

New Zealand Data Sheet

1. PRODUCT NAME

TRIUMEQ dolutegravir 50 mg, abacavir 600 mg and lamivudine 300 mg film-coated tablets

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

TRIUMEQ is supplied as film-coated tablets each containing 50 mg of dolutegravir (as dolutegravir sodium), 600 mg of abacavir (as abacavir sulfate) and 300 mg of lamivudine.

Each film-coated tablet contains 50 mg of dolutegravir (as dolutegravir sodium), 600 mg of abacavir (as abacavir sulphate) and 300 mg of lamivudine.

For the full list of excipients, see section 6.1 List of excipients.

Data Sheets for TIVICAY(dolutegravir), ZIAGEN (abacavir), 3TC (lamivudine) and KIVEXA (abacavir and lamivudine) contain additional information.

3. PHARMACEUTICAL FORM

Film-coated tablet.

Purple, film-coated, oval, biconvex tablets, debossed with '572 Tri' on one side.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

TRIUMEQ is indicated for the treatment of Human Immunodeficiency Virus (HIV) infection in adults and adolescents from 12 years of age who are antiretroviral treatment-naïve or are infected with HIV without documented or clinically suspected resistance to any of the three antiretroviral agents (dolutegravir, abacavir or lamivudine) in TRIUMEQ.

4.2 Dose and method of administration

Dose

Therapy should be initiated by a physician experienced in the management of HIV infection.

The recommended dose of TRIUMEQ in adults and adolescents weighing at least 40 kg is one tablet once daily, taken with or without food.

Because TRIUMEQ is a fixed dose tablet, it should not be prescribed for patients requiring dose adjustment:

- Adults or adolescents weighing <40 kg
- Children <12 years of age
- Patients with creatinine clearance <30 mL/min
- Patients with mild hepatic impairment
- Patients resistant to integrase inhibitors

Special populations

Elderly

There are limited data available on the use of dolutegravir, abacavir and lamivudine in patients aged 65 years and over. However, there is no evidence that elderly patients require a different dose than younger adult patients (see section 5.2 Pharmacokinetic properties). When treating elderly patients, consideration needs to be given to the greater frequency of decreased hepatic, renal and cardiac function, concomitant medicinal products or disease.

Renal impairment

Whilst no dosage adjustment of dolutegravir or abacavir is necessary in patients with renal impairment, a dose reduction of lamivudine is required due to decreased clearance. Therefore TRIUMEQ is not recommended for use in patients with a creatinine clearance less than 30 mL/min (see section 5.2 Pharmacokinetic properties).

Hepatic impairment

A dose reduction of abacavir may be required for patients with mild hepatic impairment (Child-Pugh grade A). As dose reduction is not possible with TRIUMEQ, the separate preparations of dolutegravir, abacavir or lamivudine should be used when this is judged necessary. TRIUMEQ is not recommended in patients with moderate and severe hepatic impairment (Child-Pugh grade B or C) (see section 5.2 Pharmacokinetic properties).

Separate preparations of dolutegravir, abacavir or lamivudine should be administered in cases where discontinuation or dose adjustment is indicated. In these cases the physician should refer to the individual Data Sheets for these medicinal products. A separate preparation of dolutegravir (TIVICAY) is available where a dose adjustment is required due to drug-drug interactions (see section 4.5 Interactions with other medicines and other forms of interaction).

Paediatric population

Based on indications for use for TIVICAY [dolutegravir] and KIVEXA [abacavir/lamivudine], TRIUMEQ is indicated for use in adolescents aged 12 years and above (see Data Sheets for TIVICAY [dolutegravir] and KIVEXA [abacavir/lamivudine]).

TRIUMEQ is not recommended for treatment of children less than 12 years of age as the necessary dose adjustment cannot be made. Clinical data is currently not available for this combination. Physicians should refer to the individual Data Sheets for TIVICAY [dolutegravir], ZIAGEN [abacavir] and 3TC [lamivudine].

4.3 Contraindications

TRIUMEQ is contraindicated in patients with known hypersensitivity to dolutegravir, abacavir or lamivudine, or to any of the excipients (see section 6.1 List of excipients).

TRIUMEQ must not be administered concurrently with medicinal products with narrow therapeutic windows, that are substrates of organic cation transporter 2 (OCT2), including but not limited to dofetilide, pilsicainide or fampridine (see section 4.5 Interactions with other medicines and other forms of interaction).

4.4 Special warnings and precautions for use

The special warnings and precautions relevant to dolutegravir, abacavir and lamivudine are included in this section. There are no additional precautions and warnings relevant to TRIUMEQ.

Hypersensitivity reactions (see section 4.8 Undesirable effects):

Both abacavir and dolutegravir are associated with a risk for hypersensitivity reactions (HSR) (see Clinical description of HSR below, and section 4.8 Undesirable effects), and share some common features such as fever and/or rash with other symptoms indicating multi-organ involvement. Clinically it is not possible to determine whether a HSR with TRIUMEQ is caused by abacavir or dolutegravir. Hypersensitivity reactions have been observed more commonly with abacavir, some of which have been life-threatening, and in rare cases fatal. The risk for abacavir HSR to occur is significantly increased for patients who test positive for the HLA-B*5701 allele. However, abacavir HSRs have been reported in patients who do not carry this allele.

The following should be adhered to:

- Testing for HLA-B*5701 status should be considered before initiating abacavir treatment and also before re-starting abacavir treatment in patients of unknown HLA-B*5701 status who have previously tolerated abacavir.
- TRIUMEQ is not recommended for use in patients with the HLA-B*5701 allele, or in patients who have had a suspected abacavir HSR while taking any other medicinal product containing abacavir (e.g. ZIAGEN, KIVEXA) regardless of HLA-B*5701 status.
- Each patient should be reminded of the importance of removing the Alert Card included in the carton, and keeping it with them at all times. They should be reminded to read the Consumer Medicine Information.
- In any patient treated with TRIUMEQ, the clinical diagnosis of suspected hypersensitivity reaction must remain the basis of clinical decision making.
- **TRIUMEQ must be stopped without delay, even in the absence of the HLA-B*5701 allele, if a HSR is suspected. Delay in stopping treatment with TRIUMEQ after the onset of hypersensitivity may result in a life-threatening reaction. Clinical status including liver aminotransferases and bilirubin should be monitored.**
- Patients who have experienced a hypersensitivity reaction should be instructed to dispose of their remaining TRIUMEQ tablets, in order to avoid restarting abacavir.
- **After stopping treatment with TRIUMEQ for reasons of a suspected HSR, TRIUMEQ or any other medicinal product containing abacavir or dolutegravir must never be re-initiated.**
- **Restarting abacavir containing products following a suspected abacavir HSR can result in a prompt return of symptoms within hours and may include life-threatening hypotension and death.**
- If a hypersensitivity reaction is ruled out, patients may restart TRIUMEQ. Rarely, patients who have stopped abacavir for reasons other than symptoms of HSR have also experienced life-threatening reactions within hours of re-initiating abacavir therapy (see Undesirable effects, Description of selected adverse reactions). Patients must be made aware that HSR can occur with reintroduction of TRIUMEQ or any other medicinal product containing abacavir (e.g. ZIAGEN, KIVEXA) and that reintroduction of TRIUMEQ or any other medicinal product containing abacavir (e.g. ZIAGEN, KIVEXA) should be undertaken only if medical care can be readily accessed.
- *Clinical description of HSR with dolutegravir:*

Hypersensitivity reactions have been reported with integrase inhibitors, including dolutegravir, and were characterised by rash, constitutional findings, and sometimes, organ dysfunction, including liver injury.

- *Clinical description of HSR with abacavir:*

Abacavir HSR has been well characterised through clinical studies and during post marketing follow-up. Symptoms usually appeared within the first six weeks (median time to onset 11 days) of initiation of treatment with abacavir, **although these reactions may occur at any time during therapy.**

Almost all HSR to abacavir include fever and/or rash as part of the syndrome.

Other signs and symptoms that have been observed as part of abacavir HSR include respiratory and gastrointestinal symptoms, **which may lead to misdiagnosis of HSR as respiratory disease (pneumonia, bronchitis, pharyngitis), or gastroenteritis** (see Undesirable effects). The symptoms related to HSR worsen with continued therapy and can be life-threatening. These symptoms usually resolve upon discontinuation of abacavir.

Lactic Acidosis/Severe Hepatomegaly with Steatosis

Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of antiretroviral nucleoside analogues either alone or in combination, including abacavir and lamivudine. A majority of these cases have been in women.

Clinical features which may be indicative of the development of lactic acidosis include generalised weakness, anorexia, and sudden unexplained weight loss, gastrointestinal symptoms and respiratory symptoms (dyspnoea and tachypnoea).

Caution should be exercised when administering TRIUMEQ particularly to those with known risk factors for liver disease. Treatment with TRIUMEQ should be suspended in any patient who develops clinical or laboratory findings suggestive of lactic acidosis with or without hepatitis (which may include hepatomegaly and steatosis even in the absence of marked transaminase elevations).

Serum lipids and blood glucose

Serum lipid and blood glucose levels may increase during antiretroviral therapy. Disease control and life style changes may also be contributing factors. Consideration should be given to the measurement of serum lipids and blood glucose. Lipid disorders should be managed as clinically appropriate.

Immune Reconstitution Syndrome

In HIV-infected patients with severe immune deficiency at the time of initiation of anti-retroviral therapy (ART), an inflammatory reaction to asymptomatic or residual opportunistic infections may arise and cause serious clinical conditions, or aggravation of symptoms. Typically, such reactions have been observed within the first few weeks or months of initiation of ART. Relevant examples are cytomegalovirus retinitis, generalised and/or focal mycobacterial infections and *Pneumocystis jiroveci* pneumonia (often referred to as PCP). Any inflammatory symptoms must be evaluated without delay and treatment initiated when necessary. Autoimmune disorders (such as Graves' disease, polymyositis and Guillain-Barre syndrome) have also been reported to occur in the setting of immune reconstitution, however, the time to onset is more variable, and can occur many months after initiation of treatment and sometimes can be an atypical presentation.

Liver chemistry elevations consistent with immune reconstitution syndrome were observed in some hepatitis B and/or C co-infected patients at the start of dolutegravir therapy. Monitoring of liver chemistries is recommended in patients with hepatitis B and/or C co-

infection (see Patients co-infected with hepatitis B virus (HBV) later in this section and section 4.8 Undesirable effects).

Patients co-infected with Hepatitis B Virus (HBV)

Particular diligence should be applied in initiating or maintaining effective hepatitis B therapy when starting therapy with TRIUMEQ in hepatitis B co-infected patients.

Clinical study and marketed use of lamivudine, have shown that some patients with chronic HBV disease may experience clinical or laboratory evidence of recurrent hepatitis upon discontinuation of lamivudine, which may have more severe consequences in patients with decompensated liver disease. If TRIUMEQ is discontinued in patients co-infected with HBV, periodic monitoring of both liver function tests and markers of HBV replication should be considered.

Opportunistic infections

Patients receiving TRIUMEQ or any other antiretroviral therapy may still develop opportunistic infections and other complications of HIV infection. Therefore patients should remain under close clinical observation by physicians experienced in the treatment of these associated HIV diseases.

Transmission of infection

While effective viral suppression with antiretroviral therapy has been proven to substantially reduce the risk of sexual transmission, a residual risk cannot be excluded. Precautions to prevent transmission should be taken in accordance with national guidelines.

Myocardial infarction

Several observational, epidemiological studies have reported an association with abacavir use and risk of myocardial infarction. Meta-analyses of randomised controlled trials have observed no excess risk of myocardial infarction with abacavir use. To date, there is no established biological mechanism to explain a potential increase in risk. In totality the available data from observational studies and from controlled clinical trials show inconsistency and therefore the evidence for a causal relationship between abacavir treatment and the risk of myocardial infarction is inconclusive.

As a precaution the underlying risk of coronary heart disease should be considered when prescribing antiretroviral therapies, including abacavir, and action taken to minimise all modifiable risk factors (e.g. hypertension, hyperlipidaemia, diabetes mellitus and smoking).

Patients with resistance to the integrase class (documented or clinically suspected)

TRIUMEQ alone is not recommended in patients with resistance associated with integrase substitutions or clinically suspected integrase strand transfer inhibitor resistance because the dose of dolutegravir in TRIUMEQ is insufficient in these populations [See TIVICAY [dolutegravir] Data Sheet, Dosage and Administration].

Paediatric use

TRIUMEQ is not recommended for treatment of children less than 12 years of age as the necessary dose adjustment cannot be made. Clinical data is currently not available for this combination. Physicians should refer to the individual Data Sheets for TIVICAY [dolutegravir], ZIAGEN [abacavir] and 3TC [lamivudine].

Use in the elderly

There are limited data available on the use of dolutegravir, abacavir and lamivudine in patients aged 65 years and over. However, there is no evidence that elderly patients require a different dose than younger adult patients (see section 5.2 Pharmacokinetic properties). When treating elderly patients, consideration needs to be given to the greater frequency of decreased hepatic, renal and cardiac function, concomitant medicinal products or disease.

4.5 Interactions with other medicines and other forms of interaction

Caution should be given to co-administering medications (prescription and non-prescription) that may change the exposure of dolutegravir, abacavir, lamivudine or medications that may have their exposure changed by TRIUMEQ.

Dolutegravir should not be co-administered with polyvalent cation-containing antacids. Dolutegravir is recommended to be administered 2 hours before or 6 hours after these agents.

TRIUMEQ is recommended to be administered 2 hours before or 6 hours after taking calcium or iron supplements, or alternatively, administered with food.

Dolutegravir increase metformin concentrations . A dose adjustment of metformin should be considered when starting and stopping coadministration of dolutegravir with metformin, to maintain glycaemic control.

TRIUMEQ should not be administered concurrently with other medicinal products containing any of the same active components (dolutegravir, abacavir, and/or lamivudine).

The recommended dose of dolutegravir is 50 mg twice daily when co-administered with etravirine (without boosted protease inhibitors), efavirenz, nevirapine, rifampicin, tipranavir/ritonavir, carbamazepine, phenytoin, phenobarbital and St. John's wort.

As TRIUMEQ contains dolutegravir, abacavir and lamivudine, any interactions that have been identified with these agents individually may occur with TRIUMEQ. Due to the different routes of metabolism and elimination, no clinically significant drug interactions are expected between dolutegravir, abacavir and lamivudine. In a cross study comparison, abacavir and lamivudine exposures were similar when given as TRIUMEQ compared to ABC/3TC alone.

Effect of other agents on the pharmacokinetics of TRIUMEQ

Dolutegravir is eliminated mainly through metabolism by UGT1A1. Dolutegravir is also a substrate of UGT1A3, UGT1A9, CYP3A4, Pgp, and BCRP; therefore drugs that induce these enzymes or transporters may theoretically decrease dolutegravir plasma concentration and reduce the therapeutic effect of dolutegravir. Co-administration of dolutegravir and other drugs that inhibit UGT1A1, UGT1A3, UGT1A9, CYP3A4, and/or PGP may increase dolutegravir plasma concentration (see Table 1).

In vitro, dolutegravir is not a substrate of human organic anion transporting polypeptide (OATP)1B1, OATP1B3, or OCT1, therefore drugs that solely modulate these transporter are not expected to affect dolutegravir plasma concentration.

Efavirenz, etravirine, nevirapine, rifampicin, carbamazepine and tipranavir in combination with ritonavir each reduced the plasma concentrations of dolutegravir significantly, and require dolutegravir dose adjustment to 50 mg twice daily. The effect of etravirine was mitigated by co-administration of the CYP3A4 inhibitors lopinavir/ritonavir, darunavir/ritonavir, and is expected to be mitigated by atazanavir/ritonavir. Therefore no dolutegravir dose adjustment is necessary when co-administered with etravirine and either lopinavir/ritonavir, darunavir/ritonavir, or atazanavir/ritonavir. Another inducer, fosamprenavir in combination with ritonavir decreased plasma concentrations of dolutegravir but does not require a dosage adjustment of dolutegravir. A drug interaction study with the UGT1A1 inhibitor, atazanavir, did not result in a clinically meaningful increase in the plasma concentrations of dolutegravir. Tenofovir, lopinavir/ritonavir, darunavir/ritonavir, rilpivirine, boceprevir, telaprevir, prednisone, rifabutin, daclatasvir and omeprazole had no or a minimal effect on dolutegravir pharmacokinetics, therefore no dolutegravir dose adjustment is required when co-administered with these drugs.

The likelihood of metabolic interactions with abacavir and lamivudine is low. Abacavir and lamivudine are not significantly metabolised by CYP enzymes. The primary pathways of abacavir metabolism in humans are by alcohol dehydrogenase and by glucuronidation to

produce the 5'-carboxylic acid and 5'-glucuronide which account for about 66% of the administered dose. These metabolites are excreted in the urine.

The likelihood of metabolic interactions with lamivudine is low due to limited metabolism and plasma protein binding, and almost complete renal clearance. *In vitro*, abacavir is not a substrate of OATP1B1, OATP1B3, OCT1, OCT2, OAT1, MATE1, MATE2-K, MRP2 or MRP4 therefore drugs that modulate these transporters are not expected to affect abacavir plasma concentrations.

Although abacavir and lamivudine are substrates of BCRP and Pgp *in vitro*, clinical studies demonstrate no clinically significant changes in abacavir pharmacokinetics when co-administered with lopinavir/ritonavir (Pgp and BCRP inhibitors) and inhibitors of these efflux transporters are unlikely to affect the disposition of lamivudine due to its high bioavailability. Lamivudine is an *in vitro* substrate of MATE1, MATE2-K and OCT2. Trimethoprim (an inhibitor of these drug transporters) has been shown to increase lamivudine plasma concentrations however; the resulting increase was of such magnitude that a dose adjustment is not recommended as it is not expected to have clinical significance. Lamivudine is a substrate of the hepatic uptake transporter OCT1. As hepatic elimination plays a minor role in the clearance of lamivudine, drug interactions due to inhibition of OCT1 are unlikely to be of clinical significance.

Selected drug interactions are presented in Tables 1, 2 and 3. Recommendations are based on either drug interaction studies or predicted interactions due to the expected magnitude of interaction and potential for serious adverse events or loss of efficacy

Effect of TRIUMEQ on the pharmacokinetics of other agents

In vitro, dolutegravir inhibited the basolateral renal transporters: organic anion transporter (OAT) 1 (IC₅₀ = 2.12 micromolar) and OAT3 (IC₅₀ = 1.97 micromolar). However, dolutegravir had no notable effect on the pharmacokinetics *in vivo* of the OAT substrates tenofovir and para aminohippurate, and therefore has low propensity to cause drug interactions via inhibition of OAT transporters.

In vitro, dolutegravir inhibited the renal organic cation transporter 2 (OCT2) (IC₅₀ = 1.93 micromolar), multidrug and toxin extrusion transporter (MATE) 1 (IC₅₀ = 6.34 micromolar) and MATE2-K (IC₅₀ = 24.8 micromolar). *In vivo*, dolutegravir may increase plasma concentrations of drugs in which excretion is dependent upon OCT2 or MATE1 (for example dofetilide, pilsicainide, fampridine or metformin) (see Table 1). Given dolutegravir's *in vivo* exposure, it has a low potential to affect the transport of MATE2-K substrates *in vivo*.

In vitro, dolutegravir demonstrated no direct, or weak inhibition (IC₅₀>50 µM) of the enzymes cytochrome P450 (CYP)1A2, CYP2A6, CYP2B6, CYP2C8, CYP2C9, CYP2C19, CYP2D6, CYP3A, uridine diphosphate glucuronosyl transferase (UGT)1A1 or UGT2B7, or the transporters P-glycoprotein (Pgp), breast cancer resistance protein (BCRP), bile salt export pump (BSEP), organic anion transporting polypeptide 1B1 (OATP1B1), OATP1B3, organic cation transporter 1 (OCT1), multidrug resistance-associated protein 2 (MRP2), or MRP4. *In vitro*, dolutegravir did not induce CYP1A2, CYP2B6 or CYP3A4. Based on these data, dolutegravir is not expected to affect the pharmacokinetics of drugs that are substrates of these enzymes or transporters.

In drug interaction studies, dolutegravir did not have a clinically relevant effect on the pharmacokinetics of the following: tenofovir, ritonavir, methadone, efavirenz, lopinavir, atazanvir, darunavir, etravirine, fosamprenavir, rilpivirine, boceprevir, telaprevir, daclatasvir and oral contraceptives containing norgestimate and ethinyl estradiol.

In vitro studies have shown that abacavir has potential to inhibit CYP1A1 and limited potential to inhibit metabolism mediated by CYP3A4. Lamivudine does not inhibit or induce CYP3A4. Abacavir and lamivudine are not significantly metabolised by cytochrome P450 enzymes (such as CYP 2C9 or CYP 2D6) nor do they inhibit or induce this enzyme system.

Therefore, there is little potential for interactions with other medicinal products metabolised by major P450 enzymes.

Abacavir and lamivudine demonstrate no or weak inhibition of the OATP1B3, BCRP and Pgp or MATE2-K. In addition, lamivudine demonstrates no or weak inhibition of the drug transporters MATE1 or OCT3 and abacavir demonstrates minimal inhibition of OCT1 and OCT2. Abacavir and lamivudine are therefore not expected to affect the plasma concentrations of drugs that are substrates of these enzymes or transporters.

Although abacavir is an inhibitor of MATE1 and lamivudine is an inhibitor of OCT1 and OCT2 in vitro, they have low potential to affect the plasma concentrations of substrates of these transporters at therapeutic drug exposures (up to 600 mg for abacavir or 300 mg for lamivudine).

Table 1. Drug Interactions studied with dolutegravir

Concomitant drug class: drug name	Effect on concentration of dolutegravir or concomitant drug	Clinical comment
HIV-1 Antiviral Agents		
Non-nucleoside Reverse Transcriptase Inhibitor: Etravirine (ETR) without boosted protease inhibitors	Dolutegravir ↓ AUC ↓ 71% C _{max} ↓ 52% C _τ ↓ 88% ETR ↔	Etravirine without boosted protease inhibitors decreased plasma dolutegravir concentration. The recommended dose of dolutegravir is 50 mg twice daily for patients taking etravirine without boosted protease inhibitors. As TRIUMEQ is a fixed-dose tablet, an additional dose of 50 mg dolutegravir (TIVICAY) should be administered, approximately 12 hours after TRIUMEQ. In this case the physician should refer to the individual Data Sheet for TIVICAY.
Protease inhibitor: lopinavir/ritonavir + etravirine (LPV/RTV+ETR)	Dolutegravir ↔ AUC ↑ 11% C _{max} ↑ 7% C _τ ↑ 28% LPV ↔ RTV ↔	Lopinavir/ritonavir and etravirine did not change dolutegravir plasma concentration to a clinically relevant extent. No dose adjustment is necessary.
Protease inhibitor: darunavir/ritonavir + etravirine (DRV/RTV+ETR)	Dolutegravir ↓ AUC ↓ 25% C _{max} ↓ 12% C _τ ↓ 36% DRV ↔ RTV ↔	Darunavir/ritonavir and etravirine did not change dolutegravir plasma concentration to a clinically relevant extent. No dose adjustment is necessary.
Non-nucleoside reverse transcriptase inhibitor: efavirenz (EFV)	Dolutegravir ↓ AUC ↓ 57% C _{max} ↓ 39% C _τ ↓ 75% EFV ↔	Efavirenz decreased dolutegravir plasma concentrations. The recommended dose of dolutegravir is 50 mg twice daily when co-administered with efavirenz. As TRIUMEQ is a fixed-dose tablet, an additional dose of 50 mg dolutegravir (TIVICAY) should be administered, approximately 12 hours after TRIUMEQ. In this case the physician should refer to the individual Data Sheet for TIVICAY.

Concomitant drug class: drug name	Effect on concentration of dolutegravir or concomitant drug	Clinical comment
Non-nucleoside reverse transcriptase inhibitor: nevirapine	Dolutegravir ↓	Co-administration with nevirapine has the potential to decrease dolutegravir plasma concentration due to enzyme induction and has not been studied. Effect of nevirapine on dolutegravir exposure is likely similar to or less than that of efavirenz. The recommended dose of dolutegravir is 50 mg twice daily when co-administered with nevirapine. As TRIUMEQ is a fixed-dose tablet, an additional dose of 50 mg dolutegravir (TIVICAY) should be administered, approximately 12 hours after TRIUMEQ. In this case the physician should refer to the individual Data Sheet for TIVICAY.
Protease inhibitor: atazanavir (ATV)	Dolutegravir ↑ AUC ↑ 91% C _{max} ↑ 50% C _τ ↑ 180% ATV ↔	Atazanavir increased dolutegravir plasma concentration. No dose adjustment is necessary.
Protease inhibitor: atazanavir/ritonavir (ATV+RTV)	Dolutegravir ↑ AUC ↑ 62% C _{max} ↑ 34% C _τ ↑ 121% ATV ↔ RTV ↔	Atazanavir/ritonavir increased dolutegravir plasma concentration. No dose adjustment is necessary.
Protease inhibitor: tipranavir/ritonavir (TPV+RTV)	Dolutegravir ↓ AUC ↓ 59% C _{max} ↓ 47% C _τ ↓ 76% TPV ↔ RTV ↔	Tipranavir/ritonavir decreases dolutegravir concentrations. The recommended dose of dolutegravir is 50 mg twice daily when co-administered with tipranavir/ritonavir. As TRIUMEQ is a fixed-dose tablet, an additional dose of 50 mg dolutegravir (TIVICAY) should be administered, approximately 12 hours after TRIUMEQ. In this case the physician should refer to the individual Data Sheet for TIVICAY.
Protease inhibitor: fosamprenavir/ritonavir (FPV+RTV)	Dolutegravir ↓ AUC ↓ 35% C _{max} ↓ 24% C _τ ↓ 49% FPV ↔ RTV ↔	Fosamprenavir/ritonavir decreases dolutegravir concentrations, but based on limited data, did not result in decreased efficacy in Phase III studies. No dose adjustment is necessary in INI-naïve patients.
Protease inhibitor: nelfinavir	Dolutegravir ↔	This interaction has not been studied. Although an inhibitor of CYP3A4, based on data from other inhibitors, an increase is not expected. No dose adjustment is necessary.
Protease inhibitor: lopinavir/ritonavir (LPV+RTV)	DTG ↔ AUC ↓ 4%	Lopinavir/ritonavir did not change dolutegravir plasma concentration to a clinically relevant extent. No dose adjustment is necessary.

Concomitant drug class: drug name	Effect on concentration of dolutegravir or concomitant drug	Clinical comment
	$C_{max} \leftrightarrow$ $C_{\tau} \downarrow 6\%$ LPV \leftrightarrow RTV \leftrightarrow	
Protease inhibitor: darunavir/ritonavir (DRV+RTV)	Dolutegravir \downarrow AUC $\downarrow 22\%$ $C_{max} \downarrow 11\%$ $C_{\tau} \downarrow 38\%$	Darunavir/ritonavir did not change dolutegravir plasma concentration to a clinically relevant extent. No dose adjustment is necessary.
Nucleoside reverse transcriptase inhibitor: tenofovir (TDF)	Dolutegravir \leftrightarrow AUC \leftrightarrow $C_{max} \downarrow 3\%$ $C_{\tau} \downarrow 8\%$ Tenofovir \leftrightarrow AUC $\uparrow 12\%$ $C_{max} \uparrow 9\%$ $C_{\tau} \uparrow 19\%$	Tenofovir did not change dolutegravir plasma concentration to a clinically relevant extent. No dose adjustment is necessary.
Other agents		
Dofetilide pilsicainide	Dofetilide \uparrow Pilsicainide \uparrow	Co-administration of dolutegravir has the potential to increase dofetilide or pilsicainide plasma concentration via inhibition of OCT2 transporter; co-administration has not been studied. Dofetilide or pilsicainide co-administration with dolutegravir is contraindicated due to potential life-threatening toxicity caused by high dofetilide or pilsicainide concentration.
Fampridine	Fampridine \uparrow	Co-administration of dolutegravir has the potential to cause seizures due to increased fampridine plasma concentration via inhibition of OCT2 transporter; coadministration has not been studied. Fampridine co-administration with dolutegravir is contraindicated.
Carbamazepine	Dolutegravir \downarrow AUC $\downarrow 49\%$ $C_{max} \downarrow 33\%$ $C_{\tau} \downarrow 73\%$	Carbamazepine decreased dolutegravir plasma concentration. The recommended dose of dolutegravir is 50 mg twice daily when co-administered with carbamazepine. As TRIUMEQ is a fixed-dose tablet, an additional dose of 50 mg dolutegravir (TIVICAY) should be administered, approximately 12 hours after TRIUMEQ. In this case the physician should refer to the individual Data Sheet for TIVICAY.
Phenytoin phenobarbital St. John's wort	Dolutegravir \downarrow	Co-administration with these metabolic inducers has the potential to decrease dolutegravir plasma concentration due to enzyme induction and has not been studied. The effect of these metabolic inducers on

Concomitant drug class: drug name	Effect on concentration of dolutegravir or concomitant drug	Clinical comment
		dolutegravir exposure is likely similar to carbamazepine. The recommended dose of dolutegravir is 50 mg twice daily when co-administered with these metabolic inducers. As TRIUMEQ is a fixed-dose tablet, an additional dose of 50 mg dolutegravir (TIVICAY) should be administered, approximately 12 hours after TRIUMEQ. In this case the physician should refer to the individual Data Sheet for TIVICAY.
Oxcarbazepine	Dolutegravir ↓	This interaction has not been studied. Although an inducer of CYP3A4, based on data from other inducers, a clinically significant decrease in dolutegravir is not expected. No dose adjustment is necessary.
Antacids containing polyvalent cations (e.g., Mg, Al)	Dolutegravir ↓ AUC ↓ 74% C _{max} ↓ 72% C ₂₄ ↓ 74%	Co-administration of antacids containing polyvalent cations decreased dolutegravir plasma concentration. Dolutegravir is recommended to be administered 2 hours before or 6 hours after taking antacid products containing polyvalent cations.
Calcium supplements	Dolutegravir ↓ AUC ↓ 39% C _{max} ↓ 37% C ₂₄ ↓ 39%	TRIUMEQ is recommended to be administered 2 hours before or 6 hours after taking products containing calcium, or alternatively, administer with food.
Iron supplements	Dolutegravir ↓ AUC ↓ 54% C _{max} ↓ 57% C ₂₄ ↓ 56%	TRIUMEQ is recommended to be administered 2 hours before or 6 hours after taking products containing iron, or alternatively, administer with food.
Metformin	Metformin ↑ When co-administered with dolutegravir 50mg QD: Metformin AUC ↑ 79% C _{max} ↑ 66% When co-administered with dolutegravir 50mg BID: Metformin AUC ↑ 145 % C _{max} ↑ 111%	Co-administration of dolutegravir increased metformin plasma concentration. A dose adjustment of metformin should be considered when starting and stopping coadministration of dolutegravir with metformin, to maintain glycaemic control.
Rifampicin	Dolutegravir ↓ AUC ↓ 54% C _{max} ↓ 43% C _τ ↓ 72%	Rifampicin decreased dolutegravir plasma concentration. The recommended dose of dolutegravir is 50 mg twice daily when co-administered with rifampicin. As TRIUMEQ is a fixed-dose tablet, an additional dose of 50 mg dolutegravir (TIVICAY) should be administered, approximately 12 hours after TRIUMEQ. In this case the physician should refer to the individual Data Sheet for TIVICAY.

Concomitant drug class: drug name	Effect on concentration of dolutegravir or concomitant drug	Clinical comment
Oral contraceptives (Ethinyl estradiol (EE) and Norelgestromin (NGMN))	Effect of dolutegravir: EE ↔ AUC ↑ 3% C _{max} ↓ 1% C _τ ↑ 2% Effect of dolutegravir: NGMN ↔ AUC ↓ 2% C _{max} ↓ 11% C _τ ↓ 7%	Dolutegravir did not change ethinyl estradiol and norelgestromin plasma concentrations to a clinically relevant extent. No dose adjustment of oral contraceptives is necessary when co-administered with dolutegravir.
Methadone	Effect of dolutegravir: Methadone ↔ AUC ↓ 2% C _{max} ↔ 0% C _τ ↓ 1%	Dolutegravir did not change methadone plasma concentrations to a clinically relevant extent. No dose adjustment of methadone is necessary when co-administered with dolutegravir.
Daclatasvir	Dolutegravir ↔ AUC ↑ 33% C _{max} ↑ 29% C _τ ↑ 45% Daclatasvir ↔	Daclatasvir did not change dolutegravir plasma concentration to a clinically relevant extent. Dolutegravir did not change daclatasvir plasma concentration. No dose adjustment is necessary.

Abbreviations: ↑ = increase; ↓ = decrease; ↔ = no significant change; AUC = area under the concentration versus time curve; C_{max} = maximum observed concentration, C_τ=concentration at the end of dosing interval

Table 2. Drug interactions studied with abacavir

Concomitant drug class: drug name	Effect on concentration of abacavir or concomitant drug	Clinical comment
Riociguat	Riociguat ↑	In vitro, abacavir inhibits CYP1A1. Concomitant administration of a single dose of riociguat (0.5 mg) to HIV patients receiving TRIUMEQ led to an approximately three-fold higher riociguat AUC _(0-∞) when compared to historical riociguat AUC _(0-∞) reported in healthy subjects. Riociguat dose may need to be reduced, consult the riociguat product labelling for dosing recommendations.
Methadone (40 to 90 mg once daily for 14 days/600 mg single dose, then 600 mg twice daily for 14 days)	Abacavir AUC ↔ C _{max} ↓35% Methadone CL/F ↑22%	The changes in abacavir pharmacokinetics are not considered clinically relevant. The changes in methadone pharmacokinetics are not considered clinically relevant for the majority of patients, however occasionally methadone dose re-titration may be required.
Ethanol	Abacavir AUC ↑41% Ethanol AUC ↔	Given the safety profile of abacavir, these findings are not considered clinically significant.

Abbreviations: ↑ = Increase; ↓ = decrease; ↔ = no significant change; AUC = area under the concentration versus time curve; C_{max} = maximum observed concentration, CL/F = apparent clearance

Table 3. Drug interactions studied with lamivudine

Concomitant drug class: drug name	Effect on concentration of lamivudine or concomitant drug	Clinical comment
Trimethoprim/sulfamethoxazole (Co-trimoxazole) (160 mg/800 mg once daily for 5 days/300 mg single dose)	Lamivudine: AUC ↑40% Trimethoprim: AUC ↔ Sulfamethoxazole: AUC ↔	Unless the patient has renal impairment, no dosage adjustment of lamivudine is necessary (see Dose and method of administration). Lamivudine has no effect on the pharmacokinetics of trimethoprim or sulfamethoxazole. The effect of co-administration of lamivudine with higher doses of co-trimoxazole used for the treatment of <i>Pneumocystis jiroveci</i> (<i>P. carinii</i>) pneumonia and toxoplasmosis has not been studied. TRIUMEQ is not recommended for patients with CrCl of <30 mL/min.
Emtricitabine		Lamivudine may inhibit the intracellular phosphorylation of emtricitabine when the two medicinal products are used concurrently. Additionally, the mechanism of viral resistance for both lamivudine and emtricitabine is mediated via mutation of the same viral reverse transcriptase gene (M184V) and therefore the therapeutic efficacy of these drugs in combination therapy may be limited. Lamivudine is not recommended for use in combination with emtricitabine or emtricitabine-containing fixed-dose combinations.
Other agents		
Sorbitol solution (3.2 g, 10.2 g, 13.4 g)	Single dose lamivudine oral solution 300 mg Lamivudine: AUC ↓14%; 32%; 36% C _{max} ↓28%; 52%; 55%	When possible, avoid chronic co-administration of sorbitol-containing medicines with lamivudine. Consider more frequent monitoring of HIV-1 viral load when chronic coadministration cannot be avoided.

Abbreviations: ↑ = Increase; ↓ = decrease; ↔ = no significant change; AUC = area under the concentration versus time curve; C_{max} = maximum observed concentration

4.6 Fertility, pregnancy and lactation

Pregnancy

(Category B3)

TRIUMEQ should be used during pregnancy only if the benefit to the mother outweighs the possible risk to the foetus. Women of childbearing potential (WOCBP) should be informed about the potential risk of neural tube defects with dolutegravir and counselled about the use of effective contraception. It is recommended that pregnancy testing is conducted prior to initiation of TRIUMEQ. If there are plans to become pregnant, or if pregnancy is confirmed within the first trimester while on TRIUMEQ, the risks and benefits of continuing TRIUMEQ versus switching to another antiretroviral regimen should be discussed with the patient. Factors to consider should include feasibility of switching, tolerability, ability to maintain viral suppression, actual gestational age, risk of transmission to the infant and the available data around the potential risk of neural tube defects and other pregnancy outcomes for dolutegravir and alternative antiretroviral drugs.

In a birth outcome surveillance study in Botswana, a numerically higher rate of neural tube defects was identified with exposure to dolutegravir compared to non-dolutegravir-containing antiretroviral regimens at the time of conception, however, the difference was not statistically significant. Seven cases of neural tube defects were reported in 3,591 deliveries (0.19%) to mothers taking dolutegravir-containing regimens at the time of conception, compared with 21 cases in 19,361 deliveries (0.11%) to mothers taking non-dolutegravir-containing regimens at the time of conception (Prevalence Difference 0.09%; 95% CI -0.03, 0.30).

In the same study, an increased risk of neural tube defects was not identified in women who started dolutegravir during pregnancy. Two out of 4,448 deliveries (0.04%) to mothers who started dolutegravir during pregnancy had a neural tube defect, compared with five out of 6,748 deliveries (0.07%) to mothers who started non-dolutegravir-containing regimens during pregnancy.

A causal relationship of these events to the use of dolutegravir has not been established. The incidence of neural tube defects in the general population ranges from 0.5-1 case per 1,000 live births. As most neural tube defects occur within the first 4 weeks of foetal development (approximately 6 weeks after the last menstrual period) this potential risk would concern women exposed to dolutegravir at the time of conception and in early pregnancy.

Data analysed to date from other sources including the Antiretroviral Pregnancy Registry, clinical trials, and post-marketing data are insufficient to address the risk of neural tube defects with dolutegravir.

More than 1,000 outcomes from second and third trimester exposure in pregnant women indicate no evidence of increased risk of adverse birth outcomes.

In animal reproductive toxicity studies with dolutegravir, no adverse development outcomes, including neural tube defects, were identified.

Dolutegravir, abacavir and lamivudine use during pregnancy have been evaluated in the Antiretroviral Pregnancy Registry (APR) in over 600, 2,500 and 12,500 women, respectively (as of July 2019). Available human data from the APR do not show an increased risk of major birth defects for dolutegravir, abacavir or lamivudine compared to the background rate (see section 5.1 Pharmacodynamic properties).

Dolutegravir readily crosses the placenta in humans. In HIV-infected pregnant women, the median (range) foetal umbilical cord concentrations of dolutegravir were 1.28 (1.21 to 1.28) fold greater compared with maternal peripheral plasma concentrations.

There is insufficient information on the effects of dolutegravir on neonates.

Oral administration of dolutegravir to pregnant rats at doses up to 1000 mg/kg daily from days 6 to 17 of gestation did not elicit maternal toxicity, developmental toxicity or teratogenicity (50 times the 50 mg human clinical exposure when dolutegravir is administered in combination with abacavir and lamivudine, based on AUC).

Oral administration of dolutegravir to pregnant rabbits at doses up to 1000 mg/kg daily from days 6 to 18 of gestation was associated with marked maternal toxicity, but did not elicit developmental toxicity or teratogenicity (0.74 times the 50 mg human clinical exposure when dolutegravir is administered in combination with abacavir and lamivudine, based on AUC).

There have been reports of mild, transient elevations in serum lactate levels, which may be due to mitochondrial dysfunction, in neonates and infants exposed *in utero* or peri-partum to nucleoside reverse transcriptase inhibitors (NRTIs). The clinical relevance of transient elevations in serum lactate is unknown. There have also been very rare reports of developmental delay, seizures and other neurological disease. However, a causal relationship between these events and NRTI exposure *in utero* or peri-partum has not been established. These findings do not affect current recommendations to use antiretroviral therapy in pregnant women to prevent vertical transmission of HIV.

Lamivudine and abacavir were associated with adverse findings in animal reproductive toxicity studies.

Studies in pregnant rats showed that abacavir is transferred to the fetus through the placenta. Developmental toxicity (depressed fetal body weight and reduced crown-rump length) and increased incidences of fetal anasarca and skeletal malformations were observed when rats were treated with abacavir at doses of 648 mg/kg during organogenesis (approximately 31 times the human therapeutic exposure based on AUC, for a 600 mg dose in combination with dolutegravir and lamivudine at the recommended dose). In a fertility study, evidence of toxicity to the developing embryo and fetuses (increased resorptions, decreased fetal body weights) occurred only at 427 mg/kg per day. The offspring of female rats treated with abacavir at 427 mg/kg (beginning at embryo implantation and ending at weaning) showed increased incidence of still birth and lower body weights throughout life. In the rabbit, there was no evidence of drug-related developmental toxicity and no increases in fetal malformations at doses up to 453 mg/kg (7 times the expected human exposure, based on AUC).

Lamivudine was not teratogenic in animal studies, but there were indications of an increase in early embryonic deaths in rabbits at exposure levels (based on C_{max} and AUC) comparable to or below those achieved in man. However, there was no evidence of embryonic loss in rats at exposure levels of approximately 32 times the clinical exposure (based on C_{max}).

Mitochondrial dysfunction: nucleoside and nucleotide analogues have been demonstrated *in vitro* and *in vivo* to cause a variable degree of mitochondrial damage. There have been reports of mitochondrial dysfunction in HIV-negative infants exposed in utero and/or post-natally to nucleoside analogues. The main adverse reactions reported are haematological disorders (anaemia, neutropenia), metabolic disorders (hyperlactatemia, hyperlipasemia). These reactions are often transitory. Some late-onset neurological disorders have been reported (hypertonia, convulsion, abnormal behaviour). Whether the neurological disorders are transient or permanent is currently unknown. Any child exposed in utero to nucleoside and nucleotide analogues, even HIV negative children, should have clinical and laboratory follow-up and should be fully investigated for possible mitochondrial dysfunction in case of relevant signs or symptoms. These findings do not affect current national recommendations to use antiretroviral therapy in pregnant women to prevent vertical transmission of HIV.

Breast-feeding

Health experts recommend that where possible HIV infected women do not breast-feed their infants in order to avoid transmission of HIV. In settings where formula feeding is not

feasible, local official lactation and treatment guidelines should be followed when considering breast feeding during antiretroviral therapy.

Dolutegravir is excreted in human milk in small amounts. In an open-label randomised study in which HIV-infected treatment-naïve pregnant women were administered a dolutegravir based regimen until two weeks post-partum, the median (range) dolutegravir breast milk to maternal plasma was 0.033 (0.021 to 0.050). In a study following repeat oral dose of either 150 mg lamivudine twice daily (given in combination with 300 mg zidovudine twice daily) or 300 mg lamivudine twice daily, lamivudine was excreted in human breast milk (0.5 to 8.2 micrograms/mL) at similar concentrations to those found in serum. In other studies following repeat oral dose of 150 mg lamivudine twice daily (given either in combination with 300 mg zidovudine or as COMBIVIR or TRIZIVIR) the breast milk: maternal plasma ratio ranged between 0.6 and 3.3. In a study after repeat oral administration of 300 mg abacavir twice daily (given as TRIZIVIR), the breast milk: maternal plasma ratio was 0.9. No pharmacokinetic studies were conducted with abacavir once daily oral administration. Lamivudine median infant serum concentrations ranged between 18 and 28 ng/mL and were not detectable in one of the studies (assay sensitivity 7 ng/mL). Most infants (8 out of 9) had non-detectable levels of abacavir (assay sensitivity 16 ng/mL). Intracellular carbovir and lamivudine triphosphate (active metabolites of abacavir and lamivudine) levels in breastfed infants were not measured therefore the clinical relevance of the serum concentrations of the parent compounds measured is unknown.

Fertility

There are no data on the effects of dolutegravir, abacavir or lamivudine on human male or female fertility. No studies on the effect on fertility in animals have been conducted with the dolutegravir/abacavir/lamivudine combination. Individually, dolutegravir, abacavir and lamivudine did not affect male or female mating or fertility in rats at doses associated with exposure levels approximately 44, 30 or 64 (respectively) higher than the exposures in humans at doses of 50 mg, 600 mg, and 300 mg (respectively).

4.7 Effects on ability to drive and use machines

There have been no studies to investigate the effect of dolutegravir, abacavir or lamivudine, on driving performance or the ability to operate machinery. A detrimental effect on such activities would not be anticipated given the pharmacology of these medicinal products. The clinical status of the patient and the adverse event profile of TRIUMEQ should be borne in mind when considering the patient's ability to drive or operate machinery.

4.8 Undesirable effects

Summary of the safety profile

TRIUMEQ contains dolutegravir, abacavir and lamivudine, therefore the adverse events associated with these may be expected. For many of the adverse events listed it is unclear whether they are related to the active substance, the wide range of other medicinal products used in the management of HIV infection, or whether they are a result of the underlying disease process.

Many of the adverse events listed occur commonly (nausea, vomiting, diarrhoea, fever, lethargy, rash) in patients with abacavir hypersensitivity. Therefore, patients with any of these symptoms should be carefully evaluated for the presence of this hypersensitivity reaction. If TRIUMEQ has been discontinued in patients due to experiencing any one of these symptoms and a decision is made to restart abacavir, this must be done only under direct medical supervision (see section 4.4 Special considerations following an interruption of TRIUMEQ therapy in Special warnings and precautions or use).

Adverse drug reactions for dolutegravir, abacavir or lamivudine are listed in the tables below by MedDRA system organ class and by frequency. Frequencies are defined as very common ($\geq 1/10$), common ($\geq 1/100$, $< 1/10$), uncommon ($\geq 1/1,000$, $< 1/100$), rare ($\geq 1/10,000$, $< 1/1,000$) and very rare ($< 1/10,000$), including isolated reports.

Clinical trial data

Clinical safety data with TRIUMEQ are limited. The adverse reactions observed for the combination of DTG + ABC/3TC in analysis of pooled data from Phase IIb to Phase IIIb clinical trials were generally consistent with the adverse reaction profiles for the individual components dolutegravir, abacavir and lamivudine.

There was no difference between the combination and the individual components in severity for any observed adverse reactions.

Treatment naïve patients

The safety assessment of TRIUMEQ is primarily based on the analyses of 48 and 96 week data from a randomised, international, multicentre, double-blind, active-controlled trial, SINGLE (ING114467) and supported by data in treatment-naïve patients from SPRING-2 (ING113086) and FLAMINGO (ING114915).

In SINGLE (ING114467), 833 patients were randomised and received at least 1 dose of either dolutegravir 50 mg with fixed-dose abacavir sulfate and lamivudine once daily ($n = 414$) or fixed-dose efavirenz-emtricitabine-tenofovir (EFV/TDF/FTC) once daily ($n = 419$). Through 96 weeks, the rate of adverse events leading to discontinuation was 3% in patients receiving dolutegravir + ABC/3TC and 12% in patients receiving EFV/TDF/FTC once daily.

In SPRING-2 (ING113086), 411 patients received dolutegravir once daily versus 411 who received raltegravir 400 mg twice daily, both in combination with investigator-selected nucleoside reverse transcriptase inhibitor (NRTI) background regimen (either ABC/3TC or TDF/FTC). Of these patients, 169 in the group receiving dolutegravir and 164 in the group receiving raltegravir were receiving KIVEXA [abacavir/lamivudine] as the background regimen. Through 96 weeks, the rate of adverse events leading to discontinuation in these patients was 3% in patients receiving dolutegravir and 2% in patients receiving raltegravir.

In FLAMINGO (ING114915), 243 patients received dolutegravir once daily versus 242 patients who received darunavir 800 mg/ritonavir 100 mg once daily, both in combination with investigator-selected NRTI background regimen (either ABC/3TC or TDF/FTC). There were 484 patients included in the efficacy and safety analyses. Of these patients, 79 in the group receiving dolutegravir and 80 in the group receiving darunavir were receiving ABC/3TC as the background regimen. Through 48 weeks, the rate of adverse events leading to discontinuation in these patients were 4% in patients receiving dolutegravir and 4% in patients receiving darunavir.

Treatment-emergent adverse reactions of moderate to severe intensity observed in $\geq 2\%$ of patients in either treatment arm of SINGLE are provided in Table 4.

Tabulated list of adverse reactions

Table 4. Treatment-Emergent Adverse Reactions of at Least Moderate Intensity (Grades 2 to 4) and $\geq 2\%$ Frequency in Treatment Naïve Patients in SINGLE (ING114467)

Body system/ preferred term	48-Week		96-Week	
	DTG + ABC/3TC Once daily (N = 414)	EFV/TDF/FTC Once daily (N = 419)	DTG + ABC/3TC Once daily (N = 414)	EFV/TDF/FTC Once daily (N = 419)
Psychiatric				
Insomnia	3%	2%	3%	2%
Depression	<1%	1%	1%	2%
Abnormal dreams	<1%	2%	<1%	2%
Nervous System				
Dizziness	<1%	5%	<1%	5%
Headache	2%	2%	2%	2%
Gastrointestinal				
Nausea	<1%	3%	<1%	3%
Diarrhea	<1%	2%	<1%	2%
General Disorders				
Fatigue	1%	1%	2%	2%
Skin and Subcutaneous Tissue				
Rash	<1%	3%	<1%	3%
Ear and Labyrinth				
Vertigo	0	2%	0	2%

N = Number of patients in each treatment group; EFV/TDF/FTC = efavirenz 600 mg, tenofovir 300 mg, emtricitabine 200 mg

The adverse reactions observed in the subset of patients who received dolutegravir + ABC/3TC in SPRING-2 and FLAMINGO were generally consistent with those seen for the overall patient population participating in these trials.

Treatment experienced patients

In SAILING, 719 patients were randomised and received either dolutegravir once daily (n = 357) or raltegravir 400 mg twice daily (n = 362) with investigator-selected background regimen consisting of up to 2 agents, including at least one fully active agent. There were 715 patients included in the efficacy and safety analyses. At 48 weeks, the rate of adverse events leading to discontinuation was consistent with that seen in the overall treatment naïve patient population.

Less common adverse reactions observed in clinical trials

The following adverse reactions occurred in $\leq 2\%$ of treatment naïve or treatment experienced patients in any one trial. These events have been included because of their seriousness and/or assessment of potential causal relationship.

Gastrointestinal Disorders: Abdominal pain, abdominal distention, abdominal discomfort, dyspepsia, flatulence, gastroesophageal reflux disease, upper abdominal pain, vomiting.

General Disorders: Fever, lethargy.

Hepatobiliary Disorders: Hepatitis.

Immune System Disorders: Hypersensitivity, immune reconstitution syndrome.

Metabolism and Nutrition Disorders: Anorexia, hypertriglyceridemia.

Musculoskeletal Disorders: Arthralgia.

Nervous: Somnolence.

Psychiatric: Suicidal ideation or suicide attempt (particularly in patients with pre-existing history of depression or psychiatric illness). Nightmare and sleep disorder

Skin and subcutaneous tissue disorders: Pruritus.

Laboratory abnormalities: Treatment naïve subjects

Selected laboratory abnormalities (Grades 2 to 4) with a worsening grade from baseline and representing the worst-grade toxicity in $\geq 2\%$ of subjects in SINGLE are presented in Table 5. The mean change from baseline observed for selected lipid values is presented in Table 6.

Table 5. Selected laboratory abnormalities (Grades 2 to 4) in treatment naïve patients in SINGLE (ING114467)

Laboratory parameter preferred term	48 Week		96 Week	
	DTG + ABC/3TC Once daily (N = 414)	EFV/TDF/FTC Once daily (N = 419)	DTG + ABC/3TC Once daily (N = 414)	EFV/TDF/FTC Once daily (N = 419)
ALT				
Grade 2 (>2.5-5.0 x ULN)	2%	5%	2%	5%
Grade 3 to 4 (>5.0 x ULN)	<1%	<1%	<1%	<1%
AST				
Grade 2 (>2.5-5.0 x ULN)	2%	3%	3%	3%
Grade 3 to 4 (>5.0 x ULN)	0	2%	<1%	3%
Creatine kinase				
Grade 2 (6.0-9.9 x ULN)	4%	2%	4%	2%
Grade 3 to 4 (≥ 10.0 x ULN)	3%	5%	5%	7%
Hyperglycemia				
Grade 2 (6.95–13.88 mmol/L)	7%	5%	7%	5%
Grade 3 to 4 (>13.88 mmol/L)	1%	<1%	2%	<1%
Lipase				
Grade 2 (>1.5-3.0 x ULN)	8%	7%	9%	10%
Grade 3 to 4 (>3.0 ULN)	3%	2%	4%	3%
Total neutrophils				
Grade 2 ($0.75-0.99 \times 10^9$)	2%	4%	3%	5%
Grade 3 to 4 ($<0.75 \times 10^9$)	2%	3%	2%	3%

ULN = Upper limit of normal; N = Number of patients in each treatment group; EFV/TDF/FTC = efavirenz 600 mg, tenofovir 300 mg, emtricitabine 200 mg

Table 6. Mean change from baseline in fasted lipid values in treatment naïve subjects in SINGLE (ING114467)

Laboratory parameter preferred term	48 Week		96 Week	
	DTG + ABC/3TC Once daily (N = 414)	EFV/TDF/FTC Once daily (N = 419)	DTG + ABC/3TC Once daily (N = 414)	EFV/TDF/FTC Once daily (N = 419)
Cholesterol (mmol/L)	0.441	0.622	0.615	0.724
HDL cholesterol (mmol/L)	0.135	0.206	0.138	0.194
LDL cholesterol (mmol/L)	0.219	0.339	0.384	0.465
Triglycerides (mmol/L)	0.200	0.210	0.200	0.195

N = Number of patients in each treatment group; EFV/TDF/FTC = efavirenz 600 mg, tenofovir 300 mg, emtricitabine 200 mg

The rates of laboratory abnormalities and mean change in fasted lipid values remained generally similar between the 48 and 96 week data evaluation in SINGLE.

Laboratory abnormalities observed in the subset of subjects who received dolutegravir + ABC/3TC in SPRING-2 and FLAMINGO were generally consistent with observations in SINGLE.

Laboratory abnormalities: Treatment Experienced Patients:

Changes in laboratory chemistries

Increases in serum creatinine occurred within the first week of treatment with dolutegravir and remained stable through 96 weeks. In SINGLE, a mean change from baseline of 12.6 µmol/L was observed after 96 weeks of treatment. These changes are not considered to be clinically relevant since they do not reflect a change in glomerular filtration rate (see section 5.1 Pharmacodynamic properties).

Small increases in total bilirubin were observed on dolutegravir and raltegravir (but not efavirenz) arms in the clinical trials. These changes are not considered clinically relevant as they likely reflect competition between dolutegravir and unconjugated bilirubin for a common clearance pathway (UGT1A1) (see section 5.2 Pharmacokinetic properties).

Asymptomatic creatine phosphokinase (CPK) elevations mainly in association with exercise have also been reported with dolutegravir therapy.

Description of selected adverse reactions

Hypersensitivity (see section 4.4 Special warnings and precautions for use):

Both abacavir and dolutegravir are associated with a risk for hypersensitivity reactions (HSR), which were observed more commonly with abacavir. Hypersensitivity reaction observed for each of these medicinal products (described below) share some common features such as fever and/or rash with other symptoms indicating multi-organ involvement. Time to onset was typically 10-14 days for both abacavir and dolutegravir-associated reactions, although reactions to abacavir may occur at any time during therapy.

Dolutegravir hypersensitivity:

Symptoms have included rash, constitutional findings, and sometimes, organ dysfunction, including severe liver reactions.

Abacavir hypersensitivity:

The signs and symptoms of this hypersensitivity reaction (HSR) are listed below. These have been identified either from clinical studies or post marketing surveillance. Those reported in **at least 10% of patients** with a hypersensitivity reaction are in bold text.

Almost all patients developing hypersensitivity reactions will have fever and/or rash (usually maculopapular or urticarial) as part of the syndrome, however, reactions have occurred without rash or fever. Other key symptoms include gastrointestinal, respiratory or constitutional symptoms such as lethargy and malaise.

Skin:	Rash (usually maculopapular or urticarial)
Gastrointestinal tract:	Nausea, vomiting, diarrhoea, abdominal pain , mouth ulceration
Respiratory tract:	Dyspnoea, cough , sore throat, adult respiratory distress syndrome, respiratory failure
Miscellaneous:	Fever, fatigue, malaise , oedema, lymphadenopathy, hypotension, conjunctivitis, anaphylaxis
Neurological/Psychiatry:	Headache , paraesthesia
Haematological:	Lymphopenia
Liver/pancreas:	Elevated liver function tests , hepatic failure
Musculoskeletal:	Myalgia , rarely myolysis, arthralgia, elevated creatine phosphokinase
Urology:	Elevated creatinine, renal failure

Restarting abacavir following an abacavir HSR results in a prompt return of symptoms within hours. This recurrence of the HSR is usually more severe than on initial presentation, and may include life-threatening hypotension and death. Reactions have also occurred infrequently after restarting abacavir in patients who had only one of the key symptoms of hypersensitivity (see above) prior to stopping abacavir; and on very rare occasions have also been seen in patients who have restarted therapy with no preceding symptoms of a HSR (i.e., patients previously considered to be abacavir tolerant).

For details of clinical management in the event of a suspected abacavir HSR (see section 4.4 Special warnings and precautions for use).

Paediatric population

There are no clinical study data on the effects of TRIUMEQ in the paediatric population. Individual components have been investigated in adolescents aged 12 to 18.

Based on limited available data with the dolutegravir single entity used in combination with other antiretroviral agents to treat adolescents (12 to less than 18 years of age), there were no additional types of adverse reactions beyond those observed in the adult population.

The individual preparations of ABC and 3TC have been investigated separately, and as a dual nucleoside backbone, in combination antiretroviral therapy to treat ART- naive and ART- experienced HIV- infected paediatric patients (data available on the use of ABC and 3TC in children less than three months are limited). No additional types of undesirable effects have been observed beyond those characterised for the adult population.

Abacavir sulfate and lamivudine

Laboratory abnormalities observed in clinical trials of abacavir (in combination with other antiretroviral treatment) were anemia, neutropenia, thrombocytopenia, low white blood cell count, elevated liver chemistries (AST, ALT, alkaline phosphatase, bilirubin), and elevations

of CPK, blood glucose, and triglycerides. Additional laboratory abnormalities observed in clinical trials of 3TC (in combination with other antiretrovir treatment) were thrombocytopenia and elevated levels of bilirubin, amylase, and lipase.

Post-marketing data

In addition to the adverse reactions included from clinical trial data, the adverse reactions listed in Table 7 below have been identified during post-approval use of dolutegravir, abacavir, lamivudine or dolutegravir/abacavir/lamivudine fixed dose combination. These events have been chosen for inclusion due to a potential causal connection to dolutegravir, abacavir and/or lamivudine.

Table 7. Adverse reactions based on post-marketing experience

System organ class	Dolutegravir	Abacavir	Lamivudine
Blood and lymphatic systems disorders			Very rare: pure red cell aplasia
Metabolism and nutrition disorders		Common: hyperlactataemia Rare: lactic acidosis ¹	Common: hyperlactataemia Rare: lactic acidosis ¹
Nervous system disorders			Very rare: paraesthesiae, peripheral neuropathy has been reported although a causal relationship to treatment is uncertain
Gastrointestinal disorders		Rare: pancreatitis, but a causal relationship to abacavir is uncertain	Rare: rises in serum amylase, pancreatitis, although a causal relationship to lamivudine is uncertain
Psychiatric disorders	Common: anxiety		
Skin and subcutaneous tissue disorders		Common: rash (without systemic symptoms) Very rare: erythema multiforme, Stevens-Johnson syndrome and toxic epidermal necrolysis	Common: alopecia
Musculoskeletal and connective tissue disorders	Uncommon: arthralgia Uncommon: myalgia		Common: arthralgia, muscle disorders Rare: rhabdomyolysis
Investigations	Uncommon: Weight increased		
Post marketing events observed with dolutegravir/abacavir/lamivudine fixed dose combination			
Hepatobiliary disorders	Rare: acute hepatic failure		

¹Lactic acidosis (see section 4.4 Special warnings and precautions for use)

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicine is important. It allows continued monitoring of the benefit/risk balance of the medicine. Healthcare professionals are asked to report any suspected adverse reactions via: <https://nzphvc.otago.ac.nz/reporting/>

4.9 Overdose

Symptoms and signs

There is currently limited experience with overdosage in dolutegravir.

Limited experience of single higher doses (up to 250 mg in healthy patients) revealed no specific symptoms or signs, apart from those listed as adverse reactions.

No specific symptoms or signs have been identified following acute overdose with abacavir or lamivudine, apart from those listed as adverse reactions.

Treatment

Further management should be as clinically indicated or as recommended by the national poisons centre, where available.

If overdose occurs, the patient should be treated supportively with appropriate monitoring as necessary. Since lamivudine is dialysable, continuous haemodialysis could be used in the treatment of overdose, although this has not been studied. It is not known whether abacavir can be removed by peritoneal dialysis or haemodialysis. As dolutegravir is highly bound to plasma proteins, it is unlikely that it will be significantly removed by dialysis.

Further management should be as clinically indicated or as recommended by the national poisons centre, where available.

For advice on the management of overdose please contact the National Poisons Centre on 0800 POISON (0800 764766)

5. PHARMACOLOGICAL PROPERTIES

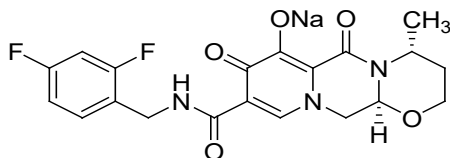
5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antivirals for systemic use, antivirals for treatment of HIV infections, combinations. ATC code: J05AR13

Chemical structure

The chemical (IUPAC) name for dolutegravir sodium is Sodium (4R,12aS)-9-[[[(2,4-difluorophenyl)methyl]carbamoyl]-4-methyl-6,8-dioxo-3,4,6,8,12,12a-hexahydro-2H-pyrido[1',2':4,5]pyrazino[2,1-b][1,3]oxazin-7-olate. It has a molecular formula of $C_{20}H_{18}F_2N_3NaO_5$ and a molecular weight of 441.36 g/mol.

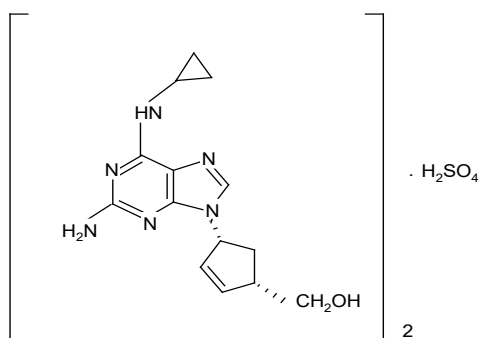
The structural formula is:



CAS Registry Number: 1051375-19-9

The chemical name of abacavir sulfate is (1*S*,*cis*)-4-[2-amino-6-(cyclopropylamino)-9*H*-purin-9-yl]-2-cyclopentene-1-methanol sulfate (salt) (2:1). Abacavir sulfate is the enantiomer with 1*S*, 4*R* absolute configuration on the cyclopentene ring. It has a molecular formula of $(C_{14}H_{18}N_6O)_2 \cdot H_2SO_4$ and a molecular weight of 670.76 g/mol.

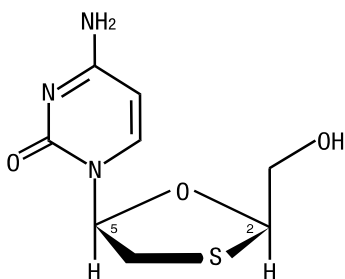
The structural formula is:



CAS Registry Number: 188062-50-2

The chemical name of lamivudine is (2*R*,*cis*)-4-amino-1-[2-(hydroxymethyl)-1,3-oxathiolan-5-yl]-2(1*H*)-pyrimidinone. Lamivudine is the (-)enantiomer of a dideoxy analogue of cytidine. Lamivudine has also been referred to as (-)2',3'-dideoxy, 3'-thiacytidine. It has a molecular formula of $C_8H_{11}N_3O_3S$ and a molecular weight of 229.3 g/mol.

The structural formula is:



CAS Registry Number: 134678-17-4

Mechanism of action

Dolutegravir inhibits HIV integrase by binding to the integrase active site and blocking the strand transfer step of retroviral deoxyribonucleic acid (DNA) integration which is essential for the HIV replication cycle. Strand transfer biochemical assays using purified HIV-1 integrase and pre-processed substrate DNA resulted in IC₅₀ values of 2.7 nM and 12.6 nM. *In vitro*, dolutegravir dissociates slowly from the active site of the wild type integrase-DNA complex ($t_{1/2}$ 71 hours).

Abacavir and lamivudine are nucleoside reverse transcriptase inhibitors (NRTIs), and are potent, selective inhibitors of HIV-1 and HIV-2 replication. Both abacavir and lamivudine are metabolised sequentially by intracellular kinases to the respective triphosphate (TP) which are the active moieties with extended intracellular half-lives supporting once daily dosing (see section 5.2 Pharmacokinetic properties). Lamivudine-TP and carbovir-TP (the active triphosphate form of abacavir) are substrates for and competitive inhibitors of HIV

reverse transcriptase (RT), however their main antiviral activity is through incorporation of the monophosphate form into the viral DNA chain, resulting in chain termination. Abacavir and lamivudine triphosphates show significantly less affinity for host cell DNA polymerases.

Pharmacodynamic effects

In a randomised, dose-ranging trial, HIV-1 infected patients treated with dolutegravir monotherapy (ING111521) demonstrated rapid and dose-dependent antiviral activity, with mean declines from baseline to day 11 in HIV-1 RNA of 1.5, 2.0, and 2.5 log₁₀ for dolutegravir 2 mg, 10 mg, and 50 mg once daily, respectively. This antiviral response was maintained for 3 to 4 days after the last dose in the 50 mg group.

Antiviral activity of dolutegravir in cell culture

Dolutegravir exhibited antiviral activity against laboratory strains of wild type HIV-1 in peripheral blood mononuclear cells (PBMC) and MT4 cells with mean IC₅₀s of 0.5 nM to 2.1 nM.

In a viral integrase susceptibility assay using the integrase coding region from 13 clinically diverse clade B isolates, dolutegravir demonstrated antiviral potency similar to laboratory strains, with a mean IC₅₀ of 0.52 nM.

When tested in PBMC assays against a panel consisting of 24 HIV-1 clinical isolates [group M (clade A, B, C, D, E, F and G) and group O] and 3 HIV-2 clinical isolates, the geometric mean IC₅₀ was 0.20 nM and IC₅₀ values ranged from 0.02 to 2.14 nM for HIV-1, while the geometric mean IC₅₀ was 0.18 nM and IC₅₀ values ranged from 0.09 to 0.61 nM for HIV-2 isolates.

Antiviral activity of dolutegravir in combination with other antiviral agents

No drugs with inherent anti-HIV activity were antagonistic with dolutegravir (in vitro assessments were conducted in checkerboard format in combination with stavudine, abacavir, efavirenz, nevirapine, lopinavir, amprenavir, enfuvirtide, maraviroc, adefovir and raltegravir). In addition, antivirals without inherent anti-HIV activity (ribavirin) had no apparent effect on dolutegravir activity.

The antiviral activity of dolutegravir in vitro was not antagonistic with the integrase inhibitor (INI) raltegravir; the non-nucleoside reverse transcriptase inhibitors (NNRTIs) efavirenz or nevirapine; the nucleoside reverse transcriptase inhibitor (NRTI) abacavir, the protease inhibitors (PIs) amprenavir or lopinavir; the CCR5 co-receptor antagonist maraviroc, or the fusion inhibitor enfuvirtide. Dolutegravir antiviral activity was not antagonistic when combined with the HBV reverse transcriptase inhibitor adefovir, or inhibited by the antiviral ribavirin. No antagonistic effects in vitro were seen with lamivudine and other antiretrovirals (tested agents: abacavir, didanosine, nevirapine, zalcitabine, and zidovudine).

Effect of human serum and serum proteins

The protein adjusted IC₉₀ (PA-IC₉₀) in PBMCs for dolutegravir was estimated to be 64 ng/mL. Dolutegravir trough concentration for a single 50 mg dose in integrase inhibitor naïve subjects was 1.20 micrograms/mL, 19 times higher than the estimated PA-IC₉₀.

Plasma protein binding studies *in vitro* indicate that abacavir binds only low to moderately (~49%) to human plasma proteins at therapeutic concentrations.

Lamivudine exhibits linear pharmacokinetics over the therapeutic dose range and displays low plasma protein binding (less than 36%).

Resistance in vitro (dolutegravir)

Dolutegravir-resistant viruses were selected in studies of potential resistance using different wild type strains and clades of HIV-1. Amino acid substitutions that emerged during

passaging included E92Q, G193E, G118R, S153F or Y, and R263K, and were associated with decreased susceptibility to dolutegravir of up to 11-fold.

In resistance development studies starting with the single raltegravir resistance mutants Q148H, Q148K or Q148R, additional mutations detected during passage with dolutegravir included E138K/Q148K, E138K/Q148R, Q140S/Q148R and G140S/Q148R, which all exhibited greater than ten-fold reductions in sensitivity to dolutegravir.

Resistance in vivo (dolutegravir): integrase inhibitor naïve patients

No INI-resistant mutations or treatment emergent resistance to the NRTI backbone therapy were isolated with dolutegravir 50 mg once daily in treatment-naïve studies [SPRING-1 (ING112276), SPRING-2 (ING113086), SINGLE (ING114467), FLAMINGO (ING114915) and ARIA (ING117172) studies]. In the SAILING study for treatment experienced (and integrase naïve) patients (n=354 in the dolutegravir arm), treatment emergent integrase substitutions were observed at Week 48 in 4 of 17 patients with virologic failure in the dolutegravir arm. Of these four, 2 patients had a unique R263K integrase substitution, with a maximum FC of 1.93, 1 patient had a polymorphic V151V/I integrase substitution, with maximum FC of 0.92, and 1 patient had pre-existing integrase mutations and is assumed to have been integrase experienced or infected with integrase resistant virus by transmission (see section 5.1 Clinical safety and efficacy).

Resistance in vitro and in vivo (abacavir and lamivudine)

HIV-1 resistance to lamivudine involves the development of a M184V amino acid change close to the active site of the viral RT. This variant arises both *in vitro* and in HIV-1 infected patients treated with lamivudine-containing antiretroviral therapy. M184V mutants display greatly reduced susceptibility to lamivudine and show diminished viral replicative capacity *in vitro*. Studies *in vitro* indicate that zidovudine-resistant virus isolates can become zidovudine sensitive when they simultaneously acquire resistance to lamivudine. The clinical relevance of such findings remains, however, not well defined.

Genetic analysis of isolates from patients failing an abacavir-containing regimen demonstrated that reverse transcriptase amino acid residue 184 was consistently the most frequent position for NRTI resistance-associated mutations (M184V or M184I). The second most frequent mutation was L74V. Mutations Y115F and K65R were uncommon. Viral resistance to abacavir develops relatively slowly *in vitro* and *in vivo*, requiring multiple mutations to reach an eight-fold increase in IC₅₀ over wild-type virus, which may be a clinically relevant level.

Cross-resistance

Cross-resistance has been observed among nucleoside reverse transcriptase inhibitors. Viruses containing abacavir and lamivudine resistance-associated mutations, namely, M184V, L74V, Y115F and K65R, exhibit cross-resistance to didanosine, emtricitabine, lamivudine, tenofovir, and zalcitabine *in vitro* and in patients. The M184V mutation can confer resistance to abacavir, didanosine, emtricitabine, lamivudine, and zalcitabine; the L74V mutation can confer resistance to abacavir, didanosine, and zalcitabine and the K65R mutation can confer resistance to abacavir, didanosine, emtricitabine, lamivudine, stavudine, tenofovir, and zalcitabine. The combination of abacavir/lamivudine has demonstrated decreased susceptibility to viruses with the L74V plus the M184V/I mutation, viruses with K65R with or without the M184V/I mutation, and viruses with thymidine analog mutations (TAMs: M41L, D67N, K70R, L210W, T215Y/F, K219 E/R/H/Q/N) plus M184V. An increasing number of TAMs is associated with a progressive reduction in abacavir susceptibility.

Effects on electrocardiogram

In a randomised, placebo-controlled, cross-over trial, 42 healthy patients received single dose oral administrations of placebo, dolutegravir 250 mg suspension (exposures

approximately 3-fold of the 50 mg once-daily dose at steady state), and moxifloxacin (400 mg, active control) in random sequence. Dolutegravir did not prolong the QTc interval for 24 hours post dose. After baseline and placebo adjustment, the maximum mean QTc change based on Fridericia correction method (QTcF) was 1.99 msec (1-sided 95% upper CI: 4.53 msec).

Similar studies were not conducted with either abacavir or lamivudine.

Effects on renal function

The effect of dolutegravir on serum creatinine clearance (CrCl), glomerular filtration rate (GFR) using iohexol as the probe and effective renal plasma flow (ERPF) using para-aminohippurate (PAH) as the probe was evaluated in an open-label, randomised, 3 arm, parallel, placebo-controlled study in 37 healthy patients, who were administered dolutegravir 50 mg once daily (n=12), 50 mg twice daily (n=13) or placebo once daily (n=12) for 14 days. A modest decrease in CrCl was observed with dolutegravir within the first week of treatment, consistent with that seen in clinical studies. Dolutegravir at both doses had no significant effect on GFR or ERPF. These data support *in vitro* studies which suggest that the small increases in creatinine observed in clinical studies are due to the nonpathologic inhibition of the organic cation transporter 2 (OCT2) in the proximal renal tubules, which mediates the tubular secretion of creatinine.

Clinical efficacy and safety

TRIUMEQ is a film-coated tablet containing an integrase inhibitor (dolutegravir) and two NRTIs (abacavir and lamivudine).

Antiretroviral naïve patients

The efficacy of TRIUMEQ is supported by data from two randomized, controlled trials in antiretroviral treatment-naïve subjects, SINGLE (ING114467) and ARIA (ING117172), and other trials in treatment-naïve subjects (refer to the TIVICAY [dolutegravir] PI).

In SINGLE (ING114467), 833 patients were randomised and received at least one dose of either dolutegravir 50 mg once daily with fixed-dose abacavir sulphate and lamivudine or fixed dose efavirenz-tenofovir-emtricitabine (EFV/TDF/FTC). At baseline, median patient age was 35 years, 16% were female, 32% non-white, 7% had hepatitis C co-infection and 4% were CDC Class C, these characteristics were similar between treatment groups.

Virologic outcomes (including outcomes by key baseline covariates) are described below.

Table 8. Virologic Outcomes of Randomised Treatment of SINGLE (ING114467) at 48 Weeks (Snapshot algorithm – missing or discontinuation = failure)

	48 Weeks	
	DTG + ABC/3TC Once Daily N=414	EFV/TDF/FTC Once Daily N=419
Virologic Success HIV-1 RNA <50 copies/mL	88%	81%
Treatment Difference*	7.4% (95% CI: 2.5%, 12.3%)	
Virologic non response†	5%	6%
No virologic data at Weeks 48 window	7%	13%
Reasons		
Discontinued study/study drug due to adverse event or death‡	2%	10%
Discontinued study/study drug for other reasons§	5%	3%
Missing data during window but on study	0	<1%
HIV-1 RNA<50 copies/mL by baseline covariates		
Baseline Plasma Viral Load (copies/mL)	n / N (%)	n / N (%)
≤100,000	253 / 280 (90%)	238 / 288 (83%)
>100,000	111 / 134 (83%)	100 / 131 (76%)
Baseline CD4+ (cells/ mm³)		
<200	45 / 57 (79%)	48 / 62 (77%)
200 to <350	143 / 163 (88%)	126 / 159 (79%)
≥350	176 / 194 (91%)	164 / 198 (83%)
Gender		
Male	307 / 347 (88%)	291 / 356 (82%)
Female	57 / 67 (85%)	47 / 63 (75%)
Race		
White	255 / 284 (90%)	238 / 285 (84%)
African-American/African Heritage/Other	109 / 130 (84%)	99 / 133 (74%)
Age (years)		
<50	319 / 361 (88%)	302 / 375 (81%)
≥50	45 / 53 (85%)	36 / 44 (82%)
<p>* Adjusted for baseline stratification factors. † Includes patients who discontinued prior to Week 48 for lack or loss of efficacy and patients who are ≥50 copies in the 48 week window. ‡ Includes patients who discontinued due to an adverse event or death at any time point from Day 1 through the Week 48 analysis window if this resulted in no virologic data on treatment during the analysis window. § Includes reasons such as withdrew consent, loss to follow-up, moved, protocol deviation. Notes: ABC/3TC = abacavir 600 mg, lamivudine 300 mg EFV/TDF/FTC = efavirenz 600 mg, tenofovir 300 mg, emtricitabine 200 mg N = Number of patients in each treatment group</p>		

In the primary 48 weeks analysis in the SINGLE study, the proportion of patients with virologic suppression (HIV-1 RNA <50 copies/mL using a missing or discontinuation = failure analysis) in the dolutegravir + ABC/3TC arm (88%), was superior to the EFV/TDF/FTC arm (81%), $p=0.003$. Similar treatment difference was observed in patients defined by baseline HIV-RNA level (< or > 100,000 copies/mL). The median time to viral suppression was 28 days in the group receiving dolutegravir + ABC/3TC and 84 days in the EFV/TDF/FTC arm ($p<0.0001$). The adjusted mean change in CD4+ T cell count from baseline were 267 cells/mm³ in the group receiving dolutegravir + ABC/3TC and 208 cells/mm³ for the EFV/TDF/FTC arm in SINGLE at 48 week [adjusted difference between arm (with 95% CI), 58.9 cells (33.4 cells to 84.4 cells), $p<0.001$]. Both the time to viral suppression and change from baseline analyses were pre-specified and adjusted for multiplicity.

At 96 weeks, 80% of study participants on the dolutegravir+ ABC/3TC regimen were virologically suppressed (<50 copies/mL using a missing or discontinuation = failure analysis) vs. 72% of participants on EFV/TDF/FTC [difference and 95% CI; 8.0% (+2.3% to +13.8%)]. The higher responses on dolutegravir + ABC/3TC were driven by withdrawals due to AEs and missing data. At 144 weeks in the open-label phase, virologic suppression was maintained, the dolutegravir + ABC/3TC arm (71%) was superior to the EFV/TDF/FTC arm (63%), treatment difference was 8.3 (2.0, 14.6).

Antiretroviral naïve female patients

In ARIA (ING117172), a randomised, open-label, active-controlled, multicentre, parallel group, non-inferiority study; 499 HIV-1 infected ART naïve adult women were randomised 1:1 to receive either; dolutegravir 50 mg/abacavir 600 mg/lamivudine 300 mg FDC (DTG/ABC/3TC); or atazanavir 300 mg plus ritonavir 100 mg plus tenofovir disoproxil fumarate/emtricitabine 300 mg/200 mg (ATV+RTV+TDF/FTC FDC), all administered once daily. Demographic characteristics were similar across treatment groups; at baseline the median patient age was 37 years, 45% of patients were white and 42% of African American/African Heritage, 93% tested negative for hepatitis C (HCV) infection and 84% were in CDC Class A.

At 48 weeks, overall virologic suppression (HIV-1 RNA <50 copies/mL) in the DTG/ABC/3TC FDC group (82%) was shown to be statistically superior to the ATC+RTV+TDF/FTC FDC group (71%). The adjusted difference in proportion and 95% CI was 10.5 (3.1% to 17.8%) [$p=0.005$].

Antiretroviral experienced subjects

The efficacy of TRIUMEQ in antiretroviral treatment experienced subjects is supported by data from STRIVING (201147). In addition, the efficacy of dolutegravir, in combination with at least two active background regimens in treatment-experienced, INI-naïve subjects is supported by data from SAILING (ING111762) (refer to the TIVICAY [dolutegravir] PI).

In STRIVING (201147), a 48-week, randomised, open-label, active controlled, multicentre, non-inferiority study; 555 HIV-1 infected, virologically suppressed (HIV-1 RNA <50 c/mL) subjects were randomly assigned (1:1) to continue their current ART regimen (2 NRTIs plus either a PI, NNRTI, or INI), or switch to DTG/ABC/3TC FDC once daily (Early Switch).

The majority of subjects in the intent-to-treat exposed (ITT-E) population were white (65%) and male (86%); the median age was 45 (range 22-80) years. At baseline, 31% of subjects had CD4+ counts of <500 cell/mm³. Overall, most subjects had negative test results at screening for HBV and HCV infection (93%), were in CDC Class A (73%), and identified homosexual activity as an HIV risk factor (72%).

Virologic suppression (HIV-1 RNA <50 copies/mL) in the DTG/ABC/3TC FDC group (85%) was statistically non-inferior to the current ART groups (88%) at 24 weeks. The adjusted difference in proportion [DTG/ABC/3TC vs current ART] was 3.4%; 95% CI: [-9.1, 2.4]. After

24 weeks all remaining subjects switched to DTG/ABC/3TC FDC (Late Switch). Similar levels of virologic suppression were maintained in both the Early and Late Switch groups at 48 weeks.

Antiretroviral Pregnancy Registry

The APR has received reports of over 600 exposures to dolutegravir during pregnancy resulting in live births, as of July 2019. These consist of over 370 exposures during the first trimester, over 230 exposures during the second/third trimester and included 12 and 9 birth defects, respectively. The prevalence (95% CI) of defects among live births exposed to dolutegravir in the first trimester was 3.2% (1.7%, 5.5%) and in the second/third trimester, 3.8% (1.7%, 7.0%).

The APR has received prospective reports of over 2,500 exposures to abacavir during pregnancy resulting in live births, as of July 2019. These consist of over 1,200 exposures during the first trimester, over 1,300 exposures during the second/third trimester and included 39 and 39 birth defects, respectively. The prevalence (95% CI) of defects among live births exposed to abacavir in the first trimester was 3.1% (2.2%, 4.2%) and in the second/third trimester, 3.0% (2.1%, 4.0%).

The APR has received reports of over 12,500 exposures to lamivudine during pregnancy resulting in live births, as of July 2019. These consist of over 5,200 exposures during the first trimester, over 7,400 exposures during the second/third trimester and included 161 and 216 birth defects, respectively. The prevalence (95% CI) of defects among live births exposed to lamivudine in the first trimester was 3.1% (2.6%, 3.6%) and in the second/third trimester, 2.9% (2.5%, 3.3%).

The available data from the APR shows no significant increase in risk of major birth defects for dolutegravir, abacavir or lamivudine compared to the background rates in the two population based surveillance systems (Metropolitan Atlanta Congenital Defects Program with defects of 2.72 per 100 live births and the Texas Birth Defects Registry with 4.17 per 100 live births).

Paediatric population

In a Phase I/II 48 week multicentre, open-label study (P1093/ING112578), the pharmacokinetic parameters, safety, tolerability and efficacy of dolutegravir was evaluated in combination regimens in HIV-1 infected infants, children and adolescents.

At 24 weeks, 16 of 23 (69%) adolescents (12 to less than 18 years of age) treated with dolutegravir once daily (35 mg n=4, 50 mg n=19) plus optimised background regimen achieved viral load less than 50 copies/mL.

5.2 Pharmacokinetic properties

TRIUMEQ has been shown to be bioequivalent to dolutegravir single entity tablet with abacavir/lamivudine fixed dose combination tablet administered separately. This was demonstrated in a single dose, 2-way crossover bioequivalence study of TRIUMEQ (fasted) versus 1 x 50 mg dolutegravir tablet, plus 1 x 600 mg abacavir/300 mg lamivudine tablet (fasted) in healthy patients (n=62). In a separate cohort there was no clinically significant effect of a high fat meal on the exposure of dolutegravir, lamivudine or abacavir. These results indicate that TRIUMEQ can be taken with or without food.

The pharmacokinetic properties of dolutegravir, lamivudine and abacavir are described below.

Absorption

Dolutegravir is rapidly absorbed following oral administration [See TIVICAY [dolutegravir] Data Sheet, Pharmacology, Absorption]. The absolute bioavailability of dolutegravir has not

been established [See TIVICAY [dolutegravir] Data Sheet, Pharmacology, Absorption]. The mean time to maximal serum concentrations (t_{max}) is about 2 to 3 hours (post dose for tablet formulation) for dolutegravir [See TIVICAY [dolutegravir] Data Sheet, Pharmacology, Absorption]. Following multiple oral doses of dolutegravir 50 mg once daily, the geometric mean steady state pharmacokinetic parameter estimates are 53.6 micrograms.h/mL for AUC_{24} , 3.67 micrograms/mL for C_{max} , and 1.11 microgram/mL for C_{24} based on population pharmacokinetic analysis in treatment-naïve subjects.

Abacavir is rapidly absorbed following oral administration. The absolute bioavailability of oral abacavir is 83%. Following a single oral dose of 600 mg of abacavir, the mean C_{max} is 4.26 micrograms/mL and the mean AUC_{∞} is 11.95 micrograms.h/mL.

Lamivudine is rapidly absorbed following oral administration. The absolute bioavailability of oral lamivudine in adults is 80 to 85% respectively. Following multiple-dose oral administration of lamivudine 300 mg once daily for seven days the mean steady-state C_{max} is 2.04 micrograms/mL and the mean AUC_{24} is 8.87 micrograms.h/mL.

Distribution

The apparent volume of distribution of dolutegravir (following oral administration of suspension formulation, V_d/F) is estimated at 12.5 L. Dolutegravir is highly bound (approximately 99.3%) to human plasma proteins based on *in vitro* data. Binding of dolutegravir to plasma proteins was independent of concentration. Total blood and plasma drug-related radioactivity concentration ratios averaged between 0.441 to 0.535 indicating minimal association of radioactivity with blood cellular components. Free fraction of dolutegravir in plasma is estimated at approximately 0.2 to 1.1% in healthy patients, approximately 0.4 to 0.5% in patients with moderate hepatic impairment, and 0.8 to 1.0% in patients with severe renal impairment and 0.5% in HIV-1 infected patients.

Intravenous studies with abacavir showed that the mean apparent volume of distribution is 0.8. Plasma protein binding studies *in vitro* indicate that abacavir binds only low to moderately (approximately 49%) to human plasma proteins at therapeutic concentrations.

Intravenous studies with lamivudine showed that the mean apparent volume of distribution is 1.3 l/kg. Lamivudine exhibits linear pharmacokinetics over the therapeutic dose range and displays low plasma protein binding (less than 36%).

Dolutegravir, abacavir and lamivudine are present in cerebrospinal fluid (CSF). In 12 treatment-naïve patients receiving a regimen of dolutegravir plus abacavir/lamivudine for 16 weeks, dolutegravir concentration in CSF averaged 16.2 ng/mL at Week 2 and 12.6 ng/mL at Week 16, ranging from 3.7 to 23.2 ng/mL (comparable to unbound plasma concentration; 16.8 ng/mL at week 2 and 23 ng/mL at week 16, ranging from 3.81 to 32.1 ng/mL). CSF:plasma concentration ratio of dolutegravir ranged from 0.11 to 2.04%. Dolutegravir concentrations in CSF exceeded the IC_{50} (0.52 nM=0.2 ng/mL), supporting the median reduction from baseline in CSF HIV-1 RNA of 2.2 log after 2 weeks and 3.4 log after 16 weeks of therapy.

Studies with abacavir demonstrate a CSF to plasma AUC ratio of between 30 to 44%. The observed values of the peak concentrations are 9 fold greater than the IC_{50} of abacavir of 0.08 micrograms/mL or 0.26 micromolar when abacavir is given at 600 mg twice daily.

The mean ratio of CSF/serum lamivudine concentrations 2 to 4 h after oral administration was approximately 12%. The true extent of CNS penetration of lamivudine and its relationship with any clinical efficacy is unknown.

Dolutegravir is present in the female and male genital tract. AUC in cervicovaginal fluid, cervical tissue, and vaginal tissue were 6 to 10% of that in corresponding plasma at steady-state. AUC was 7% in semen and 17% in rectal tissue, of those in corresponding plasma at steady-state.

Biotransformation

Dolutegravir is primarily metabolised via UGT1A1 with a minor CYP3A component (9.7% of total dose administered in a human mass balance study). Dolutegravir is the predominant circulating compound in plasma; renal elimination of unchanged drug is low (<1% of the dose). Fifty-three percent of total oral dose is excreted unchanged in the faeces. It is unknown if all or part of this is due to unabsorbed drug or biliary excretion of the glucuronidate conjugate, which can be further degraded to form the parent compound in the gut lumen. Thirty-one percent of the total oral dose is excreted in the urine, represented by ether glucuronide of dolutegravir (18.9% of total dose), N-dealkylation metabolite (3.6% of total dose), and a metabolite formed by oxidation at the benzylic carbon (3.0% of total dose).

Abacavir is primarily metabolised by the liver with less than 2% of the administered dose being renally excreted as unchanged compound. The primary pathways of metabolism in man are by alcohol dehydrogenase and by glucuronidation to produce the 5'-carboxylic acid and 5'-glucuronide which account for about 66% of the administered dose. These metabolites are excreted in the urine.

Metabolism of lamivudine is a minor route of elimination. Lamivudine is predominately cleared unchanged by renal excretion. The likelihood of metabolic interactions with lamivudine is low due to the small extent of hepatic metabolism (less than 10%).

Elimination

Dolutegravir has a terminal half-life of ~14 hours and an apparent clearance (CL/F) of 0.56 L/hr.

The mean half-life of abacavir is about 1.5 hours. The geometric mean terminal half-life of intracellular carbovir-TP at steady-state is 20.6 hours. Following multiple oral doses of abacavir 300 mg twice a day, there is no significant accumulation of abacavir. Elimination of abacavir is via hepatic metabolism with subsequent excretion of metabolites primarily in the urine. The metabolites and unchanged abacavir account for about 83% of the administered abacavir dose in the urine. The remainder is eliminated in the faeces.

The observed lamivudine half-life of elimination is 18 to 19 hours. For patients receiving lamivudine 300 mg once daily, the terminal intracellular half-life of lamivudine-TP was prolonged from 16 to 19 hours. The mean systemic clearance of lamivudine is approximately 0.32 L/h/kg, predominantly by renal clearance (greater than 70%) via the organic cationic transport system.

Special populations

Paediatric population

In a paediatric study including 23 antiretroviral treatment-experienced HIV-1 infected adolescents aged 12 to 18 years of age, the pharmacokinetics of dolutegravir was evaluated in 10 adolescents and showed that dolutegravir 50 mg once daily dosage resulted in dolutegravir exposure in paediatric patients comparable to that observed in adults who received dolutegravir 50 mg once daily (Table 9).

Table 9. Paediatric pharmacokinetic parameters (n=10)

Age/weight	Dolutegravir Dose	Dolutegravir Pharmacokinetic Parameter Estimates Geometric Mean (CV%)		
		AUC ₍₀₋₂₄₎ μg.hr/mL	C _{max} μg/mL	C ₂₄ μg/mL
12 to <18 years ≥ 40 kg ^a	50 mg once daily ^a	46 (43)	3.49 (38)	0.90 (59)

^aOne patient weighing 37 kg received 35 mg once daily.

Limited data are available in adolescents receiving a daily dose of 600 mg of abacavir and 300 mg of lamivudine. Pharmacokinetic parameters are comparable to those reported in adults.

Elderly

Population pharmacokinetic analysis of dolutegravir using data in HIV-1 infected adults showed that there was no clinically relevant effect of age on dolutegravir exposure.

Pharmacokinetic data for dolutegravir, abacavir and lamivudine in patients of >65 years old are limited.

Hepatically impaired

Pharmacokinetic data has been obtained for dolutegravir, abacavir and lamivudine alone. Based on data obtained for abacavir, TRIUMEQ is not recommended in patients with moderate and severe hepatic impairment.

Abacavir is metabolised primarily by the liver. The pharmacokinetics of abacavir have been studied in patients with mild hepatic impairment (Child-Pugh score 5 to 6). The results showed that there was a mean increase of 1.89 fold in the abacavir AUC and 1.58 fold in the half-life of abacavir. The AUCs of the metabolites were not modified by the liver disease. However, the rates of formation and elimination of these were decreased. Dosage reduction of abacavir may be required in patients with mild hepatic impairment. The separate preparation of abacavir should therefore be used to treat these patients. The pharmacokinetics of abacavir have not been studied in patients with moderate or severe hepatic impairment. Plasma concentrations of abacavir are expected to be variable and substantially increased in these patients. TRIUMEQ is therefore not recommended in patients with moderate and severe hepatic impairment.

Data obtained for lamivudine in patients with moderate to severe hepatic impairment and for dolutegravir in patients with moderate hepatic impairment show that the pharmacokinetics are not significantly affected by hepatic dysfunction.

Dolutegravir is primarily metabolised and eliminated by the liver. In a study comparing 8 patients with moderate hepatic impairment (Child-Pugh category B) to 8 matched healthy adult controls, the single 50 mg dose exposure of dolutegravir was similar between the two groups. The effect of severe hepatic impairment on the pharmacokinetics of dolutegravir has not been studied.

Renally impaired

Pharmacokinetic data have been obtained for dolutegravir, abacavir and lamivudine alone.

TRIUMEQ should not be used in patients with creatinine clearance of less than 30 mL/min because, whilst no dosage adjustment of dolutegravir or abacavir is necessary in patients

with renal impairment, dose reduction is required for the lamivudine component. Therefore, the separate preparation of lamivudine should be used to treat these patients.

Studies with lamivudine show that plasma concentrations (AUC) are increased in patients with renal dysfunction due to decreased clearance.

Abacavir is primarily metabolised by the liver, with approximately 2% of abacavir excreted unchanged in the urine. The pharmacokinetics of abacavir in patients with end-stage renal disease is similar to patients with normal renal function.

Renal clearance of unchanged drug is a minor pathway of elimination for dolutegravir. A study of the pharmacokinetics of dolutegravir was performed in patients with severe renal impairment (CL_{cr} <30 mL/min). No clinically important pharmacokinetic differences between patients with severe renal impairment (CL_{cr} <30 mL/min) and matching healthy patients were observed. There is limited information on dolutegravir in patients on dialysis, though differences in exposure are not expected.

Polymorphisms in drug metabolising enzymes

There is no evidence that common polymorphisms in drug metabolising enzymes alter dolutegravir pharmacokinetics to a clinically meaningful extent. In a meta-analysis using pharmacogenomics samples collected in clinical studies in healthy patients, patients with UGT1A1 (n=7) genotypes conferring poor dolutegravir metabolism had a 32% lower clearance of dolutegravir and 46% higher AUC compared with patients with genotypes associated with normal metabolism via UGT1A1 (n=41). Polymorphisms in CYP3A4, CYP3A5, and NR1I2 were not associated with differences in the pharmacokinetics of dolutegravir.

Gender

The dolutegravir exposure in healthy patients appear to be slightly higher (~20%) in women than men based on data obtained in a healthy patient study (males n=17, females n=24). Population PK analyses using pooled pharmacokinetic data from Phase IIb and Phase III adult trials revealed no clinically relevant effect of gender on the exposure of dolutegravir.

There is no evidence that a dose adjustment of dolutegravir, abacavir or lamivudine would be required based on the effects of gender on PK parameters.

Race

Population PK analyses using pooled pharmacokinetic data from Phase IIb and Phase III adult trials revealed no clinically relevant effect of race on the exposure of dolutegravir. The pharmacokinetics of dolutegravir following single dose oral administration to Japanese patients appear similar to observed parameters in Western (US) patients.

There is no evidence that a dose adjustment of dolutegravir, abacavir or lamivudine would be required based on the effects of race on PK parameters.

Co-infection with Hepatitis B or C

Population PK analysis indicated that hepatitis C virus co-infection had no clinically relevant effect on the exposure to dolutegravir. There are limited pharmacokinetic data on patients with hepatitis B co-infection (see section 4.4 Special warning and precautions for use).

5.3 Preclinical safety data

Genotoxicity

No genotoxicity studies have been conducted with the combination of dolutegravir, abacavir and lamivudine.

Dolutegravir was not mutagenic or clastogenic using *in vitro* tests in bacteria and cultured mammalian cells, and an *in vivo* rodent micronucleus assay.

Neither abacavir nor lamivudine were mutagenic in bacterial tests, but both induced mutations in a mouse lymphoma assay and were clastogenic in human peripheral lymphocytes *in vitro*. In rats, lamivudine did not cause chromosomal damage in bone marrow cells *in vivo* or cause DNA damage in primary hepatocytes. Abacavir was clastogenic in an *in vivo* micronucleus assay in mice, but not in rats when tested in combination with lamivudine at systemic exposures corresponding to 86 and 31 times the clinical exposure level for ABC and 3TC, respectively.

Carcinogenicity

No carcinogenicity studies have been conducted with the combination of dolutegravir, abacavir and lamivudine.

Dolutegravir was not carcinogenic in long term studies in the mouse and rat (respectively, 27 and 23 times the 50 mg human clinical exposure when dolutegravir is administered in combination with abacavir and lamivudine, based on AUC).

Carcinogenicity studies with orally administered abacavir in mice and rats showed an increase in the incidence of malignant and non-malignant tumours. Malignant tumours occurred in the preputial gland of males and the clitoral gland of females of both species, and in the liver, urinary bladder, lymph nodes and the subcutis of female rats. Nonmalignant tumours occurred in the liver of mice and rats, Harderian gland of female mice, and thyroid gland of rats. In rats, there were also increased incidences of urothelial hyperplasia and urinary bladder tumours, associated with increased urinary calculi.

The majority of these tumours occurred at the highest abacavir dose of 330 mg/kg/day in mice and 600 mg/kg/day in rats. These dose levels were equivalent to 21 to 30 times the expected systemic exposure in humans when abacavir is administered in combination with dolutegravir and lamivudine. The exception was preputial gland tumours in mice which occurred at a dose of 110 mg/kg. Exposure at this dose is approximately 5 times the expected human systemic exposure. The carcinogenic potential in humans is unknown.

When lamivudine was administered orally to separate groups of rodents at doses up to 2000 times (mice and male rats) and 3000 (female rats) mg/kg/day, there was no evidence of a carcinogenic effect due to lamivudine in the mouse study. In the rat study there was an increased incidence of endometrial tumours at the highest dose (approximately 70 times the estimated human exposure at the recommended therapeutic dose of one tablet twice daily, based on AUC). However, the relationship of this increase to treatment is uncertain.

Animal toxicology

The effect of prolonged daily treatment with high doses of dolutegravir has been evaluated in repeat oral dose toxicity studies in rats (up to 26 weeks) and in monkeys (up to 38 weeks). The primary effect of dolutegravir was gastrointestinal intolerance or irritation in rats and monkeys at doses that produce systemic exposures approximately 38 and 1.5 times the 50 mg human clinical exposure when dolutegravir is administered in combination with abacavir and lamivudine, based on AUC, respectively. Because gastrointestinal (GI) intolerance is considered to be due to local drug administration, mg/kg or mg/m² metrics are appropriate determinates of safety cover for this toxicity. GI intolerance in monkeys occurred at 30 times the human mg/kg equivalent dose (based on 50 kg human), and 11 times the human mg/m² equivalent dose for a total daily clinical dose of 50 mg.

Mild myocardial degeneration in the heart of mice and rats was observed following administration of abacavir for two years. The systemic exposures were equivalent to 7 to 19

times human exposure at 600 mg when abacavir is administered in combination with dolutegravir and lamivudine. The clinical relevance of this finding has not been determined.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Tablet core

Mannitol (E421)

Microcrystalline cellulose

Povidone K29/32

Sodium starch glycollate

Magnesium stearate

Tablet coating

Opadry II Purple 85F90057 containing:

Polyvinyl alcohol – part hydrolyzed

Titanium dioxide

Macrogol

Talc

Iron oxide black

Iron oxide red

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

3 years.

6.4 Special precautions for storage

Store below 30°C. Store in the original package in order to protect from moisture. Keep the bottle tightly closed. Do not remove the desiccant.

6.5 Nature and contents of container

TRIUMEQ tablets are supplied in white high density polyethylene (HDPE) bottles with child resistant closure packs containing 30 tablets.

6.6 Special precautions for disposal

No special requirements.

7. MEDICINE SCHEDULE

Prescription Medicine.

8. SPONSOR

GlaxoSmithKline (NZ) Ltd
Private Bag 106600
Downtown
Auckland

Phone: (09) 367 2900
Facsimile: (09) 367 2910

9. DATE OF FIRST APPROVAL

Date of publication in the New Zealand Gazette of consent to distribute the medicine: 18 June 2015.

10. DATE OF REVISION OF THE TEXT

28 April 2022

SUMMARY TABLE OF CHANGES

Section changed	Summary of new information
4.6	Addition of information in pregnancy and lactation.
	Updated copyright statement.

Version 12.0

Trade marks are owned by or licensed to the ViiV Healthcare Group of Companies.

© 2022 ViiV group of companies or its licensor.