

Table 4. Effect of Coadministered Drugs on Zidovudine AUC*

Note: ROUTINE DOSE MODIFICATION OF ZIDOVUDINE IS NOT WARRANTED WITH COADMINISTRATION OF THE FOLLOWING DRUGS.

Coadministered Drug and Dose	Zidovudine Dose	n	Zidovudine Concentrations		Concentration of Coadministered Drug
			AUC	Variability	
Atovaquone 750 mg q 12 hr with food	200 mg q 8 hr	14	↑AUC 31%	Range 23% to 78% [†]	↔
Fluconazole 400 mg daily	200 mg q 8 hr	12	↑AUC 74%	95% CI: 54% to 98%	Not Reported
Methadone 30 to 90 mg daily	200 mg q 4 hr	9	↑AUC 43%	Range 16% to 64% [†]	↔
Nelfinavir 750 mg q 8 hr x 7 to 10 days	single 200 mg	11	↓AUC 35%	Range 28% to 41%	↔
Probenecid 500 mg q 6 hr x 2 days	2 mg/kg q 8 hr x 3 days	3	↑AUC 106%	Range 100% to 170% [†]	Not Assessed
Rifampin 600 mg daily x 14 days	200 mg q 8 hr x 14 days	8	↓AUC 47%	90% CI: 41% to 53%	Not Assessed
Ritonavir 300 mg q 6 hr x 4 days	200 mg q 8 hr x 4 days	9	↓AUC 25%	95% CI: 15% to 34%	↔
Valproic acid 250 mg or 500 mg q 8 hr x 4 days	100 mg q 8 hr x 4 days	6	↑AUC 80%	Range 64% to 130% [†]	Not Assessed

↑ = Increase; ↓ = Decrease; ↔ = no significant change; AUC = area under the concentration versus time curve; CI = confidence interval.

*This table is not all inclusive.

†Estimated range of percent difference.

INDICATIONS AND USAGE

RETROVIR in combination with other antiretroviral agents is indicated for the treatment of HIV infection.

Maternal-Fetal HIV Transmission: RETROVIR is also indicated for the prevention of maternal-fetal HIV transmission as part of a regimen that includes oral RETROVIR beginning between 14 and 34 weeks of gestation, intravenous RETROVIR during labor, and administration of RETROVIR Syrup to the neonate after birth. The efficacy of this regimen for preventing HIV transmission in women who have received RETROVIR for a prolonged period before pregnancy has not been evaluated. The safety of RETROVIR for the mother or fetus during the first trimester of pregnancy has not been assessed (see Description of Clinical Studies).

Description of Clinical Studies: Therapy with RETROVIR has been shown to prolong survival and decrease the incidence of opportunistic infections in patients with advanced HIV disease and to delay disease progression in asymptomatic HIV-infected patients.

Combination Therapy in Adults: RETROVIR in combination with other antiretroviral agents has been shown to be superior to monotherapy for one or more of the following endpoints: delaying death, delaying development of AIDS, increasing CD4 cell counts, and decreasing plasma HIV RNA. The clinical efficacy of a combination regimen that includes RETROVIR was demonstrated in study ACTG320. This study was a multicenter, randomized, double-blind, placebo-controlled trial that compared RETROVIR 600 mg/day plus EPIVIR 300 mg/day to RETROVIR plus EPIVIR plus indinavir 800 mg t.i.d. The incidence of AIDS-defining events or death was lower in the triple-drug-containing arm compared to the 2-drug-containing arm (6.1% versus 10.9%, respectively).

The complete prescribing information for each drug should be consulted before combination therapy that includes RETROVIR is initiated.

Monotherapy in Adults: In controlled studies of treatment-naïve patients conducted between 1986 and 1989, monotherapy with RETROVIR, as compared to placebo, reduced the risk of HIV disease progression, as assessed using endpoints that included the occurrence of HIV-related illnesses, AIDS-defining events, or death. These studies enrolled patients with advanced disease (BW002), and asymptomatic or mildly symptomatic disease in patients with CD4 cell counts between 200 and 500 cells/mm³ (ACTG016 and ACTG019). A survival benefit for monotherapy with RETROVIR was not demonstrated in the latter 2 studies. Subsequent studies showed that the clinical benefit of monotherapy with RETROVIR was time limited.

Pediatric Patients: ACTG300 was a multicenter, randomized, double-blind study that provided for comparison of EPIVIR plus RETROVIR to didanosine monotherapy. A total of 471 symptomatic, HIV-infected therapy-naïve pediatric patients were enrolled in these 2 treatment arms. The median age was 2.7 years (range 6 weeks to 14 years), the mean baseline CD4 cell count was 868 cells/mm³, and the mean baseline plasma HIV RNA was

5.0 log₁₀ copies/mL. The median duration that patients remained on study was approximately 10 months. Results are summarized in Table 5.

Table 5. Number of Patients (%) Reaching a Primary Clinical Endpoint (Disease Progression or Death)

Endpoint	EPIVIR plus RETROVIR (n = 236)	Didanosine (n = 235)
HIV disease progression or death (total)	15 (6.4%)	37 (15.7%)
Physical growth failure	7 (3.0%)	6 (2.6%)
Central nervous system deterioration	4 (1.7%)	12 (5.1%)
CDC Clinical Category C	2 (0.8%)	8 (3.4%)
Death	2 (0.8%)	11 (4.7%)

Pregnant Women and Their Neonates: The utility of RETROVIR for the prevention of maternal-fetal HIV transmission was demonstrated in a randomized, double-blind, placebo-controlled trial (ACTG076) conducted in HIV-infected pregnant women with CD4 cell counts of 200 to 1,818 cells/mm³ (median in the treated group: 560 cells/mm³) who had little or no previous exposure to RETROVIR. Oral RETROVIR was initiated between 14 and 34 weeks of gestation (median 11 weeks of therapy) followed by IV administration of RETROVIR during labor and delivery. Following birth, neonates received oral RETROVIR Syrup for 6 weeks. The study showed a statistically significant difference in the incidence of HIV infection in the neonates (based on viral culture from peripheral blood) between the group receiving RETROVIR and the group receiving placebo. Of 363 neonates evaluated in the study, the estimated risk of HIV infection was 7.8% in the group receiving RETROVIR and 24.9% in the placebo group, a relative reduction in transmission risk of 68.7%. RETROVIR was well tolerated by mothers and infants. There was no difference in pregnancy-related adverse events between the treatment groups.

CONTRAINDICATIONS

RETROVIR Tablets, Capsules, and Syrup are contraindicated for patients who have potentially life-threatening allergic reactions to any of the components of the formulations.

WARNINGS

COMBIVIR and TRIZIVIR are combination product tablets that contain zidovudine as one of their components. RETROVIR should not be administered concomitantly with COMBIVIR or TRIZIVIR.

The incidence of adverse reactions appears to increase with disease progression; patients should be monitored carefully, especially as disease progression occurs.

Bone Marrow Suppression: RETROVIR should be used with caution in patients who have bone marrow compromise evidenced by granulocyte count $<1,000$ cells/mm³ or hemoglobin <9.5 g/dL. In patients with advanced symptomatic HIV disease, anemia and neutropenia were the most significant adverse events observed. There have been reports of pancytopenia associated with the use of RETROVIR, which was reversible in most instances after discontinuance of the drug. However, significant anemia, in many cases requiring dose adjustment, discontinuation of RETROVIR, and/or blood transfusions, has occurred during treatment with RETROVIR alone or in combination with other antiretrovirals.

Frequent blood counts are strongly recommended in patients with advanced HIV disease who are treated with RETROVIR. For HIV-infected individuals and patients with asymptomatic or early HIV disease, periodic blood counts are recommended. If anemia or neutropenia develops, dosage adjustments may be necessary (see DOSAGE AND ADMINISTRATION).

Myopathy: Myopathy and myositis with pathological changes, similar to that produced by HIV disease, have been associated with prolonged use of RETROVIR.

Lactic Acidosis/Severe Hepatomegaly with Steatosis: Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside analogues alone or in combination, including zidovudine and other antiretrovirals. A majority of these cases have been in women. Obesity and prolonged exposure to antiretroviral nucleoside analogues may be risk factors. Particular caution should be exercised when administering RETROVIR to any patient with known risk factors for liver disease; however, cases have also been reported in patients with no known risk factors. Treatment with RETROVIR should be suspended in any patient who develops clinical or laboratory findings suggestive of lactic acidosis or pronounced hepatotoxicity (which may include hepatomegaly and steatosis even in the absence of marked transaminase elevations).

PRECAUTIONS

General: Zidovudine is eliminated from the body primarily by renal excretion following metabolism in the liver (glucuronidation). In patients with severely impaired renal function ($\text{CrCl} < 15$ mL/min), dosage reduction is recommended. Although the data are limited, zidovudine concentrations appear to be increased in patients with severely impaired hepatic function which may increase the risk of hematologic toxicity (see CLINICAL PHARMACOLOGY: Pharmacokinetics and DOSAGE AND ADMINISTRATION).

Fat Redistribution: Redistribution/accumulation of body fat, including central obesity, dorsocervical fat enlargement (buffalo hump), peripheral wasting, facial wasting, breast enlargement, and “cushingoid appearance,” have been observed in patients receiving antiretroviral therapy. The mechanism and long-term consequences of these events are currently unknown. A causal relationship has not been established.

Information for Patients: RETROVIR is not a cure for HIV infection, and patients may continue to acquire illnesses associated with HIV infection, including opportunistic infections.

Therefore, patients should be advised to seek medical care for any significant change in their health status.

The safety and efficacy of RETROVIR in women, intravenous drug users, and racial minorities is not significantly different than that observed in white males.

Patients should be informed that the major toxicities of RETROVIR are neutropenia and/or anemia. The frequency and severity of these toxicities are greater in patients with more advanced disease and in those who initiate therapy later in the course of their infection. They should be told that if toxicity develops, they may require transfusions or drug discontinuation. They should be told of the extreme importance of having their blood counts followed closely while on therapy, especially for patients with advanced symptomatic HIV disease. They should be cautioned about the use of other medications, including ganciclovir and interferon-alpha, that may exacerbate the toxicity of RETROVIR (see PRECAUTIONS: Drug Interactions). Patients should be informed that other adverse effects of RETROVIR include nausea and vomiting. Patients should also be encouraged to contact their physician if they experience muscle weakness, shortness of breath, symptoms of hepatitis or pancreatitis, or any other unexpected adverse events while being treated with RETROVIR.

RETROVIR Tablets, Capsules, and Syrup are for oral ingestion only. Patients should be told of the importance of taking RETROVIR exactly as prescribed. They should be told not to share medication and not to exceed the recommended dose. Patients should be told that the long-term effects of RETROVIR are unknown at this time.

Pregnant women considering the use of RETROVIR during pregnancy for prevention of HIV-transmission to their infants should be advised that transmission may still occur in some cases despite therapy. The long-term consequences of in utero and infant exposure to RETROVIR are unknown, including the possible risk of cancer.

HIV-infected pregnant women should be advised not to breastfeed to avoid postnatal transmission of HIV to a child who may not yet be infected.

Patients should be advised that therapy with RETROVIR has not been shown to reduce the risk of transmission of HIV to others through sexual contact or blood contamination.

Patients should be informed that redistribution or accumulation of body fat may occur in patients receiving antiretroviral therapy and that the cause and long-term health effects of these conditions are not known at this time.

Drug Interactions: See CLINICAL PHARMACOLOGY section (Table 4) for information on zidovudine concentrations when coadministered with other drugs. For patients experiencing pronounced anemia or other severe zidovudine-associated events while receiving chronic administration of zidovudine and some of the drugs (e.g., fluconazole, valproic acid) listed in Table 4, zidovudine dose reduction may be considered.

Antiretroviral Agents: Concomitant use of zidovudine with stavudine should be avoided since an antagonistic relationship has been demonstrated in vitro.

Some nucleoside analogues affecting DNA replication, such as ribavirin, antagonize the in vitro antiviral activity of RETROVIR against HIV; concomitant use of such drugs should be avoided.

Doxorubicin: Concomitant use of zidovudine with doxorubicin should be avoided since an antagonistic relationship has been demonstrated in vitro (see CLINICAL PHARMACOLOGY for additional drug interactions).

Phenytoin: Phenytoin plasma levels have been reported to be low in some patients receiving RETROVIR, while in one case a high level was documented. However, in a pharmacokinetic interaction study in which 12 HIV-positive volunteers received a single 300-mg phenytoin dose alone and during steady-state zidovudine conditions (200 mg every 4 hours), no change in phenytoin kinetics was observed. Although not designed to optimally assess the effect of phenytoin on zidovudine kinetics, a 30% decrease in oral zidovudine clearance was observed with phenytoin.

Overlapping Toxicities: Coadministration of ganciclovir, interferon-alpha, and other bone marrow suppressive or cytotoxic agents may increase the hematologic toxicity of zidovudine.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Zidovudine was administered orally at 3 dosage levels to separate groups of mice and rats (60 females and 60 males in each group). Initial single daily doses were 30, 60, and 120 mg/kg/day in mice and 80, 220, and 600 mg/kg/day in rats. The doses in mice were reduced to 20, 30, and 40 mg/kg/day after day 90 because of treatment-related anemia, whereas in rats only the high dose was reduced to 450 mg/kg/day on day 91 and then to 300 mg/kg/day on day 279.

In mice, 7 late-appearing (after 19 months) vaginal neoplasms (5 nonmetastasizing squamous cell carcinomas, 1 squamous cell papilloma, and 1 squamous polyp) occurred in animals given the highest dose. One late-appearing squamous cell papilloma occurred in the vagina of a middle-dose animal. No vaginal tumors were found at the lowest dose.

In rats, 2 late-appearing (after 20 months), nonmetastasizing vaginal squamous cell carcinomas occurred in animals given the highest dose. No vaginal tumors occurred at the low or middle dose in rats. No other drug-related tumors were observed in either sex of either species.

At doses that produced tumors in mice and rats, the estimated drug exposure (as measured by AUC) was approximately 3 times (mouse) and 24 times (rat) the estimated human exposure at the recommended therapeutic dose of 100 mg every 4 hours.

Two transplacental carcinogenicity studies were conducted in mice. One study administered zidovudine at doses of 20 mg/kg/day or 40 mg/kg/day from gestation day 10 through parturition and lactation with dosing continuing in offspring for 24 months postnatally. The doses of zidovudine employed in this study produced zidovudine exposures approximately 3 times the estimated human exposure at recommended doses. After 24 months, an increase in incidence of vaginal tumors was noted with no increase in tumors in the liver or lung or any other organ in either gender. These findings are consistent with results of the standard oral carcinogenicity study in mice, as described earlier. A second study administered zidovudine at maximum tolerated doses of 12.5 mg/day or 25 mg/day (~1,000 mg/kg nonpregnant body weight or

~450 mg/kg of term body weight) to pregnant mice from days 12 through 18 of gestation. There was an increase in the number of tumors in the lung, liver, and female reproductive tracts in the offspring of mice receiving the higher dose level of zidovudine.

It is not known how predictive the results of rodent carcinogenicity studies may be for humans.

Zidovudine was mutagenic in a 5178Y/TK^{+/+} mouse lymphoma assay, positive in an in vitro cell transformation assay, clastogenic in a cytogenetic assay using cultured human lymphocytes, and positive in mouse and rat micronucleus tests after repeated doses. It was negative in a cytogenetic study in rats given a single dose.

Zidovudine, administered to male and female rats at doses up to 7 times the usual adult dose based on body surface area considerations, had no effect on fertility judged by conception rates.

Pregnancy: Pregnancy Category C. Oral teratology studies in the rat and in the rabbit at doses up to 500 mg/kg/day revealed no evidence of teratogenicity with zidovudine. Zidovudine treatment resulted in embryo/fetal toxicity as evidenced by an increase in the incidence of fetal resorptions in rats given 150 or 450 mg/kg/day and rabbits given 500 mg/kg/day. The doses used in the teratology studies resulted in peak zidovudine plasma concentrations (after one half of the daily dose) in rats 66 to 226 times, and in rabbits 12 to 87 times, mean steady-state peak human plasma concentrations (after one sixth of the daily dose) achieved with the recommended daily dose (100 mg every 4 hours). In an in vitro experiment with fertilized mouse oocytes, zidovudine exposure resulted in a dose-dependent reduction in blastocyst formation. In an additional teratology study in rats, a dose of 3,000 mg/kg/day (very near the oral median lethal dose in rats of 3,683 mg/kg) caused marked maternal toxicity and an increase in the incidence of fetal malformations. This dose resulted in peak zidovudine plasma concentrations 350 times peak human plasma concentrations. (Estimated area-under-the-curve [AUC] in rats at this dose level was 300 times the daily AUC in humans given 600 mg per day.) No evidence of teratogenicity was seen in this experiment at doses of 600 mg/kg/day or less.

Two rodent transplacental carcinogenicity studies were conducted (see Carcinogenesis, Mutagenesis, Impairment of Fertility).

A randomized, double-blind, placebo-controlled trial was conducted in HIV-infected pregnant women to determine the utility of RETROVIR for the prevention of maternal-fetal HIV-transmission (see INDICATIONS AND USAGE: Description of Clinical Studies). Congenital abnormalities occurred with similar frequency between neonates born to mothers who received RETROVIR and neonates born to mothers who received placebo. Abnormalities were either problems in embryogenesis (prior to 14 weeks) or were recognized on ultrasound before or immediately after initiation of study drug.

Antiretroviral Pregnancy Registry: To monitor maternal-fetal outcomes of pregnant women exposed to RETROVIR, an Antiretroviral Pregnancy Registry has been established. Physicians are encouraged to register patients by calling 1-800-258-4263.

Nursing Mothers: The Centers for Disease Control and Prevention recommend that HIV-infected mothers not breastfeed their infants to avoid risking postnatal transmission

of HIV. Zidovudine is excreted in human milk (see CLINICAL PHARMACOLOGY: Pharmacokinetics: Nursing Mothers). Because of both the potential for HIV transmission and the potential for serious adverse reactions in nursing infants, **mothers should be instructed not to breastfeed if they are receiving RETROVIR** (see Pediatric Use and INDICATIONS AND USAGE: Maternal-Fetal HIV Transmission).

Pediatric Use: RETROVIR has been studied in HIV-infected pediatric patients over 3 months of age who had HIV-related symptoms or who were asymptomatic with abnormal laboratory values indicating significant HIV-related immunosuppression. RETROVIR has also been studied in neonates perinatally exposed to HIV (see ADVERSE REACTIONS, DOSAGE AND ADMINISTRATION, INDICATIONS AND USAGE: Description of Clinical Studies, and CLINICAL PHARMACOLOGY: Pharmacokinetics).

Geriatric Use: Clinical studies of RETROVIR did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

ADVERSE REACTIONS

Adults: The frequency and severity of adverse events associated with the use of RETROVIR are greater in patients with more advanced infection at the time of initiation of therapy.

Table 6 summarizes events reported at a statistically significant greater incidence for patients receiving RETROVIR in a monotherapy study:

Table 6. Percentage (%) of Patients with Adverse Events* in Asymptomatic HIV Infection (ACTG019)

Adverse Event	RETROVIR 500 mg/day (n = 453)	Placebo (n = 428)
Body as a whole		
Asthenia	8.6%†	5.8%
Headache	62.5%	52.6%
Malaise	53.2%	44.9%
Gastrointestinal		
Anorexia	20.1%	10.5%
Constipation	6.4%†	3.5%
Nausea	51.4%	29.9%
Vomiting	17.2%	9.8%

*Reported in ≥5% of study population.

†Not statistically significant versus placebo.

In addition to the adverse events listed in Table 6, other adverse events observed in clinical studies were abdominal cramps, abdominal pain, arthralgia, chills, dyspepsia, fatigue, hyperbilirubinemia, insomnia, musculoskeletal pain, myalgia, and neuropathy.

Selected laboratory abnormalities observed during a clinical study of monotherapy with RETROVIR are shown in Table 7.

Table 7. Frequencies of Selected (Grade 3/4) Laboratory Abnormalities in Patients with Asymptomatic HIV Infection (ACTG019)

Adverse Event	RETROVIR 500 mg/day (n = 453)	Placebo (n = 428)
Anemia (Hgb < 8 g/dL)	1.1%	0.2%
Granulocytopenia (< 750 cells/mm ³)	1.8%	1.6%
Thrombocytopenia (platelets < 50,000/mm ³)	0%	0.5%
ALT (> 5 x ULN)	3.1%	2.6%
AST (> 5 x ULN)	0.9%	1.6%
Alkaline phosphatase (> 5 x ULN)	0%	0%

ULN = Upper limit of normal.

Pediatrics: Study ACTG300: Selected clinical adverse events and physical findings with a $\geq 5\%$ frequency during therapy with EPIVIR 4 mg/kg twice daily plus RETROVIR 160 mg/m² 3 times daily compared with didanosine in therapy-naive (≤ 56 days of antiretroviral therapy) pediatric patients are listed in Table 8.

Table 8. Selected Clinical Adverse Events and Physical Findings (≥5% Frequency) in Pediatric Patients in Study ACTG300

Adverse Event	EPIVIR plus RETROVIR (n = 236)	Didanosine (n = 235)
Body as a whole		
Fever	25%	32%
Digestive		
Hepatomegaly	11%	11%
Nausea & vomiting	8%	7%
Diarrhea	8%	6%
Stomatitis	6%	12%
Splenomegaly	5%	8%
Respiratory		
Cough	15%	18%
Abnormal breath sounds/wheezing	7%	9%
Ear, Nose, and Throat		
Signs or symptoms of ears*	7%	6%
Nasal discharge or congestion	8%	11%
Other		
Skin rashes	12%	14%
Lymphadenopathy	9%	11%

*Includes pain, discharge, erythema, or swelling of an ear.

Selected laboratory abnormalities experienced by therapy-naïve (≤56 days of antiretroviral therapy) pediatric patients are listed in Table 9.

Table 9. Frequencies of Selected (Grade 3/4) Laboratory Abnormalities in Pediatric Patients in Study ACTG300

Test (Abnormal Level)	EPIVIR plus RETROVIR	Didanosine
Neutropenia (ANC<400 cells/mm ³)	8%	3%
Anemia (Hgb<7.0 g/dL)	4%	2%
Thrombocytopenia (platelets<50,000/mm ³)	1%	3%
ALT (>10 x ULN)	1%	3%
AST (>10 x ULN)	2%	4%
Lipase (>2.5 x ULN)	3%	3%
Total amylase (>2.5 x ULN)	3%	3%

ULN = Upper limit of normal.

ANC = Absolute neutrophil count.

Additional adverse events reported in open-label studies in pediatric patients receiving RETROVIR 180 mg/m² every 6 hours were congestive heart failure, decreased reflexes, ECG abnormality, edema, hematuria, left ventricular dilation, macrocytosis, nervousness/irritability, and weight loss.

The clinical adverse events reported among adult recipients of RETROVIR may also occur in pediatric patients.

Use for the Prevention of Maternal-Fetal Transmission of HIV: In a randomized, double-blind, placebo-controlled trial in HIV-infected women and their neonates conducted to determine the utility of RETROVIR for the prevention of maternal-fetal HIV transmission, RETROVIR Syrup at 2 mg/kg was administered every 6 hours for 6 weeks to neonates beginning within 12 hours following birth. The most commonly reported adverse experiences were anemia (hemoglobin <9.0 g/dL) and neutropenia (<1,000 cells/mm³). Anemia occurred in 22% of the neonates who received RETROVIR and in 12% of the neonates who received placebo. The mean difference in hemoglobin values was less than 1.0 g/dL for neonates receiving RETROVIR compared to neonates receiving placebo. No neonates with anemia required transfusion and all hemoglobin values spontaneously returned to normal within 6 weeks after completion of therapy with RETROVIR. Neutropenia was reported with similar frequency in the group that received RETROVIR (21%) and in the group that received placebo (27%). The long-term consequences of in utero and infant exposure to RETROVIR are unknown.

Observed During Clinical Practice: In addition to adverse events reported from clinical trials, the following events have been identified during use of RETROVIR in clinical practice. Because they are reported voluntarily from a population of unknown size, estimates of frequency cannot be made. These events have been chosen for inclusion due to either their seriousness, frequency of reporting, potential causal connection to RETROVIR, or a combination of these factors.

Body as a Whole: Back pain, chest pain, flu-like syndrome, generalized pain, redistribution/accumulation of body fat (see PRECAUTIONS: Fat Redistribution).

Cardiovascular: Cardiomyopathy, syncope.

Endocrine: Gynecomastia.

Eye: Macular edema.

Gastrointestinal: Constipation, dysphagia, flatulence, oral mucosa pigmentation, mouth ulcer.

General: Sensitization reactions including anaphylaxis and angioedema, vasculitis.

Hemic and Lymphatic: Aplastic anemia, hemolytic anemia, leukopenia, lymphadenopathy, pancytopenia with marrow hypoplasia, pure red cell aplasia.

Hepatobiliary Tract and Pancreas: Hepatitis, hepatomegaly with steatosis, jaundice, lactic acidosis, pancreatitis.

Musculoskeletal: Increased CPK, increased LDH, muscle spasm, myopathy and myositis with pathological changes (similar to that produced by HIV disease), rhabdomyolysis, tremor.

Nervous: Anxiety, confusion, depression, dizziness, loss of mental acuity, mania, paresthesia, seizures, somnolence, vertigo.

Respiratory: Cough, dyspnea, rhinitis, sinusitis.

Skin: Changes in skin and nail pigmentation, pruritus, rash, Stevens-Johnson syndrome, toxic epidermal necrolysis, sweat, urticaria.

Special Senses: Amblyopia, hearing loss, photophobia, taste perversion.

Urogenital: Urinary frequency, urinary hesitancy.

OVERDOSAGE

Acute overdoses of zidovudine have been reported in pediatric patients and adults. These involved exposures up to 50 grams. No specific symptoms or signs have been identified following acute overdosage with zidovudine apart from those listed as adverse events such as fatigue, headache, vomiting, and occasional reports of hematological disturbances. All patients recovered without permanent sequelae. Hemodialysis and peritoneal dialysis appear to have a negligible effect on the removal of zidovudine while elimination of its primary metabolite, GZDV, is enhanced.

DOSAGE AND ADMINISTRATION

Adults: The recommended oral dose of RETROVIR is 600 mg per day in divided doses in combination with other antiretroviral agents.

Pediatrics: The recommended dose in pediatric patients 6 weeks to 12 years of age is 160 mg/m² every 8 hours (480 mg/m²/day up to a maximum of 200 mg every 8 hours) in combination with other antiretroviral agents.

Maternal-Fetal HIV Transmission: The recommended dosing regimen for administration to pregnant women (>14 weeks of pregnancy) and their neonates is:

Maternal Dosing: 100 mg orally 5 times per day until the start of labor (see INDICATIONS AND USAGE: Description of Clinical Studies). During labor and delivery, intravenous

RETROVIR should be administered at 2 mg/kg (total body weight) over 1 hour followed by a continuous intravenous infusion of 1 mg/kg/hour (total body weight) until clamping of the umbilical cord.

Neonatal Dosing: 2 mg/kg orally every 6 hours starting within 12 hours after birth and continuing through 6 weeks of age. Neonates unable to receive oral dosing may be administered RETROVIR intravenously at 1.5 mg/kg, infused over 30 minutes, every 6 hours. (See PRECAUTIONS if hepatic disease or renal insufficiency is present.)

Monitoring of Patients: Hematologic toxicities appear to be related to pretreatment bone marrow reserve and to dose and duration of therapy. In patients with poor bone marrow reserve, particularly in patients with advanced symptomatic HIV disease, frequent monitoring of hematologic indices is recommended to detect serious anemia or neutropenia (see WARNINGS). In patients who experience hematologic toxicity, reduction in hemoglobin may occur as early as 2 to 4 weeks, and neutropenia usually occurs after 6 to 8 weeks.

Dose Adjustment: Anemia: Significant anemia (hemoglobin of <7.5 g/dL or reduction of >25% of baseline) and/or significant neutropenia (granulocyte count of <750 cells/mm³ or reduction of >50% from baseline) may require a dose interruption until evidence of marrow recovery is observed (see WARNINGS). In patients who develop significant anemia, dose interruption does not necessarily eliminate the need for transfusion. If marrow recovery occurs following dose interruption, resumption in dose may be appropriate using adjunctive measures such as epoetin alfa at recommended doses, depending on hematologic indices such as serum erythropoetin level and patient tolerance.

For patients experiencing pronounced anemia while receiving chronic coadministration of zidovudine and some of the drugs (e.g., fluconazole, valproic acid) listed in Table 4, zidovudine dose reduction may be considered.

End-Stage Renal Disease: In patients maintained on hemodialysis or peritoneal dialysis, recommended dosing is 100 mg every 6 to 8 hours (see CLINICAL PHARMACOLOGY: Pharmacokinetics).

Hepatic Impairment: There are insufficient data to recommend dose adjustment of RETROVIR in patients with mild to moderate impaired hepatic function or liver cirrhosis. Since RETROVIR is primarily eliminated by hepatic metabolism, a reduction in the daily dose may be necessary in these patients. Frequent monitoring for hematologic toxicities is advised (see CLINICAL PHARMACOLOGY: Pharmacokinetics and PRECAUTIONS: General).

HOW SUPPLIED

RETROVIR Tablets 300 mg (biconvex, white, round, film-coated) containing 300 mg zidovudine, one side engraved "GX CW3" and "300" on the other side. Bottle of 60 (NDC 0173-0501-00).

Store at 15° to 25°C (59° to 77°F).

RETROVIR Capsules 100 mg (white, opaque cap and body with a dark blue band) containing 100 mg zidovudine and printed with “Wellcome” and unicorn logo on cap and “Y9C” and “100” on body. Bottles of 100 (NDC 0173-0108-55) and Unit Dose Pack of 100 (NDC 0173-0108-56).

Store at 15° to 25°C (59° to 77°F) and protect from moisture.

RETROVIR Syrup (colorless to pale yellow, strawberry-flavored) containing 50 mg zidovudine in each teaspoonful (5 mL). Bottle of 240 mL (NDC 0173-0113-18) with child-resistant cap.

Store at 15° to 25°C (59° to 77°F).



GlaxoSmithKline
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April 2003

RL-1194

PRESCRIBING INFORMATION

EPIVIR[®] Tablets (lamivudine tablets)

EPIVIR[®] Oral Solution (lamivudine oral solution)

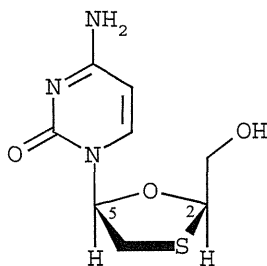
WARNING

LACTIC ACIDOSIS AND SEVERE HEPATOMEGALY WITH STEATOSIS, INCLUDING FATAL CASES, HAVE BEEN REPORTED WITH THE USE OF NUCLEOSIDE ANALOGUES ALONE OR IN COMBINATION, INCLUDING LAMIVUDINE AND OTHER ANTIRETROVIRALS (SEE WARNINGS).

EPIVIR TABLETS AND ORAL SOLUTION (USED TO TREAT HIV INFECTION) CONTAIN A HIGHER DOSE OF THE ACTIVE INGREDIENT (LAMIVUDINE) THAN EPIVIR-HBV[®] TABLETS AND ORAL SOLUTION (USED TO TREAT CHRONIC HEPATITIS B). PATIENTS WITH HIV INFECTION SHOULD RECEIVE ONLY DOSING FORMS APPROPRIATE FOR TREATMENT OF HIV (SEE WARNINGS AND PRECAUTIONS).

DESCRIPTION

EPIVIR (also known as 3TC) is a brand name for lamivudine, a synthetic nucleoside analogue with activity against human immunodeficiency virus-1 (HIV-1) and hepatitis B virus (HBV). The chemical name of lamivudine is (2R,cis)-4-amino-1-(2-hydroxymethyl-1,3-oxathiolan-5-yl)-(1H)-pyrimidin-2-one. Lamivudine is the (-)-enantiomer of a dideoxy analogue of cytidine. Lamivudine has also been referred to as (-)-2',3'-dideoxy, 3'-thiacytidine. It has a molecular formula of C₈H₁₁N₃O₃S and a molecular weight of 229.3. It has the following structural formula:



Lamivudine is a white to off-white crystalline solid with a solubility of approximately 70 mg/mL in water at 20°C.

EPIVIR® Tablets (lamivudine tablets)
EPIVIR® Oral Solution (lamivudine oral solution)

EPIVIR Tablets are for oral administration. Each 150-mg film-coated tablet contains 150 mg of lamivudine and the inactive ingredients hypromellose, magnesium stearate, microcrystalline cellulose, polyethylene glycol, polysorbate 80, sodium starch glycolate, and titanium dioxide.

Each 300-mg film-coated tablet contains 300 mg of lamivudine and the inactive ingredients black iron oxide, hypromellose, magnesium stearate, microcrystalline cellulose, polyethylene glycol, polysorbate 80, sodium starch glycolate, and titanium dioxide.

EPIVIR Oral Solution is for oral administration. One milliliter (1 mL) of EPIVIR Oral Solution contains 10 mg of lamivudine (10 mg/mL) in an aqueous solution and the inactive ingredients artificial strawberry and banana flavors, citric acid (anhydrous), methylparaben, propylene glycol, propylparaben, sodium citrate (dihydrate), and sucrose (200 mg).

MICROBIOLOGY

Mechanism of Action: Lamivudine is a synthetic nucleoside analogue. Intracellularly, lamivudine is phosphorylated to its active 5'-triphosphate metabolite, lamivudine triphosphate (L-TP). The principal mode of action of L-TP is the inhibition of HIV-1 reverse transcriptase (RT) via DNA chain termination after incorporation of the nucleoside analogue into viral DNA. L-TP is a weak inhibitor of mammalian DNA polymerases α and β , and mitochondrial DNA polymerase γ .

Antiviral Activity In Vitro: The in vitro activity of lamivudine against HIV-1 was assessed in a number of cell lines (including monocytes and fresh human peripheral blood lymphocytes) using standard susceptibility assays. IC₅₀ values (50% inhibitory concentrations) were in the range of 2 nM to 15 μ M. Lamivudine had anti-HIV-1 activity in all acute virus-cell infections tested. In HIV-1-infected MT-4 cells, lamivudine in combination with zidovudine at various ratios exhibited synergistic antiretroviral activity. The relationship between in vitro susceptibility of HIV-1 to lamivudine and the inhibition of HIV-1 replication in humans has not been established. Please see the EPIVIR-HBV package insert for information regarding the inhibitory activity of lamivudine against HBV.

Drug Resistance: Lamivudine-resistant variants of HIV-1 have been selected in vitro. Genotypic analysis showed that the resistance was due to a specific amino acid substitution in the HIV-1 reverse transcriptase at codon 184 changing the methionine residue to either isoleucine or valine.

HIV-1 strains resistant to both lamivudine and zidovudine have been isolated from patients. Susceptibility of clinical isolates to lamivudine and zidovudine was monitored in controlled clinical trials. In patients receiving lamivudine monotherapy or combination therapy with lamivudine plus zidovudine, HIV-1 isolates from most patients became phenotypically and genotypically resistant to lamivudine within 12 weeks. In some patients harboring zidovudine-resistant virus at baseline, phenotypic sensitivity to zidovudine was restored by 12 weeks of treatment with lamivudine and zidovudine. Combination therapy with lamivudine plus zidovudine delayed the emergence of mutations conferring resistance to zidovudine.

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Mutations in the HBV polymerase YMDD motif have been associated with reduced susceptibility of HBV to lamivudine in vitro. In studies of non-HIV-infected patients with chronic hepatitis B, HBV isolates with YMDD mutations were detected in some patients who received lamivudine daily for 6 months or more, and were associated with evidence of diminished treatment response; similar HBV mutants have been reported in HIV-infected patients who received lamivudine-containing antiretroviral regimens in the presence of concurrent infection with hepatitis B virus (see PRECAUTIONS and EPIVIR-HBV package insert).

Cross Resistance: Lamivudine-resistant HIV-1 mutants were cross resistant to didanosine (ddI) and zalcitabine (ddC). In some patients treated with zidovudine plus didanosine or zalcitabine, isolates resistant to multiple reverse transcriptase inhibitors, including lamivudine, have emerged.

Genotypic and Phenotypic Analysis of On-Therapy HIV-1 Isolates From Patients With Virologic Failure (see INDICATIONS AND USAGE: Description of Clinical Studies): The clinical relevance of genotypic and phenotypic changes associated with lamivudine therapy has not been fully established.

Study EPV20001: Fifty-three of 554 (10%) patients enrolled in EPV20001 were identified as virological failures (plasma HIV-1 RNA level ≥ 400 copies/mL) by Week 48. Twenty-eight patients were randomized to the lamivudine once-daily treatment group and 25 to the lamivudine twice-daily treatment group. The median baseline plasma HIV-1 RNA levels of patients in the lamivudine once-daily group and lamivudine twice-daily group were 4.9 log₁₀ copies/mL and 4.6 log₁₀ copies/mL, respectively.

Genotypic analysis of on-therapy isolates from 22 patients identified as virologic failures in the lamivudine once-daily group showed that isolates from 0/22 patients contained treatment-emergent mutations associated with zidovudine resistance (M41L, D67N, K70R, L210W, T215Y/F, or K219Q/E), isolates from 10/22 patients contained treatment-emergent mutations associated with efavirenz resistance (L100I, K101E, K103N, V108I, or Y181C), and isolates from 8/22 patients contained a treatment-emergent lamivudine resistance-associated mutation (M184I or M184V).

Genotypic analysis of on-therapy isolates from patients (n = 22) in the lamivudine twice-daily treatment group showed that isolates from 1/22 patients contained treatment-emergent zidovudine resistance mutations, isolates from 7/22 contained treatment-emergent efavirenz resistance mutations, and isolates from 5/22 contained treatment-emergent lamivudine resistance mutations.

Phenotypic analysis of baseline-matched on-therapy HIV-1 isolates from patients (n = 13) receiving lamivudine once daily showed that isolates from 12/13 patients were susceptible to zidovudine; isolates from 8/13 patients exhibited a 25- to 295-fold decrease in susceptibility to efavirenz, and isolates from 7/13 patients showed an 85- to 299-fold decrease in susceptibility to lamivudine.

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Phenotypic analysis of baseline-matched on-therapy HIV-1 isolates from patients (n = 13) receiving lamivudine twice daily showed that isolates from all 13 patients were susceptible to zidovudine; isolates from 3/13 patients exhibited a 21- to 342-fold decrease in susceptibility to efavirenz, and isolates from 4/13 patients exhibited a 29- to 159-fold decrease in susceptibility to lamivudine.

Study EPV40001: Fifty patients received zidovudine 300 mg twice daily plus abacavir 300 mg twice daily plus lamivudine 300 mg once daily and 50 patients received zidovudine 300 mg plus abacavir 300 mg plus lamivudine 150 mg all twice daily. The median baseline plasma HIV-1 RNA levels for patients in the 2 groups were 4.79 log₁₀ copies/mL and 4.83 log₁₀ copies/mL, respectively. Fourteen of 50 patients in the lamivudine once-daily treatment group and 9 of 50 patients in the lamivudine twice-daily group were identified as virologic failures.

Genotypic analysis of on-therapy HIV-1 isolates from patients (n = 9) in the lamivudine once-daily treatment group showed that isolates from 6 patients had abacavir and/or lamivudine resistance-associated mutation M184V alone. On-therapy isolates from patients (n = 6) receiving lamivudine twice daily showed that isolates from 2 patients had M184V alone, and isolates from 2 patients harbored the M184V mutation in combination with zidovudine resistance-associated mutations.

Phenotypic analysis of on-therapy isolates from patients (n = 6) receiving lamivudine once daily showed that HIV-1 isolates from 4 patients exhibited a 32- to 53-fold decrease in susceptibility to lamivudine. HIV-1 isolates from these 6 patients were susceptible to zidovudine.

Phenotypic analysis of on-therapy isolates from patients (n = 4) receiving lamivudine twice daily showed that HIV-1 isolates from 1 patient exhibited a 45-fold decrease in susceptibility to lamivudine and a 4.5-fold decrease in susceptibility to zidovudine.

CLINICAL PHARMACOLOGY

Pharmacokinetics in Adults: The steady-state pharmacokinetic properties of the EPIVIR 300-mg tablet once daily for 7 days compared to the EPIVIR 150-mg tablet twice daily for 7 days were assessed in a crossover study in 60 healthy volunteers. EPIVIR 300 mg once daily resulted in lamivudine exposures that were similar to EPIVIR 150 mg twice daily with respect to plasma AUC_{24,ss}; however, C_{max,ss} was 66% higher and the trough value was 53% lower compared to the 150-mg twice-daily regimen. Intracellular lamivudine triphosphate exposures in peripheral blood mononuclear cells were also similar with respect to AUC_{24,ss} and C_{max24,ss}; however, trough values were lower compared to the 150-mg twice-daily regimen. Inter-subject variability was greater for intracellular lamivudine triphosphate concentrations versus lamivudine plasma trough concentrations. The clinical significance of observed differences for both plasma lamivudine concentrations and intracellular lamivudine triphosphate concentrations is not known.

The pharmacokinetic properties of lamivudine have been studied in asymptomatic, HIV-infected adult patients after administration of single intravenous (IV) doses ranging from

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0.25 to 8 mg/kg, as well as single and multiple (twice-daily regimen) oral doses ranging from 0.25 to 10 mg/kg.

The pharmacokinetic properties of lamivudine have also been studied as single and multiple oral doses ranging from 5 mg to 600 mg/day administered to HBV-infected patients.

Absorption and Bioavailability: Lamivudine was rapidly absorbed after oral administration in HIV-infected patients. Absolute bioavailability in 12 adult patients was $86\% \pm 16\%$ (mean \pm SD) for the 150-mg tablet and $87\% \pm 13\%$ for the oral solution. After oral administration of 2 mg/kg twice a day to 9 adults with HIV, the peak serum lamivudine concentration (C_{\max}) was 1.5 ± 0.5 mcg/mL (mean \pm SD). The area under the plasma concentration versus time curve (AUC) and C_{\max} increased in proportion to oral dose over the range from 0.25 to 10 mg/kg.

An investigational 25-mg dosage form of lamivudine was administered orally to 12 asymptomatic, HIV-infected patients on 2 occasions, once in the fasted state and once with food (1,099 kcal; 75 grams fat, 34 grams protein, 72 grams carbohydrate). Absorption of lamivudine was slower in the fed state (T_{\max} : 3.2 ± 1.3 hours) compared with the fasted state (T_{\max} : 0.9 ± 0.3 hours); C_{\max} in the fed state was $40\% \pm 23\%$ (mean \pm SD) lower than in the fasted state. There was no significant difference in systemic exposure (AUC_{∞}) in the fed and fasted states; therefore, EPIVIR Tablets and Oral Solution may be administered with or without food.

The accumulation ratio of lamivudine in HIV-positive asymptomatic adults with normal renal function was 1.50 following 15 days of oral administration of 2 mg/kg twice daily.

Distribution: The apparent volume of distribution after IV administration of lamivudine to 20 patients was 1.3 ± 0.4 L/kg, suggesting that lamivudine distributes into extravascular spaces. Volume of distribution was independent of dose and did not correlate with body weight.

Binding of lamivudine to human plasma proteins is low (<36%). In vitro studies showed that, over the concentration range of 0.1 to 100 mcg/mL, the amount of lamivudine associated with erythrocytes ranged from 53% to 57% and was independent of concentration.

Metabolism: Metabolism of lamivudine is a minor route of elimination. In man, the only known metabolite of lamivudine is the trans-sulfoxide metabolite. Within 12 hours after a single oral dose of lamivudine in 6 HIV-infected adults, $5.2\% \pm 1.4\%$ (mean \pm SD) of the dose was excreted as the trans-sulfoxide metabolite in the urine. Serum concentrations of this metabolite have not been determined.

Elimination: The majority of lamivudine is eliminated unchanged in urine by active organic cationic secretion. In 9 healthy subjects given a single 300-mg oral dose of lamivudine, renal clearance was 199.7 ± 56.9 mL/min (mean \pm SD). In 20 HIV-infected patients given a single IV dose, renal clearance was 280.4 ± 75.2 mL/min (mean \pm SD), representing $71\% \pm 16\%$ (mean \pm SD) of total clearance of lamivudine.

In most single-dose studies in HIV-infected patients, HBV-infected patients, or healthy subjects with serum sampling for 24 hours after dosing, the observed mean elimination half-life ($t_{1/2}$) ranged from 5 to 7 hours. In HIV-infected patients, total clearance was