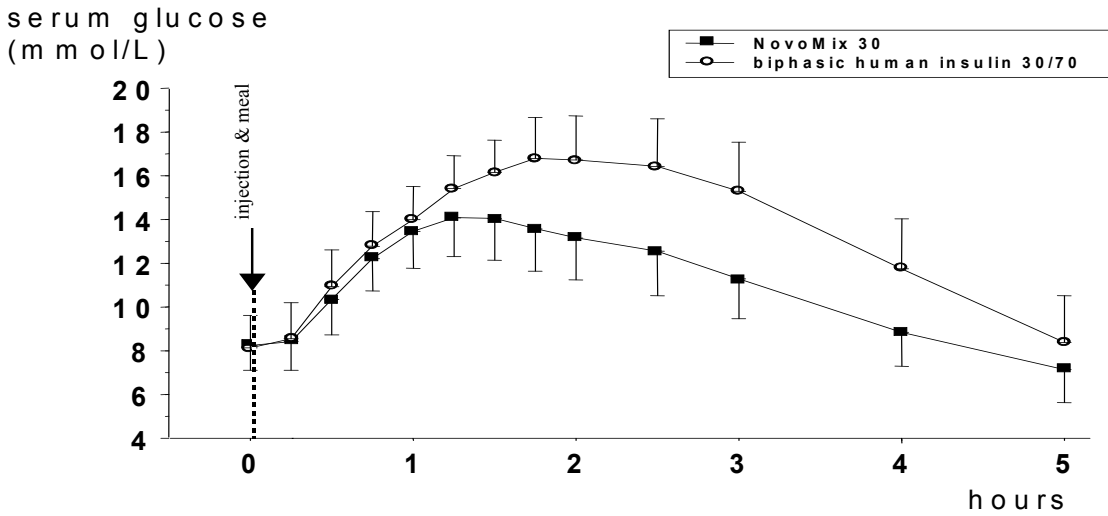
NovoMix® 30

NovoMix 30 is a biphasic insulin which contains 30% soluble insulin aspart. This has a rapid onset of action, and NovoMix 30 should thus be given closer to a meal than biphasic human insulin. The crystalline phase in NovoMix 30 is 70% insulin aspart protamine, which has an activity profile similar to that of human isophane (NPH) insulin.

The onset of action of NovoMix 30 occurs within 10-20 minutes of subcutaneous injection. The maximum effect is exerted between 1 and 4 hours after injection (Figure 2). The duration of action of NovoMix 30 is up to 24 hours.

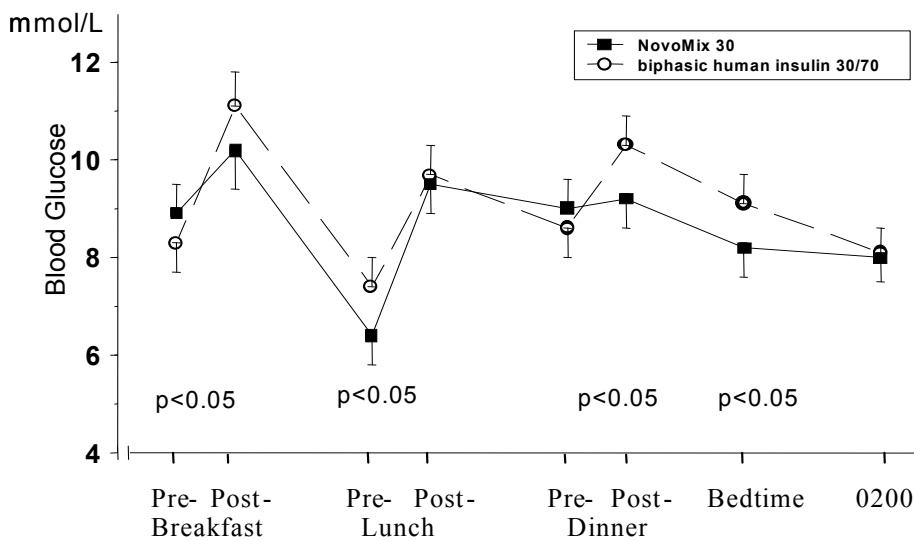
When injected immediately before a meal, NovoMix 30 has been demonstrated to better control postprandial hyperglycaemia than a corresponding 30/70 biphasic human insulin (Figure 3). This improvement in postprandial glycaemia is not of established clinical value.

Fig. 2. Serum glucose concentrations* (mean \pm 2SEM) in 13 patients with type 2 diabetes mellitus following an immediate pre-meal dose of NovoMix 30 (squares) or biphasic human insulin (circles).



* Data from Trial 046/NL, UK --- a randomised, double-blind, two-way, cross-over Phase II study.

Fig. 3. Self monitored blood glucose* (mean \pm 2SEM) in 291 patients with diabetes treated with NovoMix 30 (squares) or biphasic human insulin 30/70 (circles).



* Data from Trial 038/D, UK --- a 3 month, multicentre, open-labelled, randomised, parallel-group Phase III study.

Pharmacokinetics

Human insulin molecules self-associate to form hexamers. The substitution of proline by aspartic acid at position B28 in insulin aspart produces an intermolecular repulsion which reduces the tendency of the insulin molecules to self-associate. This increases the rate of dissociation of hexamers into dimers and monomers in the subcutaneous layer.

NovoRapid is more rapidly absorbed from the subcutaneous layer than soluble human insulin. The insulin aspart in the soluble phase of NovoMix 30 comprises 30% of the total insulin: this is absorbed more rapidly from the subcutaneous layer than the soluble insulin component of biphasic human insulin. The remaining 70% is in crystalline form as insulin aspart protamine; this has a similar prolonged absorption profile to human NPH (isophane or protamine-crystallised) insulin.

NovoRapid®

The t_{\max} is on average half of that for soluble human insulin. In different studies, the t_{\max} was reached after 40-50 minutes with NovoRapid compared to 80-120 minutes for soluble human insulin. The intra-individual variability in t_{\max} is significantly less for NovoRapid than for soluble human insulin.

The C_{\max} is on average at least twice as high with NovoRapid than with soluble human insulin. In one study in subjects with type 1 diabetes, the mean C_{\max} was 492 pmol/L with NovoRapid and 216 pmol/L with soluble human insulin (administered at a dose of 0.15 U/kg bodyweight). The return to baseline insulin levels is faster with NovoRapid than soluble human insulin.

In a clinical study in healthy subjects, the pharmacokinetic differences between NovoRapid and soluble human insulin, were maintained independent of the injection site (abdomen, thigh or deltoid).

Insulin aspart has a low binding to plasma proteins, 0-9%. After subcutaneous administration, insulin aspart was more rapidly eliminated than soluble human insulin with an average apparent half-life of 81 minutes compared to 141 minutes for soluble human insulin.

NovoMix® 30

The C_{\max} is, on average, 50% higher with NovoMix 30 than with biphasic human insulin 30/70. The T_{\max} is, on average, half of that for biphasic human insulin 30/70. A mean maximum serum concentration of 140 ± 32 pmol/L was reached after 60 minutes (interquartile range 45 to 70 minutes) after a subcutaneous dose of 0.20 U/kg body weight in healthy volunteers. The mean half life ($t_{1/2}$) of NovoMix 30 was about 8-9 hours (interquartile range 6.5-17.5 hours). Serum insulin levels returned to baseline 15-18 hours after a subcutaneous dose.

Special patient populations

Children: The pharmacokinetic and pharmacodynamic properties of soluble insulin aspart were investigated in children (6-12 years) and adolescents (13-17 years) with type 1 diabetes. The relative difference in pharmacokinetics and pharmacodynamics in children and adolescents with type 1 diabetes between soluble insulin aspart and soluble human insulin correlated well with those in healthy adult subjects and adults with type 1 diabetes. The pharmacokinetics of biphasic insulin aspart have not been investigated in children.

Elderly: The relative differences in pharmacokinetic properties between soluble insulin aspart and soluble human insulin in elderly subjects (65-83 years, mean age 70 years) with type 2 diabetes were similar to those observed in healthy subjects and in younger subjects with diabetes; i.e. the significantly earlier and higher C_{\max} is maintained with soluble insulin aspart. As in younger subjects with type 2 diabetes, t_{\max} of soluble insulin aspart may be slightly delayed in elderly subjects with type 2 diabetes, though still significantly earlier than for human insulin. The pharmacokinetics of biphasic insulin aspart have not been investigated in the elderly.

Hepatic impairment: A single dose pharmacokinetic study of soluble insulin aspart was performed in 24 subjects with hepatic function ranging from normal to severely impaired. In subjects with hepatic impairment absorption rate was decreased and more variable, resulting in delayed t_{max} from about 50 min in subjects with normal hepatic function to about 85 min in subjects with moderate and severe hepatic impairment. AUC, C_{max} and CL/F were similar in subjects with reduced hepatic function compared with subjects with normal hepatic function. The pharmacokinetics of biphasic insulin aspart have not been investigated in this population.

Renal impairment: A single dose pharmacokinetic study of soluble insulin aspart in 18 subjects with renal function ranging from normal to severely impaired was performed. No apparent effect of creatinine clearance values on AUC, C_{max} and CL of soluble insulin aspart was found. The PK in subjects with renal failure necessitating dialysis treatment was not investigated. Special precautions should be taken in these patients as insulin clearance may be reduced. The pharmacokinetics of biphasic insulin aspart have not been investigated in this population.

CLINICAL TRIALS

NovoRapid[®]

Adults: Clinical trials with NovoRapid have demonstrated an improved postprandial blood glucose control compared to soluble human insulin. In long-term trials, NovoRapid has shown a small but statistically significant improvement in glycosylated haemoglobin with no increase in hypoglycaemic events compared to soluble human insulin. In the pivotal trials, NovoRapid has shown a statistically significant reduction in the number of patients experiencing major nocturnal hypoglycaemia compared to soluble human insulin. Hypoglycaemic events with insulin aspart were seen at 2-4 hours post dose compared to 2-7 hours with soluble human insulin. There were no safety issues with NovoRapid and no evidence of increased immunogenicity with NovoRapid compared with soluble human insulin.

There were four adequate and well-controlled clinical trials in the insulin aspart clinical development program: one phase II trial in men with type I diabetes (025/UK), and three phase III trials - two in adults with type 1 diabetes (035/EU and 036/USA), and one in adults with type 2 diabetes (037/USA). In all pivotal efficacy trials, NovoRapid was administered immediately before meals, and soluble human insulin was dosed 30 minutes before meals. The phase III trials involved a wide variety of people (aged 18 - 77 years) with type 1 and 2 diabetes.

Elderly: A randomised, double-blind cross-over PK/PD trial comparing insulin aspart with soluble human insulin was performed in elderly patients with type 2 diabetes (19 patients aged 65-83 years, mean age 70 years). The relative differences in the pharmacodynamic properties between insulin aspart and human insulin in elderly were consistent with those seen in healthy subjects and in younger subjects with diabetes. No safety issues were raised, but careful glucose monitoring and individual dose adjustments of insulin, including insulin aspart, may be necessary in elderly patients.

Children and adolescents: Limited data suggest that when given to children NovoRapid showed similar glucose control compared to soluble human insulin. A clinical trial (ANA-1415) comparing preprandial soluble human insulin with postprandial insulin aspart was performed in small children (26 patients aged 2 to 6 years), and a single dose PK/PD trial (043/UK) was performed in children (6-12 years) and adolescents (13-17 years). The pharmacodynamic profile of insulin aspart in children was similar to that seen in adults. Long term data in children, including the effects on growth and development, are not available.

Continuous subcutaneous insulin infusion ('CSII'): Compatibility with NovoRapid was investigated in MiniMed 506 and Disetronic H-TRON plus V-100 infusion pumps, and in MiniMed Polyfin

(MMT-106) and Sof-set (MMT-111) and Disetronic Classic and Tender infusion sets. The infusion sets used in compatibility testing employed the same materials as the MiniMed systems registered in Australia. Two clinical trials (ANA-2018/US and ANA-2024/US) were conducted to evaluate the safety and efficacy of NovoRapid when administered by continuous subcutaneous insulin infusion ('CSII'). Clinical use was investigated in MiniMed 506, 507, 507c and Disetronic H-TRON plus V-100 insulin infusion pumps; of these, Disetronic H-TRON plus V-100, MiniMed 507 and 507c are registered in Australia.

025/UK, 035/EU, 036/USA and 037/USA

The pivotal phase II and III trials, were multi-centre, randomised, active-controlled studies of 1 month (025/UK) or 6 months (035/EU, 036/USA and 037/USA) duration, designed to evaluate short- and long term efficacy and safety of NovoRapid compared to soluble human insulin in type 1 and type 2 diabetes.

In the short term study, the NovoRapid glucose profiles were lower after meals and higher during the night than soluble human insulin. Overall 24-hour glucose control, as assessed by the excursion of glucose level outside the range 4.0 – 7.0 mmol/L, was significantly improved with NovoRapid. The number of major hypoglycaemic events was significantly lower with NovoRapid than soluble human insulin. The minor hypoglycaemic event rate with NovoRapid was the same as, if not lower than, the soluble human insulin but with fewer events during the night.

In the 6 month phase III studies, treatment with NovoRapid significantly improved HbA_{1c} in patients with type 1 diabetes. A similar improvement in HbA_{1c} was observed in type 2 patients, but was not significant due to the lower number of patients (Table 1).

Table 1: HbA_{1c} after 6 Months Treatment - Phase III Trials (ITT Population)

Trial	NovoRapid		Soluble human insulin		Difference in Mean	95% C.I.	P
	n	Mean (SEM)	n	Mean (SEM)			
Type 1 Diabetes							
036/USA	585	7.78(0.03)	278	7.93(0.05)	-0.15	[-0.26 to -0.05]	0.0048
035/EU	694	7.88(0.03)	346	8.00(0.04)	-0.12	[-0.22 to -0.03]	0.0137
Type 2 Diabetes							
037/USA	90	7.70(0.09)	86	7.82(0.10)	-0.12	[-0.38 to 0.14]	0.3684

Postprandial glucose levels and mean prandial glucose increments were significantly lower in the NovoRapid treated than in the soluble human insulin treated type 1 patients.

Overall, the relative risk of major hypoglycaemic events was 19% lower with NovoRapid compared to soluble human insulin. The number of mild hypoglycaemic events was similar between insulin groups. Treatment with NovoRapid led to higher glucose levels at night compared to human insulin, resulting in a lower incidence of nocturnal, major hypoglycaemic events. Specifically, compared to soluble human insulin, there was a 50% lower risk of experiencing a major nocturnal hypoglycaemic event with NovoRapid (p=0.013) in the 036/USA trial and, similarly, a 30% lower risk with NovoRapid (p=0.076) in the 035/EU trial.

ANA-2024/US

This was a multi-centre, open-label, parallel-group, phase IIIb study in which 146 adults with type 1 diabetes were randomised 2:2:1 to receive NovoRapid, buffered regular insulin or insulin lispro by CSII over a 4-week dose adjustment period and 12-week maintenance periods. All subjects had been on other

forms of CSII for at least 3 months prior to study entry. The primary efficacy outcome measure was a comparison against baseline of HbA_{1c} values at 16 weeks. The major endpoints for the safety analysis were comparisons of the numbers of adverse events and hypoglycaemic episodes.

Change-from-baseline values of HbA_{1c}, blood glucose variability, average daily insulin use or body weight were not significantly different between treatment groups at any time point. The adverse event profile of NovoRapid was similar to that of buffered regular insulin and insulin lispro, and the three treatment groups had similar rates of hypoglycaemia. When administered as continuous subcutaneous insulin infusion in a pump, NovoRapid was shown to be as safe and effective as buffered regular human insulin.

ANA/DCD/066

This phase IIIb, double-blind, randomized, cross-over, multi-centre trial compared the frequency of major hypoglycaemic episodes after 16 weeks treatment with NovoRapid versus 16 weeks treatment with soluble human insulin in 139 adults with well-controlled type 1 diabetes treated on a basal bolus regimen. Frequency of major hypoglycaemic episodes during the treatment periods was the primary endpoint.

A statistically non-significant ($p=0.119$) NovoRapid/soluble human insulin relative risk for major hypoglycaemia of 0.72 (95% CI: 0.47-1.09) was found. A secondary finding was that subjects treated with NovoRapid experienced a significantly ($p=0.001$) lower rate of major hypoglycaemic episodes during the night (midnight-6am). The estimated NovoRapid/soluble human insulin relative risk was 0.28 (95% CI: 0.13-0.59). This was not a predefined endpoint in the study protocol and this result represents a post hoc analysis. A statistically significant ($p=0.048$) reduction in the frequency of minor hypoglycaemic episodes was found with NovoRapid treatment (N=1590) compared to human soluble insulin (N=1752), with the estimated NovoRapid/soluble human insulin relative risk being 0.93 (95% CI: 0.87-1.00). No significant differences between insulin aspart and human soluble insulin were found for the investigated glycaemic control parameters or in the domain scores of the Quality of Life questionnaires. The statistical testing was not adjusted for the multiple variables examined.

028/UK

This phase II trial was conducted in 16 subjects with well controlled type 1 diabetes who did not require intravenous therapy. Both NovoRapid and human soluble insulin were given intravenously to determine the blood glucose threshold for autonomic activation during hypoglycaemia. There were no statistically significant differences between NovoRapid and soluble human insulin. No advantage is expected in giving NovoRapid intravenously over soluble human insulin intravenously.

ANA-1415

A clinical trial investigated the safety and efficacy of insulin aspart (N = 26) vs. soluble human insulin (N = 26) in children with type 1 diabetes aged 2 – 6 years. Human NPH insulin was used as the basal insulin in both groups. Similar results for the two primary safety and efficacy endpoints (frequency of hypoglycaemic episodes and postprandial glucose increment, respectively), as well as the secondary endpoints, were observed with both regimens.

ANA-1474 and -2067

A clinical trial comparing safety and efficacy of insulin aspart vs. soluble human insulin in the treatment of pregnant women with type 1 diabetes (322 exposed pregnancies: insulin aspart, N = 157; human insulin, N = 165) did not detect any adverse effect of insulin aspart on pregnancy or on the health of the fetus/newborn. Efficacy when measured by HbA_{1c} was observed to be comparable to insulin aspart versus soluble human insulin, whilst mean prandial glucose increments were significantly improved for insulin aspart during the first and third trimesters. In addition the data from a clinical trial including 27 women with gestational diabetes randomised to treatment with insulin aspart vs. soluble human insulin (insulin aspart, N = 14; human insulin, N = 13) showed similar safety profiles between treatments.

NovoMix® 30

038

In a 3 month, multicentre, open-labelled, randomised, parallel group Phase III study, NovoMix 30 was as effective as biphasic human insulin (BHI) in overall glycaemic control (Table 2).

Table 2. Glycaemic control of NovoMix 30 versus BHI as measured by HbA_{1c} (%) and prandial increment over the three meals (mmol/L) in people with type 1 or type 2 diabetes

	Biphasic Insulin Aspart		Biphasic Human Insulin 30/70		Difference in Mean	95%C.I.	P
	N	Mean (SEM)	N	Mean (SEM)			
HbA _{1c}	132	8.14 (0.06)	143	8.15 (0.06)	-0.01	-0.14 to 0.12	NS
prandial increments	128	1.66 (0.20)	141	2.34 (0.19)	-0.68	-1.20 to -0.16	<0.02

There were no safety issues with NovoMix 30 compared with human insulin.

1241

This was a multinational, open-label, parallel-group trial in 329 subjects with type 2 diabetes. The primary objective of the trial was to compare glycaemic control between the existing 'gold standard' metformin plus add-on treatment with sulphonylurea (glibenclamide), against metformin plus add-on treatment with NovoMix 30 b.i.d., and against NovoMix 30 b.i.d. monotherapy, in patients inadequately controlled on current metformin monotherapy. Subjects were randomised to receive as add-on therapy with metformin either NovoMix 30 b.i.d. (108 subjects exposed), or glibenclamide (114 subjects exposed), or to receive NovoMix 30 b.i.d. monotherapy (107 subjects exposed). After 16 weeks of treatment decreases in mean HbA_{1c} levels relative to baseline of at least 1.5% were observed for all three treatment groups. The mean level of HbA_{1c} at end of trial was statistically significantly lower for the NovoMix 30+Met group than for the NovoMix 30 Mono group (by 0.39%, p=0.0074).

INDICATIONS

Treatment of diabetes mellitus.

CONTRAINDICATIONS

- Hypoglycaemia
- Hypersensitivity to insulin aspart or any of the excipients

PRECAUTIONS

Inadequate dosing or discontinuation of treatment, especially in type 1 diabetes, may lead to hyperglycaemia and diabetic ketoacidosis. The first symptoms of hyperglycaemia usually come on gradually, over a period of hours or days. They include nausea, vomiting, drowsiness, flushed dry skin, dry mouth, increased urination, thirst and loss of appetite as well as acetone breath. Untreated hyperglycaemic events may be life threatening.

Patients whose blood glucose control is greatly improved, e.g. by intensified insulin therapy, may experience a change in their usual warning symptoms of hypoglycaemia, and should be advised accordingly. Usual warning symptoms may disappear in patients with longstanding diabetes.

Insulin aspart products should be administered immediately before a meal or, when necessary, after the start of a meal. The rapid onset of action should therefore be considered in patients with concomitant diseases or medication where a delayed absorption of food might be expected.

Concomitant illness, especially infections and feverish conditions, usually increases the patient's insulin requirements.

Renal or hepatic impairment, or concomitant diseases in the kidney or liver or affecting the adrenal, pituitary or thyroid gland, can require changes in the insulin dose.

As with any insulin therapy, injection site reactions may occur and include pain, redness, itching, hives, bruising, swelling and inflammation. Continuous rotation of the injection site within a given area may help to reduce or prevent these reactions. Reactions usually resolve in a few days to a few weeks. On rare occasions, injection site reactions may require discontinuation of insulin aspart products.

Insulin aspart products contain metacresol which on rare occasions may cause allergic reactions.

Safety and effectiveness of NovoMix 30 in children and adolescents under the age of 18 have not been assessed due to limited clinical experience.

NovoMix 30 is not to be used in insulin infusion pumps.

Transfer of patients between insulin types

Transferring a patient to another type or brand of insulin should be done under strict medical supervision. Changes in strength, brand (manufacturer), type, origin (human insulin, insulin analogue) and/or method of manufacture may result in the need for a change in dosage. Patients transferred to insulin aspart from another type of insulin may require an increased number of daily injections or a change in dosage from that used with their usual insulin products. If an adjustment is needed, it may occur with the first dose or during the first few weeks or months.

Carcinogenicity

Lifetime carcinogenicity studies of insulin aspart have not been performed in animals. In 52-week repeat dose toxicity studies in Sprague-Dawley rats at doses up to 50 U/kg/d SC, the only significant toxicity findings were related to hypoglycaemia. At a higher dose of 200 U/kg/d SC in female Sprague-Dawley rats, insulin aspart, like human insulin, caused induction of mammary tumours. The clinical relevance of these findings is not known. Neither clinical nor epidemiological studies conducted to date have shown an association between insulin use and carcinogenesis but the available evidence is considered too limited to be conclusive at this time. *In vitro* studies showed that the mitogenic activity of insulin aspart does not differ from that observed with human insulin.

Genotoxicity

Insulin aspart did not cause gene mutations, chromosomal damage or DNA damage in a range of genotoxicity tests.

Effects on fertility

In reproductive toxicity studies, insulin aspart did not affect the fertility of male and female rats but caused a slight increase in pre-implantation loss at subcutaneous doses greater than 10U/kg/day. Similar effects were seen with human insulin.

Use in Pregnancy

Pregnancy Category: A

Insulin aspart can be used in pregnancy. Data from two randomised controlled clinical trials with NovoRapid (157 + 14 insulin aspart-exposed pregnancies, respectively) did not indicate any adverse effect of insulin aspart on pregnancy or on the health of the foetus/newborn when compared to human insulin (see 'Clinical Trials').

There are no clinical trials with biphasic insulin aspart in pregnancy.

Intensified blood glucose control and monitoring of pregnant women with diabetes (type 1 diabetes, type 2 diabetes or gestational diabetes) are recommended throughout pregnancy and when contemplating pregnancy. Insulin requirements usually fall in the first trimester and increase subsequently during the second and third trimesters. After delivery, insulin requirements return rapidly to prepregnancy levels.

Use in Lactation

Although no clinical trial data are available with insulin aspart products during lactation, there are no restrictions on treatment with these medicines during lactation. Insulin treatment of the nursing mother should not affect the baby. However, the dosage of insulin aspart may need to be adjusted.

Interactions

Omission of a meal or unplanned, strenuous physical exercise may lead to hypoglycaemia (see 'Adverse Effects' and 'Overdosage').

A number of drugs are known to interact with glucose metabolism. Possible interactions must therefore be taken into account by the physician.

The following substances may reduce the patient's insulin requirements:

Oral hypoglycaemic agents (OHAs), octreotide, monoamine oxidase inhibitors (MAOIs), non-selective beta-adrenergic blocking agents, angiotensin converting enzyme (ACE) inhibitors, salicylates, alcohol, anabolic steroids (except danazol and oxymetholone), alpha-adrenergic blocking agents, quinine, quinidine and sulphonamides.

The following substances may increase the patient's insulin requirements:

Oral contraceptives, thiazides, glucocorticoids, thyroid hormones, sympathomimetics, octreotide, growth hormone, diazoxide, asparaginase, nicotinic acid, oxymetholone and danazol.

Beta blockers may mask the symptoms of hypoglycaemia and delay recovery from hypoglycaemia.

Alcohol may intensify and prolong the hypoglycaemic effect of insulin.

Combination of thiazolidinediones and insulin

Cases of congestive heart failure have been reported when thiazolidinediones were used in combination with insulin, especially in patients with risk factors for development of congestive heart failure. This should be kept in mind if treatment with the combination of thiazolidinediones and insulin medicinal products is considered. If the combination is used, patients should be observed for signs and symptoms of congestive heart failure, weight gain and oedema. Thiazolidinediones should be discontinued if any deterioration in cardiac symptoms occurs.

Incompatibilities

In general, insulin aspart products should only be added to compounds with which they have known compatibility. Drugs added to the insulin may cause degradation of the insulin, e.g. if the drugs contain thiols or sulphites.

NovoMix 30 should not be added to infusion fluids.

ADVERSE EFFECTS

The safety profile of insulin aspart products observed in clinical trials is similar to the safety profile reported for the respective Novo Nordisk human insulin products.

Adverse drug reactions observed in patients using insulin aspart products are mainly dose-dependent and due to the pharmacological effect of insulin. As for other insulin products, hypoglycaemia in general is the most frequently occurring undesirable effect. It may occur if the insulin dose is too high in relation to the insulin requirement. In clinical trials and during marketed use the frequency varies with patient population and dose regimens and therefore no specific frequency can be presented. Severe hypoglycaemia may lead to unconsciousness and/or convulsions and may result in temporary or permanent impairment of brain function or even death. During clinical trials the overall rates of hypoglycaemia did not differ between patients treated with insulin aspart compared with human insulin.

Frequencies of adverse drug reactions from clinical trials, which by an overall judgement are considered related to insulin aspart are listed below. The frequencies are defined as: uncommon ($> 1/1,000$, $< 1/100$) and rare ($> 1/10,000$, $< 1/1,000$). Isolated spontaneous cases are presented as very rare (defined as $< 1/10,000$).

Immune system disorders

Uncommon – Urticaria, rash, eruptions

Very rare - Generalised hypersensitivity reactions

Symptoms may include generalised skin rash, itching, sweating, gastrointestinal upset, angioneurotic oedema, difficulties in breathing, palpitation and reduction in blood pressure. Generalised hypersensitivity reactions are potentially life-threatening.

Nervous system disorders

Rare – Peripheral neuropathy

Rapid improvement in blood glucose control may be associated with a condition termed acute painful neuropathy, which is usually reversible.

Eye disorders

Uncommon – Refraction disorder

Refraction anomalies may occur upon initiation of insulin therapy. These symptoms are usually of a transitory nature.

Uncommon – Diabetic retinopathy

Intensification of insulin therapy with abrupt improvement in glycaemic control may be associated with worsening of diabetic retinopathy, which is usually reversible. Long-term improved glycaemic control decreases the risk of progression of diabetic retinopathy.

Skin and subcutaneous tissue disorders

Uncommon – Lipodystrophy

Lipodystrophy may occur at the injection site as a consequence of failure to rotate the injection site within an area.

Uncommon – Local hypersensitivity

Local hypersensitivity reactions (redness, swelling and itching at the injection site) may occur during treatment with insulin. These reactions are usually transitory and normally disappear with continued treatment.

General disorders and administration site conditions

Uncommon - Oedema

Oedema may occur upon initiation of insulin therapy. These symptoms are usually of transitory nature.

In a Phase III study of NovoMix 30, the level of antibodies cross-reactive to human insulin and insulin aspart showed an increase during the first 3 months which persisted at a lower level after 12 and 24 months. After 24 months of treatment a correlation was found between absolute antibody level and absolute insulin dose; no correlation, however, was found between the increase in antibody formation and the increase in insulin dose. There was no significant correlation with glycaemic control attained or adverse event reporting. The long-term clinical significance of insulin antibodies is uncertain.

DOSAGE AND ADMINISTRATION

NovoRapid has a faster onset and a shorter duration of action than soluble human insulin. Similarly, NovoMix 30 has a faster onset of action than biphasic human insulin. Due to the faster onset of action, insulin aspart products should generally be given immediately before a meal or when necessary, soon after the start of a meal.

The dosage of insulin aspart is determined by the physician according to the patient's individual needs. The individual insulin requirement is usually between 0.5 and 1.0 Units/kg/day in adults and children. In a meal-related treatment 50-70% of this requirement may be provided by NovoRapid and the remainder provided by an intermediate-acting or long-acting insulin given at least once a day. Alternatively, the daily insulin requirement may be fully or partially supplied with NovoMix 30.

The daily insulin requirement may be higher in patients with insulin resistance (e.g. due to obesity), and lower in patients with residual endogenous insulin production. Adjustment of dosage may also be necessary if patients undertake increased physical activity, change their usual diet, or during concomitant illness. Exercise taken immediately after a meal may increase the risk of hypoglycaemia.

In patients with diabetes mellitus optimised metabolic control effectively delays the onset and slows the progression of diabetic late complications. Optimised metabolic control, including glucose monitoring, is therefore recommended.

As with all insulins, in elderly patients and patients with hepatic or renal impairment glucose monitoring should be intensified and dosage adjusted on an individual basis.

NovoRapid 10mL Vial may be used for continuous subcutaneous insulin infusion ('CSII') in pump systems suitable for insulin infusion (see 'Clinical Trials'). When used in external insulin infusion pumps the initial programming of the pump should be based on the total daily insulin dose on the previous regimen. Approximately 50% of the total dose is to be given as the basal rate, and the remainder is to be divided between breakfast, lunch, dinner and snacks. The usual individual daily insulin requirement of between 0.5 and 1.0 U/kg/day also applies when NovoRapid is used in CSII.

When used in an insulin infusion pump NovoRapid should not be mixed with any other insulin. Patients using CSII should be comprehensively instructed in the use of the pump system. The infusion and reservoir set should be changed every 48 hours using aseptic technique. Patients administering NovoRapid by CSII must always carry a spare vial of NovoRapid and a U100 syringe, or an alternative insulin delivery system, in case of pump system failure.

Insulin aspart products are administered by subcutaneous injection in the abdominal wall, the thigh, the deltoid region or the gluteal region. NovoRapid may also be administered by subcutaneous infusion in the abdominal wall. Injection sites should be rotated within the same region. When injected subcutaneously into the abdominal wall, the onset of action for insulin aspart products, will occur

within 10-20 minutes of injection. For NovoRapid, the maximum effect is exerted between 1 and 3 hours after the injection, and the duration of action is 3 to 5 hours. The duration of action of NovoMix 30 is up to 24 hours. As with all insulins the duration of action will vary according to the dose, injection site, blood flow, temperature and level of physical activity. Based on studies of soluble insulin aspart and soluble human insulin, subcutaneous injection in the abdominal wall is expected to result in a faster absorption than from other injection sites. However, the faster onset of action of insulin aspart products compared to their respective human insulin products is expected to be maintained regardless of injection site. Formal studies on the bioavailability of NovoRapid administered by subcutaneous injection in the gluteal region have not been conducted.

NovoRapid may be administered intravenously under medical supervision. For emergency use with Penfill®/FlexPen® the NovoRapid must first be withdrawn into a syringe. Discard Penfill/FlexPen cartridge/pen after emergency use. NovoRapid has been used intravenously (see Clinical Trials). No studies have been conducted in critically ill people with diabetes who are likely to require intravenous administration. There is no pharmacokinetic or pharmacodynamic advantage in using NovoRapid over soluble human insulin when these insulins are given intravenously.

NovoMix 30 should never be administered intravenously. Intramuscular administration should be avoided.

The recommended starting dose of NovoMix 30 in combination with metformin is 0.2 Units/kg/day and should be adjusted depending on individual requirements based on blood glucose response.

Transfer of patients to insulin aspart products

NovoRapid differs from human insulin by its rapid onset and shorter duration of action. NovoMix 30 also differs from human insulin by their faster onset. Because of the rapid onset of action, the injection of insulin aspart products should immediately be followed by a meal.

Insulin aspart products are equipotent to their respective human insulin products, in regards to hypoglycaemic effect, receptor affinity and effect on lipogenesis. Patients currently treated with human insulin can be transferred to NovoRapid or NovoMix 30 on a unit for unit basis when administered just before a meal. Although no change in dose is anticipated other than the routine adjustments made in order to maintain stable diabetic control, any change to insulin therapy should be made under medical supervision and blood glucose should be monitored.

When patients are transferred between different types of insulin products, the early warning symptoms of hypoglycaemia may change or become less pronounced than those experienced with their previous insulin.

Instructions for use and handling

10mL vials

NovoRapid vials are for use with U100 insulin syringes and for use with an infusion pump system. The carton contains a Consumer Medicine Information package leaflet with instructions for use and handling.

Penfill® 3mL cartridges

The carton contains a Consumer Medicine Information package leaflet with instructions for use and handling. The leaflet refers to the instructions for using the accompanying Novo Nordisk insulin delivery system.

The suspension contained within NovoMix 30 Penfill® must be resuspended after removal from the refrigerator and immediately before use so that it appears uniformly white and cloudy. *The necessity to resuspend immediately before use is to be stressed to the patient.*

Insulin aspart Penfill products are for use by one person only. The cartridges must not be refilled.

Insulin aspart Penfill cartridges are designed to be used with Novo Nordisk insulin delivery systems and NovoFine[®] or NovoTwist[®] needles.

Failure to change the needle may result in needle blockage. The patient should be advised to discard the needle after each injection.

FlexPen[®] 3mL

The carton contains a Consumer Medicine Information package leaflet with instructions for use and handling. Please note that insulin is not delivered if the patient reverse dials the insulin pen by returning the dose selector to zero after inserting the needle. Patients should be instructed that insulin injection only occurs when the pushbutton is depressed.

The suspension contained within NovoMix 30 FlexPen[®] must be resuspended after removal from the refrigerator and immediately before use so that it appears uniformly white and cloudy. *The necessity to resuspend immediately before use is to be stressed to the patient.*

Insulin aspart FlexPen products are for use by one person only. The cartridge inside the pen must not be refilled.

NovoFine or NovoTwist needles up to a length of 8 mm are designed to be used with insulin aspart FlexPen products.

Failure to change the needle may result in needle blockage. The patient should be advised to discard the needle after each injection.

OVERDOSAGE

A specific overdose for insulin cannot be defined, however hypoglycaemia may develop over sequential stages if doses are administered which are too high relative to the patient's requirements:

- Mild hypoglycaemic episodes can be treated by oral administration of glucose or sugary products. It is therefore recommended that the person with diabetes always carry products containing sugar with them.
- Severe hypoglycaemic episodes, where the patient has become unconscious, can be treated by glucagon (0.5 to 1 mg) given intramuscularly or subcutaneously by a trained person or glucose given intravenously by a medical professional. Glucose must also be given intravenously if the patient does not respond to glucagon within 10 to 15 minutes.

Upon regaining consciousness, oral administration of carbohydrate is recommended for the patient in order to prevent relapse.

PRESENTATIONS AND STORAGE CONDITIONS

NovoRapid contains insulin aspart 100 U/mL. NovoMix 30 products contain biphasic insulin aspart 100 U/mL. The following presentations are available:

10mL Vial

The 10mL glass vial is closed with a latex-free rubber disc. One 10mL vial is packed in a carton.

NovoRapid 10mL vial

Penfill® 3mL

Penfill cartridges are made of glass, contain a rubber piston and are closed with a latex-free rubber disc. NovoMix 30 Penfill also contains a glass ball within the cartridge to facilitate resuspension. Five 3mL Penfill cartridges are packed in a carton.

NovoRapid Penfill, NovoMix 30 Penfill.

FlexPen® 3mL

FlexPen is a pre-filled, multidose, disposable pen consisting of a pen injector and a 3mL cartridge. The cartridge is made of glass, contains a rubber piston and is closed with a latex-free rubber disc. The cartridges contained within NovoMix 30 FlexPen also contain a glass ball to facilitate resuspension. The pen injector is made of plastic. Five FlexPen are packed in a carton.

NovoRapid FlexPen, NovoMix 30 FlexPen.

Insulin aspart products should be stored between 2°C and 8°C. Do not freeze. Insulin aspart products which have been frozen must not be used. The shelf-life is 30 months for NovoRapid and 24 months for NovoMix 30 when stored between 2°C and 8°C.

The in-use time is 4 weeks.

Insulin aspart products in use or carried as spares can be kept at ambient temperature (below 30°C) for up to 4 weeks, but any remainder must then be discarded. They should not be exposed to excessive heat or sunlight. Keep the product in the carton (vial, Penfill) or keep the cap on (FlexPen) when not in use, to protect it from light.

It is recommended that NovoMix 30 products in use or carried as spares be resuspended after removal from the refrigerator and immediately before use.

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POISON SCHEDULE OF THE MEDICINE

S4

DATE OF APPROVAL

Approved by the Therapeutic Goods Administration on 14 November 2008.

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