Bictegravir (BIC)

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Formulations

Bictegravir is available only in a fixed-dose combination (FDC) tablet.

FDC Tablet

- [Biktarvy]
  - Bictegravir 50 mg/emtricitabine 200 mg/tenofovir alafenamide 25 mg
  - Bictegravir 30 mg/emtricitabine 120 mg/tenofovir alafenamide 15 mg

When using FDC tablets, refer to other sections of Appendix A. Pediatric Antiretroviral Drug Information for information about the individual components of the FDC. See also Appendix A, Table 2. Antiretroviral Fixed-Dose Combination Tablets and Co-packaged Formulations: Minimum Body Weights and Considerations for Use in Children and Adolescents.

For additional information, see Drugs@FDA or DailyMed.

Dosing Recommendations

[Biktarvy] Bictegravir (BIC)/Emtricitabine (FTC)/Tenofovir Alafenamide (TAF)

Neonate or Child Aged <2 Years and Weighing <14 kg

- No data currently are available on the appropriate dose of Biktarvy in children aged <2 years and weighing <14 kg. Studies are being conducted to develop an age-appropriate formulation and identify the appropriate dose for this age and weight group.

Child (Aged ≥2 Years), Adolescent, and Adult Dose

- One tablet once daily with or without food

Body Weight	Dose
≥14 kg to <25 kg	BIC 30 mg/FTC 120 mg/TAF 15 mg
≥25 kg	BIC 50 mg/FTC 200 mg/TAF 25 mg

- The U.S. Food and Drug Administration approved Biktarvy for use in people who have no antiretroviral treatment (ART) history; in people with an ART history who are not virologically suppressed, with no known or suspected substitutions associated with resistance to the integrase strand transfer inhibitor class, emtricitabine, or tenofovir (TFV); or to replace the current antiretroviral (ARV) regimen in people who have been virologically suppressed (HIV RNA <50 copies/mL) on a stable ARV regimen with no known or suspected substitutions associated with resistance to BIC or TFV. Some members on the Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV also recommend the use of Biktarvy in children with prior treatment failure and who have virus containing the M184V mutation but no other known mutations associated with resistance to the individual components of Biktarvy (see the Efficacy in Clinical Trials in Adults section below).

Selected Adverse Events

- Diarrhea, nausea, headache

Special Instructions

- Administer Biktarvy with or without food. See the Drug Interactions section below for guidance when administering Biktarvy with antacids or iron or calcium supplements.
- For children who are unable to swallow a whole tablet, the tablet can be split and each part taken separately, as long as all parts are swallowed within approximately 10 minutes. Dissolving tablets may be an alternative, but crushing tablets **is not recommended.**
- Screen children for hepatitis B virus (HBV) infection before using FTC or TAF. Severe acute exacerbation of HBV can occur when discontinuing FTC or TAF; therefore, monitor hepatic function for several months after halting therapy with FTC or TAF.

	Metabolism/Elimination
	• BIC is metabolized by cytochrome P450 3A4 and uridine diphosphate glucuronosyltransferase 1A1. **Biktarvy Dosing in Children With Hepatic Impairment** • Biktarvy **is not recommended** for use in children with severe hepatic impairment. **Biktarvy Dosing in Children With Renal Impairment** • Biktarvy **is not recommended** for use in children with estimated creatinine clearance <30 mL/min. See the Biktarvy product label for use in adults on dialysis.

Drug Interactions

Additional information about drug interactions is available in the Liverpool HIV Drug Interaction Checker.

- *Metabolism:* Bictegravir (BIC) is a substrate of cytochrome P450 3A4 and uridine diphosphate glucuronosyltransferase (UGT) 1A1. Tenofovir alafenamide (TAF) is a substrate of P-glycoprotein and UGT1A1. Coadministration of the fixed-dose combination (FDC) tablet bictegravir/emtricitabine/tenofovir alafenamide (BIC/FTC/TAF [Biktarvy]) and rifampin is **contraindicated.**[1,2]
- *Renal effects:* BIC is an inhibitor of organic cation transporter 2 and multidrug and toxin extrusion protein 1, so it decreases tubular secretion of creatinine. This increases serum creatinine and reduces estimated glomerular filtration rate (eGFR) with no change in glomerular function. Drugs that decrease renal function could reduce clearance of emtricitabine (FTC).
- *Absorption:* Administering BIC concurrently with antacids lowers the plasma concentrations of BIC. This phenomenon occurs because of the formation of complexes in the gastrointestinal tract and not because of changes in gastric pH. Chelation by high concentrations of divalent cations, such as iron, decreases absorption of integrase strand transfer inhibitors (INSTIs), including elvitegravir and BIC. For this reason, Biktarvy should be administered at least 2 hours before or 6 hours after antacids and supplements or multivitamins that contain iron, calcium, aluminum, magnesium, and/or zinc[3] when Biktarvy is given on an empty stomach. Biktarvy and antacids or supplements that contain calcium or iron can be taken together with food.

Major Toxicities

- *More common:* Diarrhea, nausea, headache. In two clinical trials, total bilirubin increased by up to 2.5 times the upper limit of normal in 12% of adults who received Biktarvy. In general, however, bilirubin increase was mild and did not lead to drug discontinuations in these trials.[2] BIC may cause an increase in creatine kinase concentration. One participant out of 201 in a postmarketing observational study in adults experienced thrombocytopenia,[4] and 1 participant out of 100 in a prospective cohort study in children and adolescents experienced insomnia/anxiety[5] leading to drug discontinuation. Other neuropsychiatric and central nervous

system manifestations have been reported in adults (see Table 17a. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Central Nervous System Toxicity). Weight gain has been reported in adults who were receiving Biktarvy,[6,7] with an associated increased risk of cardiometabolic complications,[8] but preliminary pediatric data regarding weight gain appear to be inconsistent.[9,10] In pediatric clinical trials, weight gain has been mild and may represent recovery toward healthy body weight[5] (see Table 17h. Antiretroviral Therapy-Associated Adverse Effects and Management Recommendations—Lipodystrophies and Weight Gain).

- *Less common (more severe):* Severe immune reconstitution inflammatory syndrome may be more common with INSTIs than with other antiretroviral (ARV) agents. Drug reaction with eosinophilia and systemic symptoms, or DRESS, syndrome has been reported in an adult starting a BIC-containing regimen.[11] Additionally, two cases of drug-induced liver injury—one leading to death—have been reported in adult women with HIV who were switched to a BIC-containing regimen.[12,13]

Resistance

The International Antiviral Society–USA maintains a list of HIV drug resistance mutations, and the Stanford University HIV Drug Resistance Database offers a discussion of each mutation.

Pediatric Use

Approval

BIC—available as part of the FDC tablet Biktarvy, which contains BIC 50 mg/FTC 200 mg/TAF 25 mg—was approved by the U.S. Food and Drug Administration (FDA) in 2018 for use in adults and in 2019 for use in children or adolescents weighing ≥25 kg. Biktarvy, containing BIC 30 mg/FTC 120 mg/TAF 15 mg, was approved by the FDA in 2021 for use in children aged ≥2 years and weighing ≥14 kg to <25 kg. Biktarvy is FDA-approved for people who have no ART history; people with an antiretroviral therapy (ART) history who are not virologically suppressed, with no known or suspected substitutions associated with resistance to the INSTI class, emtricitabine, or tenofovir (TFV); or to replace current ARV regimens in people who have been virologically suppressed (HIV RNA <50 copies/mL) on a stable ARV regimen with no known or suspected substitutions associated with resistance to BIC or TFV.[2] Some members of the Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV (the Panel) also recommend the use of Biktarvy in children with prior treatment failure and who have virus containing the M184V mutation but no other known mutations associated with resistance to the individual components of Biktarvy (see the Efficacy in Clinical Trials in Adults section below).

Clinical Efficacy

In adults, a short-term Phase 1 study of BIC monotherapy at doses of BIC 50 mg or BIC 100 mg was well tolerated. Three out of eight participants in both of these dosing groups achieved HIV RNA <50 copies/mL within 11 days.[14] The efficacy (defined as viral load suppression to HIV RNA <50 copies/mL) and safety (as measured by the incidence of study drug discontinuation or death) of Biktarvy were similar to the efficacy and safety of comparator regimens in two Phase 3 randomized trials in adults who were treatment-naive. Viral load suppression occurred in 89% of participants who received coformulated BIC 50 mg/FTC 200 mg/TAF 25 mg (n = 320) and in 93% of participants who received a regimen of dolutegravir (DTG) 50 mg plus FTC 200 mg plus TAF 25 mg (n = 325). Study drug discontinuation occurred in 1% of participants in both groups.

In a separate adult trial, viral load suppression occurred in 92% of participants who received BIC/FTC/TAF (n = 314) and in 93% of participants who received coformulated abacavir

600 mg/dolutegravir 50 mg/lamivudine 300 mg (ABC/DTG/3TC) (n = 315). Study drug discontinuation was not reported for any of the participants who received BIC/FTC/TAF, although it did occur in 1% of participants who received ABC/DTG/3TC.[2,15] Studies that randomized virologically suppressed adults who were on stable ARV regimens to either continue their current regimens or switch to coformulated BIC/FTC/TAF have shown that BIC/FTC/TAF has similar safety and efficacy to existing regimens. Viral load suppression occurred in 94% of participants who were randomized to switch to BIC/FTC/TAF (n = 282) and in 95% of participants who continued taking ABC/DTG/3TC (n = 281). Study drug discontinuation was reported in 2% of participants who received BIC/FTC/TAF and 1% of participants who received ABC/DTG/3TC. Ninety-two percent of participants who were randomized to switch to BIC/FTC/TAF (n = 290) achieved viral load suppression, whereas 89% of participants who continued receiving atazanavir-based or darunavir-based combination ARV regimens (n = 287) achieved viral load suppression. Study drug discontinuation occurred in 1% of participants in both groups.[2] In an open-label extension following two randomized trials, 98.6% (426 of 432) (95% confidence interval [CI], 97.0% to 99.5%) of participants with available viral load data at Week 240 maintained HIV RNA <50 copies/mL; in an analysis counting missing viral loads as failures, 67.2% (426 of 634) (95% CI, 63.4% to 70.8%) met viral suppression criteria. No treatment-emergent resistance to BIC/FTC/TAF was detected, and adverse events led to drug discontinuation in 1.6% of participants.[6,16] BIC/FTC/TAF has a generally high genetic barrier to resistance, but emergence of nucleoside reverse transcriptase inhibitor (NRTI) resistance–associated mutations has been described in people on BIC/FTC/TAF long-term with suboptimal adherence.[17,18] BIC/FTC/TAF has utility as a rapid ART initiation regimen in ART-naive people with HIV.[19] In observational cohorts of people with HIV, viral suppression was high and discontinuation was low when using BIC/FTC/TAF, both in ART-naive and ART-experienced individuals with and without previous detection of M184V.[20,21]

Similar BIC/FTC/TAF efficacy has been demonstrated in historically underrepresented populations, including Black and female populations with HIV.[22,23] In the ALLIANCE study of adults with HIV and hepatitis B virus (HBV) coinfection, BIC/FTC/TAF was non-inferior to DTG/FTC/TDF for viral suppression of both HIV-1 and HBV.[24]

Initial studies in adults switching to BIC/FTC/TAF from stable ART required undetectable viral load for 3 or 6 months and no proven or presumed pre-existing resistance to any of the components of BIC/FTC/TAF.[2,25,26] Further analysis of data from these studies used proviral genotyping and showed presence of M184V/I mutation in 54 (10%) of 543 BIC/FTC/TAF-treated participants. Presence of this mutation did not affect viral load suppression, with Week 48 HIV RNA <50 copies/mL in 52 (96%) of 54 participants with archived M184V/I mutations compared with Week 48 HIV RNA <50 copies/mL in 561 (98%) of 570 participants without the mutation.[27] A study to measure the effect of preexisting NRTI mutations on virologic outcome in participants switching from a stable regimen to BIC/FTC/TAF showed Week 48 HIV RNA <50 copies/mL in 223 (94%) of 237 participants without M184V/I resistance and in 42 (89%) of 47 participants with M184V/I mutations at baseline.[28,29] At Week 48, HIV RNA <50 copies/mL was maintained in 199 (93%) of 213 participants with no NRTI resistance mutation and in 66 (93%) of 71 participants with any NRTI resistance mutation, including K65R/E/N, any number of thymidine analogue mutations (M41L, D67N, K70R, L210W, T215F/Y, and K219Q/E/R/N), T69 insertions, T69D, K70E/G/M/Q/S/T, L74I/V, V75A/S/M/T, Y115F, Q151M, or M184V/I.[28] That study required pre-enrollment virologic suppression for 6 months in those with suspected NRTI resistance and 3 months for those without suspected NRTI resistance.[28] In an analysis of participant data pooled from six clinical trials switching virologically suppressed adults with HIV to BIC/FTC/TAF, 98% (179 of 182) of participants with pre-existing M184V/I and 99% (2,012 of 2,034) of all participants (with or without M184V/I) had an HIV-1 RNA viral load <50 copies/mL at their last on-treatment visit, with no treatment-emergent resistance to BIC/FTC/TAF.[28,30-32] In a retrospective review at a single center in Spain involving 506 treatment-experienced adults with HIV who started BIC/FTC/TAF with a viral load <50 copies/mL, 69 (13.6%) had documented preexisting NRTI resistance mutations (11.2% M184V/I and 5.9% TFV mutations). In the intention-to-treat analysis, the proportion with a viral load <50 copies/mL was 88.4% (61/69) in

those with NRTI resistance mutations versus 82.2% (359 of 437) in those without NRTI resistance mutations. In the per-protocol analysis, the proportions were 93.8% (61 of 65) in those with NRTI resistance mutations versus 94.4% (359 of 380) in those without NRTI mutations.[33] In another analysis from an HIV program in Canada using electronic health records from 50 adults with major NRTI resistance mutations prior to starting BIC/FTC/TAF, 49 had a viral load <100 copies/mL at a mean of 18.6 months after starting the regimen, with the remaining participant having questionable adherence.[34] In practice, Panel members have used BIC/FTC/TAF even in children with detectable viral load, prior ARV failure, or virus containing the M184V mutation but no other known mutations associated with resistance to the individual components of Biktarvy. This practice is based on the premise that the ability to simplify multi-pill or multi-dose regimens to a single small pill, once daily, can overcome potential resistance barriers with definite adherence benefits.[35]

In single-arm clinical trials of BIC/FTC/TAF in children and adolescents, viral suppression has been >90% at 24 and 48 weeks[5,36] (see Use of Biktarvy in Children and Adolescents below). In a retrospective, single-center study of 74 children and adolescents (median age 11.2 years; 93% ART-experienced, 85% previously exposed to INSTIs, 32% viremic at baseline) who received BIC/FTC/TAF for ≥6 months, 28 children (38%) experienced virologic failure.[18] Virologic failure was more frequent in children with viremia (68% with failure) than viral suppression (26% with failure) at baseline. Children with the M184V/I mutation at baseline were more likely to experience virologic failure (36% vs. 12%), although poor adherence may be a common cause of pre-existing M184V/I and virologic failure. An NRTI resistance mutation emerged in one child with continuous detectable viremia for 47 months on ART; no treatment-emergent INSTI resistance was identified.

Pharmacokinetics

Pharmacokinetic (PK) studies of Biktarvy containing BIC 50 mg have been performed in adults, adolescents aged 12 years to <18 years who weigh ≥35 kg, and children aged 6 years to <12 years who weigh ≥25 kg. PK studies of "low-dose" Biktarvy, which contains BIC 30 mg, have been performed in children aged ≥2 years weighing 14 kg to <25 kg.[37] These studies show a higher BIC maximum serum concentration (C_{max}) in the younger cohorts than in the older cohorts, perhaps because the administered dose is higher on a mg/kg basis (see Table A below). The lower trough serum concentration (C_{tau}) and higher C_{max} in the younger age/lower body weight cohorts suggest more rapid clearance in children and adolescents than in adults. In the cohorts with body weight[37] ≥14 kg to <25 kg and body weight[5,36] ≥35 kg, there is a lower geometric mean ratio when C_{tau} is compared to adult values, and the lower 90% CI suggests that some children have quite rapid clearance (see Table B below). The mean C_{tau} were approximately 10 times the protein-adjusted 95% effective concentration for wild-type virus. Still, these PK observations raise the concern that some of the children in the youngest age/lowest body weight cohorts may experience suboptimal trough concentrations, which may lead to less "pharmacologic forgiveness" in people with lower adherence (see Table B below).[38]

Table A. Bictegravir Pharmacokinetics in Children, Adolescents, and Adults With HIV

PK Parameters	Children Aged ≥2 Years and Weighing ≥14 kg to <25 kg	Children Aged 6 Years to <12 Years and Weighing ≥25 kg	Adolescents Aged 12 Years to <18 Years and Weighing ≥35 kg	Adults
Dose (mg)	30	50	50	50
Dose for Lowest Weight in the Cohort (mg/kg)	2.14	2	1.43	1.25[a]
AUC_{tau} ng•h/mL Mean (CV%)	105,892	128,000 (28)	89,100 (31)	102,000 (27)
C_{max} ng/mL Mean (CV%)	9,857	9,460 (24)	6,240 (27)	6,150 (23)
C_{tau} ng/mL Mean (CV%)	1,605	2,360 (39)	1,780 (44)	2,610 (35)

[a] This dose was calculated using 40 kg as the lowest weight for adults.

Key: AUC_{tau} = area under the concentration time curve over the dosing interval; C_{max} = maximum serum concentration; C_{tau} = trough serum concentration at the end of the dosing interval; CV = coefficient of variation; PK = pharmacokinetic

Sources: Majeed S, German P, West SK, et al. B/F/TAF low-dose tablet relative bioavailability in HVs and PK in children with HIV. Abstract #841. Presented at: Conference on Retroviruses and Opportunistic Infections. 2020. Boston, MA. Available at: https://www.natap.org/2020/CROI/croi_111.htm.

Gaur AH, Cotton MF, Rodriguez CA, et al. Fixed-dose combination bictegravir, emtricitabine, and tenofovir alafenamide in adolescents and children with HIV: week 48 results of a single-arm, open-label, multicentre, Phase 2/3 trial. *Lancet Child Adolesc Health.* 2021;5(9):642-651. Available at: https://pubmed.ncbi.nlm.nih.gov/34302760.

Biktarvy (bictegravir/emtricitabine/tenofovir alafenamide) [package insert]. Food and Drug Administration. 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/210251s023lbl.pdf

Table B. Bictegravir Pharmacokinetics in Children and Adolescents With HIV

Cohort Characteristics	Dose (mg)	Dose for Lowest Weight in Cohort (mg/kg)	GMR% (90% CI) Compared to Adult Values[a]		
			AUC_{tau}	C_{max}	C_{tau}
Aged ≥2 Years and Weighing ≥14 to <25 kg[36,37]	30	2.14	108 (97–120)	165 (150–181)	65 (49–87)
Aged 6 Years to <12 Years and Weighing ≥25 kg[5]	50	2	125 (117–134)	153 (143–163)	89 (81–98)
Aged 12 Years to <18 Years and Weighing ≥35 kg[5]	50	1.43	86 (80–93)	100 (94–107)	65 (58–73)

[a] In this table, child and adolescent pharmacokinetic (PK) values are compared with the PK values of adults who received bictegravir 50 mg. The dose for the lowest weight in the adult cohort was 1.25 mg/kg; this was calculated using 40 kg as the lowest weight for adults.

Key: AUC_{tau} = area under the concentration time curve over the dosing interval; C_{max} = maximum serum concentration; C_{tau} = trough serum concentration at the end of the dosing interval; CI = confidence interval; GMR = geometric mean ratio

Use of Biktarvy in Children and Adolescents Weighing ≥25 kg

BIC 50 mg/FTC 200 mg/TAF 25 mg (Biktarvy) was administered to adolescents aged 12 years to <18 years who weighed ≥35 kg (maximum body weight 56.1 kg) and who had maintained viral loads of <50 copies/mL for ≥6 months on their previous ARV regimens. The drug was well tolerated and was associated with a fall in eGFR similar to that seen in adults. This decrease in eGFR was considered to be from changes in tubular secretion of creatinine and was not a true change in glomerular function. In comparing cohorts of children (body weight ≥14 kg to <25 kg) and adolescents (body weight ≥35 kg) with adult cohorts, the geometric mean ratio of C_{tau} was noted to be lower (see Tables A and B above). All 50 participants in the study had viral loads <50 copies/mL at Week 24, and 49 of 50 had viral loads <50 copies/mL at Week 48.[5]

BIC 50 mg/FTC 200 mg/TAF 25 mg was administered to children aged 6 years to <12 years who weighed ≥25 kg and who had had viral loads <50 copies/mL for ≥6 months on their current ARV regimens.[5] Despite a high area under the curve (AUC) and C_{max} (see Table A above), the drug combination was well tolerated, with a fall in eGFR similar to that seen in adult studies. One participant stopped the study drug because of insomnia and anxiety. The geometric mean ratio of C_{tau} compared with adult values (see Table B above) showed trough concentrations similar to those seen in adults.[5] All 50 participants in the study had viral loads <50 copies/mL at Week 24, and 49 of 50 had viral loads <50 copies/mL at Week 48.[5]

Use of Biktarvy in Children Weighing ≥14 kg to <25 kg

Biktarvy tablets consisting of BIC 30 mg/FTC 120 mg/TAF15 mg were administered to children aged ≥2 years weighing ≥14 kg to <25 kg and who had viral loads <50 copies/mL on stable ART. PK evaluation showed high AUC and C_{max}, similar to those in children aged 6 years to <12 years who weighed ≥25 kg, a similarly low C_{tau} (see Table A above), and a lower geometric mean ratio when C_{tau} was compared with adult values (see Table B above).[36,37] In general, the low-dose tablet was well tolerated over 55 weeks in the 22 children studied.[36,39] Adverse events considered related to the

study drug included transient neutropenia (n = 1); abdominal pain, constipation, and nausea (n = 1); and irritability, social avoidant behavior (onset Week 8 and resolved by Week 11), and increased weight (n = 1).[36,39] HIV RNA at <50 copies/mL was maintained in 20 (91%) of 22 participants at 24 weeks and 21 (95%) participants at 48 weeks, but no children had confirmed virologic failure.[36,39]

Use of Biktarvy in Children Weighing ≥3 kg to <14 kg

A study of PK, safety, and antiviral activity in children aged ≥1 month weighing ≥3 kg to <14 kg is ongoing.[40]

Dosing: Splitting, Dissolving, or Crushing Biktarvy Tablets

The product label states that for children who are unable to swallow a whole tablet, the tablet can be split and each part taken separately, as long as all parts are ingested within approximately 10 minutes.[2] Dissolving BIC/FTC/TAF tablets may be an alternative method of administration, but crushing tablets **is not recommended.**

In a Phase 1 open-label, single-dose, three-period crossover randomized trial of 18 adult participants without HIV, the bioavailability of Biktarvy (BIC 50 mg/FTC 200 mg/TAF 25 mg) was evaluated in fasting participants who received Biktarvy dissolved in water, crushed in applesauce, or as a solid tablet. Dissolved tablet plasma concentration AUC was considered bioequivalent for all ARV components. Although the dissolved tablet C_{max} was considered bioequivalent for BIC and FTC, the TAF C_{max} 90% lower confidence limit was not (dissolved vs. solid ratio, 96% [90% CI, 74% to 124%]). For crushed tablets mixed with applesauce, the BIC component was considered bioequivalent for AUC and C_{max}. However, crushed FTC and TAF AUC and C_{max} were lower than that of solid tablets, with FTC C_{max} (crushed vs. solid ratio, 70% [90% CI, 63% to 78%]), TAF AUC (84% [90% CI, 69% to 103%]), and TAF C_{max} (66% [90% CI, 51% to 85%]) failing to meet bioequivalence criteria. Crushing Biktarvy tablets may lead to suboptimal FTC and TAF exposures.[41]

In the clinical literature, case reports have generally been consistent, with PK results preferring dissolved pills rather than crushed. One pediatric case report described the successful use of dissolved BIC/FTC/TAF via gastrostomy tube in a 7-year-old male with perinatally acquired HIV complicated by developmental delay, seizure disorder, and oral-motor dysfunction who had improved adherence, maintained viral suppression, and no adverse effects after 12 months.[42] In contrast, case reports in adults with HIV receiving crushed BIC/FTC/TAF describe inconsistent virological and resistance outcomes.[31,43-46] These cases varied in underlying comorbidities, baseline viral loads, adherence, method of crushing and dissolving tablets, administration (i.e., orally vs. via a tube), and instructions about polyvalent cation and food administration.

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