

GUIDELINES FOR THE USE OF ANTIRETROVIRAL AGENTS IN PEDIATRIC HIV INFECTION



Developed by the HHS Panel on Antiretroviral Therapy and
Medical Management of Children Living With HIV—A Working
Group of the NIH Office of AIDS Research Advisory Council
(OARAC)

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It is emphasized that concepts relevant to HIV management evolve rapidly. The Panels have a mechanism to update recommendations on a regular basis, and the most recent information is available on the Clinicalinfo website (<https://clinicalinfo.hiv.gov/>).

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APPENDIX A: PEDIATRIC ANTIRETROVIRAL DRUG INFORMATION

Overview

Nucleoside and Nucleotide Analogue Reverse Transcriptase Inhibitors (NRTIs)

[Abacavir](#)

[Emtricitabine](#)

[Lamivudine](#)

[Tenofovir Alafenamide](#)

[Tenofovir Disoproxil Fumarate](#)

[Zidovudine](#)

Non-Nucleoside Analogue Reverse Transcriptase Inhibitors (NNRTIs)

[Doravirine](#)

[Efavirenz](#)

[Etravirine](#)

[Nevirapine](#)

[Rilpivirine](#)

Protease Inhibitors (PIs)

[Atazanavir](#)

[Darunavir](#)

[Lopinavir/Ritonavir](#)

Entry and Fusion Inhibitors

[Fostemsavir](#)

[Ibalizumab](#)

[Maraviroc](#)

Capsid Inhibitors

[Lenacapavir](#)

Integrase Inhibitors (INSTIs)

[Bictegravir](#)

[Cabotegravir](#)

[Dolutegravir](#)

[Elvitegravir](#)

[Raltegravir](#)

Pharmacokinetic Enhancers

[Cobicistat](#)

[Ritonavir](#)

Fixed-Dose Combinations

[Appendix A, Table 1. Antiretrovirals Available in Fixed-Dose Combination Tablets or as a Co-packaged Formulation, by Drug Class](#)

[Appendix A, Table 2. Antiretroviral Fixed-Dose Combination Tablets: Minimum Body Weights and Considerations for Use in Children and Adolescents](#)

Archived Drugs

[Didanosine](#)

[Enfuvirtide](#)

[Fosamprenavir](#)

[Indinavir](#)

[Nelfinavir](#)

[Saquinavir](#)

[Stavudine](#)

[Tipranavir](#)

APPENDIX A: PEDIATRIC ANTIRETROVIRAL DRUG INFORMATION

Nucleoside and Nucleotide Analogue Reverse Transcriptase Inhibitors

Abacavir (ABC, Ziagen)

Emtricitabine (FTC, Emtriva)

Lamivudine (3TC, Epivir)

Tenofovir Alafenamide (TAF, Vemlidy)

Tenofovir Disoproxil Fumarate (TDF, Viread)

Zidovudine (ZDV, Retrovir)

Abacavir (ABC)

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Formulations	
<p>Pediatric Oral Solution: 20 mg/mL</p> <p>Tablet: 300 mg (scored)</p> <p>Generic Formulations</p> <ul style="list-style-type: none"> • 300 mg tablet • 20 mg/mL pediatric oral solution <p>Fixed-Dose Combination (FDC) Tablets</p> <ul style="list-style-type: none"> • [Generic] Abacavir 600 mg/lamivudine 300 mg • [Triumeq] Abacavir 600 mg/dolutegravir 50 mg/lamivudine 300 mg • [Triumeq PD] Abacavir 60 mg/dolutegravir 5 mg/lamivudine 30 mg <p>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.</p> <p>For additional information, see Drugs@FDA or DailyMed.</p>	
Dosing Recommendations	Selected Adverse Events
<p>Neonate (Aged Birth Through <1 Month) Dose</p> <p><i>Oral Solution</i></p> <ul style="list-style-type: none"> • Abacavir (ABC) is not approved by the U.S. Food and Drug Administration (FDA) for use in infants aged <3 months. • However, the Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV (the Panel) recommends ABC 2 mg/kg twice daily for full-term infants from birth through <1 month of age. This recommendation is based on data from pharmacokinetic (PK) modeling of neonatal ABC dosing to target adult plasma ABC exposures and observational data supporting safety of ABC in neonates. The World Health Organization Optimal Antiretroviral Dosing Guidance provides weight-band dosing recommendations for full-term neonates based on the same data. See the Approval, Pharmacokinetics in Neonates and Infants, and Safety in Neonates and Infants sections below. <p>Infant (Aged ≥1 Month to <3 Months) Dose</p> <p><i>Oral Solution</i></p> <ul style="list-style-type: none"> • ABC is not approved by the FDA for use in infants aged <3 months. 	<ul style="list-style-type: none"> • Hypersensitivity reactions (HSRs) can be fatal. HSRs usually occur during the first few weeks of therapy. Symptoms may include fever, rash, nausea, vomiting, malaise or fatigue, loss of appetite, and respiratory symptoms (e.g., cough, shortness of breath).
	<p>Special Instructions</p> <ul style="list-style-type: none"> • To predict the risk of HSRs, test patients for the HLA-B*5701 allele before starting therapy. Patients who test positive for the HLA-B*5701 allele should not be given ABC. Patients with no prior HLA-B*5701 testing who are tolerating ABC do not need to be tested. • Warn patients and caregivers about the risk of serious, potentially fatal HSRs. Occurrence of an HSR requires immediate and permanent discontinuation of ABC. Do not rechallenge. • ABC and coformulated tablets can be given with or without food. The oral solution does not require refrigeration.

- The Panel recommends ABC 4 mg/kg twice daily in full-term infants aged ≥ 1 month to < 3 months. This recommendation is based on modeling data of the ABC 4 mg/kg twice-daily dose using PK simulation for full-term infants aged ≥ 1 month to < 3 months. The International Maternal Pediatric Adolescent AIDS Clinical Trials (IMPAACT) P1106 study and two observational cohorts provided reassuring data on the safety of ABC in infants with HIV aged < 3 months. See the Approval, Pharmacokinetics in Neonates and Infants, and Safety in Neonates and Infants sections below.

Infant and Child (Aged ≥ 3 Months) Dose

Oral Solution

- ABC 8 mg/kg twice daily (maximum 300 mg per dose) or ABC 16 mg/kg once daily (maximum 600 mg per dose)
- In infants and young children who are being treated with liquid formulations of ABC, initiation with once-daily ABC generally is not recommended. The ABC dose can be changed from twice daily to once daily with the liquid formulation to harmonize with other antiretroviral drugs administered once daily.

Weight-Band Dosing of ABC Tablets for Children and Adolescents Weighing ≥ 14 kg and < 25 kg

Weight	Scored 300-mg ABC Tablet		
	Twice-Daily Dose, AM	Twice-Daily Dose, PM	Once-Daily Dose
14 kg to < 20 kg	$\frac{1}{2}$ tablet (150 mg)	$\frac{1}{2}$ tablet (150 mg)	1 tablet (300 mg)
≥ 20 kg to < 25 kg	$\frac{1}{2}$ tablet (150 mg)	1 tablet (300 mg)	$1\frac{1}{2}$ tablets (450 mg)

Child and Adolescent (Weighing ≥ 25 kg) and Adult Dose

- ABC 300 mg twice daily or ABC 600 mg once daily

Abacavir/Lamivudine

Child and Adolescent (Weighing ≥ 25 kg) and Adult Dose

- One tablet once daily

[Trimeq PD] Abacavir/Dolutegravir (DTG)/Lamivudine (3TC)

Child Weighing ≥ 3 kg to < 25 kg and Aged ≥ 1 Month

- Dispersible Trimeq PD tablets are FDA approved for children aged ≥ 3 months and weighing ≥ 6 kg to < 25 kg. They are not recommended for children weighing ≥ 25 kg.
- Administer the appropriate number of tablets once daily, dispersed in 15–20 mL of water. See Special Instructions below. Trimeq PD tablets should not be swallowed whole, chewed, cut, or crushed.

- For ABC/DTG/3TC dispersible tablets, fully disperse them in 15–20 mL of drinking water in the supplied cup and swirl the suspension so that no lumps remain. After full dispersion and within 30 minutes of mixing, administer the oral suspension. Rinse the dosing cup with a small amount of water and give this additional water to the child to ensure that the child takes the full dose and that no medication remains in the dosing cup. ABC/DTG/3TC dispersible tablets should not be swallowed whole, chewed, cut, or crushed.
- Screen patients for hepatitis B virus (HBV) infection before using ABC FDC tablets that contain 3TC. Severe acute exacerbation of HBV infection can occur when 3TC is discontinued (see [Lamivudine](#)).

Metabolism/Elimination

- ABC is systemically metabolized by alcohol dehydrogenase and glucuronyl transferase.
- The majority of ABC is excreted as metabolites in urine.

Abacavir Dosing in Patients With Hepatic Impairment

- ABC requires dose adjustment in patients with mild hepatic insufficiency and is contraindicated with moderate or severe hepatic insufficiency.
- Do not use** ABC/3TC, Trimeq PD, or Trimeq (or the generic equivalents of these FDC tablets) in patients with impaired hepatic function because the dose of ABC cannot be adjusted.

Abacavir Dosing in Patients With Renal Impairment

- ABC does not require dose adjustment in patients with renal impairment.
- Do not use** FDC tablets containing 3TC (ABC/3TC, Trimeq PD, Trimeq, or the generic equivalents of these FDC tablets) in patients with creatinine clearance (CrCl) < 30 mL/min or patients on dialysis, because the doses of 3TC cannot be adjusted. Data from FDC DTG/3TC (Dovato) suggest that patients with a sustained CrCl of 30–49 mL/min may experience a higher 3TC exposure and should be monitored for hematologic toxicities and potential FDC discontinuation and subsequent adjustment

- Population PK modeling supports the use of a single Triumeq PD tablet once daily in infants weighing ≥ 3 kg to < 6 kg and aged ≥ 4 weeks.

Weight-Band Dosing of Triumeq PD Tablets for Children Aged ≥ 1 Month and Weighing ≥ 3 kg

Weight	Recommended Daily Dose	Number of Triumeq PD Tablets	Volume of Water
3 kg to < 6 kg ^a	ABC 60 mg DTG 5 mg 3TC 30 mg	1	5 mL
6 kg to < 10 kg	ABC 180 mg DTG 15 mg 3TC 90 mg	3	15 mL
10 kg to < 14 kg	ABC 240 mg DTG 20 mg 3TC 120 mg	4	20 mL
14 kg to < 20 kg	ABC 300 mg DTG 25 mg 3TC 150 mg	5	20 mL
20 kg to < 25 kg	ABC 360 mg DTG 30 mg 3TC 180 mg	6	20 mL

^a This dosing is not currently approved by the FDA. ABC/DTG/3TC dispersible tablet dosing has only been approved for those weighing ≥ 6 kg and aged ≥ 3 months. However, this dosing is recommended by the Panel based on available PK modeling and simulation data.

- Use in children who are antiretroviral (ARV) naive or ARV experienced (but integrase strand transfer inhibitor [INSTI]–naive) and who are not being treated with uridine diphosphate glucuronosyltransferase 1A1 (UGT1A1) or cytochrome P450 (CYP) 3A inducers.

[Triumeq] Abacavir/Dolutegravir/Lamivudine

Child and Adolescent (Weighing ≥ 25 kg) and Adult Dose

- One tablet once daily
- This FDC tablet can be used in patients who are ARV naive or ARV experienced (but INSTI-naive) and who are not being treated with other drugs that act as UGT1A1 or CYP3A inducers.

of the treatment regimen. See package inserts for additional information.

Drug Interactions

Additional information about drug interactions is available in the [Adult and Adolescent Antiretroviral Guidelines](#) and the [HIV Drug Interaction Checker](#).

- Abacavir (ABC) neither inhibits nor is metabolized by hepatic cytochrome P450 enzymes. Therefore, it does not cause significant changes in the clearance of agents, such as protease inhibitors (PIs) and non-nucleoside reverse transcriptase inhibitors (NNRTIs), that are metabolized through these pathways.
- ABC plasma concentrations can decrease when ABC is used concurrently with the ritonavir-boosted PIs atazanavir/ritonavir, lopinavir/ritonavir (LPV/r), and darunavir/ritonavir.¹⁻³ The mechanism and the clinical significance of the drug interactions with these PIs are unknown. Currently, no recommendations exist for dose adjustments when ABC is coadministered with one of these boosted PIs.
- In a pooled analysis of 230 African children with HIV with a median age of 2.1 years (range 0.1–12.8 years) and a median weight of 9.8 kg (range 2.5–30.0 kg), the population pharmacokinetics (PK) of ABC showed that children on boosted PI LPV/r or NNRTI efavirenz had similar ABC exposures, while concomitant tuberculosis treatment and use of superboosting with LPV significantly reduced ABC concentrations.⁴
- Alcohol exposure (0.7 g per kg ethanol, which is equivalent to five alcoholic drinks) interferes with ABC metabolism; it affects the activity of alcohol dehydrogenase and glucuronyl transferase. This interference increased ABC area under the curve plasma exposure by 41% in adult men with HIV who received ABC 600 mg daily.⁵
- ABC oral solution contains sorbitol, which decreased the exposure of lamivudine (3TC) oral solution in adults when the drugs were administered concurrently.⁶ The clinical significance of this interaction is unknown.

Major Toxicities

- *More common:* Nausea, vomiting, fever, headache, diarrhea, rash, anorexia
- *Less common (more severe):* Serious and sometimes fatal hypersensitivity reactions (HSRs) have been observed in approximately 5% of adults and children (rate varies by race/ethnicity) receiving ABC. HSRs generally occur during the first 6 weeks of therapy, but they have also been reported after a single dose of ABC. The risk of an ABC HSR is associated with the presence of the HLA-B*5701 allele; the risk is greatly reduced by not using ABC in those who test positive for the HLA-B*5701 allele. The HSR to ABC is a multiorgan clinical syndrome usually characterized by rash, or signs or symptoms in two or more of the following groups:
 - o Fever
 - o Constitutional symptoms, including malaise, fatigue, or achiness
 - o Gastrointestinal signs and symptoms, including nausea, vomiting, diarrhea, or abdominal pain
 - o Respiratory signs and symptoms, including dyspnea, cough, or pharyngitis
 - o Laboratory and radiologic abnormalities, including elevated liver function tests, elevated creatine phosphokinase, elevated creatinine, lymphopenia, and pulmonary infiltrates. Lactic acidosis and severe hepatomegaly with steatosis—including fatal cases—also have been reported. Pancreatitis with laboratory abnormalities can occur.

If an HSR is suspected, ABC **should be stopped immediately and not restarted because hypotension and death may occur upon rechallenge.**
- *Rare:* Increased levels of liver enzymes, elevated blood glucose levels, and elevated triglycerides (see information on cardiovascular risk under Safety in Children and Adolescents below). Pancreatitis, lactic acidosis, and severe hepatomegaly with steatosis—including fatal cases—have been reported.

- *Rare:* Drug reaction (or rash) with eosinophilia and systemic symptoms, or DRESS, syndrome.

Resistance

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

Pediatric Use

Approval

ABC is approved by the U.S. Food and Drug Administration (FDA) for use in children with HIV aged ≥ 3 months as part of the nucleoside reverse transcriptase inhibitor (NRTI) component of antiretroviral therapy (ART). The World Health Organization (WHO), however, provides dosing guidance for ABC as a component of the NRTI backbone for full-term neonates starting at birth and weighing ≥ 2 kg (see the WHO [Optimal Antiretroviral Dosing Guidance](#)). The WHO guidance for ABC dosing in neonates increases the choices of antiretroviral (ARV) agents for the management of newborns in special situations in which stock-outs of nevirapine or zidovudine (ZDV) may affect the ability to effectively provide postnatal prophylaxis or treatment of neonatal HIV. The WHO recommendation of ABC dosing for infants starting at 1 month of age is based on the inclusion of ABC as a preferred NRTI component of the first- and second-line ARV regimens for children in the WHO guidance. This recommendation also takes into account the availability of pediatric generic ABC formulations tentatively approved in the President's Emergency Plan for AIDS Relief (or PEPFAR)—including coformulations that include 3TC—and the cost of ARV drugs in resource-limited settings.

Efficacy

Both the once-daily and twice-daily doses of ABC have demonstrated durable antiviral efficacy in pediatric clinical trials, comparable to the efficacy observed for other NRTIs in children.⁷⁻¹¹ In an observational study of nine cohorts from the International epidemiology Databases to Evaluate AIDS Southern Africa (IeDEA-SA) collaboration, 6- and 12-month viral suppression rates (<400 copies/mL) were evaluated among infants who initiated ART at age <3 months and compared with viral suppression rates among infants aged <28 days and ≥ 28 days and weighing <3 kg and ≥ 3 kg at the time of ART initiation. Viral suppression at 12 months did not differ by age or weight at the time of ART initiation and was slightly lower in infants on ABC (174/329 [53%]) than in infants on ZDV (77/138 [56%]) (adjusted odds ratio 1.8; 95% confidence interval (CI), 1.0–3.2).¹² In the [International Maternal Pediatric Adolescent AIDS Clinical Trials \(IMPAACT\) 2019 clinical trial](#) of dispersible and immediate-release ABC/dolutegravir (DTG)/3TC tablets in children with HIV, 54 of 55 participants aged <12 years and weighing 6 kg to <40 kg who remained on the study drug through Week 48 had viral loads of <200 copies/mL; 45 of 55 participants (83%), including 2 of the 3 treatment-naïve participants, had viral loads ≤ 50 copies/mL.¹³

Pharmacokinetics

Pharmacokinetics in Neonates and Infants

The IMPAACT P1106 trial reported PK data in 25 infants aged <3 months with HIV who were initiated on a median ABC dose of 10 mg/kg (range 6–13 mg/kg) twice daily in combination with 3TC and LPV/r after 1 month of life. Median age was 6 weeks (range 1.5–11 weeks), median weight was 2,250 g (range 1,360–3,320 g), and median gestational age was 36 weeks (range 27–39 weeks). Sparse and pre-dose PK ABC samples were obtained repeatedly over the 24 weeks of study follow-

up. ABC plasma exposures were high compared with published data on infants aged >3 months and decreased rapidly between 2 and 8 months of age as the infants matured and ABC clearance increased.¹⁴ In the Tygerberg cohort study from South Africa, 10 healthy term neonates at the median postnatal age of 10 days (range 6–15 days) who were administered a single ABC dose of 8 mg/kg before 15 days of life had substantially higher exposures than those observed in infants and children and no reported adverse events.¹⁵ The higher ABC exposure levels in neonates compared with infants and children are likely due to slower drug clearance through immature enzyme pathways.

PK modeling of ABC starting at birth has been conducted using pooled data from 308 ABC concentration measurements obtained from three studies administering ABC liquid to 45 young infants (including 21 full-term neonates <15 days of age with intensive PK).¹⁵ Two of these studies, the Pediatric AIDS Clinical Trials Group (PACTG) 321 study and the Tygerberg cohort, performed intensive PK sampling in full-term neonates receiving ABC for HIV prophylaxis. The third study, IMPAACT P1106, described above, performed sparse PK sampling on full-term and low birth weight (LBW; <2,500 g) infants with HIV. LBW infants were older at the first PK assessment, with a median postnatal age of 73 days (range 41–190 days) and weight of 3.8 kg (range 2.4–5.8 kg). ABC PK parameters in neonates were estimated using PK simulations to achieve plasma ABC exposures (area under the curve from time zero to 12 hours after drug administration; AUC_{0-12}) within the expected adult range (3.2–25.2 mcg•hr/mL). The PK model predicted a slow ABC clearance of 2.51 mL/min per kg at birth, which doubled by 4 weeks of age. Simulations predicted that an ABC dose of 2 mg/kg twice daily in full-term neonates from birth to <4 weeks and an ABC dose of 4 mg/kg twice daily in infants aged 4 to 12 weeks would achieve target AUC_{0-12} ; however, data in LBW infants are lacking.¹⁵ Based on these data, the weight-band dosing of ABC for neonates has been developed for neonates from birth to age <1 month and is included in the WHO [Optimal Antiretroviral Dosing Guidance](#).¹⁶ This weight-band dosing for neonates approximates the ABC dosing per kg based on the postnatal age (see [Table 1](#) below).

Table 1. Simplified Weight-Band Dosing for Full-Term Neonates From Birth to <1 Month of Age (WHO [Consolidated Guidelines on HIV Prevention, Testing, Treatment, Service Delivery, and Monitoring](#), Annex 1: Table A1.4)

Birth to <1 Month of Age		
Weight	Volume of ABC Oral Solution 20 mg/mL Twice Daily ^{a,b}	ABC Dose in mg Twice Daily (ranges mg/kg, from lowest to highest weight within the weight band) ^{a,b}
2 kg to <3 kg	0.4 mL	8 mg (4.0–2.8 mg/kg)
3 kg to <4 kg	0.5 mL	10 mg (3.3–2.6 mg/kg)
4 kg to <5 kg	0.6 mL	12 mg (3.0–2.4 mg/kg)

^a Simplified weight-band dosing exceeds recommended mg/kg ABC dosing in neonates and infants.

^b Neonatal ABC dose is based on birth weight and does not require weight-based adjustment during the first month of life.

Key: ABC = abacavir

The PETITE trial, a recent open-label, two-stage, single-arm, Phase 1/2 PK and safety study, evaluated the generic fixed-dose combination (FDC) of ABC/3TC (120/60 mg) double-scored dispersible tablets and LPV/r (40/10 mg) granules in 24 neonates with HIV exposure (≥ 37 weeks' gestational age; birth weight 2,000–4,000 g) in South Africa.¹⁷ Following a dose-finding cohort of 8 neonates, 16 neonates received an ABC/3TC dose of 30/15 mg once daily starting between 9 and 59 hours of life and continuing through 28 days of life. No PK data were collected among neonates younger than 6 days of age. As anticipated, geometric mean ABC and 3TC exposures (area under the curve from time zero to 24 hours after drug administration) were higher at 6 to 14 days (51.7 mg•h/L for ABC and 17.2 mg•h/L for 3TC) than at 19 to 24 days of age (25.0 mg•h/L for ABC and 11.3 mg•h/L for 3TC). High ABC and 3TC exposures during the first 2 weeks of life are likely due to the relatively high dose imposed by the currently available generic pediatric FDC (i.e., 10 mg/kg ABC and 5 mg/kg 3TC for a neonate weighing 3 kg). However, due to the rapid maturation of enzymes involved in ABC metabolism, exposures rapidly decreased to within target ranges without a safety signal.¹⁸

For infants aged ≥ 1 month with weight 3 kg to <6 kg, the WHO [Optimal Antiretroviral Dosing Guidance](#) currently recommend a twice-daily dose of 3 mL (60 mg) of ABC 20 mg/mL solution (range 10–20 mg/kg/dose). The weight-band dosing for infants with weight 3 kg to <6 kg within the WHO pediatric HIV guidelines is higher than the modeled weight-based dosing and is based on the practical considerations of the generic fixed-dose pediatric formulations available in resource-limited settings.¹⁹ As new generic pediatric formulations of ABC become available in resource-limited settings, there is potential for the revision of the WHO guidelines for weight-band dosing of ABC for young infants.

Based on PK modeling from three infant studies¹⁵ and neonatal and infant safety data from the IMPAACT 1106 study and two observational cohort studies (see Safety in Neonates and Infants below), the Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV recommends an ABC dose of 2 mg/kg twice daily for neonates from birth to <1 month of age and an ABC dose of 4 mg/kg twice daily for full-term infants aged ≥ 1 month and <3 months.

Pharmacokinetics in Children

PK studies of ABC in children aged <12 years have demonstrated that metabolic clearance of ABC in adolescents and young adults (aged 13–25 years) is slower than that observed in younger children and approximates clearance seen in older adults.²⁰

The PKs of ABC administered once daily in children with HIV aged 3 months through 12 years were evaluated in three crossover open-label PK trials of twice-daily versus once-daily dosing of ABC and 3TC (PENTA 13 [n = 14], PENTA 15 [n = 18], and ARROW [n = 36]).^{5,21-24} The data from these three pediatric trials were used to develop a model for ABC PKs. This model predicted that systemic plasma ABC exposure after once-daily dosing would be equivalent to the exposure seen after twice-daily dosing in infants and children aged ≤12 years.²¹⁻²⁵ Both the trials and PK modeling have demonstrated that once-daily dosing with either the tablet or the liquid formulation of ABC produces plasma exposures comparable to those seen with a twice-daily dosing schedule that uses the same total daily dose of ABC.⁵

Dosing

Dosing and Formulations

A total daily dose of ABC 600 mg can be used safely in a person weighing 25 kg.⁵ Doses of the liquid ABC formulation are similar to those used for weight-band dosing with tablet formulations and should be considered for use in younger children who are unable to swallow a pill.²⁶

In the three ABC dosing pediatric trials described above,²¹⁻²⁴ only children who had low viral loads and who were clinically stable on the twice-daily dose of ABC were eligible to change to once-daily ABC dosing. Efficacy data from a 48-week follow-up in the ARROW trial demonstrated clinical non-inferiority of once-daily ABC (n = 336) versus twice-daily ABC (n = 333) in tablet form combined with a once-daily or twice-daily 3TC-based ARV regimen.¹¹ To date, no clinical trials have been conducted involving children who initiated therapy with once-daily dosing of the ABC liquid formulation. In children who can be treated with pill formulations, initiating therapy with once-daily dosing of ABC at a dose of 16 mg/kg (with a maximum dose of ABC 600 mg) is recommended. However, twice-daily dosing is recommended for infants and young children who initiate therapy with the liquid formulation of ABC. Switching to once-daily dosing with the liquid formulation could be considered when harmonizing with other antiretroviral drugs administered once daily, such as 3TC and dolutegravir (DTG).

Recent data from the [IMPAACT 2019 clinical trial](#) of dispersible and immediate-release ABC/DTG/3TC tablets in children with HIV have validated the FDA-approved dosing in infants and children weighing 10 kg to <25 kg and have led to a newly proposed dosing of this FDC—three tablets once daily of ABC 60 mg, DTG 5 mg, and 3TC 30 mg dispersed in 15 to 20 mL of water—in infants aged ≥3 months weighing 6 kg to <10 kg.^{5,13,27,28} ABC/DTG/3TC dispersible FDC dosing was developed based on PK and safety data in each weight band at the originally selected dosing, which aligned with WHO weight-band dosing for the individual ARV agents. In a population PK (popPK) model based on the IMPAACT 2019 results, ABC, DTG, and 3TC PK exposures following once-daily ABC/DTG/3TC (60 mg/5 mg/30 mg) dispersible tablet dosing were comparable to those observed in pediatrics and adults with single entities, supporting the extrapolation of adult efficacy data.²⁸ Follow-up through 24 and 48 weeks confirmed the overall safety, tolerability, and virological efficacy of both formulations.^{13,29}

PopPK models of ABC, DTG, and 3TC were then further extended to evaluate whether a single ABC/DTG/3TC (60 mg/5 mg/30 mg) tablet in infants aged ≥4 weeks and weighing ≥3 kg to <6 kg could achieve drug exposures comparable to those observed in older children and adults based on

dosing simulations, thus providing comparable safety and efficacy. These models applied maturation functions to the DTG, ABC, and 3TC models and used data from young children across weight bands from the IMPAACT 2019 (≥ 6 kg), P1093 (≥ 3 kg), and ODYSSEY (≥ 3 kg) clinical trials for DTG and the PETITE clinical trial for ABC and 3TC.²⁸ ABC/3TC data from the PETITE study in neonates^{15,18} and available ABC, 3TC, and DTG safety data in infants < 3 months (see Safety in Neonates and Infants below) were used to interpolate safety for infants aged ≥ 4 weeks to < 3 months and suggested no safety concerns for coadministration of ABC/3TC/DTG in young infants. Notably, doses in the safety evaluation mostly aligned with WHO weight-band dose recommendations for fixed-dose formulations of ABC/3TC 120 mg/60 mg, which were higher than the weight bands under evaluation in this modeling and simulation. Panel members agree that, based on these findings, the fixed-dose formulation of the single ABC/3TC/DTG dispersible tablet may be considered as an alternative to separate formulations of ABC, 3TC, and DTG in infants weighing ≥ 3 kg to < 6 kg and aged ≥ 4 weeks to facilitate treatment adherence.

Toxicity

Safety in Neonates and Infants

Data from the PACTG 321, the IMPAACT P1106 trial, and two observational European and African cohorts provided reassuring data on the safety of ABC in infants when initiated at < 3 months of age, including infants with weight < 3 kg.^{12,14,30} The IMPAACT P1106 trial reported 24 weeks of safety data in 27 infants in whom repeated dosing of ABC was initiated at the median age of 60 days. Fifteen infants (55.6%; 90% CI, 38.3–72.0) met the safety endpoint of death or a Grade 3 or higher adverse event (AE). None of the AEs were related to ABC, and none led to interruptions or adjustments of ABC dosing. No hypersensitivity reactions were reported with the multi-dose treatment.¹⁴ In two cohorts of neonates (< 1 month of age) who received a single ABC dose, ABC was well tolerated; all reported AEs in the PACTG 321 study were unrelated to ABC, and no AEs were reported in the Tygerberg cohort.¹⁵

The PETITE trial of generic FDC of ABC/3TC (120/60 mg) double-scored dispersible tablets and LPV/r (40/10 mg) granules in 24 neonates from South Africa reported no Grade 2 or worse AEs related to study drugs. One neonate had a Grade 1 prolonged corrected QT interval that spontaneously resolved.¹⁸

The European Pregnancy and Paediatric Infections Cohort Collaboration (EPPICC) reported safety outcomes among 139 children from 13 cohorts in 11 countries in Europe who initiated ABC at age < 3 months. By 12 months on ABC, 3.6% ($n = 4$) had discontinued ABC because of an ART safety concern, and 11.8% ($n = 15$) discontinued ABC for any reason.³⁰ Another observational study of nine cohorts from the leDEA-SA collaboration compared safety outcomes (measured as ABC discontinuations and their reasons) between infants who started ABC aged < 28 days ($n = 232$) and those aged ≥ 28 days ($n = 605$), and between infants who started ABC with weight < 3 kg ($n = 53$) and those with weight ≥ 3 kg ($n = 784$) at the time of ABC initiation.¹² ABC discontinuations at 6 and 12 months were not significantly different in infants who started ART aged < 28 days versus ≥ 28 days or in infants who weighed < 3 kg versus ≥ 3 kg. ABC discontinuations were less frequent than ZDV discontinuations (adjusted hazard ratio 0.14, 95% CI, 0.10–0.20).¹²

Safety in Children and Adolescents

ABC has less of an effect on mitochondrial function than the NRTI ZDV^{7,8} and less bone and renal toxicity than tenofovir disoproxil fumarate.^{31,32}

A systematic review and meta-analysis of 54 full-text articles reporting on observational and experimental studies that were conducted in infants, children, and adolescents with HIV aged 10 to

19 years, included data on safety, efficacy, or both, and were published in 2009–2022 in English or French concluded that toxic effects due to ABC use in infants, children, and adolescents remain rare and manageable.³³ In the [IMPAACT 2019 clinical trial](#) of dispersible and immediate-release ABC/DTG/3TC tablets in children with HIV aged <12 years and weighing 6 kg to <40 kg, out of 57 participants, 2 participants withdrew due to poor drug tolerability. All participants were HLA-B*5701 genotype negative. One participant discontinued the study drug because of the Grade 4 drug-induced liver injury attributed to ABC and DTG at Week 36; this participant's drug exposures for ABC, 3TC, and DTG were comparable to other participants on the same dose.¹³

Several observational cohort studies, including contemporary cohort analyses, suggest that an increased risk of cardiovascular disease (CVD) events—such as myocardial infarction, stroke, and invasive cardiovascular procedure—exists in adults who are currently using ABC or who have recently used ABC (see Cardiovascular Risk in [Nucleoside Reverse Transcriptase Inhibitor Options as Part of Initial Therapy](#) in the [Adult and Adolescent Guidelines](#)); however, other studies have not substantiated this finding. Limited data are available on the CVD risks associated with ABC use in children. One cohort study of South African adolescents (385 participants with HIV and 63 participants as HIV-negative controls) with a median age of 12 years reported an association between ABC exposure and insulin resistance, which was evaluated using homeostatic model assessment. These findings suggested that ABC use may be a CVD risk factor for young people with perinatally acquired HIV.³⁴ In a recent prospective study of 101 virally suppressed (≤ 400 copies/mL) youth aged 10 to 18 years with HIV and 97 uninfected controls from Uganda, the baseline common carotid artery intima-media thickness (IMT) was slightly higher in participants with HIV than in controls ($P < 0.01$), and pulse wave velocity (PWV) did not differ between groups. In longitudinal analyses, the longer ART duration was associated with lower PWV in youth with HIV ($\beta = 0.008$ [95% CI, -0.008 to 0.003]), while ABC use was associated with greater IMT in youth with HIV ($\beta = 0.043$ [95% CI, 0.012–0.074]). These findings suggest that in adolescents with HIV, early prolonged ART may prevent progression of subclinical vascular disease, while prolonged ABC use may increase it.³⁵

Emtricitabine (FTC, Emtriva)

Updated: September 30, 2025

Reviewed: September 30, 2025

Formulations	
<p>Pediatric Oral Solution: 10 mg/mL</p> <p>Capsule: 200 mg</p> <p>Fixed-Dose Combination (FDC) Tablets</p> <ul style="list-style-type: none"> • [Generic] Efavirenz 600 mg/emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg • [Biktarvy] <ul style="list-style-type: none"> o Bictegravir 50 mg/emtricitabine 200 mg/tenofovir alafenamide 25 mg o Bictegravir 30 mg/emtricitabine 120 mg/tenofovir alafenamide 15 mg • [Complera] Emtricitabine 200 mg/rilpivirine 25 mg/tenofovir disoproxil fumarate 300 mg • [Descovy] <ul style="list-style-type: none"> o Emtricitabine 200 mg/tenofovir alafenamide 25 mg o Emtricitabine 120 mg/tenofovir alafenamide 15 mg • [Genvoya] Elvitegravir 150 mg/cobicistat 150 mg/emtricitabine 200 mg/tenofovir alafenamide 10 mg • [Odefsey] Emtricitabine 200 mg/rilpivirine 25 mg/tenofovir alafenamide 25 mg • [Stribild] Elvitegravir 150 mg/cobicistat 150 mg/emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg • [Symtuza] Darunavir 800 mg/cobicistat 150 mg/emtricitabine 200 mg/tenofovir alafenamide 10 mg • [Truvada] <ul style="list-style-type: none"> o Emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg o Emtricitabine 167 mg/tenofovir disoproxil fumarate 250 mg o Emtricitabine 133 mg/tenofovir disoproxil fumarate 200 mg o Emtricitabine 100 mg/tenofovir disoproxil fumarate 150 mg <p>When using FDC tablets, refer to other sections of the Drug Appendix 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.</p> <p>For additional information, see Drugs@FDA or DailyMed.</p>	
Dosing Recommendations	Selected Adverse Events
<p>Neonatal and Infant (Aged 0 to <3 Months) Dose</p> <p><i>Oral Solution</i></p> <ul style="list-style-type: none"> • Emtricitabine (FTC) 3 mg/kg once daily 	<ul style="list-style-type: none"> • Hyperpigmentation/skin discoloration on palms and/or soles

<p>Child (Aged ≥3 Months) and Adolescent Dose</p> <p><i>Oral Solution</i></p> <ul style="list-style-type: none">• FTC 6 mg/kg once daily (maximum 240 mg per dose). The maximum dose of oral solution is higher than the capsule dose because a pediatric pharmacokinetic analysis reported that the plasma exposure for FTC was 20% lower in children who received the oral solution than in children who received the capsule formulation. <p><i>Capsules (for Children Weighing >33 kg)</i></p> <ul style="list-style-type: none">• FTC 200 mg once daily <p>Adult Dose</p> <p><i>Oral Solution for People Who Are Unable to Swallow Capsules</i></p> <ul style="list-style-type: none">• FTC 240 mg (24 mL) once daily <p><i>Capsules</i></p> <ul style="list-style-type: none">• FTC 200 mg once daily <p>[Generic] Efavirenz (EFV)/FTC/Tenofovir Disoproxil Fumarate (TDF)</p> <p><i>Child and Adolescent (Weighing ≥40 kg) and Adult Dose</i></p> <ul style="list-style-type: none">• One tablet once daily• Take on an empty stomach. <p>[Biktarvy] Bictegravir/FTC/Tenofovir Alafenamide (TAF)</p> <p><i>Neonate or Child (Aged <2 Years and Weighing <14 kg) Dose</i></p> <ul style="list-style-type: none">• No data are available on the appropriate dose of Biktarvy in children aged <2 years and weighing <14 kg. Studies are currently being conducted to identify the appropriate dose for this age and weight group. <p><i>Child, Adolescent, and Adult Dose</i></p> <ul style="list-style-type: none">• One tablet once daily, with or without food. <table><tr><th>Body Weight</th><th>Dose</th></tr><tr><td>≥14 kg to <25 kg</td><td>Bictegravir 30 mg/emtricitabine 120 mg/tenofovir alafenamide 15 mg</td></tr><tr><td>≥25 kg</td><td>Bictegravir 50 mg/emtricitabine 200 mg/tenofovir alafenamide 25 mg</td></tr></table>	Body Weight	Dose	≥14 kg to <25 kg	Bictegravir 30 mg/emtricitabine 120 mg/tenofovir alafenamide 15 mg	≥25 kg	Bictegravir 50 mg/emtricitabine 200 mg/tenofovir alafenamide 25 mg	<table><tr><th>Special Instructions</th></tr><tr><td><ul style="list-style-type: none">• Although FTC can be administered without regard to food, some FDC tablet formulations that contain FTC have food requirements.• FTC oral solution can be kept at room temperature, up to 77°F (25°C), if used within 3 months; refrigerate oral solution for long-term storage.• Screen children for hepatitis B virus (HBV) infection before using FTC or FDC tablets that contain FTC. Severe acute exacerbation of HBV infection can occur when FTC is discontinued; therefore, hepatic function and hepatitis B viral load should be monitored for several months after children with HBV infection stop taking FTC.</td></tr></table> <table><tr><th>Metabolism/Elimination</th></tr><tr><td><ul style="list-style-type: none">• No CYP interactions• Eighty-six percent of FTC is excreted in urine. FTC may compete with other compounds that undergo renal elimination.<p>FTC Dosing in Children With Hepatic Impairment</p><ul style="list-style-type: none">• EFV/FTC/TDF should be used with caution in children with hepatic impairment.• Biktarvy, Genvoya, Stribild, and Symtuza are not recommended for use in children with severe hepatic impairment.• Complera, Descovy, and Odefsey do not require dose adjustment in mild or moderate hepatic impairment but should not be used in children with severe hepatic impairment because they have not been studied in this group.<p>FTC Dosing in Children With Renal Impairment</p><ul style="list-style-type: none">• Decrease the dose of FTC in children with impaired renal function. Consult the manufacturer’s prescribing information for recommended dose adjustments.</td></tr></table>	Special Instructions	<ul style="list-style-type: none">• Although FTC can be administered without regard to food, some FDC tablet formulations that contain FTC have food requirements.• FTC oral solution can be kept at room temperature, up to 77°F (25°C), if used within 3 months; refrigerate oral solution for long-term storage.• Screen children for hepatitis B virus (HBV) infection before using FTC or FDC tablets that contain FTC. Severe acute exacerbation of HBV infection can occur when FTC is discontinued; therefore, hepatic function and hepatitis B viral load should be monitored for several months after children with HBV infection stop taking FTC.	Metabolism/Elimination	<ul style="list-style-type: none">• No CYP interactions• Eighty-six percent of FTC is excreted in urine. 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Body Weight	Dose										
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≥25 kg	Bictegravir 50 mg/emtricitabine 200 mg/tenofovir alafenamide 25 mg										
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Metabolism/Elimination											
<ul style="list-style-type: none">• No CYP interactions• Eighty-six percent of FTC is excreted in urine. FTC may compete with other compounds that undergo renal elimination. <p>FTC Dosing in Children With Hepatic Impairment</p> <ul style="list-style-type: none">• EFV/FTC/TDF should be used with caution in children with hepatic impairment.• Biktarvy, Genvoya, Stribild, and Symtuza are not recommended for use in children with severe hepatic impairment.• Complera, Descovy, and Odefsey do not require dose adjustment in mild or moderate hepatic impairment but should not be used in children with severe hepatic impairment because they have not been studied in this group. <p>FTC Dosing in Children With Renal Impairment</p> <ul style="list-style-type: none">• Decrease the dose of FTC in children with impaired renal function. Consult the manufacturer’s prescribing information for recommended dose adjustments.											

- The U.S. Food and Drug Administration approved Biktarvy for use only in people who are antiretroviral therapy (ART)–naïve 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 history of treatment failure and no known mutations associated with resistance to the individual components of Biktarvy. Some members of the Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV recommend the use of Biktarvy in children with prior treatment failure and who have virus containing the M184V mutation.
- See the [Bictegravir](#) section for additional information.

[Complera] FTC/Rilpivirine (RPV)/TDF

Child and Adolescent (Aged ≥12 Years and Weighing ≥35 kg) and Adult Dose

- One tablet once daily in people who are ART-naïve who have baseline plasma HIV RNA ≤100,000 copies/mL. This dose of Complera also can be used to replace a stable ARV regimen in people who are currently on their first or second regimen and who have been virologically suppressed (HIV RNA <50 copies/mL) with no history of treatment failure and no known mutations associated with resistance to the individual components of Complera.
- Administer with a meal of at least 500 calories.

[Descovy] FTC/TAF

Child, Adolescent, and Adult Dose

Body Weight	Dose
≥14 kg to <25 kg	FTC 120 mg/TAF 15 mg, in combination with an integrase strand transfer inhibitor (INSTI) or a non-nucleoside reverse transcriptase inhibitor (NNRTI). In this weight band, Descovy should not be used with protease inhibitors (PIs) that require a cytochrome P450 (CYP) 3A inhibitor (e.g., ritonavir [RTV] or cobicistat [COBI]).
≥25 kg to <35 kg	FTC 200 mg/TAF 25 mg, in combination with an INSTI or an NNRTI. In this weight band, Descovy should not be used with PIs that require a CYP3A inhibitor (i.e., RTV or COBI).
≥35 kg	FTC 200 mg/TAF 25 mg, in combination with an INSTI, NNRTI, or boosted PI.

- **Do not use** the FDC tablets EFV/FTC/TDF or Complera in children with creatinine clearance (CrCl) <50 mL/min or in children who require dialysis.
- **Do not use** the FDC tablets Truvada or Biktarvy in children with CrCl <30 mL/min. Do not use Truvada in children who require dialysis.
- Stribild should not be initiated in children with estimated CrCl <70 mL/min and should be discontinued in children with estimated CrCl <50 mL/min.
- TAF-containing formulations are not recommended for use in children with estimated CrCl <30 mL/min.

[Genvoya] Elvitegravir (EVG)/COBI/FTC/TAF*Child and Adolescent (Weighing ≥ 25 kg) and Adult Dose*

- One tablet once daily with food in people who are ART-naive. This dose of Genvoya also can be used to replace the current ARV regimen in people who have been virologically suppressed (HIV RNA < 50 copies/mL) on a stable ARV regimen with no history of treatment failure and no known mutations associated with resistance to the individual components of Genvoya.

[Odefsey] FTC/RPV/TAF*Child and Adolescent (Aged ≥ 12 Years and Weighing ≥ 25 kg) and Adult Dose*

- One tablet once daily in people who are ART-naive with HIV RNA $\leq 100,000$ copies/mL. This dose of Odefsey also can be used to replace the current ARV regimen in people who have been virologically suppressed (HIV RNA < 50 copies/mL) with no history of treatment failure and no known mutations associated with resistance to the individual components of Odefsey.
- Administer with a meal of at least 500 calories.

[Stribild] EVG/COBI/FTC/TDF*Child and Adolescent (Weighing ≥ 35 kg With a Sexual Maturity Rating of 4 or 5) and Adult Dose*

- One tablet once daily with food in people who are ART-naive. This dose of Stribild also can be used to replace the current ARV regimen in people who have been virologically suppressed (HIV RNA < 50 copies/mL) with no history of treatment failure and no known mutations associated with resistance to the individual components of Stribild.

[Symtuza] Darunavir (DRV)/COBI/FTC/TAF*Child and Adolescent (Weighing ≥ 40 kg) and Adult Dose*

- One tablet once daily with food in people who are ART-naive or in people who have been virologically suppressed (HIV RNA < 50 copies/mL) with no known mutations associated with resistance to DRV or tenofovir.

[Truvada] FTC/TDF*Child, Adolescent, and Adult Dose*

Body Weight	FTC/TDF Tablet Once Daily
17 kg to < 22 kg	One FTC 100 mg/TDF 150 mg tablet
22 kg to < 28 kg	One FTC 133 mg/TDF 200 mg tablet
28 kg to < 35 kg	One FTC 167 mg/TDF 250 mg tablet
≥ 35 kg and adults	One FTC 200 mg/TDF 300 mg tablet

Drug Interactions

Additional information about drug interactions is available in the [Adult and Adolescent Antiretroviral Guidelines](#) and the [HIV Drug Interaction Checker](#).

- *Other nucleoside reverse transcriptase inhibitors (NRTIs):* **Do not use** emtricitabine (FTC) in combination with lamivudine (3TC), because these agents share similar resistance profiles and lack additive benefit. **Do not use** FTC with fixed-dose combination (FDC) medications that contain 3TC or FTC. See [Appendix A, Table 1. Antiretrovirals Available in Fixed-Dose Combination Tablets or as a Co-packaged Formulation, by Drug Class](#), and refer to other sections of the [Drug Appendix](#) for drug interaction information for each individual component of an FDC tablet.
- *Renal elimination:* FTC may compete with other compounds that undergo renal tubular secretion. Drugs that decrease renal function could decrease clearance of FTC.

Major Toxicities

- *More common:* Headache, insomnia, diarrhea, nausea, rash. Hyperpigmentation/skin discoloration, which may be more common in children than in adults.
- *Less common (more severe):* Neutropenia. Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported. Exacerbations of hepatitis have occurred in people with hepatitis B virus (HBV)/HIV coinfection who switched from regimens that included FTC to regimens that did not include FTC.

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

FTC is approved by the U.S. Food and Drug Administration for once-daily administration in children, starting at birth. FTC often is used as part of a dual-NRTI backbone in antiretroviral (ARV) regimens for children and adolescents because of its once-daily dosing, minimal toxicity, and favorable pediatric pharmacokinetic (PK) data.

Efficacy and Pharmacokinetics

Comparative Clinical Trials

Studies that assess the efficacy and/or potency of nucleoside/nucleotide analogues have been more concerned with the dynamic components of the regimen—such as tenofovir disoproxil fumarate (TDF), tenofovir alafenamide, or abacavir—than the more static components, such as FTC or 3TC. FTC and 3TC have been considered interchangeable, but data to support this conclusion are lacking. Investigators studying the AIDS Therapy Evaluation in the Netherlands (ATHENA) cohort compared the efficacy of TDF plus FTC with TDF plus 3TC when these drugs were administered with a ritonavir-boosted protease inhibitor (darunavir, atazanavir, or lopinavir) in participants who were antiretroviral therapy (ART)–naïve.¹ The adjusted hazard ratio for the virologic

failure of 3TC-containing regimens compared with FTC-containing regimens within 240 weeks of starting therapy was 1.15 (95% confidence interval, 0.58–2.27). No difference between these regimens was observed in the time to virologic suppression during the first 48 weeks of therapy or time to virologic failure after attaining suppression. A Swiss cohort study found a potential difference in efficacy between FTC and 3TC; however, the difference disappeared after adjusting for pill burden.² Current evidence suggests that FTC and 3TC have equivalent efficacy and toxicity in people without ARV experience.

Efficacy

Following a dose-finding study (described in the Pharmacokinetics: Liquid Versus Capsule section below),³ a once-daily dose of FTC 6 mg/kg administered in combination with other ARV drugs was studied in 116 infants, children, and adolescents aged 3 months to 16 years.⁴ The study used a maximum dose of 240 mg of the FTC liquid formulation. PK results showed that the plasma exposures seen in these children and adolescents were similar to those seen in adults who received FTC 200 mg once daily. Follow-up data extending to Week 96 indicated that 89% of ART-naïve children and 76% of ARV-experienced children maintained plasma HIV RNA <400 copies/mL (75% of ARV-naïve children and 67% of ARV-experienced children had HIV RNA <50 copies/mL). Minimal toxicity was observed during this trial. The Pediatric AIDS Clinical Trials Group (PACTG) P1021 trial⁵ evaluated the use of FTC 6 mg/kg (with a maximum dose of FTC 200 mg per day of the liquid formulation) as part of a three-drug regimen dosed once daily to ARV-naïve children aged 3 months to 21 years. In this trial, 85% of children achieved HIV RNA <400 copies/mL, and 72% of children maintained virologic suppression (HIV RNA <50 copies/mL) through 96 weeks of therapy. The median CD4 T lymphocyte count rose by 329 cells/mm³ at Week 96.

Pharmacokinetics: Liquid Versus Capsule

A single-dose PK study of the FTC oral solution and FTC capsules enrolled 25 children with HIV aged 2 years to 17 years.³ FTC was found to be well absorbed following oral administration, with a mean elimination half-life of 11 hours (range 9.7–11.6 hours). Plasma concentrations in children who received the once-daily dose of FTC 6 mg/kg were approximately equivalent to those seen in adults who received the standard dose of FTC 200 mg. However, plasma concentrations of FTC after administration of the capsule formulation were approximately 20% higher than those observed after administration of the oral solution in this small cohort of children.

Pharmacokinetics in Infants

A study in South Africa evaluated the PK of FTC in 20 infants aged <3 months with perinatal HIV exposure. The participants received a dose of FTC 3 mg/kg once daily for two 4-day courses, separated by an interval of ≥2 weeks.⁶ FTC exposure (area under the curve [AUC]) in neonates receiving FTC 3 mg/kg once daily was within the range of exposures seen in children aged >3 months who received the recommended dose of FTC 6 mg/kg once daily and adults who received the recommended dose of FTC 200 mg once daily. During the first 3 months of life, FTC AUC decreased with increasing age, correlating with an increase in total body clearance of the drug. In a small group of neonates (n = 6) who received a single dose of FTC 3 mg/kg and whose mothers received a single dose of FTC 600 mg during delivery, the FTC AUC exceeded the AUC seen in adults and older children. However, FTC had a half-life of 9.2 hours in these neonates, which is similar to that observed in adults and older children.⁷ Extensive safety data are lacking for this age range.

Considerations for Use

The FTC oral solution has an advantage over the liquid formulation of 3TC because it can be given once daily at ARV initiation, whereas the liquid formulation of 3TC needs to be given twice daily at ARV initiation. When pill formulations of 3TC or FTC are used, they can be administered once daily.

Both FTC and 3TC have antiviral activity and efficacy against HBV. For a comprehensive review of this topic, see the [Hepatitis B Virus](#) section in the [Pediatric Opportunistic Infection Guidelines](#).

Lamivudine (3TC, Epivir)

Updated: September 30, 2025

Reviewed: September 30, 2025

Formulations	
<p>Pediatric Oral Solution</p> <ul style="list-style-type: none"> • [Epivir] 10 mg/mL • [Epivir HBV]^a 5 mg/mL <p>Tablets</p> <ul style="list-style-type: none"> • [Epivir] 150 mg (scored) and 300 mg • [Epivir HBV]^a 100 mg <p>Generic Formulations</p> <ul style="list-style-type: none"> • 100-mg, 150-mg, and 300-mg tablets <p>Fixed-Dose Combination (FDC) Tablets</p> <ul style="list-style-type: none"> • [Cimduo] Lamivudine 300 mg/tenofovir disoproxil fumarate 300 mg • [Lamivudine 150 mg/zidovudine 300 mg • [Delstrigo] Doravirine 100 mg/lamivudine 300 mg/tenofovir disoproxil fumarate 300 mg • [Dovato] Dolutegravir 50 mg/lamivudine 300 mg • Abacavir 600 mg/lamivudine 300 mg • [Symfi] Efavirenz 600 mg/lamivudine 300 mg/tenofovir disoproxil fumarate 300 mg • Efavirenz 400 mg/lamivudine 300 mg/tenofovir disoproxil fumarate 300 mg • [Temixys] Lamivudine 300 mg/tenofovir disoproxil fumarate 300 mg • [Triumeq] Abacavir 600 mg/dolutegravir 50 mg/lamivudine 300 mg • [Triumeq PD] Abacavir 60 mg/dolutegravir 5 mg/lamivudine 30 mg <p>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: Minimum Body Weights and Considerations for Use in Children and Adolescents.</p> <p>For additional information, see Drugs@FDA or DailyMed.</p>	
Dosing Recommendations	Selected Adverse Events
<p>Note: See Antiretroviral Management of Infants With <i>In Utero</i>, Intrapartum, or Breastfeeding Exposure to HIV and Table 13.1. Drug Dosing Recommendations for Antiretroviral Prophylaxis and Presumptive HIV Therapy in Infants With <i>In Utero</i> or Intrapartum Exposure to HIV for information about using lamivudine (3TC) to prevent perinatal HIV transmission.</p>	<ul style="list-style-type: none"> • Headache
	<p>Special Instructions</p> <ul style="list-style-type: none"> • 3TC and coformulated tablets can be given with and without food. • Store 3TC oral solution at room temperature.

Neonate (≥32 Weeks Gestation at Birth) and Infant (Birth to <4 Weeks) Dose**Oral Solution**

- 3TC 2 mg/kg twice daily

Infant and Child Dose

- Once-daily dosing of the 3TC oral solution is **not recommended** when initiating 3TC oral solution in infants and young children. Patients can be transitioned to once-daily treatment with the oral solution when they have been stable on twice-daily treatment for 36 weeks and are aged ≥3 years. Please see the note below and refer to the text for more detail.

Aged ≥4 Weeks to <3 Months

- 3TC 4 mg/kg twice daily of the oral solution

Aged ≥3 Months to <3 Years

- 3TC 5 mg/kg twice daily of the oral solution (maximum 150 mg per dose)

Aged ≥3 Years

- 3TC 5 mg/kg twice daily of the oral solution (maximum 150 mg per dose); or
- 3TC 10 mg/kg once daily of the oral solution (maximum 300 mg per dose)

Weight-Band Dosing for the 10-mg/mL 3TC Oral Solution in Children Weighing ≥3 kg and Aged ≥4 Weeks

Weight	Twice-Daily Dose, AM	Twice-Daily Dose, PM
3 kg to <6 kg	3 mL	3 mL
6 kg to <10 kg	4 mL	4 mL
10 kg to <14 kg	6 mL	6 mL

Note: Weight-band dosing in the table above is derived from World Health Organization recommendations. These doses result in significantly higher 3TC exposure than mg per kg doses, especially for young infants. However, given that 3TC has a generally favorable safety profile, these doses are thought to be safe and can be used as soon as infants weigh ≥3 kg and are aged ≥4 weeks.

Sources: Tremoulet AH, Nikanjam M, Cressey TR, et al. Developmental pharmacokinetic changes of lamivudine in infants and children. *J Clin Pharmacol*. 2012;52(12):1824-1832. Available at: <https://pubmed.ncbi.nlm.nih.gov/22180560>. World Health Organization. Annex 3. Dosages of ARV drugs for adults and adolescents. 2018. Available at: https://cdn.who.int/media/docs/default-source/hq-hiv-hepatitis-and-stis-library/arv_guidelines-2018-annex3a.pdf?sfvrsn=1318b82d_3.

- For abacavir (ABC)/dolutegravir (DTG)/3TC dispersible tablets, fully disperse them in 20 mL of drinking water in the supplied cup and swirl the suspension so that no lumps remain. After full dispersion and within 30 minutes of mixing, administer the oral suspension. Rinse the dosing cup with a small amount of water, and give this additional water to the child to ensure that the child takes the full dose and no medication remains in the dosing cup. ABC/DTG/3TC dispersible tablets should not be swallowed whole, chewed, cut, or crushed.
- Screen patients for hepatitis B virus (HBV) infection before using 3TC or FDC tablets that contain 3TC. Severe acute exacerbations of HBV can occur after discontinuation of 3TC. Hepatic function and HBV viral load should be monitored for several months after patients with HBV infection stop taking 3TC. Patients with HBV/HIV coinfection who receive Dovato will require additional treatment for chronic HBV infection.
- For any FDC tablet containing ABC, test patients for the HLA-B*5701 allele before starting therapy to predict the risk of hypersensitivity reactions. Patients who test positive for the HLA-B*5701 allele should not be given an ABC-containing FDC. Patients with no prior HLA-B*5701 testing who are tolerating an ABC-containing regimen do not need to be tested. See [Abacavir](#).

Metabolism/Elimination**3TC Dosing in Patients With Hepatic Impairment**

- No change in 3TC dosing is required for patients with hepatic impairment.
- FDC tablets containing ABC or ZDV should not be used in patients who have impaired hepatic function.
- Symfi (EFV 600 mg/3TC/TDF) and the FDC containing EFV 400 mg/3TC/TDF should be used with caution in patients with hepatic impairment; these FDCs are not recommended for use in moderate or severe hepatic impairment.

Weighting ≥14 kg and Able to Swallow Tablets

- Weight-band dosing (see table below; dose is approximately 3TC 5 mg/kg per day twice daily or 3TC 10 mg/kg once daily)
- The scored tablet is the preferred formulation for pediatric patients weighing ≥14 kg who can swallow a tablet.

Weight-Band Dosing for the Scored 150-mg 3TC Tablet in Children Weighing ≥14 kg

Weight	Twice-Daily Dose, AM	Twice-Daily Dose, PM	Once-Daily Dose
14 kg to <20 kg	½ tablet (75 mg)	½ tablet (75 mg)	1 tablet (150 mg)
≥20 kg to <25 kg	½ tablet (75 mg)	1 tablet (150 mg)	1½ tablets (225 mg)
≥25 kg	1 tablet (150 mg)	1 tablet (150 mg)	2 tablets (300 mg)

Note: The Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV (the Panel) supports switching from twice-daily dosing to once-daily dosing of 3TC (using the oral solution or tablets) in children aged ≥3 years who have been clinically stable for 36 weeks with undetectable viral loads and stable CD4 T lymphocyte cell counts. Clinicians should choose a once-daily regimen using the once-daily dose of 3TC indicated above (approximately 3TC 10 mg/kg, with a maximum of 3TC 300 mg once daily).

Child and Adolescent (Weighting ≥25 kg) and Adult Dose

- 3TC 150 mg twice daily; or
- 3TC 300 mg once daily

[Cimduo] 3TC/Tenofovir Disoproxil Fumarate (TDF)

Child and Adolescent (Weighting >35 kg) and Adult Dose

- One tablet once daily

3TC/Zidovudine (ZDV)

Child and Adolescent (Weighting ≥30 kg) and Adult Dose

- One tablet twice daily

[Delstrigo] Doravirine/3TC/TDF

Child and Adolescent (Weighting ≥35 kg) and Adult Dose

- One tablet once daily in antiretroviral (ARV)-naïve patients and ARV-experienced patients who have been virologically suppressed (HIV RNA <50 copies/mL) on a stable ARV regimen with no history of treatment failure and no known mutations associated with resistance to the individual components of Delstrigo

- Delstrigo and Dovato do not require dose adjustment in mild or moderate hepatic impairment but have not been studied and, therefore, are not recommended in patients with severe hepatic impairment.

3TC Dosing in Patients With Renal Impairment

- Dose adjustment of 3TC is required for patients with renal insufficiency.
- Do not use FDC tablets containing 3TC in patients with creatinine clearance <30 mL/min or patients on dialysis because the doses of 3TC cannot be adjusted. Data from the FDC DTG/3TC (Dovato) suggest that patients with a sustained creatinine clearance of 30–49 mL/min may experience a higher 3TC exposure and should be monitored for hematologic toxicities and potential FDC discontinuation and subsequent adjustment of the treatment regimen. See package inserts for additional information.

[Dovato] Dolutegravir (DTG)/3TC

Adolescent (Weighing ≥ 25 kg and aged ≥ 12 years) and Adult Dose

- One tablet once daily with or without food as a complete ARV regimen in antiretroviral therapy (ART)—naïve adults and adolescents with no known mutations associated with resistance to the individual components of Dovato.
- The combination tablet DTG/3TC (Dovato) is approved by the U.S. Food and Drug Administration (FDA) for adolescents weighing ≥ 25 kg and aged ≥ 12 years but is not approved for use in children aged < 12 years. However, it could be used as part of a three-drug regimen in patients who meet the minimum body weight requirements for each component of the drug.

Abacavir (ABC)/3TC

Child and Adolescent (Weighing ≥ 25 kg) and Adult Dose

- One tablet once daily

[Symfi] Efavirenz (EFV) 600 mg/3TC/TDF

Child and Adolescent (Weighing ≥ 40 kg) and Adult Dose

- One tablet once daily on an empty stomach

EFV 400 mg/3TC/TDF

Child and Adolescent (Weighing ≥ 35 kg) and Adult Dose

- One tablet once daily on an empty stomach
- The FDC containing 400mg EFV/3TC/TDF has not been studied in children (sexual maturity ratings [SMRs] 1–3), and major interindividual variability in EFV plasma concentrations has been found in pediatric patients in a multiethnic setting. The 400-mg dose of EFV may be too low in children or adolescents with SMRs 1 to 3 who weigh ≥ 40 kg. The use of therapeutic drug monitoring is suggested by some Panel members when this FDC is used in pediatric patients who weigh ≥ 40 kg (see the [Efavirenz](#) section for more information).

[Temixys] 3TC/TDF

Child and Adolescent (Weighing ≥ 35 kg) and Adult Dose

- One tablet once daily

[Triumeq PD] ABC/DTG/3TC

Child Weighing ≥ 6 kg to < 25 kg and Aged ≥ 3 Months

- Dispersible Triumeq PD tablets are FDA approved for children weighing ≥ 6 to < 25 kg. Triumeq PD is not recommended for children weighing ≥ 25 kg who are eligible for adult Triumeq dosing.
- Administer the appropriate number of tablets for a child's weight once daily, dispersed in 20 mL of water. See Special Instructions. Triumeq PD tablets should not be swallowed whole, chewed, cut, or crushed.

Weight-Band Dosing of Triumeq PD Tablets for Children Weighing ≥6 kg

Weight	Recommended Daily Dose	Number of Triumeq PD Tablets
6 kg to <10 kg	ABC 180 mg DTG 15 mg 3TC 90 mg	3
10 kg to <14 kg	ABC 240 mg DTG 20 mg 3TC 120 mg	4
14 kg to <20 kg	ABC 300 mg DTG 25 mg 3TC 150 mg	5
20 kg to <25 kg	ABC 360 mg DTG 30 mg 3TC 180 mg	6
≥25 kg	Use Triumeq (see below).	

- For use in children who are ARV-naïve or ARV-experienced (but integrase strand transfer inhibitor [INSTI]-naïve) and who are not being treated with uridine diphosphate glucuronosyltransferase 1A1 (UGT1A1) or cytochrome P450 (CYP) 3A inducers

[Triumeq] ABC/DTG/3TC

Child and Adolescent (Weighing ≥25 kg) and Adult Dose

- One tablet once daily
- This FDC tablet can be used in patients who are ART-naïve or ART-experienced (but INSTI-naïve) and who are not being treated with UGT1A1 or CYP3A inducers.

^a EpiVir HBV oral solution and tablets contain a lower amount of 3TC than EpiVir oral solution and tablets. The amount of 3TC in the EpiVir HBV solution and tablet was based on dosing for treatment of HBV infection in people without HIV coinfection. Patients with HIV who are taking EpiVir HBV as part of their ARV regimen should receive the appropriate amount of oral solution or the appropriate number of tablets to achieve the higher doses of 3TC that are used to treat HIV.

Drug Interactions

Additional information about drug interactions is available in the [Adult and Adolescent Antiretroviral Guidelines](#) and the [HIV Drug Interaction Checker](#).

- Drugs that decrease renal function could decrease clearance of lamivudine (3TC).
- Do not use** 3TC in combination with emtricitabine (FTC) because these drugs have similar resistance profiles and using them together offers no additional benefit.¹ **Do not use** 3TC with fixed-dose combination (FDC) medications that contain 3TC or FTC. Please see [Appendix A, Table 1. Antiretrovirals Available in Fixed-Dose Combination Tablets or as a Co-packaged Formulation, by Drug Class](#) and refer to other sections of the [Drug Appendix](#) for drug interaction information about each individual component of FDC tablets.

Major Toxicities

- *More common:* Headache, nausea
- *Less common (more severe):* Peripheral neuropathy, lipodystrophy/lipoatrophy
- *Rare:* Increased levels of liver enzymes. Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported.

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

Although 3TC is approved by the U.S. Food and Drug Administration (FDA) for the treatment of children aged ≥ 3 months, both the Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV (the Panel) and the Panel on Treatment of HIV During Pregnancy and Prevention of Perinatal Transmission recommend the use of 3TC from birth based on extensive experience, as well as safety and pharmacokinetic (PK) data in this age group.

Considerations for Use

The efficacy and toxicity of 3TC are equivalent to the efficacy and toxicity of FTC. The oral formulation of FTC has an advantage over the liquid formulation of 3TC because it can be given once daily at antiretroviral (ARV) initiation, whereas the liquid formulation of 3TC needs to be given twice daily at ARV initiation. When pill formulations of 3TC or FTC are used, they can be administered once daily.

Both FTC and 3TC have antiviral activity and efficacy against hepatitis B virus. For a comprehensive review of this topic, see the [Hepatitis B Virus](#) section in the [Pediatric Opportunistic Infection Guidelines](#).

Comparative Clinical Trials

Investigators studying the AIDS Therapy Evaluation in the Netherlands (ATHENA) cohort compared the efficacy of tenofovir disoproxil fumarate (TDF) plus FTC to TDF plus 3TC when these drugs were administered with a ritonavir-boosted protease inhibitor (darunavir, atazanavir, or lopinavir) in ART-naïve patients.² The adjusted hazard ratio for the virologic failure of 3TC-containing regimens compared to FTC-containing regimens within 240 weeks of starting therapy was 1.15 (95% confidence interval, 0.58–2.27). These regimens had no difference in time to virologic suppression during the first 48 weeks of therapy or time to virologic failure after attaining suppression. In a Swiss cohort, Yang et al. found a potential difference in efficacy between FTC and 3TC; however, the difference disappeared after adjusting for pill burden. Current evidence suggests that FTC and 3TC have equivalent efficacy and toxicity in ARV-naïve patients.³

Efficacy

3TC has been studied in children with HIV both alone and in combination with other ARV drugs. Extensive data have demonstrated the safety of 3TC and have shown that this drug is associated

with clinical improvement and virologic response. It is commonly used in children with HIV as a component of a dual nucleoside reverse transcriptase inhibitor (NRTI) backbone.⁴⁻¹² In one study that evaluated the efficacy of NRTI background components, the combination of 3TC plus abacavir (ABC) was superior to zidovudine (ZDV) plus 3TC or ZDV plus ABC in achieving long-term virologic efficacy.¹³

Pharmacokinetics in Infants

Because of its safety profile and availability in a liquid formulation, 3TC has been given to infants during the first 6 weeks of life starting at a dose of 2 mg/kg every 12 hours before age 4 weeks.⁹ A population PK analysis of infants who received 3TC affirms that adjusting the dose from 3TC 2 mg/kg to 3TC 4 mg/kg every 12 hours at age 4 weeks provides optimal 3TC exposure for infants with normal maturation of renal function.¹⁴ For infants, the World Health Organization (WHO) weight-band dosing (which is up to five times higher than the FDA-approved dose) results in greater plasma concentrations than the 3TC 2 mg/kg dose.¹⁵ In HIV Prevention Trials Network 040, 3TC was administered as a component of a three-drug regimen to prevent perinatal transmission during the first 2 weeks of life. For 2 weeks, all infants weighing >2,000 g received 3TC 6 mg twice daily, and infants weighing ≤2,000 g received 3TC 4 mg twice daily. These doses resulted in 3TC exposure that was similar to the exposure seen in infants who received the standard twice-daily dosing schedule of 3TC 2 mg/kg per dose for neonates.¹⁶

In preterm infants, PK modeling supports the use of 3TC for infants. For those with gestational age at birth of ≥24 to <30 weeks, a dose of 2 mg/kg twice daily from birth until weighing 3 kg is supported. For infants with gestational age at birth of ≥30 to <37 weeks, 2 mg/kg twice daily for the first 4 weeks of life followed by 4 mg/kg twice daily is supported. This proposed 3TC dosing has been endorsed by the WHO Pediatric Antiretroviral Working Group but has not yet been clinically validated in preterm infants.¹⁷

Pharmacokinetics of Liquid Versus Tablet Preparations

The PK of 3TC have been studied after either single or repeat doses in 210 pediatric subjects. Pediatric subjects who received 3TC oral solution according to the recommended dose regimen achieved plasma concentrations of 3TC that were approximately 25percent lower compared with those of adults with HIV who received the oral solution. Pediatric subjects who received 3TC tablets achieved plasma concentrations that were comparable to or slightly higher than those observed in adults who received tablets. In pediatric subjects, the relative bioavailability of 3TC oral solution is approximately 40% lower than the relative bioavailability of tablets that contain 3TC, despite no difference in the bioavailability of these two formulations among adults. The mechanisms for the diminished relative bioavailability of 3TC oral solution are unknown,¹⁸ but results from a study in adults that compared the PK of 3TC oral solution administered either alone or with increasing concentrations of sorbitol indicate that sorbitol decreases the total exposure of 3TC oral solution.¹⁹ Sorbitol is a component of several ARV solutions, including ABC, as well as common over-the-counter medications that may be used in infants and young children; this may explain the PK discrepancy between the oral solution and tablet formulations. Modeling of PK data in pediatric patients suggests that increasing the oral solution dose to 3TC 5 mg/kg per dose twice daily or 3TC 10 mg/kg per dose once daily (with a maximum of 3TC 300 mg administered daily) in children aged ≥3 months would provide exposures similar to those seen in adult patients who received tablet formulations. However, these models used PK data derived from studies that did not use 3TC liquid formulation, so modeling may not predict exposures for 3TC oral solution, especially when used with liquid ABC. The Panel **does not recommend** using a once-daily dose of 3TC until a child is aged ≥3 years. After 3 years of age, switching to once-daily dosing with the liquid formulation could be considered when harmonizing with other ARV drugs administered once daily, such as ABC and dolutegravir (DTG).

Dosing Considerations—Once-Daily Versus Twice-Daily Administration

The standard adult dose for 3TC is 300 mg once daily, but data are lacking on once-daily administration of 3TC in children. Population PK data indicate that once-daily dosing of 3TC 8 mg/kg leads to area under the curve over 24 hours (AUC_{0-24h}) values that are similar to those seen in patients taking 3TC 4 mg/kg twice daily, but minimum blood plasma concentration (C_{min}) values are significantly lower and maximum blood plasma concentration (C_{max}) values are significantly higher in children aged 1 year to 18 years.²⁰ Intensive PK of once-daily versus twice-daily dosing of 3TC were evaluated in children with HIV aged 2 to 13 years in the PENTA (Paediatric European Network for Treatment of AIDS) 13 trial⁴ and in children aged 3 months to 36 months in the PENTA 15 trial.²¹ Both the PENTA 13 and PENTA 15 trials used a crossover design with doses of 3TC 8 mg/kg once daily or 3TC 4 mg/kg twice daily. AUC_{0-24h} and clearance values were similar between these two dosing schedules, and most children maintained an undetectable HIV RNA value after the switch. An ARROW (AntiRetroviral Research fOr Watoto) trial PK study of 41 children aged 3 to 12 years (median age 7.6 years) in Uganda who were stable on twice-daily 3TC also showed equivalent AUC_{0-24h} and good clinical outcomes (defined by a low disease stage and a high CD4 T lymphocyte [CD4] cell count) after switching to once-daily 3TC. Median follow-up time during this study was 1.15 years.²² The larger ARROW trial was a randomized, noninferiority trial that investigated once-daily versus twice-daily doses of 3TC in more than 600 pediatric patients who had initiated therapy with twice-daily 3TC and who had been receiving therapy for ≥ 36 weeks. Median follow-up time during the study was 114 weeks. Rates of plasma HIV RNA suppression and adverse event profiles for once-daily 3TC were similar to (and statistically non-inferior to) those of twice-daily 3TC.²³

All four of the studies discussed above enrolled patients who had low plasma HIV RNA or who were clinically stable on twice-daily 3TC before switching to once-daily dosing. Therefore, the Panel supports switching from twice-daily to once-daily dosing of 3TC in children aged ≥ 3 years who have been clinically stable for 36 weeks with an undetectable viral load and stable CD4 count. Clinicians should use a 10 mg/kg per dose of 3TC oral solution or a weight-based dose of 3TC tablets (neither exceeding 3TC 300 mg) as part of a once-daily regimen.²⁴ More long-term clinical trials with viral efficacy endpoints are needed to confirm that once-daily dosing of 3TC can be used effectively as part of an initial ARV regimen in children.

3TC undergoes intracellular metabolism to reach its active form, 3TC triphosphate. In adolescents, the mean half-life of intracellular 3TC triphosphate (17.7 hours) is considerably longer than that of unphosphorylated 3TC in plasma (1.5–2 hours). Intracellular concentrations of 3TC triphosphate are equivalent whether 3TC is given once daily or twice daily in adults and adolescents. This supports a recommendation for once-daily 3TC dosing based on FDA recommendations.^{25,26}

Weight-Band Dosing

Weight-band dosing recommendations for 3TC have been developed for children weighing ≥ 3 kg and receiving either the 10-mg/mL oral solution or the 150-mg scored tablets.²⁷⁻²⁹

Recent data from the IMPAACT 2019 clinical trial of dispersible and immediate-release ABC/DTG/3TC tablets (ABC 60 mg, DTG 5 mg, and 3TC 30 mg dispersed in 15–20 mL of water) in children with HIV has confirmed the FDA-approved dosing in infants and children weighing 6 to < 25 kg. ABC/DTG/3TC dispersible FDC dosing was confirmed based on PK and safety data in each weight-band at the originally selected dosing, which aligned with WHO weight-band dosing for the individual ARV agents. Follow-up through 24 weeks confirmed the safety, tolerability, and virological efficacy of both formulations.³⁰ Post hoc population pharmacokinetic modeling of IMPAACT 2019 data further supports weight-band dosing of ABC/3TC/DTG FDC in children weighing ≥ 6 kg.³¹

Tenofovir Alafenamide (TAF, Vemlidy)

Updated: September 30, 2025

Reviewed: September 30, 2025

Formulations							
Tablet: 25 mg ^a							
Fixed-Dose (FDC) Combination Tablets							
<ul style="list-style-type: none">• [Biktarvy]<ul style="list-style-type: none">◦ Bictegravir 50 mg/emtricitabine 200 mg/tenofovir alafenamide 25 mg◦ Bictegravir 30 mg/emtricitabine 120 mg/tenofovir alafenamide 15 mg• [Descovy]<ul style="list-style-type: none">◦ Emtricitabine 200 mg/tenofovir alafenamide 25 mg◦ Emtricitabine 120 mg/tenofovir alafenamide 15 mg• [Genvoya] Elvitegravir 150 mg/cobicistat 150 mg/emtricitabine 200 mg/tenofovir alafenamide 10 mg• [Odefsey] Emtricitabine 200 mg/rilpivirine 25 mg/tenofovir alafenamide 25 mg• [Symtuza] Darunavir 800 mg/cobicistat 150 mg/emtricitabine 200 mg/tenofovir alafenamide 10 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	Selected Adverse Events						
[Biktarvy] Bictegravir (BIC)/Emtricitabine (FTC)/Tenofovir Alafenamide (TAF) <i>Neonate or Child (Aged <2 Years and Weighing <14 kg) Dose</i> <ul style="list-style-type: none">• No data are currently available on the appropriate dose of Biktarvy in children aged <2 years and weighing <14 kg. Studies are currently being conducted to identify the appropriate dose for this age and weight group. <i>Child (Aged ≥2 years), Adolescent, and Adult Dose</i> <ul style="list-style-type: none">• One tablet once daily, with or without food. <table><tr><th>Body Weight</th><th>Dose</th></tr><tr><td>≥14 kg to <25 kg</td><td>BIC 30 mg/FTC 120 mg/TAF 15 mg</td></tr><tr><td>≥25 kg</td><td>BIC 50 mg/FTC 200 mg/TAF 25 mg</td></tr></table>	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	<ul style="list-style-type: none">• Asthenia, headache, diarrhea, nausea• Increased serum lipids
	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						
	Special Instructions <ul style="list-style-type: none">• Measure serum creatinine before starting a TAF-containing regimen.• Screen patients for hepatitis B virus (HBV) infection before initiating TAF. Severe acute exacerbation of HBV infection can occur when TAF is discontinued; therefore, hepatic function should be monitored for several months after patients with HBV infection stop taking TAF.• The FDA does not recommend using Genvoya with other ARV drugs, but this FDC tablet has been safely used with DRV.¹ Descovy can be safely used² with DRV or atazanavir in patients weighing ≥35 kg.• Do not use Genvoya with EVG, COBI, tenofovir disoproxil fumarate, FTC, lamivudine, or PIs that are coformulated with COBI.						

- The U.S. Food and Drug Administration (FDA) 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 (INSTI) class, emtricitabine, or tenofovir; 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 bictegravir or tenofovir. Some members of the Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV recommend the use of Biktarvy in patients with prior treatment failure who have the virus with the M184V mutation. See the [Bictegravir](#) section for additional information.

[Descovy] FTC/TAF

Child, Adolescent, and Adult Dose

- One tablet once daily, with or without food.

Body Weight	Dose
≥14 kg to <25 kg	FTC 120 mg/TAF 15 mg, in combination with an INSTI or a non-nucleoside reverse transcriptase inhibitor (NNRTI). In this weight band, Descovy should not be used with protease inhibitors (PIs) that require a cytochrome P450 (CYP) 3A inhibitor (i.e., ritonavir [RTV] or cobicistat [COBI]).
≥25 kg to <35 kg	FTC 200 mg/TAF 25 mg, in combination with an INSTI or an NNRTI. In this weight band, Descovy should not be used with PIs that require a CYP3A inhibitor (i.e., RTV or COBI).
≥35 kg	FTC 200 mg/TAF 25 mg, in combination with an INSTI, NNRTI, or boosted PI.

[Genvoya] Elvitegravir (EVG)/COBI/FTC/TAF

Child (Aged ≥2 Years and Weighing 14 kg to <25 kg) Dose

- Data are currently limited on the appropriate dose of Genvoya in children aged ≥2 years to <6 years and weighing 14 kg to <25 kg. Studies are being conducted to identify the safety and efficacy of a low-dose Genvoya tablet. See the [Elvitegravir](#) section for details.

- When using Odefsey, patients must be able to take it with a meal of at least 500 calories on a regular schedule (a protein drink alone does not constitute a meal), because it contains RPV.

Metabolism/Elimination

TAF Dosing in Patients With Hepatic Impairment

- TAF-containing formulations do not require dose adjustment in patients with mild or moderate hepatic impairment, but they should not be used in patients with severe hepatic impairment because they have not been studied in that group.

TAF Dosing in Patients With Renal Impairment

- The TAF metabolite tenofovir is renally excreted.
- No dose adjustment of the TAF 25-mg tablet (Vemlidy)^a is required in patients with estimated creatinine clearance (CrCl) ≥15 mL/min or in patients with estimated CrCl <15 mL/min (i.e., end-stage renal disease) who are receiving chronic hemodialysis. See the Vemlidy product label³ for information on the use of the TAF 25-mg tablet in patients with estimated CrCl ≤15 mL/min.
- TAF-containing coformulations **are not recommended** for use in patients with estimated CrCl <30 mL/min.

Child and Adolescent (Weighing ≥25 kg) and Adult Dose

- One tablet once daily with food in ART-naïve patients. This dose of Genvoya also can be used to replace the current ARV regimen in patients who have been virologically suppressed (HIV RNA <50 copies/mL) on a stable ARV regimen, with no history of treatment failure, and no known mutations associated with resistance to the individual components of Genvoya.

[Odefsey] FTC/Rilpivirine (RPV)/TAF

Child and Adolescent (Weighing ≥25 kg) and Adult Dose

- One tablet once daily with a meal in ART-naïve patients with HIV RNA ≤100,000 copies/mL. This dose of Odefsey also can be used to replace the current ARV regimen in patients who have been virologically suppressed (HIV RNA <50 copies/mL) on a stable ARV regimen, with no history of treatment failure, and no known mutations associated with resistance to the individual components of Odefsey.

[Symtuza] Darunavir (DRV)/COBI/FTC/TAF

Child and Adolescent (Weighing ≥40 kg) and Adult Dose

- One tablet once daily with food in ART-naïve patients. This dose of Symtuza also can be used to replace the current ARV regimen in patients who have been virologically suppressed (HIV RNA <50 copies/mL) on a stable ARV regimen, with no history of treatment failure, and no known mutations associated with resistance to the individual components of Symtuza.

^a TAF 25-mg tablets (Vemlidy) are approved by the FDA for treatment of HBV. In certain circumstances, TAF 25-mg tablets (Vemlidy) might be used as one component of a combination ARV regimen, with dosing recommendations similar to those for Descovy.

Drug Interactions

Additional information about drug interactions is available in the [Adult and Adolescent Antiretroviral Guidelines](#) and the [HIV Drug Interaction Checker](#).

- **Metabolism:** Tenofovir alafenamide (TAF) is a substrate of the adenosine triphosphate–dependent transporters P-glycoprotein (P-gp) and the breast cancer resistance protein (BCRP). Drugs that strongly affect P-gp and BCRP activity may lead to changes in TAF absorption. P-gp inducers are expected to decrease TAF exposure, and P-gp inhibitors are expected to increase absorption and plasma concentrations of TAF.² A study of 98 healthy participants without HIV measured plasma TAF and tenofovir (TFV) exposures when TAF was administered with other antiretroviral (ARV) drugs. Coadministration of TAF with rilpivirine (RPV) and dolutegravir (DTG) did not change either TAF or TFV exposure. Coadministration of TAF with the P-gp and BCRP inhibitor cobicistat (COBI), or coadministration with atazanavir/ritonavir (ATV/r) or lopinavir/ritonavir, increased both TAF and TFV exposures. Coadministration of TAF with darunavir/ritonavir (DRV/r) resulted in

unchanged TAF area under the curve (AUC) and doubled TFV AUC. Coadministration of TAF with the P-gp and BCRP inducer efavirenz decreased TAF and TFV exposures.⁴

- Coadministration of TAF with rifamycins (rifabutin, rifampin, or rifapentine) **is not recommended**.^{3,5}
- Genvoya contains elvitegravir (EVG) and COBI in addition to TAF (see the [Elvitegravir](#) and [Cobicistat](#) sections for details). EVG is metabolized predominantly by cytochrome P450 (CYP) 3A4, secondarily by uridine diphosphate glucuronosyltransferase 1A1/3, and by oxidative metabolism pathways. EVG is a modest inducer of CYP2C9. COBI is an inhibitor of CYP3A4 and a weak inhibitor of CYP2D6; in addition, COBI inhibits the adenosine triphosphate–dependent transporters BCRP and P-gp and the organic anion–transporting polypeptides OATP1B1 and OATP1B3. Potential exists for multiple drug interactions when using both EVG and COBI.
- *Absorption*: Administering EVG and bictegravir (BIC) concurrently with antacids or supplements that contain iron, calcium, aluminum and/or magnesium lowers plasma concentrations of these ARV drugs (see the [Elvitegravir](#) and [Bictegravir](#) sections for details).
- Odefsey contains RPV, which is a CYP3A substrate, and requires dose adjustments when administered with CYP3A-modulating medications.
- Before Genvoya, Odefsey, Descovy, Biktarvy, or Symtuza is administered, a patient's medication profile should be carefully reviewed for potential drug interactions.
- *Renal elimination*: Drugs that decrease renal function or compete for active tubular secretion (e.g., acyclovir, ganciclovir, high-dose nonsteroidal anti-inflammatory drugs) could reduce clearance of the TAF metabolite TFV or emtricitabine (FTC). Concomitant use of nephrotoxic drugs should be avoided when using Genvoya.
- *Protease inhibitors*: Genvoya should not be administered concurrently with products or regimens that contain ritonavir (RTV) because COBI and RTV have similar effects on CYP3A metabolism.

Major Toxicities

- *More common*: Nausea, diarrhea, headache. Greater weight gain has been reported with the use of TAF than with tenofovir disoproxil fumarate (TDF) in adults and children⁶ (see [Table 17h. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Lipodystrophies and Weight Gain](#) for details).
- *Less common (more severe)*: Cases of lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside reverse transcriptase inhibitors (NRTIs).

Resistance

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

Pediatric Use

Approval

TAF is available as a component of several fixed-dose combination (FDC) tablets. These FDC tablets are listed in [Appendix A, Table 1. Antiretrovirals Available in Fixed-Dose Combination Tablets or as a Co-packaged Formulation, by Drug Class](#), and [Appendix A, Table 2. Antiretroviral Fixed-](#)

Dose Combination Tablets and Co-packaged Formulations: Minimum Body Weights and Considerations for Use in Children and Adolescents.

Descovy, an FDC tablet that contains FTC and TAF (FTC/TAF), is approved by the U.S. Food and Drug Administration (FDA) for use in children who weigh ≥ 14 kg to < 25 kg at a dose of FTC 120 mg/TAF 15 mg and for children who weigh ≥ 25 kg to < 35 kg at a dose of FTC 200 mg/TAF 25 mg when used as part of an ARV regimen that does not include a boosted protease inhibitor (PI). Descovy is approved by the FDA for use in children who weigh ≥ 35 kg at a dose of FTC 200 mg/TAF 25 mg when used in combination with any ARV drugs, including RTV-boosted or COBI-boosted PIs. Odefsey, an FDC tablet that contains FTC 200 mg, RPV 25 mg, and TAF 25 mg (FTC/RPV/TAF), is approved by the FDA⁷ for use in children who weigh ≥ 25 kg. Genvoya, an FDC tablet that contains EVG 150 mg, COBI 150 mg, FTC 200 mg, and TAF 10 mg (elvitegravir/cobicistat [EVG/c]/FTC/TAF), is approved by the FDA for use in children who weigh ≥ 25 kg when used without other ARV drugs⁸ (see [Table A](#) below). BIC is available only as part of the FDC tablet Biktarvy, which contains BIC, FTC, and TAF (BIC/FTC/TAF). Biktarvy is approved by the FDA^{8,9} for use in children or adolescents with body weight ≥ 14 kg to < 25 kg at a dose of BIC 30 mg/FTC 120 mg/TAF 15 mg and for children, adolescents, and adults with body weight ≥ 25 kg at a dose of BIC 50 mg/FTC 200 mg/TAF 25 mg.^{8,10-13} Symtuza, an FDC tablet that contains DRV 800 mg, COBI 150 mg, FTC 200 mg, and TAF 10 mg (darunavir/cobicistat [DRV/c]/FTC/TAF) is approved by the FDA⁸ for use in children and adolescents who weigh ≥ 40 kg.

TAF has antiviral activity and efficacy against hepatitis B virus (HBV). Testing for HBV should be performed prior to starting treatment with TAF. If HBV is found, rebound of clinical hepatitis could occur when TAF is stopped. For more information about hepatitis rebound in patients with HBV/HIV coinfection, see the [Hepatitis B Virus Infection](#) section of the [Pediatric Opportunistic Infection Guidelines](#). TAF alone (as Vemlidy) is approved by the FDA for use in people aged ≥ 8 years, but it is approved only for treating HBV, not HIV.

Formulations

TAF-containing pills are smaller than their TDF-containing counterparts, a significant advantage for some pediatric patients who may have trouble swallowing larger pills (see [Appendix A, Table 2. Antiretroviral Fixed-Dose Combination Tablets and Co-packaged Formulations: Minimum Body Weights and Considerations for Use in Children and Adolescents](#)). FTC/TAF available formulations contain either TAF 15 mg (for children weighing 14 to < 25 kg) or TAF 25 mg (for weight ≥ 25 kg), but neither formulation should be used in children weighing < 35 kg in combination with PIs that require boosting with RTV or COBI. Both EVG/c/FTC/TAF and DRV/c/FTC/TAF contain TAF 10 mg, whereas FTC/RPV/TAF contains TAF 25 mg. BIC/FTC/TAF is available in two strengths: one containing TAF 15 mg for children aged ≥ 2 years and weighing < 25 kg and the other containing TAF 25 mg for people weighing ≥ 25 kg. COBI boosts TAF blood concentrations and tenofovir diphosphate (TFV-DP) intracellular exposure after TAF administration. Therefore, in people weighing ≥ 25 kg, administration of EVG/c/FTC/TAF, which contains TAF 10 mg and COBI, achieves TFV-DP systemic exposure that is similar to the exposure achieved by FTC/RPV/TAF or BIC/FTC/TAF containing TAF 25 mg but no COBI.

Table A. U.S. Food and Drug Administration–Approved Tenofovir Alafenamide-Containing Formulations

Drug	Contains	Dose of TAF	Minimum Age	Minimum Body Weight or Weight Range	Comment
Vemlidy	TAF	25 mg	6 years	≥25 kg	Approved for HBV treatment only.
Descovy	FTC/TAF	15 mg	N/A	≥14 kg to <25 kg	Use with an INSTI or NNRTI, but not with a boosted PI.
	FTC/TAF	25 mg	N/A	≥25 kg	
	FTC/TAF	25 mg	N/A	35 kg	Use with any ARV drugs, including a boosted PI.
Odefsey	FTC/RPV/TAF	25 mg	N/A	25 kg	Generally not to be used with other ARV drugs.^a
Genvoya	EVG/c/FTC/TAF	10 mg	N/A	25 kg	TAF dose is lower due to the COBI boosting. Generally not to be used with other ARV drugs.^a
Symtuza	DRV/c/FTC/TAF	10 mg	N/A	40 kg	TAF dose is lower due to the COBI boosting. Generally not to be used with other ARV drugs.^a
Biktarvy	BIC/FTC/TAF	15 mg	N/A	≥14 kg to <25 kg	Generally not to be used with other ARV drugs.^a
	BIC/FTC/TAF	25 mg	N/A	≥25 kg	

^a Consult a specialist in HIV care before using these fixed-dose combination tablets with other ARV agents.

Key: ARV = antiretroviral; BIC = bictegravir; COBI = cobicistat; DRV/c = darunavir/cobicistat; EVG/c = elvitegravir/cobicistat; FTC = emtricitabine; HBV = hepatitis B virus; INSTI = integrase strand transfer inhibitor; NNRTI = non-nucleoside reverse transcriptase inhibitor; PI = protease inhibitor; RPV = rilpivirine; TAF = tenofovir alafenamide

Tenofovir Alafenamide Versus Tenofovir Disoproxil Fumarate

Both TDF and TAF are prodrugs of the NRTI TFV. After oral administration, TDF is well absorbed^{11,12} and is so rapidly metabolized to TFV that TDF itself cannot be measured in blood (even when plasma is sampled within 5 minutes of administration).¹³ TFV is the main compound that is measurable in plasma after TDF administration. From the bloodstream, TFV enters cells and is phosphorylated to the active agent TFV-DP.

TAF also has good oral bioavailability.^{14,15} Within the enterocyte and liver, TAF is not metabolized to TFV as quickly as TDF, so the plasma TFV concentration is much lower with administration of TAF than with TDF, and the main component in plasma is the prodrug itself, TAF.¹⁶ Once inside the cell, TAF is hydrolyzed to TFV,^{17,18} and then TFV-DP is produced by the same mechanism as for TDF. Relative to TDF, TAF more effectively delivers TFV to cells throughout the body.¹⁴ Therefore, a much lower dose of TAF results in intracellular concentrations of TFV-DP that are higher than the

concentrations seen after TDF administration (see [Table B](#) below). In a combined analysis of two randomized crossover directly observed therapy studies of FTC/TAF (200 mg/25 mg) versus FTC/TDF (200 mg/300 mg) in adults without HIV, FTC/TAF produced 6.7- to 7.3-fold higher TFV-DP in peripheral blood mononuclear cells (PBMCs) compared to FTC/TDF across adherence levels (33%, 67%, or 100%). Additionally, the half-life of TFV-DP in PBMCs appeared numerically but not significantly longer for TAF (2.9 days; 95% confidence interval [CI], 1.5–5.5) than for TDF (2.1 days; 95% CI, 1.5–2.9). These data support a conclusion of increased potency and pharmacological forgiveness with FTC/TAF over FTC/TDF in the PBMC compartment.¹⁹

The key pharmacokinetic (PK) difference between TDF and TAF is that TDF results in higher plasma TFV concentrations than TAF, but when administered at FDA-approved doses, both drugs produce high, therapeutically effective intracellular TFV-DP concentrations.^{16,20} Because it is intracellular TFV-DP that suppresses viral replication, TAF should have antiviral efficacy that is equivalent to the antiviral efficacy of TDF. However, the toxicities that are specifically related to high plasma TFV concentrations should not occur when using TAF. High plasma TFV concentration has been linked to TDF-related endocrine disruption that is associated with low bone mineral density (BMD).²¹ High plasma TFV concentration also has been closely associated with both glomerular²¹⁻²³ and proximal tubular²⁴ renal toxicity.

Table B. Multiple-Dose Pharmacokinetics at Day 10 of Once-Daily Oral Administration in Adults With HIV: Tenofovir Alafenamide vs. Tenofovir Disoproxil Fumarate

Parameter	TAF 25 mg (n = 8)	TDF 300 mg (n = 6)
Plasma TFV AUC _{tau} (ng·h/mL)	267.7 (26.7)	1,918.0 (39.4)
Plasma TFV C _{max} (ng/mL)	15.7 (22.1)	252.1 (36.6)
Plasma TFV C _{tau} (ng/mL)	9.2 (26.1)	38.7 (44.7)
PBMC TFV-DP AUC _{tau} (μM·h)	21.4 (76.9)	3.0 (119.6)

Note: The mean age of participants was 38 years, with a range of 20 to 57 years. Data presented are mean (% coefficient of variation).

Source: Ruane PJ, DeJesus E, Berger D, et al. Antiviral activity, safety, and pharmacokinetics/pharmacodynamics of tenofovir alafenamide as 10-day monotherapy in HIV-1-positive adults. *J Acquir Immune Defic Syndr*. 2013;63(4):449-455. Available at: <https://pubmed.ncbi.nlm.nih.gov/23807155>.

Key: AUC_{tau} = area under the curve for the dosing interval (i.e., 24 hours); C_{max} = peak concentration; C_{tau} = concentration at the end of a dosing interval (i.e., at 24 hours, the trough concentration); PBMC = peripheral blood mononuclear cell; TAF = tenofovir alafenamide; TDF = tenofovir disoproxil fumarate; TFV = tenofovir; TFV-DP = tenofovir diphosphate

Tenofovir Alafenamide Efficacy in Clinical Trials in Adults

In adults, TAF is non-inferior to TDF in its ability to control viral load over 48 to 96 weeks when used in combination with EVG, COBI, and FTC²⁵⁻²⁸; with FTC and RPV²⁹; with DRV, COBI, and FTC³⁰⁻³²; and when TAF and FTC are administered in combination with other ARV drugs.³³ In a switch study of adults who were virologically suppressed on a three-drug regimen that included abacavir (ABC), FTC/TAF was non-inferior to a regimen of lamivudine plus ABC plus a third ARV drug over 48 weeks. No differences occurred in BMD or the frequency of renal glomerular toxicities or renal tubular toxicities between these groups, but the TAF group showed a decline in high-density

lipoprotein (HDL) cholesterol levels, whereas the ABC group had an increase in HDL cholesterol levels³⁴ (–2 mg/dL vs. +2 mg/dL, respectively; $P = 0.0003$). Viral load suppression was attained in about 90% of study participants when TAF was given as part of the coformulated BIC/FTC/TAF.^{35–37}

Tenofovir Alafenamide Efficacy and Effectiveness in Adolescents and Children

The combination of EVG, COBI, FTC, and TAF has been shown to have similar efficacy when used in adults and two groups of children: those weighing ≥ 35 kg and aged ≥ 12 years³⁸ and those weighing ≥ 25 kg and aged ≥ 6 years³⁹ (see the [Elvitegravir](#) section for details). In a switch study, treatment with BIC/FTC/TAF resulted in viral load suppression at 48 weeks in 49 of 50 (98%) children aged 6 years to <12 years and in 50 of 50 (100%) children aged 12 years to <18 years⁹ (see the [Bictegravir](#) section for details). Initial evidence in a systematic review suggests good viral suppression and no obvious safety concerns in children and adolescents on TAF-containing regimens for more than 24 to 48 weeks.⁴⁰ However, in a retrospective single-center study in France including 74 pediatric patients who received BIC/FTC/TAF for ≥ 6 months between 2019 and 2023, virologic failure occurred in 28 children (38%), more frequently in those with viral failure than viral suppression at baseline (68% vs. 26%); notably, only one patient developed a treatment-emergent mutation (T69D/N), which is selected by NRTIs.⁴¹

Pharmacokinetics

Drug Exposure and Virologic Response

Virologic suppression in people who are taking TAF or TDF is most closely related to intracellular TFV-DP concentrations. In adults, TAF generates peripheral blood mononuclear cell TFV-DP concentrations that are twofold²⁰ to sevenfold higher than those generated with TDF at clinically meaningful doses.^{16,19,25} Higher TFV-DP concentrations result in a stronger antiviral potency¹⁶ and a higher barrier to resistance.^{42,43} Therefore, because TAF administration leads to higher intracellular TFV-DP concentrations than TDF, TAF may be more effective against NRTI-resistant virus than TDF. The mean TFV-DP concentration is higher in youth aged 12 to 18 years than in adults: 221.8 fmol/million cells (with a coefficient of variation [CV] of 94.4%) versus 120.8 fmol/million cells (CV 91.4%), respectively.³⁸

Drug Exposure and Safety: All Age Groups

FTC/TAF can be safely combined with DTG or raltegravir without concern for drug interactions (see [Table C](#) below). FTC and TAF also have been safely combined with BIC in the FDC tablet Biktarvy.

Table C. Changes in Tenofovir Alafenamide Pharmacokinetic Parameters in the Presence of Co-administered Antiretroviral Drugs in Adult Healthy Volunteers

Co-administered ARV	Dosage (Once Daily) (mg)	TAF Dosage (Once Daily) (mg)	N	Mean Ratio of TAF C _{max} (90% CI) ^a	Mean Ratio of TAF AUC (90% CI) ^a
Atazanavir	300 (+100 ritonavir)	10	10	1.77 (1.28, 2.44)	1.91 (1.55, 2.35)
Cobicistat	150	8	12	2.83 (2.20, 3.65)	2.65 (2.29, 3.07)
Darunavir	800 (+150 cobicistat)	25 ^b	11	0.93 (0.72, 1.21)	0.98 (0.80, 1.19)
	800 (+100 ritonavir)	10	10	1.42 (0.96, 2.09)	1.06 (0.84, 1.35)
Dolutegravir	50	10	10	1.24 (0.88, 1.74)	1.19 (0.96, 1.48)
Efavirenz	600	40 ^b	11	0.78 (0.58, 1.05)	0.86 (0.72, 1.02)
Lopinavir	800 (+200 ritonavir)	10	10	2.19 (1.72, 2.79)	1.47 (1.17, 1.85)
Rilpivirine	25	25	17	1.01 (0.84, 1.22)	1.01 (0.94, 1.09)

^a Ratio represents concentrations of TAF plus the concomitant drug(s) divided by concentrations of TAF alone.

^b Study was conducted with Descovy (FTC/TAF).

Source: Table was modified from the U.S. Food and Drug Administration Descovy product label.

Key: ARV = antiretroviral drug; AUC = area under the curve; CI = confidence interval; C_{max} = maximum concentration; FTC = emtricitabine; TAF = tenofovir alafenamide

When FTC/TAF, which contains TAF 25 mg, is combined with boosted atazanavir (ATV), DRV, or lopinavir (LPV), the P-gp inhibitors COBI or RTV increase the TAF exposure to higher concentrations than those seen with the use of EVG/c/FTC/TAF, which contains TAF 10 mg.

However, the plasma TFV concentrations seen with the use of EVG/c/FTC/TAF or TAF plus DRV/r or DRV/c are still much lower than those seen with the use of Stribild, an FDC tablet that contains EVG, COBI, FTC, and TDF (see [Table D](#) below).

Table D. Plasma Tenofovir Alafenamide and Plasma Tenofovir Exposures When Tenofovir Alafenamide and Tenofovir Disoproxil Fumarate Are Used With Boosted Antiretroviral Drugs

Regimen	TAF AUC (ng·h/ mL)	TAF AUC Ratio TAF AUC of TAF-Containing Regimen/TAF AUC of Genvoya (Adult Exposure)	TFV AUC (ng·h/ mL)	TFV AUC Ratio TFV AUC of TAF-Containing Regimen/TFV AUC of Stribild (Adult Exposure)
Adult				
Stribild (EVG/c/FTC/TDF 300 mg)	N/A	N/A	4,400	1.00
Genvoya (EVG/c/FTC/TAF 10 mg)	210	1.0	290	0.07
DRV/r plus TAF 25 mg^a	196	0.93	259	0.06
DRV/c plus TAF 25 mg	239	1.1	935	0.21
Pediatric				
Stribild (EVG/c/FTC/TDF 300 mg) for Ages 12–18 years	N/A	N/A	6,028	1.37
Genvoya (EVG/c/FTC/TAF 10 mg) for Ages 12–18 years	200	0.95	290	0.07
Genvoya (EVG/c/FTC/TAF 10 mg) for Ages 6–12 years	330	1.6	440	0.10

^a Values for this row do not come from observed data. These values were predicted based on data from studies that used TAF 10 mg. The AUC values predicted for TAF 25 mg were obtained by multiplying the TAF 10 mg AUC by 2.5 for both TAF and TFV AUC.

Source: Table modified from [U.S. Food and Drug Administration Summary Review of TAF](#) and from the [TAF clinical pharmacology review](#) using data from the [Stribild product label](#) and [Genvoya product label](#).

Key: AUC = area under the curve; DRV/c = darunavir/cobicistat; DRV/r = darunavir/ritonavir; EVG/c = elvitegravir/cobicistat; FTC = emtricitabine; TAF = tenofovir alafenamide; TDF = tenofovir disoproxil fumarate; TFV = tenofovir

In the CHAPAS-4 trial of African children taking TAF/FTC with DTG or a boosted PI, TAF exposures were acceptable when given with DTG, DRV/r, and lopinavir/ritonavir (LPV/r). TAF exposures were higher when TAF was given with ATV/r, but TFV exposures were comparable to administration with other boosted PIs (see Table E below).⁴⁴

Table E. Plasma Tenofovir Alafenamide and Plasma Tenofovir Exposures When Tenofovir Alafenamide and Emtricitabine Are Administered With Dolutegravir or Boosted Protease Inhibitors

Pharmacokinetic Parameter	TAF/FTC + DTG	TAF/FTC + ATV/r	TAF/FTC + DRV/r	TAF/FTC + LPV/r	Adult Reference Using TAF 25 mg Unboosted or TAF 10 mg Boosted	Adult Reference Using TAF 25 mg With DRV/c
TAF						
AUC_{last} (ng·h/mL)	285 (79)	538 (54)	232 (61)	212 (98)	206 (72)	222
C_{max} (ng/mL)	145 (91)	309 (78)	155 (104)	155 (107)	162 (51)	181
TFV						
AUC_{tau} (ng·h/mL)	324 (29)	847 (37)	744 (26)	864 (46)	293 (27)	937
C_{max} (ng/mL)	19.6 (26)	53.2 (42)	44.5 (26)	50.3 (43)	15.2 (26)	56
C_{trough} (ng/mL)	11.0 (35)	28.1 (39)	26.1 (28)	31.2 (48)	11 (28.5)	33.2

Note: Data presented are geometric mean (% coefficient of variation).

Source: Waalewijn H, Szubert AJ, Wasmann RE, et al. First pharmacokinetic data of tenofovir alafenamide fumarate and tenofovir with dolutegravir or boosted protease inhibitors in African children: a substudy of the CHAPAS-4 trial. *Clin Infect Dis.* 2023;77(6):875-882.

Key: ATV/r = atazanavir/ritonavir; AUC_{last} = area under the concentration-time curve from dosing to the time of the last measured concentration; AUC_{tau} = area under the concentration-time curve over the dosing interval; C_{max} = maximum plasma concentration; C_{trough} = trough concentration; DRV/c = darunavir/cobicistat; DRV/r = darunavir/ritonavir; DTG = dolutegravir; FTC = emtricitabine; LPV/r = lopinavir/ritonavir; TAF = tenofovir alafenamide; TFV = tenofovir

TAF is available in FDA-approved adult FDC tablets at dosages of either 10 mg or 25 mg. The initial clinical trials in adults showing the safety of FTC/TAF with ATV/r or DRV/r used FTC 200 mg/TAF 10 mg.⁴⁵ However, in [Trial GS-US-299-0102](#) (NCT01565850), a Phase 2b trial in adults that compared a regimen of DRV/c plus FTC/TAF 10 mg to a regimen of DRV/c plus FTC/TDF, virologic outcomes at Week 48 were worse for participants in the TAF 10-mg arm than in the TDF arm.⁴⁶ Hence, FTC/TAF 25 mg was initially recommended for approval instead of FTC/TAF 10 mg.⁴⁶ The FDA label states that when FTC 200 mg/TAF 25 mg is combined with boosted ATV, DRV, or LPV in adults, “no clinically significant drug interactions have been either observed or are expected.”² The combination of FTC 200 mg/TAF 25 mg was approved by the FDA for use in adults, independent of the accompanying ARV drugs (which may include a boosted PI or an integrase strand transfer inhibitor [INSTI]),² but some FDC tablets for adults (i.e., EVG/c/FTC/TAF and DRV/c/FTC/TAF) have subsequently been FDA approved with a 10-mg TAF component.^{47,48}

Drug Exposure and Safety: Aged 12 to 18 Years and Weighing ≥35 kg

A study of FTC/TAF in 18 children and adolescents (aged 12–18 years and weighing ≥35 kg) was performed using FTC 200 mg/TAF 10 mg plus a boosted third ARV drug or FTC 200 mg/TAF 25 mg

with an unboosted third ARV drug. The results of this study showed TAF exposures in children and adolescents that were like those seen in adults. TAF was well tolerated and efficacious during the 24 weeks of study. Asymptomatic Grade 3 or 4 elevations in amylase levels were noted in 5 of 28 participants (18%), and Grade 3 or 4 elevations in fasting low-density-lipoprotein (LDL) levels were noted in 2 of 28 participants (7%).⁴⁹

Studies of EVG/c/FTC/TAF in children aged 12 years to 18 years and weighing ≥ 35 kg showed that TAF and TFV exposures were like those found in adults (see [Table D](#) above), and that the drug combination was well tolerated and efficacious over 48 weeks of study.³⁸ Because these TAF and TFV exposures were similar to those seen in adults, FTC 200 mg/TAF 25 mg was also approved by the FDA for use in this age and weight group, independent of the accompanying ARV drugs in the regimen (which may include a boosted PI or an INSTI).²

The formulation of Biktarvy, which contains BIC 50 mg/FTC 200 mg/TAF 25 mg, was administered to 50 children aged 6 years to <12 years and weighing ≥ 25 kg and 50 children and adolescents aged 12 years to <18 years and weighing ≥ 35 kg who had had viral loads <50 copies/mL for at least 6 months. The drug was well tolerated. All 50 participants in the study⁹ had viral loads <50 copies/mL at Week 24, and 49 participants had viral loads <50 copies/mL at Week 48 (see the [Bictegravir](#) section for details).

Drug Exposure and Safety: Aged 6 Years to <12 Years and Weighing 25 kg to <35 kg

Studies of EVG/c/FTC/TAF in children aged 6 years to <12 years who weighed ≥ 25 kg showed that TAF and TFV exposures were somewhat higher than those found in adults (see [Table D](#) above), but the drug combination was well tolerated and efficacious over 24 weeks of study.^{39,50} This led to FDA approval of EVG/c/FTC/TAF for use in children aged ≥ 6 years and weighing ≥ 25 kg.⁴⁷ Follow-up to 96 weeks in a small number of participants showed no change from baseline in the median spine BMD z-score, but there was a decline in the median total body BMD z-score and a possible decline in the median estimated glomerular filtration rate.⁵¹

Because INSTIs do not increase TAF concentrations, regimens that include FTC/TAF 25 mg plus an INSTI are expected to result in safe drug exposures that are like those seen with coformulated EVG/c/FTC/TAF 10 mg. This led the FDA to approve FTC/TAF 25 mg for use in children aged ≥ 6 years and weighing ≥ 25 kg when used in combination with other ARV drugs that do not include a boosted PI.²

Because boosted ATV, DRV, or LPV increase TAF exposure to concentrations that are higher than those seen with use of EVG/c/FTC/TAF, and because safety and PK studies are ongoing on the use of these combinations in children weighing <35 kg, the safety of FTC/TAF combined with COBI-boosted or RTV-boosted PIs in children weighing between 25 kg and <35 kg cannot be assured.⁵² Therefore, FDA approval for FTC/TAF used in combination with boosted PIs is limited to children weighing ≥ 35 kg (see [Table A](#) above).²

Drug Exposure and Safety: Aged ≥ 2 Years and Weighing ≥ 14 kg to <25 kg

Biktarvy tablets consisting of BIC 30 mg/FTC 120 mg/TAF 15 mg were administered to children aged ≥ 2 years weighing 14 kg to <25 kg and who had viral loads <50 copies/mL on stable antiretroviral therapy (ART). TAF exposures (ratios relative to reference, area under the concentration-time curve over the dosing interval [AUC_{tau}] 145%, area under the concentration-time curve from dosing to the time of the last measured concentration [AUC_{last}] 145%, and maximum plasma concentration [C_{max}] 173%) were generally higher than reference values derived population PK modeling based on adult

Phase 3 studies, but TFV AUC and concentrations at the end of the dosing interval (ratios relative to reference, AUC_{tau} 112%, C_{max} 143%, and concentration at the end of a dosing interval [C_{tau}] 96%) were more similar to reference values. No participants experienced any severe (Grade 3 or higher) or serious adverse events, and all drug-related adverse events were mild (Grade 1) or moderate (Grade 2). The median change in CD4 T lymphocyte (CD4) cell count was –123 cells/mm³ at 48 weeks and –137 cells/mm³ at 96 weeks, and the median change in CD4 percentage was +1.1% at 48 weeks and –0.8% at 96 weeks. HIV RNA at <50 copies/mL was maintained in 20 of 22 (91%) participants at 24 weeks and 21 of 22 (95%) participants at 48 weeks; when excluding missing values from the FDA snapshot algorithm, 100% of participants had HIV RNA <50 copies/mL at Weeks 24, 48, and 96^{53,54} (see the [Bictegravir](#) section for details). Safety and PK studies in children using TAF and FTC with atazanavir/cobicistat or DRV/c are ongoing.⁵²

Dosing: Crushing, Splitting, and Swallowability of Emtricitabine/Tenofovir Alafenamide Tablets

Viral load suppression was reported in one adult patient with HIV who received crushed FTC/TAF tablets plus crushed DTG tablets. The crushed tablets were mixed with water and administered via a gastrostomy tube. Each dose was followed by a can of a nutritional supplement. No PK parameters were measured.⁵⁵ In adults without HIV, the PKs of crushed DRV/c/FTC/TAF tablets showed decreased TAF bioavailability compared to whole tablets. The clinical implications of these findings are unclear.⁵⁶ Case reports in adults with HIV who are receiving crushed BIC/FTC/TAF, a film-coated FDC tablet, lacked PK measurements and described inconsistent virological outcomes.⁵⁷ Based on an adult bioequivalence study, crushed BIC/FTC/TAF may lead to suboptimal FTC and TAF exposures.⁵⁸ Thus, crushed BIC/FTC/TAF **is not recommended** (see the [Bictegravir](#) section for details).

For children who are unable to swallow a whole tablet, BIC/FTC/TAF may be split and each part taken separately, as long as all parts are swallowed within 10 minutes. Among 18 children aged ≥2 years and weighing 14 to <25 kg, 79% to 89% reported that BIC/FTC/TAF tablets were easy or super easy to swallow. Of six children under 6 years old who split the tablet in half on at least one occasion, three were swallowing the tablet whole at Week 48.⁵⁴ Among 24 children with HIV-1 aged ≥6 years to <12 years and weighing ≥25 kg to <40 kg swallowing FDC tablets of DRV/c/FTC/TAF or who split matching placebo tablets, 96% were able to swallow the whole or split tablet after one or two attempts, and >70% rated acceptability for long-term daily use as acceptable or good. Breaking the scored matching placebo was considered easy or OK by 79% of caregivers, although whole tablets were favored over split tablets among children.⁵⁹

Toxicity

Bone

TAF causes bone toxicity less frequently than TDF.^{25-27,30-33,60,61} For example, in one study of 1,733 randomized adult participants with HIV, those treated with EVG/c/FTC/TAF had a smaller decrease in BMD at the spine (mean change –1.30% vs. –2.86%; *P* < 0.0001) and hip (–0.66% vs. –2.95%; *P* < 0.0001) at 48 weeks than those given EVG/c/FTC/TDF.²⁵ These differences were maintained until 96 weeks.²⁸ The clinical importance of these changes in BMD is unclear. Preliminary data from two open-label multicohort studies of 169 ART-naïve or ART-experienced children and adolescents living with HIV aged ≥2 years and weighing ≥14 kg who received TAF/FTC-containing ART were reassuring with respect to longitudinal (up to 144 to 288 weeks) BMD measurements.⁶² Dual-energy x-ray absorptiometry of the spine and total body less head (TBLH) BMD measurements increased from baseline over time, and height-adjusted z-scores also increased from baseline, except for a decrease in height-adjusted TBLH z-scores in the youngest and lightest

female group. One participant had a >4% decrease in spine BMD, but none had a >4% decrease in TBLH density. The increases in spine and TBLH BMD were consistent with those observed in children and adolescents without HIV.

Renal

Studies in adolescents aged 12 to 17 years³⁸ and adults^{25-27,30,31,33} show that TAF is less frequently associated with glomerular and renal tubular damage than TDF.⁶³ For example, in one study of 1,733 randomized adult participants with HIV, those treated with EVG/c/FTC/TAF had a smaller mean increase in serum creatinine (0.08 mg/dL vs. 0.12 mg/dL; $P < 0.0001$) than those given EVG/c/FTC/TDF, and a smaller percent change from baseline in urine protein to creatinine ratio (median % change -3% vs. +20%; $P < 0.0001$) at 48 weeks.²⁵ These differences persisted until 96 weeks of follow-up.²⁸ Safety of EVG/c/FTC/TAF has been demonstrated in adults with estimated creatinine clearances between 30 mL/min and 69 mL/min.⁶⁴ Postmarketing cases of renal impairment—including acute renal failure, proximal renal tubulopathy, and Fanconi syndrome—have been reported with TAF-containing products.^{2,3} TAF may require less intense renal safety monitoring than TDF, but more experience with the drug in broad clinical practice will be needed before a specific recommendation can be made.

Lipids

In treatment-naïve adults who were evaluated after 48 weeks of therapy, initiation of EVG/c/FTC/TAF was associated with increases in serum lipids that were greater than those observed with the initiation of EVG/c/FTC/TDF, with a mean increase in total cholesterol levels of 31 mg/dL versus 23 mg/dL, and a mean increase in LDL cholesterol levels of 16 mg/dL versus 4 mg/dL, respectively. In 48 adolescents who were treated with EVG/c/FTC/TAF, the following median changes from baseline occurred at Weeks 24 and 36: Fasting total cholesterol levels increased 26 mg/dL and 36 mg/dL, respectively; fasting direct LDL levels increased 10 mg/dL and 17 mg/dL, respectively; and fasting triglycerides increased 14 mg/dL and 19 mg/dL, respectively.⁶⁵ Similar TAF-related increases in total cholesterol levels and LDL cholesterol levels have been found when TAF is administered with other combinations of ARV drugs.³¹ Monitoring serum lipids while the patient is taking TAF-containing FDC tablets is warranted, given these data (see [Table 17b. Antiretroviral Therapy—Associated Adverse Effects and Management Recommendations—Dyslipidemia](#) for details).

Weight Gain

Observational data are limited, and no randomized controlled trials have examined TAF-associated weight gain in children. In adults, greater weight gain has been reported with the use of TAF than with the use of TDF⁶⁶⁻⁷³ (see [Table 17h. Antiretroviral Therapy—Associated Adverse Effects and Management Recommendations—Lipodystrophies and Weight Gain](#) for details). Although weight gain at ART initiation might represent a “return to health,”⁶³ patients initiating treatment with TAF had larger increases in weight than those initiating treatment with TDF^{67,68}; increases in weight and body mass index (BMI) have been observed in ARV switch studies, as well.^{69,72,74} In adults, the effect may be greatest in Black females,^{68,72} especially if administered in combination with INSTIs.^{68,70} A study in adult women showed increased BMI with the switch to either an INSTI or TAF, but these BMI increases were only seen in people with BMI <30 kg/m² at baseline.⁶⁶

Tenofovir Disoproxil Fumarate (TDF, Viread)

Updated: September 30, 2025

Reviewed: September 30, 2025

Formulations	
<p>Oral Powder: 40 mg per 1 g of oral powder (one level scoop, measured with supplied dosing scoop, equals 1 g oral powder)</p> <p>Tablets: 150 mg, 200 mg, 250 mg, and 300 mg</p> <p>Fixed-Dose Combination (FDC) Tablets</p> <ul style="list-style-type: none"> • [Atripla^a and generic] Efavirenz 600 mg/emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg • [Cimduo] Lamivudine 300 mg/tenofovir disoproxil fumarate 300 mg • [Complera] Emtricitabine 200 mg/rilpivirine 25 mg/tenofovir disoproxil fumarate 300 mg • [Delstrigo] Doravirine 100 mg/lamivudine 300 mg/tenofovir disoproxil fumarate 300 mg • [Stribild] Elvitegravir 150 mg/cobicistat 150 mg/emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg • [Symfi] Efavirenz 600 mg/lamivudine 300 mg/tenofovir disoproxil fumarate 300 mg • [Symfi Lo^a and generic] Efavirenz 400 mg/lamivudine 300 mg/tenofovir disoproxil fumarate 300 mg • [Temixys] Lamivudine 300 mg/tenofovir disoproxil fumarate 300 mg • [Truvada tablet] <ul style="list-style-type: none"> o Emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg o Emtricitabine 167 mg/tenofovir disoproxil fumarate 250 mg o Emtricitabine 133 mg/tenofovir disoproxil fumarate 200 mg o Emtricitabine 100 mg/tenofovir disoproxil fumarate 150 mg <p>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.</p> <p>For additional information, see Drugs@FDA or DailyMed.</p>	
Dosing Recommendations	Selected Adverse Events
<p>Neonate and Infant Dose</p> <ul style="list-style-type: none"> • Tenofovir disoproxil fumarate (TDF) has not been approved by the U.S. Food and Drug Administration or recommended for use in neonates or infants aged <2 years. <p>Child (Aged ≥2 Years to <12 Years) and Weighing ≥10 kg Dose^a</p> <ul style="list-style-type: none"> • TDF 8 mg/kg per dose once daily 	<ul style="list-style-type: none"> • Asthenia, headache, diarrhea, nausea, vomiting, flatulence • Glomerular and proximal renal tubular dysfunction • Decreased bone mineral density^b
	<p>Special Instructions</p> <ul style="list-style-type: none"> • TDF oral powder formulation is available for children who are unable to swallow tablets. • TDF oral powder should be measured only with the supplied dosing scoop: one level scoop = 1 g powder = TDF 40 mg.

TDF Oral Powder Dosing Table	
Body Weight	TDF Oral Powder Once-Daily Scoops of Powder
10 kg to <12 kg	2 scoops (80 mg)
12 kg to <14 kg	2.5 scoops (100 mg)
14 kg to <17 kg	3 scoops (120 mg)
17 kg to <19 kg	3.5 scoops (140 mg)
19 kg to <22 kg	4 scoops (160 mg)
22 kg to <24 kg	4.5 scoops (180 mg)
24 kg to <27 kg	5 scoops (200 mg)
27 kg to <29 kg	5.5 scoops (220 mg)
29 kg to <32 kg	6 scoops (240 mg)
32 kg to <34 kg	6.5 scoops (260 mg)
34 kg to <35 kg	7 scoops (280 mg)
≥35 kg	7.5 scoops (300 mg)

TDF Tablet Dosing Table	
Body Weight	TDF Tablet Once Daily
17 kg to <22 kg	150 mg
22 kg to <28 kg	200 mg
28 kg to <35 kg	250 mg
≥35 kg	300 mg

Child and Adolescent (Weighing ≥35 kg)^a and Adult Dose

- TDF 300 mg once daily

[Atripla^a and Generic] Efavirenz (EFV)/Emtricitabine (FTC)/TDF

Child and Adolescent (Weighing ≥40 kg) and Adult Dose

- One tablet once daily
- Take on an empty stomach.

[Cimduo] Lamivudine (3TC)/TDF

Child and Adolescent (Weighing ≥35 kg) and Adult Dose

- One tablet once daily

- Mix TDF oral powder with 2–4 oz of soft food that does not require chewing (e.g., applesauce, yogurt). Administer immediately after mixing to avoid the bitter taste.
- Do not try to mix the TDF oral powder with liquid. The powder may float on the top even after vigorous stirring.
- Although TDF can be administered without food, food requirements vary depending on the other antiretroviral (ARV) drugs contained in an FDC tablet. Food requirements are listed with dosing recommendations in [Appendix A, Table 2. Antiretroviral Fixed-Dose Combination Tablets and Co-packaged Formulations: Minimum Body Weights and Considerations for Use in Children and Adolescents](#).
- Measure serum creatinine and perform a urine dipstick test for protein and glucose before starting a TDF-containing regimen. Serum creatinine should be monitored, and urine should be tested for protein and glucose at intervals during continued therapy (see [Table 17i. Nephrotoxic Effects](#)). Measure serum phosphate if there is clinical suspicion of hypophosphatemia.
- Screen children for hepatitis B virus (HBV) infection before using TDF. Severe acute exacerbation of HBV infection can occur when TDF is discontinued; therefore, hepatic function should be monitored for several months after children with HBV infection stop taking TDF.
- Tenofovir alafenamide (TAF) is associated with less bone and renal toxicity than TDF, but it has equal antiviral efficacy. **Do not use TAF and TDF together.** Consider switching from TDF to TAF in appropriate clinical settings.

Metabolism/Elimination

TDF Dosing in Children With Hepatic Impairment

- No change in TDF dosing is required for children with hepatic impairment.
- Stribild **should not be used** in children with severe hepatic impairment.
- Atripla^a, Symfi, and Symfi Lo^a should be used with caution in children with hepatic impairment; Symfi and Symfi Lo^a **are not recommended** for use in moderate or severe hepatic impairment.

TDF Dosing in Children With Renal Insufficiency

- The tenofovir metabolite of TDF is renally excreted.

<p>[Complera] FTC/Rilpivirine/TDF</p> <p><i>Child and Adolescent (Aged ≥12 Years and Weighing ≥35 kg) and Adult Dose</i></p> <ul style="list-style-type: none"> One tablet once daily in antiretroviral therapy (ART)–naïve adults with baseline HIV RNA ≤100,000 copies/mL. This dose of Complera also can be used in virologically suppressed (HIV RNA <50 copies/mL) adults who are currently on their first or second regimen and have no history of virologic failure or resistance to rilpivirine and other ARV drugs. Administer with a meal of ≥500 calories. <p>[Delstrigo] Doravirine/3TC/TDF</p> <p><i>Child and Adolescent (Weighing ≥35 kg) and Adult Dose</i></p> <ul style="list-style-type: none"> One tablet once daily in people who are ART-naïve and people who are ARV-experienced who have been virologically suppressed (HIV RNA <50 copies/mL) on a stable ARV regimen, with no history of treatment failure, and with no known mutations associated with resistance to the individual components of Delstrigo. <p>[Stribild] Elvitegravir/Cobicistat/FTC/TDF</p> <p><i>Adolescent (Weighing >35 kg With a Sexual Maturity Rating [SMR] of 4 or 5) and Adult Dose</i></p> <ul style="list-style-type: none"> One tablet once daily in ART-naïve adults. This dose of Stribild also can be used to replace the current ARV regimen in adolescents and adults who have been virologically suppressed (HIV RNA <50 copies/mL) on a stable ARV regimen, with no history of treatment failure, and with no known mutations associated with resistance to the individual components of Stribild. Administer with food. <p>[Symfi] EFV 600 mg/3TC/TDF</p> <p><i>Child and Adolescent (Weighing ≥40 kg) and Adult Dose</i></p> <ul style="list-style-type: none"> One tablet once daily Take on an empty stomach. <p>[Symfi Lo^a and Generic] EFV 400 mg/3TC/TDF</p> <p><i>Child and Adolescent (Weighing ≥35 kg) and Adult Dose</i></p> <ul style="list-style-type: none"> One tablet once daily Take on an empty stomach. 	<ul style="list-style-type: none"> The dose of TDF should be decreased in children with impaired renal function (creatinine clearance [CrCl] <50 mL/min). Consult the manufacturer's prescribing information for directions on how to adjust the dose in accordance with CrCl. The FDCs Atripla^a, Cimduo, Complera, Delstrigo, Symfi, Symfi Lo^a, or Temixys should not be used in children with CrCl <50 mL/min or in children who require dialysis. The FDC Truvada should not be used in children with CrCl <30 mL/min or in children who require dialysis. The FDC Stribild should not be initiated in children with estimated CrCl <70 mL/min and should be discontinued in children with estimated CrCl <50 mL/min. FTC and TDF require dosage adjustments in children with these levels of renal impairment, and such adjustments cannot be achieved with an FDC tablet.
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- Symfi Lo^a has not been studied in children (SMR 1–3), and major inter-individual variability in efavirenz (EFV) plasma concentrations has been found in children in a multi-ethnic setting. The 400-mg dose of EFV may be too low in children or adolescents with SMRs of 1–3 who weigh ≥ 40 kg. Some members of the Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV suggest therapeutic drug monitoring when used in children weighing ≥ 40 kg. See the [Efavirenz](#) section for more information.

[Temixys] 3TC/TDF

Child and Adolescent (Weighing ≥ 35 kg) and Adult Dose

- One tablet once daily

[Truvada] FTC/TDF

Child, Adolescent, and Adult Dose

Truvada Dosing Table

Body Weight	FTC/TDF Tablet Once Daily
17 kg to <22 kg	One FTC 100 mg/ TDF 150 mg tablet
22 kg to <28 kg	One FTC 133 mg/ TDF 200 mg tablet
28 kg to <35 kg	One FTC 167 mg/ TDF 250 mg tablet
≥ 35 kg and adults	One FTC 200 mg/ TDF 300 mg tablet

^a Brand name product has been discontinued; generic version is still available.

^b See the text for a discussion of the concerns about decreased bone mineral density in children who are receiving TDF, especially in prepubertal children and those in early puberty (SMR 1 or 2).

Drug Interactions

Additional information about drug interactions is available in the [Adult and Adolescent Antiretroviral Guidelines](#) and the [HIV Drug Interaction Checker](#).

- **Metabolism:** Tenofovir disoproxil fumarate (TDF) is a substrate of the adenosine triphosphate–dependent transporters P-glycoprotein and breast cancer resistance protein. When TDF is coadministered with inhibitors of these transporters, an increase in TDF absorption may be observed, with the potential for enhanced TDF toxicity.¹
- **Renal elimination:** Drugs that decrease renal function or compete for active tubular secretion could reduce clearance of plasma tenofovir (TFV). Avoid frequent or long-term use of nonsteroidal anti-inflammatory drugs in children who are taking TDF.

- *Other nucleoside reverse transcriptase inhibitors (NRTIs)*: Didanosine (ddI) serum concentrations increase when this drug is coadministered with TDF, and this combination **should not be used** because of the increased risk of ddI toxicity.
- *Protease inhibitors (PIs)*: Atazanavir (ATV) without ritonavir **should not be coadministered** with TDF, because TDF decreases ATV plasma concentrations. The combination of atazanavir/ritonavir, darunavir/ritonavir (DRV/r), and lopinavir/ritonavir increases plasma TFV concentrations and increases the risk of TDF-associated toxicity.^{1,2}
- *Absorption*: Administering elvitegravir (EVG) concurrently with antacids and supplements that contain iron, calcium, aluminum, and/or magnesium lowers plasma concentrations of EVG. Similarly, dolutegravir (DTG) should be taken 2 hours before or 6 hours after taking cation-containing antacids or laxatives, sucralfate, oral iron supplements, oral calcium supplements, or buffered medications.³ If using Stribild, see the [Elvitegravir](#) section of [Appendix A. Pediatric Antiretroviral Drug Information](#) for additional information.

Major Toxicities

- *More common*: Nausea, diarrhea, vomiting, flatulence
- *Less common (more severe)*: TDF caused bone toxicity (osteomalacia and reduced bone mineral density [BMD]) in animals when given in high doses. Decreases in BMD have been reported in both adults and children taking TDF. Renal toxicity—including increased serum creatinine, glycosuria, proteinuria, phosphaturia, and/or calcinuria and decreased serum phosphate—has been observed. Children at increased risk of renal glomerular or tubular dysfunction should be closely monitored. Cases of lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported.

Resistance

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

Pediatric Use

Approval

TDF has been approved by the U.S. Food and Drug Administration (FDA) for use in children aged ≥ 2 years and weighing ≥ 10 kg when used as a component of antiretroviral therapy (ART). TDF is available as a component of fixed-dose combination tablets (see [Appendix A, Table 2. Antiretroviral Fixed-Dose Combination Tablets and Co-packaged Formulations: Minimum Body Weights and Considerations for Use in Children and Adolescents](#)).

TDF has antiviral activity and efficacy against hepatitis B virus (HBV) and is approved by the FDA for HBV treatment in children aged ≥ 2 years and weighing ≥ 10 kg. For a comprehensive review of this topic, see the [Hepatitis B Virus](#) section in the [Pediatric Opportunistic Infection Guidelines](#).

Efficacy in Clinical Trials in Adults Compared With Children and Adolescents

The standard adult dose that was approved by the FDA for adults and children aged ≥ 12 years and weighing ≥ 35 kg is TDF 300 mg once daily. For children aged 2 to 12 years, the FDA-approved dose

is TDF 8 mg/kg per dose administered once daily, which closely approximates the dose of TDF 208 mg/m² per dose used in early studies in children.⁴

In adults, the recommended once-daily dose of TDF 300 mg is highly effective when used in combination with other antiretroviral (ARV) drugs.⁵⁻¹² The FDA-approved Cimduo and Temixys (both of which contain lamivudine [3TC] 300 mg/TDF 300 mg) and Symfi (efavirenz [EFV] 600 mg/3TC 300 mg/TDF 300 mg) based on results of prior clinical trials.^{6,13} FDA approval of Symfi Lo^a (EFV 400 mg/3TC 300 mg/TDF 300 mg) was based on a study that compared the use of EFV 400 mg with the use of EFV 600 mg, each administered with emtricitabine 200 mg and TDF 300 mg, in 630 ART-naïve adults.¹⁴ See the [Efavirenz](#) section for a detailed discussion of this study. In a large randomized controlled trial comparing second-line ART regimens, continuing TDF was superior to switching to zidovudine (ZDV) when given in combination with 3TC and either DTG or DRV/r.¹⁵⁻¹⁷

In children, the published efficacy data for TDF-containing ARV combinations are mixed, but potency equal to that in adults has been seen in children aged 3 to 18 years with susceptible virus. A recent clinical trial of adolescents without prior documented resistance who initiated or switched to a fixed-dose combination of doravirine/3TC/TDF demonstrated plasma concentrations comparable to those measured in adults for all three agents and >90% viral suppression through 96 weeks.^{18,19} In children aged 2 years to <12 years, TDF 8 mg/kg per dose once daily was non-inferior to twice-daily ZDV-containing ART or stavudine-containing ART over 48 weeks of randomized treatment.^{20,21} Virologic success is lower in treatment-experienced children and adolescents with extensive multiclass drug resistance.²²⁻²⁴ In an analysis of genotypic resistance testing performed on 650 unique children at a single laboratory in the Republic of South Africa, predicted intermediate or high-level resistance to TDF was lower for children experiencing virologic failure while on abacavir (ABC)-containing (8.5%) and ZDV-containing (9.4%) regimens than those experiencing virologic failure while on a TDF-containing regimen (24.6%). Clinical data are lacking in children on the efficacy of switching from a failing regimen containing these NRTIs to a regimen containing TDF.²⁵

Pharmacokinetics

Relationship of Drug Exposure to Virologic Response

Virologic suppression is most closely related to intracellular tenofovir diphosphate (TFV-DP) concentrations and, for TDF, intracellular TFV-DP is linked to plasma TFV concentration.²⁶ A modeling study suggests that children and adolescents who are treated with TDF may have higher intracellular TFV-DP concentrations than adults,²⁷ even though plasma TFV concentrations are lower in children and adolescents, because weight-adjusted renal clearance of TFV is higher in children than in adults.^{4,28,29}

Formulations

Special Considerations

The taste-masked granules that make up the TDF oral powder give the vehicle (e.g., applesauce, yogurt) a gritty consistency. Once mixed with a vehicle, TDF should be administered promptly because its taste becomes bitter when it is allowed to sit for too long.

Toxicity

Bone Toxicity

TDF administration is associated with decreased BMD in both adults^{30,31} and children.^{21,32-34} When treated with TDF, younger children with sexual maturity ratings (SMRs) of 1 and 2 may be at a higher risk of decreased BMD than children with more advanced pubertal development (i.e., SMRs ≥ 3).²⁸ Discontinuation of TDF results in partial or complete recovery of BMD.^{32,35}

In the study that led to FDA approval of TDF in adolescents aged ≥ 12 years and weighing ≥ 35 kg, 6 of 33 participants (18%) in the TDF arm experienced a $>4\%$ decline in absolute lumbar spine BMD in 48 weeks, whereas only 1 of 33 participants (3%) in the placebo arm experienced this decline.²²

TDF administration disrupts vitamin D metabolism,^{36,37} and the decrease in BMD associated with TDF initiation was attenuated in adults with coadministration of high doses of vitamin D3 (4,000 IU daily) and calcium carbonate (1,000 mg daily) for the first 48 weeks of TDF treatment.³⁸ During chronic TDF administration, youth with HIV who received vitamin D3 supplements (50,000 IU once monthly) had decreased serum parathyroid hormone levels and increased lumbar spine BMD compared with study participants who were not treated with high doses of vitamin D3.^{36,39} The serum 25-hydroxy vitamin D concentration was 37 ng/mL in the group with improved BMD. Similar improvements in BMD were seen in youth with HIV who were treated with an ARV regimen that included TDF and who received vitamin D3 2,000 IU or 4,000 IU daily.⁴⁰ Measurement of plasma vitamin D concentration is recommended for children who are being treated with an ARV regimen that includes TDF, and vitamin D supplementation is recommended for those with vitamin D deficiency (see [Table 17j. Osteopenia and Osteoporosis](#)).

High concentrations of the TDF metabolite plasma TFV have been associated with TDF-related endocrine disruption and low BMD.⁴¹ Plasma TFV concentrations are higher when TDF is coadministered with boosted PIs.¹ Tenofovir alafenamide (TAF), which is associated with lower plasma TFV concentrations than TDF, has less effect on parathyroid hormone levels⁴² and causes less decline in BMD than TDF. See the [Tenofovir Alafenamide](#) section for more information. Consider switching from TDF to TAF or avoiding coadministration of TDF with boosted PIs in children for whom loss of BMD is a concern.

Monitoring Potential Bone Toxicity

The Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV (the Panel) **does not recommend** routine dual-energy X-ray absorptiometry monitoring for children or adolescents who are being treated with TDF (see [Table 17j. Osteopenia and Osteoporosis](#)).

TDF has been shown to be effective, and it can be administered once daily; however, the use of TDF has been associated with a risk of BMD loss. Because childhood and early adolescence are important periods of rapid bone accrual, and because children with perinatally acquired HIV are at risk for low peak bone mass,^{43,44} the Panel favors the use of ABC or TAF over TDF in children with SMRs 1 to 3.

Renal Toxicity

New-onset renal impairment and worsening renal impairment have been reported in adults⁴⁵ and children^{46,47} receiving TDF. In one study, renal toxicity led to the discontinuation of TDF in 6 of 159 (3.7%) children with HIV who were treated with TDF.²⁴ Although TDF is clearly associated with a decline in glomerular filtration rate, the effect is generally small, and severe glomerular toxicity is rare.^{45,46} Irreversible renal failure is quite rare, but cases have been reported.⁴⁸

The main target of TDF nephrotoxicity is the renal proximal tubule.⁴⁶ Case reports highlight the infrequent but most severe manifestations of renal Fanconi syndrome, hypophosphatemia, hypocalcemia, diabetes insipidus, myalgias, bone pain, and fractures.^{49,50}

Subclinical renal tubular damage is more common than clinically apparent renal tubular injury. Increased urinary beta-2 microglobulin was identified in 12 of 44 children (27%) who were treated with TDF and in 2 of 48 children (4%) who were not treated with TDF.⁵¹ The risks of TDF-associated proteinuria and chronic kidney disease increase with the duration of treatment.^{52,53} Of 89 participants aged 2 to 12 years who received TDF in Gilead Study 352 (where participants had a median drug exposure of 104 weeks), four participants were discontinued from the study for renal tubular dysfunction, with the discontinuations occurring between 84 and 156 weeks on TDF therapy.²⁰ In adults, renal dysfunction is more common when TDF is used in people with older age or a pre-existing renal disease⁵⁴; in children, renal dysfunction may be more common when TDF is used with boosted PIs than with non-nucleoside reverse transcriptase inhibitors.⁵⁵

Plasma TFV is the TDF metabolite most closely associated with both glomerular^{41,56} and proximal tubular⁵⁷ toxicity. As previously noted, plasma TFV concentrations are higher when TDF is coadministered with boosted PIs.¹ TAF, which generates lower plasma TFV concentrations than TDF, is associated with a lower risk of renal toxicity than TDF⁵⁸ (see [Tenofovir Alafenamide](#)).

Monitoring Potential Renal Toxicity

Because TDF has the potential to decrease creatinine clearance and cause renal tubular dysfunction, the Panel recommends measuring serum creatinine and using a urine dipstick to check protein and glucose concentration before initiating TDF. It is unclear how often creatinine and renal tubular function (urine protein and glucose) should be monitored in asymptomatic children. Many Panel members monitor creatinine with other blood tests every 3 to 4 months and perform urinalysis every 6 to 12 months. Serum phosphate should be measured if clinically indicated; renal phosphate loss can occur in the presence of normal creatinine and in the absence of proteinuria. Because nephrotoxicity increases with the duration of TDF treatment, monitoring should be continued during long-term therapy with the drug.

Because renal glomerular damage primarily increases the concentration of albumin in urine, and proximal renal tubular damage increases the concentration of low-molecular-weight proteins like beta-2 microglobulin in urine, dipstick urinalysis (which primarily measures urine albumin) may be a relatively insensitive marker for TDF-associated tubular damage. Measuring urine albumin and urine protein and calculating the ratio of urine albumin to urine protein can be helpful in identifying the non-albumin proteinuria that is seen in TDF-associated nephrotoxicity.^{59,60} Although these more complex and expensive tests may be used in research settings, in clinical practice, using a renal dipstick to identify normoglycemic glycosuria and proteinuria is the easiest way to detect renal damage.

Zidovudine (ZDV, Retrovir)

Updated: June 25, 2026

Reviewed: June 25, 2026

Formulations					
Syrup: 10 mg/mL					
Capsule: 100 mg					
Concentrate for Injection or Intravenous Infusion: 10 mg/mL (Retrovir)					
Generic Formulations					
<ul style="list-style-type: none">100-mg capsule10-mg/mL syrup300-mg tablet					
Fixed-Dose Combination (FDC) Tablets					
<ul style="list-style-type: none">[Generic] Lamivudine 150 mg/zidovudine 300 mg (scored)[Generic] Abacavir 300 mg/lamivudine 150 mg/zidovudine 300 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	Selected Adverse Events				
<p>Note: Zidovudine (ZDV) is frequently used in neonates to prevent perinatal transmission of HIV. See Antiretroviral Management of Infants With In Utero, Intrapartum, or Breastfeeding Exposure to HIV and Table 13 for information about using ZDV to prevent perinatal HIV transmission.</p> <p>Recommended Neonatal Dose for Treatment of HIV by Gestational Age at Birth^a</p> <table><tr><th>Gestational Age at Birth</th><th>Oral ZDV Dose</th></tr><tr><td>≥35 Weeks</td><td><p>Birth to Age 4 Weeks</p><ul style="list-style-type: none">ZDV 4 mg/kg twice daily; <i>or</i>Alternative simplified weight-band dosing</td></tr></table>	Gestational Age at Birth	Oral ZDV Dose	≥35 Weeks	<p>Birth to Age 4 Weeks</p> <ul style="list-style-type: none">ZDV 4 mg/kg twice daily; <i>or</i>Alternative simplified weight-band dosing	<ul style="list-style-type: none">Bone marrow suppression leading to anemia and neutropenia, macrocytosis with or without anemiaNausea, vomiting, headache, insomnia, astheniaLactic acidosis/severe hepatomegaly with hepatic steatosisLipodystrophy and lipoatrophyMyopathy (associated with prolonged use of ZDV) and myositis
Gestational Age at Birth	Oral ZDV Dose				
≥35 Weeks	<p>Birth to Age 4 Weeks</p> <ul style="list-style-type: none">ZDV 4 mg/kg twice daily; <i>or</i>Alternative simplified weight-band dosing				
	Special Instructions				
	<ul style="list-style-type: none">Give ZDV without regard to food.Initial ZDV dose should be based on weight at birth and estimated gestational age at delivery.Dose reduction is not recommended for anticipated weight loss in the first few weeks of life unless clinically indicated for renal or hepatic impairment.				

	<p>Simplified Weight-Band Dosing for Infants With a Gestational Age ≥ 35 Weeks at Birth</p> <p>Note: The doses in this table provide approximately ZDV 4 mg/kg twice daily from birth to age 4 weeks.</p> <table><tr><th>Weight Band</th><th>Twice-Daily Volume of ZDV 10 mg/mL Syrup</th></tr><tr><td>2 kg to <3 kg</td><td>1 mL</td></tr><tr><td>3 kg to <4 kg</td><td>1.5 mL</td></tr><tr><td>4 kg to <5 kg</td><td>2 mL</td></tr></table> <p>Aged >4 Weeks</p> <ul style="list-style-type: none">ZDV 12 mg/kg twice daily	Weight Band	Twice-Daily Volume of ZDV 10 mg/mL Syrup	2 kg to <3 kg	1 mL	3 kg to <4 kg	1.5 mL	4 kg to <5 kg	2 mL	<ul style="list-style-type: none">Simplified weight-band dosing is indicated only for infants with gestational age of ≥ 35 weeks.If substantial granulocytopenia or anemia develops in patients who are receiving ZDV, it may be necessary to discontinue therapy until bone marrow recovery is observed. In this setting, some patients may require erythropoietin or filgrastim injections or transfusions of red blood cells.Screen patients for hepatitis B virus (HBV) infection before using FDC products that contain lamivudine (3TC). Severe acute exacerbation of HBV infection can occur when 3TC is discontinued; therefore, hepatic function should be monitored for several months after patients with HBV infection stop taking 3TC.
Weight Band	Twice-Daily Volume of ZDV 10 mg/mL Syrup									
2 kg to <3 kg	1 mL									
3 kg to <4 kg	1.5 mL									
4 kg to <5 kg	2 mL									
≥ 30 Weeks to <35 Weeks	<p>Birth to Age 2 Weeks</p> <ul style="list-style-type: none">ZDV 2 mg/kg twice daily <p>Aged 2 Weeks to 6 Weeks</p> <ul style="list-style-type: none">ZDV 3 mg/kg twice daily <p>Aged >6 Weeks</p> <ul style="list-style-type: none">ZDV 12 mg/kg twice daily									
<30 Weeks	<p>Birth to Age 4 Weeks</p> <ul style="list-style-type: none">ZDV 2 mg/kg twice daily <p>Aged 4 Weeks to 8 Weeks</p> <ul style="list-style-type: none">ZDV 3 mg/kg twice daily <p>Aged >8 Weeks</p> <ul style="list-style-type: none">ZDV 12 mg/kg twice daily									

Note: For infants who are unable to tolerate oral agents, the intravenous dose should be 75% of the oral dose, but the dosing interval should remain the same.

Infant (Aged ≥ 35 Weeks Postconception and ≥ 4 Weeks Postdelivery, Weighing ≥ 4 kg) and Child Dose Weight-Based Dosing for ZDV

Weight	Twice-Daily Dosing
4 kg to <9 kg	12 mg/kg
9 kg to <30 kg	9 mg/kg
≥ 30 kg	300 mg

Metabolism/Elimination

- ZDV is eliminated primarily by hepatic metabolism. The major metabolite is ZDV glucuronide, which is renally excreted.
- ZDV is phosphorylated intracellularly to active ZDV triphosphate.

ZDV Dosing in Patients With Hepatic Impairment

- The dose of ZDV may need to be reduced in patients with hepatic impairment.
- Do not use FDC products in patients who have impaired hepatic function.

ZDV Dosing in Patients With Renal Impairment

- A dose adjustment is required for ZDV in patients with renal failure¹ (see the [manufacturer's prescribing information](#) and Pharmacokinetics below). Do not use FDC products in patients with creatinine clearance <50 mL/min or in patients who are on hemodialysis.

<p>Alternative Body Surface Area Dosing</p> <p><i>Oral</i></p> <ul style="list-style-type: none"> • ZDV 180–240 mg per m² of body surface area every 12 hours <p>Child and Adolescent (Weighing ≥30 kg) and Adult Dose</p> <ul style="list-style-type: none"> • ZDV 300 mg twice daily <p>Lamivudine (3TC)/ZDV</p> <p><i>Child and Adolescent (Weighing ≥30 kg) and Adult Dose</i></p> <ul style="list-style-type: none"> • One tablet twice daily <p>Abacavir/3TC/ZDV</p> <p><i>Child and Adolescent (Weighing ≥30 kg) and Adult Dose</i></p> <ul style="list-style-type: none"> • One tablet twice daily 	
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^a For premature infants who receive an HIV diagnosis, the time to change to the continuation dose varies with postgestational age and clinical status of the infant.

Drug Interactions

Additional information about drug interactions is available in the [Liverpool HIV Drug Interaction Checker](#).

- *Bone marrow suppressive/cytotoxic agents, including ganciclovir, valganciclovir, interferon alfa, and ribavirin:* These agents may increase the hematologic toxicity of zidovudine (ZDV).
- *Nucleoside analogues that affect DNA replication:* Nucleoside analogues—such as ribavirin—antagonize *in vitro* antiviral activity of ZDV.
- *Doxorubicin:* Simultaneous use of doxorubicin and ZDV **should be avoided**. Doxorubicin may inhibit the phosphorylation of ZDV to its active form.

Major Toxicities

- *More common:* Hematologic toxicity, including neutropenia and anemia, particularly in patients with advanced HIV disease. Headache, malaise, nausea, vomiting, and anorexia. Neutropenia may occur more frequently in infants who are receiving both lamivudine (3TC) and ZDV than in infants who are receiving only ZDV.²
- *Less common (more severe):* Myopathy (associated with prolonged use), myositis, and liver toxicity. Cases of lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported. Fat maldistribution has been observed in patients receiving antiretroviral (ARV) medications.
- *Rare:* Possible increased risk of cardiomyopathy.³⁻⁵

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

Pediatric experience with ZDV—both for treating HIV and for preventing perinatal transmission—is extensive.⁶⁻⁹ However, the mitochondrial toxicity of ZDV leads many experts to favor the use of abacavir (ABC) or tenofovir alafenamide in cases where the individual's age and the results of viral resistance testing do not restrict the use of these drugs.

Efficacy in Clinical Trials

ZDV—an NRTI (nucleoside reverse transcriptase inhibitor)—has been extensively studied in pediatric clinical trials with other NRTIs (i.e., ABC, 3TC, stavudine) as part of an antiretroviral therapy (ART) regimen. All ZDV-based dual-NRTI regimens had low toxicity and produced good clinical, immunologic, and virologic responses.¹⁰⁻¹³

For second-line ART, ZDV as an NRTI backbone may be less effective than ABC or tenofovir.^{14,15} In the NADIA study in adults and adolescents, a higher likelihood of the emergence of dolutegravir (DTG) resistance was seen in the participants receiving ZDV compared to those on tenofovir disoproxil fumarate as an NRTI backbone.¹⁴ Recently, a secondary analysis of the ODYSSEY study in infants, children, and adolescents starting first-line or second-line treatment with DTG-based ART versus standard of care (non-nucleoside reverse transcriptase inhibitor, boosted protease inhibitor, or non-DTG integrase strand transfer inhibitor) was performed. Participants starting second-line DTG-based ART with ZDV were more likely to experience virologic failure than those on an ABC or tenofovir backbone.¹⁵ Because ZDV needs to be taken twice daily, lower adherence may be responsible for the higher virologic failure rates in both children and adults¹⁵ (see [Recognizing and Managing Antiretroviral Treatment Failure](#)).

Infants With Perinatal HIV Exposure

The Pediatric AIDS Clinical Trials Group (PACTG) 076 clinical trial¹⁶ demonstrated that administering ZDV to pregnant women and their infants could reduce the risk of perinatal HIV transmission by nearly 70%. See [Antiretroviral Management of Infants With *In Utero*, Intrapartum, or Breastfeeding Exposure to HIV](#) for further discussion on using ZDV to prevent perinatal transmission of HIV. A ZDV dose of approximately 4 mg/kg of body weight every 12 hours is recommended for prevention of perinatal HIV transmission in neonates and infants with gestational ages ≥ 35 weeks. Infants who have been exposed to HIV but are uninfected should continue on the prophylactic dose for 2 to 6 weeks, depending on their gestational age at time of delivery and the risk assessment for perinatal transmission.

Simplified, alternative weight-band dosing has also been developed, and the rationale for these doses is based on the intracellular metabolism of ZDV (see Pharmacokinetics below). The rate-limiting step in the phosphorylation of ZDV to active ZDV triphosphate is the limited amount of thymidylate kinase. Increasing the dose of ZDV will lead to increased ZDV plasma concentrations and increased intracellular concentrations of ZDV monophosphate, but not to increased concentrations of ZDV diphosphate or ZDV triphosphate.

In 31 infants who received ZDV to prevent perinatal transmission, levels of intracellular ZDV metabolites were measured after delivery. Plasma ZDV and intracellular ZDV monophosphate decreased by roughly 50% between postdelivery Day 1 and Day 28, whereas ZDV diphosphate and ZDV triphosphate remained low throughout the sampling period.¹⁷ ZDV dose is poorly correlated with the active form of ZDV that is found intracellularly. Because of this, a simplified weight-band dosing approach can be used for the first 4 weeks of life in infants with gestational ages ≥ 35 weeks

(see the dosing table above). This approach should simplify the minor dose adjustments that are commonly made due to changes in infant weight during ZDV use in the first 4 weeks of life and will make it easier for caregivers to administer ZDV oral syrup to their infants. The changes in weight and the small differences in ZDV dose will have minor effects on the intracellular concentrations of ZDV triphosphate.

Infants With HIV Infection

The Early Infant Treatment Study in Botswana evaluated the safety and efficacy of initiation of ART in the first week of life. Forty infants who tested positive for HIV within 96 hours of birth were started on ZDV, 3TC, and nevirapine (NVP) with successful transition to lopinavir/ritonavir (LPV/r) at 2 to 5 weeks after delivery. Early treatment was found to be safe and effective, with most infants achieving and maintaining viral suppression by 24 weeks of age.¹⁸

For full-term neonates who receive an HIV diagnosis during the first days to weeks of life, the ZDV dose should be increased to the continuation dose at age 4 weeks (see the dosing table above). The activity of the enzymes responsible for glucuronidation is low at birth and increases dramatically during the first 4 to 6 weeks of life in full-term neonates. This increase in metabolizing enzyme activity leads to an increased clearance of plasma ZDV, and the dose of ZDV should be adjusted when ZDV is used to treat HIV after the first 4 weeks in full-term infants.

For premature infants who receive an HIV diagnosis, the time to increase the ZDV dose from the initial dose varies with **postnatal** age and the clinical status of the neonate. On the basis of population pharmacokinetic (PK) modeling and simulations and data from studies that have evaluated ZDV PKs in premature infants, the Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV recommends the following:

- For infants with HIV born at ≥ 30 weeks to < 35 weeks, switch to a dose of ZDV 12 mg/kg twice daily at a **postnatal** age of > 6 weeks.
- For infants born at < 30 weeks, switch to ZDV 12 mg/kg twice daily at a **postnatal** age of > 8 weeks.¹⁹

Clinicians should perform a careful clinical assessment of the infant, evaluate hepatic and renal function, and review concomitant medications before increasing the ZDV dose to the dose recommended for full-term infants.

Pharmacokinetics

ZDV undergoes intracellular metabolism to achieve its active form, ZDV triphosphate. Phosphorylation requires multiple steps: ZDV is phosphorylated by thymidine kinase to ZDV monophosphate, ZDV monophosphate is phosphorylated by thymidylate kinase to ZDV diphosphate, and ZDV diphosphate is phosphorylated by nucleoside diphosphate kinase to ZDV triphosphate. Overall, ZDV PK in infants aged > 3 months are like those seen in adults. Although the mean half-life of intracellular ZDV triphosphate (9.1 hours) is considerably longer than that of unmetabolized ZDV in plasma (1.5 hours), once-daily ZDV dosing is not recommended because of the low intracellular ZDV triphosphate concentrations seen with 600-mg, once-daily dosing in adolescents.²⁰ PK studies, such as PACTG 331, demonstrate that dose adjustments are necessary for premature infants because they have reduced clearance of ZDV compared with the clearance observed in term newborns of similar postnatal ages.⁷ ZDV has good central nervous system (CNS) penetration (cerebrospinal fluid-to-plasma concentration ratio is 0.68), and ZDV has been used in children with HIV-related CNS disease.⁹

PK and safety of ZDV, 3TC, and LPV/r in children with HIV and severe acute malnutrition (SAM) were studied in International Maternal, Pediatric, Adolescent AIDS Clinical Trials (IMPAACT) P1092.²¹ Steady-state PK, safety, and tolerability were compared in children with HIV with and without SAM. Overall safety and tolerability did not differ between the two cohorts, and similar area-under-the-curve values for ZDV, 3TC, and LPV/r were observed in these children who were dosed according to World Health Organization weight-band dosing recommendations.²¹

ZDV clearance is decreased in patients with impaired renal function. A dose reduction of 50% is recommended for adolescents and adults with renal failure (creatinine clearance [CrCl] <15 mL/min) or on hemodialysis or peritoneal dialysis (see the [manufacturer's prescribing information](#)). Although no neonate-specific data exist, based on expert opinion, a similar dose reduction of 50% is recommended in neonates with renal failure (CrCl < 10 mL/min).

The PK of intravenous ZDV in a premature neonate with gestational age of 32 weeks on extra corporal membrane oxygenation (ECMO) has been reported in a single case report. Based on measurements of ZDV plasma concentrations during and after ECMO, the authors concluded that ECMO did not have an impact on ZDV PK and that standard intravenous dosing of ZDV can be used in preterm neonates.²²

Toxicity

Several studies suggest that the adverse hematologic effects of ZDV may be concentration-dependent, with a higher risk of anemia and neutropenia in patients who have higher mean plasma area-under-the-curve values for ZDV.^{6,7,23} A significant reduction in the incidence of hematologic toxicity was observed during a retrospective analysis of infants who received a short course of ZDV (2 weeks) to prevent perinatal HIV transmission.²⁴ In this study, 137 infants received ZDV for 2 weeks, and 184 infants received ZDV for >2 weeks; of these infants, 168 (91.3%) received 4 weeks of ZDV prophylaxis. The risk of anemia (defined as a Division of AIDS severity grade of mild or higher) was significantly lower in the short-course group at both age 1 month ($P < 0.001$) and age 3 months ($P < 0.001$).²⁴ For infants who develop significant anemia while receiving ZDV for prevention of perinatal HIV transmission, early discontinuation may be considered for infants who are determined to be at a low risk of transmission after expert consultation. A prospective cohort study conducted in Thailand evaluated the safety of triple ARV neonatal presumptive therapy with ZDV/3TC/NVP for 6 weeks in infants at high risk of acquisition of HIV compared with 4 weeks of monotherapy with ZDV in infants considered at low risk. No significant differences were observed in the incidence of neutropenia, hepatotoxicity, or severe anemia between the triple ARV and the ZDV monotherapy groups.²⁵

Incidence of hematological toxicity was investigated in the ARROW study, which randomized Ugandan and Zimbabwean children who were ART-naïve to receive either ZDV-containing regimens or ABC-containing regimens. The incidence of severe anemia was similar regardless of ZDV use; this finding suggests that advanced HIV disease contributed to low hemoglobin values. ZDV use was associated with severe neutropenia in a small number of children.²⁶ In a retrospective study conducted in Ethiopia, an evaluation of predictors of anemia among children on ART²⁷ was conducted from 2007 to 2017. Study participants receiving ZDV-containing regimens were four times more likely to develop anemia than children receiving ABC-containing regimens. Other predictors of anemia in addition to ZDV in this patient population included tuberculosis, severe immunosuppression, and undernutrition.

ZDV is associated with greater mitochondrial toxicity than ABC and tenofovir disoproxil fumarate.^{28,29}

Although the incidence of cardiomyopathy associated with perinatal HIV infection has decreased dramatically since the use of ART became routine, the use of a regimen that contains ZDV may increase the risk.^{3,5} Analysis of data from a U.S.-based multicenter prospective cohort

study (PACTG 219/219C) found that ongoing ZDV exposure was independently associated with a higher rate of cardiomyopathy.³ As part of the Pediatric HIV/AIDS Cohort Study (PHACS)/Adolescent Master Protocol (AMP) study, echocardiogram measurements were collected between 2008 and 2010 in 325 youth aged 7 to 16 years with perinatally acquired HIV infection. An association between ZDV use and increased end-systolic wall stress was observed in this study. The investigators speculate that alterations in cardiac structure in these children could progress to symptomatic cardiomyopathy later in life.⁴ A large cohort study to evaluate the prevalence of cardiac dysfunction in children and young adults <26 years of age was conducted in Kenya.⁵ Approximately 28% of participants were found to have evidence of early cardiac dysfunction. Left ventricular ejection fraction negatively correlated with prior ZDV exposure, detectable HIV RNA, and elevated interleukin-6 concentrations.⁵

APPENDIX A: PEDIATRIC ANTIRETROVIRAL DRUG INFORMATION

Non-nucleoside Analogue Reverse Transcriptase Inhibitors

Doravirine (DOR, Pifeltro)

Efavirenz (EFV, Sustiva)

Etravirine (ETR, Intelence)

Nevirapine (NVP, Viramune)

Rilpivirine (RPV, Edurant)

Doravirine (DOR, Pifeltro)

Updated: September 30, 2025

Reviewed: June 25, 2026

Formulations	
<p>Tablet: 100 mg</p> <p>Fixed-Dose Combination (FDC) Tablet</p> <ul style="list-style-type: none"> [Delstrigo] Doravirine 100 mg/lamivudine 300 mg/tenofovir disoproxil fumarate 300 mg <p>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.</p> <p>For additional information, see Drugs@FDA or DailyMed.</p>	
Dosing Recommendations	Selected Adverse Events
<p>Child and Adolescent (Weighing ≥ 35 kg) and Adult Dose</p> <ul style="list-style-type: none"> Doravirine (DOR) 100 mg once daily in antiretroviral (ARV)-naïve and ARV-experienced people who have been virologically suppressed (HIV RNA <50 copies/mL) on a stable ARV regimen with no history of treatment failure and no known mutations associated with resistance to DOR <p>[Delstrigo] DOR/Lamivudine (3TC)/Tenofovir Disoproxil Fumarate (TDF)</p> <p><i>Child and Adolescent (Weighing ≥ 35 kg) and Adult Dose</i></p> <ul style="list-style-type: none"> One tablet once daily in ARV-naïve and ARV-experienced people who have been virologically suppressed (HIV RNA <50 copies/mL) on a stable ARV regimen with no history of treatment failure and no known mutations associated with resistance to the individual components of Delstrigo 	<ul style="list-style-type: none"> Nausea Abdominal pain Diarrhea Abnormal dreams Insomnia, somnolence
	Special Instructions
	<ul style="list-style-type: none"> DOR can be taken with or without food. Screen children for hepatitis B virus (HBV) infection before using Delstrigo, which contains 3TC and TDF. Severe acute exacerbation of HBV can occur when 3TC or TDF are discontinued; therefore, hepatic function and HBV viral load should be monitored for several months after halting therapy with 3TC or TDF.
	Metabolism/Elimination
	<ul style="list-style-type: none"> DOR is metabolized by the enzyme cytochrome P450 3A. DOR has multiple interactions with several drugs (see the Drug Interactions section below). <p>DOR Dosing in Children With Hepatic Impairment</p> <ul style="list-style-type: none"> Dose adjustment is not required in children with mild or moderate hepatic impairment. DOR has not been studied in people with severe hepatic impairment.

	<p>DOR Dosing in Children With Renal Impairment</p> <ul style="list-style-type: none"> • Dose adjustment is not required when using DOR in children with mild, moderate, or severe renal impairment. DOR use has not been studied in people with end-stage renal disease or in people on dialysis. • DOR administered with 3TC and TDF as components of Delstrigo is not recommended in children with estimated creatinine clearance <50 mL/min.
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Drug Interactions

Additional information about drug interactions is available in the [Liverpool HIV Drug Interaction Checker](#).

- Doravirine (DOR) is a cytochrome P450 (CYP) 3A substrate that is associated with several important drug interactions with drugs that are strong CYP3A enzyme inducers. Coadministration with these drugs may cause significant decreases in DOR plasma concentrations and potential decreases in efficacy, which can lead to the development of resistance. Before DOR is administered, a child's medication profile should be reviewed carefully for potential drug interactions with DOR.^{1,2}
- In a Phase 1 trial (described below under Efficacy in Clinical Trials), DOR plasma exposure transiently decreased by 62% when DOR was started immediately after stopping efavirenz (EFV). A *post hoc* analysis of the Phase 3 DRIVE-SHIFT study (described below under Efficacy in Clinical Trials), however, showed that at Week 4, DOR plasma levels in participants who had switched from an EFV-based regimen to a DOR-based regimen were similar to DOR plasma levels in participants who switched from a protease inhibitor (PI)-based regimen to a DOR-based regimen (all of the regimens in the study used a backbone of lamivudine [3TC] plus tenofovir disoproxil fumarate [TDF]).³ A similar effect of prior EFV-based antiretroviral therapy (ART) on the pharmacokinetics (PK) of DOR was demonstrated in IMPAACT 2014 (described below under Efficacy in Clinical Trials) among adolescents weighing ≥45 kg who switched from EFV-based ART to DOR-based ART with 3TC/TDF.⁴
- DOR **should not be coadministered** with the following drugs: the anticonvulsants carbamazepine, oxcarbazepine, phenobarbital, and phenytoin; the androgen receptor inhibitor enzalutamide; the antimycobacterials rifampin and rifapentine; the cytotoxic agent mitotane; or St. John's wort.^{5,6}
- Drug interactions between DOR and rifabutin induce the metabolism of DOR and **require an additional dose of DOR 100 mg to be administered 12 hours** after a fixed-dose combination of DOR/3TC/TDF or an increase of the DOR dose to 100 mg twice daily.^{2,5,6}

Major Toxicities

- *More common*: Nausea, headache, fatigue, diarrhea, abdominal pain, abnormal dreams.
- *Less common (more severe)*: Neuropsychiatric adverse events (AEs), including insomnia, somnolence, dizziness, depression, suicidality, altered consciousness, and altered sensorium. Autoimmune disorder and immune reconstitution inflammatory syndrome may occur. Serious reactions can also include severe skin and hypersensitivity reactions.

Resistance

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

DOR is expected to have activity against HIV with isolated non-nucleoside reverse transcriptase inhibitor (NNRTI) resistance that is associated with mutations at positions 103, 181, or 190. Some single mutations and combinations of viral mutations, however, have been shown to significantly decrease susceptibility to DOR. Specifically, clinical HIV isolates containing the Y188L mutation alone or in combinations with K103N or V106I, combinations of V106A with G190A and F227L, or combinations of E138K with Y181C and M230L have shown ≥ 100 -fold reduction in susceptibility to DOR.^{5,6} In children with multiple NNRTI mutations, consult an HIV expert and a resistance database to evaluate the potential efficacy of DOR.

Pediatric Use

Approval

DOR is approved by the U.S. Food and Drug Administration (FDA) for use in children and adolescents weighing ≥ 35 kg.^{5,6} [IMPAACT 2014](#), a Phase 1/2 study (described below under Efficacy in Clinical Trials) evaluated the PK, safety, and tolerability of DOR and DOR/3TC/TDF in children and adolescents with HIV.^{4,7}

Efficacy in Clinical Trials

The efficacy of DOR was evaluated using data from four randomized adult clinical trials. The first study was a Phase 2b dose-selection, double-blind trial that enrolled adults with HIV who were treatment-naïve.⁸ The efficacy trials included two randomized, multicenter, double-blind, active-controlled Phase 3 trials ([DRIVE-FORWARD](#) and [DRIVE-AHEAD](#)) in treatment-naïve adults⁹⁻¹³ and one open-label, active-controlled, randomized noninferiority trial that enrolled virologically suppressed adults on ART ([DRIVE-SHIFT](#)).¹⁴

In the DRIVE-FORWARD trial, adults with HIV were randomized to receive either DOR 100 mg (n = 383) or darunavir 800 mg/ritonavir 100 mg (DRV/r) (n = 383) once daily, each in combination with emtricitabine (FTC)/TDF or abacavir/3TC.^{9,11} In the DRIVE-AHEAD trial, adults received either coformulated DOR/3TC/TDF (n = 364) or EFV/FTC/TDF (n = 364) once daily.^{10,12} An integrated efficacy analysis from both trials (DRIVE-FORWARD and DRIVE-AHEAD) at Week 48 demonstrated that 84.1% of participants who were treated with the DOR-based regimen achieved HIV RNA < 50 copies/mL, compared with 79.9% of participants who were treated with the DRV/r-based regimen and 80.8% of participants who were treated with EFV/FTC/TDF. Results were similar across different baseline viral loads, genders, races, and HIV-1 subtypes.¹⁰ In a long-term extension arm for both trials (DRIVE-FORWARD and DRIVE-AHEAD) at Week 192, of 1,494 participants treated in the double-blind phase, 550 continued DOR-based regimens and 502 switched to DOR-based regimens.¹³ In the FDA snapshot analysis, HIV RNA < 50 copies/mL was maintained in 457 (83%) of 550 participants who continued DOR-based ART and 404 (80%) of 502 participants who switched to DOR-based regimens. Protocol-defined virological failure and development of resistance were low, occurring mainly before Week 96.¹³

In the DRIVE-SHIFT study, adults with HIV who were virologically suppressed for ≥ 6 months on two nucleoside reverse transcriptase inhibitors plus a boosted PI, boosted elvitegravir, or an NNRTI were randomized to switch to a once-daily, single-tablet regimen of DOR 100 mg/3TC 300 mg/TDF 300 mg or continue their current therapy (baseline regimen). At Week 48, 90.8% on DOR/3TC/TDF had HIV-1 RNA < 50 copies/mL, demonstrating noninferiority versus baseline regimen at Week 24.

(difference -3.8 [-7.9 to 0.3]).¹⁴ Long-term efficacy in the extension arm at Week 144 showed HIV RNA <50 copies/mL in 80.1% of those who switched to DOR/3TC/TDF immediately and 83.7% of those who switched to DOR/3TC/TDF during the open-label extension in FDA snapshot analysis.¹⁵

IMPAACT 2014 study data in treatment-naïve or treatment-experienced virologically suppressed adolescents aged 12 years to ≤18 years demonstrated efficacy comparable to adult data.^{4,7} A total of 45 participants (median age 15 years; 58% females; two ART-naïve) were treated with DOR/3TC/TDF. At Week 24, 42 of 45 (93.3%) participants achieved or maintained HIV-1 RNA <40 copies/mL in FDA snapshot analysis, while 42 of 43 (97.7%) achieved or maintained HIV-1 RNA <40 copies/mL in observed failure (on-treatment) analysis.⁴ At Week 48, 41 of 42 (97.6%) participants had achieved or maintained HIV-1 RNA <40 copies/mL, and at Week 96, 37 of 40 (92.5%) had achieved or maintained HIV-1 RNA <40 copies/mL.⁷

Toxicity in Clinical Trials

In trials that compared DOR-based regimens and EFV-based regimens, central nervous system (CNS) AEs (dizziness, sleep disorder and disturbances, and altered sensorium) occurred less frequently among the participants who received DOR than among those who received EFV.⁸ In the integrated safety analysis from the DRIVE-FORWARD and DRIVE-AHEAD trials, 25.5% of participants on DOR-based regimens experienced CNS AEs at Week 48, compared with 55.9% of participants on EFV-based regimens.^{10,16} In a long-term follow-up including extension stages for both trials (DRIVE-FORWARD and DRIVE-AHEAD), at Week 192, <1% of 550 participants who continued DOR-based ART reported serious drug-related AEs, and 1% who continued DOR-based regimens and <1% of those who switched to DOR-based ART discontinued ART due to drug-related AEs. Participants continuing or switching to DOR showed generally favorable lipid profiles, little weight gain, and small decreases in estimated glomerular filtration rates, with no discontinuations due to increased creatinine or renal AEs.¹³ In the DRIVE-SHIFT study, among adults who were receiving a ritonavir-boosted PI at study entry, the reduction in fasting lipids was achieved at Week 24 and maintained through Week 144 in the extension arm of the DRIVE-SHIFT study.¹⁵

In the IMPAACT 2014 study of 43 treatment-experienced (50% who switched from EFV-based ART) and 2 ARV-naïve adolescents aged 12 years to <18 years on DOR/3TC/TDF, at Week 24, there were no Grade 3 or 4 AEs, serious AEs, or premature study drug discontinuations due to AEs.⁴ At Week 96, there were no treatment-related discontinuations due to AEs and no deaths or drug-related AEs ≥Grade 3.⁷ While the study did not measure fasting lipids in all adolescents, favorable lipid profile changes from baseline to Week 96 were observed.

Efavirenz (EFV)

Updated: September 30, 2025

Reviewed: September 30, 2025

Formulations	
<p>Generic Formulations</p> <ul style="list-style-type: none"> • 50-mg and 200-mg capsules • 600-mg tablet <p>Fixed-Dose Combination (FDC) Tablets</p> <ul style="list-style-type: none"> • Efavirenz 600 mg/emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg • Efavirenz 400 mg/lamivudine 300 mg/tenofovir disoproxil fumarate 300 mg • [Symfi and generic] Efavirenz 600 mg/lamivudine 300 mg/tenofovir disoproxil fumarate 300 mg <p>When using FDC tablets, refer to other sections of the Drug Appendix 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.</p> <p>For additional information, see Drugs@FDA or DailyMed.</p>	
Dosing Recommendations	Selected Adverse Events
<p>Neonatal Dose</p> <ul style="list-style-type: none"> • Efavirenz (EFV) is not approved for use in neonates. <p>Pediatric Dose</p> <ul style="list-style-type: none"> • EFV capsules can be opened and the contents used as a sprinkle preparation for infants and children who are unable to swallow capsules. <p><i>Infants and Children Aged 3 Months to <3 Years and Weighing ≥3.5 kg</i></p> <ul style="list-style-type: none"> • The Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV (the Panel) does not recommend the use of EFV in children aged 3 months to <3 years due to highly variable pharmacokinetics in this age group. 	<ul style="list-style-type: none"> • Rash, which is generally mild and transient • Central nervous system (CNS) symptoms, such as fatigue, poor sleeping patterns, insomnia, vivid dreams, impaired concentration, agitation, seizures, depression, suicidal ideation, late-onset ataxia, and encephalopathy • Gynecomastia • Hepatotoxicity • Corrected QT prolongation • Use of EFV may produce false-positive results with some cannabinoid and benzodiazepine tests.
	Special Instructions
	<ul style="list-style-type: none"> • EFV capsules and tablets can be swallowed whole, or EFV capsules can be administered by sprinkling the contents of an opened capsule on food, as described below. • Bedtime dosing is recommended, particularly during the first 2 to 4 weeks of therapy, to improve tolerability of CNS side effects. • Administer EFV and FDC formulations of EFV on an empty stomach. Avoid administration with a high-fat meal because this has the potential to increase absorption.

Children Aged ≥3 Years and Weighing ≥10 kg

Once-Daily Doses of EFV by Weight

Weight	EFV Dose ^{a,b}
10 kg to <15 kg	200 mg
15 kg to <20 kg	250 mg
20 kg to <25 kg	300 mg
25 kg to <32.5 kg	350 mg
32.5 kg to <40 kg	400 mg
≥40 kg	600 mg

^a The dose in mg can be dispensed in any combination of capsule strengths. Capsules may be administered by sprinkling the contents onto an age-appropriate food (see Special Instructions below).

^b Some experts recommend a dose of EFV 367 mg per m² of body surface area (maximum dose 600 mg) due to concerns about underdosing at the upper end of each weight band (see the Pediatric Use section below for details). Weight bands approximate a dose of EFV 367 mg per m² of body surface area, with a maximum dose of 600 mg.

Child and Adolescent (Weighing ≥40 kg) and Adult Dose

- EFV 600 mg once daily

EFV 600 mg/Emtricitabine/Tenofovir Disoproxil Fumarate (TDF)

Child and Adolescent (Weighing ≥40 kg) and Adult Dose

- One tablet once daily
- Take on an empty stomach.

[Symfi] EFV 600 mg/Lamivudine (3TC)/TDF

Child and Adolescent (Weighing ≥40 kg) and Adult Dose

- One tablet once daily
- Take on an empty stomach.

EFV 400 mg/3TC/TDF

Child and Adolescent (Weighing ≥35 kg) and Adult Dose

- One tablet once daily
- Take on an empty stomach.

Instructions for Using the EFV Capsule as a Sprinkle Preparation With Food

- Hold capsule horizontally over a small container and carefully twist open to avoid spillage.
- Gently mix capsule contents with 1 to 2 teaspoons of an age-appropriate soft food (e.g., applesauce, grape jelly, yogurt).
- Administer within 30 minutes of mixing, and do not consume additional food for 2 hours after administration.

Metabolism/Elimination

- Cytochrome P450 (CYP) 2B6 is the primary enzyme for EFV metabolism. CYP2A6, CYP3A4, CYP3A5, and uridine diphosphate glucuronosyltransferases (UGT) also contribute to metabolism.
- CYP3A and CYP2B6 inducer *in vivo*
- Interpatient variability in EFV exposure can be explained in part by polymorphisms in CYP, particularly in CYP2B6. Slower metabolizers are at higher risk of toxicity. See the Therapeutic Drug Monitoring section below for information about the management of mild or moderate toxicity.

EFV Dosing in Children With Hepatic Impairment

- EFV is **not recommended** for children with moderate or severe hepatic impairment.

Efavirenz FDC Dosing in Children With Renal Impairment

- Because EFV FDC products contain TDF, lamivudine, and/or emtricitabine that require dose adjustments based on renal function, they should not be used in children with creatinine clearance <50 mL/min or in children on dialysis.

<p>Note: EFV 400 mg/3TC/TDF has not been studied in children (sexual maturity ratings [SMRs] 1–3), and major interindividual variability in EFV plasma concentrations has been found in children in a multiethnic setting. The 400-mg dose of EFV may be too low in children or adolescents with SMRs 1 to 3 who weigh ≥ 40 kg. Therapeutic drug monitoring is suggested by some Panel members when EFV 400 mg/3TC/TDF is used in children weighing ≥ 40 kg (see the Therapeutic Drug Monitoring section below).</p>	
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Drug Interactions

Additional information about drug interactions is available in the [Adult and Adolescent Antiretroviral Guidelines](#) and the [HIV Drug Interaction Checker](#).

- **Metabolism:** Coadministration of efavirenz (EFV) with drugs that are primarily metabolized by cytochrome P450 (CYP) 2C9, CYP2C19, CYP2B6, or CYP3A isozymes may result in altered plasma concentrations of the coadministered drugs. Drugs that induce CYP3A and CYP2B6 activity would be expected to increase the clearance of EFV, resulting in lower plasma concentrations. There is potential for multiple drug interactions with EFV. Importantly, dose adjustment or the addition of ritonavir may be necessary when EFV is used in combination with atazanavir (ATV), lopinavir/ritonavir (LPV/r), or maraviroc (MVC).
- Before EFV is administered, a child's medication profile should be reviewed carefully for potential drug interactions with EFV.
- Corrected QT (QTc) prolongation has been observed with the use of EFV.^{1,2} An alternative to EFV should be considered in children who are receiving a drug that has a known risk of Torsades de Pointes or in children who are at higher risk of Torsades de Pointes.

Major Toxicities

- **More common:** Skin rash and increased transaminase levels. Central nervous system (CNS) abnormalities—such as dizziness, somnolence, insomnia, abnormal dreams, confusion, abnormal thinking, impaired concentration, amnesia, agitation, depersonalization, hallucinations, euphoria, and seizures—have been reported, primarily in adults. See [Table 17a. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Central Nervous System Toxicity](#) for information on managing these toxicities.
- **Rare:** QTc prolongation has been observed with the use of EFV, and Torsades de Pointes has been reported with EFV use.³ An association between EFV and suicidal ideation, suicide, and attempted suicide (especially among those with a history of mental illness or substance use) was found in one retrospective analysis of four comparative trials in adults. This association, however, was not found in analyses of two large observational cohorts.

Resistance

The International Antiviral Society–USA maintains a [list of updated resistance mutations](#), and the [Stanford University HIV Drug Resistance Database](#) offers a discussion of each mutation.

Pediatric Use

Approval

EFV has been approved by the U.S. Food and Drug Administration (FDA) for use as part of antiretroviral (ARV) therapy in children aged ≥ 3 months and weighing ≥ 3.5 kg. The FDA also has approved the use of the fixed-dose combination of EFV 400 mg/lamivudine (3TC) 300 mg/tenofovir disoproxil fumarate (TDF) 300 mg, in children weighing ≥ 35 kg.

Efficacy in Clinical Trials

EFV-based regimens have proven virologically superior or non-inferior to a variety of regimens in adults, including those containing LPV/r, nevirapine, rilpivirine, ATV, elvitegravir, raltegravir, and MVC.⁴⁻¹⁰ EFV was shown to be inferior to dolutegravir (DTG) in the SINGLE trial in adults, which compared the virologic response of DTG plus abacavir/3TC with that of EFV/TDF/emtricitabine (FTC) at Weeks 48 and 144. The differences were most likely due to more drug discontinuations in the EFV group.¹¹

In clinical trials in adults and children with HIV, EFV used in combination with two nucleoside reverse transcriptase inhibitors (NRTIs) has been associated with excellent virologic response. The 96-week results of the Evaluation of Novel Concepts in Optimization of antiRetroviral Efficacy (ENCORE) 1 trial, a randomized trial in adults, showed that EFV 400 mg used in combination with TDF and FTC was non-inferior to EFV 600 mg used in combination with TDF and FTC.¹² EFV used in combination either with two NRTIs or with an NRTI and a protease inhibitor has been studied in children and has shown virologic potency and safety comparable to what has been seen in adults.¹³⁻¹⁵

Pharmacokinetics: Pharmacogenomics

Genetic polymorphisms in the genes that code for enzymes involved in the metabolism of EFV may alter enzyme activity, which causes a high degree of interpatient variability in drug exposure. CYP2B6 is the primary enzyme for EFV metabolism, and children with the CYP2B6-516-T/T genotype have reduced metabolism, resulting in higher EFV levels in these children than in those with the G/G or G/T genotypes.¹⁶⁻¹⁹ CYP2B6-516-T/T allele frequency varies by ethnicity. In a study of adults from the United States and Italy, this allele had a frequency of 24.4% among White participants, 31.3% among Black participants, and 34.9% among Hispanic participants.²⁰ A retrospective study of children in a multiethnic, high-income setting confirmed that EFV plasma concentrations can vary among children. The interindividual variability could be explained in large part by polymorphisms in drug metabolizing genes, as well as by age at treatment initiation and time since treatment initiation.²¹ International Maternal Pediatric Adolescent AIDS Clinical Trials (IMPAACT) P1070 has shown that aggressive dosing with approximately 40 mg/kg of EFV using opened capsules resulted in therapeutic EFV concentrations in 58% of children aged < 3 years with the G/G or G/T genotypes, but excessive exposure occurred in those with the T/T genotype.^{19,22} Optimal dosing may require pre-treatment CYP2B6 genotyping in children aged < 3 years (see Pharmacokinetics and Dosing: Infants and Children Aged < 3 Years below).^{18,19,22}

Other variants—CYP2B6 alleles and variant CYP2A6 alleles—have been found to influence EFV concentrations in adults and children.^{18,23-26}

Pharmacokinetics and Dosing: Infants and Children Aged <3 Years

The Panel **does not recommend** the use of EFV in children aged 3 months to <3 years. Pharmacokinetic (PK) data in children aged <3 years or weighing <14 kg have shown that it is difficult to achieve target trough concentrations in this age group.^{22,27}

Pharmacokinetics: Children Aged ≥3 Years and Adolescents

Even with the use of FDA-approved pediatric dosing in children aged ≥3 years, EFV concentrations can be suboptimal.^{16,28-32} Therefore, some experts recommend using therapeutic drug monitoring (TDM) in children who are receiving EFV and possibly using higher doses in young children, especially in certain clinical situations, such as virologic rebound or lack of response in an adherent child. In one study in which the EFV dose was adjusted in response to measurement of the area under the curve, the median administered dose was EFV 13 mg/kg (367 mg per m² of body surface area), and the range was from 3 mg/kg to 23 mg/kg (69–559 mg per m² of body surface area).³³

Toxicity: Children Versus Adults

The toxicity profile for EFV differs for adults and children. One adverse effect (AE) commonly seen in children is rash, which was reported in up to 40% of children and 27% of adults.³⁴ The rash is usually maculopapular, pruritic, and mild to moderate in severity and rarely requires drug discontinuation. Onset is typically during the first 2 weeks of treatment. Although severe rash and Stevens-Johnson syndrome have been reported, they are rare.

Multiple studies in adults have shown that EFV use is associated with low vitamin D levels, and several studies have found an association between EFV use and low bone mineral density.³⁵⁻³⁸ EFV induces CYP3A4 and CYP24 enzymes that may affect vitamin D homeostasis. Because of these findings, the Panel recommends measurement of vitamin D in children receiving EFV and vitamin D supplementation for those with vitamin D deficiency (see [Table 17j. Antiretroviral Therapy-Associated Adverse Effects and Management Recommendations—Osteopenia and Osteoporosis](#)).

In adults, CNS symptoms are commonly reported and affected 29.6% of people in one meta-analysis of randomized trials.³⁹ These symptoms usually occur early in treatment and rarely require drug discontinuation, but they sometimes can persist for months. Administering EFV at bedtime appears to decrease the occurrence and severity of these neuropsychiatric AEs. For people who can swallow capsules or tablets, ensuring that EFV is taken on an empty stomach also reduces the occurrence of neuropsychiatric AEs. In several studies, the incidence of neuropsychiatric AEs was correlated with EFV plasma concentrations, and the symptoms occurred more frequently in people with higher concentrations.⁴⁰⁻⁴³ The ENCORE1 study in adults demonstrated that a dose of EFV 400 mg is associated with fewer AEs and a non-inferior virologic response when compared with the recommended 600-mg dose of EFV.^{12,44} A Tanzanian study of children aged 6 to 12 years showed that those who were receiving EFV, especially doses of EFV that were higher than or equal to those recommended by the World Health Organization, had more anxiety and more difficulty concentrating at school than children who were receiving alternative ARV medications.⁴⁵ Adverse CNS events occurred in 14% of children who received EFV in clinical studies⁴⁶ and in 30% of children⁴⁷ with plasma EFV concentrations >4 mg/L. Late-onset neurotoxicity, including ataxia and encephalopathy, may occur months to years after initiating EFV. Some events of late-onset neurotoxicity have occurred in people with certain CYP2B6 genetic polymorphisms who received standard doses of EFV. These polymorphisms have been associated with slow metabolism of EFV and increased EFV levels (see the [package insert for EFV](#)).

An association between EFV and suicidal ideation, suicide, and attempted suicide (especially among those with a history of mental illness or substance abuse) was found in a retrospective analysis of four comparative trials in adults and in the Strategic Timing of AntiRetroviral Treatment (START) Trial, a prospective analysis of adults.^{48,49} This association, however, was not found in the analyses of two large observational cohorts,^{50,51} and no cases of suicide were reported in a systematic review of randomized trials.³⁹ In people with preexisting psychiatric conditions, EFV should be used cautiously.

Toxicity: Prolongation of the Corrected QT

The effect of EFV on the QTc interval was evaluated in a study of 58 healthy adult participants; a variety of CYP2B6 polymorphisms was represented within this group. A positive relationship between EFV concentration and QTc prolongation was observed.¹ Clinicians should consider using an alternative to EFV in children who are receiving a drug that has a known risk of Torsades de Pointes (e.g., quinidine, clarithromycin) or in children who are at higher risk for Torsades de Pointes.²

Therapeutic Drug Monitoring

It is reasonable for a clinician to use TDM to determine whether a person is experiencing toxicity, because the concentration of EFV is higher than the normal therapeutic range for some toxicities.^{52,53} Dose reduction or drug discontinuation would be considered appropriate management of drug toxicity. Dose reduction is best performed in consultation with an expert in pediatric HIV. Also, TDM should be considered when administering EFV to children aged 3 months to <3 years due to increased oral clearance and variable PK properties in this young age group. TDM should also be considered when using a lower dose of EFV—such as the dose found in EFV 400 mg/3TC/TDF—in children weighing ≥ 40 kg. Two weeks after initiating EFV in infants and children aged <3 years, clinicians should measure the plasma concentration of EFV. In cases where a dose adjustment may be necessary, clinicians should consult an expert in pediatric HIV infection prior to adjusting the dose. If a child initiated EFV at an investigational dose at <3 years of age, some experts would also measure plasma concentration at age 3 years, after the child transitions to the recommended dose for children aged ≥ 3 years.

The currently accepted minimum effective concentration of EFV is a mid-dose concentration at 12 hours postdose (C_{12h}) of >1 mg/L in adults, and concentrations of >4.0 mg/L are associated with CNS side effects.⁴¹ However, the validity of using a single target has been called into question.⁵⁴ In addition, a lower limit of $C_{12h} >0.7$ mg/L was most predictive of virologic outcome in a study of 180 adults.⁵⁵ Findings from a study of 128 African children (aged 1.7–13.5 years) suggest that the concentration at 24 hours (C_{24h}) threshold for increased risk of unsuppressed viral load is $C_{24h} 0.65$ mg/L.⁵⁶

Etravirine (ETR, Intelence)

Updated: September 30, 2025

Reviewed: June 25, 2026

Formulations											
Tablets: 25 mg, 100 mg, 200 mg For additional information, see Drugs@FDA or DailyMed .											
Dosing Recommendations	Selected Adverse Events										
Neonate and Infant Dose <ul style="list-style-type: none">Etravirine (ETR) is not approved for use in neonates or infants. Child Dose <ul style="list-style-type: none">ETR is not approved for use in children aged <2 years. ETR Dosing Table for Antiretroviral Therapy–Experienced Children and Adolescents Aged 2 to 18 Years and Weighing ≥10 kg <table><tr><th>Body Weight</th><th>Twice-Daily Dose</th></tr><tr><td>10 kg to <20 kg</td><td>100 mg</td></tr><tr><td>20 kg to <25 kg</td><td>125 mg</td></tr><tr><td>25 kg to <30 kg</td><td>150 mg</td></tr><tr><td>≥30 kg</td><td>200 mg</td></tr></table> <ul style="list-style-type: none">ETR is approved for use in children and adolescents who are treatment experienced. The Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV recommends that ETR is used as part of a regimen that includes a ritonavir (RTV)-boosted protease inhibitor (PI) (see Efficacy in Clinical Trials and Drug Interactions below).Cobicistat-boosted PIs, non-nucleoside reverse transcriptase inhibitors, bictegravir, and elvitegravir/cobicistat should not be used with ETR. Raltegravir and dolutegravir should only be used with ETR with RTV-boosted atazanavir, darunavir, or lopinavir. Adult Dose for Antiretroviral Therapy–Experienced People <ul style="list-style-type: none">ETR 200 mg twice daily with food	Body Weight	Twice-Daily Dose	10 kg to <20 kg	100 mg	20 kg to <25 kg	125 mg	25 kg to <30 kg	150 mg	≥30 kg	200 mg	<ul style="list-style-type: none">NauseaDiarrheaRash, including Stevens-Johnson syndromeHypersensitivity with rash; constitutional symptoms; and, sometimes, organ dysfunction, including hepatic failure
Body Weight	Twice-Daily Dose										
10 kg to <20 kg	100 mg										
20 kg to <25 kg	125 mg										
25 kg to <30 kg	150 mg										
≥30 kg	200 mg										
	Special Instructions										
	<ul style="list-style-type: none">ETR tablets are sensitive to moisture; store the tablets at room temperature in the original container with desiccant.Always administer ETR with food. Area under the curve of ETR is decreased by about 50% when the drug is taken on an empty stomach. The type of food does not affect the exposure to ETR.Swallowing ETR tablets whole is the preferred means of administration. Although the package insert contains instructions for dispersing ETR tablets in water or other liquids, using this administration method generally results in lower ETR exposures compared with swallowing tablets whole. Children who receive dispersed ETR tablets should switch to swallowing tablets whole as soon as developmentally able.										
	Metabolism/Elimination										
	<ul style="list-style-type: none">ETR is an inducer of cytochrome P450 (CYP) 3A4 and an inhibitor of CYP2C9, CYP2C19, and P-glycoprotein. It is a substrate for CYP3A4, CYP2C9, and CYP2C19.ETR is involved in multiple interactions with antiretroviral agents and other drugs (see Drug Interactions below).										

	<p>ETR Dosing in Children With Hepatic Impairment</p> <ul style="list-style-type: none"> • No dose adjustment is required when using ETR in children with mild or moderate hepatic insufficiency. No dosing information is available for children with severe hepatic impairment. <p>ETR Dosing in Children With Renal Impairment</p> <ul style="list-style-type: none"> • No dose adjustment is required when using ETR in children with renal impairment.
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Drug Interactions

Additional information about drug interactions is available in the [Liverpool HIV Drug Interaction Checker](#).

- Etravirine (ETR) is associated with multiple drug interactions. A child's medication profile should be carefully reviewed for potential drug interactions before ETR is administered.
- ETR **should not be administered** with tipranavir/ritonavir, fosamprenavir/ritonavir, unboosted protease inhibitors (PIs), or cobicistat-boosted PIs.¹
- ETR **should not be administered** with other non-nucleoside reverse transcriptase inhibitors (NNRTIs) (i.e., nevirapine [NVP], efavirenz [EFV], rilpivirine, doravirine).
- ETR **should not be administered** with bictegravir or elvitegravir/cobicistat. ETR reduces the trough concentration of raltegravir² (RAL) and dolutegravir (DTG). RAL and DTG should be used with ETR only when these drugs are coadministered with atazanavir/ritonavir, darunavir/ritonavir, or lopinavir/ritonavir.

Major Toxicities

- *More common:* Nausea, diarrhea, and mild rash. Rash occurs most commonly during the first 6 weeks of therapy. Rash generally resolves after 1 to 2 weeks on continued therapy. A history of NNRTI-related rash does not appear to increase the risk of developing rash with ETR. However, people who have a history of severe rash with prior NNRTI use **should not receive ETR**.
- *Less common (more severe):* Peripheral neuropathy, severe rash, hypersensitivity reactions (HSRs), and erythema multiforme all have been reported. Instances of severe rash have included Stevens-Johnson syndrome, and HSRs have included constitutional symptoms and organ dysfunction, including hepatic failure. Discontinue ETR immediately if signs or symptoms of severe skin reactions or HSRs develop (including severe rash or rash accompanied by fever, general malaise, fatigue, muscle or joint aches, blisters, oral lesions, conjunctivitis, facial edema, hepatitis, and eosinophilia). Clinicians should monitor a person's clinical status, including levels of liver transaminases, and initiate appropriate therapy when necessary. Continuing to use ETR after the onset of severe rash may result in a life-threatening reaction. People who have a history of severe rash while using NVP or EFV **should not receive ETR**.

Resistance

The International AIDS Society–USA maintains [a list of updated resistance mutations](#), and the [Stanford University HIV Drug Resistance Database](#) offers a discussion of each mutation.

Pediatric Use

Approval

ETR is approved by the U.S. Food and Drug Administration for use in antiretroviral therapy (ART)—experienced children and adolescents aged 2 to <18 years of age and weighing ≥ 10 kg.

Efficacy in Clinical Trials

In the Paediatric study of Intelence As an NNRTI Option (PIANO) study,³ ART-experienced children aged 6 years to <18 years received ETR with a ritonavir (RTV)-boosted PI as part of an optimized background regimen. At Week 24, 67% of these participants had plasma HIV RNA concentrations <400 copies/mL and 52% had HIV RNA <50 copies/mL. At Week 48, 56% of the participants had HIV RNA <50 copies/mL and a mean increase in their CD4 T lymphocyte (CD4) cell counts of 156 cells/mm³ from baseline. At Week 48, 68% of children aged 6 years to <12 years had plasma HIV RNA <50 copies/mL, whereas only 48% of adolescents aged 12 years to <18 years achieved a plasma viral load of <50 copies/mL.

In a retrospective study of 23 children and adolescents with multi-drug resistant HIV receiving ETR-based therapy in Spain, 78% of participants achieved HIV RNA <50 copies/mL at a median of 48.4 weeks of follow-up.⁴ A separate pooled analysis of treatment-experienced children and adolescents <18 years of age on ETR-based therapy showed 69% (85 of 124 participants) with follow-up data through 12 months achieved HIV RNA <50 copies/mL, and 80% (99 of 124 participants) achieved HIV RNA <400 copies/mL.⁵

In the International Maternal Pediatric Adolescent AIDS Clinical Trials (IMPAACT) P1090 trial,⁶ ART-experienced children aged ≥ 2 years to <6 years received ETR with an RTV-boosted PI as part of an optimized background regimen. Participants received ETR at a dose of 100 mg twice daily (10 kg to <20 kg) or 125 mg twice daily (20 kg to <25 kg). At Week 48, 75% had an HIV-1 RNA <400 copies/mL or a >2-log reduction in HIV-1 RNA from baseline. The mean increase in CD4 count and CD4 percentage over 48 weeks was 298.5 cells/mm³ and 5.2%, respectively. Due to the PIANO and IMPAACT P1090 study findings, if ETR is utilized to treat an ART-experienced child or adolescent, the Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV (the Panel) recommends that ETR is part of a regimen that includes an RTV-boosted PI plus an optimized background regimen.

Pharmacokinetics

In a Phase 1 dose-finding study that involved children aged 6 to 17 years, 17 children were given ETR 4 mg/kg twice daily. The study reported that two pharmacokinetic (PK) parameters—area under the curve through 12 hours postdose (AUC_{0-12h}) and minimum plasma concentration—were lower than the corresponding parameters observed in adults during previous studies.⁷ However, a higher dose (ETR 5.2 mg/kg twice daily; maximum 200 mg per dose) yielded acceptable parameters and was chosen for evaluation in the Phase 2 PIANO study. Exposures (mean AUC_{0-12h}) remained lower in older adolescents than in adults and younger children, and exposures were lower in Asian participants than in either White or Black participants. In the PIANO study, children and adolescents with ETR concentrations in the lowest quartile (<2,704 ng•hr/mL or pre-dose concentration <145 ng/mL) were less likely to achieve sustained virologic responses (defined as plasma viral loads <50 copies/mL) after 48 weeks of treatment than those with ETR concentrations in the upper three quartiles.³

Table A. Pharmacokinetic Parameters in Children, Adolescents, and Adults Receiving Etravirine Twice Daily With an Optimized Background Regimen, Including a Ritonavir-Boosted Protease Inhibitor

Population	Mean ETR AUC _{0-12h} (ng•hr/mL)	Mean ETR C _{0h} (ng/mL)
Children Aged 6–11 Years (n = 41)	5,684	377
Adolescents Aged 12–17 Years (n = 60)	4,895	325
Adults (n = 575)	5,506	393

Key: AUC_{0-12h} = area under the curve from time zero to 12 hours postdose; C_{0h} = pre-dose concentration; ETR = etravirine

Source: Kakuda TN, Brochot A, Green B, et al. Pharmacokinetics and pharmacokinetic/pharmacodynamic relationships of etravirine in HIV-1-infected, treatment-experienced children and adolescents in PIANO. *J Clin Pharmacol*. 2016;56(11):1395-1405. Available at: <https://pubmed.ncbi.nlm.nih.gov/27060341>.

IMPAACT P1090 examined the PK and safety of ETR in treatment-experienced children with HIV aged ≥2 years to <6 years.⁶ All participants received ETR as part of an optimized background regimen, which included an RTV-boosted PI. The tablets were swallowed whole or dispersed in liquid. ETR was initially given at a dose of 5.2 mg/kg twice daily to a cohort of six children; however, at this dose, the geometric mean ETR AUC_{0-12h} values fell below the target range of 60% of the values seen in adults. Subsequent participants were given twice-daily doses of ETR that were determined by weight band: children weighing 10 kg to <20 kg were given 100 mg twice daily, and children weighing 20 kg to <25 kg were given 125 mg twice daily.

The protocol-specified PK targets for ETR were achieved at these doses; the geometric mean AUC_{0-12h} was 3,823 ng•hr/mL, which was within the target range of 2,713 ng•hr/mL to 6,783 ng•hr/mL (60% to 150% of the AUC_{0-12h} value seen in adults). However, considerable intersubject variability was observed, with 5 (33.3%) of 15 participants having AUC_{0-12h} values that were below the 10th percentile for the adult AUC_{0-12h} range (<2,350 ng•hr/mL). The ETR AUC_{0-12h} values were significantly lower in children who received dispersed tablets than in children who swallowed intact tablets: 2,919 ng•hr/mL (n = 11) versus 10,982 ng•hr/mL (n = 3), respectively (*P* = 0.0008). The Panel recommends that children swallow tablets whole (rather than dispersed in liquid) as soon as developmentally able.

Six children with HIV who were aged 1 year to <2 years also were enrolled in IMPAACT P1090. Although the ETR exposures satisfied protocol-defined PK targets (AUC_{0-12h} between 2,713 ng•hr/mL and 6,783 ng•hr/mL), they were lower in these children compared with historical data in adults and adolescents (geometric mean ETR AUC_{0-12h} of 3,328 ng•hr/mL). Virologic failure, which was defined as a confirmed viral load of ≥400 copies/mL or less than a 2-log reduction in HIV-1 RNA from baseline, occurred in four of six children by Week 48. Thus, the Panel does not recommend the use of ETR in those younger than 2 years of age.

Given that both the PIANO and IMPAACT P1090 trials were conducted in children receiving RTV-boosted PIs as part of their optimized background regimens, the Panel recommends using ETR as part of a regimen that includes an RTV-boosted PI.

Toxicity

In the PIANO study, rash and diarrhea were the most common adverse drug reactions that were deemed to be possibly related to the use of ETR. Rash (Grade 2 or higher) deemed possibly related to ETR occurred in 13% of pediatric participants and emerged at a median of 10 days, lasting a median of 7 days. The occurrence of any rash was observed more frequently in female participants (17 of 64 participants; 26.6%) than in male participants (6 of 37 participants; 16.2%).³ In IMPAACT P1090, adverse drug reactions that were reported for children aged ≥ 2 years to < 6 years were comparable in frequency, type, and severity to those reported for adults. Twelve participants (46.2%) developed Grade 1 or 2 rashes within the first 48 weeks of ETR, but no participant discontinued the study prematurely due to rash. Diarrhea occurred in 8 (30.8%) of 26 participants.⁶

Nevirapine (NVP)

Updated: June 25, 2026

Reviewed: June 25, 2026

Formulations	
<p>Oral Suspension: 10 mg/mL</p> <p>Tablet: Immediate-release 200 mg</p> <p>Generic Formulations</p> <ul style="list-style-type: none"> 10-mg/mL suspension Immediate-release 200-mg tablet 	
Dosing Recommendations	Selected Adverse Events
<p>Note: Nevirapine (NVP) is often used as part of newborn antiretroviral prophylaxis or presumptive HIV therapy regimens to prevent perinatal transmission of HIV. Doses of NVP used for prophylaxis can differ substantially from doses used for treatment. See Antiretroviral Management of Infants With In Utero, Intrapartum, or Breastfeeding Exposure to HIV.</p> <p>Child and Adolescent Dose</p> <ul style="list-style-type: none"> When initiated in children aged >2 years, NVP is given once daily for 2 weeks to allow autoinduction of the enzymes involved in its metabolism. This may not be necessary in children aged ≤2 years.^a Dosing is available for neonates as young as 32 weeks' gestation. For more information, see Special Considerations for Dosing: Neonates and Premature Infants below. <p>Immediate-Release Tablets and Oral Suspension</p> <p><i>Gestational Age of 32 to <34 Weeks</i></p> <ul style="list-style-type: none"> Birth to age 2 weeks: NVP 2 mg/kg per dose twice daily (no lead-in dosing)^a Age 2–4 weeks: NVP 4 mg/kg per dose twice daily Age 4–6 weeks: NVP 6 mg/kg per dose twice daily Age >6 weeks: NVP 200 mg/m² of body surface area (BSA) per dose twice daily; only make this dose increase for infants with confirmed HIV infection. This dosing strategy is recommended by the Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV (the Panel) based on the review of pharmacokinetic (PK) modeling and simulation data. This dosing strategy has not been evaluated in clinical trials and is not approved by the U.S. Food and Drug Administration (FDA). 	<ul style="list-style-type: none"> Rash, including Stevens-Johnson syndrome Symptomatic hepatitis, including fatal hepatic necrosis^b Severe systemic hypersensitivity syndrome with potential for multisystem organ involvement and shock
	<p>Special Instructions</p> <ul style="list-style-type: none"> The total daily dose should not exceed NVP 400 mg daily. The extended-release tablet formulation of NVP is no longer available. The oral suspension must be shaken well before administering, and it should be stored at room temperature. NVP can be given with or without food. NVP-associated skin rash usually occurs within the first 6 weeks of therapy. If rash occurs during the initial 14-day lead-in period, do not increase the dose until the rash resolves (see Major Toxicities below).

<p>Gestational Age of 34 to <37 Weeks</p> <ul style="list-style-type: none"> • Birth to age 1 week: NVP 4 mg/kg per dose twice daily (no lead-in dosing)^a • Age 1 week to 4 weeks: NVP 6 mg/kg per dose twice daily • Age >4 weeks: NVP 200 mg/m² of BSA per dose twice daily; only make this dose increase for infants with confirmed HIV infection. • This dosing strategy is recommended by the Panel based on the review of PK and safety data on this regimen from clinical trials. This dosing strategy is not approved by the FDA. <p>Gestational Age of ≥37 Weeks to Age of <1 Month</p> <ul style="list-style-type: none"> • Birth to age 4 weeks: NVP 6 mg/kg per dose twice daily (no lead-in dosing)^a • Age >4 weeks: NVP 200 mg/m² of BSA per dose twice daily; only make this dose increase for infants with confirmed HIV infection. • This dosing strategy is recommended by the Panel based on the review of PK and safety data on this regimen from clinical trials. This dosing strategy is not approved by the FDA. <p>Aged ≥1 Month to <8 Years</p> <ul style="list-style-type: none"> • NVP 200 mg/m² of BSA per dose twice daily after lead-in dosing.^a In children aged ≤2 years, some experts initiate NVP without lead-in dosing (maximum dose of immediate-release tablets is NVP 200 mg twice daily). <p>Aged ≥8 Years</p> <ul style="list-style-type: none"> • NVP 120 mg to 150 mg/m² of BSA per dose twice daily after lead-in dosing^a (maximum dose of immediate-release tablets is NVP 200 mg twice daily). • When adjusting the dose for a growing child, the absolute dose need not be decreased as the child reaches age 8 years; rather, the absolute dose can be left static to achieve the appropriate mg-per-m² dose as the child grows, assuming no adverse effects emerge. <p>NVP Used in Combination With Lopinavir/Ritonavir (LPV/r)</p> <ul style="list-style-type: none"> • A higher dose of LPV/r may be needed in children who also are receiving NVP (see the Lopinavir/Ritonavir section). 	<ul style="list-style-type: none"> • If NVP dosing is interrupted for >14 days, NVP should be restarted with once-daily dosing for 14 days, followed by escalation to the full twice-daily regimen (see Dosing Considerations: Lead-In Dosing below). • Most cases of NVP-associated hepatic toxicity occur during the first 12 weeks of therapy; frequent clinical and laboratory monitoring, including liver function tests, is important during this period (see Major Toxicities below). <p>Metabolism/Elimination</p> <ul style="list-style-type: none"> • NVP is a substrate and inducer of cytochrome P450 (CYP) 3A4 and CYP2B6. More than 80% of an NVP dose is eliminated in urine as uridine diphosphate glucuronosyltransferase–derived glucuronidated metabolites. <p>NVP Dosing in Children With Hepatic Impairment</p> <ul style="list-style-type: none"> • NVP should not be administered to children with moderate or severe hepatic impairment. <p>NVP Dosing in Children With Renal Failure Who Are Receiving Hemodialysis</p> <ul style="list-style-type: none"> • An additional dose of NVP should be given following each dialysis session.
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^a NVP is usually initiated at a lower dose that is increased in a stepwise fashion. NVP induces CYP metabolizing enzymes, which results in increased drug clearance. The stepwise increase in dose reduces the frequency of rash. Clinicians generally should initiate therapy with the immediate-release tablet formulation once daily instead of twice daily for the first 14 days of therapy. If no rashes or other adverse effects emerge after 14 days of therapy, increase the dose of NVP to the age-appropriate full dose of the immediate-release tablet formulation administered twice daily. For example, the recommended oral dose for infants and children aged ≥1 month to <8 years is NVP 200 mg/m² of BSA once daily for the first 14 days, followed by NVP 200 mg/m² of BSA twice daily thereafter. However, in children aged ≤2 years, some experts initiate NVP without lead-in dosing (see the Dosing Considerations: Lead-In Dosing and Special Considerations for Dosing: Neonates and Premature Infants sections below).

^b Severe life-threatening and, in rare cases, fatal hepatotoxicity—including fulminant and cholestatic hepatitis, hepatic necrosis, and hepatic failure—has occurred in people who were taking NVP. These toxicities are less common in children than adults. Most cases occur during the first 12 weeks of therapy and may be associated

with rash or other signs or symptoms of hypersensitivity reaction (HSR). NVP **should be discontinued and not restarted** in children or adults who develop symptomatic hepatitis, severe transaminase elevations, or HSRs.

Special Considerations for Dosing: Neonates and Premature Infants

Nevirapine (NVP) is now used primarily for the treatment or presumptive treatment of HIV in infants, including those born preterm (see [What to Start: Antiretroviral Treatment Regimens Recommended for Initial Therapy in Infants and Children With HIV](#) and [Antiretroviral Management of Infants With In Utero, Intrapartum, or Breastfeeding Exposure to HIV](#)).

The pharmacokinetic (PK) and safety of NVP during the first weeks of life were evaluated as part of IMPAACT P1115. This study demonstrated that NVP dosed at 6 mg/kg twice daily for infants ≥ 37 weeks gestational age (GA) and 4 mg/kg twice daily for 1 week and 6 mg/kg twice daily thereafter for infants 34 to <37 weeks GA achieved concentrations appropriate for treatment.¹ Among 438 infants (389 infants ≥ 37 weeks GA), measured NVP concentrations were above the minimum HIV treatment target (3 mcg/mL) in 90% of infants at Week 1 and 87% of infants at Week 2. Grade 3 and 4 adverse events possibly related to treatment occurred in 7% of infants (with neutropenia and anemia being the most common) but did not lead to NVP cessation.

PK modeling and simulation were performed with partial data from IMPAACT P1106 and P1115 to determine appropriate NVP dosing in premature infants 32 to <34 weeks GA. GA and postnatal age were significantly correlated with NVP oral clearance; thus, the authors recommended a GA-based starting dose for premature infants treated with NVP and a stepwise increase in dosing at 2-week intervals.² These data might underestimate potential drug toxicity in infants of 32 to <34 weeks GA because the doses used to develop the model were lower than the doses now recommended. NVP is shown to be safe in infants >34 weeks GA, so the risk of toxicity in infants 32 to <34 weeks GA seems low. The Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV (the Panel) considers that this risk–benefit ratio may justify the use of this dose in premature infants 32 to <34 weeks GA.

The Early Infant Treatment Study in Botswana started 40 infants with HIV ≥ 35 weeks GA on NVP 6 mg/kg twice daily (without lead-in dosing) along with zidovudine and lamivudine at a median age 2 days (range 1–5 days). NVP was switched to lopinavir/ritonavir at Week 2, 3, 4, or 5 according to delivery GA. Although NVP trough concentrations were below the therapeutic target (3,000 ng/mL) for 50% of 2-week measurements, 37 of 40 infants (92.5%) had an HIV RNA decline.³ Among this cohort, 38 of 40 participants survived to 96 weeks with a preserved CD4 T lymphocyte (CD4) cell count and low reservoir, which was predicted by a low pre–antiretroviral therapy (ART) reservoir size.⁴ Providers who consider initiating treatment in premature infants or in infants aged <2 weeks should weigh the risks and benefits of using unapproved ART dosing and should incorporate case-specific factors, such as exposure to antiretroviral prophylaxis.

Drug Interactions

Additional information about drug interactions is available in the [Liverpool HIV Drug Interaction Checker](#).

- **Metabolism:** NVP is metabolized by and induces hepatic cytochrome P450 (CYP) 3A and CYP2B6; autoinduction of metabolism occurs in 2 to 4 weeks of NVP dosing, leading to a 1.5-fold to 2-fold increase in NVP clearance. Multiple drug interactions with NVP are possible. Some genetic polymorphisms of CYP2B6 are associated with increased NVP plasma concentrations. The prevalence of CYP2B6 polymorphisms varies among populations and may

contribute to differences in NVP exposure. See the [Efavirenz](#) section for more information on how polymorphisms can alter metabolic enzyme activity.

- NVP should not be coadministered to children who are receiving atazanavir (ATV) (with or without ritonavir) because NVP substantially decreases ATV exposure.
- NVP increases the metabolism of lopinavir (LPV). A dose adjustment of LPV is recommended when the two drugs are coadministered (see the [Lopinavir/Ritonavir](#) section).
- Before NVP is initiated, a child's medication profile should be carefully reviewed for potential drug interactions.

Major Toxicities

The following toxicities are seen with chronic dosing.

- More common: Skin rash (some severe cases have required hospitalization, and some cases have been life-threatening, including instances of Stevens-Johnson syndrome and toxic epidermal necrolysis), fever, nausea, headache, and elevated hepatic transaminases. In the two largest case series of NVP-induced Stevens-Johnson syndrome in children, the incidence rate was estimated between 1.4% and 7.1%.^{5,6} NVP should be discontinued and not restarted in children or adults who develop severe rash, rash with constitutional symptoms (i.e., fever, oral lesions, conjunctivitis, or blistering), or rash with elevated levels of hepatic transaminases. NVP-associated skin rash usually occurs within the first 6 weeks of therapy. If rash occurs during the initial 14-day lead-in period, do not increase the dose until rash resolves. However, the risk of developing NVP resistance with extended lead-in dosing is unknown, and this concern must be weighed against the current antiviral response and a person's overall ability to tolerate the regimen.
- *Less common (more severe):* Symptomatic hepatitis, including fatal hepatic necrosis, and severe systemic hypersensitivity syndrome with potential for multisystem organ involvement and shock. These toxicities are less common in children than adults. Most cases occur during the first 12 weeks of therapy and may be associated with rash or other signs or symptoms of hypersensitivity reaction (HSR). Risk factors for NVP-related hepatic toxicity in adults include baseline elevation in serum transaminase levels, hepatitis B or hepatitis C virus infection, female sex, and higher CD4 count at time of therapy initiation (CD4 count >250 cells/mm³ in adult females and >400 cells/mm³ in adult males). Children with CD4 percentages >15% have a threefold increase in the risk of rash and hepatotoxicity after initiating NVP.⁷ HSRs have been reported, including, but not limited to, severe rash or rash accompanied by fever, blisters, oral lesions, conjunctivitis, facial edema, muscle or joint aches, general malaise, and significant hepatic abnormalities. NVP **should be discontinued and not restarted** in children or adults who develop symptomatic hepatitis, severe transaminase elevations, or HSRs.
- *Less common (more severe):* In a cross-sectional study of 201 children with HIV aged 6 to 16 years, 43% of whom had hypertension, the use of NVP was associated with left ventricular hypertrophy (LVH) (adjusted odds ratio 3.14; confidence interval 1.13–8.72; *P* = 0.03) but not left ventricular diastolic dysfunction.⁸ The median duration on ART in this cohort was 4.7 years (interquartile range [IQR] 2.6–6.4 years). Most participants (76.6%) were receiving a regimen that included two nucleoside reverse transcriptase inhibitors and a non-nucleoside reverse transcriptase inhibitor (NNRTI). However, the use of NVP was not associated with LVH in a more recent study by the same authors. LVH has been associated with NVP use in adults.^{9,10}

Resistance

The International AIDS Society–USA maintains a [list of updated resistance mutations](#), and the [Stanford University HIV Drug Resistance Database](#) offers a discussion of each mutation.

Pediatric Use

Approval

NVP is approved by the U.S. Food and Drug Administration (FDA) for treatment of HIV in children from infancy (aged ≥ 15 days) onward. The Panel recommends dosing for preterm infants based on either PK and safety data from clinical trials, or PK modeling and simulation; however, dosing strategies for preterm infants are not FDA approved.

The NVP extended-release tablet formulation (400 mg) was previously approved by the FDA for use in children aged ≥ 6 years but is now discontinued.

Efficacy in Clinical Trials

Randomized clinical trials evaluating the efficacy of NVP in children with HIV are of historical significance. Refer to [archived versions of the Pediatric Antiretroviral Guidelines](#) for details.

General Dosing Considerations

Body surface area (BSA) has traditionally been used to guide NVP dosing in infants and young children. It is important to avoid underdosing NVP, because a single point mutation (K103N) in the HIV genome may confer NNRTI resistance to both NVP and efavirenz. Younger children (aged ≤ 8 years) have higher apparent oral clearance than older children. To achieve drug exposures that are comparable to those seen in children aged >8 years, younger children require higher doses of NVP than older children.^{11,12} Because of this, it is recommended that children aged <8 years receive NVP 200 mg/m² of BSA per dose twice daily (the maximum dose of the immediate-release tablet formulation is NVP 200 mg twice daily). For children aged ≥ 8 years, the recommended dose of the immediate-release tablet formulation is NVP 120 mg/m² of BSA per dose (with a maximum dose of NVP 200 mg) administered twice daily.

When adjusting the dose for a growing child, the milligram dose need not be decreased (from NVP 200 mg to NVP 120 mg/m² of BSA) as the child reaches 8 years of age; rather, the milligram dose can be left static if no adverse effects emerge and the dose achieves the appropriate mg/m² of BSA dose as the child grows. Some practitioners dose NVP at 150 mg/m² of BSA every 12 hours, regardless of age, as recommended in the FDA-approved product label. Regardless of age, the maximum dose should never exceed NVP 200 mg twice daily for immediate-release formulations of NVP.

Dosing Considerations: Lead-in Dosing

Underdosing during the lead-in period may have potentially contributed to the poorer performance of NVP in the IMPAACT P1060 trial. This potential for underdosing, which can increase the risk of resistance, led to a re-evaluation of lead-in dosing in children who have never received NVP. Traditionally, NVP is initiated with an age-appropriate dose that is given only once daily instead of twice daily (NVP 200 mg/m² of BSA in infants aged ≥ 15 days and children aged <8 years, using the immediate-release formulations) during the first 2 weeks of treatment to allow the autoinduction of the liver enzymes CYP3A and CYP2B6, which are involved in NVP metabolism.

Studies have previously indicated potential for greater drug toxicity without lead-in dosing; however, most of these studies have been performed in adult cohorts.¹³ The CHAPAS-1 trial¹⁴ randomized 211 children with a median (IQR) age of 5 (2–9) years to initiate ART with immediate-release NVP without a lead-in dose (participants received an age-appropriate dose twice daily) or with a lead-in

dose (participants received an age-appropriate dose once daily) for 2 weeks, followed by the standard twice-daily dosing of the immediate-release formulation of NVP. Children were followed for a median of 92 weeks (with a range of 68–116 weeks), and no difference emerged in the frequency of Grade 3 or 4 adverse events between the two groups. The group that initiated NVP without a lead-in dose had a statistically significant increase in the incidence of Grade 2 rash, but most participants were able to continue NVP therapy after a brief interruption. Through 96 weeks, a similar percentage of participants in both groups reached the CD4 count and virologic failure endpoints.

After children in CHAPAS-1 had been on NVP for 2 weeks, investigators conducted a substudy that examined NVP plasma concentrations 3 to 4 hours after a morning dose of NVP. Among children aged <2 years, 3 of 23 children (13%) who initiated at full dose had subtherapeutic NVP levels (<3 mg/L) at 2 weeks compared with 7 of 22 children (32%) who initiated at half dose ($P = 0.16$). No rash events occurred in the substudy group of participants aged <2 years; in the parent CHAPAS study, a strong age effect on rash occurrence was seen, with the risk of rash increasing with age. These findings suggest that a lead-in dose may not be necessary in young children.¹⁵

The standard practice has been to reinstitute half-dose NVP for another 2 weeks in children who have interrupted therapy for 7 days or longer; however, given the current understanding of NVP resistance, the half-life of CYP enzymes,¹⁶ and the results of CHAPAS-1, the Panel recommends restarting full-dose NVP in children who interrupt therapy for 14 days or less.

Rilpivirine (RPV, Edurant)

Updated: June 25, 2026

Reviewed: June 25, 2026

Formulations			
Tablets <ul style="list-style-type: none">• [Edurant PED] 2.5-mg dispersible tablets for oral suspension• [Edurant] 25-mg tablets			
Fixed-Dose Combination Tablets <ul style="list-style-type: none">• [Complera] Emtricitabine 200 mg/rilpivirine 25 mg/tenofovir disoproxil fumarate 300 mg• [Juluca] Dolutegravir 50 mg/rilpivirine 25 mg• [Odefsey] Emtricitabine 200 mg/rilpivirine 25 mg/tenofovir alafenamide 25 mg			
When using fixed-dose combination (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 .			
Co-packaged Formulations <ul style="list-style-type: none">• [Cabenuva Kit] Cabotegravir 400 mg/2 mL (200 mg/mL) and rilpivirine 600 mg/2 mL (300 mg/mL) suspension for intramuscular injection• [Cabenuva Kit] Cabotegravir 600 mg/3 mL (200 mg/mL) and rilpivirine 900 mg/3 mL (300 mg/mL) suspension for intramuscular injection			
When using the co-packaged formulation, refer to the Cabotegravir section for additional information.			
For additional information, see Drugs@FDA or DailyMed .			
Dosing Recommendations		Selected Adverse Events	
Infants and Children Aged <2 Years and Weighing <14 kg Dose <ul style="list-style-type: none">• Rilpivirine (RPV) is not approved for use in infants and children aged <2 years and/or weighing <14 kg. [Edurant PED] RPV Dispersible Tablets <i>Child (Aged ≥2 Years and Weighing ≥14 kg to <25 kg) Dose</i>		<ul style="list-style-type: none">• Depression• Insomnia• Headache• Rash, which can be severe and include DRESS (drug reaction [or rash] with eosinophilia and systemic symptoms)• Hepatotoxicity• Altered adrenocorticotrophic hormone stimulation test of uncertain clinical significance	
Pediatric Body Weight	Recommended Dose^a of RPV Dispersible Tablets		
14 kg to <20 kg	12.5 mg once daily with meal		5
20 kg to <25 kg	15 mg once daily with meal		6
≥25 kg	Not recommended	N/A	
		Special Instructions	
		<ul style="list-style-type: none">• Do not start RPV in children with HIV RNA >100,000 copies/mL because of the increased risk of virologic failure.	

[Edurant] RPV Tablets

Child and Adolescent (Aged ≥2 Years and Weighing ≥25 kg) and Adult Dose

- RPV 25 mg once daily with a meal in people who are antiretroviral therapy (ART)–naïve and who have HIV RNA ≤100,000 copies/mL or in people who are virologically suppressed (HIV RNA <50 copies/mL) with no history of virologic failure or resistance to RPV and other antiretroviral (ARV) drugs in the new regimen.

[Complera] Emtricitabine (FTC)/RPV/Tenofovir Disoproxil Fumarate (TDF)

Child and Adolescent (Aged ≥12 Years and Weighing ≥35 kg) and Adult Dose

- One tablet once daily with a meal in people who are ART-naïve with baseline viral loads ≤100,000 copies/mL. One tablet once daily also can be used to replace the current ARV regimen in people who are currently on their first or second regimen and who have been virologically suppressed (HIV RNA <50 copies/mL) for at least 6 months with no history of treatment failure and no known mutations associated with resistance to the individual components of Complera.

[Juluca] Dolutegravir (DTG)/RPV

Adult Dose

- One tablet once daily with a meal as a complete regimen to replace the current ARV regimen in adults who have been virologically suppressed (HIV RNA <50 copies/mL) on a stable ARV regimen for at least 6 months with no history of treatment failure and no known mutations associated with resistance to the individual components of Juluca.
- Not approved for use in children or adolescents (see the Simplification of Treatment section below).

[Odefsey] FTC/RPV/Tenofovir Alafenamide (TAF)

Child (Weighing ≥25 kg) and Adolescent and Adult Dose

- One tablet once daily with a meal in people who are ART-naïve with HIV RNA ≤100,000 copies/mL. One tablet once daily also can be used to replace a stable ARV regimen in people who have been virologically suppressed (HIV RNA <50 copies/mL) for at least 6 months with no history of treatment failure and no known mutations associated with resistance to the individual components of Odefsey.

- RPV concentrations are significantly increased when either RPV or DTG/RPV is administered with a moderate- or high-fat meal.¹ Children must be able to take RPV (or DTG/RPV) with a meal of at least 500 calories on a regular schedule (a protein drink alone does not constitute a meal).
- **Do not use** RPV with other non-nucleoside reverse transcriptase inhibitors.
- **Do not use** RPV with proton pump inhibitors (e.g., omeprazole, pantoprazole).
- Antacids should only be taken at least 2 hours before or at least 4 hours after RPV.
- H2 receptor antagonists (e.g., cimetidine, famotidine) should only be administered at least 12 hours before or at least 4 hours after RPV.
- Use RPV with caution when coadministering it with a drug that has a known risk of prolonging the QTc (QT corrected for heart rate) interval or causing Torsades de Pointes (for more information, see [CredibleMeds](#)).
- For RPV dispersible tablets, fully disperse the dispersible tablets in 5 mL (1 teaspoon) of room temperature drinking water in a cup and take immediately with a meal. If not taken immediately, the oral suspension should be discarded and a new dose prepared. Swirl the cup carefully for 1–2 minutes to disperse the tablets. The solution will start to look cloudy. The oral suspension can be further diluted with 5 mL (1 teaspoon) of drinking water, milk, orange juice, or applesauce. Swirl and take all the medicine immediately. A spoon can be used to give the prepared medicine if needed. Make sure the entire dose is taken and no medicine is left in the cup. If necessary, add another 5 mL (1 teaspoon) of drinking water (or alternative beverage or soft food), swirl, and drink immediately.
- RPV dispersible tablets **should not** be chewed or swallowed whole.
- Different formulations are not substitutable. Do not substitute RPV tablets and RPV dispersible tablets on a milligram-per-milligram basis because they have differing pharmacokinetic profiles. When a child weighs ≥25 kg, switch from RPV dispersible tablets to one 25-mg RPV tablet daily.

[Cabenuva] Cabotegravir (CAB) and RPV Kit

Child and Adolescent (Aged ≥12 Years and Weighing ≥35 kg) and Adult Dose

- Cabenuva is a two-drug co-packaged product for intramuscular (IM) injection that is approved by the U.S. Food and Drug Administration as a complete regimen for the treatment of HIV-1 in people with HIV RNA levels <50 copies/mL on a stable ARV regimen with no history of treatment failure and no known or suspected resistance to CAB or RPV.
- Oral lead-in dosing for at least 28 days can be used to assess tolerability prior to initiating IM CAB and RPV injections or people can proceed directly to IM CAB and RPV on the last day of their current ARV regimen.
- Refer to the [Cabotegravir](#) section for dosing information.
- Long-acting CAB and RPV for IM injection are not approved for children aged <12 years.

- Screen children for hepatitis B virus (HBV) infection before using FDC tablets that contain TDF or TAF. Severe acute exacerbation of HBV infection can occur when TDF or TAF are discontinued (see the [Tenofovir Disoproxil Fumarate](#) and [Tenofovir Alafenamide](#) sections). Therefore, hepatic function and hepatitis B viral load should be monitored for several months after therapy with TDF or TAF is discontinued in children with HBV.
- Refer to the [Cabotegravir](#) section for special instructions when using CAB and RPV for IM injection.

Metabolism/Elimination

- Cytochrome P450 3A substrate
- Refer to the [Cabotegravir](#) section for information about the IM CAB and RPV regimen.

RPV Dosing in Children With Hepatic Impairment

- No dose adjustment is necessary in children with mild or moderate hepatic impairment.

RPV Dosing in Children With Renal Impairment

- RPV decreases tubular secretion of creatinine and slightly increases measured serum creatinine, but it does not affect glomerular filtration.
- No dose adjustment is necessary in children with mild or moderate renal impairment. However, RPV should be used with caution in children with severe renal impairment or end-stage renal disease. These children should be monitored more frequently for adverse events; renal dysfunction may alter drug absorption, distribution, and metabolism, leading to increased RPV concentrations.
- The FDC tablet Complera **should not be used** in children with creatinine clearance (CrCl) <50 mL/min, and the FDC tablet Odefsey **should not be used** in children with CrCl <30 mL/min. Children with CrCl <30 mL/min who are taking Juluca should be monitored closely.
- When using Complera, see the [Tenofovir Disoproxil Fumarate](#) section of the guidelines; when using Odefsey, see the [Tenofovir Alafenamide](#) section.

^a Recommended dose in children who are ART-naïve and who have HIV RNA ≤100,000 copies/mL or in children who are virologically suppressed (HIV RNA <50 copies/mL) with no history of virologic failure or resistance to RPV and other ARV drugs in the new regimen.

Drug Interactions

Additional information about drug interactions is available in the [Liverpool HIV Drug Interaction Checker](#).

- *Metabolism:* Rilpivirine (RPV) is a cytochrome P450 (CYP) 3A substrate, and concentrations may be affected when administered with CYP3A-modulating medications.
- A child's medication profile should be carefully reviewed for potential drug interactions before RPV is administered.
- Coadministering RPV with drugs that increase gastric pH may decrease plasma concentrations of RPV.
 - o Antacids should only be taken at least 2 hours before or at least 4 hours after RPV.
 - o H2 receptor antagonists should only be administered at least 12 hours before or at least 4 hours after RPV.
 - o **Do not use** RPV with proton pump inhibitors.
- All the rifamycins significantly reduce RPV plasma concentrations; coadministration of rifampin and oral RPV is **contraindicated**. For children who are concomitantly receiving rifabutin and oral RPV, the dose of RPV should be doubled to 50 mg once daily and taken with a meal. Intramuscular (IM) RPV given with IM cabotegravir (CAB) is **contraindicated** with rifampin, rifabutin, and rifapentine.
- In a cohort of adolescents, RPV exposure was two to three times greater when RPV was administered in combination with darunavir/ritonavir (DRV/r) than when RPV was administered alone.²

Major Toxicities

- *More common:* Insomnia, headache, rash
- *Less common (more severe):* Depression or mood changes, suicidal ideation
In studies of adults, 7.3% of participants who were treated with RPV showed a change in adrenal function characterized by an abnormal 250-microgram (mcg) adrenocorticotrophic hormone (ACTH) stimulation test (peak cortisol level <18.1 mcg/dL). In a study of adolescents, 6 of 30 participants (20%) developed this abnormality.³ The clinical significance of these results is unknown.
- *Rare:* RPV drug-induced liver injury has been reported.⁴

Resistance

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

Transmitted drug resistance to second-generation non-nucleoside reverse transcriptase inhibitors (NNRTIs) may be present in infants and children who have recently received a diagnosis of HIV.

Pediatric Use

Approval

With the viral load and antiretroviral (ARV) resistance restrictions noted above, RPV (Edurant) used in combination with other ARV agents, the fixed-dose combination (FDC) tablet emtricitabine/rilpivirine/tenofovir disoproxil fumarate (FTC/RPV/TDF; Complera), and the long-acting regimen of cabotegravir (CAB) and RPV for IM injection (IM CAB and RPV; Cabenuva) are all approved by the U.S. Food and Drug Administration (FDA) for use in people aged ≥ 12 years and weighing ≥ 35 kg. The FDC tablet emtricitabine/rilpivirine/tenofovir alafenamide (FTC/RPV/TAF; Odefsey) is approved for people weighing ≥ 25 kg. RPV dispersible tablets (Edurant PED) are approved for children aged ≥ 2 years and weighing ≥ 14 kg to < 25 kg. The FDC tablet dolutegravir/rilpivirine (DTG/RPV; Juluca) **is not approved** for use in children or adolescents at the time of this review.

Efficacy in Clinical Trials

An RPV-containing regimen has been compared to an efavirenz (EFV)-containing regimen in two large clinical trials in adults—ECHO and THRIVE. In both studies, RPV was shown to be non-inferior to EFV. Participants with pre-treatment HIV viral loads $\geq 100,000$ copies/mL who received RPV had higher rates of virologic failure than those who received EFV. These findings resulted in FDA approval for initial therapy with RPV only in people with HIV viral loads $\leq 100,000$ copies/mL.

A study of antiretroviral therapy (ART)—naïve adolescents aged 12 to 17 years demonstrated that RPV 25 mg, given once daily in combination with two nucleoside reverse transcriptase inhibitors (NRTIs), was well tolerated over 48 weeks. In adolescents with baseline viral loads $\leq 100,000$ copies/mL, 86% had a virologic response at 24 weeks and 79% had a virologic response at 48 weeks. In adolescents with baseline viral loads $> 100,000$ copies/mL, 38% had a virologic response at 24 weeks and 50% had a virologic response at 48 weeks.⁵

People must be able to take RPV on a regular schedule and with a full meal, which may limit its usefulness for some adolescents with irregular schedules. The FDC formulation Odefsey is a small pill and can be useful for certain children or adolescents who have difficulty swallowing pills or want to switch from a multi-pill regimen and who do not have any drug-resistance mutations associated with components of Odefsey.

A Spanish multicenter observational study enrolled 17 adolescents (aged < 18 years) who acquired HIV perinatally to receive FTC/RPV/TDF (Complera) as part of an off-label medication use program. At the time of enrollment, 12 participants were on a protease inhibitor–based regimen, 4 were on an NNRTI-based regimen, and 1 had not received ART. After a median follow-up of 90 weeks (for participants with undetectable viral loads at baseline) or 40 weeks (for participants with detectable viral loads at baseline), 86% and 89% of participants, respectively, maintained and achieved an undetectable viral load. None of the participants discontinued RPV-based therapy because of adverse events (AEs); no skin rashes or central nervous system (CNS)–related events were observed. In addition, serum lipids improved, and two adolescents with a history of insomnia and abnormal dreams while receiving EFV-based therapy did not report similar problems while receiving RPV-based therapy.⁶

Another study evaluated 102 virologically suppressed Thai adolescents who were switched from an EFV-based therapy to an RPV-based therapy. Ninety-four of the adolescents remained virologically suppressed through 48 weeks; six experienced virologic failure. Overall, RPV was well tolerated. No improvement in EFV-related symptoms (e.g., sleep, mood, dizziness, headache, concentration) was observed, and no change in quality of life or depression scores could be documented; however,

there were significant improvements in some assessments of cognitive and executive function as measured at Week 24.⁷

Pharmacokinetics

The Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV (the Panel) has agreed that the use of RPV may be appropriate in certain children weighing ≥ 25 kg. However, the Panel advises consulting an expert in pediatric HIV infection prior to prescribing RPV for a child in this group.

An international (India, Thailand, Uganda, and South Africa) Phase 2 trial—Pediatric Study in Adolescents Investigating a New NNRTI TMC278 (PAINT)—investigated a 25-mg dose of RPV given in combination with two NRTIs in ARV-naïve adolescents aged 12 years to <18 years who weighed ≥ 32 kg and who had viral loads $\leq 100,000$ copies/mL.⁵ In the dose-finding phase of the study, 11 adolescents aged >12 years to ≤ 15 years and 12 adolescents aged >15 years to ≤ 18 years underwent intensive pharmacokinetics (PK) assessment after they took an observed dose of RPV with a meal. PK were comparable to those in adults; results are listed in the table below.⁸

Table A. Rilpivirine Pharmacokinetics in Adults and Adolescents Aged 12 Years to <18 Years

Parameter	Adults	Adolescents Aged 12 Years to <18 Years
Dose	RPV 25 mg once daily	RPV 25 mg once daily
Number of Participants Studied	679	34
AUC_{24h} (ng·h/mL)		
Mean $\pm$ SD	2,235 $\pm$ 851	2,424 $\pm$ 1,024
Median (Range)	2,096 (198–7,307)	2,269 (417–5,166)
C_{0h} (ng/mL)		
Mean $\pm$ SD	79 $\pm$ 35	85 $\pm$ 40
Median (Range)	73 (2–288)	79 (7–202)

Source: Adapted from Rilpivirine [package insert]. Food and Drug Administration. 2021. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/202022s014lbl.pdf.

Key: AUC_{24h} = area under the curve after 24 hours; C_{0h} = plasma concentration just prior to next dose; RPV = rilpivirine; SD = standard deviation

In Cohort 2 of the PAINT study, the PK of weight-based RPV were investigated in ARV-naïve children with HIV-1 who are aged ≥ 6 years to <12 years ($n = 14$ with reported PK data). RPV exposures were similar across the recommended once-daily weight-based doses and comparable to exposures seen in adults.⁹

In a PK study of adolescents and young adults aged 13 to 23 years who received RPV,² RPV exposure was comparable to the exposure observed during the PAINT study in participants who received 25-mg doses of RPV without DRV/r and substantially higher than the exposure observed in those who received 25-mg doses of RPV with DRV/r (RPV area under the curve in this study was

6,740 ng·h/mL). No dose adjustments are currently recommended for adults when RPV is coadministered with DRV/r, where a similar twofold to threefold increase in RPV exposure has been reported.³

RPV has been reported to have fewer CNS AEs than EFV, and it has been promoted as a replacement ARV drug for some people who experience CNS effects while receiving EFV. However, concern exists that the prolonged half-life of EFV might result in residual drug levels that could have an impact on RPV levels. A study evaluated 20 Thai adolescents 4 weeks after they switched from EFV to RPV. The PK parameters of RPV in this study population were comparable to those in previous pediatric (PAINT) and adult (ECHO/THRIVE) PK substudies. No virologic failure was detected at 12 or 24 weeks, and no participants discontinued RPV because of AEs.¹⁰

Simplification of Treatment

Juluca is an FDC tablet that contains DTG 50 mg and RPV 25 mg. The results from two trials in adults (SWORD-1 and SWORD-2) supported FDA approval of DTG/RPV as a complete regimen for treatment simplification or maintenance therapy in certain people. The two identical SWORD trials enrolled 1,024 participants with suppressed viral replication who had been on stable ART for at least 6 months and had no history of treatment failure or evidence of resistance mutations that are associated with DTG or RPV. The participants were randomized to receive DTG/RPV (“early switch”) or to continue their suppressive ARV regimen. After 48 weeks of treatment, 95% of participants in both arms maintained HIV RNA <50 copies/mL.¹¹ After 52 weeks, the participants who had been randomized to continue their suppressive ARV regimen were switched to DTG/RPV (“late switch”). At 148 weeks of treatment, 84% of the early switch participants and 90% of the late switch participants remained virologically suppressed, and only 11 participants receiving dual therapy (DTG/RPV) met virologic failure criteria. No integrase inhibitor resistance was identified.¹² More AEs were reported and more AEs led to treatment discontinuation in the DTG/RPV arm during the comparative randomized phase. In a subgroup of SWORD study participants whose original ARV regimen contained tenofovir disoproxil fumarate, small but statistically significant increases in hip and spine bone mineral density were observed.¹³ Although DTG/RPV as Juluca is not approved for use in adolescents, the doses of both component drugs that make up Juluca are approved for use in adolescents. This product may be appropriate for certain adolescents; however, because the strategy of treatment simplification has not been evaluated in adolescents, who may have difficulties adhering to therapy, the Panel **does not recommend** using Juluca in adolescents and children until more data are available.

Long-Acting Injectable Rilpivirine

A long-acting IM injectable formulation of RPV is approved for coadministration with IM CAB as a complete ARV regimen for children and adolescents aged ≥12 years and weighing ≥35 kg and adults with HIV RNA levels <50 copies/mL, on a stable ARV regimen, with no history of treatment failure, and no known or suspected resistance to CAB or RPV.¹⁴ This formulation has been evaluated in adults as monthly or every-other-month IM injections following an initial oral lead-in daily dose for 4 weeks to assess toxicity.¹⁵⁻¹⁷ These studies in adults demonstrated non-inferior efficacy to standard oral therapy and good participant satisfaction and tolerability through 96 weeks. A follow-on study demonstrated that dosing IM CAB and RPV every 2 months in virally suppressed participants provided similar safety and efficacy to monthly injections through 48 weeks.¹⁸ Additionally, an extension of one study evaluated the benefit of oral lead-in therapy prior to initiating IM CAB and RPV, demonstrating that initial oral therapy can be optional based on the needs and desires of people initiating treatment.¹⁹ [IMPAACT study 2017](#), More Options for Children and Adolescents (MOCHA), evaluated the safety, tolerability, acceptability, and PK profile of IM CAB and RPV in adolescents weighing ≥35 kg and has reported acceptable PKs and safety for the single IM products administered monthly and good acceptability by both adolescents and their parents.^{20,21} [In Cohort 2 of IMPAACT 2017/MOCHA, dual IM CAB and RPV administered to adolescents at](#)

recommended adult dosages every 8 weeks showed no unanticipated safety concerns in the 24 weeks following administration. See the [Cabotegravir](#) section for more information about this regimen.

Toxicity

In the PAINT study, the observed AEs were similar to those reported in adults (e.g., somnolence, nausea, vomiting, abdominal pain, dizziness, headache). The incidence of depressive disorders was 19.4% (7 of 36 participants) compared to 9% in the Phase 3 trials in adults. The incidence of Grade 3 and 4 depressive disorders was 5.6% (2 of 36 participants).³

Six of 30 adolescents (20%) with a normal ACTH stimulation test at baseline developed an abnormal test during the trial. No serious AEs, deaths, or treatment discontinuations were attributed to adrenal insufficiency. The clinical significance of abnormal ACTH stimulation tests is not known, but this finding warrants further evaluation.³

Crushing Tablets for Enteral Administration

Some cases report DTG/RPV tablets' being crushed and successfully administered via an enteral tube.²² If DTG/RPV is administered via enteral tube, care should be taken to disperse the tablets completely and flush the tube to avoid clogging.

APPENDIX A: PEDIATRIC ANTIRETROVIRAL DRUG INFORMATION

Protease Inhibitors

Atazanavir (ATV, Reyataz)

Darunavir (DRV, Prezista)

Lopinavir/Ritonavir (LPV/r, Kaletra)

Atazanavir (ATV, Reyataz)

Updated: September 30, 2025

Reviewed: September 30, 2025

Formulations					
<p>Powder Packet: 50 mg/packet</p> <p>Capsules: 200 mg, 300 mg</p> <p>Generic Formulations</p> <ul style="list-style-type: none">150-mg, 200-mg, and 300-mg capsules <p>Fixed-Dose Combination Tablets</p> <ul style="list-style-type: none">[Evotaz] Atazanavir 300 mg/cobicistat 150 mg <p>Capsules and powder packets are not interchangeable.</p> <p>For additional information, see Drugs@FDA: FDA-Approved Drugs or DailyMed.</p>					
Dosing Recommendations	Selected Adverse Events				
<p>Neonate Dose</p> <ul style="list-style-type: none">Atazanavir (ATV) is not approved for use in neonates and infants aged <3 months. ATV should not be administered to neonates because of risks associated with hyperbilirubinemia (e.g., bilirubin-induced neurologic dysfunction). <p>Infant and Child Dose</p> <p><i>Powder Formulation of ATV^a</i></p> <ul style="list-style-type: none">The powder formulation of ATV must be administered with ritonavir (RTV).The powder formulation is not approved for use in infants aged <3 months or weighing <5 kg. <p>ATV Powder Dosing Table for Infants and Children Aged ≥3 Months and Weighing ≥15 kg^a</p> <table><tr><th>Weight</th><th>Once-Daily Dose</th></tr><tr><td>15 kg to <25 kg^b</td><td>ATV 250 mg (five packets) plus RTV 100 mg (powder or tablet) with food</td></tr></table> <p><i>Capsule Formulation of ATV^a</i></p> <ul style="list-style-type: none">ATV capsules are not approved for use in children aged <6 years or weighing <15 kg.	Weight	Once-Daily Dose	15 kg to <25 kg^b	ATV 250 mg (five packets) plus RTV 100 mg (powder or tablet) with food	<ul style="list-style-type: none">Indirect hyperbilirubinemiaProlonged electrocardiogram PR interval, first-degree symptomatic atrioventricular block in some patientsNephrolithiasisIncreased serum transaminasesHyperlipidemia (occurs primarily with RTV boosting)
Weight	Once-Daily Dose				
15 kg to <25 kg^b	ATV 250 mg (five packets) plus RTV 100 mg (powder or tablet) with food				
	Special Instructions				
	<ul style="list-style-type: none">Administer ATV with food to enhance absorption.Capsules and powder packets are not interchangeable.Do not open capsules.Because ATV can prolong the PR interval of the electrocardiogram, use ATV with caution in patients with preexisting cardiac conduction system disease or with other drugs that are known to prolong the PR interval (e.g., calcium channel blockers, beta-blockers, digoxin, verapamil).				

Atazanavir/Ritonavir (ATV/r) Capsule Dosing Table for Children and Adolescents Aged ≥6 Years and Weighing ≥15 kg

Weight	Once-Daily Dose
<15 kg	Capsules not recommended
15 kg to <35 kg	ATV/r 200 mg/100 mg, both with food
≥35 kg	ATV/r 300 mg/100 mg, both with food

ART-Naive Patients Who Are Unable to Tolerate RTV

Child and Adolescent (Aged ≥13 Years and Weighing ≥40 kg) and Adult Dose

- ATV 400 mg (capsule formulation only) once daily with food
- ATV powder is not an option because it must be administered with RTV.
- For the capsule formulation, the U.S. Food and Drug Administration (FDA) and the Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV (the Panel) **do not recommend** the use of unboosted ATV in children aged <13 years.
- Although the FDA does allow for unboosted ATV in adolescents aged ≥13 years and weighing ≥40 kg if they are not concurrently taking tenofovir disoproxil fumarate (TDF) or tenofovir alafenamide (TAF), the Panel **does not recommend** the use of unboosted ATV in this population. Unboosted ATV **is not recommended** because adolescents may require doses of ATV that are higher than those recommended for use in adults to achieve target drug concentrations (see Pediatric Use below).

ART-Naive and ART-Experienced Patients

Child and Adolescent (Weighing ≥35 kg) and Adult Dose

- ATV/r 300 mg/100 mg once daily with food^c
- Atazanavir/cobicistat (ATV/c) 300 mg/150 mg once daily with food, administered as single agents simultaneously or as the coformulated drug Evotaz^d
- Both ATV/r and ATV/c must be used in combination with other antiretroviral drugs.

[Evotaz] ATV/c

Child and Adolescent (Weighing ≥35 kg) and Adult Dose

- One tablet once daily with food

- ATV absorption is dependent on low gastric pH; therefore, when ATV is administered with medications that increase gastric pH, dosing adjustments may be indicated (see the Drug Interactions section in the [ATV package insert](#)).
- The plasma concentration and, therefore, the therapeutic effect of ATV can be expected to decrease substantially when ATV is coadministered with proton-pump inhibitors (PPIs). Antiretroviral therapy (ART)–naive patients who are receiving any PPI should receive a dose of that PPI that is equivalent to no more than a 20-mg dose of omeprazole. PPIs should be taken approximately 12 hours before taking boosted ATV. Coadministration of ATV with PPIs **is not recommended** in ART-experienced patients.
- Patients with hepatitis B or C virus infections and patients who have marked elevations in transaminase levels before treatment may have an increased risk of further elevations in transaminase levels or hepatic decompensation.

Powder Administration

- ATV oral powder contains phenylalanine, which can be harmful to patients with phenylketonuria. Each packet of oral powder contains 35 mg of phenylalanine.
- Mix ATV oral powder with at least 1 tablespoon of soft food (e.g., applesauce, yogurt). Oral powder mixed with a beverage (at least 30 mL of milk or water) may be used for older infants who can drink from a cup. For young infants (aged <6 months) who cannot eat solid food or drink from a cup, oral powder should be mixed with at least 10 mL of infant formula and administered using an oral dosing syringe.
- Administer RTV immediately following powder administration.
- Administer the entire dose of oral powder within 1 hour of preparation.

Metabolism/Elimination

- ATV is a substrate and inhibitor of cytochrome P450 (CYP) 3A4 and an inhibitor of CYP1A2, CYP2C9, and uridine diphosphate glucuronosyl transferase 1A1.

ATV Dosing in Patients With Hepatic Impairment

- ATV should be used with caution in patients with mild or moderate hepatic impairment. Consult the manufacturer's prescribing information for the dose adjustment in patients with moderate impairment.

	<ul style="list-style-type: none"> ATV is not recommended in patients with severe hepatic impairment. ATV/r is not recommended in people with any degree of hepatic impairment. <p>ATV Dosing in Patients With Renal Impairment</p> <ul style="list-style-type: none"> No dose adjustment is required for patients with renal impairment. ATV should not be given to ART-experienced patients with end-stage renal disease who are on hemodialysis.
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^a mg/kg dosing is higher for the ATV powder packets than for the capsules. In P1020A, children of similar age and size who were taking ATV powder had lower exposures than those who were taking ATV capsules.

^b Children weighing ≥ 25 kg who cannot swallow ATV capsules may receive ATV 300-mg oral powder (six packets) plus RTV 100-mg oral solution, both administered once daily with food.

^c Adult patients who cannot swallow capsules may take ATV oral powder once daily with food using the adult dose for the capsules. ATV oral powder should be administered with RTV.

^d See the [Cobicistat](#) section for important information about toxicity, drug interactions, and monitoring of patients who receive cobicistat (COBI) and the combination of COBI and TDF.

Drug Interactions

Additional information about drug interactions is available in the [Adult and Adolescent Antiretroviral Guidelines](#) and the [HIV Drug Interaction Checker](#).

- Metabolism:** Atazanavir (ATV) is both a substrate and an inhibitor of the cytochrome P450 (CYP) 3A4 enzyme system and has significant interactions with drugs that are highly dependent on CYP3A4 for metabolism. ATV also competitively inhibits CYP1A2 and CYP2C9. ATV is a weak inhibitor of CYP2C8. ATV inhibits the glucuronidation enzyme uridine diphosphate glucuronosyl transferase (UGT1A1). Because of the potential for multiple drug interactions with ATV, a patient's medication profile should be carefully reviewed for potential drug interactions before administering ATV.
- Nucleoside reverse transcriptase inhibitors (NRTIs):** Tenofovir disoproxil fumarate (TDF) decreases ATV plasma concentrations, and the effect of tenofovir alafenamide (TAF) on unboosted ATV is unknown. Thus, only atazanavir/ritonavir (ATV/r) or atazanavir/cobicistat (ATV/c) should be used in combination with TDF or TAF.
- Non-nucleoside reverse transcriptase inhibitors:** Efavirenz (EFV), etravirine (ETR), and nevirapine (NVP) decrease ATV plasma concentrations significantly. NVP and ETR **should not be administered** to patients who are receiving ATV (with or without a booster). Although the combination of EFV and ATV/r is not commonly used in clinical practice, EFV 600 mg once daily may be used in combination with ritonavir (RTV)-boosted ATV 400 mg once daily in antiretroviral therapy (ART)-naïve patients. ATV/r should be taken with food, and EFV should be taken on an empty stomach, preferably at bedtime. Coadministering ATV/r and EFV in ART-experienced patients **is not recommended** because this combination is expected to result in suboptimal ATV exposure in these patients.
- Integrase strand transfer inhibitors:** ATV is an inhibitor of UGT1A1 and may increase plasma concentrations of raltegravir (RAL). This interaction may not be clinically significant.
- Absorption:** ATV absorption is dependent on low gastric pH. The dose for ATV should be adjusted when it is administered with medications that increase gastric pH. Guidelines for the appropriate doses of ATV to use with antacids, H2 receptor antagonists, and proton-pump

inhibitors in adults are complex and can be found in the [package insert for ATV](#). No information is available on the appropriate doses of ATV to use in children when the drug is coadministered with medications that increase gastric pH.

- Coadministering cobicistat (COBI)—a CYP3A4 inhibitor—and medications that are metabolized by CYP3A4 may increase the plasma concentrations of these medications. This may increase the risk of clinically significant adverse reactions (including life-threatening or fatal reactions) that are associated with the concomitant medications. Coadministration of COBI, ATV, and CYP3A4 inducers may lead to lower exposures of COBI and ATV, a loss of efficacy of ATV, and possible development of resistance.^{1,2} Coadministering COBI and ATV with some antiretroviral (ARV) agents (i.e., with ETR, with EFV in ART-experienced patients, or with another ARV drug that requires pharmacokinetic [PK] enhancement, such as another protease inhibitor [PI] or elvitegravir) may result in decreased plasma concentrations of that agent, leading to loss of therapeutic effect and the development of resistance.

Major Toxicities

- *More common:* Indirect hyperbilirubinemia that can result in jaundice or icterus but is not a marker of hepatic toxicity. Headache, fever, arthralgia, depression, insomnia, dizziness, nausea, vomiting, diarrhea, and paresthesia.
- *Less common:* Prolongation of the electrocardiogram PR interval. Abnormalities in atrioventricular (AV) conduction are generally limited to first-degree AV block, but second-degree AV block has been reported. Rash is generally mild or moderate, but in rare cases includes life-threatening Stevens-Johnson syndrome. Fat maldistribution and lipid abnormalities may be less common than with other PIs. The use of ATV/r is associated with lipid abnormalities, but to a lesser extent than with other boosted PIs.
- *Rare:* New-onset diabetes mellitus, hyperglycemia, ketoacidosis, exacerbation of preexisting diabetes mellitus, spontaneous bleeding in hemophiliacs, and elevation in serum transaminases. Chronic kidney disease, including biopsy-proven cases of granulomatous interstitial nephritis that were associated with the deposition of ATV drug crystals in the renal parenchyma, has occurred. Nephrolithiasis and cholelithiasis have been reported. Hepatotoxicity (patients with hepatitis B virus or hepatitis C virus infections are at increased risk of hepatotoxicity).

Resistance

The International Antiviral Society–USA maintains a [list of updated resistance mutations](#), and the [Stanford University HIV Drug Resistance Database](#) offers a discussion of each mutation.

Pediatric Use

Approval

ATV is approved by the U.S. Food and Drug Administration (FDA) for use in infants (aged ≥ 3 months and weighing ≥ 5 kg), children, and adolescents. Because RTV oral solution is no longer commercially available, use of ATV/r is limited to children weighing ≥ 15 kg who can use the RTV 100-mg powder packet or 100-mg tablet. ATV coformulated with COBI (as Evotaz) has been approved by the FDA for use in pediatric patients weighing ≥ 35 kg.

Efficacy

Studies in ART-naïve adults have shown that ATV/r is as effective as EFV and lopinavir/ritonavir (LPV/r) when administered with two NRTIs.³⁻⁶ In AIDS Clinical Trials

Group (ACTG) A5257, ATV/r was compared to darunavir/ritonavir (DRV/r) or RAL, each administered with a TDF/emtricitabine backbone. Although all three regimens had equal virologic efficacy, the regimen that contained ATV/r was discontinued more frequently than the other regimens because of toxicity, but most often because of hyperbilirubinemia or gastrointestinal complaints.⁷

International Maternal Pediatric Adolescent AIDS Clinical Trials (IMPAACT)/Pediatric AIDS Clinical Trials Group (PACTG) P1020 enrolled 195 ART-naïve and ART-experienced patients with HIV aged 3 months to 21 years. Capsule and powder formulations of ATV given with and without RTV boosting were investigated in this open-label study; area under the curve (AUC) targeting was used to direct dose finding. Of the 195 patients enrolled, 142 patients received ATV-based treatment at the final recommended dose. Among these patients, 58% were ART-naïve. At Week 48, 69.5% of the ART-naïve patients and 43.3% of the ART-experienced patients had HIV viral loads ≤ 400 copies/mL.^{8,9}

Two open-label clinical trials in infants and children, PRINCE-1 and PRINCE-2, studied a powder formulation of ATV that was administered once daily and boosted with liquid RTV.¹⁰⁻¹² In total, 134 infants and children aged ≥ 3 months and weighing between 5 and 35 kg were evaluated. Using a modified intent-to-treat analysis, 28 of 52 ARV-naïve patients (54%) and 41 of 82 ART-experienced patients (50%) had HIV RNA < 50 copies/mL at Week 48. The median increase from baseline in absolute CD4 T lymphocyte cell count at 48 weeks of therapy was 215 cells/mm³ (a 6% increase) in ARV-naïve patients and 133 cells/mm³ (a 4% increase) in ARV-experienced patients.

Pharmacokinetics and Dosing

Oral Capsule

The IMPAACT/PACTG 1020A trial in children and adolescents indicated that ATV could only achieve protocol-defined PK targets in the absence of RTV boosting when used at higher doses (on a mg per kg body weight or mg per m² of body surface area basis) than the 400 mg dose per day that is currently recommended in adults. Median doses of ATV, both with and without RTV boosting, from IMPAACT/PACTG 1020A are outlined in [Table A](#) below.^{9,13} In this study, the AUCs for the unboosted arms were similar to those seen in the ATV/r arms, but the maximum plasma concentration (C_{max}) was higher and the minimum plasma concentration (C_{min}) was lower in the unboosted arms. When administering unboosted ATV to pediatric patients, therapeutic drug monitoring is recommended to ensure that adequate ATV plasma concentrations have been achieved. A minimum target trough concentration for ATV is 150 ng/mL,¹⁴ but higher target trough concentrations may be required in PI-experienced patients. IMPAACT P1058, a study of unboosted ATV PK in ART-experienced children, concluded that once-daily ATV 400 mg provided suboptimal exposure and that administering higher, unboosted doses or splitting the daily dose into twice-daily doses warranted investigation in ART-experienced children, adolescents, and young adults.¹⁵

In contrast to unboosted ATV, PK criteria were satisfied at a dose of at least 205 mg per m² of body surface area in pediatric subjects when ATV was administered with RTV.¹³ A model-based approach that used ATV concentration–time data from three adult studies and one pediatric study (P1020A),¹⁶ along with refined PK modeling,¹⁷ informed the current FDA-approved product label for children aged ≥ 6 years to < 18 years and weighing ≥ 15 kg.

Table A. Summary of Atazanavir Dosing Information Obtained From IMPAACT/PACTG 1020A

Age Range	ATV Given With RTV	ATV Median Dose (mg/m ²) ^a	ATV Median Dose (mg)
6–13 years	No	509	475
6–13 years	Yes	206	200
>13 years	No	620	900
>13 years	Yes	195	350

^a These doses satisfied protocol-defined area under the curve/pharmacokinetic parameters and met all acceptable safety targets. These doses differ from those recommended by the manufacturer. Therapeutic drug monitoring was used to determine patient-specific dosing in this trial.

Source: Kiser JJ, Rutstein RM, Samson P, et al. Atazanavir and atazanavir/ritonavir pharmacokinetics in HIV-infected infants, children, and adolescents. *AIDS*. 2011;25(12):1489-96.

Key: ATV = atazanavir; RTV = ritonavir

Cobicistat as a Pharmacokinetic Enhancer

COBI (as Tybost) is approved by the FDA at the 150-mg dose for use with ATV 300 mg in children and adolescents weighing ≥35 kg. A study of 14 adolescents, aged 12 to 18 years, showed that COBI is a safe and effective PK enhancer when used in combination with ATV and two NRTIs in adolescent patients.¹⁸ PK findings from this study are summarized in [Table B](#) below.

Table B. Pharmacokinetic Parameters for Atazanavir Administered With Cobicistat (as Tybost) in Pediatric Patients Aged 12 to 18 Years and Adults

PK Parameters ^a	ATV		COBI	
	Pediatric Patients (n = 12)	Adult Patients (n = 30)	Pediatric Patients (n = 12)	Adult Patients (n = 30)
AUC _{tau} µg·h/mL Geometric mean (CV%)	49.48 (49.1)	39.96 (52.1)	12.11 (44.7)	9.65 (41.8)
C _{max} µg/mL Geometric mean (CV%)	4.32 (49.9)	3.54 (45.8)	1.28 (31.7)	1.28 (35.6)
C _{tau} µg/mL Geometric mean (CV%)	0.91 (96.4)	0.58 (84.7)	0.09 (156.2)	0.04 (112.7)

^a The information in this table comes from the Tybost package insert.¹

Key: ATV = atazanavir; 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; COBI = cobicistat; CV = coefficient of variation; PK = pharmacokinetic

Oral Powder

The unboosted ATV powder arms in IMPAACT/PACTG P1020A were closed because participants were unable to achieve protocol-defined AUC target exposures of 30,000 to 90,000 ng·hr/mL based on exposures in adults on unboosted ATV. Children aged 3 months to 2 years who were in the boosted ATV powder cohorts and received a daily dose of ATV 310 mg per m² of body surface area achieved average ATV exposures that approached, but did not meet, protocol targets. Variability in exposures was high, especially among the very young children of 3 months to 2 years in this study.⁹

Two separate open-label, multicenter clinical trials assessed the PK, safety, tolerability, and virologic response of ATV oral powder for FDA approval. These included PRINCE-1, which enrolled pediatric patients aged 3 months to <6 years,¹⁰ and PRINCE-2, which enrolled pediatric patients aged 3 months to <11 years.¹ All patients in the PRINCE trials were treated with boosted ATV oral powder and two NRTIs. RTV was administered as an oral solution in PRINCE-1 and as either an oral solution, capsule, or tablet in PRINCE-2.

In total, 134 treated patients (weighing 5 to <35 kg) from both studies were evaluated during the FDA approval process. [Table C](#) lists the recommended doses for each weight band and the PK parameters that were measured during the PRINCE trials, including mean AUC. In these PK studies, although the PK targets were met in all patients using ATV powder except those in the 5 kg to <10 kg weight band, the coefficients of variation were large, especially among the youngest patients.

Table C. Pharmacokinetic Parameters for Atazanavir Powder in Children (PRINCE-1 and PRINCE-2) Versus Capsules in Young Adults and Adults

PK Parameters	PRINCE Trial ^a ATV/r					Young Adult Study ^b	Adult Study
	Dose: 150 mg/ 80 mg Weighing: 5 kg to <10 kg	Dose: 200 mg/ 80 mg Weighing: 5 kg to <10 kg	Dose: 200 mg/ 80 mg Weighing: 10 kg to <15 kg	Dose: 250 mg/ 80 mg Weighing: 15 kg to <25 kg	Dose: 300 mg/ 100 mg Weighing: ≥25 kg to <35 kg		
AUC ng·h/mL Mean ^c (CV% or 95% CI)	32,503 (61) n = 20	39,519 (54) n = 10	50,305 (67) n = 18	55,687 (45) n = 31	44,329 (63) n = 8	35,971 (30,853– 41,898) n = 22	46,073 (66) n = 10
C_{24h} ng/mL Mean ^c (CV% or 95% CI)	336 (76) n = 20	550 (60) n = 10	572 (111) n = 18	686 (68) n = 31	468 (104) n = 8	578 (474–704) n = 22	636 (97) n = 10

^a This information comes from the Reyataz package insert.¹¹

^b The young adults were also receiving tenofovir disoproxil fumarate.⁸

^c Means are geometric means.

Note: RTV oral solution is no longer available. Use of ATV/r is now limited to children weighing ≥15 mg who can receive 100 mg RTV using powder or tablets.

Key: ATV/r = atazanavir/ritonavir; AUC = area under the curve; CI = confidence interval; CV = coefficient of variation; PK = pharmacokinetic

Transitioning From Powder to Capsules

For children who reach a weight of ≥ 25 kg and require the powder formulation, ATV 300-mg powder (six packets) plus RTV 100-mg powder, both administered once daily with food, may be used. ATV capsules and RTV tablets should be used for children who can swallow pills. Bioavailability is higher for the capsules than for the powder; therefore, a lower mg/kg dose is recommended when using capsules. Opened capsules have not been studied and should not be used.

Toxicity

In the IMPAACT/PACTG 1020A trial, 9% of patients enrolled had a total bilirubin ≥ 5.1 times the upper limit of normal,¹³ whereas 9% of patients enrolled in the PRINCE studies had a total bilirubin ≥ 2.6 times the upper limit of normal.^{10,12} The most common laboratory abnormality during the PRINCE trials was elevated amylase levels, which occurred in 33% of patients.¹¹ Three children (2%) had treatment-related cardiac disorders during the PRINCE trials; one child discontinued therapy because of QT corrected for heart rate (QTc) prolongation, and two experienced first-degree AV block.^{10,12} In IMPAACT/PACTG P1020A, three children (3%) had QTc prolongations >470 msec; two of these children came off the study, and all were asymptomatic.

Darunavir (DRV, Prezista)

Updated: June 25, 2026

Reviewed: June 25, 2026

Formulations	
<p>Oral Suspension: 100 mg/mL</p> <p>Tablets: 75 mg, 150 mg, 600 mg, 800 mg</p> <p>Fixed-Dose Combination (FDC) Tablets</p> <ul style="list-style-type: none"> [Prezcobix] <ul style="list-style-type: none"> Darunavir 800 mg/cobicistat 150 mg Darunavir 675 mg/cobicistat 150 mg Darunavir 600-mg/cobicistat 90-mg dispersible tablet [Symtuza] Darunavir 800 mg/cobicistat 150 mg/emtricitabine 200 mg/tenofovir alafenamide 10 mg <p>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.</p> <p>For additional information, see Drugs@FDA or DailyMed.</p>	
Dosing Recommendations	Selected Adverse Events
<p>Note: Darunavir (DRV) should not be used <i>without</i> a pharmacokinetic enhancer (boosting agent).</p> <p>Neonate/Infant Dose</p> <ul style="list-style-type: none"> DRV is not approved for use in neonates/infants. <p>Child Dose</p> <p><i>Aged <3 Years</i></p> <ul style="list-style-type: none"> Do not use DRV in children aged <3 years or weighing ≤10 kg. In juvenile rats, DRV caused convulsions and death; these events have been attributed to immaturity of the blood–brain barrier and liver metabolic pathways. <p><i>Aged ≥3 Years to <12 Years</i></p> <ul style="list-style-type: none"> Dosing recommendations in the table below are for children aged ≥3 years to <12 years and weighing ≥20 kg who are antiretroviral therapy naive or treatment experienced and with or without resistance testing results that demonstrate that they have at least one mutation that is associated with DRV resistance. 	<ul style="list-style-type: none"> Skin rash, including Stevens-Johnson syndrome and erythema multiforme Hepatotoxicity Diarrhea, nausea Headache Hyperlipidemia, transaminase elevation, hyperglycemia Fat maldistribution
	Special Instructions
	<ul style="list-style-type: none"> Once-daily DRV is not generally recommended for use in children aged <12 years or weighing <40 kg. Dosing estimates for these patients were based on limited data, and limited clinical experience exists with this dosing schedule in this age group. Once-daily DRV should not be used if any one of the following resistance-associated mutations is present: V11I, V32I, L33F, I47V, I50V, I54L, I54M, T74P, L76V, I84V, or L89V. DRV must be administered with food, which increases DRV plasma concentrations by about 30%.

Twice-Daily DRV and Ritonavir (RTV) Doses for Children Aged ≥3 Years to <12 Years and Weighing ≥20 kg

Weight	Dose (Twice Daily with Food) ^a
20 kg to <30 kg ^b	DRV 375 mg (combination of tablets or 3.8 mL) ^d plus RTV 100 mg (tablet or powder) ^c
30 kg to <40 kg ^b	DRV 450 mg (combination of tablets or 4.6 mL) ^{c,d} plus RTV 100 mg (tablet or powder)
≥40 kg ^b	DRV 600 mg (tablet or 6 mL) plus RTV 100 mg (tablet or powder)

Child and Adolescent (Aged ≥12 Years and Weighing ≥30 kg to <40 kg) Dose for Treatment-Naive or Treatment-Experienced Patients With or Without at Least One Mutation Associated With DRV Resistance

- DRV 450 mg (using a combination of tablets) plus RTV 100 mg, both twice daily with food

Child and Adolescent (Aged ≥12 Years and Weighing ≥40 kg)^d and Adult Dose for Treatment-Naive or Treatment-Experienced Patients With No Mutations Associated With DRV Resistance

- DRV 800 mg (using a tablet or combination of tablets) plus RTV 100 mg, both once daily with food

Child and Adolescent (Weighing ≥40 kg) and Adult Dose for Treatment-Naive or Treatment-Experienced Patients With No Mutations Associated With DRV Resistance

- DRV 800 mg plus cobicistat (COBI)^e 150 mg coformulation Prezcoibx, once daily with food

Child and Adolescent (Weighing ≥40 kg) and Adult Dose for Treatment-Experienced Patients With at Least One Mutation Associated With DRV Resistance

- DRV 600 mg plus RTV 100 mg, both twice daily with food
- The use of COBI is **not recommended** with DRV 600 mg twice daily.

- DRV contains a sulfonamide moiety. Use DRV with caution in patients with known sulfonamide allergies.
- Pediatric dosing requires coadministration of tablets of different strengths to achieve the recommended dose for each weight band. It is important to provide careful instructions to caregivers when recommending a combination of different-strength tablets.
- Store DRV tablets and oral suspension at room temperature (25° C or 77° F). The suspension must be shaken well before dosing.
- Screen patients for hepatitis B virus (HBV) infection before using FDC tablets that contain FTC or TAF. Severe acute exacerbation of HBV infection can occur when FTC or TAF are discontinued; therefore, liver function should be monitored for several months after patients with HBV infection stop taking FTC or TAF.

Metabolism/Elimination

- Cytochrome P450 3A4 substrate and inhibitor

DRV Dosing in Patients With Hepatic Impairment

- DRV is primarily metabolized by the liver. Caution should be used when administering DRV to patients with hepatic impairment. DRV is **not recommended** in patients with severe hepatic impairment.

DRV Dosing in Patients With Renal Impairment

- No DRV dose adjustment is required in patients with moderate renal impairment (creatinine clearance [CrCl] 30–60 mL/min).
- The FDC Symtuza is **not recommended** for use in patients with an estimated CrCl <30 mL/min.

Lactation

- **Milk Exposures.** Data from two mothers taking DRV 800 mg and RTV 100 mg daily found that median DRV concentration in breastmilk at 15 hours postdose was 316 mcg/L, corresponding to an infant dosage of 50 mcg/kg daily and a relative infant dose of 0.12% of the maternal weight-adjusted dosage. Another study found breastmilk concentrations all under 250 mcg/mL.

<p>[Prezcobix] DRV/COBI</p> <p>Child (Aged ≥3 Years and Weighing ≥15 kg to <25 kg) Dose for Treatment-Naïve or Treatment-Experienced Patients With No Mutations Associated With DRV Resistance</p> <ul style="list-style-type: none"> One DRV 600-mg/COBI 90-mg tablet for oral suspension once daily with food (disperse in drinking water) <p>Child (Weighing ≥25 kg to <40 kg) Dose for Treatment-Naïve or Treatment-Experienced Patients With No Mutations Associated With DRV Resistance</p> <ul style="list-style-type: none"> One DRV 675 mg/COBI 150 mg tablet once daily with food <p>Child and Adolescent (Weighing ≥40 kg) and Adult Dose for Treatment-Naïve or Treatment-Experienced Patients With No Mutations Associated With DRV Resistance</p> <ul style="list-style-type: none"> One DRV 800-mg/COBI 150-mg tablet once daily with food <p>[Symtuza] DRV/COBI/Emtricitabine (FTC)/Tenofovir Alafenamide (TAF)</p> <p><i>Child and Adolescent (Weighing ≥40 kg) and Adult Dose</i></p> <ul style="list-style-type: none"> One tablet once daily with food in antiretroviral-naïve patients or in patients who have been virologically suppressed (HIV RNA <50 copies/mL) for at least 6 months with no known mutations associated with resistance to DRV or tenofovir. 	<ul style="list-style-type: none"> Infant^f Exposures. Serum concentrations from the breastfed infant of a mother taking DRV/r 800 mg/100 mg were undetectable at 16 hours after the mother's dose. Another retrospective study found that an exclusively breastfed infant of a mother taking DRV/r 800 mg/100 mg had all serum DRV concentrations under 50 mcg/L.^g
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^a Once-daily dosing of DRV is approved by the U.S. Food and Drug Administration (FDA), but the Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV (the Panel) does not generally recommend using this dosing schedule in children (see Frequency of Administration below).

^b RTV oral solution is no longer available. Use of DRV boosted with RTV is now limited to children weighing ≥20 kg who can receive RTV 100 mg using powder or tablets.

^c The volumes for the 375-mg and 450-mg DRV doses are rounded for dosing convenience of suspension.

^d Some Panel members recommend using the FDA-approved dose of once-daily DRV 675 mg (administered using a combination of tablets) plus RTV 100 mg once daily for adolescents weighing ≥30 kg to <40 kg (see [Table B](#) below).

^e See [Cobicistat](#) for important information about toxicity, drug interactions, and monitoring in patients who receive COBI.

^f Infant refers to a young child, from birth through one year of age.

^g For reference, typical serum concentrations in adults taking DRV/RTV 800mg/100mg are 3,000-4,000 mcg/L.

Drug Interactions

Additional information about drug interactions is available in the [Liverpool HIV Drug Interaction Checker](#).

- **Metabolism:** Darunavir (DRV) is primarily metabolized by cytochrome P450 (CYP) 3A4. Both ritonavir (RTV) and cobicistat (COBI) are inhibitors of CYP3A4, thereby increasing the plasma concentration of DRV. Coadministration of DRV plus RTV (DRV/r) or DRV plus COBI (DRV/c) with drugs that are highly dependent on CYP3A clearance creates potential for multiple drug–drug interactions and may be associated with suboptimal efficacy or serious and/or life-threatening events.
- Coadministration of several drugs, including other protease inhibitors (PIs) and rifampin, is **contraindicated** with DRV/r and DRV/c. A study involving adults with HIV suggested that etravirine (ETR) may reduce serum DRV concentrations by induction of CYP3A5, which is more commonly expressed in individuals of African descent.¹ Before administering DRV with a pharmacokinetic (PK) enhancer (boosting agent), a patient's medication profile should be carefully reviewed for potential drug interactions.
- When twice-daily DRV/r was used in combination with tenofovir disoproxil fumarate (TDF) in 13 patients aged 13 to 16 years with HIV, both TDF and DRV exposures were lower than those found in adults treated with the same combination.² No dose adjustment is recommended when using DRV/r with TDF, but caution is advised and therapeutic drug monitoring (TDM) may be useful.³ Data from the International Maternal Pediatric Adolescent AIDS Clinical Trials (IMPAACT) protocol P1058A indicate that coadministering once-daily DRV/r with once-daily or twice-daily ETR in children, adolescents, and young adults aged 9 years to <24 years did not have a significant effect on DRV plasma concentrations.⁴ When DRV/r was coadministered with ETR twice daily in pediatric patients, target concentrations for both DRV and ETR were achieved.⁵ DRV PK were not affected when DRV was coadministered with rilpivirine (RPV) in a study of adolescents and young adults.⁶ DRV/r coadministration increased RPV exposure twofold to threefold; close monitoring for RPV-related adverse events is advisable.
- Coadministration of emtricitabine (FTC)/tenofovir alafenamide (TAF) plus DRV/c in children aged 2 years to <12 years weighing 14 kg to <40 kg had a favorable safety profile without any bone or renal toxicities or adverse weight effects (in an interim analysis at 24 weeks).⁷
- In a drug–drug interaction study in healthy adults without HIV, coadministration of DRV/c with bictegravir (BIC) was associated with increases in BIC exposures (74% increase in area under the concentration time curve over the dosing interval [AUC_{tau}], 52% increase in maximum plasma concentration [C_{max}], and 111% increase in trough concentration [C_{trough}]) compared with BIC administration alone, with no effect on median time to reach maximum concentration.⁸

Major Toxicities

- **More common:** Diarrhea, nausea, vomiting, abdominal pain, headache, and fatigue.
- **Less common:** Skin rash, including erythema multiforme and Stevens-Johnson syndrome; fever and elevated levels of hepatic transaminases; lipid abnormalities; and crystalluria.
- **Rare:** New-onset diabetes mellitus, hyperglycemia, ketoacidosis, exacerbation of preexisting diabetes mellitus, spontaneous bleeding in people with hemophilia, and hepatic dysfunction, particularly in patients with underlying risk factors, such as hepatitis B or hepatitis C virus coinfection.
- **In utero exposure risks:** An analysis of data from the French National Health Data System from 2012 to 2022, including data on 9,035 live single-born children born to mothers with HIV who were all prenatally exposed to antiretroviral (ARV) drugs, found that the incidence⁹ of neurodevelopmental disorders among exposed children was higher than in the general population, even after matching for five sociodemographic criteria (ZIP code, social vulnerability indicator, salary, maternal age, year of birth) and gestational age, (hazard ratio [HR] 1.24, 95% confidence interval [CI], 1.04–1.47). The relative contributions of maternal HIV infection as

opposed to maternal treatment could not be separated, as all children were coexposed to both HIV and its treatment. However, the combination of DRV/r/TDF/FTC was associated with a significantly higher incidence of neurodevelopmental disorders compared to other PIs with TDF/FTC (log rank, $P < 0.001$).

Resistance

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

Pediatric Use

Approval

DRV/r is approved by the U.S. Food and Drug Administration (FDA) as a component of antiretroviral therapy (ART) in treatment-naïve and treatment-experienced children aged ≥ 3 years. Because RTV oral solution is no longer commercially available, use of DRV/r is limited to children weighing ≥ 20 kg who can use the RTV 100-mg powder packet or 100-mg tablet.

DRV is approved by the FDA to be administered with COBI (Tybost) boosting in pediatric patients weighing ≥ 40 kg. The fixed-dose combination (FDC) DRV/c (Prezcobix) is approved by the FDA for use in pediatric patients aged ≥ 3 years weighing ≥ 15 kg at a dose of DRV 600 mg/COBI 90 mg, for use in pediatric patients weighing < 20 kg ≥ 25 kg to < 40 kg at a dose of DRV 675 mg/COBI 150 mg, and for use in people weighing ≥ 40 kg at a dose of DRV 800 mg/COBI 150 mg. DRV/c/FTC/TAF (Symtuza) is approved by the FDA for use in pediatric patients weighing ≥ 40 kg.

A pediatric formulation of Symtuza (DRV 675 mg/COBI 150 mg/FTC 200 mg/TAF 10 mg) is being developed as a scored tablet (to enable splitting) for use in the European Union; this formulation is **not** approved by the FDA. In healthy adults, this FDC was found to be bioequivalent to coadministration of all of the individual formulations of each component of the FDC.¹⁰ In another bioequivalence study, 32 healthy adult participants received either a single dose of the DRV/c 600 mg/90 mg FDC tablet dispersed in water or the separate formulations (DRV 100 mg/mL at a dose of DRV 600 mg/COBI 90 mg), after a ≥ 7 day washout period. The geometric mean ratios for DRV $C_{\max}$ and AUC over the dosing interval of the dispersed DRV 600-mg/ COBI 90-mg FDC tablet versus the separate formulations fell within the prespecified 80% to 125% bioequivalence limits.

The swallowability and acceptability of a placebo tablet (size $21 \times 11 \times 7$ mm) matching this pediatric fixed-dose formulation of Symtuza has been studied in an open-label randomized crossover PK bioequivalence clinical trial in 24 virologically suppressed children with HIV aged 6 years to < 12 years of age weighing 25 kg to < 40 kg.^{11,12} Participants were also taking their stable ART regimen. Twenty-three of 24 (95.8%) participants were able to swallow the whole and the split tablets after one or two attempts; $> 70\%$ of participants rated the tablets to be acceptable or good, and whole tablets were favored over split tablets. In a separate study¹⁰ in children with HIV aged ≥ 3 years and weighing ≥ 15 kg to < 25 kg, the acceptability of a single dose of dispersed DRV 600-mg/COBI 90-mg FDC tablet was evaluated. According to independent observers, 83% (10/12) of the children were able to swallow the dispersion completely and rated the dispersed FDC tablet as “OK” to “very easy” to swallow.

Efficacy in Clinical Trials

In an international, multisite clinical trial (TMC114-TiDP29-C228) that enrolled treatment-experienced children aged 3 years to < 6 years, 17 (81%) of 21 children who received DRV/r twice daily had viral loads < 50 copies/mL at Week 48.¹³⁻¹⁵

A randomized, open-label, multicenter pediatric trial¹⁵ that evaluated twice-daily DRV/r among 80 treatment-experienced children aged 6 years to <18 years reported that 66% of patients had plasma HIV RNA <400 copies/mL and 51% had HIV RNA <50 copies/mL at Week 24.

Once-daily DRV/r has been investigated in a small study involving 12 treatment-experienced children aged 6 to 12 years who had maintained HIV viral loads <50 copies/mL for at least 6 months.¹⁶ All but one child continued to have undetectable viral loads during a median of 11.6 months of follow-up (range 0.5–14.2 months). The remaining child had detectable viral load measurements between 20 copies/mL and 200 copies/mL on three occasions during a 3-month period before, again, becoming undetectable without a change in regimen.

In one study, 12 participants aged 12 to 17 years received DRV/r once daily.¹⁷ After 48 weeks, all but one participant had viral loads <50 copies/mL.

The SMILE (Penta-17-ANRS 152) trial released results¹⁸ showing that a nucleoside/nucleotide reverse transcriptase inhibitor (NRTI)–sparing regimen of integrase strand transfer inhibitor (INSTI) plus boosted DRV was non-inferior to the standard of care (SOC) (i.e., two NRTIs + boosted PI/non-nucleoside reverse transcriptase inhibitor) at 48 weeks in maintaining virologic suppression among children and adolescents with HIV aged 6 to 18 years. Eight (5%) of 158 participants in the INSTI+DRV/r arm and 12 (7.5%) of 160 in the SOC arm had HIV viral loads ≥50 copies/mL at 48 weeks post-enrollment; difference of –2.5% (95% CI, –7.6% to 2.5%), meeting the non-inferiority margin of 10%. Safety was similar between the arms. There were small significant differences between the two arms in CD4 T lymphocyte (CD4) cell count mean change from baseline, high-density lipoprotein (HDL) cholesterol, weight, and body mass index (BMI): CD4 and HDL decreased more in the INSTI+DRV/r arm than in the SOC arm, and weight and BMI had greater increases in the INSTI+DRV/r arm than the SOC arm over the 48 weeks. The difference between the INSTI+DRV/r experimental arm compared to SOC in mean CD4 count change and mean HDL change from baseline were –48.3 cells/mm³ (95% CI, –93.4 to –3.2; *P* = 0.036) and –4.1 mg/dL (95% CI, –6.7 to –1.4; *P* = 0.003), respectively. The differences in weight and BMI between the INSTI+DRV/r experimental arm and the SOC were 1.97 kg (95% CI, 1.1–2.9; *P* < 0.001) and 0.66 kg/m² (95% CI, 0.3–1.0; *P* < 0.001), respectively.

Because of concerns about a potential interaction between DRV/r and dolutegravir (DTG), the SMILE trial (PENTA 17-ANRS152) also assessed the safety, efficacy, and drug interactions of once-daily dual therapy, using DTG 50 mg combined with DRV/r (100 mg/800 mg), both once daily, in virologically suppressed adolescents aged 12 years and older. Unbound DTG concentrations were measured and used in this study. There was a slight effect—DTG clearance was 12.1% lower (and corresponding DTG trough 14.3% higher) when unbound DRV AUC from time zero to 24 hours postdose (AUC_{0-24h}) was higher than 4.7 mg h/L. However, the key finding of this analysis was that there was a clinically negligible impact of DRV/r on DTG concentrations at steady-state.¹⁹ In a separate modeling paper, there was no clinically relevant interaction identified between DRV/r and the clearance of DTG at steady-state, and the influence of unbound DRV exposures on unbound DTG concentrations was quite small.

Observational Data

An observational cohort²⁰ of children and youth <25 years of age on DRV-based ART in nine countries in sub-Saharan Africa found that, over a median duration of follow-up of 28.3 months, 771 (87.9%) were alive at the end of follow-up for the study, 29 (3.6%) died, and 69 (8.5%) moved away or were lost to follow-up; 809 participants had final outcomes. Males were marginally less likely to be retained in care than females (adjusted HR 0.85, 95% CI, 0.72–1.0), and adolescents aged 15 to 19 years were more likely to die than children younger than 10 years (adjusted subdistribution HR 4.20, 95% CI, 1.37–12.87).

In another retrospective study²¹ in India, people aged ≥ 13 years who experienced virological failure on first-line ART and were transitioned to second-line ART (dual NRTI + RTV-boosted PI) between September 2015 and October 2018 were followed for 5 years. Overall, 219 individuals switched to RTV-boosted PI-based second-line ART after 68 (median) months (interquartile range [IQR] 68) of first-line ART exposure and were followed up for 57 (median) months (IQR 48). The incidence of virological failure was 6.9% at 36 months and 15.9% at 60 months. Drug resistance analysis revealed 17.4% lopinavir (LPV) resistance, 34.8% atazanavir resistance, and DRV cross-resistance in only three sequences. The conclusion was that PIs are quite resilient when used as second-line ART and there was a low incidence of virologic failure that was caused by PI resistance.

Pharmacokinetics and Dosing

Pharmacokinetics in Children Aged 3 Years to <6 Years

Twenty-one children aged 3 years to <6 years and weighing 10 kg to <20 kg received twice-daily DRV/r oral suspension. These children had experienced virologic failure on their previous ARV regimens and had fewer than three DRV resistance mutations, confirmed by genotypic testing.^{13,14,22} The DRV area under the curve from 0 to 12 hours (AUC_{0-12h}), measured as a percent of the adult AUC value,^{13,14,22} was 126% overall, 143% in children weighing 10 kg to <15 kg, and 121% in children weighing 15 kg to <20 kg.

The CHAPAS-4 trial²³ examined efficacy and safety of second-line ARV treatment, including DRV/r. The study randomized African children aged 3 to 15 years who had failed first-line treatment to either TAF/FTC (dosed according to World Health Organization [WHO]–recommended weight bands) or SOC dual-NRTI treatment, in combination with DTG or a boosted PI. Out of 919 children, 232 children received DRV/r. There was favorable safety (8.6% of children experienced Grade 3 or 4 adverse events with DRV/r, as compared to 11.5% with LPV/r [$P = 0.31$]). In terms of efficacy criteria of having an HIV viral load <400 copies/mL at 96 weeks, DRV/r failed to meet the pre-specified superiority criteria for comparison to LPV/r and ATV/r (combined analysis) but had numerically higher efficacy (88.3% as compared to 82.5%, adjusted difference 5.6 percentage points; 95% CI, 0.3–11.0; $P = 0.04$ [prespecified threshold, $P = 0.03$]).

The CHAPAS-4 trial included a PK substudy²⁴ in a subset of 104 of children aged 3 to 15 years weighing ≥ 14 kg and receiving a failing first-line ART; plasma PK data were collected at steady-state. TAF was administered in combination with DTG ($n = 18$), DRV/r ($n = 34$), or LPV/r ($n = 20$), and the measured geometric mean (coefficient of variation [CV] %) TAF AUC from dose to the time of the last measurable concentration (AUC_{last}) for those combinations was 284.5 (79), 232.0 (61), and 210.2 (98) ng•hour/mL, respectively, similar to reference values in adults taking TAF 10 mg in conjunction with a boosted PI (adult dosing recommended by the European Medicines Agency). All of the children had TAF $AUC_{last} > 55$ ng•hour/mL, the predefined target value associated with favorable virologic efficacy in adults. In combination with atazanavir/ritonavir ($n = 32$), TAF AUC_{last} was higher, at 511.4 (68) ng•hour/mL, and TAF C_{max} was 86% higher than the C_{max} in adults taking TAF 25 mg with boosted PI. In all of these combinations, tenofovir geometric mean (CV%) AUC_{0-24h} and C_{max} was below the exposures observed in adults taking TAF 25 mg once daily in conjunction with boosted PI (TAF 25 mg dosing for adults is recommended by the FDA, except in the case of the FDC DRV/c/FTC/TAF, in which case the dose is 10 mg of TAF). This study provided reassurance that in children aged 3 to 15 years, TAF can achieve safe and well-tolerated exposures when used in conjunction with DRV/r.²⁵ See the [Tenofovir Alafenamide](#) section for more information.

Pharmacokinetics in Children Aged ≥ 6 Years

Initial pediatric PK evaluation of DRV tablets and RTV oral solution or tablets was based on a Phase 2 randomized, open-label, multicenter study that enrolled 80 treatment-experienced children

and adolescents aged 6 years to <18 years and weighing ≥ 20 kg.²⁶ Part 1 of the trial used a weight-adjusted dose of DRV (9–15 mg/kg) and RTV (1.5–2.5 mg/kg) twice daily, approximating the standard adult dose of DRV/r 600 mg/100 mg twice daily on a per-weight basis. This dose resulted in inadequate drug exposure in the pediatric population studied, with an AUC_{0-24h} that was 81% of the AUC_{0-24h} observed in adults and a predose concentration (C_{0h}) that was 91% of the C_{0h} observed in adults. A pediatric dose that was 20% to 33% higher than the directly scaled adult dose was needed to achieve a drug exposure that was similar to that found in adults, and this was the dose selected for Part 2 of the study. The higher dose used for the safety and efficacy evaluation was DRV 11 to 19 mg/kg and RTV 1.5 to 2.5 mg/kg twice daily. This dose resulted in a DRV AUC_{0-24h} of 123.3 mcg•h/mL (range 71.9–201.5 mcg•h/mL) and a C_{0h} of 3,693 ng/mL (range 1,842–7,191 ng/mL), representing 102% and 114% of the respective values in adults. Doses were given twice daily and were stratified into body-weight bands of 20 kg to <30 kg and 30 kg to <40 kg. The current weight-band doses of twice-daily DRV/r for treatment-experienced pediatric patients weighing >20 kg to <40 kg were selected using the findings from the safety and efficacy portion of this study (see [Table A](#) below).

A small study that involved 12 treatment-experienced children aged 6 to 12 years examined the PK and efficacy of DRV/r once daily administered in combination with abacavir and lamivudine.¹⁶ All participants had maintained HIV plasma viral loads <50 copies/mL for at least 6 months prior to beginning this regimen. The weight-based doses used for once-daily DRV/r were based on a prior modeling study²⁷: 600 mg/100 mg for patients weighing 15 to 30 kg, 675 mg/100 mg for patients weighing 30 to 40 kg, and 800 mg/100 mg for patients weighing >40 kg. The geometric mean AUC_{0-24h} was below the study target of 80% of the value seen in adults (63.1 mg•h/L vs. 71.8 mg•h/L), but the trough values that were observed at 23.1 hours to 25.1 hours after the previous dose exceeded the trough plasma concentration recommended for treatment-experienced adults (0.55 mg/L).²⁸ One child developed neuropsychiatric symptoms (anxiety and hallucinations) and was removed from study. This child did not have an excessive exposure to DRV; the AUC_{0-24h} was 47.8 mg•h/L.

A population PK sub-study was done as part of the SMILE trial,²⁹ examining the protein binding and PK of DRV among virologically suppressed adolescents on an INSTI and DRV/r. A total of 443 plasma PK samples from 152 adolescents were incorporated. The median unbound-to-total concentration ratio was 5.4%; DRV displays a total protein binding in plasma of 94.5% (73.7% bound to alpha-1 glycoprotein and 20.8% bound to albumin). A significant impact of alpha-1 glycoprotein concentrations on DRV clearance was observed. The simulations showed that 86.8% of DRV C_{trough} were above 0.55 mg/L (10 x protein binding-adjusted EC_{50}) for wild-type HIV-1, and 86.8% of DRV *unbound* C_{trough} were above 0.0243 mg/L (10 x PA EC_{90}) for wild-type HIV-1. Overall, individual C_{trough} in adolescents given DRV/r 800 mg/100 mg daily were in line with those observed in adults given DRV/r 800/100 mg daily. This provided reassuring evidence of satisfactory exposures in adolescents given an adult dosing regimen of DRV/r.

The PK substudy of the CHAPAS-4 study also included an analysis of DRV exposures³⁰ in a subset of 59 CHAPAS-4 participants, with median age 10.9 (range 3.8–14.7) years and weight 26.0 (14.5–47.0) kg. The observed DRV geometric mean (%CV) AUC_{0-24h} 94.3(50) mg•h/L and C_{max} , 9.1(35) mg/L were both above exposures seen in adults, but the C_{trough} , 1.5(111) mg/L, was comparable to adult exposures. Children with higher levels of alpha-1-acid glycoprotein were observed to have decreased apparent clearance of DRV, likely due to binding of DRV. Population PK methods were used to simulate the WHO-recommended 600/100 mg DRV/r dose for children in the 25 kg to 34.9 kg weight band, achieving exposures in the range of adult exposures. The conclusion of this PK substudy was that either the simulated dose (600 mg/100 mg) or the CHAPAS-4 studied dose (800 mg/100 mg) had acceptable exposures and could be used in the 25 kg to 34.9 kg weight band, depending on tablet availability.

An analysis of genotypic resistance in children in the CHAPAS-4 study was reassuring. At the 2025 Conference on Retroviruses and Opportunistic Infections (CROI), Week 96 data from this trial were presented on resistance that emerged on study and associations between baseline resistance and ultimate virological failure. Sequencing for resistance (defined using the Stanford algorithm) was performed on baseline samples and on participants who had a week 96 viral load of 400 copies/mL or greater. Intermediate or high-level resistance to the anchor drug was seen at week 96 in: 0/29 LPV/r, 1/26 (4%) ATV/r, 0/18 DRV/r and 2/9 (22%) DTG (all of whom were taking zidovudine as one of their NRTIs).

Table A. Darunavir Pharmacokinetics With Twice-Daily Administration With Ritonavir and Optimized Background Therapy in Children, Adolescents, and Adults

Population	n	Dose of DRV/r	AUC _{12h} (mcg•h/mL) Median ^a	C _{0h} (ng/mL) Median ^a
Children Weighing 10 kg to <15 kg ^a	13	20 mg/kg/3 mg/kg	66.0	3,533
Children Weighing 10 kg to <15 kg ^a	4	25 mg/kg/3 mg/kg	116.0	8,522
Children Weighing 15 kg to <20 kg ^a	11	20 mg/kg/3 mg/kg	54.2	3,387
Children Weighing 15 kg to <20 kg ^a	14	25 mg/kg/3 mg/kg	68.6	4,365
Children Aged 6 Years to <12 Years ^b	24	Determined by weight bands ^b	56.4	3,354
Adolescents Aged 12 Years to <18 Years ^b	50	Determined by weight bands ^b	66.4	4,059
Adults Aged >18 Years ^c (Three Studies)	285/278/119	600 mg/100 mg	54.7–61.7	3,197–3,539

^a Source: U.S. Food and Drug Administration. FDA clinical pharmacologic review of darunavir. 2011. Available at: <https://www.fda.gov/downloads/Drugs/DevelopmentApprovalProcess/DevelopmentResources/UCM287674.pdf>.

^b DRV/r was administered at doses of 375 mg/50 mg twice daily for patients weighing 20 to <30 kg, 450 mg/60 mg twice daily for patients weighing 30 to <40 kg, and 600 mg/100 mg twice daily for patients weighing ≥40 kg. Data from the 2008 FDA pharmacokinetics review. Available at: <https://www.fda.gov/downloads/Drugs/DevelopmentApprovalProcess/DevelopmentResources/ucm129567.pdf>.

^c Source: Darunavir [package insert]. Food and Drug Administration. 2016. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/021976s043.202895s0171bledt.pdf.

Note: Ritonavir (RTV) oral solution is no longer available. Use of DRV/r is now limited to children weighing ≥20 mg who can receive 100 mg RTV using powder or tablets.

Key: AUC_{12h} = 12-hour area under the curve; C_{0h} = predose concentration; DRV/r = darunavir/ritonavir

Dosing

Pharmacokinetic Enhancers

DRV should not be used without a PK enhancer (boosting agent). RTV may be used as a boosting agent in children and adults. COBI may be used as a boosting agent in children weighing ≥ 40 kg and adults.

A study that enrolled 19 Thai children used the RTV 100-mg capsule twice daily as the boosting dose for twice-daily DRV 375 mg (in children weighing 20 kg to <30 kg), 450 mg (in children weighing 30–40 kg), and 600 mg (in children weighing ≥ 40 kg).³¹ The DRV exposures with RTV 100 mg twice daily were similar to those obtained in the studies with lower (<100 mg) doses of liquid RTV.^{26,31} The tolerability and PK data from this small study support the use of RTV 100 mg for boosting using either the powder or tablet formulation in children weighing ≥ 20 kg. No data are available on the safety and tolerability of using DRV with the RTV 100-mg tablet or powder formulation in children weighing <20 kg.

Data on the dosing of DRV/c are available primarily for adult patients.³² Data on once-daily use of the FDC tablet DRV/c 800 mg/150 mg (Prezcobix) showed bioavailability that was comparable to the bioavailability observed with the use of DRV/r 800 mg/100 mg once daily.²⁸

In an open-label switch study, eight adolescent patients with a median age of 14 years (range 12–17 years) who received DRV/c had DRV exposures (AUC_{τ}) that were similar to those observed in adults, except for a lower trough concentration at the end of the dosing interval (C_{τ}). The median DRV C_{τ} (494 ng/mL) was above the protein binding–adjusted half-maximal inhibitory concentration for wild-type virus (55 ng/mL). Adolescent patients in this study received the adult dose of COBI 150 mg daily. DRV dosing was based on weight, with patients who weighed ≥ 40 kg receiving DRV 800 mg once daily and patients who weighed 30 kg to <40 kg receiving DRV 675 mg once daily. In this small sample, 95.5% of patients had HIV RNA <50 copies/mL at Week 12. COBI appeared to be well tolerated with no discontinuations due to adverse events.³³

Frequency of Administration

In February 2013, the FDA approved the use of once-daily DRV for treatment-naïve children and for treatment-experienced children without DRV resistance–associated mutations (see [Table B](#) below). Population PK modeling and simulation were used to develop recommendations for once-daily dosing in younger pediatric subjects aged 3 years to <12 years and weighing 10 kg to <40 kg.^{14,34} Currently, limited data exist on the efficacy of once-daily DRV/r dosing in treatment-naïve or treatment-experienced children aged <6 years. Therefore, the Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV (the Panel) generally recommends dosing DRV/r twice daily in children aged ≥ 3 years to <12 years (see Once-Daily Administration in Children Aged <12 Years and Weighing <40 kg below). The Panel recommends that once-daily DRV/r be used only in treatment-naïve and treatment-experienced adolescents weighing ≥ 40 kg who do not have mutations that are associated with DRV resistance. If DRV and RTV are used once daily in children aged <12 years, the Panel recommends conducting a PK evaluation of plasma concentrations of DRV and closely monitoring viral load.

Table B. U.S. Food and Drug Administration–Approved Once-Daily Dosing for Pediatric Patients Aged ≥3 Years and Weighing >20 kg Who Are Treatment Naïve or Treatment Experienced With No Darunavir Resistance–Associated Mutations

Note: The Panel generally recommends dosing DRV plus RTV *twice daily* in children aged ≥3 to <12 years.

Weight	DRV/r Dose (Once Daily With Food)
20 kg to <30 kg	DRV 600 mg (tablet, combination of tablets, or 6 mL) plus RTV 100 mg (tablet or powder) ^a
30 kg to <40 kg	DRV 675 mg (combination of tablets or 6.8 mL) ^{b,c} plus RTV 100 mg (tablet or powder) ^a
≥40 kg	DRV 800 mg (tablet, combination of tablets, or 8 mL) ^c plus RTV 100 mg (tablet or powder) ^a

^a RTV oral solution is no longer available. Use of DRV/r is now limited to children weighing ≥20 kg who can receive 100 mg RTV using powder or tablets.

^b DRV 100 mg/mL oral suspension; the 675-mg once daily DRV dose is rounded for dosing convenience of suspension.

^c The 6.8-mL and 8-mL DRV doses can be taken as two administrations (3.4 mL and 4 mL, respectively) once daily by refilling the oral dosing syringe supplied by the manufacturer or as one administration once daily if a larger syringe is provided by a pharmacy or provider.

Key: DRV = darunavir; DRV/r = darunavir/ritonavir; RTV = ritonavir

Once-Daily Administration in Children Aged <12 Years and Weighing <40 kg

During the TMC114-C228 trial, the researchers investigated once-daily dosing of DRV for 2 weeks; DRV PK were evaluated in treatment-experienced children aged 3 years to <12 years as part of a substudy. After the conclusion of the substudy, the participants switched back to a twice-daily regimen.^{28,34} The DRV/r dose for once-daily use, which was based on PK simulation and did not include a relative bioavailability factor, was DRV 40 mg/kg coadministered with approximately 7 mg/kg of RTV for children weighing <15 kg and DRV/r 600 mg/100 mg once daily for children weighing ≥15 kg.^{34,35} The PK data obtained from 10 children aged 3 to 6 years in this substudy (see [Table C](#) below) were included as part of the population PK modeling and simulation that was used to determine the FDA-approved dose for once-daily DRV/r in children aged 3 years to <12 years.

In a small study in which DRV/r was administered once daily to 12 treatment-experienced children aged 6 to 12 years,¹⁶ the geometric mean AUC_{0–24h} achieved was below the study target of 80% of the value seen in adults (63.1 mg•h/L vs. 71.8 mg•h/L). Trough values exceeded the plasma concentration that is recommended for treatment-experienced patients (0.55 mg/L). Despite the FDA dosing guidelines, the Panel generally recommends dosing DRV/r twice daily in children aged ≥3 years to <12 years. The Panel makes this recommendation because of the small data set used for once-daily DRV/r PK modeling and the limited amount of data on the use of once-daily DRV/r in children aged <12 years.

Table C. Pharmacokinetics of Once-Daily Darunavir in Children Aged 3 to 6 Years After 2 Weeks of Therapy With Ritonavir and Optimized Background Therapy

PK Parameter	Children Aged 3 to 6 Years (n = 10) ^a	Adults (n = 335)
DRV AUC _{0–24h} geometric mean, ng•h/mL (SD)	115 (40.6)	89.7 (27.0)
DRV C _{0h} geometric mean, ng/mL (SD)	3,029 (1,715)	2,027 (1,168)

^a Source: Kakuda TN, Brochot A, van de Casteele T, et al. Establishing darunavir dosing recommendations in treatment-naïve and treatment-experienced pediatric patients. Presented at: 14th Clinical Pharmacology Workshop on HIV. 2013. Amsterdam, Netherlands. Available at: https://www.natap.org/2013/Pharm/Pharm_19.htm.

Key: AUC_{0–24h} = 24-hour area under the curve; C_{0h} = predose concentration; DRV = darunavir; PK = pharmacokinetic; SD = standard deviation

Once-Daily Administration in Adolescents Aged ≥12 Years and Weighing ≥40 kg

A substudy of once-daily dosing of DRV/r 800 mg/100 mg demonstrated that DRV exposures in 12 treatment-naïve adolescents (aged 12–17 years and weighing ≥40 kg) were similar to those seen in adults treated with once-daily DRV (see [Table D](#) below).¹⁷ After 48 weeks, 83.3% of patients had viral loads <50 copies/mL and 91.7% had viral loads <400 copies/mL.¹⁷ Interestingly, no relationship was observed between DRV AUC_{0–24h} and C_{0h} and virologic outcome (HIV RNA <50 copies/mL) in this study. DRV exposures were found to be similar to those observed in adults with once-daily dosing in another study in which a single dose of DRV/r 800 mg/100 mg was administered to 24 subjects with a median age of 19.5 years (range 14–23 years).³⁶ However, DRV exposures were slightly below the lower target concentrations in adolescent patients aged 14 to 17 years (n = 7) within the cohort, suggesting that higher doses may be needed in younger adolescents. A single case report involving a highly-treatment-experienced adolescent patient suggests that using an increased DRV dose with standard RTV boosting and employing TDM can lead to virologic suppression.

Table D. Darunavir Pharmacokinetics With Once-Daily Administration in Adolescents Aged ≥12 Years and Adults Aged >18 Years

Population	n	Dose of DRV/r	AUC _{0–24h} ^a (mcg•h/L) Median	C _{0h} (ng/mL) Median
Adolescents Aged 12–17 Years (Mean Age 14.6 years) ^b	12	800 mg/100 mg	86.7	2,141
Adolescents and Adults Aged 14–23 Years (Mean Age 19.5 years) ^c	24	800 mg/100 mg	69.5	1,300
Adults Aged >18 Years (Two Studies) ^a	335/280	800 mg/100 mg	87.8–87.9	1,896– 2,041

Table D. Darunavir Pharmacokinetics With Once-Daily Administration in Adolescents Aged ≥12 Years and Adults Aged >18 Years

^a Source: Darunavir [package insert]. Food and Drug Administration. 2020. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/021976Orig1s063lbl.pdf.

^b Source: Kakuda TN, Brochot A, van de Casteele T, et al. Establishing darunavir dosing recommendations in treatment-naïve and treatment-experienced pediatric patients. Presented at: 14th Clinical Pharmacology Workshop on HIV. 2013. Amsterdam, Netherlands. Available at: https://www.natap.org/2013/Pharm/Pharm_19.htm.

^c Source: Flynn P, Blanche S, Giaquinto C, et al. DIONE – 24-week efficacy, safety, tolerability and pharmacokinetics of darunavir/ritonavir once daily in treatment-naïve adolescents aged 12 to < 18 years. Abstract # PP_2. Presented at: 3rd International Workshop on HIV Pediatrics. 2011. Rome, Italy. Available at: https://www.natap.org/2011/IAS/IAS_40.htm.

Key: AUC_{0–24h} = 24-hour area under the curve; C_{0h} = predose concentration; DRV/r = darunavir/ritonavir

The efficacy of once-daily DRV has been established within a limited number of studies in small cohorts of adolescents that reported long-term data on virologic and immunologic outcomes.^{17,37}

Lopinavir/Ritonavir (LPV/r, Kaletra)

Updated: September 30, 2025

Reviewed: September 30, 2025

Formulations	
<p>Oral Solution</p> <ul style="list-style-type: none"> [Kaletra] Lopinavir 80 mg/mL and ritonavir 20 mg/mL (contains 42.4% alcohol by volume and 15.3% propylene glycol by weight/volume) <p>Film-Coated Tablets</p> <ul style="list-style-type: none"> [Kaletra] Lopinavir 100 mg/ritonavir 25 mg [Kaletra] Lopinavir 200 mg/ritonavir 50 mg <p>Generic Formulations</p> <ul style="list-style-type: none"> Lopinavir 80 mg/mL and ritonavir 20 mg/mL oral solution (contains 42.4% alcohol by volume and 15.3% propylene glycol by weight/volume) Lopinavir 100 mg/ritonavir 25 mg oral tablet Lopinavir 200 mg/ritonavir 50 mg oral tablet <p>When using fixed-dose combination (FDC) tablets, refer to other sections of the Drug Appendix 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.</p> <p>For additional information, see Drugs@FDA or DailyMed.</p>	
Dosing Recommendations	Selected Adverse Events
<p>Neonate (Aged <14 Days) Dose</p> <ul style="list-style-type: none"> Lopinavir/ritonavir (LPV/r) is not approved by the U.S. Food and Drug Administration (FDA) for use in neonates before a postmenstrual age of 42 weeks and a postnatal age of at least 14 days. <p>Dosing for Individuals Who Are Not Receiving Concomitant Nevirapine (NVP) or Efavirenz (EFV)</p> <p><i>Infant (Aged 14 Days to 12 Months) Dose</i></p> <ul style="list-style-type: none"> Once-daily dosing is not recommended. LPV/r 300 mg/75 mg per m² of body surface area per dose twice daily. This approximates LPV/r 16 mg/4 mg (both per kg body weight) twice daily. Use of this dose in infants aged <12 months is associated with lower lopinavir (LPV) trough levels than those found in adults; LPV dosing should be adjusted for growth at frequent intervals (see Pharmacokinetics and Dosing below). 	<ul style="list-style-type: none"> Gastrointestinal (GI) intolerance, nausea, vomiting, diarrhea, alteration of taste Hyperlipidemia, especially hypertriglyceridemia Elevated transaminases Hyperglycemia PR interval prolongation QT interval prolongation and Torsades de Pointes Risk of toxicity—including life-threatening cardiotoxicity—is increased in premature infants (see Major Toxicities below).
	<p>Special Instructions</p> <ul style="list-style-type: none"> LPV/r tablets can be administered without regard to food; administration with or after meals may enhance GI tolerability.

Child and Adolescent (Aged >12 Months to ≤18 Years) Dose

- Once-daily dosing **is not recommended**.
- LPV/r 300 mg/75 mg per m² of body surface area per dose twice daily (maximum dose LPV/r 400 mg/100 mg twice daily, except as noted below). For patients weighing <15 kg, this dose approximates LPV/r 13 mg/3.25 mg (both per kg body weight) twice daily. For patients weighing ≥15 kg to 45 kg, this dose approximates LPV/r 11 mg/2.75 mg (both per kg body weight) twice daily. This dose is routinely used by many clinicians and is the preferred dose for antiretroviral therapy—experienced patients who could harbor virus with decreased LPV susceptibility (see Pharmacokinetics and Dosing below).
- LPV/r 230 mg/57.5 mg per m² of body surface area per dose twice daily can be used in antiretroviral (ARV)-naïve patients aged >12 months. For patients weighing <15 kg, this dose approximates LPV/r 12 mg/3 mg per kg body weight given twice daily. For patients weighing ≥15 kg to 40 kg, this dose approximates LPV/r 10 mg/2.5 mg per kg body weight given twice daily. This lower dose **should not be used** in treatment-experienced patients who could harbor virus with decreased LPV susceptibility.
- See the table below for weight-band dosing when using tablets.

Adult (Aged ≥18 Years) Dose

- LPV/r 800 mg/200 mg once daily; or
- LPV/r 400 mg/100 mg twice daily
- **Do not use** once-daily dosing in patients receiving concomitant therapy with NVP or EFV, or patients with three or more LPV-associated mutations (see Special Instructions for a list of mutations).

Dosing for Individuals Receiving Concomitant NVP or EFV

- These drugs induce LPV metabolism and reduce LPV plasma levels. Increased LPV/r dosing is required with concomitant administration of these drugs. Once-daily dosing **should not be used** in these patients.

Infant (Aged 14 Days to 12 Months) Dose

- Once-daily dosing **is not recommended**.
- LPV/r 300 mg/75 mg per m² of body surface area per dose twice daily. This approximates LPV/r 16 mg/4 mg (both per kg body weight) twice daily. Use of this dose in infants aged <12 months is associated with lower lopinavir (LPV) trough levels than those found in adults; LPV dosing should be adjusted for growth at frequent intervals (see Pharmacokinetics and Dosing below).

- LPV/r tablets must be swallowed whole. **Do not crush or split tablets.**
- LPV/r oral solution should be administered with food because a high-fat meal increases absorption.
- The poor palatability of LPV/r oral solution is difficult to mask with flavorings or foods (see Formulations below).
- LPV/r oral solution can be kept at room temperature (up to 77°F or 25°C) if used within 2 months. If kept refrigerated (36°F to 46°F or 2°C to 8°C), LPV/r oral solution remains stable until the expiration date printed on the label.
- Children aged <18 years who receive once-daily dosing of LPV/r have shown considerable variability in plasma concentrations and have a higher incidence of diarrhea. Therefore, once-daily dosing **is not recommended** for this age group.
- **Do not use** once-daily dosing in patients receiving concomitant therapy with NVP or EFV.
- Use of LPV/r once daily is **contraindicated** if three or more of the following LPV resistance-associated substitutions are present: L10F/I/R/V, K20M/N/R, L24I, L33F, M36I, I47V, G48V, I54L/T/V, V82A/C/F/S/T, and I84V. This is because higher LPV trough concentrations may be required to suppress resistant virus.

Metabolism/Elimination

- Cytochrome P450 (CYP) 3A4 substrate and inhibitor. LPV/r **is contraindicated** with (1) drugs that are highly dependent on CYP3A4 for clearance and for which elevated plasma concentrations are associated with serious and/or life-threatening reactions; and (2) drugs that are potent CYP3A inducers for which significantly reduced LPV plasma concentrations may be associated with the potential for loss of virologic response and possible resistance and cross-resistance.
- LPV/r is eliminated primarily by hepatic metabolism. Use caution when administering LPV to patients with hepatic impairment, because LPV concentrations may be increased. No dosing information is currently available for children or adults with hepatic insufficiency.

Child and Adolescent (Aged >12 Months to ≤18 Years) Dose

- Once-daily dosing **is not recommended**.
- LPV/r 300 mg/75 mg per m² of body surface area per dose twice daily. See the table below for weight-band dosing when using tablets.

Adult (Aged ≥18 Years) Dose

- The FDA-approved dose is LPV/r 500 mg/125 mg twice daily, given as a combination of two tablets of LPV/r 200 mg/50 mg and one tablet of LPV/r 100 mg/25 mg. Alternatively, three tablets of LPV/r 200 mg/50 mg can be used for ease of dosing.
- Once-daily dosing **should not be used**.

LPV/r Used in Combination With Maraviroc (MVC)

- MVC doses may need modification (see the [HIV Drug Interaction Checker](#)) and the [Maraviroc](#) section.

Weight-Band Dosing for LPV/r 100-mg/25-mg Pediatric Tablets in Children and Adolescents

Recommended Number of LPV/r 100-mg/25-mg Tablets Given Twice Daily		
Dosing target	300 mg/m ² per dose given twice daily	230 mg/m ² per dose given twice daily
Body Weight		
15 kg to 20 kg	2	2
>20 kg to 25 kg	3	2
>25 kg to 30 kg	3	3
>30 kg to 35 kg	4 ^a	3
>35 kg to 45 kg	4 ^a	4 ^a
>45 kg	4 ^a or 5 ^b	4 ^a

^a Two tablets that each contain LPV/r 200 mg/50 mg can be substituted for the four LPV/r 100-mg/25-mg tablets in children who are capable of swallowing a larger tablet.

^b In patients who weigh >45 kg and who are receiving concomitant NVP or EFV, the FDA-approved adult dose is LPV/r 500 mg/125 mg twice daily, given as a combination of two tablets of LPV/r 200 mg/50 mg and one tablet of LPV/r 100 mg/25 mg. Alternatively, three tablets of LPV/r 200 mg/50 mg can be used for ease of dosing.

- In the coformulation of LPV/r, ritonavir (RTV) acts as a pharmacokinetic enhancer, not as an ARV agent. RTV inhibits the metabolism of LPV and increases LPV plasma concentrations.

Drug Interactions

Additional information about drug interactions is available in the [Adult and Adolescent Antiretroviral Guidelines](#) and the [HIV Drug Interaction Checker](#).

- **Metabolism:** Lopinavir/ritonavir (LPV/r) is a cytochrome P450 (CYP) 3A4 substrate and inhibitor with the potential for multiple drug interactions. Coadministering LPV/r with drugs that induce CYP3A4 may decrease lopinavir (LPV) plasma concentrations, whereas coadministering LPV/r with other CYP3A4 inhibitors may increase LPV plasma concentrations. Coadministering LPV/r with other CYP3A4 substrates may require dose adjustments and additional monitoring.

Before initiating therapy with LPV/r, a patient's medication profile should be carefully reviewed for potential drug interactions. In patients treated with LPV/r, fluticasone (a commonly used inhaled and intranasal steroid) should be avoided, and an alternative steroid should be used. Fluticasone is a CYP3A substrate and LPV/r significantly increases fluticasone exposures, potentially resulting in adverse systemic corticosteroid effects including Cushing's syndrome and adrenal suppression.¹ Drug interactions with antituberculous drugs are common. Coadministration of LPV/r with the antituberculosis drug rifampin—a strong CYP3A4 inducer—may lead to suboptimal LPV levels.²⁻⁴ Patients who are receiving both LPV/r and antituberculous drugs may need a dose adjustment for LPV/r, or they may need to switch to an antiretroviral (ARV) regimen that does not include LPV/r.

Major Toxicities

- **More common:** Diarrhea, headache, asthenia, nausea and vomiting, rash, insulin resistance,⁵ and hyperlipidemia, especially hypercholesterolemia and hypertriglyceridemia,⁶⁻⁸ which may be more pronounced in girls than in boys.⁹ LPV requires a higher dose of ritonavir than some other protease inhibitors (PIs); this higher dose may exacerbate these adverse events.
- **Rare:** New-onset diabetes mellitus, hyperglycemia, ketoacidosis, exacerbation of preexisting diabetes mellitus, hemolytic anemia, spontaneous and/or increased bleeding in hemophiliacs, pancreatitis, elevation in serum transaminases, hepatitis (which has been life-threatening in rare cases), PR interval prolongation, QT interval prolongation, and Torsades de Pointes may occur.¹⁰

Special Populations: Neonates

- An increased risk of toxicity in premature infants has been reported, including cases of transient symptomatic adrenal insufficiency,^{11,12} life-threatening bradyarrhythmias and cardiac dysfunction (including complete atrioventricular block, bradycardia, and cardiomyopathy),¹³⁻¹⁵ lactic acidosis, acute renal failure, central nervous system depression, and respiratory depression. Transient asymptomatic elevation in 17-hydroxyprogesterone levels also has been reported¹¹ in term newborns treated at birth with LPV/r. These toxicities may be caused by the drug itself and/or by the inactive ingredients in the oral solution,¹⁵ which include propylene glycol (15.3%) and ethanol (42.4%).
- Since these cases have been reported, the pharmacokinetics (PK) and safety of LPV/r have been studied in neonates in two clinical trials. In IMPAACT P1106, a Phase 4 prospective study evaluating the safety and PK of ARV medications in low and normal birthweight infants <3 months old, one group received LPV/r as standard of care.¹⁶ A total of 28 neonates with HIV were enrolled, with a median birth weight of 2,288 g (interquartile range [IQR] 1,360–3,320 g) and a median gestational age of 36 weeks (IQR 27–39 weeks). All infants started LPV/r at ≥13 days postnatal age and 34 weeks postmenstrual age. In 25 infants with available PK data, the median LPV dose was 418 mg/m² twice daily (23.6 mg/kg). The median trough LPV level was 5.14 (IQR 2.95–8.51) µg/mL, above the minimal effective target concentration of 1 µg/mL.

Nearly half of infants initiated therapy prior to 42 weeks postmenstrual age with no observed safety or PK differences compared with infants who initiated LPV/r at or after 42 weeks postmenstrual age. No adverse events Grade 3 or higher were considered related to LPV/r treatment. The authors concluded that oral LPV/r solution is safe and effective in preterm infants at ≥ 13 days postnatal age and ≥ 34 weeks postmenstrual age.¹⁶ The PETITE study evaluated the PK and safety of LPV/r oral granules in term neonates exposed to HIV in South Africa.¹⁷ No adverse events of Grade 2 or higher related to study drugs occurred among 16 infants exposed to LPV/r granules. The authors also concluded that administration of LPV/r granules to term neonates beginning at birth was safe and well tolerated.¹⁷ It should be noted that the use of LPV/r oral granules avoids exposure to the excipients present in the oral solution (propylene glycol and ethanol), which may reduce the risk of neonatal toxicity; however, the LPV/r granule formulation is not readily available in the United States.

- Although these recent studies provide some reassurance about the safety of LPV/r in neonates, they enrolled small numbers of participants, and further studies are needed of LPV/r in this age group. The potential benefit of using LPV/r in infants who are < 42 weeks postmenstrual age or < 14 days postnatal age must be carefully balanced against the risk of potentially life-threatening metabolic and cardiac toxicity.

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

LPV/r is approved by the U.S. Food and Drug Administration (FDA) for use in children, including neonates who have attained a postmenstrual age of 42 weeks and a postnatal age of at least 14 days. The potential benefit of using LPV/r in infants who have not met these age thresholds must be carefully balanced with the risk of metabolic and cardiac toxicity. In addition, in pediatric patients receiving LPV/r at a dose of 300 mg/75 mg per m^2 twice daily, lower LPV exposure has been observed in infants aged < 6 weeks relative to older children.¹⁸

Efficacy

Clinical trials involving antiretroviral therapy (ART)–naïve adults have shown that regimens that contain LPV/r plus two nucleoside reverse transcriptase inhibitors are comparable to a variety of other regimens, including regimens that contain atazanavir, darunavir, or efavirenz (EFV).^{19–23}

LPV/r has been studied in both ART-naïve and ART-experienced children and has demonstrated durable virologic activity and acceptable toxicity.^{24–33}

Pharmacokinetics

General Considerations

Children have lower LPV/r exposure than adults when treated with doses that are directly scaled for body surface area. The directly scaled dose approximation of the adult dose in children is calculated by dividing the adult dose by the typical adult body surface area of $1.73 m^2$. For the adult dose of LPV/r 400 mg/100 mg, the scaled pediatric dose would be approximately LPV/r 230 mg/57.5 mg per m^2 of body surface area. However, younger children have higher LPV clearance and need higher

doses to achieve LPV exposures that are similar to those seen in adults treated with standard doses. To achieve a trough concentration (C_{trough}) similar to that observed in adults, the pediatric dose needs to be increased 30% greater than the dose that is directly scaled for body surface area. LPV exposures in infants^{18,26,31} are compared to those in older children²⁴ and adults³⁴ in [Table A](#) below.

Table A. Pharmacokinetics of Lopinavir/Ritonavir by Age

PK Parameters	Adults (n = 19) ³⁴	Children (n = 12) ²⁴	Children (n = 15) ²⁴	Infants ^a at 12 Months (n = 20) ³¹	Infants at 6 Weeks to 6 Months (n = 18) ²⁶	Infants at 14 Days to <6 Weeks (n = 9) ¹⁸
LPV Dose	400 mg	230 mg/m ²	300 mg/m ²	300 mg/m ²	300 mg/m ²	300 mg/m ²
AUC _{0–12h} (mcg·hr/mL)	92.6	72.6	116.0	101.0	74.5	43.4
C _{max} (mcg/mL)	9.8	8.2	12.5	12.1	9.4	5.2
C _{trough} (mcg/mL)	7.1	4.7	7.9	4.9	2.7	2.5
C _{min} (mcg/mL)	5.5	3.4	6.5	3.8	2.0	1.4

^a This column contains unreported data that were originally generated for a published study. The data were provided by Edmund Capparelli, Pharm.D., in a personal communication (April 18, 2012).

Note: Values are means, and PK parameters refer to the LPV component; all data come from studies wherein none of the participants received non-nucleoside reverse transcriptase inhibitors as part of their antiretroviral therapy.

Key: AUC_{0–12h} = area under the curve from time zero to 12 hours after drug administration; C_{max} = maximum plasma concentration; C_{min} = minimum plasma concentration; C_{trough} = trough concentration; LPV = lopinavir; PK = pharmacokinetic

Models suggest that diet, body weight, and postnatal age are important factors in LPV PK, with higher bioavailability as dietary fat increases during the first year of life³⁵ and clearance slowing by age 2.3 years.³⁶ A study from the United Kingdom and Ireland compared outcomes of LPV/r treatment with either 230 mg per m² of body surface area per dose or 300 mg per m² of body surface area per dose in children aged 5.6 to 12.8 years at the time of LPV/r initiation. The findings suggested that the higher dose was associated with improved long-term viral load suppression.³⁷

Pharmacokinetics and Dosing

14 Days to 12 Months (Without Concurrent Nevirapine or Efavirenz)

The PK of the oral solution at approximately LPV/r 300 mg/75 mg per m² of body surface area per dose twice daily were evaluated in infants aged <6 weeks¹⁸ and infants aged 6 weeks to 6 months.²⁶ Even at this higher dose, C_{trough} levels were highly variable, but they were lower in infants than in children aged >6 months. C_{trough} levels were lower in infants aged ≤6 weeks than in infants aged 6 weeks to 6 months. By age 12 months, LPV area under the curve (AUC) was similar to that found in older children.³¹ Because infants grow rapidly in the first months of life, it is important to optimize LPV dosing by adjusting the dose at frequent intervals. Given the safety of doses as high as 400 mg per m² of body surface area in older children and adolescents,²⁷ some practitioners anticipate rapid

infant growth and prescribe doses somewhat higher than the 300 mg per m² of body surface area dose to allow for projected growth between clinic appointments.

12 Months to 12 Years (Without Concurrent Nevirapine or Efavirenz)

Lower C_{trough} values have been observed in children receiving LPV/r 230 mg/57.5 mg per m² of body surface area per dose twice daily than in children receiving LPV/r 300 mg/75 mg per m² of body surface area per dose twice daily (see [Table A](#) above).²³ Therefore, some clinicians choose to initiate therapy in children aged 12 months to 12 years using LPV/r 300 mg/75 mg per m² of body surface area per dose twice daily (when LPV/r is given without nevirapine [NVP] or EFV), rather than the FDA-approved dose of LPV/r 230 mg/57.5 mg per m² of body surface area per dose twice daily.

For infants receiving LPV/r 300 mg/75 mg per m² of body surface area per dose twice daily, immediate dose reduction at age 12 months **is not recommended**; many practitioners would allow patients to “grow into” the dose of LPV/r 230 mg/57.5 mg per m² of body surface area per dose twice daily as they gain weight over time. Some practitioners would continue the infant dose (LPV/r 300 mg/75 mg per m² of body surface area per dose twice daily) while using the LPV/r liquid formulation.

Pharmacokinetics and Dosing With Concurrent Nevirapine or Efavirenz

In both children and adults, the LPV C_{trough} is reduced by concurrent treatment with non-nucleoside reverse transcriptase inhibitors (NNRTIs). Higher doses of LPV are recommended when the drug is given in combination with NVP or EFV. In 14 children who were treated with LPV/r 230 mg/57.5 mg per m² of body surface area per dose twice daily plus NVP,²⁴ the mean LPV C_{trough} was 3.77 ± 3.57 mcg/mL. Not only are these trough plasma concentrations lower than those found in adults treated with standard doses of LPV/r, but the variability in concentration is much higher in children than in adults.^{24,38} In a study of 15 children with HIV aged 5.7 to 16.3 years who were treated with LPV/r 300 mg/75 mg per m² of body surface area per dose twice daily plus EFV 14 mg/kg body weight per dose once daily, there was a 34-fold interindividual variation in LPV C_{trough} values. Five of 15 children (33%) had LPV 12-hour C_{trough} values that were <1.0 mcg/mL, the plasma concentration needed to inhibit wild-type HIV.³⁹ A PK study in 20 children aged 10 to 16 years who were treated with LPV/r 300 mg/75 mg per m² of body surface area twice daily plus EFV 350 mg per m² of body surface area once daily reported only one patient (6.6%) with subtherapeutic LPV C_{trough} values,⁴⁰ perhaps because the trial used an EFV dose that was approximately 11 mg/kg body weight⁴⁰ instead of the 14 mg/kg body weight dose used in the trial discussed above.³⁹

Dosing

Once Daily

A single daily dose of LPV/r 800 mg/200 mg is approved by the FDA for treatment of HIV in treatment-naïve adults aged >18 years. However, **once-daily administration cannot be recommended for use in children in the absence of therapeutic drug monitoring (TDM)**; once-daily administration may be successful in select, closely monitored children.⁴¹ There is high interindividual variability in drug exposure for LPV/r, and trough plasma concentrations may fall below the therapeutic range for wild-type virus, as demonstrated in studies of ARV-naïve children and adolescents.⁴²⁻⁴⁵ The currently available tablet formulation of LPV/r has lower variability in trough levels than the previously used soft-gel formulation.^{45,46} An international, randomized, open-label trial attempted to demonstrate that once-daily LPV/r dosing was non-inferior to twice-daily LPV/r dosing in

children and adolescents with HIV. This trial was unsuccessful, because a greater number of children and adolescents who received once-daily doses had viral loads ≥ 50 copies/mL within 48 weeks.⁴⁷

Dosing and Its Relation to Efficacy

LPV/r is effective in treatment-experienced patients with severe immune suppression,^{48,49} although heavily pretreated patients may be slower to reach undetectable viral loads^{49,50} and may have less robust CD4 T lymphocyte (CD4) cell count percentage responses.⁵¹

The relationship between LPV exposure and the susceptibility of the HIV-1 isolate is a key component of successful treatment. The ratio of C_{trough} to half maximal effective concentration (EC_{50}) is called the inhibitory quotient (IQ), and in both adults and children treated with LPV/r, viral load reduction is more closely associated with IQ than with either C_{trough} or EC_{50} alone.⁵²⁻⁵⁴ One study investigated the use of the IQ as a guide for therapy by administering higher doses of LPV/r to children and adolescents until a target IQ of 15 was reached. This study showed that doses of LPV/r 400 mg/100 mg per m^2 of body surface area per dose twice daily (without NVP or EFV) and LPV/r 480 mg/120 mg per m^2 of body surface area per dose twice daily (with NVP or EFV) were safe and tolerable.²⁷ Results of a modeling study suggest that standard doses of LPV/r may be inadequate for treatment-experienced children and indicate the potential utility of TDM when LPV/r is used in children who were previously treated with PIs.⁵⁵ An LPV plasma concentration of ≥ 1 mcg/mL is cited as a minimum target C_{trough} ,⁵⁶⁻⁵⁸ but this C_{trough} may not adequately control viremia in patients with multiple LPV resistance mutations.^{59,60}

Formulations

Palatability

The poor palatability of the LPV/r oral solution can be a significant challenge to medication adherence for some children and families. Numbing the taste buds with ice chips before or after administering the solution, masking the taste of the solution by administering it with sweet or tangy foods (e.g., chocolate syrup, peanut butter), or having the pharmacist flavor the solution prior to dispensing it are examples of interventions that may improve tolerability. Alternative pediatric formulations of LPV/r, including oral pellets and oral granules, are tentatively approved by the FDA, but are largely used in resource-limited settings and are not readily available in the United States.^{17,34,61-64}

Do Not Use Crushed Tablets

LPV/r tablets must be swallowed whole. Crushed tablets are slowly and erratically absorbed and result in significantly reduced AUC, maximum concentration, and C_{trough} compared with swallowing the whole tablet. The variability of the reduced exposure with the crushed tablets (5% to 75% reduction in AUC) means that a dose modification cannot be relied on to overcome the reduced absorption. **Crushed tablets cannot be recommended for use.**⁶⁵ In a PK study that used a generic adult formulation of LPV/r manufactured in Thailand, 21 of 54 children were administered cut (not crushed) pills and had adequate LPV C_{trough} measurements.⁴⁶

Toxicity

Children treated with LPV/r may have less robust weight gain and smaller increases in CD4 percentage than children treated with NNRTI-based regimens.^{29,66-70} However, one study did not observe this difference in the effect of LPV/r on CD4 count,⁷¹ and another study found that the difference did not persist after a year of therapy.³² Some studies found no differences between the weight gain of children treated with LPV/r and those treated with EFV.^{69,72} Switching to an EFV-

based regimen at or after age 3 years removed the risk of LPV-associated metabolic toxicity, with no loss of virologic control (see Table 16 in [Modifying Antiretroviral Regimens in Children With Sustained Virologic Suppression on Antiretroviral Therapy](#)).^{69,70} Bone mineral density improved when children were treated with EFV-containing regimens instead of regimens that contained LPV/r.⁷³ Among 212 children randomized to either remain on an LPV/r-based regimen or switch to an EFV-containing regimen, osteocalcin—a biochemical marker of bone turnover—was higher in the LPV/r group than the EFV group at both 8 weeks and 2 years post-randomization. Levels of C-telopeptide of type 1 collagen and procollagen type I N-terminal propeptide did not differ between the two groups.⁷⁴ In a separate study, among 220 children with HIV (mean age 6.38 years), lower bone mass was observed in children on LPV/r-based regimens than those with EFV-based regimens over 2 years of follow-up.⁷⁵

APPENDIX A: PEDIATRIC ANTIRETROVIRAL DRUG INFORMATION

Entry and Fusion Inhibitors

Fostemsavir (FTR, Rukobia)

Ibalizumab (IBA, Trogarzo)

Maraviroc (MVC, Selzentry)

Fostemsavir (FTR, Rukobia)

Updated: September 30, 2025

Reviewed: September 30, 2025

Formulations	
Extended-Release Tablet: 600 mg For additional information, see Drugs@FDA or DailyMed .	
Dosing Recommendations	Selected Adverse Events
Child and Adolescent (Aged <18 Years) Dose <ul style="list-style-type: none"> The safety and efficacy of using fostemsavir (FTR) in children and adolescents aged <18 years have not been established. Adult Dose <ul style="list-style-type: none"> One tablet twice daily 	<ul style="list-style-type: none"> QTc (QT corrected for heart rate) interval prolongation with higher-than-recommended dosages Increased hepatic transaminases in children with hepatitis B or hepatitis C coinfection
	Special Instructions
	<ul style="list-style-type: none"> Can be taken with or without food Extended-release tablet must be swallowed whole. Do not chew, crush, or split tablets. Should not be coadministered with strong cytochrome P450 (CYP) 3A4 inducers of metabolism, such as rifampin, carbamazepine, phenytoin, and phenobarbital Potential for multiple drug interactions. Check concomitant medications before prescribing FTR. Tablets have a slight odor similar to vinegar.
	Metabolism/Elimination
	<ul style="list-style-type: none"> FTR tromethamine is a prodrug of temsavir (TMR), an HIV-1 glycoprotein 120-directed attachment inhibitor. FTR is rapidly converted to TMR after oral administration. Metabolic pathways of TMR include hydrolysis (esterases) (36.1% of oral dose), oxidation (CYP3A4) (21.1% of oral dose), and uridine diphosphate glucotransferase (<1% of oral dose). TMR is a substrate of CYP3A, esterases, P-glycoprotein, and breast cancer resistance protein (BCRP). TMR is an inhibitor of organic anion transporter OATP1B1 and OATP1B3; TMR and two of its metabolites are inhibitors of BCRP. FTR Dosing in Children With Hepatic Impairment <ul style="list-style-type: none"> No dose adjustment is required in children with mild-to-severe hepatic impairment. FTR Dosing in Children With Renal Impairment <ul style="list-style-type: none"> No dose adjustment is required in children with renal impairment or those on hemodialysis.

Drug Interactions

Additional information about drug interactions is available in the [Adult and Adolescent Antiretroviral Guidelines](#) and the [HIV Drug Interaction Checker](#).

- *Metabolism:* Coadministration with strong cytochrome P450 3A inducers is contraindicated, because the plasma concentrations of the active metabolite, temsavir (TMR), are significantly reduced, which could result in loss of virologic efficacy.
- *Cardiac toxicity:* Caution is required when used in combination with drugs that are associated with prolongation of the QT corrected for heart rate (QTc) interval of the echocardiogram.
- *Oral contraceptives and gender-affirming hormonal therapy:* TMR may increase ethinyl estradiol concentrations and risk of thrombosis. Do not exceed 30 mcg ethinyl estradiol daily when fostemsavir is co-administered with estrogen-based therapies. For gender-affirming hormonal therapy, estrogen concentrations can be monitored with dose adjustments as needed.¹
- *3-hydroxy-3-methylglutaryl coenzyme A (or HMG-CoA) reductase inhibitors (statins):* TMR may increase plasma concentrations of statins, including rosuvastatin, atorvastatin, fluvastatin, pitavastatin, and simvastatin. Use the lowest possible starting dose of statin and monitor for statin-associated adverse effects.
- *Hepatitis C virus direct-acting antivirals:* TMR may increase plasma concentrations of grazoprevir and voxilaprevir due to organic anion transporting polypeptide OATP1B1 and OATP1B3 inhibition.
- *Other antiretroviral (ARV) agents:* Drug interaction studies of fostemsavir (FTR) in combination with darunavir/cobicistat, darunavir/ritonavir, etravirine, and maraviroc have been conducted in healthy volunteers. FTR given in combination with these other ARVs was generally well tolerated, and no dose adjustments were required.^{2,3}

Major Toxicities

- *More common:* Nausea, fatigue, diarrhea (reported in ≥5% of people)
- *Less common:* QTc prolongation with higher-than-recommended doses⁴
- *Less common:* Increased hepatic transaminases in people with hepatitis B or hepatitis C coinfection

Resistance

The International AIDS Society–USA maintains a list of [HIV drug resistance mutations](#), and the [Stanford University HIV Drug Resistance Database](#) offers a discussion of each mutation.

TMR showed reduced antiviral activity against HIV subtype AE (the predominant subtype found in Southeast Asia but not commonly found elsewhere in the world). Treatment-emergent glycoprotein 120 (gp120) genotypic substitutions at four key sites—S375, M434, M426, and M475—have been found in evaluable participants with virologic failure in clinical trials. However, overall frequency of polymorphisms previously associated with the potential to reduce susceptibility to TMR is low and should not be a barrier to its usage in people with multidrug resistance.⁵ At this time, standard HIV drug resistance testing does not include FTR.

Pediatric Use

FTR is an HIV-1 gp120-directed attachment inhibitor that is not approved for use in children. FTR was approved by the U.S. Food and Drug Administration in 2020 for use in adults in combination with other ARV drugs, with approval limited to heavily treatment-experienced adults with multidrug-resistant HIV who are experiencing virologic failure on their current regimen due to resistance, intolerance, or safety considerations.⁶ A pharmacokinetic, safety, acceptability, and swallowability study of FTR in children and adolescents weighing ≥ 20 kg is open to enrollment (PENTA Foundation: NCT04648280). The dose selection of FTR for children and adolescents weighing ≥ 20 kg utilized a population pharmacokinetic model-based approach to achieve similar adult TMR exposures following FTR 600 mg twice daily dosing that was demonstrated to be safe and effective in the BRIGHT study in heavily treatment-experienced children and adolescents.⁷

Efficacy in Clinical Trials

The safety and efficacy of FTR in heavily treatment-experienced adults with HIV were evaluated in the BRIGHT trial, a Phase 3, double-blind placebo-controlled trial. A total of 371 participants were enrolled into two cohorts (randomized and nonrandomized), depending on remaining treatment options. The randomized cohort included 272 participants, with at least one fully active drug in at least one but no more than two ARV classes that could be added to FTR. Participants received either FTR or a placebo twice daily for 8 days, in addition to their failing ARV regimen. On Day 8, participants treated with FTR had a significantly greater decrease in levels of HIV-RNA than those taking the placebo (0.79 vs. 0.17 log₁₀ copies, respectively).⁸ After Day 8, all participants received FTR as part of an optimized regimen. In results reported through 48 weeks,⁸ 54% of participants had an HIV viral load of <40 copies/mL. At Week 96, 60% of participants^{6,9} had HIV viral loads of <40 copies/mL and a mean increase in CD4 T lymphocyte (CD4) cell counts of 205 cells/mm³. In 51% (27 out of 53) of evaluable participants with virologic failure, treatment-emergent gp120 genotypic substitutions were detected at four key sites—S375, M434, M426, and M475. In the randomized cohort, virologic response rates increased over time, between the 24-week and 96-week analyses. Response rates were associated with better susceptibility scores for new optimized treatment regimens.¹⁰ Participants with the lowest CD4 counts at baseline were more likely to experience serious adverse events or death.¹⁰ Improvements in patient-reported outcomes in health-related quality of life were observed among participants in both cohorts of the BRIGHT trial at 48 weeks.¹¹

An additional nonrandomized cohort of 99 adults who had no active drugs as treatment options but had FTR added to an optimized ARV regimen was studied. Of these, 38% achieved an HIV viral load of <40 copies/mL at 48 weeks.⁸ For this cohort, at 96 weeks,⁶ 37% of participants had HIV viral loads of <40 copies/mL, and the mean increase in CD4 counts was 119 cells/mm³.

Recently, long-term efficacy and safety of FTR plus optimized therapy at 240 weeks has been reported for participants enrolled in the Phase 3 BRIGHT study. Durable virologic responses were observed with no new safety concerns.^{12,13}

The real-world OPERA prospective cohort study, using a large database of electronic medical records, was conducted in the United States in 182 heavily treatment-experienced adults who initiated therapy with FTR and were followed for up to 1 year.¹⁴ Most participants virologically suppressed at FTR initiation were able to maintain suppression regardless of CD4 count at start. Only 52% of participants viremic at initiation with CD4 counts ≥ 350 cells/mm³ achieved viral suppression, and only 33% of those with CD4 counts <350 cells/mm³ achieved viral suppression.¹⁴ Immunologic responses were variable, but improvements were seen in CD4 counts (increase of 66 cells/mm³) among participants who were virologically suppressed with low CD4 counts at initiation.¹⁴

Mechanism of Action

FTR tromethamine is a prodrug of TMR, an HIV-1 gp120-directed attachment inhibitor. FTR is rapidly converted to TMR after oral administration. TMR binds directly to the HIV-1 gp120 and prevents viral attachment and subsequent entry of virus into host T cells. FTR has a novel mechanism of action and no *in vitro* cross-resistance with other ARVs, and it can be used regardless of HIV-1 tropism.⁵

Pharmacokinetics

FTR is pre-systemically metabolized to the active moiety TMR by alkaline phosphatase in the luminal surface of the small intestine, and then TMR is rapidly absorbed. In healthy adults, the estimated half-life is approximately 11 hours.^{15,16}

FTR has a novel mechanism of action, lacks significant drug–drug interactions with other ARVs, and does not require dosage adjustment in people with renal or hepatic impairment.¹⁶ The [PENTA study](#) “Safety and Pharmacokinetics Evaluation of Fostemsavir + (OBT) in HIV-1 Infected Children and Adolescents Who Are Failing Their CART and Have Dual- or Triple-Class Antiretroviral Resistance” is currently recruiting participants.

Ibalizumab (IBA, Trogarzo)

Updated: September 30, 2025

Reviewed: September 30, 2025

Formulations	
<p>Single-Dose Vial for Intravenous (IV) Administration: 200 mg/1.33 mL (150 mg/mL) in a single-dose vial. Each single-dose vial contains the following inactive ingredients: L-histidine, polysorbate 80, sodium chloride, and sucrose.</p> <p>For additional information, see Drugs@FDA or DailyMed.</p>	
Dosing Recommendations	Selected Adverse Events
<p>Child and Adolescent Dose</p> <ul style="list-style-type: none"> The safety and efficacy of using ibalizumab (IBA) in children and adolescents has not been established. <p>Adult Dose (Diluted IV Infusion or Undiluted IV Push)</p> <ul style="list-style-type: none"> A single loading dose IV infusion of IBA, 2,000 mg of diluted solution, is administered IV over 30 minutes. Alternatively, a single loading dose of undiluted IBA 2,000 mg is administered IV by IV push over 90 seconds. The maintenance dose of IBA is 800 mg given every 2 weeks. The maintenance dose can be given as 800 mg of diluted solution administered IV over 15 minutes or as 800 mg of undiluted solution given by IV push over 30 seconds. U.S. Food and Drug Administration approval of IBA is limited to heavily treatment-experienced adults with multidrug-resistant HIV infection who are experiencing treatment failure on their current regimen. IBA is used in combination with other antiretroviral drugs. 	<ul style="list-style-type: none"> Diarrhea, dizziness, nausea, rash Immune reconstitution inflammatory syndrome In studies of cynomolgus macaque monkeys, IBA use during pregnancy was associated with reversible immunosuppression (CD4 T and B cell lymphopenia) in offspring with IBA exposure <i>in utero</i>. Whether this association exists for offspring of a human birthing parent treated with IBA during pregnancy is unknown.
	Special Instructions
	<ul style="list-style-type: none"> For administration by IV infusion, the appropriate number of vials must be diluted in 250 mL of 0.9% sodium chloride injection. For administration of diluted solution, using aseptic technique, withdraw 1.33 mL from each vial and transfer into a 250-mL bag of 0.9% sodium chloride for IV injection. Other IV diluents must not be used. Once diluted, the solution should be administered immediately. If not used immediately, the solution can be stored at room temperature for up to 4 hours or refrigerated for up to 24 hours. Refrigerated solution should be allowed to stand at room temperature for at least 30 minutes but no more than 4 hours prior to administration. Diluted solution is administered as an IV infusion, not as a bolus or IV push. Undiluted solution may be given by IV push over 90 seconds to administer the loading dose and over 30 seconds to administer the maintenance dose.
	Metabolism/Elimination
	<ul style="list-style-type: none"> Monoclonal antibodies are metabolized to peptides and amino acids.

Drug Interactions

Additional information about drug interactions is available in the [Adult and Adolescent Antiretroviral Guidelines](#) and the [HIV Drug Interaction Checker](#).

- Ibalizumab (IBA) is a humanized immunoglobulin G4 monoclonal antibody that blocks HIV entry into CD4 T lymphocyte (CD4) cells. Based on IBA's mechanism of action and target-mediated drug disposition, drug–drug interactions are not expected. However, no drug interaction studies have been conducted.¹

Major Toxicities

- *More common:* Rash, diarrhea, headache, nausea, dizziness, depression^{1,2}
- *Less common (more severe):* Immune reconstitution inflammatory syndrome, hypersensitivity reaction¹

Resistance

HIV has shown reduced susceptibility to IBA, as defined by a decrease in maximum percent inhibition, when HIV loses N-linked glycosylation sites in the V5 loop of glycoprotein 120.¹⁻³

Phenotypic and genotypic test results showed no evidence of cross-resistance between IBA and any U.S. Food and Drug Administration (FDA)–approved classes of antiretroviral (ARV) drugs.⁴ IBA exhibits ARV activity against R5-tropic, X4-tropic, and dual-tropic HIV.⁴

Pediatric Use

Approval

IBA is not approved by the FDA for use in pediatric patients. IBA was approved by the FDA in 2018 for use in adults in combination with other ARV drugs, with approval limited to heavily treatment-experienced adults with multidrug-resistant HIV who are experiencing treatment failure on their current regimen.⁵ IBA has an orphan drug designation exempting the requirement for pediatric studies under the Pediatric Research Equity Act. The FDA requested that the company (i.e., Theratechnologies) create a registry to collect prospective data in individuals exposed to IBA during pregnancy to monitor maternal and pregnancy outcomes, including adverse effects on the developing fetus, neonate, and infant. Health care providers are encouraged to report these adverse events to Theratechnologies by calling 1-833-23-THERA (1-833-23-4372).

Efficacy in Clinical Trials

A TaiMed Biologics trial, TMB-301, was conducted in 40 adults aged 23 to 65 years who had body weights ranging from 50 kg to 130 kg, had resistance to ARV drugs from three classes, had been treated for at least 6 months on stable ARV regimens, had viral loads >1,000 copies/mL, and had viral sensitivity to at least one ARV drug.^{3,5} Participants continued their current ARV regimens and received a 2,000-mg loading dose of IBA on Day 7 of the study. One week after the loading dose, participants optimized their ARV regimens. Participants received IBA 800 mg on Day 21 and every 2 weeks thereafter. At Week 25, 43% of participants achieved suppressed viral loads^{1,3} of <50 copies/mL. At Week 48 of an open-label extension study, 24 participants were taking IBA and their optimized ARV regimen. Sixteen of 27 participants (59%) had viral loads <50 copies/mL at 48 weeks.^{6,7}

Mechanism of Action

IBA is a recombinant humanized monoclonal antibody that blocks HIV from infecting CD4 cells. It does this by binding to domain 2 of the CD4 receptor, which interferes with the post-attachment steps that allow HIV virus particles to enter host cells and prevent the viral transmission that occurs via cell–cell fusion.^{1,7} IBA does not interfere with CD4-mediated immune functions because it binds to a conformational epitope located primarily in domain 2 of the extracellular portion of the CD4 receptor, away from major histocompatibility complex II molecule binding sites.

Embryo-Fetal Toxicity

In an enhanced prenatal and postnatal development study, pregnant cynomolgus monkeys were administered intravenous doses of IBA, and significant changes in infant monkey immune cell levels were found (CD4 T cell and B cell lymphocytopenia) that were attributed to *in utero* IBA exposure.¹ The lymphocyte changes correlated with infant monkey IBA serum concentrations and appeared to return to near-normal levels when IBA concentrations were nearly undetectable. One treatment-group infant monkey died from a systemic viral infection with secondary superficial bacterial infection that was acquired during the postnatal period. Despite the low incidence of death (1 of 20 infant monkeys), the death may be related to IBA-induced immunosuppression.¹

Based on these animal data, IBA may cause reversible immunosuppression (CD4 T cell and B cell lymphocytopenia) in infants born to human birthing parents who were treated with IBA during pregnancy. Immune phenotyping of the peripheral blood and expert consultation are recommended to provide guidance regarding monitoring and management of exposed infants based on the degree of immunosuppression observed. Furthermore, the safety of administering live or live-attenuated vaccines to infants with *in utero* IBA exposure and abnormal lymphocyte levels is unknown.

Maraviroc (MVC, Selzentry)

Updated: September 30, 2025

Reviewed: September 30, 2025

Formulations																																			
Oral Solution: 20 mg/mL Tablets: 150 mg, 300 mg For additional information, see Drugs@FDA or DailyMed .																																			
Dosing Recommendations		Selected Adverse Events																																	
<ul style="list-style-type: none"> Maraviroc (MVC) is approved by the U.S. Food and Drug Administration for use, in combination with other antiretroviral (ARV) agents, for the treatment of CCR5-tropic HIV-1 infection in infants born full term and weighing ≥ 2 kg, children, adolescents, and adults. Recommended MVC Dose for Full-Term Infants and Treatment-Experienced Children and Adolescents Weighing ≥ 2 kg: Tablets or Oral Solution <table> <tr> <th>Weight Band</th><th>Twice-Daily Dosing</th><th>Oral Solution (20 mg/mL)</th><th>Tablets</th></tr> <tr> <td colspan="4">Recommended doses when MVC is given with noninteracting drugs, such as nucleoside reverse transcriptase inhibitors (NRTIs), nevirapine (NVP), dolutegravir (DTG), and raltegravir (RAL)</td></tr> <tr> <td>2 kg to <4 kg</td><td>30 mg</td><td>1.5 mL</td><td>N/A</td></tr> <tr> <td>4 kg to <6 kg</td><td>40 mg</td><td>2 mL</td><td>N/A</td></tr> <tr> <td>6 kg to <10 kg</td><td>100 mg</td><td>5 mL</td><td>N/A</td></tr> <tr> <td>10 kg to <14 kg</td><td>150 mg</td><td>7.5 mL</td><td>One 150-mg tablet</td></tr> <tr> <td>14 kg to <30 kg</td><td>200 mg</td><td>10 mL</td><td>N/A</td></tr> <tr> <td>≥ 30 kg</td><td>300 mg</td><td>15 mL</td><td>One 300-mg tablet</td></tr> </table>		Weight Band	Twice-Daily Dosing	Oral Solution (20 mg/mL)	Tablets	Recommended doses when MVC is given with noninteracting drugs, such as nucleoside reverse transcriptase inhibitors (NRTIs), nevirapine (NVP), dolutegravir (DTG), and raltegravir (RAL)				2 kg to <4 kg	30 mg	1.5 mL	N/A	4 kg to <6 kg	40 mg	2 mL	N/A	6 kg to <10 kg	100 mg	5 mL	N/A	10 kg to <14 kg	150 mg	7.5 mL	One 150-mg tablet	14 kg to <30 kg	200 mg	10 mL	N/A	≥ 30 kg	300 mg	15 mL	One 300-mg tablet	<ul style="list-style-type: none"> Nausea, vomiting Abdominal pain, diarrhea Cough Upper respiratory tract infections Fever Rash Hepatotoxicity (which may be preceded by severe rash and/or other signs of systemic allergic reaction) Postural hypotension (generally seen in patients with severe renal insufficiency) Dizziness 	
Weight Band	Twice-Daily Dosing	Oral Solution (20 mg/mL)	Tablets																																
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14 kg to <30 kg	200 mg	10 mL	N/A																																
≥ 30 kg	300 mg	15 mL	One 300-mg tablet																																
		Special Instructions																																	
		<ul style="list-style-type: none"> MVC is recommended for use in patients who have only CCR5-tropic HIV-1. Before using MVC, conduct testing with an HIV tropism assay (see Drug-Resistance Testing in the Adult and Adolescent Antiretroviral Guidelines) to exclude the presence of CXCR4-tropic or mixed/dual-tropic HIV. Do not use MVC if CXCR4-tropic or mixed/dual-tropic HIV is present. Measure alanine aminotransferase, aspartate aminotransferase, and bilirubin prior to initiation of MVC and as clinically indicated while receiving MVC. Additional monitoring may be necessary for individuals with hepatitis B virus or hepatitis C virus coinfection or preexisting liver dysfunction. MVC can be given without regard to food. 																																	

Recommended doses when MVC is given with potent cytochrome P450 (CYP) 3A inhibitors (with or without a potent CYP3A inducer), including all protease inhibitors (PIs)				<ul style="list-style-type: none">• Instruct patients on how to recognize symptoms of allergic reactions or hepatitis.• Use caution when administering MVC to patients with underlying cardiac disease.
2 kg to <10 kg	Not recommended. Data are insufficient to make dosing recommendations for infants weighing <10 kg and receiving a potent CYP3A inhibitor.			
10 kg to <20 kg	50 mg	2.5 mL	N/A	
20 kg to <30 kg	75 mg	4 mL	N/A	
30 kg to <40 kg	100 mg	5 mL	N/A	
≥40 kg	150 mg	7.5 mL	One 150-mg tablet	
Recommended doses when MVC is given with potent CYP3A inducers (without a potent CYP3A inhibitor), including efavirenz (EFV) and etravirine (ETR)				
Infants and children and adolescents in all weight bands	Not recommended. Data are insufficient to make dosing recommendations.			
Recommended MVC Dose for Adults: Tablets				
When Coadministered With		Dose		
Noninteracting concomitant medications, including NRTIs, NVP, DTG, and RAL		300 mg twice daily		
Potent CYP3A inhibitors (with or without a potent CYP3A inducer), including all PIs		150 mg twice daily		
Potent CYP3A inducers (without a potent CYP3A inhibitor), including EFV and ETR		600 mg twice daily		

Metabolism/Elimination
<ul style="list-style-type: none">• MVC is a substrate of CYP3A4. If a patient is receiving ARV agents or other medications that act as CYP3A inducers or inhibitors, the dose of MVC should be adjusted accordingly.
MVC Dosing in Patients With Hepatic Impairment
<ul style="list-style-type: none">• Use caution when administering MVC to patients with hepatic impairment; MVC concentrations may be increased in these patients.
MVC Dosing in Patients With Renal Impairment
<ul style="list-style-type: none">• No data recommend specific doses of MVC for pediatric patients with mild or moderate renal impairment. MVC is contraindicated for pediatric patients with severe renal impairment or end-stage renal disease (creatinine clearance <30 mL/min or who are receiving regular hemodialysis) and who are concomitantly receiving potent CYP3A inhibitors or inducers.• Refer to the manufacturer's prescribing information for the appropriate doses to use in adolescent and adult patients with renal impairment (See Appendix B in the Adult and Adolescent Antiretroviral Guidelines).

Drug Interactions

Additional information about drug interactions is available in the [Adult and Adolescent Antiretroviral Guidelines](#) and the [HIV Drug Interaction Checker](#).

- Absorption:** Absorption of maraviroc (MVC) is slightly reduced with ingestion of a high-fat meal. Food restrictions were not part of either the adult trials (which used the tablet formulation) or the pediatric trial (which used both the tablet and oral solution formulations) that demonstrated the efficacy, antiviral activity, and safety of MVC. Therefore, MVC can be given with or without food.

- *Metabolism:* MVC is a cytochrome P450 (CYP) 3A and P-glycoprotein (P-gp) substrate and requires dose adjustments when administered with medications that modulate CYP3A or P-gp. A patient's medication profile should be carefully reviewed for potential drug interactions before MVC is administered; recommended MVC doses are based on concomitant medications and their anticipated effect on MVC metabolism. Particular attention should be paid to antimycobacterial and antiseizure agents, which may substantially decrease MVC levels (See [Drug-Drug Interactions](#) in the [Adult and Adolescent Antiretroviral Guidelines](#)). Concomitant use of MVC and St. John's wort (*Hypericum perforatum*) **is not recommended** because it may result in suboptimal levels of MVC.

Major Toxicities

- *More common:* Cough, fever, upper respiratory tract infections, rash, musculoskeletal symptoms, abdominal pain, vomiting, diarrhea, and headache. Dizziness or postural hypotension occurred in 12.2% of adults but only 3.2% of children when MVC was administered twice daily.
- *Less common (more severe):* Hepatotoxicity has been reported; some cases were preceded by evidence of a systemic allergic reaction (including pruritic rash, eosinophilia, or elevated levels of immunoglobulin E). Stevens-Johnson syndrome, toxic epidermal necrolysis, and drug rash with eosinophilia and systemic symptoms (or DRESS) have been reported. Serious adverse events (AEs) occurred in <2% of MVC-treated adult patients and included cardiovascular abnormalities (e.g., angina, heart failure, myocardial infarction), hepatic cirrhosis or failure, cholestatic jaundice, viral meningitis, pneumonia, myositis, osteonecrosis, and rhabdomyolysis.

Mechanism of Action

MVC is a CCR5 receptor antagonist that selectively binds to the human chemokine receptor CCR5 on the cell membrane, preventing interaction between HIV-1 glycoprotein 120 and CCR5-tropic HIV-1, inhibiting viral entry into the cell.

Resistance

An HIV tropism assay should be performed before MVC is administered, and MVC should only be used for patients with CCR5-tropic HIV. Clinical failure on MVC may represent the outgrowth of preexisting, undetected CXCR4-tropic (naturally resistant) HIV variants. In addition, HIV-1 variants have been identified with amino acid substitutions that confer reduced susceptibility to MVC despite remaining CCR5-tropic. However, clinically available genotypic resistance testing typically does not report susceptibility to MVC.

In circumstances when MVC is needed for presumptive HIV therapy for full-term neonates at high risk of perinatal HIV transmission, initiation of MVC should not be deferred until tropism assay results are available; consultation with an HIV expert is recommended.

Pediatric Use

Approval

MVC is approved by the U.S. Food and Drug Administration (FDA) for treatment of CCR5-tropic HIV virus, when used in conjunction with other antiretroviral (ARV) drugs, in full-term infants weighing ≥ 2 kg, children, adolescents, and adults.^{1,2}

Pharmacokinetics and Efficacy

The International Maternal Pediatric Adolescent AIDS Clinical Trials (IMPAACT) 2007 study evaluated the pharmacokinetics (PK) and safety of MVC added to a 6-week prophylactic ARV regimen to prevent perinatal HIV transmission among infants born to mothers with HIV.² Analyses were stratified by exposure to efavirenz (EFV), either *in utero* or through breastmilk, versus non-EFV exposure. The MVC exposure target was average plasma concentration (C_{avg}) ≥ 75 ng/mL, as determined by adult treatment studies. MVC oral solution was dosed at 8 mg/kg twice daily for the first 6 weeks of life. Among 25 infants with evaluable PK data, 12 of whom were EFV-exposed, 67% of the EFV-exposed infants achieved a $C_{avg} \geq 75$ ng/mL at Week 1, whereas 77% of the EFV-unexposed infants had a $C_{avg} \geq 75$ ng/mL. At Week 4, the proportion of infants achieving a $C_{avg} \geq 75$ ng/mL declined to 42% among EFV-exposed infants and 31% among EFV-unexposed infants. No infants in the study met safety endpoints or discontinued MVC during the study, and no infants acquired HIV. A population PK model, which included assessment of age and maturational changes, was developed from IMPAACT 2007 data to describe MVC disposition within the first 6 weeks of life.³ Simulations with FDA-approved weight-band dosing resulted in the majority of simulated patients (84.3%) achieving an average concentration of ≥ 75 ng/mL. The FDA recommendation for MVC dosing among children >6 weeks of life but younger than 2 years of age is based on modeling using PK data from the IMPAACT 2007 study. When considering the use of MVC for neonates and infants, a pediatric HIV specialist should be consulted.

PK, safety, and efficacy of MVC for treatment-experienced children ages 2 years to <18 years and weighing ≥ 10 kg, and who had plasma HIV RNA >1,000 copies/mL were examined in an international dose-finding and efficacy study ([NCT00791700](#)). Of the 103 children who participated in the study, all of whom had CCR5-tropic HIV, 51% had HIV-1 subtype C, 25% had subtype B, and 23% had other subtypes. In this trial, the MVC dose was based on body surface area and the composition of the patient's optimized background therapy. Most participants (87%) received MVC in combination with potent CYP3A inhibitors; 10 participants received MVC with noninteracting medications; and only 3 participants received MVC with CYP3A inducers (without CYP3A inhibitors). The key pharmacologic target (geometric mean $C_{avg} > 100$ ng/mL) was achieved with both the tablet and oral solution formulation of MVC in 98% of the 50 participants who entered the safety and efficacy stage of the study.⁴ Only two participants discontinued the study due to AEs. The most common MVC-related AEs through 48 weeks were diarrhea (20.3% of participants), vomiting (19.8% of participants), and upper respiratory infections (16.2% of participants). At Week 48, 48% of participants had HIV RNA <48 copies/mL. From a mean baseline plasma HIV RNA concentration of 4.4 log₁₀ copies/mL, a decrease of ≥ 1.5 log₁₀ occurred in all four age-based cohorts.⁴ However, this study was not designed to evaluate efficacy, and most treatment failures were suspected to be related to adherence challenges.

APPENDIX A: PEDIATRIC ANTIRETROVIRAL DRUG INFORMATION

Capsid Inhibitors

Lenacapavir (LEN, Sunlenca)

Lenacapavir

Updated: June 25, 2026

Reviewed: June 25, 2026

Lenacapavir (LEN, Sunlenca, Yeztugo)

Formulations	
Tablets <ul style="list-style-type: none"> [Sunlenca] Lenacapavir: 300 mg for treatment [Yeztugo] Lenacapavir: 300 mg for HIV pre-exposure prophylaxis (PrEP) Single-Use Vial for Subcutaneous Injections <ul style="list-style-type: none"> [Sunlenca] Lenacapavir: 463.5 mg/1.5 mL suspension for treatment [Yeztugo] Lenacapavir: 463.5 mg/1.5 mL suspension for HIV PrEP <p>For additional information, see Drugs@FDA or DailyMed.</p>	
Dosing Recommendations	Selected Adverse Events
Child and Adolescent Dose <ul style="list-style-type: none"> The safety and efficacy of using lenacapavir (LEN) in children and adolescents has not been established. Adult Dose <ul style="list-style-type: none"> Approved for use in heavily treatment-experienced adults with multidrug-resistant HIV-1 infection who are experiencing virologic failure on their current antiretroviral (ARV) regimen due to resistance, intolerance, or safety considerations. LEN is used in combination with an optimized background regimen. Approved for use as HIV pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1 in adults and adolescents weighing ≥35 kg who are at risk for HIV-1 acquisition. Individuals must have a negative HIV-1 test prior to initiating. Initiation Option 1 (For Sunlenca or Yeztugo) <ul style="list-style-type: none"> Day 1: 927 mg by SQ injection (two 1.5-mL SQ injections in the abdomen) and 600 mg orally (two 300-mg tablets) Day 2: 600 mg orally (two 300-mg tablets) Initiation Option 2 (For Sunlenca Only) <ul style="list-style-type: none"> Day 1: 600 mg orally (two 300-mg tablets) Day 2: 600 mg orally (two 300-mg tablets) Day 8: 300 mg orally (one 300-mg tablet) Day 15: 927 mg by SQ injection (two 1.5-mL SQ injections in the abdomen) 	<ul style="list-style-type: none"> Injection site reaction Nausea Headache
	Special Instructions
	<ul style="list-style-type: none"> If LEN is discontinued, initiate an alternative, fully suppressive ARV regimen ≤28 weeks after the final injection of LEN to avoid virologic resistance. Planned missed injections: If scheduled injection is to be missed by more than 2 weeks, Sunlenca tablets may be used for oral bridging for up to 6 months until injections resume. Recommended dosage is 300 mg orally once every 7 days. Unplanned missed injections: If more than 28 weeks since last injection and tablets have not been taken for oral bridging, restart initiation from Day 1 (using Option 1 or Option 2) if clinically appropriate.
	Metabolism/Elimination
	<ul style="list-style-type: none"> Minor metabolism by cytochrome P450 3A4 and uridine diphosphate glucuronosyltransferase 1A1. Major route of elimination is unchanged drug in feces.

<p>Maintenance</p> <ul style="list-style-type: none"> 927 mg by SQ injection (two 1.5-mL SQ injections in the abdomen) every 26 weeks +/- 2 weeks from date of last injection 	<p>Dosing in Patients With Hepatic Impairment</p> <ul style="list-style-type: none"> No dosage adjustments were recommended for adults with mild (Child-Pugh-Turcotte Class A: score 5–6) or moderate (Child-Pugh-Turcotte Class B: score 7–9) hepatic impairment. <p>Dosing in Patients With Renal Impairment</p> <ul style="list-style-type: none"> Creatinine clearance (CrCl) ≥15 mL/minute: No dosage adjustment is required. CrCl <15 mL/minute: No dosage adjustments are provided in the manufacturer's prescribing information (i.e., not studied).¹ Dialysis: No dosage adjustments are required. Not expected to be significantly removed by dialysis due to high protein binding. There is one published case report of a patient with estimated glomerular filtration rate 4 mL/min on hemodialysis who received LEN, fostemsavir, and lamivudine, with resultant viral suppression sustained over 1 year.²
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Drug Interactions

Additional information about drug interactions is available in the [Liverpool HIV Drug Interaction Checker](#).

- Metabolism:**
 - Treatment (Sunlenca):** Concomitant administration of lenacapavir (LEN) (a moderate cytochrome P450 [CYP] 3A inhibitor) with moderate or strong CYP3A inducers may significantly decrease LEN plasma concentrations, which may result in the loss of therapeutic effect and development of resistance to LEN. Concomitant administration with strong inducers is contraindicated and with moderate inducers **is not recommended**.
 - Pre-exposure prophylaxis (PrEP) (Yeztugo):** Concomitant administration of Yeztugo with moderate or strong inducers can be considered, with dosing adjustments. Supplemental dosing instructions are provided in Section 2.5 of the [FDA label](#) and specifies additional doses of Yeztugo to give when a moderate or strong CYP3A inducer is initiated.
- Combined P-glycoprotein, uridine diphosphate glucuronosyltransferase 1A1, and strong CYP3A inhibitors may significantly increase plasma concentrations of LEN. Concomitant administration of LEN with these inhibitors **is not recommended**.
- LEN is a moderate inhibitor of CYP3A. Due to the long half-life of LEN following subcutaneous (SQ) administration, LEN may increase the exposure of drugs primarily metabolized by CYP3A.
- Drug interactions may occur up to 9 months after the last SQ dose of LEN.

Major Toxicities

- More common (incidence >10%):** Injection site reactions (62% to 83%)—including pain (19% to 31%), swelling (23% to 36%), erythema (25% to 31%), induration (15%), or the development of a nodule (14% to 25%)—were reported. Most injection site reactions resolve within days; however, nodules may persist for long periods of time consistent with their depot formulation.³⁻⁵ Nausea (12% to 14%), headache (8% to 13%),^{4,5} constipation (11% to 13%),^{3,4} and diarrhea (8% to

14%)³⁻⁵ have been reported. No Grade 3 or 4 laboratory abnormalities were deemed clinically significant; the most frequent was abnormal creatinine clearance (CrCl) (13%). Low levels of CrCl or estimated glomerular filtration rate or high creatinine levels were transient or unconfirmed abnormalities.⁴

- *Less common (more severe)*: Immune reconstitution syndrome has been reported in patients treated with combination antiretroviral therapy (ART).

Resistance

In a randomized, placebo-controlled, double-blind, multicenter trial (CAPELLA), treatment-emergent LEN resistance developed in 14 of 72 participants (19%) at 2 years, with capsid substitutions including M66I, Q67H/K/N, K70H/N/R/S, and N74D/H/K, all linked to functional LEN monotherapy. Resistance largely occurred early in the trial (i.e., 8 participants by Week 26), and half of the patients with resistance development had evidence of low adherence to their optimized background therapy as indicated by plasma drug concentrations. Of these 14 participants, 5 developed LEN resistance before Week 26 and 9 at 52 weeks or later.³ Notably, 7 of the 14 were able to achieve viral suppression on continued LEN, with a change in or resumption of an optimized background regimen.^{4,6}

The reported prevalence of LEN-resistance mutations is low (0.14%) among individuals who were ART naive.^{7,8} A recent study analyzed 10,057 HIV genotypic sequences from clinical trials and publicly available datasets (of which approximately 5% were A1 and 4% were D subtypes), and found a 0% prevalence of polymorphisms associated with LEN resistance, except for T107A. T107A was present at 1.8% and 0% among the subtype A1 and subtype D genomes, respectively.⁸

The International Antiviral Society–USA maintains a list of updated [HIV Drug Resistance Mutations](#), and the [Stanford University HIV Drug Resistance Database](#) offers a discussion of each mutation.

Pediatric Use

Approval

LEN is not approved by the U.S. Food and Drug Administration (FDA) for use in pediatric patients for treatment of HIV; LEN is approved for use as HIV PrEP among adolescents weighing ≥35 kg who are at risk for HIV-1 acquisition. LEN was approved by the FDA in 2022 in combination with other antiretrovirals (ARVs) and is indicated for the treatment of HIV-1 infection in heavily treatment-experienced adults with multidrug-resistant HIV-1 infection who are experiencing virologic failure on their current ARV regimen due to resistance, intolerance, or safety considerations. LEN is given alongside two other fully active agents in the treatment of HIV if at least one agent has a high barrier to resistance; otherwise, three fully active agents are recommended in addition to LEN.⁹

There are limited data on the efficacy and safety of LEN in people with HIV who are initiating ART.

LEN is in Phase 3 development for HIV PrEP in adults and adolescents and received FDA approval as PrEP on June 18, 2025. The Phase 3 PURPOSE-1 study of LEN as PrEP in female adolescents aged ≥16 years and women showed 100% efficacy of LEN, with no cases of HIV among 2,134 women and adolescent girls receiving LEN, as compared to 16 incident cases of HIV in 1,068 women receiving tenofovir disoproxil fumarate/emtricitabine (TDF/FTC) PrEP (incidence 0 and 1.69 per 100 person-years, respectively; $P < 0.001$).¹⁰ On the basis of this data, the Data Monitoring Committee recommended that the blinded phase of the trial be stopped at the interim analysis and LEN be offered to all participants. Published results of the Phase 3 PURPOSE-2 study of LEN as PrEP in men and individuals with other self-expressions who have sex with men are now available.

PURPOSE-2 found two cases of incident HIV (0.10 per 100 person-years; n = 2,180) in the group that received LEN and nine cases of incident HIV in the group that received TDF/FTC (0.93 per 100 person-years; n = 1,087), with 96% relative risk reduction (95% confidence interval (CI), 82%–99%) as compared to the estimated baseline HIV incidence of 2.37 per 100 person-years (incidence rate ratio 0.04; $P < 0.001$). When compared to the group who received TDF/FTC, the HIV incidence rate ratio in the LEN group was 0.11; 95% CI, 0.02 to 0.51; $P = 0.002$).¹¹

Efficacy and Pharmacokinetics in Clinical Trials

Clinical Trials in Adults

The CAPELLA trial evaluated LEN in combination with an optimized background ART regimen in 72 patients with multidrug-resistant HIV-1.⁴ Because CAPELLA was a clinical trial, the optimized background ART regimen did not include experimental agents. CAPELLA enrolled participants 23 to 78 years of age (enrollment criteria included those ≥ 12 years of age) who were experiencing virologic failure on their current regimen and with documented resistance to at least two ARV medications from at least three of the four main classes (nucleoside reverse transcriptase inhibitors, non-nucleoside reverse transcriptase inhibitors, protease inhibitors, and integrase strand transfer inhibitors) and to no more than two fully active ARV drugs from the four main classes that could be effectively combined. Patients were enrolled in two cohorts according to change in plasma HIV-1 RNA level between the screening and cohort-selection visits. In cohort 1, patients were first randomly assigned in a 2:1 ratio to receive oral LEN or placebo in addition to their failing therapy for 14 days. During the maintenance period, starting on Day 15, patients in the LEN group received SQ LEN once every 6 months, and those in the placebo group received oral LEN, followed by SQ LEN. Both groups also received optimized background therapy. In cohort 2, all the patients received open-label oral LEN with optimized background therapy on Days 1 through 14, and then SQ LEN was administered once every 6 months starting on Day 15. The primary endpoint was defined by the percentage of patients in the first cohort who had a decrease of at least 0.5 log₁₀ copies/mL viral load from baseline to Day 15. The secondary endpoint was a viral load of <50 copies/mL at Week 26. The results showed that 21 of 24 (88%) patients in the LEN group met the primary endpoint, as compared to 2 of 12 (17%) patients in the placebo group ($P < 0.001$); 81% of patients met the secondary endpoint.¹² None of the patients developed serious adverse events that were considered related to LEN. At 2-year follow-up in CAPELLA, 14 participants had developed emergent LEN resistance, 7 of whom resuppressed to <50 copies/mL with maintenance of LEN and concomitant changes to or reinitiation of a background regimen. A high rate of viral suppression was achieved in this treatment-experienced cohort, with (when missing results were excluded) 44 of 54 (82%) (95% CI, 67% to 94%) achieving suppression to <50 copies/mL.¹³ LEN added to an optimized background regimen led to high efficacy in highly treatment-experienced participants with multidrug resistance but could select for resistance when used unintentionally as functional monotherapy (e.g., when patients have poor adherence to a self-administered optimized background regimen).¹²

CALIBRATE was a Phase 2, randomized, open-label trial that enrolled 183 treatment-naïve patients with HIV ≥ 18 years of age to evaluate the efficacy of LEN in various combinations versus bictegravir (BIC)/tenofovir alafenamide/3TC combination pill. At Week 54, virologic suppression was greater for the BIC-containing combination pill group (92%) compared to various combinations with LEN (75% to 87%).⁵ Final results showed that at Week 132, viral suppression was 98% to 100% among 130 participants without missing data who received at least one dose of LEN.¹⁴ No serious treatment-related adverse events occurred. Across all LEN-containing treatment groups, five participants discontinued LEN due to adverse events. Injection site reactions were mostly mild to moderate. Resistance-associated mutations emerged among four participants undergoing LEN treatment.

Observational or Effectiveness Data

One case series¹⁵ reported on the salvage strategy of the use of LEN as part of a hybrid long-acting ART regimen in adults with viremia and resistance to one or more components of long-acting ART. This series included one patient with perinatally acquired HIV and a large viral reservoir who achieved viral suppression on the combination of LEN and cabotegravir/rilpivirine (CAB/RPV). A cohort from Ward 86 in San Francisco reported on the use of LEN concurrently with CAB/RPV in an adult with sluggish viral load decline on CAB/RPV.¹⁶ Accumulating data suggest that real-world use of LEN and CAB, LEN and CAB/RPV, or LEN and 3TC is associated with favorable clinical outcomes among adults who do not achieve or maintain suppression on oral ART.^{17,18}

Pharmacokinetic Considerations

The elimination half-life of LEN is about 10 to 12 days (oral formulation) and 8 to 12 weeks (SQ formulation). Residual concentrations of LEN long-acting injection may remain in the systemic circulation of patients for ≥ 12 months. To minimize the potential risk of resistance development under conditions of functional monotherapy at subtherapeutic levels, an alternative, fully suppressive ARV regimen should be initiated no later than 28 weeks after the final LEN injection when possible.

Hepatic and Renal Impairment

Two Phase 1 single-dose studies have assessed LEN pharmacokinetics (PK) in the setting of hepatic impairment (Child-Pugh-Turcotte Class B) or renal impairment (with CrCl < 15 mL/min). Ten participants with impaired hepatic or renal function and 10 participants with normal hepatic and renal function were given a single oral dose of LEN 300 mg and PK measured thereafter. Compared to participants with normal hepatic function, people with hepatic impairment had LEN areas under the concentration-time curve extrapolated to infinity (AUC_{inf}) and maximum plasma concentrations (C_{max}) 1.47-fold and 2.61-fold higher, respectively. For participants with renal impairment, LEN AUC_{inf} and C_{max} were 1.84-fold and 2.62-fold¹ higher, respectively, compared to those with normal renal function. These exposure changes were not considered clinically significant, and no LEN dosing adjustments were recommended for people with mild (Child-Pugh-Turcotte Class A: score 5–6) or moderate (Child-Pugh-Turcotte Class B: score 7–9) hepatic impairment or for people with mild ($60 \leq CrCl \leq 89$ mL/min), moderate ($30 \leq CrCl \leq 59$ mL/min), and severe (≤ 15 CrCl < 30 mL/min) renal impairment.

APPENDIX A: PEDIATRIC ANTIRETROVIRAL DRUG INFORMATION

Integrase Inhibitors

Bictegravir (BIC)

Cabotegravir (CAB, Vocabria)

Dolutegravir (DTG, Tivicay)

Elvitegravir (EVG)

Raltegravir (RAL, Isentress)

Bictegravir (BIC)

Updated: June 25, 2026

Reviewed: June 25, 2026

Formulations							
Bictegravir is available only in a fixed-dose combination (FDC) tablet.							
FDC Tablet							
<ul style="list-style-type: none">[Biktarvy]<ul style="list-style-type: none">Bictegravir 50 mg/emtricitabine 200 mg/tenofovir alafenamide 25 mgBictegravir 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	Selected Adverse Events						
[Biktarvy] Bictegravir (BIC)/Emtricitabine (FTC)/Tenofovir Alafenamide (TAF) <i>Neonate or Child Aged <2 Years and Weighing <14 kg</i> <ul style="list-style-type: none">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. <i>Child (Aged ≥2 Years), Adolescent, and Adult Dose</i> <ul style="list-style-type: none">One tablet once daily with or without food <table><tr><th>Body Weight</th><th>Dose</th></tr><tr><td>≥14 kg to <25 kg</td><td>BIC 30 mg/FTC 120 mg/TAF 15 mg</td></tr><tr><td>≥25 kg</td><td>BIC 50 mg/FTC 200 mg/TAF 25 mg</td></tr></table> <ul style="list-style-type: none">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).	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	<ul style="list-style-type: none">Diarrhea, nausea, headache
	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						
	Special Instructions <ul style="list-style-type: none">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
	<ul style="list-style-type: none"> BIC is metabolized by cytochrome P450 3A4 and uridine diphosphate glucuronosyltransferase 1A1. <p>Biktarvy Dosing in Children With Hepatic Impairment</p> <ul style="list-style-type: none"> Biktarvy is not recommended for use in children with severe hepatic impairment. <p>Biktarvy Dosing in Children With Renal Impairment</p> <ul style="list-style-type: none"> 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 zinc³ 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/anxiety⁵ 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 weight⁵ (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-naïve. 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-naïve 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-naïve 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 weight³⁷ ≥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.

Cabotegravir

Updated: June 25, 2026

Reviewed: June 25, 2026

Cabotegravir (CAB, Vocabria)

Cabotegravir for Intramuscular Injection (CAB, Apretude)

Cabotegravir and Rilpivirine for Intramuscular Injections (Long-Acting Injectable CAB and RPV, Cabenuva)

Formulations	
<p>Tablet</p> <ul style="list-style-type: none"> [Vocabria] Cabotegravir: 30 mg <p>Single-Dose Vial for Intramuscular (IM) Injection</p> <ul style="list-style-type: none"> [Apretude] Cabotegravir 600-mg/3-mL (200-mg/mL) suspension for IM injection for use as HIV pre-exposure prophylaxis (PrEP) only <p>Co-packaged Formulations</p> <ul style="list-style-type: none"> [Cabenuva Kit] Cabotegravir 400-mg/2-mL (200-mg/mL) and rilpivirine 600-mg/2-mL (300-mg/mL) suspension for IM injection (each drug packaged in a separate syringe) [Cabenuva Kit] Cabotegravir 600-mg/3-mL (200-mg/mL) and rilpivirine 900-mg/3-mL (300-mg/mL) suspension for IM injection (each drug packaged in a separate syringe) <p>When using the co-packaged formulation, refer to the Rilpivirine section for additional information.</p> <p>For additional information, see Drugs@FDA or DailyMed.</p>	
Dosing Recommendations	Selected Adverse Events
<p>[Apretude] Cabotegravir (CAB) for IM Injection</p> <ul style="list-style-type: none"> CAB 600 mg/3 mL for IM injection is approved by the U.S. Food and Drug Administration (FDA) for use as HIV PrEP in adults and adolescents weighing ≥ 35 kg; an oral dosing lead-in period of approximately 1 month is optional. See package insert for additional information about dosing and administration of CAB as PrEP; this indication is not addressed in the Pediatric Antiretroviral (ARV) Guidelines. <p>[Cabenuva] CAB and Rilpivirine (RPV) for IM Injection (Long-Acting Injectable CAB and RPV)</p> <p><i>Pediatric Dose</i></p> <ul style="list-style-type: none"> CAB tablets and co-packaged long-acting injectable CAB and RPV (LA CAB/RPV) are not FDA approved for the treatment of HIV in children aged <12 years. 	<ul style="list-style-type: none"> Depression Insomnia Headache Rash (can be severe) or hypersensitivity Hepatotoxicity Altered adrenocorticotrophic hormone stimulation test of uncertain clinical significance Injection site reactions (pain, tenderness, induration, nodules, erythema; common and typically mild to moderate) Postinjection reactions Creatine phosphokinase elevation following IM injection Weight gain

<p>Child and Adolescent (Aged ≥12 Years and Weighing ≥35 kg) and Adult Dose</p> <ul style="list-style-type: none">CAB and RPV is a two-drug co-packaged product for IM injection that is FDA approved as a complete regimen for the treatment of HIV-1 in people with HIV RNA levels <50 copies/mL on a stable ARV regimen with no history of treatment failure and no known or suspected resistance to CAB or RPV.Oral lead-in dosing with CAB and RPV for at least 28 days can be used to assess tolerability prior to initiating LA CAB/RPV injections; however, many providers initiate therapy without an oral lead-in when there are no concerns regarding tolerability, drug interactions, or resistance.Refer to the package insert for instructions about changing the frequency of IM injections (i.e., from monthly to every-2-month dosing or from every-2-month to monthly dosing). <p>Oral Lead-in Dosing</p> <ul style="list-style-type: none">CAB 30 mg orally and RPV 25 mg orally once daily with a meal for at least 28 days. <p>Dosing for Monthly Administration of LA CAB/RPV</p> <ul style="list-style-type: none">On the last day of oral lead-in therapy or the current oral ARV regimen, a loading dose of CAB 600 mg (3 mL) and RPV 900 mg (3 mL) should be given as two separate IM injections in separate ventrogluteal sites.Continuation therapy of CAB 400 mg (2 mL) and RPV 600 mg (2 mL) IM is given 1 month after the loading dose and once a month thereafter, with allowance for a ±7-day administration window. <p>Dosing for Every-2-Month Administration of LA CAB/RPV</p> <ul style="list-style-type: none">To initiate every-2-month dosing, CAB 600 mg (3 mL) and RPV 900 mg (3 mL) should be given as two separate IM injections in separate ventrogluteal sites on the last day of oral lead-in or the current oral ARV regimen and 1 month after the initial injections.After these two initiation injections 1 month apart for 2 months, continuation therapy with IM CAB 600 mg (3 mL) and RPV 900 mg (3 mL) is administered every 2 months, with allowance for a ±7-day administration window.	<table><tr><th>Special Instructions</th></tr><tr><td><ul style="list-style-type: none">Refer to the Rilpivirine section for considerations related to oral lead-in dosing, including administration requirements and potential drug interactions.Serious hypersensitivity reactions have been reported with CAB- and RPV-containing regimens. Severe cutaneous reactions, including Stevens-Johnson syndrome and toxic epidermal necrolysis, have been reported with CAB. Discontinue therapy immediately if hypersensitivity is suspected. See the Rilpivirine section for additional information.If monthly injections are missed or delayed by more than 7 days and oral therapy has not been taken, clinically reassess the child to determine whether resumption of injection dosing remains appropriate. Refer to the package insert for information about managing planned and unplanned missed doses.LA CAB/RPV is a complete regimen. Coadministration with other ARV drugs is not recommended.When LA CAB/RPV injections are stopped, residual concentrations may remain measurable for up to 12 months or longer. It is essential to initiate an alternative, fully suppressive ARV regimen no later than 1 month after the final injections of LA CAB/RPV.Use CAB and RPV with caution when coadministering with a drug that has a known risk of prolonging the QT corrected for heart rate interval or causing Torsades de Pointes (for more information, see CredibleMeds).</td></tr><tr><th>Metabolism/Elimination</th></tr><tr><td><ul style="list-style-type: none">CAB is metabolized by uridine diphosphate-glucuronosyltransferase 1A1.RPV is a cytochrome P450 3A substrate.</td></tr><tr><th>Dosing in Children With Hepatic Impairment</th></tr><tr><td><ul style="list-style-type: none">No dose adjustment of CAB or LA CAB/RPV is necessary in children with mild or moderate hepatic impairment.</td></tr><tr><th>Dosing in Children With Renal Impairment</th></tr><tr><td><ul style="list-style-type: none">RPV decreases tubular secretion of creatinine and slightly increases measured serum creatinine, but it does not affect glomerular filtration.No dose adjustment of CAB or LA CAB/RPV is necessary in children with mild or moderate renal impairment. However, LA CAB/RPV should be used with caution in children with severe renal impairment or end-stage renal disease. These children should be monitored more frequently for adverse events.</td></tr></table>	Special Instructions	<ul style="list-style-type: none">Refer to the Rilpivirine section for considerations related to oral lead-in dosing, including administration requirements and potential drug interactions.Serious hypersensitivity reactions have been reported with CAB- and RPV-containing regimens. Severe cutaneous reactions, including Stevens-Johnson syndrome and toxic epidermal necrolysis, have been reported with CAB. Discontinue therapy immediately if hypersensitivity is suspected. See the Rilpivirine section for additional information.If monthly injections are missed or delayed by more than 7 days and oral therapy has not been taken, clinically reassess the child to determine whether resumption of injection dosing remains appropriate. 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<p>Children should be monitored for approximately 10 minutes for postinjection reactions. A 23-gauge, 1.5-inch IM needle is recommended and is provided in the packaging. Longer 2-inch needles (not included with packaging) should be used in children with a body mass index >30 kg/m². The Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV recommends that providers review instructions available with the package insert prior to beginning IM administration of LA CAB/RPV. Additional clinical resources, including injection education, are available from the manufacturer, ViiV.</p>	
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Drug Interactions

Additional information about drug interactions is available in the [Liverpool HIV Drug Interaction Checker](#).

- *Metabolism:* Cabotegravir (CAB) is metabolized primarily by uridine diphosphate glucuronosyltransferase 1A1 (UGT1A1). CAB is **contraindicated** in children receiving strong inducers of UGT1A1 because such inducers decrease CAB plasma concentrations, which may result in a loss of virologic response.
- Rilpivirine (RPV) is a cytochrome P450 (CYP) 3A substrate, and RPV concentrations may be affected when administered with CYP3A-modulating medications.
- A child's medication profile should be carefully reviewed for potential drug interactions before CAB plus RPV is administered.
- CAB and RPV are both highly protein bound and unlikely to be removed by hemodialysis.
- Coadministering oral RPV with drugs that increase gastric pH may decrease plasma concentrations of RPV.
 - o Antacids should not be taken 2 hours before or 4 hours after oral RPV.
 - o H2 receptor antagonists should not be administered 12 hours before or 4 hours after oral RPV.
 - o Oral RPV is **contraindicated** with proton pump inhibitors.
- Rifamycin drugs significantly reduce CAB and RPV plasma concentrations. For children who are concomitantly receiving rifabutin and oral RPV, the dose of RPV should be doubled to 50 mg once daily and taken with a meal. Coadministration of the following drugs is **contraindicated**:
 - o Rifampin and oral RPV
 - o Rifampin or rifapentine and CAB
 - o Rifabutin and long-acting injectable CAB and RPV (LA CAB/RPV)

Major Toxicities

- *More common:* Injection site reactions (mild to moderate pain, tenderness, induration, nodules, erythema), insomnia, headache, rash, elevated creatine phosphokinase serum concentrations

- *More common:* In studies of adults, 7.3% of participants who were treated with RPV showed a change in adrenal function characterized by an abnormal 250-microgram adrenocorticotrophic hormone stimulation test (peak cortisol level <18.1 micrograms/dL). In a study of adolescents, 6 of 30 participants (20%) developed this abnormality.¹ The clinical significance of these results is unknown.
- *Less common (more severe):* Depression or mood changes and suicidal ideation
- *Rare:* Serious hypersensitivity reactions, including Stevens-Johnson syndrome and toxic epidermal necrolysis
- *Rare:* Serious postinjection reactions have been reported with LA CAB/RPV and are primarily associated with the RPV component. These reactions should be distinguished from hypersensitivity reactions. Symptoms may include dyspnea, bronchospasm, agitation, abdominal cramping, flushing, sweating, oral numbness, changes in blood pressure, and pain (e.g., back and chest pain). These events are uncommon, generally occur within minutes after injection, and typically resolve with supportive care. See the [Rilpivirine](#) section for additional information.
- *Rare:* RPV drug-induced liver injury has been reported.²

Resistance

The International Antiviral Society–USA maintains a list of updated [HIV Drug Resistance Mutations](#), and the [Stanford University HIV Drug Resistance Database](#) offers a discussion of each mutation.

Pediatric Use

Approval

CAB oral tablets (Vocabria) and co-packaged LA CAB/RPV (Cabenuva) are approved by the U.S. Food and Drug Administration (FDA) for the treatment of HIV in children or adolescents aged ≥12 years and weighing ≥35 kg (2022) and in adults (2021). They are not approved for use in children aged <12 years. CAB tablets were approved by the FDA in 2021 for use in adults as part of the oral lead-in prior to beginning LA CAB/RPV or as an oral interim treatment when people miss planned injections.^{1,3} CAB and RPV co-packaged, extended-release injectable suspensions for IM use are approved for use in people (monthly or every 2 months) who are virologically suppressed on a stable antiretroviral (ARV) regimen with no history of virologic failure or known resistance affecting either of the component drugs.³

In December 2021, the FDA approved CAB IM (Apretude) for HIV pre-exposure prophylaxis (PrEP) in adults and adolescents weighing ≥35 kg; an oral lead-in period of approximately 1 month may be used to assess safety and tolerability but is optional. Refer to the package insert for additional information about dosing and administration,⁴ and see the Centers for Disease Control and Prevention [Guidelines for Pre-exposure Prophylaxis for the Prevention of HIV in the United States](#) for further information about the use of CAB for PrEP.

Safety, Efficacy, and Pharmacokinetics in Clinical Trials

Clinical Trials in Children and Adolescents 12 Years to <18 Years

The safety and efficacy of CAB, an HIV-1 integrase inhibitor, given in combination with RPV, a non-nucleoside reverse transcriptase inhibitor (NNRTI), has been characterized in a series of clinical trials conducted in adults, which form the basis for approval.

The International Maternal Pediatric Adolescent AIDS Clinical Trials (IMPAACT) Network Study 2017, More Options for Children and Adolescents (MOCHA), evaluated the safety, tolerability, acceptability, and pharmacokinetics (PK) of this injectable regimen in adolescents ([MOCHA Trial](#)) and has reported results leading to FDA approval in this age group.

MOCHA evaluated the safety and PK of intramuscular (IM) LA CAB/RPV in virologically suppressed adolescents aged 12–17 years weighing ≥ 35 kg). In cohort 1, after 4 to 6 weeks of oral CAB (n = 30) or RPV (n = 25), participants received IM LA CAB or long-acting (LA) RPV every 4 weeks or 8 weeks per the adult dosing regimens while continuing pre-study antiretroviral therapy (ART). Injection site reactions were observed but did not lead to any treatment discontinuations. Two adolescents experienced Grade 3 drug-related adverse events (AEs), one due to insomnia (CAB arm) and one due to hypersensitivity reaction to oral RPV, which led to discontinuation.^{5,6} In a concurrent assessment of adolescent and parental experiences with IM treatment in MOCHA, overall perceptions of the injectable treatment were favorable. Of the 21 adolescents who received all three study injections, >90% “definitely” or “probably” wanted to continue IM treatment.^{7,8} For participants receiving IM CAB or IM RPV, exposures were similar to those observed in adults.

In Cohort 2, 144 virologically suppressed adolescents with HIV-1 received 4 weeks of oral CAB plus RPV followed by IM CAB 600 mg and IM RPV 900 mg every 2 months. The first and second injections were 4 weeks apart, with subsequent injections every 8 weeks. The primary outcome in Cohort 2 was safety, including all AEs, at Week 24. Overall, 10.8% of participants in the evaluable analysis population had at least one AE of Grade 3 or above by Week 24.⁹ Among participants who received at least one injection, 30% experienced at least one injection site reaction. All injection site reactions were either Grade 1 or Grade 2, and 91.5% resolved within 7 days. Nonserious injection site reactions were common but did not lead to treatment discontinuation in the majority of participants. The most common injection site reaction was pain disproportionate to what would be expected when a person receives an IM injection. No participant experienced a drug-related serious AE or prematurely discontinued treatment due to a drug-related AE. Non-injection-site-associated adverse reactions reported by more than one participant (regardless of severity) were headache (n = 3), nausea (n = 2), rash (n = 2) and pruritic rash (n = 2).¹⁰ No virologic failure was observed through Week 24. Pre-dose concentrations of CAB and RPV were similar to those in adults. One participant had a low CAB pre-dose concentration at Week 24 (0.03 $\mu\text{g/mL}$). Overall, 97% participants at Week 8 and 99% of participants at Week 24 preferred injectable medications over daily oral dosing, which was driven primarily by convenience and burden reduction (i.e., adherence-related stress and increased privacy).¹¹ In a separate real-world, single-center, cross-sectional survey among adolescents and young adults with HIV, most participants (n = 17; 94.4%) receiving the LA injectable regimen found it to be acceptable. Facilitators to acceptance included reduced pill burden and medication fatigue and thinking less about HIV diagnosis. Barriers to acceptance included concerns about side effects and the need for more frequent clinic visits.^{12,13}

Intermittent viremias have been reported in young adults transitioned to LA CAB/RPV with oral lead-in.¹⁴ The Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV notes that questions remain regarding the use of LA CAB/RPV in children and adolescents, including whether there are additional adverse effects specific to the pediatric population and what potential implementation challenges might exist (e.g., cost, procurement and access, retention in care).¹⁵

Clinical Trials in Adults

The Phase 3 Antiretroviral Therapy as Long-Acting Suppression (ATLAS) study randomized stable, virologically suppressed adults to receive either CAB and RPV (n = 308) or continue their oral ART (n = 308). Participants assigned to CAB and RPV initiated therapy with an oral regimen for 4 weeks prior to beginning monthly IM injections. The initial assessment at 48 weeks demonstrated that switching to monthly LA CAB/RPV was non-inferior to continuing a three-drug oral therapy. After 48 weeks, participants were allowed to transition to injections every 2 months in a follow-up study

(ATLAS-2M, see below); 52 participants remaining on the original ATLAS study were included in the 96-week analysis. AEs were more common among participants receiving injectable ART; injection site reactions were common, but only 1% withdrew from the study because of these events.¹⁶ The ATLAS-2M trial randomized participants to monthly IM CAB 400 mg and RPV 600 mg (n = 523) or every-2-month injections of CAB 600 mg and RPV 900 mg (n = 522); it enrolled both new participants and those continuing from the ATLAS trial. After 96 weeks, the every-2-month injections were non-inferior to monthly injections, with 11 (2%) confirmed virologic failures in the every-2-month injection group and 6 (1%) in the monthly injection group. No new safety signals were identified, and the rate of injection site reactions—the most common AE—was similar across treatment arms. Of those failing the every-2-month injection regimen, a majority had NNRTI resistance-associated mutations.¹⁷

The First Long-Acting Injectable Regimen (FLAIR) study enrolled 631 adults who were treatment-naïve and initiated treatment with a standard oral ARV regimen consisting of dolutegravir/abacavir/lamivudine (DTG/ABC/3TC) for 20 weeks. Those participants with documented HIV-1 RNA <50 copies/mL after 16 weeks were randomized to either continue oral DTG/ABC/3TC (n = 283) or switch to oral CAB and RPV for 4 weeks, followed by monthly injections of CAB and RPV (n = 283). After 96 weeks of randomized therapy, nine participants (3.2%) in each arm had HIV RNA >50 copies/mL. AEs were common in both treatment groups, but AEs leading to withdrawal from the study were observed in only 14 (5%) participants in the LA CAB/RPV group and 4 (1%) participants in the oral standard care group. Injection site reactions were the most common AEs, reported by 245 (88%) participants in the LA CAB/RPV, and lasted a median of 3 days.¹⁸ The FLAIR study was extended to include an assessment of switching those participants remaining in the oral ARV arm after 120 weeks to LA CAB/RPV either with or without the initial oral lead-in phase. There were no differences between the lead-in group and the direct-to-injection group in terms of safety, tolerability, or efficacy through an additional 24 weeks on the study.¹⁹

These studies demonstrated noninferiority of switching to monthly LA CAB/RPV compared with continuing oral ART. In all studies, adults expressed a high degree of treatment satisfaction and preference for the LA CAB/RPV regimen. Although documented virologic failure with the LA CAB/RPV regimen has been rare to date, investigators have attempted to assess the baseline factors associated with treatment failure. In a multivariate analysis of the adult LA CAB/RPV Phase 3 trials, presence of at least two baseline factors of RPV resistance-associated mutations, HIV-1 subtype A6/A1, and body mass index >30 kg/m² was associated with increased risk of virologic failure at 48 weeks.²⁰

Oral Lead-In

An oral lead-in with CAB/RPV may be used prior to initiation of LA CAB/RPV to assess short-term tolerability. The original rationale for the oral lead-in was to identify hypersensitivity reactions or other clinically significant adverse effects before administration of the LA IM injection. Because both CAB and RPV have prolonged elimination phases after IM administration, drug concentrations persist for months, and the drugs cannot be removed rapidly after being injected. The oral lead-in was therefore intended to minimize the risk of prolonged exposure in individuals who might not tolerate one or both agents.

However, accumulating clinical trial data in adults—including studies directly comparing oral lead-in with direct-to-injection initiation—have demonstrated similar safety, tolerability, and efficacy outcomes between approaches, with no meaningful differences in hypersensitivity or serious AEs.²¹ PK analyses have also shown that LA CAB exposure is similar with or without an oral lead-in.²² Based on these data, routine use of an oral lead-in is not required. The decision to use an oral lead-in may be individualized based on clinical judgment, including prior history of medication intolerance, concerns about potential drug–drug interactions, patient or caregiver preference, or other clinical factors. CAB/RPV experience is more limited in adolescents than in adults; however, available data

suggest a safety profile comparable to that observed in adult studies, and many providers initiate therapy without an oral lead-in.

Pharmacokinetics

The PK of IM CAB are driven by slow absorption from the injection site. IM CAB reaches its maximum plasma concentration in adults in about 7 days and has a mean half-life of 5.6 to 11.5 weeks. Measurable levels of CAB can be detected in plasma for up to a year or longer. Due to this prolonged drug exposure, it is essential to initiate an alternative, fully suppressive ARV regimen no later than 1 month after the final injections of CAB and RPV to minimize the potential risk of developing viral resistance.³ The PK profiles observed in adolescents enrolled in MOCHA were comparable to those observed in adults receiving monthly LA injectable CAB and RPV in the ATLAS and FLAIR studies described above.⁵

Dolutegravir (DTG, Tivicay, Tivicay PD)

Updated: June 25, 2026

Reviewed: June 25, 2026

Formulations	
Tablets <ul style="list-style-type: none"> Dispersible tablets for oral suspension [Tivicay PD] 5 mg Film-coated tablets [Tivicay] 50 mg Fixed-Dose Combination (FDC) Tablets <ul style="list-style-type: none"> [Dovato] Dolutegravir 50 mg/lamivudine 300 mg [Juluca] Dolutegravir 50 mg/rilpivirine 25 mg [Triumeq] Abacavir 600 mg/dolutegravir 50 mg/lamivudine 300 mg [Triumeq PD] Abacavir 60 mg/dolutegravir 5 mg/lamivudine 30 mg <p>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.</p> <p>For additional information, see Drugs@FDA or DailyMed.</p>	
Dosing Recommendations	Selected Adverse Events
<p>All formulations and FDCs of dolutegravir (DTG) are U.S. Food and Drug Administration (FDA)–approved for use in treatment-naïve or treatment-experienced pediatric, adolescent, and adult patients naïve to the integrase strand transfer inhibitor (INSTI) drug class. The Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV (the Panel) endorses the use of DTG as appropriate for some children with prior INSTI use (see Modifying Antiretroviral Regimens in Children With Sustained Virologic Suppression on Antiretroviral Therapy and Recognizing and Managing Antiretroviral Treatment Failure in Management of Children Receiving Antiretroviral Therapy).</p> <p>[Tivicay PD] DTG Dispersible Tablets</p> <p>Neonates (Gestational Age of ≥37 Weeks to Age of <4 Weeks and Weighing ≥2 kg)^a</p> <ul style="list-style-type: none"> Birth to age <14 days: DTG 5 mg orally every 48 hours Age ≥14 days to <4 weeks: DTG 5 mg orally once daily <p>Note: This dosing strategy is recommended by the Panel based on available pharmacokinetic (PK) modeling and simulation and clinical trial data. The above dosing strategy is not currently approved by the FDA. No dosing information is available in preterm neonates (gestational age <37 weeks) or infants weighing <2 kg.</p>	<ul style="list-style-type: none"> Insomnia Headache Neuropsychiatric symptoms (i.e., depression and/or suicidal thoughts or actions), especially in patients with a history of psychiatric illness Rare cases of hypersensitivity reactions (HSRs), including rash and DRESS (drug reaction [or rash] with eosinophilia and systemic symptoms), constitutional symptoms, and organ dysfunction (including liver injury)
	Special Instructions
	<ul style="list-style-type: none"> DTG may be taken with or without food. DTG should be taken 2 hours before or 6 hours after taking cation-containing antacids or laxatives, sucralfate, oral iron supplements, oral calcium supplements, or buffered medications.

Infant (Aged ≥4 Weeks and Weighing ≥2 kg), Child, and Adolescent Dose

Weight	Recommended Dose ^a of DTG Dispersible Tablets	Number of 5-mg Tablets	Volume of Water
2 kg to <3 kg ^b	5 mg once daily	1	5 mL
3 kg to <6 kg	5 mg once daily	1	5 mL
6 kg to <10 kg	15 mg once daily	3	5 mL
10 kg to <14 kg	20 mg once daily	4	10 mL
14 kg to <20 kg	25 mg once daily	5	10 mL
≥20 kg	30 mg once daily	6	10 mL

^a If certain drugs that induce uridine diphosphate glucuronyl transferase (UGT) 1A or cytochrome P450 (CYP) 3A are coadministered, administer DTG dispersible tablets twice daily (see the Drug Interactions section below).

^b This dosing is not currently approved by the FDA. DTG dispersible tablets have been approved only for those weighing ≥3 kg and aged ≥4 weeks. However, this dosing is recommended by the Panel based on available PK modeling and simulation and clinical trial data.

[Tivicay] DTG Film-Coated Tablets

Child and Adolescent (Weighing ≥14 kg) Dose

- DTG film-coated tablets and DTG dispersible tablets are not bioequivalent and are not interchangeable on a milligram-per-milligram basis. Each formulation has different doses.

Dosing of Film-Coated Tablets for Pediatric Patients Weighing ≥14 kg Who Can Swallow Tablets

Pediatric Body Weight	Recommended Dose ^a of DTG Film-Coated Tablets	Number of Tablets
14 kg to <20 kg	40 mg once daily	4 x 10 mg ^b
≥20 kg	50 mg once daily	1 x 50 mg

^a If certain drugs that induce UGT1A or CYP3A are coadministered, administer DTG tablets twice daily (see the Drug Interactions section below).

^b 10-mg tablets are no longer commercially available. Dosing from the package insert remains in the table above.

- For DTG dispersible tablets, fully disperse the dispersible tablets in 5 mL of drinking water (if using one or three tablets) or in 10 mL of drinking water (if using four, five, or six tablets) in the supplied cup; swirl the suspension so that no lumps remain. After full dispersion and within 30 minutes of mixing, administer the oral suspension. Rinse the dosing cup with a small amount of water (~2 mL) and give this additional water to the child to ensure the child takes the full dose and no medication remains in the dosing cup.

- DTG dispersible tablets may be swallowed whole. If more than one tablet is required, swallow one tablet at a time to reduce the risk of choking. DTG dispersible tablets should not be chewed or crushed.

- For ABC/DTG/3TC dispersible tablets, fully disperse the tablets in 5 mL of drinking water (if using one tablet), 15 mL of drinking water (if using three tablets) or 20 mL of drinking water (if using four to six tablets) in the supplied cup; swirl the suspension so that no lumps remain. After full dispersion and within 30 minutes of mixing, administer the oral suspension. Rinse the dosing cup with a small amount (~2 mL) of water and give this additional water to the child to ensure the child takes the full dose and no medication remains in the dosing cup.

- ABC/DTG/3TC dispersible tablets should not be swallowed whole, chewed, or crushed.
- No data exist regarding dispersion in breast milk or any vehicles other than water.
- In patients who have difficulty swallowing the film-coated tablets whole, 50-mg tablets may be either split into halves followed by immediate ingestion of **both halves** of the tablet or crushed and added to a small amount of semisolid food or liquid, all of which should be consumed **immediately**.¹

Some infants may have received raltegravir as presumptive HIV therapy prior to diagnosis. These infants and other infants and children with HIV who have received INSTIs are candidates to switch to once-daily DTG if they are virologically suppressed or have no mutations associated with resistance to INSTIs.

Adult Dose

- One 50-mg DTG film-coated tablet once daily
- If certain drugs that induce UGT1A or CYP3A are coadministered, administer DTG 50 mg twice daily (see the Drug Interactions section below).
- Adults who are INSTI-experienced with certain INSTI-associated resistance mutations or clinically suspected INSTI resistance should receive 50 mg DTG twice daily.

[Dovato] DTG/Lamivudine (3TC)

Adolescents Aged ≥12 Years and Weighing ≥25 kg and

Adult Dose

- One tablet once daily with or without food as a complete regimen in antiretroviral (ARV)-naïve adolescents with no known mutations associated with resistance to the individual components of Dovato

[Juluca] DTG/Rilpivirine

Adult Dose

- One tablet once daily with a meal as a complete regimen to replace the current ARV regimen in patients who have been virologically suppressed (HIV RNA <50 copies/mL) on a stable ARV regimen for at least 6 months, with no history of treatment failure, and no known mutations associated with resistance to the individual components of Juluca

[Triumeq PD] Abacavir (ABC)/DTG/3TC

Children Aged ≥4 Weeks and Weighing ≥3 kg to <25 kg

- Dispersible Triumeq PD tablets are FDA approved for children aged ≥3 months weighing ≥6 kg to <25 kg. They are not recommended for children weighing ≥25 kg.
- Population PK modeling and simulation supports the use of a single Triumeq PD tablet in infants weighing ≥3 kg to <6 kg and aged ≥4 weeks.
- Administer the appropriate number of tablets for a child's weight once daily. Tablets should be dispersed in appropriate volume of water (see Weight-Band Dosing table below and Special Instructions).

- The efficacy of DTG is reduced in patients with certain combinations of INSTI-resistance mutations. DTG dosing strategies in pediatric patients with first-generation INSTI mutations differ from those in adults (see [Table A](#) and the Resistance section below). Screen patients for hepatitis B virus (HBV) infection before using FDC tablets that contain 3TC. Severe acute exacerbations of HBV can occur after discontinuation of 3TC. Patients with HBV/HIV coinfection who receive Dovato will require additional treatment for chronic HBV infection.

- For any FDC tablets containing ABC, test patients for the HLA-B*5701 allele before starting therapy to predict the risk of HSRs. Patients who test positive for the HLA-B*5701 allele should not be given an ABC-containing FDC. Patients with no prior HLA-B*5701 testing who are tolerating an ABC-containing regimen do not need to be tested. See the [Abacavir](#) section.

Metabolism/Elimination

- Substrate for UGT1A1 and CYP3A. Also, a substrate of UGT1A3, UGT1A9, breast cancer resistance protein, and P-glycoprotein *in vitro*. Drugs that induce these enzymes and transporters may decrease plasma concentrations of DTG. Drugs that inhibit these enzymes or transporters may increase DTG plasma concentrations.

DTG Dosing in Patients With Hepatic Impairment

- No dose adjustment is necessary in patients with mild or moderate hepatic impairment. Due to the lack of data, DTG is **not recommended** for use in patients with severe hepatic impairment.
- FDC tablets containing ABC or 3TC should not be used in patients with impaired hepatic function.

Weight-Band Dosing of Triumeq PD Tablets for Children Aged ≥ 4 Weeks and Weighing ≥ 3 kg

Weight	Recommended Daily Dose	Number of Triumeq PD Tablets	Volume of Water
3 kg to <6 kg ^a	ABC 60 mg, DTG 5 mg, 3TC 30 mg once daily	1	5 mL
6 kg to <10 kg	ABC 180 mg, DTG 15 mg, 3TC 90 mg once daily	3	15 mL
10 kg to <14 kg	ABC 240 mg, DTG 20 mg, 3TC 120 mg once daily	4	20 mL
14 kg to <20 kg	ABC 300 mg, DTG 25 mg, 3TC 150 mg once daily	5	20 mL
20 kg to <25 kg	ABC 360 mg, DTG 30 mg, 3TC 180 mg once daily	6	20 mL
≥ 25 kg	Use Triumeq. See below.		

^a This dosing is not currently approved by the FDA. ABC/DTG/3TC dispersible tablet dosing has been approved only for those weighing ≥ 6 kg and aged ≥ 3 months. However, this dosing is recommended by the Panel based on available PK modeling and simulation data.

- For use in patients who are ARV naive or ARV experienced (but INSTI naive) and who are not being treated with UGT1A1 or CYP3A inducers
- See the [Abacavir](#) section for special instructions about testing for ABC hypersensitivity.

[Triumeq] ABC/DTG/3TC

Child and Adolescent (Weighing ≥ 25 kg) and Adult Dose

- One tablet once daily with or without food
- For use in patients who are ARV naive or ARV experienced (but INSTI naive) and who are not being treated with UGT1A1 or CYP3A inducers
- See the [Abacavir](#) section for special instructions about testing for ABC hypersensitivity.

DTG Dosing in Patients With Renal Impairment

- DTG decreases tubular secretion of creatinine and increases measured serum creatinine without affecting glomerular filtration.
- No dose adjustment is required in INSTI-naïve patients with mild, moderate, or severe renal impairment, or in INSTI-experienced patients with mild or moderate renal impairment.
- Use DTG with caution in INSTI-experienced patients with severe renal impairment (creatinine clearance [CrCl] <30 mL/min), because DTG concentrations will be decreased. The cause of this decrease is unknown.
- FDC tablets containing 3TC (Dovato, Triumeq PD, and Triumeq) should not be used in patients who have CrCl <30 mL/min or patients who are on dialysis because the doses of 3TC cannot be adjusted. Data about the FDC DTG/3TC (Dovato) suggest that patients with a sustained creatinine clearance 30–49 mL/min may experience a higher 3TC exposure and should be monitored for hematologic toxicities and potential FDC discontinuation and subsequent adjustment of the treatment regimen. See package inserts for additional information.

Drug Interactions

Additional information about drug interactions is available in the [Liverpool HIV Drug Interaction Checker](#).

- *Metabolism:* Dolutegravir (DTG) is a uridine diphosphate glucuronosyltransferase (UGT) 1A and cytochrome P450 (CYP) 3A substrate and may require dose adjustments when administered with UGT1A-modulating or CYP3A-modulating medications. DTG dosing should be adjusted to twice daily (i.e., twice the usual dose) when coadministered with drugs such as efavirenz and rifampin.²⁻⁴ Because etravirine (ETR) significantly reduces plasma DTG concentrations, DTG **should not be administered** with ETR without coadministration of atazanavir/ritonavir, darunavir/ritonavir (DRV/r), or lopinavir/ritonavir, which counteract this effect on DTG concentrations. DTG **should not be administered** with nevirapine because of insufficient data on interactions between these drugs. See the product label for a full listing of significant drug–drug interactions.
- Atazanavir (ATV) is an inhibitor of UGT1A1. In a pharmacologic survey of adult patients who were receiving DTG, patients who also received ATV had plasma concentrations of DTG that were twofold to fourfold higher than those of patients who received other antiretroviral (ARV) drugs.⁵
- Before administering DTG, clinicians should carefully review a patient's medication profile for potential drug interactions.

Major Toxicities

- *More common:* Insomnia and headache. Excessive weight gain and increased body mass index (BMI) have been reported in adults who received DTG in clinical trials and in some pediatric and adolescent cohorts (see [Table 17h. Lipodystrophies and Weight Gain](#)),⁶⁻⁹ whereas other cohort studies have not identified an association with excessive weight gain.¹⁰
- *Less common (more severe):* Hypersensitivity reactions characterized by rash, constitutional symptoms, and sometimes organ dysfunction; neuropsychiatric symptoms, especially in patients with a history of psychiatric illness. Multiple postmarketing reports note that neuropsychiatric adverse events (AEs) have occurred following the initiation of DTG-based therapy in adults.^{11,12}
- *Immune reconstitution inflammatory syndrome (IRIS):* In retrospective observational studies, severe cases of IRIS that required hospitalization appeared to be more frequent in patients who presented with advanced HIV disease and who initiated treatment with integrase strand transfer inhibitors (INSTIs), particularly DTG.^{13,14} This phenomenon is presumed to be linked to the rapid decline in HIV RNA observed in patients receiving INSTI-based therapy.
- *Rare:* Hepatotoxicity has been reported; two cases of liver injury were presumed to be related to the use of DTG. One of these cases required liver transplantation.^{15,16}
- *Rare:* A single case of drug reaction (or rash) with eosinophilia and systemic symptoms (or DRESS) has been reported.¹⁷

Resistance

The International Antiviral Society–USA maintains a [list of updated resistance mutations](#), and the [Stanford University HIV Drug Resistance Database](#) offers a discussion of each mutation. For additional considerations on the impact of nucleoside reverse transcriptase inhibitor (NRTI) resistance and the use of DTG-containing fixed-dose combinations (FDCs), see [Recognizing and Managing Antiretroviral Treatment Failure](#).

The efficacy of DTG is reduced in patients with the INSTI-resistance Q148 substitution plus two or more additional INSTI-resistance mutations, and this reduced efficacy cannot be completely overcome with increased DTG dosing.^{18,19}

For INSTI-experienced adults with certain INSTI-resistance mutations or clinically suspected INSTI resistance, the [Tivicay package insert](#) recommends giving the standard 50-mg dose twice daily rather than once daily. However, modeling and simulation of this potential strategy with the dispersible tablet formulation of DTG in children suggested elevated maximum plasma concentrations (C_{max}) in comparison to historical data in adults, adolescents, and children would result. Thus, a different dosing strategy was needed for children with certain or clinically suspected INSTI-resistance mutations. The proposed dosing schedule in [Table A](#) below was based on simulations with the goal of achieving geometric mean concentration at 12 hours postdose $>1.97 \mu\text{g/mL}$ and area under the curve (AUC) through 12 hours postdose $>32.2 \mu\text{g}\cdot\text{h/mL}$ while avoiding elevated C_{max} values.²⁰ Additionally, the coformulated dispersible tablet containing abacavir (ABC)/DTG/lamivudine (3TC) cannot be used in combination with a separate dose of single-agent dispersible release DTG because the dosing of the separate formulation is not double the regular dose and the modified dosing strategy would result in underdosing the ABC and 3TC components.

Table A. Weight-Band Dosing of Dolutegravir Dispersible Tablets for Pediatric Patients Weighing ≥ 3 kg and Aged ≥ 3 Months With First-Generation Integrase Strand Transfer Inhibitors–Resistance Mutations

Weight	Recommended Twice-Daily Dose	Number of Tablets per Dose
3 kg to <6 kg	5 mg	1
6 kg to <10 kg	10 mg	2
10 kg to <14 kg	15 mg	3
14 kg to <20 kg	15 mg	3
20 kg to <30 kg	20 mg	4
30 kg to <40 kg	20 mg	4

Pediatric Use

Approval

DTG is approved by the U.S. Food and Drug Administration (FDA) for use, in combination with other ARV drugs, in pediatric patients aged ≥ 4 weeks and weighing ≥ 3 kg who are treatment naive or treatment experienced but INSTI naive (see [Appendix A, Table 2. Antiretroviral Fixed-Dose Combination Tablets and Co-packaged Formulations: Minimum Body Weights and Considerations for Use in Children and Adolescents](#)). DTG dispersible tablets and film-coated tablets in either the single-entity or FDC form can be administered with or without food.^{21,22} Pediatric patients weighing ≥ 20 kg may take the DTG 50-mg film-coated tablets if they are able to swallow tablets.

The combination tablet ABC/DTG/3TC (Triumeq) is approved by the FDA for use in children and adolescents weighing ≥ 25 kg. Dispersible ABC/DTG/3TC tablets (Triumeq PD) are FDA approved for use in children weighing ≥ 6 kg to <25 kg.

The combination tablet DTG/3TC (Dovato) is approved by the FDA for adolescents weighing ≥ 25 kg and aged ≥ 12 years but is not approved for use in children aged < 12 years.

The combination tablet DTG/rilpivirine (RPV) (Juluca) is not approved by the FDA for use in children or adolescents. However, the doses of the component drugs that make up this FDC tablet are approved for use in adolescents, and the Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV (the Panel) generally endorses the use of adult formulations for drugs that have been approved for use in children and adolescents. The FDC tablet may be appropriate for use in certain adolescents. See [Modifying Antiretroviral Regimens in Children With Sustained Virologic Suppression on Antiretroviral Therapy](#) for additional considerations on the use of this combination.

Formulation Differences: Film-Coated Tablet Compared to Dispersible Tablet

DTG is currently available as either film-coated tablets or dispersible tablets (tablets for oral suspension). The dispersible tablet has 60% to 80% greater bioavailability in adults than the film-coated tablet,²³ so recommended doses using the dispersible tablet cannot be directly compared to those using the film-coated tablets. The drug exposure provided by the 50-mg film-coated tablet is approximately equal to that of DTG 30 mg administered as dispersible tablets.

Efficacy and Pharmacokinetics

Pediatric Patients Aged < 4 Weeks

DTG is primarily metabolized by UGT1A1 (90%) and to a minor extent by CYP3A4 (10%). Because UGT enzyme activity is low at birth, DTG elimination is prolonged in neonates, and thus further assessments are needed to evaluate potential dosing strategies accounting for enzyme maturation in this population. Dosing of dispersible release DTG in full-term neonates (≥ 37 weeks' gestation) aged < 4 weeks was evaluated in two separate studies: PETITE-DTG and IMPAACT 2023.

PETITE-DTG was a Phase I/II, open-label, two-stage study in South Africa that evaluated the pharmacokinetic (PK) and safety of DTG in full-term neonates (≥ 37 weeks gestational age) weighing ≥ 2 kg and born to individuals receiving a DTG-containing therapy during pregnancy.²⁴ In Stage 1, single doses of DTG 5 mg were administered to eight neonates aged < 14 days and eight neonates aged ≥ 14 to < 28 days. These data were incorporated into population PK modeling to identify a dosing regimen to be used in Stage 2 that achieved the protocol-defined PK targets of a geometric mean concentration at the end of the dosing interval (C_{tau}) ≥ 0.67 mcg/mL and maximum plasma concentration (C_{max}) < 17.0 mcg/mL. During Stage 2, DTG 5 mg was administered every 48 hours for the first 2 weeks of life, followed by once daily administration through 4 weeks of life. A total of 41 infants were enrolled, with DTG administered either as half of a scored dispersible 10-mg tablet (51%) or one 5-mg dispersible film (49%).²⁵ The scored 10-mg dispersible tablet is a generic formulation available in South Africa and other resource-limited settings, but the film is still an investigational product. Both formulations achieved the protocol-defined PK targets and achieved comparable exposures to each other. No AEs related to DTG occurred, and all 39 infants who completed follow-up were HIV seronegative at the time of study exit.

IMPAACT 2023 was a Phase 1 open-label, noncomparative dose-finding study of the safety, tolerability, and PK of DTG in full-term neonates (≥ 37 weeks gestational age) perinatally exposed to HIV-1 and weighing ≥ 2 kg. The study enrolled infants with and without *in utero* DTG exposure and was conducted in two sequential cohorts. In Cohort 1, 18 neonates received single doses of DTG using either a weight-based liquid formulation or a 5-mg dispersible tablet formulation within 5 days of birth, with a repeat single dose 7 to 10 days after the initial dose. Population PK modeling was

performed to characterize neonatal DTG disposition and to inform the selection of an appropriate multidose regimen for evaluation in Cohort 2 that achieved protocol-defined PK targets of $C_{\text{trough}} > 0.697$ mcg/mL, $AUC_{0-\text{tau}} > 37$ mcg·h/mL, and $C_{\text{max}} < 18.35$ mcg/mL). In Cohort 2, 18 neonates initiated the dispersible tablet formulation of DTG within 5 days of birth and received 5 mg every 48 hours during the first 2 weeks of life, followed by 5 mg once daily through 4 to 6 weeks of age.²⁶ Available PK data demonstrate that this regimen achieves exposures within acceptable target ranges, regardless of whether the mother received a DTG-containing regimen, with variability consistent with maturation of drug-metabolizing pathways (UGT1A1 and CYP3A4) during the neonatal period. No serious AEs were attributed to DTG, and the regimen was generally well tolerated. The study has since been fully enrolled, and ongoing analyses of the data support the Panel's neonatal dosing recommendations for full-term infants weighing ≥ 2 kg.

Pediatric Patients Aged 4 Weeks to <18 Years

Single-Entity Dolutegravir

[IMPAACT P1093](#) was a multinational, open-label trial of DTG in children with HIV. Data from IMPAACT P1093 Cohort 1 (aged 12 years to <18 years) and Cohort 2 (aged 6 years to <12 years) provided support for use of DTG film-coated tablets in pediatric patients weighing ≥ 14 kg; Cohort 3 (aged 2 years to <6 years), Cohort 4 (aged 6 months to <2 years), and Cohort 5 (aged 4 weeks to <6 months) provided evidence supporting the use of DTG 5-mg dispersible tablets. Dosing recommendations that previously included the 25-mg film-coated tablets have been replaced with other formulations.

Results of PK, safety, and efficacy assessments have been reported sequentially for different age and weight cohorts as data became available; similarly, dosing recommendations have been revised sequentially.²⁷⁻²⁹ A total of 181 participants were enrolled across these cohorts, of whom 96 received dispersible DTG tablets and 85 received nondispersible formulations.²⁹ Seventy-five participants received the recommended doses of the film-coated or dispersible tablets based on their weight and age, of whom 80% were treatment experienced and all were INSTI naive.³⁰ At Week 48, of the 42 participants with available data, 69% achieved HIV RNA < 50 copies/mL and 79% achieved HIV RNA < 400 copies/mL. The effectiveness observed in the trial was comparable to that of treatment-experienced adult participants.³⁰ The median CD4 T lymphocyte cell (CD4) count (percent) increased from baseline to Week 48 by 141 cells/mm³ (7%). Overall, the safety profile in P1093 participants was comparable to that observed in adults, and both formulations were well tolerated.³⁰ Follow-up data among 16 adolescents in Cohort 1 through 144 weeks showed 43% and 35% of participants achieving and maintaining HIV RNA levels < 400 copies/mL and < 50 copies/mL, respectively.³¹ Genotypic testing was available at the time of treatment failure for 6 of the 13 participants; one of these adolescents developed DTG resistance.^{29,31}

The Once-daily DTG-based ART in Young people vS Standard thErapY (ODYSSEY) trial, conducted by the Pediatric European Network for the Treatment of AIDS (PENTA), enrolled both treatment-naïve and treatment-experienced pediatric patients from the European Union, Thailand, and several African countries; this trial initially evaluated doses approved by the European Medicines Agency at the time the trial started. A total of 707 children aged <18 years were enrolled; 311 children started DTG as first-line therapy, and 396 started DTG as second-line therapy.³² DTG-based antiretroviral therapy (ART) as both first-line therapy and second-line therapy in children was superior to standard care through 96 weeks of treatment.³³ Results from the younger ODYSSEY cohort of children weighing between 3 kg and 14 kg showed superiority of DTG-based ART compared with other regimens, of which over 70% were protease inhibitor (PI)-based regimens.³³⁻³⁵ Follow-up data through 192 weeks continued to demonstrate the superiority of DTG-containing ART for virologic suppression compared with first- and second-line ART.³⁶ **Secondary analyses have also shown that DTG resulted in faster virologic suppression versus those on standard of care (SOC), which**

consisted primarily of PIs, and that those on DTG with a backbone containing ABC or tenofovir were at lower risk of virologic failure than those on zidovudine (ZDV).³⁷

Nested PK substudies within ODYSSEY also evaluated simplified pediatric dosing that aligned with World Health Organization (WHO)–recommended weight bands. PK data are available from a cohort of children weighing >25 kg who switched to the DTG 50-mg film-coated tablet, 20 kg to <25 kg who received either the DTG 50-mg film-coated tablet or DTG 30 mg administered as six 5-mg dispersible tablets,^{38,39} 14 kg to <20 kg who received 25 mg, 3 kg to <6 kg and younger than 6 months who received 5 mg DTG, 3 kg to <6 kg and older than 6 months who received 10 mg, 6 kg to <10 kg who received 15 mg, and 10 kg to <14 kg who received 20 mg.³⁹ A total of 19 children weighing <20 kg experienced Grade 3 or higher AEs, including two deaths (one kwashiorkor and one accidental trauma) assessed as unrelated to the study drug. Eleven participants experienced serious AEs, 69% of which were due to infectious diseases.

Combined PK data from P1093 and ODYSSEY across all age/weight cohorts form the basis for the current FDA dose recommendations and are summarized in [Table B](#) below. Generally speaking, the AUC and C_{max} values were comparable to or higher than adult values, whereas troughs were slightly lower and more variable, but exposures still fell within acceptable exposure ranges across weight bands. These data support the administration of either DTG 30 mg as dispersible tablets or DTG 50 mg as a film-coated tablet in patients weighing ≥20 kg. In addition, modeling and simulations that included UGT1A1 maturation in infants were used to support the dose of DTG in infants ≥4 weeks of age and weighing ≥3 kg. Dosing in neonates is under investigation.

Table B. Summary of Pharmacokinetic Parameters in Pediatric Participants With HIV-1 (Pooled Analyses for IMPAACT P1093 and ODYSSEY Trials)

Weight Band ^a	Dose ^b of DTG FCT or DTG DT	n	Pharmacokinetic Parameter Geometric Mean (% CV)		
			C _{max} (mcg/mL)	AUC _{0-24h} (mcg·h/mL)	C _{24h} (ng/mL)
3 kg to <6 kg	DTG DT 5 mg once daily	8	3.80 (34)	49.37 (49)	962 (98)
6 kg to <10 kg	DTG DT 15 mg once daily	17	5.27 (50)	57.17 (76)	706 (177)
10 kg to <14 kg	DTG DT 20 mg once daily	13	5.99 (33)	68.75 (48)	977 (100)
14 kg to <20 kg	DTG DT 25 mg once daily	19	5.97 (42)	58.97 (44)	725 (75)
20 kg to <25 kg	DTG DT 30 mg once daily	9	7.16 (26)	71.53 (26)	759 (73)
≥20 kg	DTG FCT 50 mg once daily	49	4.92 (40)	54.98 (43)	778 (62)
Adults ^c	DTG FCT 50 mg once daily	N/A	3.67 (20)	53.6 (27)	1,110 (46)

Table B: Summary of Pharmacokinetic Parameters in Pediatric Participants With HIV-1 (Pooled Analyses for IMPAACT P1093 and ODYSSEY Trials)

Weight Band ^a	Dose ^b of DTG FCT or DTG DT	n	Pharmacokinetic Parameter Geometric Mean (% CV)		
			C _{max} (mcg/mL)	AUC _{0-24h} (mcg·h/mL)	C _{24h} (ng/mL)
Adults ^c	DTG FCT 50 mg twice daily	N/A	4.15 (29)	75.1 (35)	2,120 (47)

^a Data are from two weight-band-based pharmacokinetic substudies in the ODYSSEY trial.

^b The bioavailability of DTG tablets for oral suspension is approximately 1.6-fold that of DTG film-coated tablets.

^c Adult pharmacokinetic data are based on population pharmacokinetic analyses from clinical trials.³⁰

Key: AUC_{0-24h} = 24-hour area under the curve; C_{24h} = concentration at 24 hours postdose; C_{max} = maximum plasma concentration; CV = coefficient of variation; DT = dispersible tablets; DTG = dolutegravir; FCT = film-coated tablets

Separate PK studies and population PK models have continued to support adequate DTG exposures among children and adolescents at the currently recommended doses.^{21,40-45} One of these analyses identified that tenofovir alafenamide fumerate/emtricitabine may reduce DTG bioavailability by approximately 20% in comparison to those on backbones of ABC or ZDV, but DTG AUC and C_{trough} were still adequate.⁴⁵ Separate assessments of metabolic ratios of DTG glucuronide (a major DTG metabolite) to DTG in infants and children with HIV did not identify any difference in metabolic ratios by age, weight, NRTI backbone, or kidney function.⁴⁶ The only factor that altered these ratios was rifampicin subsequent to its known induction of metabolism. Exploratory investigations also have identified that genetic variants in adenosine triphosphate-binding cassette subfamily G member 2 (ABCG2), nuclear receptor subfamily 1 group I member 2, and UGT1A1 may affect DTG PK in infants and children, which may explain some of the additional variability observed in this population.⁴⁷ Genetic variants in ABCG2 and UGT1A1 that were associated with higher DTG exposures showed a trend toward sustained virologic suppression.

Dolutegravir/Abacavir/Lamivudine

The PK, safety, tolerability, and efficacy of dispersible and immediate-release ABC/DTG/3TC FDC tablet formulations were investigated in the IMPAACT 2019 study.^{48,49} A total of 57 children weighing 6 kg to <40 kg and aged <12 years were enrolled and dosed across five weight bands in alignment with the WHO ARV dosing recommendations for each component. Children weighing 6 kg to <25 kg received dispersible FDC tablets containing ABC 60 mg/DTG 5 mg/3TC 30 mg (Triumeq PD), and those weighing 25 kg to <40 kg received the immediate-release FDC tablet containing ABC 600 mg/DTG 50 mg/3TC 300 mg (Triumeq). Drug exposures for all three components were comparable to previous studies in children and adults with HIV, including DTG exposures from IMPAACT P1093 and ODYSSEY.⁴⁸ Dosing was confirmed based on PK and safety criteria across all weight bands. At Week 24, 54 of 57 (95%) participants were suppressed to HIV-1 RNA <200 copies/mL, 52 of 57 (91%) were suppressed to HIV-1 RNA <50 copies/mL, and all treatment-experienced patients who switched to ABC/DTG/3TC maintained suppression. At Week 48, a total of 54 participants remained on treatment, of whom all achieved HIV-1 RNA <200 copies/mL, and 45 (83%) achieved HIV-1 RNA <50 copies/mL.⁴⁹ A single participant discontinued treatment due to drug-induced liver injury that occurred at Week 36. This event was attributed to ABC and DTG. CD4 counts were stable throughout the 48 weeks of treatment. Both formulations were otherwise safe and well tolerated, with 10 of 11 participants in the highest weight band able to swallow the larger immediate-release tablet whole and intact (see [Appendix A, Table 2. Antiretroviral Fixed-Dose Combination Tablets and Co-packaged Formulations: Minimum Body Weights and Considerations for](#)

[Use in Children and Adolescents](#)).^{48,49} This finding contrasted a separate cohort of 12 adolescents in Spain, where half needed to crush or split the immediate-release tablet because of its size.⁵⁰

Population PK modeling of IMPAACT 2019 data through 48 weeks further demonstrated alignment of PK data collected within this study with existing population PK models for the individual components, further supporting dose confirmation of the dispersible FDC.⁴⁴ These models were then modified with maturation functions specific to each component to evaluate whether a single ABC 60 mg/DTG 5 mg/3TC 30 mg tablet in infants weighing ≥ 3 kg to < 6 kg (aged ≥ 4 weeks) could achieve comparable drug exposures observed in older children and adults based on dosing simulations, and thus provide comparable safety and efficacy observed in older children and adults.⁵¹ These models used data from young children across weight bands from IMPAACT 2019 (≥ 6 kg), P1093 (≥ 3 kg), ODYSSEY (≥ 3 kg) clinical trials for DTG, and the PETITE clinical trial for ABC and 3TC.^{29,39,44,48,52,53} Review of the ABC/3TC data from the PETITE study in neonates^{52,53} and available ABC, 3TC, and DTG safety data in infants aged < 3 months (see below under Pediatric Postmarketing Safety Studies) were used to interpolate safety for infants aged ≥ 4 weeks to < 3 months and suggested no safety concerns for coadministration of ABC/3TC/DTG in young infants. Notably, the doses in the safety evaluation were mostly in alignment with the WHO weight-band dose recommendations of fixed-dose formulations of ABC 120 mg/3TC 60 mg, which were higher than those under evaluation in this modeling and simulation. Based on these findings, the Panel supports the use of the single ABC/3TC/DTG FDC dispersible tablet as an alternative to the separate formulations of ABC, 3TC, and DTG in infants weighing ≥ 3 kg to < 6 kg and aged ≥ 4 weeks to facilitate treatment adherence.

Retrospective & Prospective Cohort Studies

The efficacy and safety of DTG-based regimens have been evaluated in a few randomized controlled trials and multiple observational cohort studies.⁵⁴⁻⁵⁹

Observational cohort studies have included a variety of populations, including children, adolescents, and young adults who were ART experienced but INSTI naive and either virologically suppressed or viremic at baseline. Virologic suppression rates between about 80% to 93% have been reported following at least 6 months to 24 months of DTG-containing therapy.^{55-58,60,61} Discontinuation rates due to toxicity have generally been low ($< 1\%$).⁵⁵ Factors associated with a higher likelihood of virologic suppression following the switch included suppressed viral loads at baseline,^{54-56,58,60} use of once-daily tenofovir disoproxil fumarate (TDF)/3TC/DTG as a single-tablet regimen (compared with ABC/3TC/DTG or ZDV/3TC/DTG),⁵⁵ and good medication adherence. Factors associated with lower odds of virologic suppression included age increases and poorer adherence.^{55,57,58} Given the retrospective nature of these analyses, many of which were performed following national rollout programs, direct comparisons among participants who were not suppressed and did not switch to a DTG-containing regimen could not always be performed.⁵⁵

Although observational studies have shown high virologic suppression rates, emerging INSTI mutations specific to DTG have been reported among children being monitored in national treatment programs.⁶¹ Thus, continued assessments of sustained long-term virologic suppression (i.e., > 24 months) and the development of resistance will be important.^{62,63} Additionally, one study noted⁶⁰ more than one-third of children experienced at least two regimen changes during the follow-up period from 2019 to 2021, some of which involved switching from DTG to either a PI or non-nucleoside reverse transcriptase inhibitor (NNRTI). These changes were attributable, in part, to drug shortage, illustrating the importance of continued access to and supply of DTG to support rollout initiatives.⁵⁰

Pediatric Postmarketing Safety Studies

Several studies continue to investigate longer-term safety outcomes in pediatric populations with the expanded use of DTG. Notable outcomes of interest include neuropsychiatric outcomes and growth, weight gain, and metabolic effects over time based on findings in adults.

ODYSSEY reported a small number of neuropsychiatric AEs among 707 children and adolescents randomized to DTG, which was not significantly different from those reported in study participants receiving standard care. However, participants receiving DTG were more likely to have suicidal ideation than those receiving SOC; however, these symptoms were described as transient and did not lead to changes in ART.³⁴ In IMPAACT 2019, 6 of 57 (10.5%) participants reported at least one central nervous system disorder event, but all were Grade 1 severity.⁴⁹ Sleep and mood questionnaires revealed one participant had expressed thoughts that life was not worth living at Week 4 only, and an increase in frequency of nightmares was also reported at Weeks 4 and 24 in comparison to study entry. A separate systematic review of INSTI use in 3,448 children with perinatal HIV infection identified rates of neuropsychiatric effects from 1% to 16% among those receiving DTG.⁶⁴

Reports of weight gain among adults enrolled in clinical trials prompted similar studies to investigate the metabolic effects of DTG in adolescents. Some studies have identified increases in weight-for-age z-score and BMI-for-age z-score,^{7,9,35,49} as well as trunk fat and trunk/total body fat ratios.⁶ However, others have not identified significant changes^{8,10,65} or lower rates of change among those with baseline BMI $\geq$ 50th percentile.⁶⁶ Lipid changes also have been evaluated, with one study detailing decreases in total cholesterol and low-density lipoproteins, while serum triglycerides decreased early in the study and subsequently increased.⁶ In another study, adolescents who switched to DTG (n = 30) demonstrated reduced hepatic steatosis and lower total cholesterol and triglycerides compared to those who remained on their initial ART regimens (84% PI-based).⁶⁵ Based on these collective data, weight gain may be observed in adolescents receiving DTG, as observed in adults; the long-term clinical significance of these changes is unclear, and further studies are needed in adolescents and children receiving DTG. See the [What to Start](#) section for additional considerations.

Simplification of Treatment

Dolutegravir With Rilpivirine

Two trials in adults (Regimen Switch to DTG + Rilpivirine from Current Antiretroviral Regimen in Human Immunodeficiency Virus Type 1 Infected and Virologically Suppressed Adults [SWORD-1 and SWORD-2]) supported the approval of a DTG 50-mg/RPV 25-mg FDC tablet as a complete regimen for treatment simplification or maintenance therapy in selected patients. The two identical SWORD trials enrolled 1,024 virologically suppressed patients who had been on stable ART for at least 6 months and who had no history of treatment failure or evidence of resistance mutations. The participants were randomized either to receive DTG/RPV or to continue their suppressive ARV regimen. After 48 weeks of treatment, 95% of patients in both arms maintained HIV RNA levels <50 copies/mL.⁶⁷ After 52 weeks, the participants who had been randomized to continue their suppressive ARV regimen were switched to DTG/RPV. At 148 weeks, 84% of the early-switch patients and 90% of the late-switch patients remained virologically suppressed, and only 11 patients receiving dual therapy met virologic failure criteria. No INSTI resistance was identified.⁶⁸ During the comparative randomized phase of the study, more AEs were reported and led to discontinuation in the DTG/RPV arm. In a subgroup of the SWORD study, small but statistically significant increases in hip and spine bone mineral density and bone turnover markers were observed in patients whose original ARV regimen contained TDF.⁶⁹

Although Juluca is not approved by the FDA for use in adolescents, the doses of the component drugs that make up this FDC tablet are approved for use in adolescents. The Panel generally endorses the use of adult formulations for drugs that have been approved for use in children and adolescents, and these products may be appropriate for use in certain adolescents. The use of DTG/RPV regimens could be useful in patients in whom there is concern for toxicity from NRTIs. However, the Panel notes that adolescents may have difficulties adhering to therapy and suggests considering close monitoring with viral load testing (see the Treatment Simplification section of [Management of Children Receiving Antiretroviral Therapy](#)).

Dolutegravir With Lamivudine

The approval of DTG 50 mg/3TC 300 mg as a complete regimen in adults was supported by data from two randomized, double-blind, controlled trials (Efficacy, Safety, and Tolerability Study Comparing DTG Plus Lamivudine With DTG Plus Tenofovir/Emtricitabine in Treatment naive HIV Infected Subjects [GEMINI-1 and GEMINI-2]). GEMINI-1 and GEMINI-2 were identical 148-week trials that enrolled a total of 1,433 adults with HIV who had plasma HIV RNA levels between 1,000 copies/mL and $\leq 500,000$ copies/mL at screening and no evidence of major resistance mutations or hepatitis B virus infection. Participants were randomized to receive either DTG plus 3TC or DTG plus 3TC/TDF. During 96 weeks of treatment, 86% of patients who received DTG plus 3TC and 89.5% of patients who received DTG plus 3TC/TDF achieved HIV RNA levels < 50 copies/mL. Patients who received DTG plus 3TC had a lower rate of adverse drug reactions (19.6%) than those who received DTG plus 3TC/TDF (25%).⁷⁰

The combination of DTG/3TC was evaluated as initial ART in adolescents weighing ≥ 25 kg and aged ≥ 12 years to < 18 years with baseline HIV-1 RNA between 1,000 copies/mL and $\leq 500,000$ copies/mL through the DANCE study. A total of 32 participants were enrolled, of whom 81% and 69% achieved HIV RNA levels < 50 copies/mL at Weeks 48 and 96, respectively.^{71,72} These results included individuals with missing data due to site closures; thus, sensitivity analyses were performed with the participants excluded. Virologic suppression rates in the sensitivity analyses were 87% (26 of 30) at Week 48 and 88% (22 of 25) at Week 96. Drug exposures for both components were also comparable to historical data in adults, and the combination was overall safe and well tolerated.

Both film-coated tablet and dispersible tablet formulations of DTG/3TC are also under active investigation in children aged 2 years to < 15 years of age and weighing 6 kg to < 40 kg through the D3/Penta21 study.⁷³ The doses under evaluation include DTG 15 mg/3TC 90 mg for 6 kg to < 10 kg, DTG 20 mg/3TC 120 mg for 10 kg to < 14 kg, DTG 25 mg/3TC 150 mg for 14 kg to < 20 kg, DTG 30 mg/3TC 180 mg or DTG 50 mg/3TC 300 mg film-coated tablet for 20 kg to < 25 kg, and DTG 50 mg/3TC 300 mg for ≥ 25 kg, with DTG 50 mg/3TC 300 mg as the only film-coated formulation. These doses were largely aligned with the WHO weight-band dosing recommendations, except for the DTG 50 mg/3TC 300 mg film-coated tablet option in those weighing 20 kg to < 25 kg, which is 1.3 times higher than the currently recommended dose from that weight band. PK data from nested substudies in 72 children weighing 10 kg to < 40 kg demonstrated that all participants achieved DTG C_{trough} above the *in vitro* protein-adjusted 90% maximal inhibitory concentration (IC_{90}) of 0.064 mg/L and 69 of 72 children exceeded the 90% effective concentration of 0.32 mg/L.⁷⁴ Exposures for DTG and 3TC were generally comparable to historical data from ODYSSEY and IMPAACT 2019, respectively.

Dolutegravir With Darunavir/Ritonavir

The combination of once-daily DRV/r with an INSTI is being investigated in a randomized non-inferiority trial among virologically suppressed children aged 6 years to < 18 years through the SMILE Penta-17-ANRS 152 clinical trial.⁷⁵ Participants were randomized to either once-daily DRV/r with an INSTI or continuing their SOC regimen consisting of a boosted PI or NNRTI with a NRTI backbone.

A total of 318 participants were enrolled between 2016 and 2019, of whom 158 were randomized to DRV/r with an INSTI (97% DTG, 3% elvitegravir). DRV/r with an INSTI was non-inferior to SOC at Week 48 (HIV viral load ≥ 50 copies/mL in 5% for DRV/r with an INSTI vs. 7.6% in the SOC arm; difference -2.5% [95% confidence interval (CI), -7.6% and 2.5%]). Secondary analyses comparing DRV/r with an INSTI versus SOC revealed decreases in CD4 counts (-48.3 cells/mm³ [95% CI, -93.4 and -3.2; $P = 0.036$] and mean high-density lipoprotein change from baseline (-4.1 mg/dL [95% CI, -6.7 and -1.4; $P = 0.003$]), and increases in weight and BMI (+1.97 kg [95% CI, 1.1 and 2.9; $P < 0.001$] and +0.66 kg/m² [95% CI, 0.3 and 1.0; $P < 0.001$], respectively). A nested PK substudy in 153 adolescents aged ≥ 12 years to < 18 years from SMILE also demonstrated that total and unbound DTG concentrations were adequate and well above the protein-adjusted IC₉₀ for DTG.⁷⁶ DTG C_{trough} were also comparable to those measured in adults receiving 50 mg once daily. Apparent clearance of the unbound DTG was influenced by total bilirubin concentrations, Asian ethnicity and unbound darunavir concentrations, but the impacts on DTG concentrations were deemed not clinically relevant.⁷⁷

Crushing Film-Coated Tablets for Administration

Dispersible tablets are now considered the preferred formulation for pediatric patients weighing < 20 kg, and film-coated tablets should not be used in children weighing < 14 kg. In children weighing > 14 kg who have difficulty swallowing whole tablets, when the preferred dispersible tablets are not available, the 50-mg tablets either may be split into halves followed by immediate ingestion of **both halves** of the tablet or crushed and added to a small amount of semisolid food or liquid, all of which must be consumed **immediately**.¹ In healthy adults, the use of crushed tablets resulted in slightly higher exposures than the use of whole tablets.⁷⁸ No information exists on the impact of splitting or crushing film-coated tablets on palatability. Some case reports describe DTG-containing film-coated tablets being crushed and successfully administered via orogastric tube⁷⁹ or nasogastric tube.⁸⁰ If DTG is administered via enteral tube, care should be taken to disperse the tablets completely and flush the tube to avoid clogging.

Elvitegravir (EVG)

Updated: September 30, 2026

Reviewed: September 30, 2026

Formulations	
<p>Tablet: Elvitegravir is available only in fixed-dose combination (FDC) tablets.</p> <p>FDC Tablets</p> <ul style="list-style-type: none"> [Genvoya] Elvitegravir 150 mg/cobicistat 150 mg/emtricitabine 200 mg/tenofovir alafenamide 10 mg [Stribild] Elvitegravir 150 mg/cobicistat 150 mg/emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg <p>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.</p> <p>For additional information, see Drugs@FDA or DailyMed.</p>	
Dosing Recommendations	Selected Adverse Events
<p>[Genvoya] Elvitegravir/Cobicistat/Emtricitabine/Tenofovir Alafenamide (EVG/c/FTC/TAF)</p> <p><i>Child (Weighing ≥ 14 kg to < 25 kg)</i></p> <ul style="list-style-type: none"> Limited data are available on the dosing of the low-dose pediatric formulation of Genvoya (EVG 90 mg/cobicistat [COBI or c] 90 mg/FTC 120 mg/TAF 6 mg) in children ≥ 2 years and weighing ≥ 14 kg to < 25 kg. This formulation is approved for use in young children by the European Medicines Agency; however, this formulation is not approved by the U.S. Food and Drug Administration and is not available for clinical use in the United States. <p><i>Child and Adolescent (Weighing ≥ 25 kg) and Adult Dose</i></p> <ul style="list-style-type: none"> One tablet once daily with food in antiretroviral therapy (ART)–naïve or treatment-experienced people who have been virologically suppressed (HIV RNA < 50 copies/mL) on a stable ART regimen for ≥ 6 months with no history of treatment failure and no known mutations associated with resistance to the individual components of Genvoya. <p>[Stribild] Elvitegravir/Cobicistat/Emtricitabine/Tenofovir Disoproxil Fumarate (EVG/c/FTC/TDF)</p> <p><i>Child and Adolescent (Weighing ≥ 35 kg) and Adult Dose</i></p> <ul style="list-style-type: none"> One tablet once daily with food in ART-naïve or treatment-experienced people who have been virologically suppressed (HIV RNA < 50 copies/mL) on a stable ART regimen for at least 6 months with no history of treatment failure and no known mutations associated with resistance to the individual components of Stribild. 	<p>Genvoya- and Stribild-Associated Adverse Events</p> <ul style="list-style-type: none"> Nausea, diarrhea, fatigue, headache
	<p>Special Instructions</p> <ul style="list-style-type: none"> Administer both Genvoya and Stribild with food. Genvoya and Stribild should be administered at least 2 hours before or after antacids and supplements or multivitamins that contain iron, calcium, aluminum, and/or magnesium. When using Genvoya or Stribild, monitor serum creatinine, serum phosphorus, estimated creatinine clearance (CrCl), urine glucose, and urine protein at baseline and every 3–6 months while on therapy. In children who are at risk of renal impairment, also monitor serum phosphate. Children with an increase in serum creatinine levels > 0.4 mg/dL from the baseline should be closely monitored for renal safety. Screen children for hepatitis B virus (HBV) infection before initiating FTC, TDF, or TAF. Severe acute exacerbation of HBV can occur when FTC, TDF, or TAF are discontinued. In children with HBV, monitor hepatic function for several months after stopping therapy with FTC, TDF, or TAF.

	<ul style="list-style-type: none"> For information on crushing and cutting tablets, see the Information on Crushing and Liquid Drug Formulations table from Toronto General Hospital.
	Metabolism/Elimination
	<ul style="list-style-type: none"> EVG is metabolized by cytochrome P450 (CYP) 3A4 and is a modest inducer of CYP2C9. EVG is available only in combination with the pharmacokinetic enhancer (boosting agent) COBI in Stribild or Genvoya. Refer to the Cobicistat, Tenofovir Disoproxil Fumarate, and Tenofovir Alafenamide sections for further details on these drugs. <p>EVG Dosing in Children With Hepatic Impairment</p> <ul style="list-style-type: none"> Stribild and Genvoya should not be used in children with severe hepatic impairment. <p>EVG Dosing in Children With Renal Impairment</p> <ul style="list-style-type: none"> Stribild should not be initiated in children with estimated CrCl <70 mL/min and should be discontinued in children with estimated CrCl <50 mL/min. FTC and TDF require dose adjustments in these children, and these adjustments cannot be achieved with an FDC tablet. Genvoya is not recommended in children with estimated CrCl 15 to <30 mL/min or in children with estimated CrCl <15 mL/min who are not receiving chronic hemodialysis.

Drug Interactions

Additional information about drug interactions is available in the [Adult and Adolescent Antiretroviral Guidelines](#) and the [HIV Drug Interaction Checker](#).

- Absorption:** Elvitegravir (EVG) plasma concentrations are lower with concurrent administration of divalent cations due to the formation of complexes in the gastrointestinal tract and not due to changes in gastric pH. Therefore, Stribild and Genvoya should be administered at least 2 hours before or after administering antacids and supplements or multivitamins that contain iron, calcium, aluminum, and/or magnesium.¹
- Metabolism:** Stribild and Genvoya contain EVG and cobicistat (COBI). COBI itself does not have antiretroviral activity, but it is a cytochrome P450 (CYP) 3A4 inhibitor that acts as a pharmacokinetic (PK) enhancer, similar to ritonavir (RTV).² EVG is metabolized predominantly by CYP3A4, secondarily by uridine diphosphate glucuronosyltransferase 1A1/3, and by oxidative metabolism pathways. EVG is a moderate inducer of CYP2C9. COBI is a strong inhibitor of CYP3A4 and a weak inhibitor of CYP2D6. In addition, COBI inhibits the adenosine triphosphate–dependent transporters, P-glycoprotein and the breast cancer resistance protein, and the

organic anion-transporting (OAT) polypeptides OATP1B1 and OATP1B3. See the [Cobicistat](#) section for a more detailed summary of drug interactions. Multiple drug interactions are possible when using both EVG and COBI. Neither Stribild nor Genvoya should be administered concurrently with products or regimens that contain RTV because of the similar effects of COBI and RTV on CYP3A4 metabolism. Coadministration of medications that induce or inhibit CYP3A4 may respectively decrease or increase exposures of EVG and COBI. Coadministration of medications that are CYP3A4 substrates may result in clinically significant adverse reactions that are severe, life-threatening, or fatal, or may result in loss of therapeutic effect if dependent on conversion to an active metabolite due to CYP3A4 inhibition by COBI. The combination of Stribild or Genvoya plus darunavir (DRV) has been reported to have potentially significant drug interactions between elvitegravir/cobicistat (EVG/c) and DRV.³⁻⁶ However, a single study among treatment-experienced adults with HIV who switched from a virologically suppressive (<50 copies/mL) regimen containing DRV boosted by RTV to Genvoya plus DRV 800 mg once daily demonstrated high efficacy with this combination (i.e., 96.6% had maintained virologic suppression at 24 weeks), suggesting a lack of clinical significance of EVG/c and DRV drug interactions with this rarely used combination.⁵

- *Renal elimination:* Drugs that decrease renal function or compete for active tubular secretion could reduce clearance of tenofovir (TFV), in the form of tenofovir alafenamide (TAF) or tenofovir disoproxil fumarate (TDF), or emtricitabine (FTC). Concomitant use of nephrotoxic drugs should be avoided when using Genvoya or Stribild. COBI inhibits MATE1, which increases serum creatinine levels up to 0.4 mg/dL from baseline in adults. Creatinine-based calculations of estimated glomerular filtration rate (eGFR) will be altered, but the actual glomerular filtration rate might be only minimally changed.⁷ Significant increases in serum creatinine levels >0.4 mg/dL from baseline may represent renal toxicity and should be evaluated. People who experience a confirmed increase in serum creatinine levels should be closely monitored for renal toxicity; clinicians should monitor creatinine levels for further increases and perform a urinalysis to look for evidence of proteinuria or glycosuria.²

Major Toxicities

- *More common:* Nausea, diarrhea, fatigue, headache, flatulence
- *Less common (more severe):* Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported in people receiving nucleoside reverse transcriptase inhibitors, including TDF and FTC. TDF caused bone toxicity (osteomalacia and reduced bone mineral density [BMD]) in animals when given in high doses. Decreases in BMD have been reported in both adults and children who were taking TDF; the clinical significance of these changes is not yet known. Evidence of renal toxicity has been observed in people taking TAF or TDF, including a higher incidence of glycosuria, proteinuria, phosphaturia, and/or calciuria; increases in serum creatinine and blood urea nitrogen; and decreases in serum phosphate levels. Numerous case reports of renal tubular dysfunction have been reported in people receiving TAF or TDF; people at increased risk of renal dysfunction should be closely monitored if they are being treated with Genvoya or Stribild. This nephrotoxicity may be more pronounced in people with preexisting renal disease.² Although postmarketing cases of renal impairment have been reported with TAF, Genvoya, which contains TAF, has an improved bone and renal safety profile in children and adults when compared to Stribild, which contains TDF.^{8,9}

Resistance

The International Antiviral Society–USA maintains [a list of updated HIV drug resistance mutations](#), and the [Stanford University HIV Drug Resistance Database](#) offers a discussion of each mutation. There is phenotypic cross-resistance between EVG and raltegravir (RAL).¹⁰

Pediatric Use

Approval

Genvoya (EVG/c/FTC/TAF) is approved by the U.S. Food and Drug Administration (FDA) for use in antiretroviral (ARV)-naïve children and adolescents with HIV weighing ≥ 25 kg. It also can be used to replace the current ARV regimen in those who have been virologically suppressed (HIV RNA < 50 copies/mL) on a stable ARV regimen for at least 6 months with no history of treatment failure and no known mutations associated with resistance to the individual components of Genvoya. Low-dose pediatric Genvoya (EVG 90 mg/c 90 mg/FTC 120 mg/TAF 6 mg) is approved by the European Medicines Agency for use in children aged ≥ 2 years and weighing ≥ 14 kg to < 25 kg; however, this formulation is not approved by the FDA and is not available for clinical use in the United States.¹¹

Stribild (EVG/c/FTC/TDF) is approved by the FDA as a complete regimen for use in children and adolescents aged ≥ 12 years and weighing ≥ 35 kg. It can also be used to replace the current ARV regimen in those who have been virologically suppressed (HIV RNA < 50 copies/mL) on a stable ARV regimen for at least 6 months with no history of treatment failure and no known mutations associated with resistance to the individual components of Stribild.¹²

Efficacy

Studies of EVG/c/FTC/TDF and EVG/c/FTC/TAF in children with HIV aged ≥ 12 years and weighing ≥ 35 kg have demonstrated 90% efficacy (as measured by virological suppression) similar to that seen in adults through 24 weeks and 48 weeks of study, respectively.^{13,14}

EVG/c/FTC/TAF is FDA approved to treat children weighing ≥ 25 kg based on 24 weeks of data in 23 children.¹⁵ In this study, all children who had been virologically suppressed (HIV RNA < 50 copies/mL) for at least 6 months were switched from their current regimens to EVG/c/FTC/TAF, and all participants maintained virological suppression (HIV-1 RNA < 50 copies/mL) at Week 24.

A retrospective analysis of integrase strand transfer inhibitor (INSTI) use in children and adolescents showed that 83.7% (61/73) of participants on an EVG/c-containing therapy continued their prescribed regimen through the end of the study follow-up period (median 2.0 years of exposure, interquartile range [IQR] 1.4–2.7). Treatment interruption due to virologic failure occurred in 4.1% (3/73) of those on EVG/c, which was comparable to that of dolutegravir (DTG)-based regimens (3.7%) and lower than RAL-based regimens (17.3%). Two of the participants who experienced virologic failure with EVG had major INSTI drug-resistance mutations, but both attained virologic suppression after switching to regimens containing DRV or DRV with DTG.¹⁶

In a PK, safety, and efficacy study with a low-dose EVG 90 mg/c 90 mg/FTC 120 mg/TAF 6 mg tablet in children aged ≥ 2 years and weighing ≥ 14 kg to < 25 kg, children had to be virologically suppressed (HIV RNA < 50 copies/mL) for at least 6 months prior to switching to this regimen. Virologic suppression at < 50 copies/mL (FDA Snapshot algorithm) was maintained by 26 of 27 (96%) participants at Weeks 24 and 48.^{11,17} However, due to the significantly lower median observed EVG trough plasma concentrations in young children compared with the correlating efficacy values in adults, the efficacy of this fixed-dose formulation could not be extrapolated from adults to young children ≥ 2 years weighing ≥ 14 kg to < 25 kg.

Pharmacokinetics

EVG/c/FTC/TDF (Stribild)

The PK of EVG 150 mg/c 150 mg/FTC 200 mg/TDF 300 mg tablet were evaluated in 14 treatment-naïve adolescents with HIV who were between 12 years and <18 years of age and weighing ≥ 35 kg. EVG area under the plasma concentration versus time curve over the dosing interval (AUC_{τ}) and peak concentrations ($C_{\max}$) were 30% higher (90% confidence interval [CI], 105% to 162%) and 42% higher (90% CI, 116% to 173%), respectively, in comparison to historical data in adults. EVG concentrations at the end of the dosing interval (C_{τ}) were 6% higher (90% CI, 70% to 160%) than in adults, and approximately ninefold higher than the protein-adjusted 95% inhibitory concentration (PA-IC₉₅) of 44.5 ng/mL for EVG. COBI, FTC, and TFV exposures were comparable to those measured in adults.¹⁴

EVG/c/FTC/TAF (Genvoya)

The PK of EVG 150 mg/c 150 mg/FTC 200 mg/TAF 10 mg tablet have been evaluated in adolescents aged 12 years to <18 years weighing ≥ 35 kg and aged children 6 years to <12 years weighing ≥ 25 kg.¹⁵ AUC_{τ} , $C_{\max}$, and C_{τ} for EVG, COBI, FTC, TAF, and TFV were comparable to or higher than those measured in adults with HIV in both cohorts (see Table A for EVG PK).

The PK of a low-dose FDC tablet containing EVG 90 mg/c 90 mg/FTC 120 mg/TAF 6 mg were evaluated in 27 children with HIV weighing ≥ 14 kg and <25 kg.¹¹ EVG and TAF AUC_{τ} and $C_{\max}$ were higher compared with historical data in adults receiving full-strength Genvoya (see Tables A for EVG PK). EVG C_{τ} was 21% lower (90% CI, 53% to 117%) in children versus adults but was approximately fourfold higher and ninefold higher than the PA-IC₉₅ and protein-adjusted 50% inhibitory concentration (PA-IC₅₀) for wild-type virus, respectively. Because $C_{\max}$ and AUC_{τ} were elevated but within the adult range, EVG exposures were considered adequate in the study. EVG C_{τ} in young children receiving a low-dose FDC EVG/c/FTC/TAF formulation was also lower than those previously measured in children and adolescents weighing ≥ 25 kg on EVG at the 150-mg dose. COBI, FTC, and TFV exposures were all comparable to or higher than historical data in adults.

Table A. Pharmacokinetics of Elvitegravir Administered as EVG/c/FTC/TAF (Genvoya) in Children and Adolescents With HIV Between 2 Years and <18 Years of Age and Weighing ≥14 kg Compared With Adults

Drug	PK Parameter	Children Aged ≥2 Years and Weighing ≥14 to <25 kg ¹¹	Children Aged 6 Years to <12 Years and Weighing ≥25 kg ¹⁵	Adolescents Aged 12 Years to <18 Years and Weighing ≥35 kg ¹³	Adults ^{a,13,15}	
		GLSM	Mean	Mean	Mean	GLSM
EVG	AUC _{tau} (ng·h/mL)	29,864	33,814	23,840	22,800	21,554
	C _{max} (ng/mL)	2,850	3,055	2,230	2,100	1,998
	C _{tau} (ng/mL)	195	370	301	290	248

^a Adult EVG, COBI, and FTC pharmacokinetic parameters are from a Phase 2 study GS 102.

Key: AUC_{tau} = area under the plasma concentration versus time curve over the dosing interval; C_{max} = maximum observed plasma concentration of drug; C_{tau} = observed drug concentration at the end of the dosing interval; EVG = elvitegravir; GLSM = geometric least squares mean; PK = pharmacokinetic

Toxicity

In studies comparing EVG/c/FTC/TDF or EVG/c/FTC/TAF over 48 weeks in 1,733 adults, those receiving EVG/c/FTC/TAF had significantly smaller mean serum creatinine increases (0.08 vs. 0.12 mg/dL; $P < 0.0001$), significantly less proteinuria (median percent change in protein −3% vs. +20%; $P < 0.0001$), and a significantly smaller decrease in BMD at the spine (mean percent change −1.30% vs. −2.86%; $P < 0.0001$) and hip (−0.66% vs. −2.95%; $P < 0.0001$).⁹ Larger increases in fasting lipid levels were observed with EVG/c/FTC/TAF than with EVG/c/FTC/TDF; the median increases in levels of total cholesterol, low-density lipoprotein cholesterol, high-density lipoprotein cholesterol, and triglycerides were all higher in participants who received EVG/c/FTC/TAF.

In children and adolescents, EVG/c/FTC/TAF is generally preferred over EVG/c/FTC/TDF because of the lower risk of renal and bone toxicity with EVG/c/FTC/TAF compared with EVG/c/FTC/TDF (see the [Tenofovir Alafenamide](#) section). Long-term bone safety data through 96 weeks with EVG/c/FTC/TAF in adolescents weighing ≥35 kg showed no concerns for toxicity¹⁷ in this age group based on BMD (median change from baseline spine BMD height-age [HA] z-score +0.14 and total body less head [TBLH] HA z-score of −0.07) and serum biomarkers of bone formation and resorption.¹⁸

In the approval study of EVG/c/FTC/TAF in children weighing ≥25 kg, no study discontinuations occurred due to medication toxicity. Long-term bone safety data with EVG/c/FTC/TAF through 96 weeks revealed no concerns for toxicity in this cohort based on BMD (median change from baseline spine BMD HA z-score of −0.2 and TBLH HA z-score of −0.32) and serum biomarkers of bone formation and resorption.¹⁹ A concerning decline in CD4 T lymphocyte (CD4) cell counts was observed in all 23 children over the first 24 weeks of EVG/c/FTC/TAF treatment.¹⁵ CD4 counts declined by a median of 130 cells/mm³ (with a range of −472 cells/mm³ to 266 cells/mm³) from baseline. However, after enrolling additional children (for a total of 52 participants),²⁰ the median CD4 count decline at 48 weeks was 25 cells/mm³ and at 96 weeks was 45 cells/mm³. Additionally, the CD4 percentage did not significantly change across Weeks 24, 48, and 96.¹⁹ The mechanism for

the reduction in CD4 count is unclear, and this reduction has only been reported in this study. Plasma exposures of all four drugs were higher in these children than the plasma exposures seen in historical data from adults, but no association was identified between plasma exposures of the four components of EVG/c/FTC/TAF and CD4 counts.²¹

In a PK, safety, and efficacy study with a low-dose EVG/c/FTC/TAF tablet in children aged ≥ 2 years and weighing ≥ 14 kg to < 25 kg,¹¹ long-term bone safety data with the low-dose formulation through 48 weeks revealed no concerns for bone safety. Overall, lumbar spine (LS) and TBLH BMD increased relative to baseline during follow-up, while LS and TBLH height-for-age z-score–adjusted BMD z-scores remained relatively stable. Changes from baseline in median eGFR and body mass index z-score were small. The median absolute CD4 count decreased from 1,061 cells/mm³ at baseline to 941 cells/mm³ and 883 cells/mm³ at Weeks 24 and 48, respectively. CD4 percentage remained stable (37.4% at baseline, 34.0% at Week 24, and 36.3% at Week 48). In a cumulative analysis of two pediatric cohorts (Cohort 2 aged 6 years to < 12 years and weighing ≥ 25 kg and Cohort 3 aged ≥ 2 years and weighing ≥ 14 kg to < 25 kg) on EVG/c/FTC/TAF once daily for at least 48 weeks, the absolute lymphocyte counts and absolute CD4 counts decreased from baseline to Week 48 in both cohorts, with larger decreases in the younger cohort.²² Median (IQR) absolute lymphocyte counts ($\times 10^3$ per μL) at baseline in Cohort 2 and Cohort 3 were 2.31 (range, 1.92–2.78) and 2.96 (range, 2.39–3.82), respectively. The absolute lymphocyte counts decreased during treatment (particularly in Cohort 3), with changes of -0.04 (range, -0.67 to 0.29) and -0.52 (range, -1.16 to 0.05) in Cohorts 2 and 3, respectively, at Week 48. Small decreases were seen in median absolute CD4 counts (cells/ μL), with changes of -33 (IQR -194 to 80) and -187 (IQR -370 to 44) in Cohorts 2 and 3, respectively, at Week 48. However, the relative proportion of CD4 cells and the CD4:CD8 ratio remained stable during treatment. Overall, the decline in absolute CD4 counts mirrored known physiological fluctuations in young children and was mainly observed in those aged < 6 years.²²

Raltegravir (RAL, Isentress)

Updated: June 25, 2026

Reviewed: June 25, 2026

Formulations																			
<p>Tablet: 400 mg (film-coated poloxamer tablet)</p> <p>High-Dose (HD) Tablet: 600 mg (film-coated poloxamer tablet)</p> <p>Chewable Tablets: 100 mg (scored) and 25 mg</p> <p>Granules for Oral Suspension: Single-use packet of 100 mg of raltegravir, suspended in 10 mL of water for a final concentration of 10 mg/mL</p> <p>Film-coated tablets, chewable tablets, and oral suspension are not interchangeable.</p> <p>For additional information, see Drugs@FDA or DailyMed.</p>																			
Dosing Recommendations	Selected Adverse Events																		
<p>Note: No dosing information is available for preterm infants or infants weighing <2 kg at birth. See Table 13.1 Drug Dosing Recommendations for Antiretroviral Prophylaxis and Presumptive HIV Therapy in Infants With In Utero or Intrapartum Exposure to HIV for information about using raltegravir (RAL) for the prevention of perinatal HIV transmission.</p> <p>Neonate (Weighing ≥2 kg) Dose^{a,b}</p> <p>RAL Oral Suspension Dosing Table for Full-Term Neonates From Birth to Age 4 Weeks</p> <p><i>Neonates Aged ≥37 Weeks and Weighing ≥2 kg</i></p> <table><tr><th>Weight</th><th>Volume (Dose) of Suspension^b</th></tr><tr><td>Birth to 1 Week of Age: Once-Daily Dosing</td><td>Approximately 1.5 mg/kg per Dose</td></tr><tr><td>2 kg to <3 kg</td><td>0.4 mL (4 mg) once daily</td></tr><tr><td>3 kg to <4 kg</td><td>0.5 mL (5 mg) once daily</td></tr><tr><td>4 kg to <5 kg</td><td>0.7 mL (7 mg) once daily</td></tr><tr><td>1–4 Weeks of Age: Twice-Daily Dosing</td><td>Approximately 3 mg/kg per Dose</td></tr><tr><td>2 kg to <3 kg</td><td>0.8 mL (8 mg) twice daily</td></tr><tr><td>3 kg to <4 kg</td><td>1 mL (10 mg) twice daily</td></tr><tr><td>4 kg to <5 kg</td><td>1.5 mL (15 mg) twice daily</td></tr></table>	Weight	Volume (Dose) of Suspension ^b	Birth to 1 Week of Age: Once-Daily Dosing	Approximately 1.5 mg/kg per Dose	2 kg to <3 kg	0.4 mL (4 mg) once daily	3 kg to <4 kg	0.5 mL (5 mg) once daily	4 kg to <5 kg	0.7 mL (7 mg) once daily	1–4 Weeks of Age: Twice-Daily Dosing	Approximately 3 mg/kg per Dose	2 kg to <3 kg	0.8 mL (8 mg) twice daily	3 kg to <4 kg	1 mL (10 mg) twice daily	4 kg to <5 kg	1.5 mL (15 mg) twice daily	<ul style="list-style-type: none">• Rash, including Stevens-Johnson syndrome, hypersensitivity reaction, and toxic epidermal necrolysis• Nausea, diarrhea• Headache, dizziness, fatigue• Insomnia• Fever• Creatine phosphokinase elevation, muscle weakness, and rhabdomyolysis
Weight	Volume (Dose) of Suspension ^b																		
Birth to 1 Week of Age: Once-Daily Dosing	Approximately 1.5 mg/kg per Dose																		
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3 kg to <4 kg	1 mL (10 mg) twice daily																		
4 kg to <5 kg	1.5 mL (15 mg) twice daily																		
Special Instructions																			
<ul style="list-style-type: none">• RAL can be given without regard to food.• Coadministration or staggered administration of aluminum-containing and magnesium-containing antacids is not recommended with any RAL formulations.• Significant drug interactions are more likely to occur when the RAL HD formulation is used once daily. The following drugs should not be coadministered with once-daily RAL HD dosing: calcium carbonate antacids, rifampin, tipranavir/ritonavir, and etravirine.• Chewable tablets can be chewed, crushed (before administration), or swallowed whole.• Film-coated tablets, including HD tablets, must be swallowed whole.																			

^a RAL is metabolized by uridine diphosphate glucuronosyltransferase (UGT) 1A1, and enzyme activity is low at birth; enzyme activity increases rapidly during the next 4 to 6 weeks of life.

^b For neonates, most of the prepared oral suspension will be discarded. The volume for the required dose is much smaller than the 10 mL suspension that is prepared.

Note: If the birthing parent has taken RAL 2 to 24 hours prior to delivery, the neonate's first dose **may** be delayed until 24 to 48 hours after birth.

Infant >4 Weeks of Age and Child (Weighing ≥3 kg to <20 kg) Dose

- For children weighing 3 to 20 kg, either oral suspension or chewable tablets can be used.

RAL Oral Suspension Dosing Table for Patients Aged >4 Weeks^a

Note: The maximum dose of oral suspension is 10 mL (RAL 100 mg) twice daily.

Weight	Twice-Daily Volume (Dose) of Suspension ^b
3 kg to <4 kg	2.5 mL (25 mg) twice daily
4 kg to <6 kg	3 mL (30 mg) twice daily
6 kg to <8 kg	4 mL (40 mg) twice daily
8 kg to <10 kg	6 mL (60 mg) twice daily
10 kg to <14 kg	8 mL (80 mg) twice daily
14 kg to <20 kg	10 mL (100 mg) twice daily

^a The weight-based dose recommendation for the oral suspension is based on a dose of approximately RAL 6 mg/kg per dose twice daily.

^b For neonates, most of the prepared oral suspension will be discarded, because the volume for the required dose is much smaller than 10 mL.

Child and Adolescent Dose for Chewable Tablets, Film-Coated Tablets, and HD Tablets

Children Weighing ≥3 kg

- Weighing <25 kg
 - Chewable tablets twice daily. See the table below for chewable tablet doses.
- Weighing ≥25 kg
 - RAL 400 mg, film-coated tablets twice daily **or** chewable tablets twice daily. See the table below for chewable tablet doses.

- The chewable tablets and oral suspension have better bioavailability than the film-coated tablets. Because the formulations are not interchangeable, **do not substitute** chewable tablets or oral suspension for film-coated tablets. See specific recommendations for proper dosing of different formulations.

- The chewable tablets should be stored in the original package with a desiccant to protect them from moisture.

- Instructions for preparing and administering the chewable tablet as a crushed tablet are as follows:** Place the tablet(s) in a small, clean cup. For each tablet, add a teaspoon (~5 mL) of liquid (e.g., water, juice, or breast milk). Within 2 minutes, the tablet(s) will absorb the liquid and fall apart. Using a spoon, crush any remaining pieces of the tablet(s). Immediately administer the entire dose orally. If any portion of the dose is left in the cup, add another teaspoon (~5 mL) of liquid, swirl, and administer immediately.

- The chewable tablets contain phenylalanine, a component of aspartame. Phenylalanine can be harmful to patients with phenylketonuria, and the necessary dietary adjustments should be made in consultation with a metabolic specialist.

- The oral suspension comes in a kit that includes instructions for use, mixing cups, oral dosing syringes, and 60 foil packets. Detailed instructions for preparation are provided in the Instructions for Use document.¹ Each single-use foil packet contains 100 mg of RAL, which will be suspended in 10 mL of water for a final concentration of RAL 10 mg/mL. Gently swirl the mixing cup for 45 seconds in a circular motion to mix the powder into a uniform suspension.

- Do not shake the oral suspension.** Dose should be administered within 30 minutes of mixing; unused solution should be discarded as directed in the Instructions for Use document. For neonates, most of the prepared oral suspension will be discarded, because the volume for the required dose is much smaller than 10 mL.

Metabolism/Elimination

- UGT1A1-mediated glucuronidation

Children and Adolescents Weighing ≥ 40 kg

- Two RAL 600-mg HD tablets (1,200 mg) once daily
- This dose is for antiretroviral therapy–naïve or virologically suppressed patients who are on an initial dose of RAL 400 mg twice daily.

Chewable Tablet Dosing Table^a

Note: The maximum dose of chewable tablets is RAL 300 mg twice daily.

Weight	Twice-Daily Dose	Number of Chewable Tablets
3 kg to <6 kg	RAL 25 mg	1 tablet (25 mg)
6 kg to <10 kg	RAL 50 mg	2 tablets (25 mg)
10 kg to <14 kg	RAL 75 mg	3 tablets (25 mg)
14 kg to <20 kg	RAL 100 mg	1 tablet (100 mg)
20 kg to <28 kg	RAL 150 mg	1½ tablets ^b (100 mg)
28 kg to <40 kg	RAL 200 mg	2 tablets (100 mg)
≥ 40 kg	RAL 300 mg	3 tablets (100 mg)

^a The weight-based dose recommendation for the chewable tablet is based on a dose of approximately RAL 6 mg/kg per dose twice daily.

^b The RAL 100-mg chewable tablet can be divided into equal halves.

RAL Dosing in Patients With Hepatic Impairment

- No dose adjustment is necessary for patients with mild-to-moderate hepatic insufficiency who are receiving RAL twice daily.
- No studies have been conducted on the use of RAL HD in patients with hepatic impairment. Therefore, administering RAL HD is **not recommended** in patients with hepatic impairment.
- The effect of severe hepatic impairment on RAL pharmacokinetics has not been studied.

RAL Dosing in Patients With Renal Impairment

- No dose adjustment is necessary in patients with any degree of renal impairment.

Drug Interactions

Additional information about drug interactions is available in the [Liverpool HIV Drug Interaction Checker](#).

- **Metabolism:** The major route of raltegravir (RAL) elimination is mediated through glucuronidation by uridine diphosphate glucuronosyltransferase (UGT) 1A1.
- Coadministering RAL with inducers of UGT1A1—such as rifampin and tipranavir—may result in reduced plasma concentrations of RAL. Inhibitors of UGT1A1—such as atazanavir—may increase plasma concentrations of RAL. No dosing modifications are recommended when RAL is coadministered with atazanavir/ritonavir or tipranavir/ritonavir (TPV/r). However, RAL high-dose (HD) tablets **should not be coadministered** with TPV/r.
- In adults, an increased dose of RAL is recommended when it is coadministered with rifampin. For adults receiving rifampin, the recommended RAL dose is 800 mg twice daily. **Do not coadminister** rifampin with once-daily RAL HD tablets. In children aged 4 weeks to <12 years who had tuberculosis (TB)/HIV coinfection and were taking rifampin, RAL 12 mg/kg per dose twice daily of the chewable tablet formulation safely achieved pharmacokinetic (PK) targets.^{2,3}

In a single case report of a 6-month-old infant receiving RAL oral granules for suspension and rifampicin for TB prophylaxis, three to four times the currently recommended dose of 12 mg/kg twice daily was needed⁴ to achieve target trough concentrations (C_{trough}) >0.022 mg/L.

- Aluminum-containing antacids and magnesium-containing antacids may reduce RAL plasma concentrations and **should not be coadministered** with RAL.
- Significant drug interactions may be more likely to occur with RAL HD once daily. C_{trough} in adults is approximately 30% lower with RAL HD 1,200 mg once daily than with RAL 400 mg twice daily. A lower C_{trough} increases the potential for clinically significant drug interactions with interfering drugs that decrease RAL exposure and further lower C_{trough} . In addition to aluminum-containing and magnesium-containing antacids, the following drugs **should not be coadministered** with the RAL HD formulation: calcium carbonate antacids, rifampin, TPV/r, and etravirine. The impact of other strong inducers of drug-metabolizing enzymes on RAL is unknown; coadministration with phenytoin, phenobarbital, and carbamazepine **is not recommended**.
- Before administering RAL, clinicians should carefully review a patient's medication profile for potential drug interactions with RAL.

Major Toxicities

- *More common:* Nausea, headache, dizziness, diarrhea, fatigue, itching, insomnia.
- *Less common:* Abdominal pain, vomiting. Patients with chronic active hepatitis B virus infection and/or hepatitis C virus infection are more likely to experience a worsening adverse events (AEs) grade from baseline for laboratory abnormalities of aspartate aminotransferase, alanine aminotransferase, or total bilirubin than patients who are not coinfecting.
- *Rare:* Moderate-to-severe increase in creatine phosphokinase levels. Use RAL with caution in patients who are receiving medications that are associated with myopathy and rhabdomyolysis. Anxiety, depression, and paranoia, especially in those with a history of these conditions. Rash (including Stevens-Johnson syndrome), hypersensitivity reaction, DRESS (drug reaction with eosinophilia and systemic symptoms),^{5,6} and toxic epidermal necrolysis. Thrombocytopenia. Cerebellar ataxia. Hepatic failure (with and without associated hypersensitivity) in patients with underlying liver disease and/or concomitant medications.

Resistance

The International AIDS Society–USA maintains a [list of updated HIV resistance mutations](#), and the [Stanford University HIV Drug Resistance Database](#) offers a discussion of each mutation.

Pediatric Use

Approval

RAL is an integrase strand transfer inhibitor (INSTI) that is approved by the U.S. Food and Drug Administration (FDA) for use in combination with other antiretroviral (ARV) drugs for the treatment of HIV in pediatric patients weighing ≥ 2 kg. The current pediatric FDA approval and dose recommendations are based on evaluations of 122 patients aged ≥ 4 weeks to 18 years who participated in [IMPAACT P1066](#) and 42 full-term neonates who were treated for ≤ 6 weeks starting from birth and followed for a total of 24 weeks during [IMPAACT P1110](#).⁷

The FDA has approved RAL HD, which allows once-daily dosing, for use in children and adolescents weighing ≥ 40 kg.

Efficacy and Pharmacokinetics in Children

IMPAACT P1066 evaluated the PK, safety, and efficacy of RAL in treatment-experienced children aged 4 weeks to 18 years. A summary of RAL steady-state PK parameters, following administration of the recommended twice-daily doses (approximately 6 mg/kg twice daily), can be found in Table A below.^{8,9}

Table A. Raltegravir Steady-State Pharmacokinetic Parameters in Pediatric Patients Following Administration of Recommended Twice-Daily Doses: IMPAACT P1066

Body Weight	Formulation	Dose	N ^a	Geometric Mean (% CV ^b) AUC _{0–12h} (μM•h) ^{c,d}	Geometric Mean (% CV ^b) C _{12h} (nM) ^{c,d}
≥25 kg	Film-coated tablet	400 mg twice daily	18	14.1 (121%)	233 (157%)
≥25 kg	Chewable tablet	Weight-based dosing ^e	9	22.1 (36%)	113 (80%)
11 kg to <25 kg	Chewable tablet	Weight-based dosing ^e	13	18.6 (68%)	82 (123%)
3 kg to <20 kg	Oral suspension	Weight-based dosing ^e	19	24.5 (43%)	113 (69%)

^a Number of patients with intensive PK results at the final recommended dose

^b Geometric coefficient of variation

^c Pharmacokinetic targets for film-coated tablets and chewable tablets: AUC_{0–12h} 14–25 μM•h (6–11 mg•h/L); C_{12h} nM ≥33 nM (14.7 ng/mL)

^d Pharmacokinetic targets for oral suspension: AUC_{0–12h} 14–45 μM•h (6–20 mg•h/L); C_{12h} nM ≥75 nM (33.3 ng/mL)

^e To approximate 6 mg/kg twice daily

Key: AUC = area under the curve; AUC_{0–12h} = AUC from time zero to 12 hours after drug administration; C_{12h} = concentration at 12 hours (trough); CV = coefficient of variation

Children Aged 2 to 18 Years

IMPAACT P1066 was a Phase 1/2 open-label, multicenter study that evaluated the PK profile, safety, tolerability, and efficacy of various formulations of RAL in antiretroviral therapy (ART)–experienced children and adolescents with HIV aged 2 to 18 years. RAL was administered in combination with an optimized background ARV regimen.^{8,10} Participants received either the RAL 400-mg, film-coated tablet formulation twice daily (patients aged 6–18 years and weighing ≥25 kg) or the chewable tablet formulation at a dose of RAL 6 mg/kg twice daily (patients aged 2 years to <12 years). Doses were selected with the aim of achieving target PK parameters that were similar to those seen in adults (see Table A above).

A total of 126 treatment-experienced participants were enrolled, with 96 participants receiving the final recommended dose of RAL. Ninety-six participants completed 48 weeks of treatment. Seventy-nine percent of participants achieved HIV RNA <400 copies/mL, and 57% of participants achieved

HIV RNA <50 copies/mL, with a mean CD4 T lymphocyte (CD4) cell count increase⁸ of 156 cells/mm³ (4.6%). Among 36 participants who experienced virologic failure, the development of drug resistance and/or poor adherence were contributing factors. Genotypic resistance data were available for 34 patients who experienced virologic failure, and RAL-associated mutations were detected in 12 out of 34 of those patients. The frequency, type, and severity of AEs through Week 48 were comparable to those observed in adult studies. Patients with AEs that were considered to be drug related included one patient with Grade 3 psychomotor hyperactivity, abnormal behavior, and insomnia, as well as one patient with a Grade 2 allergic rash on Day 17 and Grade 3 alanine transaminase and Grade 4 aspartate transaminase laboratory elevations after Day 122. There were no discontinuations due to AEs and no drug-related deaths.⁸ Overall, RAL was well tolerated when administered as a film-coated tablet twice daily in participants aged 6 years to <19 years and as chewable tablets at a dose of approximately 6 mg/kg twice daily in participants aged 2 years to <12 years, with favorable virologic and immunologic responses.¹¹

Children Aged ≥4 Weeks to <2 Years

IMPAACT P1066 studied 26 infants and toddlers aged 4 weeks to <2 years who were administered the granules for RAL oral suspension in combination with an optimized background ARV regimen. All participants had previously received ARV drugs to prevent perinatal transmission and/or treat HIV, and 69% had baseline plasma HIV RNA exceeding 100,000 copies/mL.

By Week 48, two participants experienced AEs that were thought to be related to the study drug: one patient experienced a serious erythematous rash that resulted in permanent discontinuation of RAL, and one patient experienced immune reconstitution inflammatory syndrome. Virologic success, defined as $\geq 1 \log_{10}$ decline in HIV RNA or <400 copies/mL at 48 weeks, was achieved in >87% of participants. At 48 weeks of follow-up, 45.5% of participants had HIV RNA <50 copies/mL and a mean CD4 count increase of 527.6 cells/mm³ (7.3%). Four participants in Cohort 4 experienced virologic failure by Week 48, and one participant had a RAL-associated resistance mutation. Overall, the granules for oral suspension, at a dose of approximately RAL 6 mg/kg twice daily, were well tolerated and had good efficacy.⁹

Efficacy and Pharmacokinetics of Once-Daily Dosing in Children and Adults

RAL PK exhibit considerable intrasubject and intersubject variability.^{12,13} Current PK targets are based on results from a clinical trial in adults (ONCEMRK) in which patients with HIV who were treatment-naïve were randomized to receive RAL 800 mg once daily or RAL 400 mg twice daily.¹⁴ (Cahn 2018) After 48 weeks of treatment, the percent of patients who achieved HIV RNA viral loads <50 copies/mL was 83% in the once-daily group, compared with 89% in the twice-daily group. Patients in the once-daily arm with C_{trough} concentrations <45 nM (20 ng/mL) were at greater risk of experiencing treatment failure.^{12,13} Overall drug exposures were similar in both groups, but the association between higher risk of treatment failure and lower C_{trough} concentrations suggests that maintaining RAL trough plasma concentrations >45 nM (20 ng/mL) is important for efficacy.^{12,13}

The highest concentration (or C_{max}) is approximately six times higher in patients receiving RAL 1,200 mg once daily than in those receiving RAL 400 mg twice daily, with a twofold higher area under the curve (AUC). Although modeling and simulations for pediatric patients indicate that PK targets are met using the once-daily RAL 1,200-mg dose, no clinical data exist on the use of this dose in children weighing <50 kg. Six children in IMPAACT P1066 had drug exposures that were similar to those observed in ONCEMRK, but all six children weighed >50 kg. Dose-related central nervous system toxicities—such as insomnia or hyperactivity—may occur in children who are exposed to very high concentrations of RAL.⁷

Long-Term Follow-Up in Children

The IMPAACT P1066 study team reported results regarding the safety and efficacy of different RAL formulations at 240 weeks in children enrolled in this multicenter trial.¹⁵ Eligible participants were children aged 4 weeks to 18 years who had previously been treated with ART and who were experiencing virologic failure at the time of enrollment. RAL was added to an optimized ARV regimen in all participants. RAL was well tolerated, and few serious clinical or laboratory safety events were noted during the study.¹⁵

The proportion of participants who achieved virologic success at 240 weeks varied by the RAL formulation used: 19 of 43 children (44.2%) who received RAL 400-mg tablets; 24 of 31 children (77.4%) who received chewable tablets; and 13 of 15 children (86.7%) who received the oral granules for suspension. RAL resistance was documented in 19 of 50 patients (38%) who experienced virologic rebound after initial suppression. These results suggest that younger children with less treatment experience are more likely to have sustained virologic suppression, whereas older children with an extensive treatment history are more likely to experience treatment failure and develop resistance to RAL. Poor adherence among adolescents may have contributed to the lower efficacy observed in older children who received the RAL 400-mg tablets.¹⁵

Neonates Aged <4 Weeks

RAL is metabolized by UGT1A1, the same enzyme that is responsible for the elimination of bilirubin. UGT enzyme activity is low at birth, and RAL elimination is prolonged in neonates. Washout PKs of RAL in neonates born to pregnant women with HIV were studied in [IMPAACT P1097](#).¹⁶ The neonatal plasma half-life of RAL was highly variable, ranging from 9.3 to 184 hours. This suggests that neonatal development may impact UGT1A1 enzyme activity, redistribution, and/or enterohepatic recirculation of RAL. RAL competes with unconjugated bilirubin for albumin binding sites. When RAL plasma concentrations are extremely high, unconjugated bilirubin may be displaced from albumin by RAL and cross the blood–brain barrier, leading to bilirubin-induced neurologic dysfunction. The effect of RAL on neonatal bilirubin binding is unlikely to be clinically significant, unless concentrations that are 50-fold to 100-fold higher than typical peak concentrations are reached (approximately 5,000 ng/mL).¹⁷

IMPAACT P1110 was a Phase 1 multicenter trial that enrolled full-term neonates with or without *in utero* RAL exposure at risk of acquiring HIV. RAL-exposed neonates were those whose mothers received RAL within 2 to 24 hours of delivery. For neonates who were RAL-exposed, the initial dose of RAL was delayed until 12 to 60 hours after delivery. The study design included two cohorts: Cohort 1 infants received two RAL doses that were administered 1 week apart, and Cohort 2 infants received daily RAL doses for the first 6 weeks of life. PK data from Cohort 1 and from older infants and children were combined in a population PK model, and simulations were used to select the following RAL dosing regimen for evaluation in infants in Cohort 2: RAL 1.5 mg/kg daily, starting within 48 hours of life and continuing through Day 7; RAL 3 mg/kg twice daily on Days 8 to 28 of life; and RAL 6 mg/kg twice daily after 4 weeks of age.¹⁸ Protocol exposure targets for each participant were AUC from time zero to 24 hours after drug administration (AUC_{0-24hr}) 12 mg•h/L to 40 mg•h/L, AUC from time zero to 12 hours after drug administration 6 mg•h/L to 20 mg•h/L, and concentration at 12 hours or 24 hours postdose >33 ng/mL. Safety was assessed using clinical and laboratory evaluations.^{16,19,20}

Twenty-six infants who were RAL-naïve and 10 infants who were RAL-exposed were enrolled in Cohort 2; 25 infants who were RAL-naïve and 10 infants who were RAL-exposed had evaluable PK results and safety data. Results for the infants who were RAL-naïve and the infants who were RAL-exposed who were enrolled in Cohort 2 are contained in Table B below.²⁰

Table B. Raltegravir Pharmacokinetic Parameters for Raltegravir-Naive and Raltegravir-Exposed Neonates

PK Parameter	Initial Dose: RAL 1.5 mg/kg Once Daily RAL-Naive (n = 25) ^d	Initial Dose: RAL 1.5 mg/kg Once Daily RAL-Exposed (n = 10)	Days 15–18: RAL 3.0 mg/kg Twice Daily RAL-Naive (n = 24) ^e	Days 15–18: RAL 3.0 mg/kg Twice Daily RAL-Exposed (n = 10) ^f
	GM (CV%)	GM (CV%)	GM (CV%)	GM (CV%)
AUC _{0–24h} (mg•h/L) ^a	38.2 (42.0%)	42.9 (25.3%)	—	—
AUC _{0–12h} (mg•h/L)	—	—	14.3 (49.5%)	18.3 (62.8%)
C _{trough} (ng/mL) ^b	948 (84.0%)	946 (74.0%)	176 (162.1%)	274 (176.4%)
C _{max} (ng/mL) ^c	2,350 (36.5%)	2,565 (23.1%)	2,849 (47.5%)	3,667 (46.3%)
T _{max} (hours)	5.4 (71.5%)	3.8 (88.8%)	2.3 (77.1%)	1.9 (52.3%)
T _{1/2} (hours)	15.8 (101.4%)	14.4 (69.5%)	2.5 (34.1%)	2.9 (20.7%)

^a AUC targets: AUC_{0–24h} 12–40 mg•h/L and AUC_{0–12h} 6–20 mg•h/L.

^b C_{trough} concentration >33 ng/mL. For initial dose, the last measurable plasma concentration collected at 24 hours was used. For Days 15–18, C_{12h} was estimated when the 12-hour postdose sample was collected earlier than 12 hours after dosing (the protocol specified a sample collection time of 8–12 hours postdose).

^c C_{max} <8,724 ng/mL

^d AUC_{0–24h} could not be estimated for one infant.

^e AUC_{0–12h} and C_{trough} could not be estimated for one infant with delayed absorption.

^f AUC_{0–12h} and C_{max} could not be estimated for one infant with incomplete sample collection.

Key: AUC = area under the curve; AUC_{0–12h} = AUC from time zero to 12 hours after drug administration; AUC_{0–24h} = AUC from time zero to 24 hours after drug administration; C_{max} = maximum concentration; C_{trough} = trough concentration; CV = coefficient of variation; GM = geometric mean; PK = pharmacokinetic; RAL = raltegravir; T_{1/2} = half-life; T_{max} = time to reach maximum concentration

Daily RAL was safe and well tolerated during the first 6 weeks of life. Infants were treated for up to 6 weeks from birth and followed for a total of 24 weeks. All GM protocol exposure targets were met. In some infants, AUC_{0–24h} following the initial dose was slightly above the target range, but this is considered acceptable given the rapid increase in RAL metabolism during the first week of life. The PK targets and the safety guidelines were met for both RAL-naïve and RAL-exposed infants in Cohort 2 using the specified dosing regimen. No drug-related clinical AEs were observed. Three laboratory AEs were reported among the infants who were RAL-naïve: Grade 4 transient neutropenia occurred in one infant who received a zidovudine-containing regimen; two bilirubin elevations (one Grade 1 and one Grade 2) were considered nonserious and did not require specific therapy.⁷ Among the infants who were RAL-exposed, four infants exhibited Grade 3 or 4 toxicities: anemia in one infant, neutropenia in one infant, and hyperbilirubinemia in two infants. No specific therapy was required to treat these toxicities, and no infants required phototherapy or exchange transfusion for hyperbilirubinemia.

Results from IMPAACT P1110^{19,20} confirmed the PK modeling and simulation submitted for FDA approval and labeling. The current RAL dosing regimen with two dose changes in the first month of life may be challenging for some families. To simplify medication teaching and minimize dosing changes, some experts increase to the 3 mg/kg twice-daily dose on Day 4 or 5 of life. Because many infants receiving RAL as part of presumptive HIV therapy will have a longer hospital stay following birth by cesarean section, this dosing change can generally be made at the time of hospital discharge.

RAL can be safely administered to full-term infants using the daily dosing regimen that was studied in IMPAACT P1110. This regimen **is not recommended** for use in preterm infants. A population PK analysis incorporating RAL PK data from term and preterm neonates suggests slower RAL elimination in preterm infants, and use of the term neonate RAL dosing regimen in preterm neonates may result in elevated and potentially dangerous RAL plasma concentrations.¹⁸ When RAL plasma concentrations are extremely high, unconjugated bilirubin may be displaced from albumin by RAL and cross the blood–brain barrier, leading to bilirubin-induced neurologic dysfunction (BIND). Preterm infants have impaired bilirubin-albumin binding and are at higher risk of BIND.²¹ Clinical assays to measure unbound, unconjugated bilirubin are not routinely available, and therefore, it is not always possible to assess the risk of BIND in a preterm infant if RAL or other INSTIs were administered.

Two case reports of preterm infants who received RAL to prevent perinatal transmission have been published.^{22,23} These case reports involved one infant born at a gestational age of 24 weeks and 6 days who weighed 800 g and another infant born at 33 weeks gestation who weighed 1,910 g. In both infants, intermittent dosing of RAL was done using real-time therapeutic drug monitoring in the neonatal intensive care unit.^{22,23} Less-frequent dosing was required because RAL elimination was significantly delayed in these preterm infants. RAL PKs and safety must be studied in preterm infants before RAL can be safely used without real-time PK monitoring in this population. An accidental overdose was reported in a full-term neonate because of incorrect preparation of the RAL oral granules for suspension.²⁴ For neonates, since the volume for the required dose is much smaller than the 10 mL reconstitution volume, most of the prepared oral suspension will be discarded. Clear documentation of caregiver instruction on dose preparation by clinical staff is critical.

Formulations

The PK of RAL in adult patients with HIV who swallowed intact 400-mg tablets were compared with those observed in patients who chewed the 400-mg, film-coated tablets because of swallowing difficulties. Drug absorption was significantly higher among patients who chewed the tablets, although the palatability was rated as poor.²⁵ In adult volunteers, the PK of RAL 800 mg taken once daily by chewing was compared with the PK of two doses of RAL 400 mg taken every 12 hours by swallowing. Participants who took RAL by chewing had significantly higher drug exposure and reduced PK variability than those who swallowed whole tablets according to current recommendations.²⁶ According to the manufacturer, the film-coated tablets must be swallowed whole.

The RAL chewable tablet and oral suspension have higher oral bioavailability than the 400-mg, film-coated tablet, according to a comparative study in healthy adult volunteers.²⁷ Compared with the RAL 400-mg tablet formulation, the RAL 600-mg tablet has higher relative bioavailability.^{7,28} Interpatient and inpatient variability for PK parameters of RAL are considerable, especially with the film-coated tablets.^{7,29} Because of differences in the bioavailability of various formulations, the dosing recommendations for each formulation differ, and the formulations **are not interchangeable**. When prescribing RAL, clinicians should refer to the appropriate dosing table for the chosen formulation. The use of RAL chewable tablets as dispersible tablets in children aged <2 years has been studied in [IMPAACT P1101](#) for infants and toddlers with TB/HIV coinfection who received

rifampin as part of their TB treatment. The use of RAL chewable tablets dispersed in water at a dose of RAL 12 mg/kg per dose twice daily safely achieved PK targets.^{2,30} The RAL chewable tablets are now approved for use in infants and young children 4 weeks of age and older and weighing at least 2 kg.³¹ An *in vitro* evaluation demonstrated that the chewable tablets are stable in various liquids, including water, apple juice, and breast milk.³¹ The chewable tablets may be crushed and mixed with a small amount of liquid to facilitate administration (see Special Instructions above).

Palatability was evaluated as part of IMPAACT P1066. Both chewable tablets and oral granules for suspension were thought to have acceptable palatability. Seventy-three percent of those surveyed reported no problems with chewable tablets; 82.6% reported no problems with administering the oral granules.^{8,9} The acceptability and feasibility of administering RAL granules for oral suspension in a low-resource setting have been studied in clinics in South Africa and Zimbabwe. With proper training by health care personnel, caregivers were able to prepare the suspension safely and accurately.^{32,33}

APPENDIX A: PEDIATRIC ANTIRETROVIRAL DRUG INFORMATION

Pharmacokinetic Enhancers

Cobicistat (COBI, Tybost)

Ritonavir (RTV, Norvir)

Cobicistat (COBI)

Updated: June 25, 2026

Reviewed: September 30, 2025

Formulations	
Fixed-Dose Combination (FDC) Tablets <ul style="list-style-type: none"> [Evotaz] Atazanavir 300 mg/cobicistat 150 mg [Genvoya] Elvitegravir 150 mg/cobicistat 150 mg/emtricitabine 200 mg/tenofovir alafenamide 10 mg [Prezcobix] Darunavir 800 mg/cobicistat 150 mg (pediatric dose for children ≥40 kg) [Prezcobix] Darunavir 675 mg/cobicistat 150 mg (pediatric dose for children 25 kg to 40 kg) [Prezcobix PED] Darunavir 600-mg/cobicistat 90-mg dispersible tablet (pediatric dose for children weighing ≥15 kg to <25 kg) [Stribild] Elvitegravir 150 mg/cobicistat 150 mg/emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg [Symtuza] Darunavir 800 mg/cobicistat 150 mg/emtricitabine 200 mg/ tenofovir alafenamide 10 mg <p>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.</p> <p>For additional information, see Drugs@FDA or DailyMed.</p>	
Dosing Recommendations	Selected Adverse Events
Cobicistat (COBI) Is a Pharmacokinetic (PK) Enhancer <ul style="list-style-type: none"> The only use of COBI is as a PK enhancer (boosting agent) for certain protease inhibitors (PIs) and integrase strand transfer inhibitors. COBI is not interchangeable with ritonavir (RTV) and has no antiviral activity. <p>Note: DRV use is restricted to children age ≥3 years.</p> <p>Child (Weighing ≥15 kg to <25 kg)</p> <ul style="list-style-type: none"> COBI 90-mg/darunavir (DRV) 600-mg FDC dispersible tablet <p>Child and Adolescent (Weighing ≥25 kg to <40 kg)</p> <ul style="list-style-type: none"> COBI 150-mg/DRV 675-mg FDC tablet <p>Child and Adolescent (Weighing ≥35 kg) and Adult Dose</p> <ul style="list-style-type: none"> COBI 150 mg coformulated with atazanavir (ATV) 300 mg administered at the same time with food 	<ul style="list-style-type: none"> COBI is an inhibitor of renal tubular transporters of creatinine. This increases serum creatinine and reduces the estimated glomerular filtration rate, with no change in glomerular function.
	Special Instructions <ul style="list-style-type: none"> COBI 150 mg is not interchangeable with RTV, but it has a PK-boosting effect that is comparable to RTV 100 mg. Drug interactions may differ between RTV and COBI because COBI is a stronger P-glycoprotein inhibitor and lacks some of the induction effects of RTV. Do not administer COBI with RTV or with FDC tablets that contain COBI. COBI is not recommended for use with more than one ARV drug that requires PK enhancement (e.g., EVG used in combination with a PI). Using COBI with PIs other than once-daily ATV or DRV is not recommended.

<p>Child and Adolescent (Weighing ≥ 40 kg) and Adult Dose</p> <ul style="list-style-type: none"> COBI 150 mg with DRV 800 mg administered at the same time with food <p>[Evotaz] ATV/COBI</p> <p><i>Child and Adolescent (Weighing ≥ 35 kg) and Adult Dose</i></p> <ul style="list-style-type: none"> One tablet once daily with food Use in combination with other antiretroviral (ARV) drugs. <p>[Genvoya] Elvitegravir (EVG)/COBI/Emtricitabine (FTC)/Tenofovir Alafenamide (TAF)</p> <p><i>Child (Weighing ≥ 14 kg to < 25 kg)</i></p> <ul style="list-style-type: none"> Limited data currently exist on the appropriate dose of Genvoya in children weighing ≥ 14 kg to < 25 kg. Studies assessing the safety and efficacy of a low-dose tablet with EVG 90 mg/COBI 90 mg/FTC 120 mg/TAF 6 mg found that it resulted in maintenance of viral suppression but lower median observed EVG trough concentrations than in adults. (See the Elvitegravir section). <p><i>Child and Adolescent (Weighing ≥ 25 kg) and Adult Dose</i></p> <ul style="list-style-type: none"> One tablet once daily with food <p>[Prezcobix] DRV/COBI</p> <p><i>Child (Aged ≥ 3 Years and Weighing ≥ 15 kg to < 25 kg)</i></p> <ul style="list-style-type: none"> DRV 600 mg/COBI 90 mg (Prezcobix PED) One tablet for oral suspension taken once daily with food. <p><i>Child and Adolescent (Weighing ≥ 25 kg and ≤ 40 kg)</i></p> <ul style="list-style-type: none"> DRV 675 mg/COBI 150 mg One tablet once daily with food Use in combination with other ARV drugs <p><i>Child and Adolescent (Weighing ≥ 40 kg) and Adult Dose</i></p> <ul style="list-style-type: none"> DRV 800 mg/COBI 150 mg One tablet once daily with food Use in combination with other ARV drugs. <p>[Stribild] EVG/COBI/FTC/Tenofovir Disoproxil Fumarate (TDF)</p> <p><i>Child and Adolescent (Weighing ≥ 35 kg) and Adult Dose</i></p> <ul style="list-style-type: none"> One tablet once daily with food 	<ul style="list-style-type: none"> Patients with a confirmed increase in serum creatinine > 0.4 mg/dL from baseline should be closely monitored for renal safety. When using COBI in combination with TDF, monitor serum creatinine, urine protein, and urine glucose at baseline and every 3 to 6 months while the patient is receiving therapy (see Table 17i. Nephrotoxic Effects). In patients who are at risk of renal impairment, serum phosphate also should be monitored. For information on crushing and cutting tablets, see Information on Crushing and Liquid Drug Formulations from Toronto General Hospital. <p>Metabolism/Elimination</p> <ul style="list-style-type: none"> COBI is a strong inhibitor of cytochrome P450 (CYP) 3A4 and a weak inhibitor of CYP2D6. <p>COBI Dosing in Patients With Hepatic Impairment</p> <ul style="list-style-type: none"> COBI does not require dose adjustment in patients with mild-to-moderate hepatic impairment. No data are available in patients with severe hepatic impairment. Dosing recommendations for medications that are coadministered with COBI should be followed. Genvoya, Prezcobix, Stribild, and Symtuza are not recommended in patients with severe hepatic impairment. Evotaz is not recommended in patients with any degree of hepatic impairment. <p>COBI Dosing in Patients With Renal Impairment</p> <ul style="list-style-type: none"> COBI does not require a dose adjustment in patients with renal impairment, including those with severe renal impairment. Dosing recommendations for medications that are coadministered with COBI should be followed. The use of COBI plus TDF is not recommended in patients with creatinine clearance (CrCl) < 70 mL/min. Dose adjustments for TDF are required for patients with CrCl < 50 mL/min, and the necessary dose adjustments for TDF when this drug is used with COBI have not been established in this group of patients. Genvoya is not recommended in patients with estimated CrCl 15 to < 30 mL/min, or in patients with estimated CrCl < 15 mL/min who are not receiving chronic hemodialysis.
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<ul style="list-style-type: none"> The Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV recommends using Stribild only in patients with sexual maturity ratings of 4 or 5. <p>[Symtuza] DRV/COBI/FTC/TAF</p> <p><i>Child and Adolescent (Weighing ≥ 40 kg) and Adult Dose</i></p> <ul style="list-style-type: none"> One tablet once daily with food 	<ul style="list-style-type: none"> Stribild should not be initiated in patients with estimated CrCl <70 mL/min and should be discontinued in patients with estimated CrCl <50 mL/min. The dose adjustments required for FTC and TDF in these patients cannot be achieved with an FDC tablet. Symtuza is not recommended in patients with estimated CrCl <30 mL/min.
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Drug Interactions

Additional information about drug interactions is available in the [Liverpool HIV Drug Interaction Checker](#).

- Metabolism:** Metabolism of cobicistat (COBI) is mainly via cytochrome P450 (CYP) 3A4 and, to a lesser degree, CYP2D6. COBI is a strong inhibitor of CYP3A4 and a weak inhibitor of CYP2D6. COBI also inhibits breast cancer resistance protein, P-glycoprotein (P-gp), the organic anion transporting polypeptides organic anion transporting polypeptide (OATP) 1B1 and OATP1B3, and multidrug and toxin extrusion 1. Unlike ritonavir, COBI does not demonstrate any enzyme-inducing effects. The potential exists for multiple drug interactions when using COBI. Before COBI is administered, a patient's medication profile should be carefully reviewed for potential interactions and overlapping toxicities with other drugs. Coadministration of medications that induce or inhibit CYP3A4 may respectively decrease or increase exposures of COBI and coformulated antiretroviral (ARV) medications. Coadministration of medications that are CYP3A4 substrates may result in clinically significant adverse reactions that are severe, life-threatening, or fatal, or may result in loss of therapeutic effect if dependent on conversion to an active metabolite due to CYP3A4 inhibition by COBI.¹
- Nucleoside reverse transcriptase inhibitors:** COBI is a strong P-gp inhibitor; thus, a dose of tenofovir alafenamide (TAF) 10 mg combined with COBI produces tenofovir (TFV) exposures that are similar to those produced by TAF 25 mg without COBI.² COBI increases plasma TFV exposures by 23% when it is coadministered with TDF; thus, renal safety should be monitored in patients who are receiving this combination.^{1,3}
- Non-nucleoside reverse transcriptase inhibitors:** Efavirenz, etravirine, and nevirapine **should not be used** with COBI.
- Protease inhibitors:** Using COBI as a dual booster for elvitegravir (EVG) and darunavir (DRV) has been studied in people with and without HIV, and the evidence is conflicting. When EVG plus COBI plus DRV was administered to people without HIV, the trough concentration (C_{trough}) of EVG was 50% lower than the C_{trough} seen in people who received elvitegravir/cobicistat (EVG/c)/emtricitabine (FTC)/tenofovir disoproxil fumarate (TDF) without DRV.⁴ When EVG/c/FTC/TAF was administered with DRV to patients with HIV, both DRV and EVG concentrations were comparable to those seen in historic controls.^{5,6}
- Integrase inhibitors:** In one small study, dolutegravir (DTG) C_{trough} was 107% higher when DTG was administered with darunavir/cobicistat (DRV/c) than when it was administered with darunavir/ritonavir.⁷ Bictegravir (BIC) area under the curve increases 74% when BIC is administered with DRV/c.⁸
- Corticosteroids:** Increased serum concentrations of corticosteroids can occur when corticosteroids and COBI are coadministered; this can lead to clinically significant adrenal suppression. Adrenal suppression occurs regardless of whether the corticosteroids are administered orally or by some other route (e.g., intranasal, inhaled, interlaminar, intraarticular)

and regardless of whether the corticosteroids are administered routinely or intermittently. A possible exception is beclomethasone, which appears to be a relatively safe option with inhaled or intranasal administration.^{9,10}

Major Toxicities

- *More common:* Nausea, vomiting, diarrhea, abdominal pain, anorexia
- *Less common (more severe):* New onset renal impairment or worsening of renal impairment when used with TAF or TDF, rhabdomyolysis, increased amylase and lipase levels
- *Case Report:* One case report exists of a woman with low body weight (36 kg) and declining renal function who developed severe Type B lactic acidosis while on the combination of COBI, DRV, and non-dose-adjusted TDF/FTC. The woman's TFV C_{trough} during this episode was found to be up to fivefold higher than trough values reported in adults with normal renal function. The woman's FTC concentration was not measured.¹¹

Resistance

Not applicable because COBI has no antiviral activity.

Pediatric Use

Approval

COBI is a pharmacokinetic (PK) enhancer of ARV drugs that is available as a single agent or a component of fixed-dose combination products. COBI, as a component of Stribild, is approved by the U.S. Food and Drug Administration (FDA) at the adult dose for use in children and adolescents aged ≥ 12 years and weighing ≥ 35 kg.¹² The Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV recommends limiting the use of Stribild to those with a sexual maturity rating of 4 or 5. COBI, as a component of Genvoya, is approved by the FDA at the adult dose for use in children weighing ≥ 25 kg.¹³ The FDA has not approved COBI as a component of Genvoya for use in children weighing < 25 kg, but a PK, safety, and efficacy study has been conducted with a low-dose tablet in children weighing ≥ 14 kg to < 25 kg (see the [Elvitegravir](#) section). COBI alone (as Tybost) has been discontinued, and no generic standalone tablet formulation of COBI exists.¹ Prezcobix PED dispersible tablets are available for HIV treatment in children aged ≥ 3 years and weighing ≥ 15 kg.¹⁵ COBI, coformulated with ATV (as Evotaz),¹⁴ is approved by the FDA at the adult dose for use in children and adolescents weighing ≥ 35 kg. COBI, coformulated with DRV (as Prezcobix)¹⁵ and as a component of Symtuza,¹⁶ is approved by the FDA in children and adolescents weighing ≥ 25 kg. COBI, as a component of Symtuza, is approved by the FDA at the adult dose in children and adolescents weighing ≥ 40 kg.

Ritonavir (RTV, Norvir)

Updated: September 30, 2025

Reviewed: September 30, 2025

Formulations	
<p>Oral Powder: 100 mg per packet</p> <p>Tablet: 100 mg</p> <p>Generic Formulation</p> <ul style="list-style-type: none"> 100-mg tablet <p>Fixed-Dose Combination (FDC) Solution</p> <ul style="list-style-type: none"> [Kaletra] Lopinavir 80 mg/ritonavir 20 mg/mL. Oral solution contains 42.4% (volume per volume) ethanol and 15.3% (weight per volume) propylene glycol. <p>FDC Tablets</p> <ul style="list-style-type: none"> [Kaletra] Lopinavir 100 mg/ritonavir 25 mg [Kaletra] Lopinavir 200 mg/ritonavir 50 mg <p>When using FDC tablets or solution, 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.</p> <p>For additional information, see Drugs@FDA or DailyMed.</p>	
Dosing Recommendations	Selected Adverse Events
<p>Ritonavir (RTV) as a Pharmacokinetic Enhancer</p> <ul style="list-style-type: none"> RTV is used as a pharmacokinetic (PK) enhancer of other protease inhibitors (PIs). The recommended dose of RTV varies and is specific to the drug combination selected. See other sections of Appendix A. Pediatric Antiretroviral Drug Information for information about the recommended doses of RTV to use with specific PIs. RTV has antiviral activity, but it is not used as an antiviral agent; instead, it is used as a PK enhancer of other PIs. <p>Formulation Considerations</p> <ul style="list-style-type: none"> RTV oral powder should be used only for dosing increments of 100 mg and cannot be used for doses <100 mg. <p>[Kaletra] Lopinavir/RTV</p> <p><i>Infant, Child, Adolescent, and Adult Dose</i></p> <ul style="list-style-type: none"> See the Lopinavir/Ritonavir section of Appendix A. Pediatric Antiretroviral Drug Information for information. 	<ul style="list-style-type: none"> Gastrointestinal (GI) intolerance, nausea, vomiting, diarrhea Hyperlipidemia, especially hypertriglyceridemia Hepatitis Hyperglycemia Fat maldistribution
	Special Instructions
	<ul style="list-style-type: none"> Administer RTV with food to increase absorption and reduce the likelihood and severity of GI adverse events. Do not administer RTV with cobicistat (COBI) or drugs that contain COBI (i.e., Evotaz, Genvoya, Prezcoibix, Stribild, Symtuza). RTV oral powder should be mixed with a soft food (e.g., applesauce, vanilla pudding) or a liquid (e.g., water, chocolate milk, infant formula) to help mitigate the bitter taste. Administer or discard the mixture within 2 hours of mixing.

	<p>To Increase Tolerability of RTV Oral Powder in Children</p> <ul style="list-style-type: none"> • Mix the powder with milk, chocolate milk, ice cream, or vanilla or chocolate pudding. • Before administering RTV, give a child ice chips, an ice pop, or spoonfuls of partially frozen orange or grape juice concentrate to dull the taste buds. Another option is to give a nonallergic child peanut butter or hazelnut chocolate spread to coat the mouth.¹ • After administration, give foods with strong tastes (e.g., maple syrup, cheese). • Check a child's food allergy history before making these recommendations. • Counsel caregivers or patients that the bad taste will not be completely masked. <p>Metabolism/Elimination</p> <ul style="list-style-type: none"> • Cytochrome P450 (CYP) 3A and CYP2D6 inhibitor; CYP1A2, CYP2B6, CYP2C9, CYP2C19, and glucuronidation inducer. RTV inhibits the intestinal transporter P-glycoprotein. <p>RTV Dosing in Patients With Hepatic Impairment</p> <ul style="list-style-type: none"> • RTV is primarily metabolized by the liver. • No dose adjustment is necessary in patients with mild or moderate hepatic impairment. • No data exist on RTV dosing for adult or pediatric patients with severe hepatic impairment. Use caution when administering RTV to patients with moderate-to-severe hepatic impairment.
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Drug Interactions

Additional information about drug interactions is available in the [Adult and Adolescent Antiretroviral Guidelines](#) and the [HIV Drug Interaction Checker](#).

- **Metabolism:** Ritonavir (RTV) is extensively metabolized by (and is one of the most potent inhibitors of) hepatic cytochrome P450 (CYP) 3A. Also, RTV is a CYP2D6 inhibitor and a CYP1A2, CYP2B6, CYP2C9, CYP2C19, and glucuronidation inducer. RTV inhibits the intestinal transporter P-glycoprotein. There is potential for multiple drug interactions with RTV.
- Before RTV is administered, a patient's medication profile should be reviewed carefully for potential interactions with RTV and overlapping toxicities with other drugs.
- RTV and cobicistat **are not interchangeable**. The potential drug interactions for these drugs are different.²
- Avoid concomitant use of corticosteroids, including intranasal or inhaled fluticasone or inhaled budesonide. Reduced elimination of steroids can increase steroid effects, leading to adrenal insufficiency.^{3,4} Use caution when prescribing RTV with other inhaled steroids. Limited data suggest that beclomethasone may be a suitable alternative to fluticasone when a patient who is

taking RTV requires an inhaled or intranasal corticosteroid.^{5,6} Iatrogenic Cushing's syndrome and suppression of the hypothalamic-pituitary axis secondary to the drug interaction between RTV and local injection of triamcinolone has occurred.^{7,8} See [Table 24a. Drug Interactions Between Protease Inhibitors and Other Drugs](#) in the [Adult and Adolescent Antiretroviral Guidelines](#) for additional information.

Major Toxicities

- *More common:* Nausea, vomiting, diarrhea, headache, abdominal pain, anorexia, circumoral paresthesia, abnormal lipid levels
- *Less common (more severe):* Exacerbation of chronic liver disease, fat maldistribution
- *Rare:* New-onset diabetes mellitus, hyperglycemia, ketoacidosis, exacerbation of preexisting diabetes mellitus, spontaneous bleeding in hemophiliacs, pancreatitis. Cases of hepatitis, including life-threatening cases, have been reported. Allergic reactions, including bronchospasm, urticaria, and angioedema have occurred. Toxic epidermal necrolysis and Stevens-Johnson syndrome have occurred.⁹

Resistance

Resistance to RTV is not clinically relevant when the drug is used as a pharmacokinetic (PK) enhancer of other antiretroviral (ARV) medications.

Pediatric Use

Approval

RTV has been approved by the U.S. Food and Drug Administration for use in the pediatric population.

Effectiveness in Practice

Use of RTV as the sole protease inhibitor (PI) in ARV therapy in children **is not recommended**. In both children and adults, RTV is recommended as a PK enhancer for use with other PIs. RTV is a CYP3A inhibitor and functions as a PK enhancer by slowing the metabolism of the PI.

Dosing

Dosing regimens for RTV-boosted darunavir and atazanavir, as well as coformulated lopinavir/ritonavir (LPV/r) are available for pediatric patients. See the [Darunavir](#), [Atazanavir](#), and [Lopinavir/Ritonavir](#) sections for specific guidance. For more information about individual PIs, see other sections of [Appendix A: Pediatric Antiretroviral Drug Information](#). RTV oral solution is no longer available.

Toxicity

Full-dose RTV has been shown to prolong the PR interval in a study of healthy adults who were given RTV 400 mg twice daily.⁹ Potentially life-threatening arrhythmias have been reported in premature infants who were treated with LPV/r; therefore, the use of LPV/r is generally not recommended before a gestational age of 42 weeks (see the [Lopinavir/Ritonavir](#) section).^{10,11} Coadministration of RTV with other drugs that prolong the PR interval (e.g., macrolides, quinolones, methadone) should be undertaken with caution because it is unknown how coadministering any of

these drugs with RTV will affect the PR interval. In addition, RTV should be used with caution in patients who may be at increased risk of developing cardiac conduction abnormalities, such as patients who have underlying structural heart disease, conduction system abnormalities, ischemic heart disease, or cardiomyopathy.

APPENDIX A: PEDIATRIC ANTIRETROVIRAL DRUG INFORMATION

Archived Drugs

The Archived Drugs section of Appendix A: Pediatric Antiretroviral Drug Information provides access to the last updated versions of drug sections that are no longer being reviewed by the Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV (the Panel). Archived Drugs includes older antiretroviral drugs that the Panel does not recommend for use in children because they have unacceptable toxicities, inferior virologic efficacy, a high pill burden, pharmacologic concerns, and/or a limited amount of pediatric data.

[Didanosine \(ddl, Videx\)](#)

[Enfuvirtide \(T-20, Fuzeon\)](#)

[Fosamprenavir \(FPV, Lexiva\)](#)

[Indinavir \(IDV, Crixivan\)](#)

[Nelfinavir \(NFV, Viracept\)](#)

[Saquinavir \(SQV, Invirase\)](#)

[Stavudine \(d4t, Zerit\)](#)

[Tipranavir \(TPV, Aptivus\)](#)

Didanosine (ddI, Videx)

Updated: May 22, 2018

Reviewed: May 22, 2018

Formulations									
Pediatric Oral Solution: 10 mg/mL Enteric-Coated (EC) Delayed-Release Capsules (EC Beadlets): 125 mg, 200 mg, 250 mg, and 400 mg Generic Formulations Delayed-Release Capsules: 125 mg, 200 mg, 250 mg, and 400 mg For additional information, see Drugs@FDA .									
Dosing Recommendations	Selected Adverse Events								
<p>Note: Didanosine is no longer recommended by the Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV for use in children due to higher rates of adverse effects than other NRTIs.</p> <p>Neonate/Infant Dose (Aged 2 Weeks to <3 Months)</p> <ul style="list-style-type: none">50 mg/m² of body surface area every 12 hours. See dosing section below for justification of this dose. <p>Infant Dose (Aged ≥3 Months to 8 Months)</p> <ul style="list-style-type: none">100 mg/m² of body surface area every 12 hours <p>Pediatric Dose of Oral Solution (Aged >8 Months)</p> <ul style="list-style-type: none">120 mg/m² of body surface area every 12 hoursDose range: 90–150 mg/m² of body surface area every 12 hours. Do not exceed maximum adult dose; see table below.In treatment-naïve children aged 3 years to 21 years, 240 mg/m² of body surface area once daily (oral solution or capsules) has resulted in viral suppression. <p>Pediatric Dose of Videx EC or Generic Capsules (Aged 6–18 Years and Weighing ≥20 kg)</p> <table><tr><th>Body Weight</th><th>Dose</th></tr><tr><td>20 kg to <25 kg</td><td>200 mg once daily</td></tr><tr><td>25 kg to <60 kg</td><td>250 mg once daily</td></tr><tr><td>≥60 kg</td><td>400 mg once daily</td></tr></table>	Body Weight	Dose	20 kg to <25 kg	200 mg once daily	25 kg to <60 kg	250 mg once daily	≥60 kg	400 mg once daily	<ul style="list-style-type: none">Peripheral neuropathyDiarrhea, abdominal pain, nausea, vomitingLactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported (the risk is increased when didanosine is used in combination with stavudine).Pancreatitis (less common in children than in adults, more common when didanosine is used in combination with tenofovir disoproxil fumarate or stavudine)Non-cirrhotic portal hypertensionRetinal changes, optic neuritisInsulin resistance/diabetes mellitus
Body Weight	Dose								
20 kg to <25 kg	200 mg once daily								
25 kg to <60 kg	250 mg once daily								
≥60 kg	400 mg once daily								
	Special Instructions								
	<ul style="list-style-type: none">Administer didanosine on an empty stomach (30 minutes before or 2 hours after a meal). To improve adherence, some practitioners administer didanosine without regard to timing of meals (see text below).Didanosine powder for oral solution contains antacids that may interfere with the absorption of other medications, including protease inhibitors (PIs). See individual PI for instructions on timing of administration.Shake didanosine oral solution well before use. Keep refrigerated; solution is stable for 30 days.								

Adolescent and Adult Dose		Metabolism/Elimination
Body Weight	Dose	<ul style="list-style-type: none"> Renal excretion 50% Decrease dosage in patients with impaired renal function. Consult manufacturer's prescribing information for adjustment of dosage in accordance with creatinine clearance.
<60 kg	250 mg once daily	
≥60 kg	400 mg once daily	
Pediatric and Adolescent Dose of Didanosine When Combined With Tenofovir Disoproxil Fumarate <ul style="list-style-type: none"> This combination should be avoided because of enhanced didanosine toxicity, reports of immunologic nonresponse, high rates of early virologic failure, and rapid selection of resistance mutations (see the Adult and Adolescent Guidelines). 		

Drug Interactions

Additional information about drug interactions is available in the [Adult and Adolescent Guidelines](#) and the [HIV Drug Interaction Checker](#).

- Absorption:** Antacids in didanosine oral solution can decrease the absorption of a number of medications if given at the same time. Avoid giving other medications concurrently with didanosine oral solution.
- Mechanism unknown:** Didanosine serum concentrations are increased when didanosine is co-administered with tenofovir disoproxil fumarate (TDF). This combination should be avoided.
- Renal elimination:** Drugs that decrease renal function can decrease didanosine clearance.
- Overlapping toxicities:** The combination of stavudine with didanosine may result in enhanced toxicity. This combination should be avoided (see the Major Toxicities section below).

Major Toxicities

- More common:** Diarrhea, abdominal pain, nausea, vomiting
- Less common (more severe):** Peripheral neuropathy, electrolyte abnormalities, and hyperuricemia. Lactic acidosis and hepatomegaly with steatosis, including fatal cases, have been reported, and are more common when didanosine is used in combination with stavudine. Pancreatitis (less common in children than in adults, more common when didanosine is used in combination with TDF or stavudine) can occur. Increased liver enzymes, retinal depigmentation, and optic neuritis have been reported. Decreases in CD4 T lymphocyte counts have been reported when didanosine is used in combination with TDF.
- Rare:** Non-cirrhotic portal hypertension, presenting clinically with hematemesis, esophageal varices, ascites, and splenomegaly, and associated with increased transaminases, increased alkaline phosphatase, and thrombocytopenia, has been associated with long-term didanosine use.¹

- *Possible risk of cancer after in-utero exposure:* In a study of 15,163 children without HIV infection who were exposed to at least one nucleoside reverse transcriptase inhibitor (NRTI) *in utero*, 21 cancers were identified. Didanosine accounted for only 10% of prescriptions but was associated with one-third of identified cancers, and, in multivariate analysis, didanosine was associated with a 5.5-fold (95% CI, 2.1–14.4) increased risk of cancer with first-trimester exposure.² During adolescence, didanosine use while pregnant or at risk of becoming pregnant should prompt health care professionals to caution about this cancer risk.

Resistance

The International AIDS Society–USA maintains a [list of updated resistance mutations](#) and the [Stanford University HIV Drug Resistance Database](#) offers a discussion of each mutation.

Pediatric Use

Approval

Although didanosine is a Food and Drug Administration (FDA)-approved NRTI for use in children as part of antiretroviral therapy, it is **not recommended** for in children due to its significant toxicity and the availability of safer agents.

Dosing

Standard Dose in Children Aged >8 Months

The standard dose of didanosine oral solution in children aged >8 months is 120 mg/m² of body surface area twice daily.^{3,4} Doses higher than 180 mg/m² of body surface area twice daily are associated with increased toxicity.⁵

Special Considerations for Children Aged 2 Weeks to <8 Months

For infants aged 2 weeks to 8 months, the FDA recommends 100 mg/m² of body surface area per dose twice daily. However, because pharmacokinetic (PK) differences in younger infants (aged 2 weeks–3 months) compared with older children raise concerns for increased toxicity in this younger age group, the Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV recommends a dose of 50 mg/m² of body surface area twice daily for infants aged 2 weeks to 3 months, with an increase to 100 mg/m² of body surface area per dose twice daily at 3 months, and finally increasing to 120 mg/m² of body surface area per dose twice daily at age 8 months (as discussed above).

Frequency of Administration (Once Daily or Twice Daily)

In those aged >3 years, a once-daily dosing regimen may be preferable to promote adherence, and multiple studies support the favorable PKs and efficacy of once-daily dosing of 240 mg/m² of body surface area.⁶

Food Restrictions

Although the prescribing information recommends taking didanosine on an empty stomach, this is impractical for infants who must be fed frequently, and it may decrease medication adherence by increasing regimen complexity. A comparison showed that systemic exposure measured by area under the curve was similar whether didanosine oral solution was given to children with or without

food; absorption of didanosine administered with food was slower and elimination more prolonged.⁷ To improve adherence, some practitioners administer didanosine without regard to timing of meals. Studies in adults suggest that didanosine can be given without regard to food.^{8,9} A European study dosed didanosine oral solution as part of a four-drug regimen either 1 hour before or 1 hour after meals, but allowed the extended-release formulation to be given without food restriction. The study showed good virologic outcome with up to 96 weeks of follow-up.¹⁰

Enfuvirtide (T-20, Fuzeon)

Updated: May 22, 2018

Reviewed: May 22, 2018

Formulations	
<p>Lyophilized Powder for Injection: 108-mg vial of enfuvirtide. Reconstitution with 1.1 mL sterile water will deliver 90 mg/mL.</p> <p>Convenience Kit: 60 single-use vials of enfuvirtide (108-mg vial reconstituted as 90 mg/mL), 60 vials of sterile water for injection, 60 reconstitution syringes (3 mL), 60 administration syringes (1 mL), alcohol wipes</p> <p>For additional information, see Drugs@FDA.</p>	
Dosage Recommendations	Selected Adverse Events
<p>Pediatric and Adolescent Dose (Aged 6–16 Years)</p> <p><i>Children Aged <6 Years</i></p> <ul style="list-style-type: none"> Not approved for use in children aged <6 years <p><i>Children Aged ≥6 Years</i></p> <ul style="list-style-type: none"> 2 mg/kg (maximum dose 90 mg [1 mL]) twice daily injected subcutaneously (SQ) into the upper arm, anterior thigh, or abdomen <p>Adolescent (Aged >16 Years) and Adult Dose</p> <ul style="list-style-type: none"> 90 mg (1 mL) twice daily injected SQ into the upper arm, anterior thigh, or abdomen 	<ul style="list-style-type: none"> Local injection site reactions (e.g., pain, erythema, induration, nodules and cysts, pruritus, ecchymosis) in up to 98% of patients. Increased rate of bacterial pneumonia (unclear association). Hypersensitivity reaction (HSR)—symptoms may include rash, fever, nausea, vomiting, chills, rigors, hypotension, or elevated serum transaminases. Rechallenge is not recommended.
	Special Instructions
	<ul style="list-style-type: none"> Carefully instruct patient or caregiver in proper technique for drug reconstitution and administration of SQ injections. Enfuvirtide injection instructions are provided with convenience kits. Allow reconstituted vial to stand until the powder goes completely into solution, which could take up to 45 minutes. Do not shake. Once reconstituted, inject enfuvirtide immediately or keep refrigerated in the original vial until use. Reconstituted enfuvirtide must be used within 24 hours. Enfuvirtide must be given SQ; severity of reactions increases if given intramuscularly. Give each injection at a site different from the preceding injection site; do not inject into moles, scar tissue, bruises, or the navel. Both the patient/caregiver and health care provider should carefully monitor for signs and symptoms of local infection or cellulitis.

	<ul style="list-style-type: none"> • To minimize local reactions, apply ice or heat after injection or gently massage injection site to better disperse the dose. There are reports of injection-associated neuralgia and paresthesia when alternative delivery systems, such as needle-free injection devices, are used. • Advise patients/caregivers of the possibility of a HSR; instruct them to discontinue treatment and seek immediate medical attention if a patient develops signs and symptoms consistent with a HSR.
	<p style="text-align: center;">Metabolism/Elimination</p>
	<ul style="list-style-type: none"> • Catabolism to constituent amino acids.

Drug Interactions

Additional information about drug interactions is available in the [Adult and Adolescent Guidelines](#) and the [HIV Drug Interaction Checker](#).

There are no known significant drug interactions with enfuvirtide.

Major Toxicities

- *More common:* Almost all patients (87% to 98%) experience local injection site reactions including pain and discomfort, induration, erythema, nodules and cysts, pruritus, and ecchymosis. Reactions are usually mild to moderate in severity but can be more severe. Average duration of local injection site reaction is 3 to 7 days but was >7 days in 24% of patients.
- *Less common (more severe):* Increased rate of bacterial pneumonia (unclear association).¹ Pediatric studies have lacked the statistical power to answer questions concerning enfuvirtide use and increased risk of pneumonia.
- *Rare:* Hypersensitivity reactions (HSRs) (<1%) including fever, nausea and vomiting, chills, rigors, hypotension, and elevated liver transaminases; immune-mediated reactions including primary immune complex reaction, respiratory distress, glomerulonephritis, and Guillain-Barre syndrome. Patients experiencing HSRs should seek immediate medical attention. Therapy should not be restarted in patients with signs and symptoms consistent with HSRs.
- *Pediatric specific:* Local site cellulitis requiring antimicrobial therapy (up to 11% in certain subgroups of patients in pediatric studies).²

Resistance

The International AIDS Society–USA maintains a [list of updated resistance mutations](#) and the [Stanford University HIV Drug Resistance Database](#) offers a discussion of each mutation.

Resistance testing must be ordered specifically for fusion inhibitors, as it is not performed on routine genotypic or phenotypic assays.

Pediatric Use

Approval

Although enfuvirtide is Food and Drug Administration (FDA)-approved for use in children, it is not commonly used because of its high cost, need for twice-daily subcutaneous (SQ) injections, and high rate of injection site reactions. Use in deep salvage regimens³ has also declined with the availability of integrase inhibitors and other entry inhibitors (such as maraviroc).

Pharmacokinetics

A single-dose pharmacokinetic evaluation study of enfuvirtide, given SQ to 14 children with HIV aged 4 years to 12 years (PACTG 1005), identified that enfuvirtide 60 mg/m² of body surface area per dose resulted in a target trough concentration that approximated the equivalent of a 90-mg dose delivered SQ to an adult (1000 mg/mL).⁴ In a second pediatric study of 25 children aged 5 years to 16 years, a 2-mg/kg dose (maximum 90 mg) of enfuvirtide given twice daily yielded drug concentrations similar to 60 mg/m² of body surface area dose independent of age group, body weight, body surface area, and sexual maturation.⁵ The FDA-recommended dose of enfuvirtide for children aged 6 to 16 years is 2 mg/kg (maximum 90 mg) administered SQ twice daily. Further data are needed for dosing in children aged <6 years.

Efficacy

The safety and antiretroviral (ARV) activity of twice-daily SQ enfuvirtide administration at 60 mg/m² per dose plus optimized background therapy (OBT) was evaluated over 96 weeks in 14 children aged 4 to 12 years who had failed to achieve viral suppression on multiple prior ARV regimens (PACTG 1005). At 24 weeks 71% of the children had a >1.0_{log} reduction in viral load; 43% and 21% had HIV RNA levels suppressed to <400 copies/mL and <50 copies/mL, respectively. However, only 36% of children maintained virologic suppression (>1.0_{log} decrease in HIV RNA) at Week 96. Most children had local injection site reactions.⁶ Significant improvements in CD4 T lymphocyte (CD4) cell percentages and height z scores were observed in children receiving enfuvirtide for 48 and 96 weeks.

T20-310, a Phase 1/2 study of enfuvirtide (2.0 mg/kg SQ, maximum 90 mg, twice daily) plus OBT, enrolled 52 treatment-experienced children aged 3 to 16 years for 48 weeks. Only 64% of the children completed 48 weeks of therapy. The median decrease in HIV RNA was -1.17 log₁₀ copies/mL (n = 32) and increase in CD4 cell count was 106 cells/mm³ (n = 25). At Week 8, treatment responses as measured by several plasma HIV RNA parameters were superior in younger children (aged <11 years) compared with adolescents. Median increases in CD4 cell count were 257 cells/mm³ in children and 84 cells/mm³ in adolescents. Local skin reactions were common in all age groups (87% of study participants). The observed differential responses between children and adolescents probably reflect unique challenges to adherence with the prescribed regimen.²

Fosamprenavir (FPV, Lexiva)

Updated: May 22, 2018

Reviewed: May 22, 2018

Formulations											
Tablets: 700 mg											
Oral Suspension: 50 mg/mL											
For additional information, see Drugs@FDA .											
Dosing Recommendations	Selected Adverse Events										
Pediatric Dose (Aged >6 Months to 18 Years) <ul style="list-style-type: none">Unboosted fosamprenavir (without ritonavir) is Food and Drug Administration (FDA)-approved for antiretroviral (ARV)-naïve children aged 2 to 5 years, but not recommended by the Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV (the Panel) because of low exposures (see text below).Boosted fosamprenavir (with ritonavir) is FDA-approved for ARV-naïve infants ≥4 weeks and for treatment-experienced infants ≥6 months; however, the Panel does not recommend use in infants aged <6 months because of similarly low exposures (see text below). If used in infants as young as 4 weeks, it should only be administered to infants born at 38 weeks' gestation or greater. <p>Note: Once-daily dosing is not recommended for any pediatric patient.</p> <p>Pediatric Dose (Aged ≥6 Months to 18 Years)</p> <p>Twice-Daily Dose Regimens by Weight for Pediatric Patients ≥6 Months Using Fosamprenavir Oral Suspension with Ritonavir</p> <table><tr><th>Weight</th><th>Dose (Both Drugs Twice Daily^a with Food)</th></tr><tr><td><11 kg</td><td>Fosamprenavir 45 mg/kg/dose plus ritonavir 7 mg/kg/dose</td></tr><tr><td>11 kg to <15 kg</td><td>Fosamprenavir 30 mg/kg/dose plus ritonavir 3 mg/kg/dose</td></tr><tr><td>15 kg to <20 kg</td><td>Fosamprenavir 23 mg/kg/dose plus ritonavir 3 mg/kg/dose</td></tr><tr><td>≥20 kg</td><td>Fosamprenavir 18 mg/kg/dose plus ritonavir 3 mg/kg/dose</td></tr></table>	Weight	Dose (Both Drugs Twice Daily ^a with Food)	<11 kg	Fosamprenavir 45 mg/kg/dose plus ritonavir 7 mg/kg/dose	11 kg to <15 kg	Fosamprenavir 30 mg/kg/dose plus ritonavir 3 mg/kg/dose	15 kg to <20 kg	Fosamprenavir 23 mg/kg/dose plus ritonavir 3 mg/kg/dose	≥20 kg	Fosamprenavir 18 mg/kg/dose plus ritonavir 3 mg/kg/dose	<ul style="list-style-type: none">Diarrhea, nausea, vomitingSkin rash (fosamprenavir has a sulfonamide moiety. Stevens-Johnson syndrome and erythema multiforme have been reported.)HeadacheHyperlipidemia, hyperglycemiaNephrolithiasisTransaminase elevationFat maldistributionPossible increased bleeding episodes in patients with hemophilia
Weight	Dose (Both Drugs Twice Daily ^a with Food)										
<11 kg	Fosamprenavir 45 mg/kg/dose plus ritonavir 7 mg/kg/dose										
11 kg to <15 kg	Fosamprenavir 30 mg/kg/dose plus ritonavir 3 mg/kg/dose										
15 kg to <20 kg	Fosamprenavir 23 mg/kg/dose plus ritonavir 3 mg/kg/dose										
≥20 kg	Fosamprenavir 18 mg/kg/dose plus ritonavir 3 mg/kg/dose										
	Special Instructions										
	<ul style="list-style-type: none">Fosamprenavir tablets with ritonavir should be taken with food. Children should take the suspension with food.Patients taking antacids should take fosamprenavir at least 1 hour before or after antacid use.Fosamprenavir contains a sulfonamide moiety. The potential for cross sensitivity between fosamprenavir and other drugs in the sulfonamide class is unknown. Fosamprenavir should be used with caution in patients with sulfonamide allergy.Shake oral suspension well before use. Refrigeration is not required.										

<p>^a Not to exceed the adult dose of fosamprenavir 700 mg plus ritonavir 100 mg twice daily.</p> <p>Note: When administered with ritonavir, the adult regimen of 700 mg fosamprenavir tablets plus 100 mg ritonavir, both given twice daily, can be used in patients weighing ≥39 kg. Ritonavir tablets can be used in patients weighing ≥33 kg.</p> <p>Adolescent and Adult Dose</p> <ul style="list-style-type: none"> Dosing regimen depends on whether the patient is ARV-naïve or ARV-experienced. <p><i>ARV-Naïve Patients</i></p> <ul style="list-style-type: none"> Fosamprenavir 700 mg plus ritonavir 100 mg, both twice daily Fosamprenavir 1400 mg plus ritonavir 100–200 mg, both once daily <p><i>Protease-Inhibitor-Experienced Patients</i></p> <ul style="list-style-type: none"> Fosamprenavir 700 mg plus ritonavir 100 mg, both twice daily. <p>Note: Once-daily administration of fosamprenavir plus ritonavir is not recommended.</p>	<p>Metabolism/Elimination</p> <ul style="list-style-type: none"> The prodrug fosamprenavir is rapidly and almost completely hydrolyzed to amprenavir by cellular phosphatases in the gut as it is absorbed. Amprenavir is a cytochrome P (CYP) 450 3A4 inhibitor, inducer, and substrate. <p>Fosamprenavir Dosing in Patients with Hepatic Impairment</p> <ul style="list-style-type: none"> Specific dose adjustments are recommended for adults with mild, moderate, and severe hepatic impairment. However, there are no data to support dosing recommendations for pediatric patients with hepatic impairment. Please refer to the package insert. <p>Fosamprenavir Dosing in Patients With Renal Impairment</p> <ul style="list-style-type: none"> No dose adjustment is required in patients with renal impairment.
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Drug Interactions

Additional information about drug interactions is available in the [Adult and Adolescent Guidelines](#) and the [HIV Drug Interaction Checker](#).

- Fosamprenavir may interact with a number of other drugs, and using ritonavir as a boosting agent increases the potential for drug interactions. Before administration, a patient's medication profile should be carefully reviewed for potential drug interactions with fosamprenavir.

Major Toxicities

- More common:* Vomiting, nausea, diarrhea, perioral paresthesia, headache, rash, lipid abnormalities
- Less common (more severe):* Life-threatening rash, including Stevens-Johnson syndrome, in <1% of patients. Fat maldistribution, neutropenia, and elevated serum creatinine kinase levels.
- Rare:* New-onset diabetes mellitus, hyperglycemia, ketoacidosis, exacerbation of preexisting diabetes mellitus, spontaneous bleeding in hemophiliacs, hemolytic anemia, elevation in serum transaminases, angioedema, and nephrolithiasis.
- Pediatric-specific:* Vomiting was more frequent in children than in adults during clinical trials of fosamprenavir with ritonavir (20% to 36% vs. 10%, respectively) and in trials of fosamprenavir without ritonavir (60% vs. 16%, respectively). Neutropenia was also more common in children across all the trials (15% vs. 3%, respectively).¹

Resistance

The International AIDS Society–USA maintains a [list of updated resistance mutations](#) and the [Stanford University HIV Drug Resistance Database](#) offers a discussion of each mutation.

Pediatric Use

Approval

Fosamprenavir is Food and Drug Administration (FDA)-approved for use in children as young as age 4 weeks, but the Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV (the Panel) recommends use only in children aged ≥ 6 months. Although unboosted fosamprenavir has been approved by the FDA for antiretroviral-naïve children aged 2 to 5 years, the Panel **does not recommend** unboosted fosamprenavir for this—or any other—age group because of low exposures and also because unboosted fosamprenavir may select for mutations associated with resistance to darunavir.²

Efficacy and Pharmacokinetics

Dosing recommendations for fosamprenavir are based on three pediatric studies that enrolled more than 200 children aged 4 weeks to 18 years. In two, open-label trials in both treatment-experienced and treatment-naïve children aged 2 to 18 years,^{3,4} fosamprenavir was well-tolerated and effective in suppressing viral load and increasing CD4 T lymphocyte count. However, data were insufficient to support a once-daily dosing regimen of fosamprenavir/ritonavir in children; therefore, once-daily dosing **is not recommended** for pediatric patients.

Pharmacokinetics in Infants

In a study of infants, higher doses of both fosamprenavir and ritonavir were used in treatment-naïve infants as young as age 4 weeks and in treatment-experienced infants as young as age 6 months.^{1,5} Exposures in those aged < 6 months were much lower than those achieved in older children and adults and comparable to those seen with unboosted fosamprenavir (see table below). Given these low exposures, limited data, large dosing volumes, unpleasant taste, and the availability of alternatives for infants and young children, the Panel **does not recommend** fosamprenavir use in infants aged < 6 months.

Table A. Fosamprenavir Dose and Amprenavir Exposure by Age Group

Population	Dose	AUC _{0-24h} (mcg*hr/mL) Except Where Noted	C _{min} (mcg/mL)
Infants Aged <6 Months	FPV 45 mg/kg plus RTV 10 mg/kg twice daily	26.6 ^a	0.86
Children Aged 2 Years to <6 Years	FPV 30 mg/kg twice daily (no RTV)	22.3 ^a	0.513
Children Weighing <11 kg	FPV 45 mg/kg plus RTV 7 mg/kg twice daily	57.3	1.65
Children Weighing 15 kg to <20 kg	FPV 23 mg/kg FPV plus RTV 3 mg/kg twice daily	121.0	3.56
Children Weighing ≥20 kg	FPV 18 mg/kg plus RTV 3 mg/kg twice daily (maximum 700/100 mg)	72.3–97.9	1.98–2.54
Adults	FPV 1400 mg twice daily (no RTV)	33	0.35
Adults	FPV 1400 mg plus RTV 100–200 mg RTV once daily	66.4–69.4	0.86–1.45
Adults	FPV 700 mg plus RTV 100 mg twice daily	79.2	2.12

^a AUC₀₋₁₂ (mcg*hr/mL)

Key: AUC_{0-24h} = area under the curve for 24 hours post-dose; C_{min} = minimum plasma concentration;
FPV = fosamprenavir; RTV = ritonavir

Note: Dose for those weighing 11 kg to <15 kg is based on population pharmacokinetic studies; therefore, AUC and C_{min} are not available.

References

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5. Cotton M, Cassim H, Pavia-Ruz N, et al. Pharmacokinetics, safety and antiviral activity of fosamprenavir/ritonavir-containing regimens in HIV-infected children aged 4 weeks to 2 years-48-week study data. *Pediatr Infect Dis J*. 2014;33(1):57-62. Available at <https://www.ncbi.nlm.nih.gov/pubmed/23811743>.

Indinavir (IDV, Crixivan)

Updated: May 22, 2018

Reviewed: May 22, 2018

Formulations	
Capsules: 100 mg, 200 mg, and 400 mg For additional information, see Drugs@FDA .	
Dosing Recommendations	Selected Adverse Events
<p>Neonate and Infant Dose</p> <ul style="list-style-type: none"> Not approved for use in neonates/infants Should not be administered to neonates because of the risks associated with hyperbilirubinemia (kernicterus) <p>Pediatric Dose</p> <ul style="list-style-type: none"> Not approved for use in children A range of indinavir doses (234–500 mg/m² body surface area) boosted with low-dose ritonavir has been studied in children (see text below). <p>Adolescent and Adult Dose</p> <ul style="list-style-type: none"> 800 mg indinavir plus 100 or 200 mg ritonavir every 12 hours The Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV does not recommend the use of indinavir in adolescents. 	<ul style="list-style-type: none"> Nephrolithiasis Gastrointestinal intolerance, nausea Hepatitis Indirect hyperbilirubinemia Hyperlipidemia Hyperglycemia Fat maldistribution Possible increased bleeding episodes in patients with hemophilia
	Special Instructions
	<ul style="list-style-type: none"> When indinavir is given in combination with ritonavir, meal restrictions are not necessary. Adequate hydration is required to minimize risk of nephrolithiasis (≥48 oz of fluid daily in adult patients). Indinavir capsules are sensitive to moisture; store at room temperature (59–86°F) in original container with desiccant.
	Metabolism/Elimination
	<ul style="list-style-type: none"> Cytochrome P450 3A4 (CYP3A4) inhibitor and substrate <p>Indinavir Dosing in Patients With Hepatic Impairment</p> <ul style="list-style-type: none"> Dose should be decreased in patients with mild-to-moderate hepatic impairment (recommended dose for adults is 600 mg indinavir every 8 hours). No dosing information is available for children with any degree of hepatic impairment or for adults with severe hepatic impairment.

Drug Interactions

Additional information about drug interactions is available in the [Adult and Adolescent Guidelines](#) and the [HIV Drug Interaction Checker](#).

- *Metabolism:* Cytochrome P450 3A4 (CYP3A4) is the major enzyme responsible for metabolism. There is potential for multiple drug interactions with indinavir.
- Avoid other drugs that cause hyperbilirubinemia, such as atazanavir.
- Before administration, a patient's medication profile should be carefully reviewed for potential drug interactions with indinavir.

Major Toxicities

- *More common:* Nephrolithiasis/urolithiasis with indinavir crystal deposit is reported more frequently in children (29%) than in adults (12.4%).¹ Interstitial nephritis and urothelial inflammation has been commonly reported in adults.² Nausea, abdominal pain, headache, metallic taste, dizziness, asymptomatic hyperbilirubinemia (10%), lipid abnormalities, pruritus, and rash.
- *Less common (more severe):* Fat maldistribution.
- *Rare:* New-onset diabetes mellitus, hyperglycemia, ketoacidosis, exacerbation of preexisting diabetes mellitus, spontaneous bleeding in hemophiliacs, acute hemolytic anemia, and hepatitis (life-threatening in rare cases).

Resistance

The International AIDS Society–USA maintains a [list of updated resistance mutations](#) and the [Stanford University HIV Drug Resistance Database](#) offers a discussion of each mutation.

Pediatric Use

Approval

Indinavir has not been approved by the Food and Drug Administration for use in the pediatric population. Although indinavir was one of the first protease inhibitors to be studied in children, its use in pediatrics has never been common and is currently very rare.³ Indinavir **is not recommended** by the Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV for use in children and adolescents because of its unfavorable toxicity profile, limited efficacy data, and uncertain pharmacokinetics.

Efficacy and Pharmacokinetics

Both unboosted and ritonavir-boosted indinavir have been studied in children with HIV. In children, an unboosted indinavir dose of 500 to 600 mg/m² body surface area given every 8 hours results in peak blood concentrations and area under the curve that are slightly higher than those in adults, but trough concentrations are considerably lower. A significant proportion of children have trough indinavir concentrations less than the 0.1 mg/L value associated with virologic efficacy in adults.⁴⁻⁷ Studies that investigated a range of indinavir/ritonavir doses in small groups of children have shown that indinavir 500 mg/m² body surface area plus ritonavir 100 mg/m² body surface area twice daily is probably too high,⁸ that indinavir 234 to 250 mg/m² body surface area plus low-dose ritonavir twice

daily is too low,^{9,10} and that indinavir 400 mg/m² body surface area plus ritonavir 100 to 125 mg/m² body surface area twice daily results in exposures approximating those seen with indinavir 800 mg plus ritonavir 100 mg twice daily in adults, albeit with considerable inter-individual variability and high rates of toxicity.¹⁰⁻¹²

Nelfinavir (NFV, Viracept)

Updated: May 22, 2018

Reviewed: May 22, 2018

Formulations	
Tablets: 250 mg and 625 mg For additional information, see Drugs@FDA .	
Dosing Recommendations	Selected Adverse Events
<p>Note: The Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV no longer recommends nelfinavir-based regimens for use in children due to inferior potency compared to other regimens.</p> <p>Neonate and Infant Dose</p> <ul style="list-style-type: none"> Nelfinavir should not be used for treatment in children aged <2 years. <p>Pediatric Dose (Aged ≥2 Years)</p> <ul style="list-style-type: none"> 45–55 mg/kg twice daily <p>Adolescent and Adult Dose</p> <ul style="list-style-type: none"> 1,250 mg (five 250-mg tablets or two 625-mg tablets) twice daily 	<ul style="list-style-type: none"> Diarrhea Hyperlipidemia Hyperglycemia Fat maldistribution Serum transaminase elevations
	Special Instructions
	<ul style="list-style-type: none"> Administer nelfinavir with meal or light snack. If co-administered with didanosine, administer nelfinavir 2 hours before or 1 hour after didanosine. Patients unable to swallow nelfinavir tablets can dissolve the tablets in a small amount of water. Once tablets are dissolved, mix the cloudy mixture well and consume it immediately. The glass should be rinsed with water and the rinse swallowed to ensure that the entire dose is consumed. Tablets can also be crushed and administered with pudding or other nonacidic foods.
	Metabolism/Elimination
	<ul style="list-style-type: none"> Cytochrome P (CYP) 2C19 and 3A4 substrate Metabolized to active M8 metabolite CYP3A4 inhibitor

Drug Interactions

Additional information about drug interactions is available in the [Adult and Adolescent Guidelines](#) and the [HIV Drug Interaction Checker](#).

- Metabolism:** Cytochrome P (CYP) 2C19 and 3A4 substrate and CYP3A4 inhibitor. Ritonavir boosting does not significantly increase nelfinavir concentrations, and co-administration of nelfinavir with ritonavir **is not recommended**.
- There is potential for multiple drug interactions with nelfinavir. Before administering nelfinavir, carefully review a patient's medication profile for potential drug interactions.

Major Toxicities

- *More common:* Diarrhea (most common), asthenia, abdominal pain, rash, lipid abnormalities
- *Less common (more severe):* Fat redistribution, exacerbation of chronic liver disease
- *Rare:* New-onset diabetes mellitus, hyperglycemia, ketoacidosis, exacerbation of pre-existing diabetes mellitus, spontaneous bleeding in patients with hemophilia, elevations in transaminases

Resistance

The International AIDS Society–USA maintains a [list of updated resistance mutations](#) and the [Stanford University HIV Drug Resistance Database](#) offers a discussion of each mutation.

Pediatric Use

Approval

Nelfinavir is approved by the Food and Drug Administration (FDA) for use in children aged ≥ 2 years. Given the higher variability of nelfinavir plasma concentrations in infants and younger children,^{1,2} nelfinavir is not approved for children aged < 2 years. Despite being FDA-approved for pediatric use, nelfinavir **is not recommended** for use in children and adolescents by the Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV, due to its limited efficacy and uncertain pharmacokinetics (PK).

Efficacy in Pediatric Clinical Trials

Nelfinavir used in combination with other antiretroviral (ARV) drugs has been extensively studied in children with HIV infection.³⁻¹⁰ In randomized trials of children aged 2 to 13 years receiving nelfinavir as part of triple combination therapy, the proportion of patients with HIV RNA < 400 copies/mL through 48 weeks of therapy has been quite variable, ranging from 26% to 69%. The antiviral response to nelfinavir is significantly less in children aged < 2 years than in older children.^{8,10,11} In clinical studies, virologic and immunologic response to nelfinavir-based therapy has varied according to the patient's age or prior treatment history, the number of drugs included in the combination regimen, and the dose of nelfinavir used.

Pharmacokinetics: Exposure-Response Relationships

Nelfinavir's relatively poor ability to control plasma viremia in infants and children in clinical trials may be related to its lower potency when compared with other ARV drugs, as well as highly variable drug exposure, metabolism, and poor palatability.¹²⁻¹⁴ The bioavailability of dissolved nelfinavir tablets is comparable to that of tablets swallowed whole.^{3,15}

Administration of nelfinavir with food increases nelfinavir exposure (area under the curve increases by up to fivefold) and decreases PK variability when compared to the fasted state. Nelfinavir plasma exposure may be even more unpredictable in pediatric patients than in adults due to the increased clearance of nelfinavir observed in children and difficulties in taking nelfinavir with sufficient food to improve bioavailability.

Nelfinavir is metabolized by multiple CYP450 enzymes, including CYP3A4 and CYP2C19. The variability of drug exposure at any given dose is much higher for children than for adults,¹⁶ which has been attributed—at least in part—to differences in the diets of children and adults. Two population PK studies of nelfinavir and its active metabolite, M8, describe the large intersubject variability

observed in children.^{17,18} Furthermore, CYP2C19 genotype has been shown to affect nelfinavir PK and the virologic responses in children with HIV.¹²

Several studies have demonstrated a correlation between nelfinavir trough concentrations and virologic response. In both children and adults, an increased risk of virologic failure was associated with low nelfinavir drug exposure, particularly with a nelfinavir minimum plasma concentration (C_{min}) <1.0 mcg/mL.¹⁹⁻²¹

In a study of 32 children treated with a high dose of nelfinavir (a twofold increase of the recommended dose), 80% of children with morning trough nelfinavir plasma concentration >0.8 mcg/mL had HIV RNA concentrations <50 copies/mL at Week 48, compared with only 29% of those with morning trough <0.8 mcg/mL.²² Children in the group with C_{trough} <0.8 mcg/mL were younger than the children in the group with C_{trough} >0.8 mcg/mL (median ages in these groups were 3.8 years and 8.3 years, respectively).²² Therapeutic drug monitoring of nelfinavir plasma concentrations, with appropriate adjustments for low drug exposure, has been shown to improve virologic response in adults and children.^{18,19,23,24} Pediatric and adolescent patients may require doses higher than those recommended in adults to achieve higher plasma nelfinavir exposure.

Saquinavir (SQV, Invirase)

Updated: May 22, 2018

Reviewed: May 22, 2018

Formulations	
<p>Capsules: 200 mg</p> <p>Tablets: 500 mg</p> <p>For additional information, see Drugs@FDA.</p>	
Dosing Recommendations	Selected Adverse Events
<p>Pediatric Dose</p> <ul style="list-style-type: none"> Not approved for use in infants, children, and adolescents aged <16 years. <p>Adolescent and Adult Dose</p> <ul style="list-style-type: none"> Saquinavir should only be used in combination with ritonavir. Saquinavir 1000 mg plus ritonavir 100 mg twice daily 	<ul style="list-style-type: none"> Gastrointestinal intolerance, nausea, diarrhea Elevated transaminases Hyperlipidemia Hyperglycemia Fat maldistribution PR interval prolongation, QT interval prolongation, and ventricular tachycardia (Torsades de Pointes)
	Special Instructions
	<ul style="list-style-type: none"> Administer within 2 hours after a full meal. Sun exposure can cause photosensitivity reactions; advise patients to use sunscreen or protective clothing. Pre-therapy electrocardiogram is recommended; saquinavir is contraindicated in patients with a prolonged QT interval.
	Metabolism/Elimination
	<ul style="list-style-type: none"> Cytochrome P450 3A4 (CYP3A4) substrate and inhibitor 90% metabolized in the liver Use saquinavir with caution in patients who have hepatic impairment; no dose adjustment recommended.

Drug Interactions

Additional information about drug interactions is available in the [Adult and Adolescent Guidelines](#) and the [HIV Drug Interaction Checker](#).

- Saquinavir is both a substrate and inhibitor of the cytochrome P 450 3A4 (CYP3A4) system. Potential exists for multiple drug interactions. Saquinavir **should not be coadministered** with drugs that are highly dependent on CYP3A clearance, especially in cases where elevated plasma concentrations of the coadministered drug can cause serious or life-threatening events.

- Before administration, a patient's medication profile should be carefully reviewed for potential drug interactions.

Major Toxicities

- *More common:* Diarrhea, abdominal discomfort, headache, nausea, paresthesia, skin rash, lipid abnormalities
- *Less common (more severe):* Exacerbation of chronic liver disease, lipodystrophy
- *Rare:* New-onset diabetes mellitus, hyperglycemia, ketoacidosis, exacerbation of pre-existing diabetes mellitus, spontaneous bleeding in patients with hemophilia, pancreatitis, and elevation in serum transaminases. Saquinavir administered with ritonavir can lead to prolonged QT and/or PR intervals with potential for heart block and ventricular tachycardia (Torsades de Pointes).

Resistance

The International AIDS Society–USA maintains a [list of updated resistance mutations](#) and the [Stanford University HIV Drug Resistance Database](#) offers a discussion of each mutation.

Pediatric Use

Approval

Saquinavir is not approved for use in children or adolescents aged <16 years.¹

Efficacy

Saquinavir has been studied with nucleoside reverse transcriptase inhibitors and other protease inhibitors in children with HIV.²⁻⁹ Saquinavir/ritonavir (SQV/r) and a dual-protease inhibitor saquinavir/lopinavir/ritonavir regimen were considered for salvage therapy in children prior to the emergence of the new classes of antiretroviral medications; these regimens **are no longer recommended**.

Pharmacokinetics

Pharmacokinetic (PK) data from children who received SQV/r showed prohibitively low exposure in children younger than 2 years.¹⁰ In children aged ≥2 years, a dose of saquinavir 50 mg/kg twice daily in combination with ritonavir and lopinavir/ritonavir resulted in steady-state plasma trough concentrations (C_{trough}) similar to those seen adults.^{9,11} No clinical trials have collected data on the efficacy of saquinavir doses <50 mg/kg in children.

Toxicity

In healthy adult volunteers, SQV/r dose and exposure were associated with increases in both QT and PR intervals.^{1,12} Rare cases of Torsades de Pointes and complete heart block have been reported in postmarketing surveillance. SQV/r **is not recommended** for adolescent and adult patients with any of the following conditions: documented congenital or acquired QT prolongation, pretreatment QT interval of >450 milliseconds, refractory hypokalemia or hypomagnesemia, complete atrioventricular block without implanted pacemakers, at risk of complete atrioventricular block, or the use of other drugs that prolong QT interval. An electrocardiogram (EKG) is recommended before initiation of therapy with saquinavir and repeat EKGs should be considered during therapy.

Steady-state saquinavir exposures observed in one pediatric trial (NV20911) were substantially higher than those seen in historical data from adults with QT and PR prolongation.^{1,12} Although no EKG abnormalities have been reported among the small number of subjects in pediatric trials, pediatric PK/pharmacodynamics modeling suggests that reducing the saquinavir dose in order to minimize the risk of QT prolongation would decrease saquinavir efficacy in children. Pediatric saquinavir dose recommendations that were both reliably effective and below the thresholds of concern for QT and PR prolongation were not determined.

Stavudine (d4T, Zerit)

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Formulations	
<p>Powder for Oral Solution: 1 mg/mL</p> <p>Capsules: 15 mg, 20 mg, 30 mg, and 40 mg</p> <p>Generic Formulations</p> <p>Powder for Oral Solution: 1 mg/mL</p> <p>Capsules: 15 mg, 20 mg, 30 mg, and 40 mg</p> <p>For additional information, see Drugs@FDA.</p>	
Dosing Recommendations	Selected Adverse Events
<p>Note: Stavudine is no longer recommended for use in children by the Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV, because it causes higher rates of adverse effects than other nucleoside reverse transcriptase inhibitors (NRTIs).</p> <p>Pediatric (Aged ≥14 Days and Weighing <30 kg) Dose</p> <ul style="list-style-type: none"> 1 mg/kg per dose twice daily <p>Adolescent (Weighing ≥30 kg) and Adult Dose</p> <ul style="list-style-type: none"> 30 mg per dose twice daily 	<ul style="list-style-type: none"> Associated with a higher risk of mitochondrial toxicity than other NRTI drugs Peripheral neuropathy is dose-related and occurs more frequently in patients who have advanced HIV disease or a prior history of peripheral neuropathy, and in patients receiving other drugs associated with neuropathy. Facial/peripheral lipoatrophy Pancreatitis Lactic acidosis/severe hepatomegaly with hepatic steatosis (higher incidence than with other NRTIs). The risk increases when stavudine is used in combination with didanosine. Dyslipidemia Insulin resistance, asymptomatic hyperglycemia Rapidly progressive ascending neuromuscular weakness (rare)
	Special Instructions
	<ul style="list-style-type: none"> Stavudine can be given without regard to food. Shake stavudine oral solution well before use. Keep refrigerated; the solution is stable for 30 days.
	Metabolism/Elimination
	<ul style="list-style-type: none"> Renal excretion 50%. Decrease dose in patients with renal dysfunction. Stavudine is phosphorylated intracellularly to the active metabolite stavudine triphosphate.

Drug Interactions

Additional information about drug interactions is available in the [Adult and Adolescent Guidelines](#) and the [HIV Drug Interaction Checker](#).

- *Renal elimination:* Drugs that decrease renal function could decrease stavudine clearance.
- *Other nucleoside reverse transcriptase inhibitors (NRTIs):* Stavudine **should not be administered** in combination with zidovudine because of virologic antagonism.
- *Overlapping toxicities:* The combination of stavudine and didanosine **is not recommended** because of overlapping toxicities. Reported toxicities occur more frequently in adults and include serious, even fatal, cases of lactic acidosis with hepatic steatosis with or without pancreatitis in pregnant women.
- *Ribavirin and interferon:* Hepatic decompensation (sometimes fatal) has occurred in patients with HIV/hepatitis C virus co-infection who are receiving antiretroviral therapy (ART), interferon, and ribavirin.
- *Doxorubicin:* Simultaneous use of doxorubicin and stavudine should be avoided. Doxorubicin may inhibit the phosphorylation of stavudine to its active form.

Major Toxicities

- *More common:* Headache, gastrointestinal disturbances, skin rashes, hyperlipidemia, fat maldistribution
- *Less common (more severe):* Peripheral sensory neuropathy is dose-related. It occurs more frequently in patients with advanced HIV disease, a prior history of peripheral neuropathy, and in patients receiving other drugs associated with neuropathy. Pancreatitis. Lactic acidosis and severe hepatomegaly with hepatic steatosis, including fatal cases, have been reported.¹⁻³ The combination of stavudine and didanosine may result in enhanced toxicity (increased risk of fatal and nonfatal cases of lactic acidosis, pancreatitis, peripheral neuropathy, and hepatotoxicity), particularly in adults, including pregnant persons—**this combination should not be used**. Risk factors found to be associated with lactic acidosis in adults include female sex, obesity, and prolonged nucleoside exposure.⁴
- *Rare:* Increased liver enzymes and hepatic toxicity, which may be severe or fatal. Neurologic symptoms, including rapidly progressive ascending neuromuscular weakness, are most often seen in the setting of lactic acidosis. Noncirrhotic portal hypertension with prolonged exposure.

Resistance

The International AIDS Society–USA maintains a [list of updated resistance mutations](#) and the [Stanford University HIV Drug Resistance Database](#) offers a discussion of each mutation.

Pediatric Use

Approval

Although stavudine is Food and Drug Administration (FDA)-approved for use in infants aged ≥ 14 days and children, it **is no longer recommended** for use by the Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV because it carries a higher risk of adverse effects associated with mitochondrial toxicity and a higher incidence of lipoatrophy than other NRTIs.

Efficacy

Data from multiple pediatric studies of stavudine administered alone or in combination with other antiretroviral (ARV) agents demonstrate that stavudine is associated with clinical and virologic response.⁵⁻¹¹ In resource-limited countries, stavudine is frequently a component of initial ART in children, given with lamivudine and nevirapine. Stavudine is often a component of fixed-dose combinations that are not available in the United States. In this setting, reported outcomes from observational studies are good; data show substantial increases in the CD4 T lymphocyte (CD4) cell count and complete viral suppression in 50% to 80% of treatment-naïve children.¹²⁻¹⁵ In such a setting, where pediatric patients are already predisposed to anemia because of malnutrition, parasitic infestations, or sickle cell anemia, stavudine carries a lower risk of hematologic toxicity than zidovudine, especially in patients receiving trimethoprim-sulfamethoxazole (TMP-SMX) prophylaxis.¹⁶ Short-term use of stavudine in certain settings where access to other ARVs may be limited remains an important strategy for treating HIV in children.^{17,18}

Toxicity

Stavudine is associated with a higher rate of adverse events than zidovudine in adults and children receiving ART.^{19,20} In a large pediatric natural history study (PACTG 219C), stavudine-containing regimens had a modest—but significantly higher—rate of clinical and laboratory toxicities than regimens containing zidovudine, with pancreatitis, peripheral neuropathy, and lipodystrophy/lipoatrophy (fat maldistribution) associated more often with stavudine use.²⁰

Lipodystrophy and Metabolic Abnormalities

Lipodystrophy syndrome (LS), and specifically lipoatrophy (loss of subcutaneous fat), are toxicities associated with NRTIs, particularly stavudine, in adults and children.²¹⁻²⁴ Stavudine use has consistently been associated with a higher risk of lipodystrophy and other metabolic abnormalities (e.g., insulin resistance) in multiple pediatric studies involving children.²⁵⁻³³ Improvements in (or resolution of) lipodystrophy were reported in 22.9% to 73% of cases after discontinuation of stavudine in two separate studies.^{30,34}

Lactic acidosis with hepatic steatosis, including fatal cases, has been reported with use of nucleoside analogues, including stavudine, alone or in combination with didanosine.¹⁻³

Mechanism

Many of the stavudine-related adverse events are believed to be due to mitochondrial toxicity resulting from inhibition of mitochondrial DNA polymerase gamma, with depletion of mitochondrial DNA in fat, muscle, peripheral blood mononuclear cells, and other tissues.^{1,35-37} In a recent analysis involving a large cohort of pediatric patients (PACTG protocols 219 and 219C), possible mitochondrial dysfunction was associated with NRTI use, especially in children receiving stavudine and/or lamivudine.³⁸

World Health Organization Recommendations

The World Health Organization (WHO) cautions against using doses of stavudine that exceed 30 mg twice daily. This is in contrast to the FDA-recommended dose of 40 mg twice daily in patients weighing 60 kg or more.^{39,40} Studies comparing the efficacy and toxicity of the two doses have consistently shown that both doses have similar efficacy. However, while the 30-mg dose shows lower toxicity than the 40-mg dose, the overall incidence of toxicity with the 30-mg dose is considered to be unacceptably high.⁴¹⁻⁴⁵ WHO recommends that stavudine be phased out of use in

all patients because of concerns about unacceptable toxicity, even at the lower dose. Safer alternative agents can be prescribed.

Pharmacokinetics

Current pediatric dosing recommendations are based on early pharmacokinetic (PK) studies designed to achieve exposure (area under the curve) in children similar to that found in adults receiving a dose with proven efficacy.⁴⁶ Although WHO has recommended using a reduced dose in adults, a similar dose reduction has not been suggested in children. A reduced pediatric dose has been proposed based on PK modeling, but clinical data on intracellular concentrations of the active stavudine triphosphate are lacking.^{47,48} Intracellular stavudine triphosphate concentrations have not been measured in neonates.

Formulations

The pediatric formulation for stavudine oral solution requires refrigeration and has limited stability once reconstituted. As an alternative dosing method for children, capsules can be opened and dispersed in a small amount of water, with the appropriate dose drawn up into an oral syringe and administered immediately. Because plasma exposure of stavudine is equivalent whether the drug is administered in an intact or a dispersed capsule, dosing with the dispersal method can be used as an alternative to the oral solution.⁴⁹

Tipranavir (TPV, Aptivus)

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Formulations	
<p>Oral Solution: 100 mg tipranavir/mL with 116 International Units (IU) vitamin E/mL</p> <p>Capsules: 250 mg</p> <p>For additional information, see Drugs@FDA.</p>	
Dosing Recommendations	Selected Adverse Events
<p>Note: Tipranavir must be boosted with ritonavir. The ritonavir boosting dose used for tipranavir is higher than the doses used for other protease inhibitors.</p> <p>Pediatric (Aged <2 Years) Dose</p> <ul style="list-style-type: none"> Not approved for use in children aged <2 years <p>Pediatric (Aged 2–18 Years) Dose</p> <p>Note: Not recommended for treatment-naïve patients</p> <p><i>Body Surface Area Dosing</i></p> <ul style="list-style-type: none"> Tipranavir/ritonavir (TPV/r) 375 mg/m²/150 mg/m², both twice daily (maximum dose is TPV/r 500 mg/200 mg, both twice daily) <p><i>Weight-Based Dosing</i></p> <ul style="list-style-type: none"> TPV/r 14 mg/kg/6 mg/kg, both twice daily (maximum dose is TPV/r 500 mg/200 mg, both twice daily) <p>Adult Dose</p> <ul style="list-style-type: none"> TPV/r 500 mg (as two 250-mg capsules)/200 mg, both twice daily <p>Note: Not recommended for treatment-naïve patients</p>	<ul style="list-style-type: none"> Rare cases of fatal and nonfatal intracranial hemorrhage Skin rash (more common in children than adults) Nausea, vomiting, diarrhea Hepatotoxicity: elevated transaminases; clinical hepatitis Hyperlipidemia Hyperglycemia Elevated creatine phosphokinase
	Special Instructions
	<ul style="list-style-type: none"> Administer tipranavir and ritonavir together and with food. Tipranavir oral solution contains 116 IU vitamin E per mL, which is significantly higher than the reference daily intake for vitamin E. Patients taking the oral solution should avoid taking any form of supplemental vitamin E that contains more vitamin E than found in a standard multivitamin. Tipranavir contains a sulfonamide moiety and should be used with caution in patients with sulfonamide allergy. Store tipranavir oral solution at room temperature, 25°C (77°F); do not refrigerate or freeze. Oral solution must be used within 60 days after the bottle is first opened. Store unopened bottles of oral tipranavir capsules in a refrigerator at 2°C to 8°C (36°F to 46°F). Once the bottle has been opened, capsules can be kept at room temperature (maximum of 77°F or 25°C) if used within 60 days.

	<ul style="list-style-type: none"> • Use tipranavir with caution in patients who may be at increased risk of intracranial hemorrhage, including individuals with brain lesion, head trauma, recent neurosurgery, coagulopathy, hypertension, or alcoholism, or who use anticoagulant or antiplatelet agents (including vitamin E). • Use of tipranavir is contraindicated in patients with moderate or severe hepatic impairment.
	<p style="text-align: center;">Metabolism/Elimination</p>
	<ul style="list-style-type: none"> • Cytochrome P450 3A4 (CYP3A4) inducer and substrate • P-glycoprotein substrate <p>Tipranavir Dosing in Patients With Renal Impairment</p> <ul style="list-style-type: none"> • No dose adjustment is required. <p>Tipranavir Dosing in Patients With Hepatic Impairment</p> <ul style="list-style-type: none"> • No dose adjustment is required for mild hepatic impairment. • Use of tipranavir is contraindicated in patients with moderate-to-severe hepatic impairment.

Drug Interactions

Additional information about drug interactions is available in the [Adult and Adolescent Guidelines](#) and the [HIV Drug Interaction Checker](#).

- Tipranavir has the potential for multiple drug interactions. Co-administration of tipranavir/ritonavir (TPV/r) with drugs that are highly dependent on cytochrome P (CYP) 3A for clearance or are potent CYP3A inducers is contraindicated.
- Before tipranavir is administered, a patient's medication profile should be carefully reviewed for potential drug interactions.
- TPV/r is a potent enzyme inducer and has the potential to decrease plasma concentrations of other antiretroviral drugs. TPV/r significantly decreases plasma concentrations of etravirine. Etravirine and TPV/r **should not be co-administered**.
- TPV/r has been shown to decrease raltegravir concentrations. TPV/r dose adjustment is **not currently recommended** when raltegravir is administered twice daily. However, TPV/r **should not be co-administered** with raltegravir HD once daily because significantly lower raltegravir concentrations are likely to occur.
- Tipranavir should be used with caution in patients who are receiving medications known to increase the risk of bleeding, such as antiplatelet agents, anticoagulants, or high doses of supplemental vitamin E.

Major Toxicities

- *More common:* Diarrhea, nausea, fatigue, headache, rash (which is more frequent in children than in adults), and vomiting. Elevated transaminases, cholesterol, and triglycerides. Elevated creatine phosphokinase.
- *Less common (more severe):* Lipodystrophy. Hepatotoxicity: clinical hepatitis and hepatic decompensation, including some fatalities. Patients with chronic hepatitis B or hepatitis C coinfection or elevations in transaminases are at increased risk of developing further transaminase elevations or hepatic decompensation (approximately 2.5-fold risk). Epistaxis, which is more common with oral solution than capsule formulation.
- *Rare:* New-onset diabetes mellitus, hyperglycemia, ketoacidosis, exacerbation of preexisting diabetes mellitus, spontaneous bleeding in hemophiliacs. Increased risk of intracranial hemorrhage. Tipranavir should be used with caution in patients who may be at risk of increased bleeding from trauma, surgery, or other medical conditions.

Resistance

The International AIDS Society–USA maintains a [list of updated resistance mutations](#) and the [Stanford University HIV Drug Resistance Database](#) offers a discussion of each mutation.

Pediatric Use

Approval and General Considerations

Tipranavir is approved for use in children aged as young as 2 years and is available in a liquid formulation.

Its indication is limited to those patients who are treatment-experienced and who have HIV strains that are resistant to more than one protease inhibitor (PI).¹ Tipranavir imposes a high pill burden on patients taking tipranavir capsules and requires a higher dose of boosting ritonavir than the doses used with other PIs. This increased dose of ritonavir is associated with a greater potential for drug interactions and increased toxicity. In addition, tipranavir is associated with serious adverse events (AEs) that limit its use to patients with few treatment options.

Efficacy

The Food and Drug Administration's approval of tipranavir was based on a multicenter, pediatric study of the safety, efficacy, and pharmacokinetics (PKs) of TPV/r in children with HIV (PACTG 1051/BI-1182.14).² This study enrolled 110 treatment-experienced children (with the exception of three treatment-naïve patients) aged 2 years to 18 years (with a median age of 11.7 years). Patients were randomized to receive two different dosing regimens. The higher dose of TPV/r (375 mg/150 mg/m² body surface area [BSA] twice daily) plus optimized background therapy was associated with better virologic responses at 48 weeks, particularly in the older, more heavily pretreated patients, when compared to the lower dose that was studied. A follow-up study of PACTG 1051 participants evaluated the long-term safety, efficacy, and tolerability of TPV/r in pediatric patients.³ At Week 288, most children were no longer receiving TPV/r. Reasons for discontinuation included AEs, virologic failure, and nonadherence. The youngest patients who were stable at Week 48 were more likely to still be on treatment after 5 years with continued efficacy.³

Pharmacokinetics

PK evaluation of the liquid formulation at steady state in children was assessed.⁴ In children aged 2 to <12 years, a dose of TPV/r 290 mg/115 mg/m² BSA achieved tipranavir trough concentrations that were consistent with those achieved in adults receiving standard TPV/r 500 mg/200 mg dosing. However, children aged 12 to 18 years required a higher dose (375 mg/150 mg/m² BSA, 30% higher than the directly scaled adult dose) to achieve drug exposure similar to that seen in adults receiving the standard TPV/r dose. Based on available data, a dose of TPV/r 375 mg/150 mg/m² BSA twice daily is recommended.

Toxicity

AEs were similar between treatment groups in the multicenter, pediatric study.² Twenty-five percent of children experienced a drug-related serious AE, and 9% of patients discontinued study drugs because of AEs. The most common AEs were gastrointestinal disturbances: 37% of participants had vomiting and 24% had diarrhea. The most common Grade 3 through 4 laboratory abnormalities were increases in the levels of creatine phosphokinase (11% of participants), alanine aminotransferase (6.5% of participants), and amylase (7.5% of participants). In the long-term follow-up report for PACTG 1051, incidence of AEs defined as drug-related was 55% to 65% regardless of age at entry, with higher discontinuation rates due to AEs in the older age groups.³

Vitamin E is an excipient in the tipranavir oral solution, with a concentration of 116 international units (IU) of vitamin E and 100 mg tipranavir per mL of solution. The recommended dose of tipranavir (14 mg/kg body weight) results in a vitamin E dose of 16 IU/kg body weight per day, significantly higher than the reference daily intake for vitamin E (which is 30 IU for adults and approximately 6–22 IU for children and adolescents, depending on age of the child or adolescent) and close to the upper limit of tolerability for children. In PACTG 1051, bleeding events were reported more commonly in children receiving tipranavir oral capsules (14.3%) than in children taking tipranavir oral solution (5.75%).² Overall, the incidence of bleeding episodes (primarily epistaxis) in pediatric patients observed in clinical trials was 7.5%.⁵