ANNEX I

SUMMARY OF PRODUCT CHARACTERISTICS
1. NAME OF THE MEDICINAL PRODUCT

Viread 123 mg film-coated tablets

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains 123 mg of tenofovir disoproxil (as fumarate).

**Excipient with known effect**
Each tablet contains 82 mg lactose (as monohydrate).

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Film-coated tablet (tablet).

White, triangle-shaped, film-coated tablets, 8.5 mm in diameter, debossed on one side with “GSI” and on the other side with “150”.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Viread 123 mg film-coated tablets are indicated in combination with other antiretroviral medicinal products for the treatment of HIV-1 infected paediatric patients, with NRTI resistance or toxicities precluding the use of first line agents, aged 6 to < 12 years who weigh from 17 kg to less than 22 kg.

The choice of Viread to treat antiretroviral-experienced patients with HIV-1 infection should be based on individual viral resistance testing and/or treatment history of patients.

4.2 Posology and method of administration

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

**Posology**

The recommended dose for HIV-1 infected paediatric patients aged 6 to < 12 years weighing 17 kg to < 22 kg who are able to swallow film-coated tablets is one 123 mg tablet once daily taken orally with food.

Please refer to the Summaries of Product Characteristics for Viread 163 mg and 204 mg film-coated tablets for the treatment of HIV-1 infected paediatric patients aged 6 to < 12 years weighing 22 kg to < 28 kg and 28 kg to < 35 kg, respectively.

Viread is also available as 33 mg/g granules for use in HIV-1 infected paediatric patients aged 2 to < 12 years who weigh < 17 kg or who are unable to swallow film-coated tablets. Please refer to the Summary of Product Characteristics for Viread 33 mg/g granules.

**Missed dose**

If a patient misses a dose of Viread within 12 hours of the time it is usually taken, the patient should take Viread with food as soon as possible and resume their normal dosing schedule. If a patient misses a dose of Viread by more than 12 hours and it is almost time for their next dose, the patient should not take the missed dose and simply resume the usual dosing schedule.
If the patient vomits within 1 hour of taking Viread, another tablet should be taken. If the patient vomits more than 1 hour after taking Viread they do not need to take another dose.

Special populations
Renal impairment
The use of tenofovir disoproxil fumarate is not recommended in paediatric patients with renal impairment (see section 4.4).

Hepatic impairment
No dose adjustment is required in patients with hepatic impairment (see sections 4.4 and 5.2).

If Viread 123 mg film-coated tablets are discontinued in patients co-infected with HIV and hepatitis B virus (HBV), these patients should be closely monitored for evidence of exacerbation of hepatitis (see section 4.4).

Paediatric population
The safety and efficacy of tenofovir disoproxil fumarate in HIV-1 infected children under 2 years of age have not been established. No data are available.

The safety and efficacy of tenofovir disoproxil fumarate in children with chronic hepatitis B aged 2 to < 12 years or weighing < 35 kg have not been established. No data are available.

Method of administration
Viread 123 mg film-coated tablets should be taken once daily, orally with food.

4.3 Contraindications

Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.

4.4 Special warnings and precautions for use

General
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.

Co-administration of other medicinal products
- Viread should not be administered concomitantly with other medicinal products containing tenofovir disoproxil fumarate or tenofovir alafenamide.
- Viread should not be administered concomitantly with adefovir dipivoxil.
- Co-administration of tenofovir disoproxil fumarate and didanosine is not recommended. Co-administration of tenofovir disoproxil fumarate and didanosine results in a 40-60% increase in systemic exposure to didanosine that may increase the risk of didanosine-related adverse reactions (see section 4.5). Rarely, pancreatitis and lactic acidosis, sometimes fatal, have been reported. Co-administration of tenofovir disoproxil fumarate and didanosine at a dose of 400 mg daily has been associated with a significant decrease in CD4 cell count, possibly due to an intracellular interaction increasing phosphorylated (i.e. active) didanosine. A decreased dosage of 250 mg didanosine co-administered with tenofovir disoproxil fumarate therapy has been associated with reports of high rates of virological failure within several tested combinations for the treatment of HIV-1 infection.

Triple therapy with nucleosides/nucleotides
There have been reports of a high rate of virological failure and of emergence of resistance at an early stage in HIV patients when tenofovir disoproxil fumarate was combined with lamivudine and abacavir as well as with lamivudine and didanosine as a once-daily regimen.
Renal and bone effects in adult population

Renal effects
Tenofovir is principally eliminated via the kidney. Renal failure, renal impairment, elevated creatinine, hypophosphataemia and proximal tubulopathy (including Fanconi syndrome) have been reported with the use of tenofovir disoproxil fumarate in clinical practice (see section 4.8).

Renal impairment
Renal safety with tenofovir has only been studied to a very limited degree in adult patients with impaired renal function (creatinine clearance < 80 ml/min).

Bone effects
In HIV infected patients, in a 144-week controlled clinical study that compared tenofovir disoproxil fumarate with stavudine in combination with lamivudine and efavirenz in antiretroviral-naive adult patients, small decreases in bone mineral density (BMD) of the hip and spine were observed in both treatment groups. Decreases in BMD of spine and changes in bone biomarkers from baseline were significantly greater in the tenofovir disoproxil fumarate treatment group at 144 weeks. Decreases in BMD of hip were significantly greater in this group until 96 weeks. However, there was no increased risk of fractures or evidence for clinically relevant bone abnormalities over 144 weeks.

In other studies (prospective and cross-sectional), the most pronounced decreases in BMD were seen in patients treated with tenofovir disoproxil fumarate as part of a regimen containing a boosted protease inhibitor. Alternative treatment regimens should be considered for patients with osteoporosis that are at a high risk for fractures.

Bone abnormalities (infrequently contributing to fractures) may be associated with proximal renal tubulopathy (see section 4.8).

Renal and bone effects in paediatric population
There are uncertainties associated with the long term effects of bone and renal toxicity. Moreover, the reversibility of renal toxicity cannot be fully ascertained. Therefore, a multidisciplinary approach is recommended to adequately weigh on a case by case basis the benefit/risk balance of treatment, decide the appropriate monitoring during treatment (including decision for treatment withdrawal) and consider the need for supplementation.

Renal effects
Renal adverse reactions consistent with proximal renal tubulopathy have been reported in HIV-1 infected paediatric patients aged 2 to < 12 years in clinical study GS-US-104-0352 (see sections 4.8 and 5.1).

Renal monitoring
It is recommended that renal function (creatinine clearance and serum phosphate) is assessed in all patients prior to initiating therapy with tenofovir disoproxil fumarate and that it is also monitored after two to four weeks of treatment, after three months of treatment and every three to six months thereafter in patients without renal risk factors. In patients at risk for renal impairment, a more frequent monitoring of renal function is required.

Renal management
If serum phosphate is confirmed to be < 3.0 mg/dl (0.96 mmol/l) in any paediatric patient receiving tenofovir disoproxil fumarate, renal function should be re-evaluated within one week, including measurements of blood glucose, blood potassium and urine glucose concentrations (see section 4.8, proximal tubulopathy). If renal abnormalities are suspected or detected then consultation with a nephrologist should be obtained to consider interruption of tenofovir disoproxil fumarate treatment. Interrupting treatment with tenofovir disoproxil fumarate should also be considered in case of progressive decline of renal function when no other cause has been identified.
Co-administration and risk of renal toxicity

Use of tenofovir disoproxil fumarate should be avoided with concurrent or recent use of a nephrotoxic medicinal product (e.g. aminoglycosides, amphotericin B, foscarnet, ganciclovir, pentamidine, vancomycin, cidofovir or interleukin-2). If concomitant use of tenofovir disoproxil fumarate and nephrotoxic agents is unavoidable, renal function should be monitored weekly.

Cases of acute renal failure after initiation of high dose or multiple non-steroidal anti-inflammatory drugs (NSAIDs) have been reported in patients treated with tenofovir disoproxil fumarate and with risk factors for renal dysfunction. If tenofovir disoproxil fumarate is co-administered with an NSAID, renal function should be monitored adequately.

A higher risk of renal impairment has been reported in patients receiving tenofovir disoproxil fumarate in combination with a ritonavir or cobicistat boosted protease inhibitor. A close monitoring of renal function is required in these patients (see section 4.5). In patients with renal risk factors, the co-administration of tenofovir disoproxil fumarate with a boosted protease inhibitor should be carefully evaluated.

Tenofovir disoproxil fumarate has not been clinically evaluated in patients receiving medicinal products which are secreted by the same renal pathway, including the transport proteins human organic anion transporter (hOAT) 1 and 3 or MRP 4 (e.g. cidofovir, a known nephrotoxic medicinal product). These renal transport proteins may be responsible for tubular secretion and in part, renal elimination of tenofovir and cidofovir. Consequently, the pharmacokinetics of these medicinal products, which are secreted by the same renal pathway including transport proteins hOAT 1 and 3 or MRP 4, might be modified if they are co-administered. Unless clearly necessary, concomitant use of these medicinal products which are secreted by the same renal pathway is not recommended, but if such use is unavoidable, renal function should be monitored weekly (see section 4.5).

Renal impairment

The use of tenofovir disoproxil fumarate is not recommended in paediatric patients with renal impairment (see section 4.2). Tenofovir disoproxil fumarate should not be initiated in paediatric patients with renal impairment and should be discontinued in paediatric patients who develop renal impairment during tenofovir disoproxil fumarate therapy.

Bone effects

Viread may cause a reduction in BMD. The effects of tenofovir disoproxil fumarate-associated changes in BMD on long-term bone health and future fracture risk are currently unknown (see section 5.1).

If bone abnormalities are detected or suspected in paediatric patients, consultation with an endocrinologist and/or nephrologist should be obtained.

Patients with HIV and hepatitis B or C virus co-infection

Patients with chronic hepatitis B or C and treated with antiretroviral therapy are at an increased risk for severe and potentially fatal hepatic adverse reactions.

Physicians should refer to current HIV treatment guidelines for the optimal management of HIV infection in patients co-infected with hepatitis B virus (HBV).

In case of concomitant antiviral therapy for hepatitis B or C, please refer also to the relevant Summary of Product Characteristics for these medicinal products.

Discontinuation of Viread therapy in patients co-infected with HIV and HBV may be associated with severe acute exacerbations of hepatitis. Patients co-infected with HIV and HBV who discontinue Viread should be closely monitored with both clinical and laboratory follow-up for at least 6 months after stopping treatment. In patients with advanced liver disease or cirrhosis, treatment discontinuation is not recommended since post-treatment exacerbation of hepatitis may lead to hepatic decompensation.
Use with certain hepatitis C virus antiviral agents
Co-administration of tenofovir disoproxil fumarate with ledipasvir/sofosbuvir or sofosbuvir/velpatasvir has been shown to increase plasma concentrations of tenofovir, especially when used together with an HIV regimen containing tenofovir disoproxil fumarate and a pharmacokinetic enhancer (ritonavir or cobicistat). The safety of tenofovir disoproxil fumarate in the setting of ledipasvir/sofosbuvir or sofosbuvir/velpatasvir and a pharmacokinetic enhancer has not been established. The potential risks and benefits associated with co-administration of ledipasvir/sofosbuvir or sofosbuvir/velpatasvir with tenofovir disoproxil fumarate given in conjunction with a boosted HIV protease inhibitor (e.g. atazanavir or darunavir) should be considered, particularly in patients at increased risk of renal dysfunction. Patients receiving ledipasvir/sofosbuvir or sofosbuvir/velpatasvir concomitantly with tenofovir disoproxil fumarate and a boosted HIV protease inhibitor should be monitored for adverse reactions related to tenofovir disoproxil fumarate.

Liver disease
Tenofovir and tenofovir disoproxil fumarate are not metabolised by liver enzymes. A pharmacokinetic study has been performed in non-HIV infected adult patients with various degrees of hepatic impairment. No significant pharmacokinetic alteration has been observed in these patients (see section 5.2).

Patients with pre-existing liver dysfunction, including chronic active hepatitis, have an increased frequency of liver function abnormalities during combination antiretroviral therapy (CART) and should be monitored according to standard practice. If there is evidence of worsening liver disease in such patients, interruption or discontinuation of treatment must be considered.

Weight and metabolic parameters
An increase in weight and in levels of blood lipids and glucose may occur during antiretroviral therapy. Such changes may in part be linked to disease control and life style. For lipids, there is in some cases evidence for a treatment effect, while for weight gain there is no strong evidence relating this to any particular treatment. For monitoring of blood lipids and glucose reference is made to established HIV treatment guidelines. Lipid disorders should be managed as clinically appropriate.

Mitochondrial dysfunction following exposure in utero
Nucleos(t)ide analogues may impact mitochondrial function to a variable degree, which is most pronounced with stavudine, didanosine and zidovudine. There have been reports of mitochondrial dysfunction in HIV negative infants exposed in utero and/or postnatally to nucleoside analogues; these have predominantly concerned treatment with regimens containing zidovudine. The main adverse reactions reported are haematological disorders (anaemia, neutropenia) and metabolic disorders (hyperlactatemia, hyperlipasemia). These events have often been transitory. Late onset neurological disorders have been reported rarely (hypertonia, convulsion, abnormal behaviour). Whether such neurological disorders are transient or permanent is currently unknown. These findings should be considered for any child exposed in utero to nucleos(t)ide analogues, who present with severe clinical findings of unknown etiology, particularly neurologic findings. These findings do not affect current national recommendations to use antiretroviral therapy in pregnant women to prevent vertical transmission of HIV.

Immune reactivation syndrome
In HIV infected patients with severe immune deficiency at the time of institution of CART, an inflammatory reaction to asymptomatic or residual opportunistic pathogens 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 CART. Relevant examples are cytomegalovirus retinitis, generalised and/or focal mycobacterial infections, and *Pneumocystis jiroveci* pneumonia. Any inflammatory symptoms should be evaluated and treatment instituted when necessary.

Autoimmune disorders (such as Graves’ disease) have also been reported to occur in the setting of immune reactivation; however, the reported time to onset is more variable and these events can occur many months after initiation of treatment.
Osteonecrosis
Although the aetiology is considered to be multifactorial (including corticosteroid use, alcohol consumption, severe immunosuppression, higher body mass index), cases of osteonecrosis have been reported, particularly in patients with advanced HIV disease and/or long-term exposure to CART. Patients should be advised to seek medical advice if they experience joint aches and pain, joint stiffness or difficulty in movement.

Viread 123 mg film-coated tablets contain lactose monohydrate. Consequently, patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency, or glucose-galactose malabsorption should not take this medicinal product.

4.5 Interaction with other medicinal products and other forms of interaction
Interaction studies have only been performed in adults.

Based on the results of in vitro experiments and the known elimination pathway of tenofovir, the potential for CYP450-mediated interactions involving tenofovir with other medicinal products is low.

Concomitant use not recommended
Viread should not be administered concomitantly with other medicinal products containing tenofovir disoproxil fumarate or tenofovir alafenamide.

Viread should not be administered concomitantly with adefovir dipivoxil.

Didanosine
Co-administration of tenofovir disoproxil fumarate and didanosine is not recommended (see section 4.4 and Table 1).

Renally eliminated medicinal products
Since tenofovir is primarily eliminated by the kidneys, co-administration of tenofovir disoproxil fumarate with medicinal products that reduce renal function or compete for active tubular secretion via transport proteins hOAT 1, hOAT 3 or MRP 4 (e.g. cidofovir) may increase serum concentrations of tenofovir and/or the co-administered medicinal products.

Use of tenofovir disoproxil fumarate should be avoided with concurrent or recent use of a nephrotoxic medicinal product. Some examples include, but are not limited to, aminoglycosides, amphotericin B, foscarinet, ganciclovir, pentamidine, vancomycin, cidofovir or interleukin-2 (see section 4.4).

Given that tacrolimus can affect renal function, close monitoring is recommended when it is co-administered with tenofovir disoproxil fumarate.

Other interactions
Interactions between tenofovir disoproxil fumarate and other medicinal products are listed in Table 1 below (increase is indicated as “↑”, decrease as “↓”, no change as “↔”, twice daily as “b.i.d.”, and once daily as “q.d.”).
### Table 1: Interactions between tenofovir disoproxil fumarate and other medicinal products

<table>
<thead>
<tr>
<th>Medicinal product by therapeutic areas (dose in mg)</th>
<th>Effects on drug levels Mean percent change in AUC, $C_{\text{max}}$, $C_{\text{min}}$</th>
<th>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</th>
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</thead>
<tbody>
<tr>
<td><strong>ANTI-INFECTIVES</strong></td>
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<tr>
<td><strong>Antiretrovirals</strong></td>
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<tr>
<td><strong>Protease inhibitors</strong></td>
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</tbody>
</table>
| Atazanavir/Ritonavir (300 q.d./100 q.d./300 q.d.) | Atazanavir: AUC: ↓ 25%  
$C_{\text{max}}$: ↓ 28%  
$C_{\text{min}}$: ↓ 26%  
Tenofovir: AUC: ↑ 37%  
$C_{\text{max}}$: ↑ 34%  
$C_{\text{min}}$: ↑ 29% | No dose adjustment is recommended. The increased exposure of tenofovir could potentiate tenofovir-associated adverse events, including renal disorders. Renal function should be closely monitored (see section 4.4). |
| Lopinavir/Ritonavir (400 b.i.d./100 b.i.d./300 q.d.) | Lopinavir/ritonavir: No significant effect on lopinavir/ritonavir PK parameters.  
Tenofovir: AUC: ↑ 32%  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↑ 51% | No dose adjustment is recommended. The increased exposure of tenofovir could potentiate tenofovir-associated adverse events, including renal disorders. Renal function should be closely monitored (see section 4.4). |
| Darunavir/Ritonavir (300/100 b.i.d./300 q.d.) | Darunavir: No significant effect on darunavir/ritonavir PK parameters.  
Tenofovir: AUC: ↑ 22%  
$C_{\text{min}}$: ↑ 37% | No dose adjustment is recommended. The increased exposure of tenofovir could potentiate tenofovir-associated adverse events, including renal disorders. Renal function should be closely monitored (see section 4.4). |
<p>| <strong>NRTIs</strong>                                        |                                                                                  |                                                                                  |
| Didanosine                                       | Co-administration of tenofovir disoproxil fumarate and didanosine results in a 40-60% increase in systemic exposure to didanosine that may increase the risk for didanosine-related adverse reactions. Rarely, pancreatitis and lactic acidosis, sometimes fatal, have been reported. Co-administration of tenofovir disoproxil fumarate and didanosine at a dose of 400 mg daily has been associated with a significant decrease in CD4 cell count, possibly due to an intracellular interaction increasing phosphorylated (i.e. active) didanosine. A decreased dosage of 250 mg didanosine co-administered with tenofovir disoproxil fumarate therapy has been associated with reports of high rates of virological failure within several tested combinations for the treatment of HIV-1 infection. | Co-administration of tenofovir disoproxil fumarate and didanosine is not recommended (see section 4.4). |</p>
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<th>Medicinal product by therapeutic areas (dose in mg)</th>
<th>Effects on drug levels Mean percent change in AUC, C&lt;sub&gt;max&lt;/sub&gt;, C&lt;sub&gt;min&lt;/sub&gt;</th>
<th>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</th>
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<tbody>
<tr>
<td>Adefovir dipivoxil</td>
<td>AUC: ↔ C&lt;sub&gt;max&lt;/sub&gt;: ↔</td>
<td>Tenofovir disoproxil fumarate should not be administered concurrently with adefovir dipivoxil (see section 4.4).</td>
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<tr>
<td><strong>Hepatitis C virus antiviral agents</strong></td>
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<tr>
<td>Ledipasvir/Sofosbuvir (90 mg/400 mg q.d.) +</td>
<td>Ledipasvir: AUC: ↑ 96% C&lt;sub&gt;max&lt;/sub&gt;: ↑ 68% C&lt;sub&gt;min&lt;/sub&gt;: ↑ 118%</td>
<td>Increased plasma concentrations of tenofovir resulting from co-administration of tenofovir disoproxil fumarate, ledipasvir/sofosbuvir and atazanavir/ritonavir may increase adverse reactions related to tenofovir disoproxil fumarate, including renal disorders. The safety of tenofovir disoproxil fumarate when used with ledipasvir/sofosbuvir and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established. The combination should be used with caution with frequent renal monitoring, if other alternatives are not available (see section 4.4).</td>
</tr>
<tr>
<td>Atazanavir/Ritonavir (300 mg q.d./100 mg q.d.) +</td>
<td>Sofosbuvir: AUC: ↔ C&lt;sub&gt;max&lt;/sub&gt;: ↔ C&lt;sub&gt;min&lt;/sub&gt;: ↑ 42%</td>
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</tr>
<tr>
<td>Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.)¹</td>
<td>GS-331007²: AUC: ↔ C&lt;sub&gt;max&lt;/sub&gt;: ↔ C&lt;sub&gt;min&lt;/sub&gt;: ↑ 42%</td>
<td></td>
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<tr>
<td>Atazanavir: AUC: ↔ C&lt;sub&gt;max&lt;/sub&gt;: ↔ C&lt;sub&gt;min&lt;/sub&gt;: ↑ 63%</td>
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<tr>
<td>Ritonavir: AUC: ↔ C&lt;sub&gt;max&lt;/sub&gt;: ↔ C&lt;sub&gt;min&lt;/sub&gt;: ↑ 45%</td>
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<tr>
<td>Emtricitabine: AUC: ↔ C&lt;sub&gt;max&lt;/sub&gt;: ↔ C&lt;sub&gt;min&lt;/sub&gt;: ↔</td>
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<tr>
<td>Tenofovir: AUC: ↔ C&lt;sub&gt;max&lt;/sub&gt;: ↑ 47% C&lt;sub&gt;min&lt;/sub&gt;: ↑ 47%</td>
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<td>Medicinal product by therapeutic areas (dose in mg)</td>
<td>Effects on drug levels Mean percent change in AUC, C&lt;sub&gt;max&lt;/sub&gt;, C&lt;sub&gt;min&lt;/sub&gt;</td>
<td>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</td>
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<tr>
<td>----------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
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</tbody>
</table>
| Ledipasvir/Sofosbuvir (90 mg/400 mg q.d.) + Darunavir/Ritonavir (800 mg q.d./100 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.)<sup>1</sup> | **Ledipasvir:** AUC: ↔  
C<sub>max</sub>: ↔  
C<sub>min</sub>: ↔  

**Sofosbuvir:** AUC: ↓ 27%  
C<sub>max</sub>: ↓ 37%  

**GS-331007<sup>2</sup>:** AUC: ↔  
C<sub>max</sub>: ↔  
C<sub>min</sub>: ↔  

**Darunavir:** AUC: ↔  
C<sub>max</sub>: ↔  
C<sub>min</sub>: ↔  

**Ritonavir:** AUC: ↔  
C<sub>max</sub>: ↔  
C<sub>min</sub>: ↑ 48%  

**Emtricitabine:** AUC: ↔  
C<sub>max</sub>: ↔  
C<sub>min</sub>: ↔  

**Tenofovir:** AUC: ↑ 50%  
C<sub>max</sub>: ↑ 64%  
C<sub>min</sub>: ↑ 59% | Increased plasma concentrations of tenofovir resulting from co-administration of tenofovir disopropil fumarate, ledipasvir/sofosbuvir and darunavir/ritonavir may increase adverse reactions related to tenofovir disopropil fumarate, including renal disorders. The safety of tenofovir disopropil fumarate when used with ledipasvir/sofosbuvir and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established. The combination should be used with caution with frequent renal monitoring, if other alternatives are not available (see section 4.4). |
| Ledipasvir/Sofosbuvir (90 mg/400 mg q.d.) + Efavirenz/Emtricitabine/Tenofovir disoproxil fumarate (600 mg/200 mg/300 mg q.d.) | **Ledipasvir:** AUC: ↓ 34%  
C<sub>max</sub>: ↓ 34%  
C<sub>min</sub>: ↓ 34%  

**Sofosbuvir:** AUC: ↔  
C<sub>max</sub>: ↔  

**GS-331007<sup>2</sup>:** AUC: ↔  
C<sub>max</sub>: ↔  
C<sub>min</sub>: ↔  

**Efavirenz:** AUC: ↔  
C<sub>max</sub>: ↔  
C<sub>min</sub>: ↔  

**Emtricitabine:** AUC: ↔  
C<sub>max</sub>: ↔  
C<sub>min</sub>: ↔ | No dose adjustment is recommended. The increased exposure of tenofovir could potentiate adverse reactions associated with tenofovir disoproxil fumarate, including renal disorders. Renal function should be closely monitored (see section 4.4). |
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</thead>
</table>
| Tenofovir:                                       | **AUC: ↑ 98%**  
$C_{\text{max}}$: ↑ 79%  
$C_{\text{min}}$: ↑ 163% | No dose adjustment is recommended. The increased exposure of tenofovir could potentiate adverse reactions associated with tenofovir disoproxil fumarate, including renal disorders. Renal function should be closely monitored (see section 4.4). |
| Ledipasvir/Sofosbuvir (90 mg/400 mg q.d.) + Emtricitabine/Rilpivirine/Tenofovir disoproxil fumarate (200 mg/25 mg/300 mg q.d.) | **Ledipasvir:**  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
**Sofosbuvir:**  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
**GS-331007**:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
**Emtricitabine:**  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
**Rilpivirine:**  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
**Tenofovir:**  
AUC: ↑ 40%  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↑ 91% | |
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<td>Ledipasvir/Sofosbuvir (90 mg/400 mg q.d.) + Dolutegravir (50 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.)</td>
<td>Sofosbuvir: AUC: ↔ $C_{\text{max}}$: ↔ GS-3310072 AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔ Ledipasvir: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔ Dolutegravir AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔ Emtricitabine: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔ Tenofovir: AUC: ↑ 65% $C_{\text{max}}$: ↑ 61% $C_{\text{min}}$: ↑ 115%</td>
<td>No dose adjustment is recommended. The increased exposure of tenofovir could potentiate adverse reactions associated with tenofovir disoproxil fumarate, including renal disorders. Renal function should be closely monitored (see section 4.4).</td>
</tr>
<tr>
<td>Medicinal product by therapeutic areas (dose in mg)</td>
<td>Effects on drug levels Mean percent change in AUC, C&lt;sub&gt;max&lt;/sub&gt;, C&lt;sub&gt;min&lt;/sub&gt;</td>
<td>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
</tbody>
</table>
| Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Atazanavir/Ritonavir (300 mg q.d./100 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.) | Sofosbuvir:  
AUC: ↔  
C<sub>max</sub>: ↔  
GS-331007<sup>2</sup>:  
AUC: ↔  
C<sub>max</sub>: ↔  
C<sub>min</sub>: ↑ 42%  
Velpatasvir:  
AUC: ↑ 142%  
C<sub>max</sub>: ↑ 55%  
C<sub>min</sub>: ↑ 301%  
Atazanavir:  
AUC: ↔  
C<sub>max</sub>: ↔  
C<sub>min</sub>: ↑ 39%  
Ritonavir:  
AUC: ↔  
C<sub>max</sub>: ↔  
C<sub>min</sub>: ↑ 29%  
Emtricitabine:  
AUC: ↔  
C<sub>max</sub>: ↔  
C<sub>min</sub>: ↔  
Tenofovir:  
AUC: ↔  
C<sub>max</sub>: ↑ 55%  
C<sub>min</sub>: ↑ 39% | Increased plasma concentrations of tenofovir resulting from co-administration of tenofovir disoproxil fumarate, sofosbuvir/velpatasvir and atazanavir/ritonavir may increase adverse reactions related to tenofovir disoproxil fumarate, including renal disorders. The safety of tenofovir disoproxil fumarate when used with sofosbuvir/velpatasvir and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established.  
The combination should be used with caution with frequent renal monitoring (see section 4.4). |
<table>
<thead>
<tr>
<th>Medicinal product by therapeutic areas (dose in mg)</th>
<th>Effects on drug levels</th>
<th>Recommendation concerning co-administration with 245 mg tenofovir disopropil fumarate</th>
</tr>
</thead>
</table>
| Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Darunavir/Ritonavir (800 mg q.d./100 mg q.d.) + Emtricitabine/Tenofovir disopropil fumarate (200 mg/300 mg q.d.) | Sofosbuvir:  
AUC: ↓28%  
C<sub>max</sub>: ↓38%  
GS-331007<sup>2</sup>:  
AUC: ↔  
C<sub>max</sub>: ↔  
C<sub>min</sub>: ↔  
Velpatasvir:  
AUC: ↔  
C<sub>max</sub>: ↓24%  
C<sub>min</sub>: ↔  
Darunavir:  
AUC: ↔  
C<sub>max</sub>: ↔  
C<sub>min</sub>: ↔  
Ritonavir:  
AUC: ↔  
C<sub>max</sub>: ↔  
C<sub>min</sub>: ↔  
Emtricitabine:  
AUC: ↔  
C<sub>max</sub>: ↔  
C<sub>min</sub>: ↔  
Tenofovir:  
AUC: ↑39%  
C<sub>max</sub>: ↑55%  
C<sub>min</sub>: ↑52% | Increased plasma concentrations of tenofovir resulting from co-administration of tenofovir disopropil fumarate, sofosbuvir/velpatasvir and darunavir/ritonavir may increase adverse reactions related to tenofovir disopropil fumarate, including renal disorders. The safety of tenofovir disopropil fumarate when used with sofosbuvir/velpatasvir and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established.  
The combination should be used with caution with frequent renal monitoring (see section 4.4). |
<table>
<thead>
<tr>
<th>Medicinal product by therapeutic areas (dose in mg)</th>
<th>Effects on drug levels Mean percent change in AUC, C&lt;sub&gt;max&lt;/sub&gt;, C&lt;sub&gt;min&lt;/sub&gt;</th>
<th>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</th>
</tr>
</thead>
</table>
| Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Lopinavir/Ritonavir (800 mg/200 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.) | Sofosbuvir:  
AUC: ↓ 29%  
C<sub>max</sub>: ↓ 41%  
GS-331007:  
AUC: ↔  
C<sub>max</sub>: ↔  
C<sub>min</sub>: ↔  
Velpatasvir:  
AUC: ↔  
C<sub>max</sub>: ↓ 30%  
C<sub>min</sub>: ↑ 63%  
Lopinavir:  
AUC: ↔  
C<sub>max</sub>: ↔  
C<sub>min</sub>: ↔  
Ritonavir:  
AUC: ↔  
C<sub>max</sub>: ↔  
C<sub>min</sub>: ↔  
Emtricitabine:  
AUC: ↔  
C<sub>max</sub>: ↔  
C<sub>min</sub>: ↔  
Tenofovir:  
AUC: ↔  
C<sub>max</sub>: ↑ 42%  
C<sub>min</sub>: ↔  | Increased plasma concentrations of tenofovir resulting from co-administration of tenofovir disoproxil fumarate, sofosbuvir/velpatasvir and lopinavir/ritonavir may increase adverse reactions related to tenofovir disoproxil fumarate, including renal disorders. The safety of tenofovir disoproxil fumarate when used with sofosbuvir/velpatasvir and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established. The combination should be used with caution with frequent renal monitoring (see section 4.4). |
<table>
<thead>
<tr>
<th>Medicinal product by therapeutic areas (dose in mg)</th>
<th>Effects on drug levels Mean percent change in AUC, $C_{\text{max}}$, $C_{\text{min}}$</th>
<th>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</th>
</tr>
</thead>
</table>
| Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Raltegravir (400 mg b.i.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.) | Sofosbuvir:  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: $\leftrightarrow$  
GS-331007$^2$:  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: $\leftrightarrow$  
$C_{\text{min}}$: $\leftrightarrow$  
Velpatasvir:  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: $\leftrightarrow$  
$C_{\text{min}}$: $\leftrightarrow$  
Raltegravir:  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: $\leftrightarrow$  
$C_{\text{min}}$: ↓ 21%  
Emtricitabine:  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: $\leftrightarrow$  
$C_{\text{min}}$: $\leftrightarrow$  
Tenofovir:  
AUC: ↑ 40%  
$C_{\text{max}}$: ↑ 46%  
$C_{\text{min}}$: ↑ 70%  | No dose adjustment is recommended. The increased exposure of tenofovir could potentiate adverse reactions associated with tenofovir disoproxil fumarate, including renal disorders. Renal function should be closely monitored (see section 4.4). |
| Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Efavirenz/Emtricitabine/Tenofovir disoproxil fumarate (600 mg/200 mg/300 mg q.d.) | Sofosbuvir:  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: ↑ 38%  
GS-331007$^2$:  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: $\leftrightarrow$  
$C_{\text{min}}$: $\leftrightarrow$  
Velpatasvir:  
AUC: ↓ 53%  
$C_{\text{max}}$: ↓ 47%  
$C_{\text{min}}$: ↓ 57%  
Efavirenz:  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: $\leftrightarrow$  
$C_{\text{min}}$: $\leftrightarrow$  
Emtricitabine:  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: $\leftrightarrow$  
$C_{\text{min}}$: $\leftrightarrow$  
Tenofovir:  
AUC: ↑ 81%  
$C_{\text{max}}$: ↑ 77%  
$C_{\text{min}}$: ↑ 121%  | Concomitant administration of sofosbuvir/velpatasvir and efavirenz is expected to decrease plasma concentrations of velpatasvir. Co-administration of sofosbuvir/velpatasvir with efavirenz-containing regimens is not recommended. |
<table>
<thead>
<tr>
<th>Medicinal product by therapeutic areas (dose in mg)</th>
<th>Effects on drug levels Mean percent change in AUC, $C_{\text{max}}$, $C_{\text{min}}$</th>
<th>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Emtricitabine/Rilpivirine/Tenofovir disoproxil fumarate (200 mg/25 mg/300 mg q.d.)</td>
<td>Sofosbuvir: AUC: $\leftrightarrow$ $C_{\text{max}}$: $\leftrightarrow$ $C_{\text{min}}$: $\leftrightarrow$ GS-331007$^2$: AUC: $\leftrightarrow$ $C_{\text{max}}$: $\leftrightarrow$ $C_{\text{min}}$: $\leftrightarrow$ Velpatasvir: AUC: $\leftrightarrow$ $C_{\text{max}}$: $\leftrightarrow$ $C_{\text{min}}$: $\leftrightarrow$ Emtricitabine: AUC: $\leftrightarrow$ $C_{\text{max}}$: $\leftrightarrow$ $C_{\text{min}}$: $\leftrightarrow$ Rilpivirine: AUC: $\leftrightarrow$ $C_{\text{max}}$: $\leftrightarrow$ $C_{\text{min}}$: $\leftrightarrow$ Tenofovir: AUC: ↑ 40% $C_{\text{max}}$: ↑ 44% $C_{\text{min}}$: ↑ 84%</td>
<td>No dose adjustment is recommended. The increased exposure of tenofovir could potentiate adverse reactions associated with tenofovir disoproxil fumarate, including renal disorders. Renal function should be closely monitored (see section 4.4).</td>
</tr>
<tr>
<td>Sofosbuvir (400 mg q.d.) + Efavirenz/Emtricitabine/Tenofovir disoproxil fumarate (600 mg/200 mg/300 mg q.d.)</td>
<td>Sofosbuvir: AUC: $\leftrightarrow$ $C_{\text{max}}$: ↓ 19% GS-331007$^2$: AUC: $\leftrightarrow$ $C_{\text{max}}$: ↓ 23% Efavirenz: AUC: $\leftrightarrow$ $C_{\text{max}}$: $\leftrightarrow$ $C_{\text{min}}$: $\leftrightarrow$ Emtricitabine: AUC: $\leftrightarrow$ $C_{\text{max}}$: $\leftrightarrow$ $C_{\text{min}}$: $\leftrightarrow$ Tenofovir: AUC: $\leftrightarrow$ $C_{\text{max}}$: ↑ 25% $C_{\text{min}}$: $\leftrightarrow$</td>
<td>No dose adjustment is required.</td>
</tr>
</tbody>
</table>

$^1$ Data generated from simultaneous dosing with ledipasvir/sofosbuvir. Staggered administration (12 hours apart) provided similar results.

$^2$ The predominant circulating metabolite of sofosbuvir.

**Studies conducted with other medicinal products**
There were no clinically significant pharmacokinetic interactions when tenofovir disoproxil fumarate was co-administered with emtricitabine, lamivudine, indinavir, efavirenz, nelfinavir, saquinavir
(ritonavir boosted), methadone, ribavirin, rifampicin, tacrolimus, or the hormonal contraceptive norgestimate/ethinyl oestradiol.

Tenofovir disoproxil fumarate must be taken with food, as food enhances the bioavailability of tenofovir (see section 5.2).

### 4.6 Fertility, pregnancy and lactation

**Pregnancy**

A moderate amount of data on pregnant women (between 300-1,000 pregnancy outcomes) indicate no malformations or foetal/neonatal toxicity associated with tenofovir disoproxil fumarate. Animal studies do not indicate reproductive toxicity (see section 5.3). The use of tenofovir disoproxil fumarate may be considered during pregnancy, if necessary.

**Breast-feeding**

Tenofovir has been shown to be excreted in human milk. There is insufficient information on the effects of tenofovir in newborns/infants. Therefore Viread should not be used during breast-feeding.

As a general rule, it is recommended that HIV infected women do not breast-feed their infants in order to avoid transmission of HIV to the infant.

**Fertility**

There are limited clinical data with respect to the effect of tenofovir disoproxil fumarate on fertility. Animal studies do not indicate harmful effects of tenofovir disoproxil fumarate on fertility.

### 4.7 Effects on ability to drive and use machines

No studies on the effects on the ability to drive and use machines have been performed. However, patients should be informed that dizziness has been reported during treatment with tenofovir disoproxil fumarate.

### 4.8 Undesirable effects

**Summary of the safety profile**

In patients receiving tenofovir disoproxil fumarate, rare events of renal impairment, renal failure and uncommon events of proximal renal tubulopathy (including Fanconi syndrome) sometimes leading to bone abnormalities (infrequently contributing to fractures) have been reported. Monitoring of renal function is recommended for patients receiving Viread (see section 4.4).

Approximately one third of patients can be expected to experience adverse reactions following treatment with tenofovir disoproxil fumarate in combination with other antiretroviral agents. These reactions are usually mild to moderate gastrointestinal events. Approximately 1% of tenofovir disoproxil fumarate-treated adult patients discontinued treatment due to the gastrointestinal events.

Co-administration of Viread and didanosine is not recommended as this may result in an increased risk of adverse reactions (see section 4.5). Rarely, pancreatitis and lactic acidosis, sometimes fatal, have been reported (see section 4.4).

Discontinuation of Viread in patients co-infected with HIV and HBV may be associated with severe acute exacerbations of hepatitis (see section 4.4).

**Tabulated summary of adverse reactions**

Assessment of adverse reactions for tenofovir disoproxil fumarate is based on safety data from clinical studies and post-marketing experience. All adverse reactions are presented in Table 2.

Assessment of adverse reactions from HIV-1 clinical study data is based on experience in two studies in 653 treatment-experienced adult patients receiving treatment with tenofovir disoproxil fumarate
(n = 443) or placebo (n = 210) in combination with other antiretroviral medicinal products for 24 weeks and also in a double-blind comparative controlled study in which 600 treatment-naïve adult patients received treatment with tenofovir disoproxil 245 mg (as fumarate) (n = 299) or stavudine (n = 301) in combination with lamivudine and efavirenz for 144 weeks.

The adverse reactions with suspected (at least possible) relationship to treatment are listed below by body system organ class and frequency. Within each frequency grouping, undesirable effects are presented in order of decreasing seriousness. Frequencies are defined as very common (≥ 1/10), common (≥ 1/100 to < 1/10), uncommon (≥ 1/1,000 to < 1/100) or rare (≥ 1/10,000 to < 1/1,000).

Table 2: Tabulated summary of adverse reactions associated with tenofovir disoproxil fumarate based on clinical study and post-marketing experience

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Tenofovir disoproxil fumarate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metabolism and nutrition disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Very common:</td>
<td>hypophosphataemia¹</td>
</tr>
<tr>
<td>Uncommon:</td>
<td>hypokalaemia¹</td>
</tr>
<tr>
<td>Rare:</td>
<td>lactic acidosis</td>
</tr>
<tr>
<td><strong>Nervous system disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Very common:</td>
<td>dizziness</td>
</tr>
<tr>
<td><strong>Gastrointestinal disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Very common:</td>
<td>diarrhoea, vomiting, nausea</td>
</tr>
<tr>
<td>Common:</td>
<td>flatulence</td>
</tr>
<tr>
<td>Uncommon:</td>
<td>pancreatitis</td>
</tr>
<tr>
<td><strong>Hepatobiliary disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Common:</td>
<td>increased transaminases</td>
</tr>
<tr>
<td>Rare:</td>
<td>hepatic steatosis, hepatitis</td>
</tr>
<tr>
<td><strong>Skin and subcutaneous tissue disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Very common:</td>
<td>rash</td>
</tr>
<tr>
<td>Rare:</td>
<td>angioedema</td>
</tr>
<tr>
<td><strong>Musculoskeletal and connective tissue disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Uncommon:</td>
<td>rhabdomyolysis¹, muscular weakness¹</td>
</tr>
<tr>
<td>Rare:</td>
<td>osteomalacia (manifested as bone pain and infrequently contributing to fractures)¹,², myopathy¹</td>
</tr>
<tr>
<td><strong>Renal and urinary disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Uncommon:</td>
<td>increased creatinine, proximal renal tubulopathy (including Fanconi syndrome)</td>
</tr>
<tr>
<td>Rare:</td>
<td>acute renal failure, renal failure, acute tubular necrosis, nephritis (including acute interstitial nephritis)², nephrogenic diabetes insipidus</td>
</tr>
<tr>
<td><strong>General disorders and administration site conditions:</strong></td>
<td></td>
</tr>
<tr>
<td>Very common:</td>
<td>asthenia</td>
</tr>
</tbody>
</table>

¹ This adverse reaction may occur as a consequence of proximal renal tubulopathy. It is not considered to be causally associated with tenofovir disoproxil fumarate in the absence of this condition.
² This adverse reaction was identified through post-marketing surveillance but not observed in randomised controlled clinical trials or the tenofovir disoproxil fumarate expanded access program. The frequency category was estimated from a statistical calculation based on the total number of patients exposed to tenofovir disoproxil fumarate in randomised controlled clinical trials and the expanded access program (n = 7,319).
Description of selected adverse reactions

Renal impairment
As Viread may cause renal damage monitoring of renal function is recommended (see sections 4.4 and 4.8 Summary of the safety profile). Proximal renal tubulopathy generally resolved or improved after tenofovir disoproxil fumarate discontinuation. However, in some patients, declines in creatinine clearance did not completely resolve despite tenofovir disoproxil fumarate discontinuation. Patients at risk of renal impairment (such as patients with baseline renal risk factors, advanced HIV disease, or patients receiving concomitant nephrotoxic medications) are at increased risk of experiencing incomplete recovery of renal function despite tenofovir disoproxil fumarate discontinuation (see section 4.4).

Interaction with didanosine
Co-administration of tenofovir disoproxil fumarate and didanosine is not recommended as it results in a 40-60% increase in systemic exposure to didanosine that may increase the risk of didanosine-related adverse reactions (see section 4.5). Rarely, pancreatitis and lactic acidosis, sometimes fatal, have been reported.

Metabolic parameters
Weight and levels of blood lipids and glucose may increase during antiretroviral therapy (see section 4.4).

Immune reactivation syndrome
In HIV infected patients with severe immune deficiency at the time of initiation of CART, an inflammatory reaction to asymptomatic or residual opportunistic infections may arise. Autoimmune disorders (such as Graves’ disease) have also been reported; however, the reported time to onset is more variable and these events can occur many months after initiation of treatment (see section 4.4).

Osteonecrosis
Cases of osteonecrosis have been reported, particularly in patients with generally acknowledged risk factors, advanced HIV disease or long-term exposure to CART. The frequency of this is unknown (see section 4.4).

Paediatric population
Assessment of adverse reactions is based on two randomised trials (studies GS-US-104-0321 and GS-US-104-0352) in 184 HIV-1 infected paediatric patients (aged 2 to < 18 years) who received treatment with tenofovir disoproxil fumarate (n = 93) or placebo/active comparator (n = 91) in combination with other antiretroviral agents for 48 weeks (see section 5.1). The adverse reactions observed in paediatric patients who received treatment with tenofovir disoproxil fumarate were consistent with those observed in clinical studies of tenofovir disoproxil fumarate in adults (see section 4.8 Tabulated summary of adverse reactions and 5.1).

Reductions in BMD have been reported in paediatric patients. In HIV-1 infected adolescents, the BMD Z-scores observed in subjects who received tenofovir disoproxil fumarate were lower than those observed in subjects who received placebo. In HIV-1 infected children, the BMD Z-scores observed in subjects who switched to tenofovir disoproxil fumarate were lower than those observed in subjects who remained on their stavudine- or zidovudine-containing regimen (see sections 4.4 and 5.1).

In study GS-US-104-0352, 4 out of 89 paediatric patients exposed to tenofovir disoproxil fumarate (median tenofovir disoproxil fumarate exposure 312 weeks) discontinued due to adverse reactions consistent with proximal renal tubulopathy. Seven patients had estimated glomerular filtration rate (GFR) values between 70 and 90 mL/min/1.73 m². Among them, two patients experienced a clinically meaningful decline in estimated GFR which improved after discontinuation of tenofovir disoproxil fumarate.
Other special population(s)

Patients with renal impairment

The use of tenofovir disoproxil fumarate is not recommended in paediatric patients with renal impairment (see sections 4.2 and 4.4).

Exacerbations of hepatitis after discontinuation of treatment

In HIV infected patients co-infected with HBV, clinical and laboratory evidence of hepatitis have occurred after discontinuation of tenofovir disoproxil fumarate (see section 4.4).

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via the national reporting system listed in Appendix V.

4.9 Overdose

Symptoms

If overdose occurs the patient must be monitored for evidence of toxicity (see sections 4.8 and 5.3), and standard supportive treatment applied as necessary.

Management

Tenofovir can be removed by haemodialysis; the median haemodialysis clearance of tenofovir is 134 ml/min. It is not known whether tenofovir can be removed by peritoneal dialysis.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antiviral for systemic use; nucleoside and nucleotide reverse transcriptase inhibitors, ATC code: J05AF07

Mechanism of action and pharmacodynamic effects

Tenofovir disoproxil fumarate is the fumarate salt of the prodrug tenofovir disoproxil. Tenofovir disoproxil is absorbed and converted to the active substance tenofovir, which is a nucleoside monophosphate (nucleotide) analogue. Tenofovir is then converted to the active metabolite, tenofovir diphosphate, an obligate chain terminator, by constitutively expressed cellular enzymes. Tenofovir diphosphate has an intracellular half-life of 10 hours in activated and 50 hours in resting peripheral blood mononuclear cells (PBMCs). Tenofovir diphosphate inhibits HIV-1 reverse transcriptase and the HBV polymerase by direct binding competition with the natural deoxyribonucleotide substrate and, after incorporation into DNA, by DNA chain termination. Tenofovir diphosphate is a weak inhibitor of cellular polymerases α, β, and γ. At concentrations of up to 300 µmol/l, tenofovir has also shown no effect on the synthesis of mitochondrial DNA or the production of lactic acid in in vitro assays.

Data pertaining to HIV

HIV antiviral activity in vitro: The concentration of tenofovir required for 50% inhibition (EC50) of the wild-type laboratory strain HIV-1lai is 1-6 µmol/l in lymphoid cell lines and 1.1 µmol/l against primary HIV-1 subtype B isolates in PBMCs. Tenofovir is also active against HIV-1 subtypes A, C, D, E, F, G, and O and against HIV_BaL in primary monocyte/macrophage cells. Tenofovir shows activity in vitro against HIV-2, with an EC50 of 4.9 µmol/l in MT-4 cells.
**Resistance:** Strains of HIV-1 with reduced susceptibility to tenofovir and a K65R mutation in reverse transcriptase have been selected in vitro and in some patients (see Clinical efficacy and safety). Tenofovir disoproxil fumarate should be avoided in antiretroviral-experienced patients with strains harbouring the K65R mutation (see section 4.4). In addition, a K70E substitution in HIV-1 reverse transcriptase has been selected by tenofovir and results in low-level reduced susceptibility to tenofovir.

Clinical studies in treatment-experienced patients have assessed the anti-HIV activity of tenofovir disoproxil fumarate 245 mg (as fumarate) against strains of HIV-1 with resistance to nucleoside inhibitors. The results indicate that patients whose HIV expressed 3 or more thymidine-analogue associated mutations (TAMs) that included either the M41L or L210W reverse transcriptase mutation showed reduced response to tenofovir disoproxil 245 mg (as fumarate) therapy.

**Clinical efficacy and safety**

The effects of tenofovir disoproxil fumarate in treatment-experienced and treatment-naïve HIV-1 infected adults have been demonstrated in trials of 48 weeks and 144 weeks duration, respectively.

In study GS-99-907, 550 treatment-experienced adult patients were treated with placebo or tenofovir disoproxil fumarate 245 mg (as fumarate) for 24 weeks. The mean baseline CD4 cell count was 427 cells/mm³, the mean baseline plasma HIV-1 RNA was 3.4 log₁₀ copies/ml (78% of patients had a viral load of < 5,000 copies/ml) and the mean duration of prior HIV treatment was 5.4 years. Baseline genotypic analysis of HIV isolates from 253 patients revealed that 94% of patients had HIV-1 resistance mutations associated with nucleoside reverse transcriptase inhibitors, 58% had mutations associated with protease inhibitors and 48% had mutations associated with non-nucleoside reverse transcriptase inhibitors.

At week 24 the time-weighted average change from baseline in log₁₀ plasma HIV-1 RNA levels (DAVG₂₄) was -0.03 log₁₀ copies/ml and -0.61 log₁₀ copies/ml for the placebo and tenofovir disoproxil 245 mg (as fumarate) recipients (p < 0.0001). A statistically significant difference in favour of tenofovir disoproxil 245 mg (as fumarate) was seen in the time-weighted average change from baseline at week 24 (DAVG₂₄) for CD4 count (+13 cells/mm³ for tenofovir disoproxil 245 mg (as fumarate) versus -11 cells/mm³ for placebo, p-value = 0.0008). The antiviral response to tenofovir disoproxil fumarate was durable through 48 weeks (DAVG₄₈ was -0.57 log₁₀ copies/ml, proportion of patients with HIV-1 RNA below 400 or 50 copies/ml was 41% and 18% respectively). Eight (2%) tenofovir disoproxil 245 mg (as fumarate) treated patients developed the K65R mutation within the first 48 weeks.

The 144-week, double-blind, active controlled phase of study GS-99-903 evaluated the efficacy and safety of tenofovir disoproxil 245 mg (as fumarate) versus stavudine when used in combination with lamivudine and efavirenz in HIV-1 infected adult patients naïve to antiretroviral therapy. The mean baseline CD4 cell count was 279 cells/mm³, the mean baseline plasma HIV-1 RNA was 4.91 log₁₀ copies/ml, 19% of patients had symptomatic HIV-1 infection and 18% had AIDS. Patients were stratified by baseline HIV-1 RNA and CD4 count. Forty-three percent of patients had baseline viral loads > 100,000 copies/ml and 39% had CD4 cell counts < 200 cells/ml.

By intent to treat analysis (missing data and switch in antiretroviral therapy (ART) considered as failure), the proportion of patients with HIV-1 RNA below 400 copies/ml and 50 copies/ml at 48 weeks of treatment was 80% and 76% respectively in the tenofovir disoproxil 245 mg (as fumarate) arm, compared to 84% and 80% in the stavudine arm. At 144 weeks, the proportion of patients with HIV-1 RNA below 400 copies/ml and 50 copies/ml was 71% and 68% respectively in the tenofovir disoproxil 245 mg (as fumarate) arm, compared to 64% and 63% in the stavudine arm.

The average change from baseline for HIV-1 RNA and CD4 count at 48 weeks of treatment was similar in both treatment groups (-3.09 and -3.09 log₁₀ copies/ml; +169 and 167 cells/mm³ in the tenofovir disoproxil 245 mg (as fumarate) and stavudine groups, respectively). At 144 weeks of treatment, the average change from baseline remained similar in both treatment groups (-3.07 and -3.03 log₁₀ copies/ml; +263 and +283 cells/mm³ in the tenofovir disoproxil 245 mg (as fumarate))
and stavudine groups, respectively). A consistent response to treatment with tenofovir disoproxil 245 mg (as fumarate) was seen regardless of baseline HIV-1 RNA and CD4 count.

The K65R mutation occurred in a slightly higher percentage of patients in the tenofovir disoproxil fumarate group than the active control group (2.7% versus 0.7%). Efavirenz or lamivudine resistance either preceded or was coincident with the development of K65R in all cases. Eight patients had HIV that expressed K65R in the tenofovir disoproxil 245 mg (as fumarate) arm, 7 of these occurred during the first 48 weeks of treatment and the last one at week 96. No further K65R development was observed up to week 144. One patient in the tenofovir disoproxil (as fumarate) arm developed the K70E substitution in the virus. From both the genotypic and phenotypic analyses there was no evidence for other pathways of resistance to tenofovir.

Data pertaining to HBV
The antiviral activity of tenofovir disoproxil fumarate against hepatitis B virus (HBV) has been demonstrated in vitro and clinically in adults and adolescents. Please refer to the Summaries of Product Characteristics for Viread 245 mg film-coated tablets and Viread 33 mg/g granules.

Paediatric population
In study GS-US-104-0321, 87 HIV-1 infected treatment-experienced patients 12 to < 18 years of age were treated with tenofovir disoproxil fumarate (n = 45) or placebo (n = 42) in combination with an optimised background regimen (OBR) for 48 weeks. Due to limitations of the study, a benefit of tenofovir disoproxil fumarate over placebo was not demonstrated based on plasma HIV-1 RNA levels at week 24. However, a benefit is expected for the adolescent population based on extrapolation of adult data and comparative pharmacokinetic data (see section 5.2).

In patients who received treatment with tenofovir disoproxil fumarate or placebo, mean lumbar spine BMD Z-score was -1.004 and -0.809, and mean total body BMD Z-score was -0.866 and -0.584, respectively, at baseline. Mean changes at week 48 (end of double-blind phase) were -0.215 and -0.165 in lumbar spine BMD Z-score, and -0.254 and -0.179 in total body BMD Z-score for the tenofovir disoproxil fumarate and placebo groups, respectively. The mean rate of BMD gain was less in the tenofovir disoproxil fumarate group compared to the placebo group. At week 48, six adolescents in the tenofovir disoproxil fumarate group and one adolescent in the placebo group had significant lumbar spine BMD loss (defined as > 4% loss). Among 28 patients receiving 96 weeks of treatment with tenofovir disoproxil fumarate, BMD Z-scores declined by -0.341 for lumbar spine and -0.458 for total body.

In study GS-US-104-0352, 97 treatment-experienced patients 2 to < 12 years of age with stable, virologic suppression on stavudine- or zidovudine-containing regimens were randomised to either replace stavudine or zidovudine with tenofovir disoproxil fumarate (n = 48) or continue on their original regimen (n = 49) for 48 weeks. At week 48, 83% of patients in the tenofovir disoproxil fumarate treatment group and 92% of patients in the stavudine or zidovudine treatment group had HIV-1 RNA concentrations < 400 copies/ml. The difference in the proportion of patients who maintained < 400 copies/ml at week 48 was mainly influenced by the higher number of discontinuations in the tenofovir disoproxil fumarate treatment group. When missing data were excluded, 91% of patients in the tenofovir disoproxil fumarate treatment group and 94% of patients in the stavudine or zidovudine treatment group had HIV-1 RNA concentrations < 400 copies/ml at week 48.

Reductions in BMD have been reported in paediatric patients. In patients who received treatment with tenofovir disoproxil fumarate, or stavudine or zidovudine, mean lumbar spine BMD Z-score was -1.034 and -0.498, and mean total body BMD Z-score was -0.471 and -0.386, respectively, at baseline. Mean changes at week 48 (end of randomised phase) were 0.032 and 0.087 in lumbar spine BMD Z-score, and -0.184 and -0.027 in total body BMD Z-score for the tenofovir disoproxil fumarate and stavudine or zidovudine groups, respectively. The mean rate of lumbar spine bone gain at week 48 was similar between the tenofovir disoproxil fumarate treatment group and the stavudine or zidovudine treatment group. Total body bone gain was less in the tenofovir disoproxil fumarate treatment group compared to the stavudine or zidovudine treatment group. One tenofovir disoproxil
fumarate treated subject and no stavudine or zidovudine treated subjects experienced significant (> 4%) lumbar spine BMD loss at week 48. BMD Z-scores declined by -0.012 for lumbar spine and by -0.338 for total body in the 64 subjects who were treated with tenofovir disoproxil fumarate for 96 weeks. BMD Z-scores were not adjusted for height and weight.

In study GS-US-104-0352, 4 out of 89 paediatric patients exposed to tenofovir disoproxil fumarate discontinued due to adverse reactions consistent with proximal renal tubulopathy (median tenofovir disoproxil fumarate exposure 104 weeks).

The European Medicines Agency has deferred the obligation to submit the results of studies with Viread in one or more subsets of the paediatric population in HIV and chronic hepatitis B (see section 4.2 for information on paediatric use).

5.2 Pharmacokinetic properties

Tenofovir disoproxil fumarate is a water soluble ester prodrug which is rapidly converted in vivo to tenofovir and formaldehyde.

Tenofovir is converted intracellularly to tenofovir monophosphate and to the active component, tenofovir diphosphate.

Absorption

Following oral administration of tenofovir disoproxil fumarate to HIV infected patients, tenofovir disoproxil fumarate is rapidly absorbed and converted to tenofovir. Administration of multiple doses of tenofovir disoproxil fumarate with a meal to HIV infected patients resulted in mean (%CV) tenofovir C\text{max}, AUC, and C\text{min} values of 326 (36.6%) ng/ml, 3,324 (41.2%) ng·h/ml and 64.4 (39.4%) ng/ml, respectively. Maximum tenofovir concentrations are observed in serum within one hour of dosing in the fasted state and within two hours when taken with food. The oral bioavailability of tenofovir from tenofovir disoproxil fumarate in fasted patients was approximately 25%. Administration of tenofovir disoproxil fumarate with a high fat meal enhanced the oral bioavailability, with an increase in tenofovir AUC by approximately 40% and C\text{max} by approximately 14%. Following the first dose of tenofovir disoproxil fumarate in fed patients, the median C\text{max} in serum ranged from 213 to 375 ng/ml. However, administration of tenofovir disoproxil fumarate with a light meal did not have a significant effect on the pharmacokinetics of tenofovir.

Distribution

Following intravenous administration the steady-state volume of distribution of tenofovir was estimated to be approximately 800 ml/kg. After oral administration of tenofovir disoproxil fumarate, tenofovir is distributed to most tissues with the highest concentrations occurring in the kidney, liver and the intestinal contents (preclinical studies). In vitro protein binding of tenofovir to plasma or serum protein was less than 0.7 and 7.2%, respectively, over the tenofovir concentration range 0.01 to 25 µg/ml.

Biotransformation

In vitro studies have determined that neither tenofovir disoproxil fumarate nor tenofovir are substrates for the CYP450 enzymes. Moreover, at concentrations substantially higher (approximately 300-fold) than those observed in vivo, tenofovir did not inhibit in vitro drug metabolism mediated by any of the major human CYP450 isoforms involved in drug biotransformation (CYP3A4, CYP2D6, CYP2C9, CYP2E1, or CYP1A1/2). Tenofovir disoproxil fumarate at a concentration of 100 µmol/l had no effect on any of the CYP450 isoforms, except CYP1A1/2, where a small (6%) but statistically significant reduction in metabolism of CYP1A1/2 substrate was observed. Based on these data, it is unlikely that clinically significant interactions involving tenofovir disoproxil fumarate and medicinal products metabolised by CYP450 would occur.
Elimination
Tenofovir is primarily excreted by the kidney by both filtration and an active tubular transport system with approximately 70-80% of the dose excreted unchanged in urine following intravenous administration. Total clearance has been estimated to be approximately 230 ml/h/kg (approximately 300 ml/min). Renal clearance has been estimated to be approximately 160 ml/h/kg (approximately 210 ml/min), which is in excess of the glomerular filtration rate. This indicates that active tubular secretion is an important part of the elimination of tenofovir. Following oral administration the terminal half-life of tenofovir is approximately 12 to 18 hours.

Studies have established the pathway of active tubular secretion of tenofovir to be influx into proximal tubule cell by the human organic anion transporters (hOAT) 1 and 3 and efflux into the urine by the multidrug resistant protein 4 (MRP 4).

Linearity/non-linearity
The pharmacokinetics of tenofovir were independent of tenofovir disoproxil fumarate dose over the dose range 75 to 600 mg and were not affected by repeated dosing at any dose level.

Gender
Limited data on the pharmacokinetics of tenofovir in women indicate no major gender effect.

Ethnicity
Pharmacokinetics have not been specifically studied in different ethnic groups.

Paediatric population
Steady-state pharmacokinetics of tenofovir were evaluated in 8 HIV-1 infected adolescent patients (aged 12 to < 18 years) with body weight ≥ 35 kg and in 23 HIV-1 infected children aged 2 to < 12 years (see Table 3 below). Tenofovir exposure achieved in these paediatric patients receiving oral daily doses of tenofovir disoproxil 245 mg (as fumarate) or 6.5 mg/kg body weight tenofovir disoproxil (as fumarate) up to a maximum dose of 245 mg was similar to exposures achieved in adults receiving once-daily doses of tenofovir disoproxil 245 mg (as fumarate).

Table 3: Mean (± SD) tenofovir pharmacokinetic parameters by age groups for paediatric patients

<table>
<thead>
<tr>
<th>Dose and formulation</th>
<th>245 mg film-coated tablet 12 to &lt; 18 years (n = 8)</th>
<th>6.5 mg/kg granules 2 to &lt; 12 years (n = 23)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cmax (μg/ml)</td>
<td>0.38 ± 0.13</td>
<td>0.24 ± 0.13</td>
</tr>
<tr>
<td>AUCτ (μg·h/ml)</td>
<td>3.39 ± 1.22</td>
<td>2.59 ± 1.06</td>
</tr>
</tbody>
</table>

Pharmacokinetic studies have not been performed in children under 2 years.

Renal impairment
Pharmacokinetic parameters of tenofovir were determined following administration of a single dose of tenofovir disoproxil 245 mg to 40 non-HIV infected adult patients with varying degrees of renal impairment defined according to baseline creatinine clearance (CrCl) (normal renal function when CrCl > 80 ml/min; mild with CrCl = 50-79 ml/min; moderate with CrCl = 30-49 ml/min and severe with CrCl = 10-29 ml/min). Compared with patients with normal renal function, the mean (%CV) tenofovir exposure increased from 2,185 (12%) ng·h/ml in subjects with CrCl > 80 ml/min to respectively 3,064 (30%) ng·h/ml, 6,009 (42%) ng·h/ml and 15,985 (45%) ng·h/ml in patients with mild, moderate and severe renal impairment.

The pharmacokinetics of tenofovir in non-haemodialysis adult patients with creatinine clearance < 10 ml/min and in patients with ESRD managed by peritoneal or other forms of dialysis have not been studied.

The pharmacokinetics of tenofovir in paediatric patients with renal impairment have not been studied. No data are available to make dose recommendations (see sections 4.2 and 4.4).
Hepatic impairment
A single 245 mg dose of tenofovir disoproxil was administered to non-HIV infected adult patients with varying degrees of hepatic impairment defined according to Child-Pugh-Turcotte (CPT) classification. Tenofovir pharmacokinetics were not substantially altered in subjects with hepatic impairment suggesting that no dose adjustment is required in these subjects. The mean (%CV) tenofovir C\text{max} and AUC\text{0-\infty} values were 223 (34.8%) ng/ml and 2,050 (50.8%) ng·h/ml, respectively, in normal subjects compared with 289 (46.0%) ng/ml and 2,310 (43.5%) ng·h/ml in subjects with moderate hepatic impairment, and 305 (24.8%) ng/ml and 2,740 (44.0%) ng·h/ml in subjects with severe hepatic impairment.

Intracellular pharmacokinetics
In non-proliferating human peripheral blood mononuclear cells (PBMCs) the half-life of tenofovir diphosphate was found to be approximately 50 hours, whereas the half-life in phytohaemagglutinin-stimulated PBMCs was found to be approximately 10 hours.

5.3 Preclinical safety data
Non-clinical safety pharmacology studies reveal no special hazard for humans. Findings in repeated dose toxicity studies in rats, dogs and monkeys at exposure levels greater than or equal to clinical exposure levels and with possible relevance to clinical use include renal and bone toxicity and a decrease in serum phosphate concentration. Bone toxicity was diagnosed as osteomalacia (monkeys) and reduced bone mineral density (BMD) (rats and dogs). The bone toxicity in young adult rats and dogs occurred at exposures ≥ 5-fold the exposure in paediatric or adult patients; bone toxicity occurred in juvenile infected monkeys at very high exposures following subcutaneous dosing (≥ 40-fold the exposure in patients). Findings in the rat and monkey studies indicated that there was a substance-related decrease in intestinal absorption of phosphate with potential secondary reduction in BMD.

Genotoxicity studies revealed positive results in the \textit{in vitro} mouse lymphoma assay, equivocal results in one of the strains used in the Ames test, and weakly positive results in an UDS test in primary rat hepatocytes. However, it was negative in an \textit{in vivo} mouse bone marrow micronucleus assay.

Oral carcinogenicity studies in rats and mice only revealed a low incidence of duodenal tumours at an extremely high dose in mice. These tumours are unlikely to be of relevance to humans.

Reproductive studies in rats and rabbits showed no effects on mating, fertility, pregnancy or foetal parameters. However, tenofovir disoproxil fumarate reduced the viability index and weight of pups in peri-postnatal toxicity studies at maternally toxic doses.

The active substance tenofovir disoproxil fumarate and its main transformation products are persistent in the environment.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

\textit{Tablet core}
Croscarmellose sodium
Lactose monohydrate
Magnesium stearate (E572)
Microcrystalline cellulose (E460)
Starch pregelatinised
Film-coating
Glycerol triacetate (E1518)
Hypromellose (E464)
Lactose monohydrate
Titanium dioxide (E171)

6.2 Incompatibilities
Not applicable.

6.3 Shelf life
3 years.

6.4 Special precautions for storage
This medicinal product does not require any special storage conditions.

6.5 Nature and contents of container
High density polyethylene (HDPE) bottle with a polypropylene child-resistant closure containing
30 film-coated tablets and a silica gel desiccant.

The following pack sizes are available: outer cartons containing 1 bottle of 30 film-coated tablets and
outer cartons containing 90 (3 bottles of 30) film-coated tablets. Not all pack sizes may be marketed.

6.6 Special precautions for disposal
Any unused medicinal product or waste material should be disposed of in accordance with local
requirements.

7. MARKETING AUTHORITY HOLDER
Gilead Sciences International Limited
Cambridge
CB2 1 6GT
United Kingdom

8. MARKETING AUTHORITY NUMBER(S)
EU/1/01/200/004
EU/1/01/200/005

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORIZATION
Date of first authorisation: 5 February 2002
Date of latest renewal: 14 December 2011

10. DATE OF REVISION OF THE TEXT
Detailed information on this medicinal product is available on the website of the European Medicines
Agency http://www.ema.europa.eu
1. NAME OF THE MEDICINAL PRODUCT

Viread 163 mg film-coated tablets

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains 163 mg of tenofovir disoproxil (as fumarate).

Excipient with known effect
Each tablet contains 109 mg lactose (as monohydrate).

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Film-coated tablet (tablet).

White, round-shaped, film-coated tablets, 10.7 mm in diameter, debossed on one side with “GSI” and on the other side with “200”.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Viread 163 mg film-coated tablets are indicated in combination with other antiretroviral medicinal products for the treatment of HIV-1 infected paediatric patients, with NRTI resistance or toxicities precluding the use of first line agents, aged 6 to < 12 years who weigh from 22 kg to less than 28 kg.

The choice of Viread to treat antiretroviral-experienced patients with HIV-1 infection should be based on individual viral resistance testing and/or treatment history of patients.

4.2 Posology and method of administration

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

Posology
The recommended dose for HIV-1 infected paediatric patients aged 6 to < 12 years weighing 22 kg to < 28 kg who are able to swallow film-coated tablets is one 163 mg tablet once daily taken orally with food.

Please refer to the Summaries of Product Characteristics for Viread 123 mg and 204 mg film-coated tablets for the treatment of HIV-1 infected paediatric patients aged 6 to < 12 years weighing 17 kg to < 22 kg and 28 kg to < 35 kg, respectively.

Viread is also available as 33 mg/g granules for use in HIV-1 infected paediatric patients aged 2 to < 12 years who weigh < 17 kg or who are unable to swallow film-coated tablets. Please refer to the Summary of Product Characteristics for Viread 33 mg/g granules.

Missed dose
If a patient misses a dose of Viread within 12 hours of the time it is usually taken, the patient should take Viread with food as soon as possible and resume their normal dosing schedule. If a patient misses a dose of Viread by more than 12 hours and it is almost time for their next dose, the patient should not take the missed dose and simply resume the usual dosing schedule.
If the patient vomits within 1 hour of taking Viread, another tablet should be taken. If the patient vomits more than 1 hour after taking Viread they do not need to take another dose.

**Special populations**

**Renal impairment**
The use of tenofovir disoproxil fumarate is not recommended in paediatric patients with renal impairment (see section 4.4).

**Hepatic impairment**
No dose adjustment is required in patients with hepatic impairment (see sections 4.4 and 5.2).

If Viread 163 mg film-coated tablets are discontinued in patients co-infected with HIV and hepatitis B virus (HBV), these patients should be closely monitored for evidence of exacerbation of hepatitis (see section 4.4).

**Paediatric population**
The safety and efficacy of tenofovir disoproxil fumarate in HIV-1 infected children under 2 years of age have not been established. No data are available.

The safety and efficacy of tenofovir disoproxil fumarate in children with chronic hepatitis B aged 2 to < 12 years or weighing < 35 kg have not been established. No data are available.

**Method of administration**
Viread 163 mg film-coated tablets should be taken once daily, orally with food.

### 4.3 Contraindications

Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.

### 4.4 Special warnings and precautions for use

**General**
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.

**Co-administration of other medicinal products**
- Viread should not be administered concomitantly with other medicinal products containing tenofovir disoproxil fumarate or tenofovir alafenamide.
- Viread should not be administered concomitantly with adefovir dipivoxil.
- Co-administration of tenofovir disoproxil fumarate and didanosine is not recommended. Co-administration of tenofovir disoproxil fumarate and didanosine results in a 40-60% increase in systemic exposure to didanosine that may increase the risk of didanosine-related adverse reactions (see section 4.5). Rarely, pancreatitis and lactic acidosis, sometimes fatal, have been reported. Co-administration of tenofovir disoproxil fumarate and didanosine at a dose of 400 mg daily has been associated with a significant decrease in CD4 cell count, possibly due to an intracellular interaction increasing phosphorylated (i.e. active) didanosine. A decreased dosage of 250 mg didanosine co-administered with tenofovir disoproxil fumarate therapy has been associated with reports of high rates of virological failure within several tested combinations for the treatment of HIV-1 infection.

**Triple therapy with nucleosides/nucleotides**
There have been reports of a high rate of virological failure and of emergence of resistance at an early stage in HIV patients when tenofovir disoproxil fumarate was combined with lamivudine and abacavir as well as with lamivudine and didanosine as a once-daily regimen.
Renal and bone effects in adult population

Renal effects
Tenofovir is principally eliminated via the kidney. Renal failure, renal impairment, elevated creatinine, hypophosphataemia and proximal tubulopathy (including Fanconi syndrome) have been reported with the use of tenofovir disoproxil fumarate in clinical practice (see section 4.8).

Renal impairment
Renal safety with tenofovir has only been studied to a very limited degree in adult patients with impaired renal function (creatinine clearance < 80 ml/min).

Bone effects
In HIV infected patients, in a 144-week controlled clinical study that compared tenofovir disoproxil fumarate with stavudine in combination with lamivudine and efavirenz in antiretroviral-naïve adult patients, small decreases in bone mineral density (BMD) of the hip and spine were observed in both treatment groups. Decreases in BMD of spine and changes in bone biomarkers from baseline were significantly greater in the tenofovir disoproxil fumarate treatment group at 144 weeks. Decreases in BMD of hip were significantly greater in this group until 96 weeks. However, there was no increased risk of fractures or evidence for clinically relevant bone abnormalities over 144 weeks.

In other studies (prospective and cross-sectional), the most pronounced decreases in BMD were seen in patients treated with tenofovir disoproxil fumarate as part of a regimen containing a boosted protease inhibitor. Alternative treatment regimens should be considered for patients with osteoporosis that are at a high risk for fractures.

Bone abnormalities (infrequently contributing to fractures) may be associated with proximal renal tubulopathy (see section 4.8).

Renal and bone effects in paediatric population
There are uncertainties associated with the long term effects of bone and renal toxicity. Moreover, the reversibility of renal toxicity cannot be fully ascertained. Therefore, a multidisciplinary approach is recommended to adequately weigh on a case by case basis the benefit/risk balance of treatment, decide the appropriate monitoring during treatment (including decision for treatment withdrawal) and consider the need for supplementation.

Renal effects
Renal adverse reactions consistent with proximal renal tubulopathy have been reported in HIV-1 infected paediatric patients aged 2 to < 12 years in clinical study GS-US-104-0352 (see sections 4.8 and 5.1).

Renal monitoring
It is recommended that renal function (creatinine clearance and serum phosphate) is assessed in all patients prior to initiating therapy with tenofovir disoproxil fumarate and that it is also monitored after two to four weeks of treatment, after three months of treatment and every three to six months thereafter in patients without renal risk factors. In patients at risk for renal impairment, a more frequent monitoring of renal function is required.

Renal management
If serum phosphate is confirmed to be < 3.0 mg/dl (0.96 mmol/l) in any paediatric patient receiving tenofovir disoproxil fumarate, renal function should be re-evaluated within one week, including measurements of blood glucose, blood potassium and urine glucose concentrations (see section 4.8, proximal tubulopathy). If renal abnormalities are suspected or detected then consultation with a nephrologist should be obtained to consider interruption of tenofovir disoproxil fumarate treatment. Interrupting treatment with tenofovir disoproxil fumarate should also be considered in case of progressive decline of renal function when no other cause has been identified.
Co-administration and risk of renal toxicity

Use of tenofovir disoproxil fumarate should be avoided with concurrent or recent use of a nephrotoxic medicinal product (e.g. aminoglycosides, amphotericin B, foscarnet, ganciclovir, pentamidine, vancomycin, cidofovir or interleukin-2). If concomitant use of tenofovir disoproxil fumarate and nephrotoxic agents is unavoidable, renal function should be monitored weekly.

Cases of acute renal failure after initiation of high dose or multiple non-steroidal anti-inflammatory drugs (NSAIDs) have been reported in patients treated with tenofovir disoproxil fumarate and with risk factors for renal dysfunction. If tenofovir disoproxil fumarate is co-administered with an NSAID, renal function should be monitored adequately.

A higher risk of renal impairment has been reported in patients receiving tenofovir disoproxil fumarate in combination with a ritonavir or cobicistat boosted protease inhibitor. A close monitoring of renal function is required in these patients (see section 4.5). In patients with renal risk factors, the co-administration of tenofovir disoproxil fumarate with a boosted protease inhibitor should be carefully evaluated.

Tenofovir disoproxil fumarate has not been clinically evaluated in patients receiving medicinal products which are secreted by the same renal pathway, including the transport proteins human organic anion transporter (hOAT) 1 and 3 or MRP 4 (e.g. cidofovir, a known nephrotoxic medicinal product). These renal transport proteins may be responsible for tubular secretion and in part, renal elimination of tenofovir and cidofovir. Consequently, the pharmacokinetics of these medicinal products, which are secreted by the same renal pathway including transport proteins hOAT 1 and 3 or MRP 4, might be modified if they are co-administered. Unless clearly necessary, concomitant use of these medicinal products which are secreted by the same renal pathway is not recommended, but if such use is unavoidable, renal function should be monitored weekly (see section 4.5).

Renal impairment

The use of tenofovir disoproxil fumarate is not recommended in paediatric patients with renal impairment (see section 4.2). Tenofovir disoproxil fumarate should not be initiated in paediatric patients with renal impairment and should be discontinued in paediatric patients who develop renal impairment during tenofovir disoproxil fumarate therapy.

Bone effects

Viread may cause a reduction in BMD. The effects of tenofovir disoproxil fumarate-associated changes in BMD on long-term bone health and future fracture risk are currently unknown (see section 5.1).

If bone abnormalities are detected or suspected in paediatric patients, consultation with an endocrinologist and/or nephrologist should be obtained.

Patients with HIV and hepatitis B or C virus co-infection

Patients with chronic hepatitis B or C and treated with antiretroviral therapy are at an increased risk for severe and potentially fatal hepatic adverse reactions.

Physicians should refer to current HIV treatment guidelines for the optimal management of HIV infection in patients co-infected with hepatitis B virus (HBV).

In case of concomitant antiviral therapy for hepatitis B or C, please refer also to the relevant Summary of Product Characteristics for these medicinal products.

Discontinuation of Viread therapy in patients co-infected with HIV and HBV may be associated with severe acute exacerbations of hepatitis. Patients co-infected with HIV and HBV who discontinue Viread should be closely monitored with both clinical and laboratory follow-up for at least 6 months after stopping treatment. In patients with advanced liver disease or cirrhosis, treatment discontinuation is not recommended since post-treatment exacerbation of hepatitis may lead to hepatic decompensation.
Use with certain hepatitis C virus antiviral agents
Co-administration of tenofovir disoproxil fumarate with ledipasvir/sofosbuvir or sofosbuvir/velpatasvir has been shown to increase plasma concentrations of tenofovir, especially when used together with an HIV regimen containing tenofovir disoproxil fumarate and a pharmacokinetic enhancer (ritonavir or cobicistat). The safety of tenofovir disoproxil fumarate in the setting of ledipasvir/sofosbuvir or sofosbuvir/velpatasvir and a pharmacokinetic enhancer has not been established. The potential risks and benefits associated with co-administration of ledipasvir/sofosbuvir or sofosbuvir/velpatasvir with tenofovir disoproxil fumarate given in conjunction with a boosted HIV protease inhibitor (e.g. atazanavir or darunavir) should be considered, particularly in patients at increased risk of renal dysfunction. Patients receiving ledipasvir/sofosbuvir or sofosbuvir/velpatasvir concomitantly with tenofovir disoproxil fumarate and a boosted HIV protease inhibitor should be monitored for adverse reactions related to tenofovir disoproxil fumarate.

Liver disease
Tenofovir and tenofovir disoproxil fumarate are not metabolised by liver enzymes. A pharmacokinetic study has been performed in non-HIV infected adult patients with various degrees of hepatic impairment. No significant pharmacokinetic alteration has been observed in these patients (see section 5.2).

Patients with pre-existing liver dysfunction, including chronic active hepatitis, have an increased frequency of liver function abnormalities during combination antiretroviral therapy (CART) and should be monitored according to standard practice. If there is evidence of worsening liver disease in such patients, interruption or discontinuation of treatment must be considered.

Weight and metabolic parameters
An increase in weight and in levels of blood lipids and glucose may occur during antiretroviral therapy. Such changes may in part be linked to disease control and lifestyle. For lipids, there is in some cases evidence for a treatment effect, while for weight gain there is no strong evidence relating this to any particular treatment. For monitoring of blood lipids and glucose reference is made to established HIV treatment guidelines. Lipid disorders should be managed as clinically appropriate.

Mitochondrial dysfunction following exposure in utero
Nucleos(t)ide analogues may impact mitochondrial function to a variable degree, which is most pronounced with stavudine, didanosine and zidovudine. There have been reports of mitochondrial dysfunction in HIV negative infants exposed in utero and/or postnatally to nucleoside analogues; these have predominantly concerned treatment with regimens containing zidovudine. The main adverse reactions reported are haematological disorders (anaemia, neutropenia) and metabolic disorders (hyperlactatemia, hyperlipasemia). These events have often been transitory. Late onset neurological disorders have been reported rarely (hypertonia, convulsion, abnormal behaviour). Whether such neurological disorders are transient or permanent is currently unknown. These findings should be considered for any child exposed in utero to nucleos(t)ide analogues, who present with severe clinical findings of unknown etiology, particularly neurologic findings. These findings do not affect current national recommendations to use antiretroviral therapy in pregnant women to prevent vertical transmission of HIV.

Immune reactivation syndrome
In HIV infected patients with severe immune deficiency at the time of institution of CART, an inflammatory reaction to asymptomatic or residual opportunistic pathogens 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 CART. Relevant examples are cytomegalovirus retinitis, generalised and/or focal mycobacterial infections, and Pneumocystis jirovecii pneumonia. Any inflammatory symptoms should be evaluated and treatment instituted when necessary.

Autoimmune disorders (such as Graves’ disease) have also been reported to occur in the setting of immune reactivation; however, the reported time to onset is more variable and these events can occur many months after initiation of treatment.
Osteonecrosis
Although the aetiology is considered to be multifactorial (including corticosteroid use, alcohol consumption, severe immunosuppression, higher body mass index), cases of osteonecrosis have been reported, particularly in patients with advanced HIV disease and/or long-term exposure to CART. Patients should be advised to seek medical advice if they experience joint aches and pain, joint stiffness or difficulty in movement.

Viread 163 mg film-coated tablets contain lactose monohydrate. Consequently, patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency, or glucose-galactose malabsorption should not take this medicinal product.

4.5 Interaction with other medicinal products and other forms of interaction

Interaction studies have only been performed in adults.

Based on the results of *in vitro* experiments and the known elimination pathway of tenofovir, the potential for CYP450-mediated interactions involving tenofovir with other medicinal products is low.

**Concomitant use not recommended**
Viread should not be administered concomitantly with other medicinal products containing tenofovir disoproxil fumarate or tenofovir alafenamide.

Viread should not be administered concomitantly with adefovir dipivoxil.

**Didanosine**
Co-administration of tenofovir disoproxil fumarate and didanosine is not recommended (see section 4.4 and Table 1).

**Renally eliminated medicinal products**
Since tenofovir is primarily eliminated by the kidneys, co-administration of tenofovir disoproxil fumarate with medicinal products that reduce renal function or compete for active tubular secretion via transport proteins hOAT 1, hOAT 3 or MRP 4 (e.g. cidofovir) may increase serum concentrations of tenofovir and/or the co-administered medicinal products.

Use of tenofovir disoproxil fumarate should be avoided with concurrent or recent use of a nephrotoxic medicinal product. Some examples include, but are not limited to, aminoglycosides, amphotericin B, foscarnet, ganciclovir, pentamidine, vancomycin, cidofovir or interleukin-2 (see section 4.4).

Given that tacrolimus can affect renal function, close monitoring is recommended when it is co-administered with tenofovir disoproxil fumarate.

**Other interactions**
Interactions between tenofovir disoproxil fumarate and other medicinal products are listed in Table 1 below (increase is indicated as “↑”, decrease as “↓”, no change as “↔”, twice daily as “b.i.d.”, and once daily as “q.d.”).
Table 1: Interactions between tenofovir disoproxil fumarate and other medicinal products

<table>
<thead>
<tr>
<th>Medicinal product by therapeutic areas (dose in mg)</th>
<th>Effects on drug levels Mean percent change in AUC, $C_{\text{max}}$, $C_{\text{min}}$</th>
<th>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANTI-INFECTIVES</strong></td>
<td></td>
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<tr>
<td><strong>Antiretrovirals</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Protease inhibitors</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Atazanavir/Ritonavir (300 q.d./100 q.d./300 q.d.)| Atazanavir: AUC: ↓ 25%  
C$_{\text{max}}$: ↓ 28%  
C$_{\text{min}}$: ↓ 26%  
Tenofovir: AUC: ↑ 37%  
C$_{\text{max}}$: ↑ 34%  
C$_{\text{min}}$: ↑ 29% | No dose adjustment is recommended. The increased exposure of tenofovir could potentiate tenofovir-associated adverse events, including renal disorders. Renal function should be closely monitored (see section 4.4). |
| Lopinavir/Ritonavir (400 b.i.d./100 b.i.d./300 q.d.) | Lopinavir/ritonavir: No significant effect on lopinavir/ritonavir PK parameters.  
Tenofovir: AUC: ↑ 32%  
C$_{\text{max}}$: ↔  
C$_{\text{min}}$: ↑ 51% | No dose adjustment is recommended. The increased exposure of tenofovir could potentiate tenofovir-associated adverse events, including renal disorders. Renal function should be closely monitored (see section 4.4). |
| Darunavir/Ritonavir (300/100 b.i.d./300 q.d.)     | Darunavir: No significant effect on darunavir/ritonavir PK parameters.  
Tenofovir: AUC: ↑ 22%  
C$_{\text{min}}$: ↑ 37% | No dose adjustment is recommended. The increased exposure of tenofovir could potentiate tenofovir-associated adverse events, including renal disorders. Renal function should be closely monitored (see section 4.4). |
<p>| <strong>NRTIs</strong>                                        |                                                                                  |                                                                                       |
| Didanosine                                       | Co-administration of tenofovir disoproxil fumarate and didanosine results in a 40-60% increase in systemic exposure to didanosine that may increase the risk for didanosine-related adverse reactions. Rarely, pancreatitis and lactic acidosis, sometimes fatal, have been reported. Co-administration of tenofovir disoproxil fumarate and didanosine at a dose of 400 mg daily has been associated with a significant decrease in CD4 cell count, possibly due to an intracellular interaction increasing phosphorylated (i.e. active) didanosine. A decreased dosage of 250 mg didanosine co-administered with tenofovir disoproxil fumarate therapy has been associated with reports of high rates of virological failure within several tested combinations for the treatment of HIV-1 infection. | Co-administration of tenofovir disoproxil fumarate and didanosine is not recommended (see section 4.4). |</p>
<table>
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<tr>
<th>Medicinal product by therapeutic areas (dose in mg)</th>
<th>Effects on drug levels Mean percent change in AUC, $C_{\text{max}}$, $C_{\text{min}}$</th>
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</thead>
<tbody>
<tr>
<td>Adefovir dipivoxil</td>
<td>$\text{AUC: } \leftrightarrow$ $C_{\text{max}}: \leftrightarrow$</td>
<td>Tenofovir disoproxil fumarate should not be administered concurrently with adefovir dipivoxil (see section 4.4).</td>
</tr>
<tr>
<td><strong>Hepatitis C virus antiviral agents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ledipasvir/Sofosbuvir (90 mg/400 mg q.d.) + Atazanavir/Ritonavir (300 mg q.d./100 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.)</td>
<td>Ledipasvir: $\text{AUC: } \uparrow 96%$ $C_{\text{max}}: \uparrow 68%$ $C_{\text{min}}: \uparrow 118%$ GS-331007: $\text{AUC: } \leftrightarrow$ $C_{\text{max}}: \leftrightarrow$ $C_{\text{min}}: \uparrow 42%$ Atazanavir: $\text{AUC: } \leftrightarrow$ $C_{\text{max}}: \leftrightarrow$ $C_{\text{min}}: \uparrow 63%$ Ritonavir: $\text{AUC: } \leftrightarrow$ $C_{\text{max}}: \leftrightarrow$ $C_{\text{min}}: \uparrow 45%$ Emtricitabine: $\text{AUC: } \leftrightarrow$ $C_{\text{max}}: \leftrightarrow$ $C_{\text{min}}: \leftrightarrow$ Tenofovir: $\text{AUC: } \leftrightarrow$ $C_{\text{max}}: \uparrow 47%$ $C_{\text{min}}: \uparrow 47%$</td>
<td>Increased plasma concentrations of tenofovir resulting from co-administration of tenofovir disoproxil fumarate, ledipasvir/sofosbuvir and atazanavir/ritonavir may increase adverse reactions related to tenofovir disoproxil fumarate, including renal disorders. The safety of tenofovir disoproxil fumarate when used with ledipasvir/sofosbuvir and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established. The combination should be used with caution with frequent renal monitoring, if other alternatives are not available (see section 4.4).</td>
</tr>
</tbody>
</table>
## Medicinal product by therapeutic areas

<table>
<thead>
<tr>
<th>Medicinal product by therapeutic areas (dose in mg)</th>
<th>Effects on drug levels Mean percent change in AUC, ( C_{\text{max}} ), ( C_{\text{min}} )</th>
<th>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ledipasvir/Sofosbuvir (90 mg/400 mg q.d.) + Darunavir/Ritonavir (800 mg q.d./100 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.)¹</td>
<td>Ledipasvir: ( \text{AUC}: \leftrightarrow ) ( \text{C}<em>{\text{max}}: \leftrightarrow ) ( \text{C}</em>{\text{min}}: \leftrightarrow ) Sofosbuvir: ( \text{AUC}: \downarrow 27% ) ( \text{C}<em>{\text{max}}: \downarrow 37% ) GS-331007²: ( \text{AUC}: \leftrightarrow ) ( \text{C}</em>{\text{max}}: \leftrightarrow ) ( \text{C}<em>{\text{min}}: \leftrightarrow ) Darunavir: ( \text{AUC}: \leftrightarrow ) ( \text{C}</em>{\text{max}}: \leftrightarrow ) ( \text{C}<em>{\text{min}}: \leftrightarrow ) Ritonavir: ( \text{AUC}: \leftrightarrow ) ( \text{C}</em>{\text{max}}: \leftrightarrow ) ( \text{C}<em>{\text{min}}: \uparrow 48% ) Emtricitabine: ( \text{AUC}: \leftrightarrow ) ( \text{C}</em>{\text{max}}: \leftrightarrow ) ( \text{C}<em>{\text{min}}: \leftrightarrow ) Tenofovir: ( \text{AUC}: \uparrow 50% ) ( \text{C}</em>{\text{max}}: \uparrow 64% ) ( \text{C}_{\text{min}}: \uparrow 59% )</td>
<td>Increased plasma concentrations of tenofovir resulting from co-administration of tenofovir disoproxil fumarate, ledipasvir/sofosbuvir and darunavir/ritonavir may increase adverse reactions related to tenofovir disoproxil fumarate, including renal disorders. The safety of tenofovir disoproxil fumarate when used with ledipasvir/sofosbuvir and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established. The combination should be used with caution with frequent renal monitoring, if other alternatives are not available (see section 4.4).</td>
</tr>
<tr>
<td>Ledipasvir/Sofosbuvir (90 mg/400 mg q.d.) + Efavirenz/Emtricitabine/Tenofovir disoproxil fumarate (600 mg/200 mg/300 mg q.d.)</td>
<td>Ledipasvir: ( \text{AUC}: \downarrow 34% ) ( \text{C}<em>{\text{max}}: \downarrow 34% ) ( \text{C}</em>{\text{min}}: \downarrow 34% ) Sofosbuvir: ( \text{AUC}: \leftrightarrow ) ( \text{C}<em>{\text{max}}: \leftrightarrow ) GS-331007²: ( \text{AUC}: \leftrightarrow ) ( \text{C}</em>{\text{max}}: \leftrightarrow ) ( \text{C}<em>{\text{min}}: \leftrightarrow ) Efavirenz: ( \text{AUC}: \leftrightarrow ) ( \text{C}</em>{\text{max}}: \leftrightarrow ) ( \text{C}<em>{\text{min}}: \leftrightarrow ) Emtricitabine: ( \text{AUC}: \leftrightarrow ) ( \text{C}</em>{\text{max}}: \leftrightarrow ) ( \text{C}_{\text{min}}: \leftrightarrow )</td>
<td>No dose adjustment is recommended. The increased exposure of tenofovir could potentiate adverse reactions associated with tenofovir disoproxil fumarate, including renal disorders. Renal function should be closely monitored (see section 4.4).</td>
</tr>
</tbody>
</table>

¹ Note: GS-331007 is a pharmacokinetic enhancer (e.g. ritonavir or cobicistat).
<table>
<thead>
<tr>
<th>Medicinal product by therapeutic areas (dose in mg)</th>
<th>Effects on drug levels Mean percent change in AUC, $C_{\text{max}}$, $C_{\text{min}}$</th>
<th>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</th>
</tr>
</thead>
</table>
| Tenofovir:                                       | AUC: ↑ 98%  
$C_{\text{max}}$: ↑ 79%  
$C_{\text{min}}$: ↑ 163% | No dose adjustment is recommended. The increased exposure of tenofovir could potentiate adverse reactions associated with tenofovir disoproxil fumarate, including renal disorders. Renal function should be closely monitored (see section 4.4). |
| Ledipasvir/Sofosbuvir (90 mg/400 mg q.d.) + Emtricitabine/Rilpivirine/Tenofovir disoproxil fumarate (200 mg/25 mg/300 mg q.d.) | Ledipasvir:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Sofosbuvir:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
GS-331007²:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Emtricitabine:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Rilpivirine:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Tenofovir:  
AUC: ↑ 40%  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↑ 91% |
<table>
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<th>Medicinal product by therapeutic areas (dose in mg)</th>
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<th>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</th>
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</table>
| Ledipasvir/Sofosbuvir (90 mg/400 mg q.d.) + Dolutegravir (50 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.) | Sofosbuvir:  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: $\leftrightarrow$  
$C_{\text{min}}$: $\leftrightarrow$  
GS-331007$^2$  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: $\leftrightarrow$  
$C_{\text{min}}$: $\leftrightarrow$  
Ledipasvir:  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: $\leftrightarrow$  
$C_{\text{min}}$: $\leftrightarrow$  
Dolutegravir  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: $\leftrightarrow$  
$C_{\text{min}}$: $\leftrightarrow$  
Emtricitabine:  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: $\leftrightarrow$  
$C_{\text{min}}$: $\leftrightarrow$  
Tenofovir:  
AUC: $\uparrow$ 65%  
$C_{\text{max}}$: $\uparrow$ 61%  
$C_{\text{min}}$: $\uparrow$ 115% | No dose adjustment is recommended. The increased exposure of tenofovir could potentiate adverse reactions associated with tenofovir disoproxil fumarate, including renal disorders. Renal function should be closely monitored (see section 4.4). |
<table>
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<tr>
<th>Medicinal product by therapeutic areas (dose in mg)</th>
<th>Effects on drug levels</th>
<th>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Atazanavir/Ritonavir (300 mg q.d./100 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.)</td>
<td>Sofosbuvir: AUC: ↔ C\text{max}: ↔ GS-331007²: AUC: ↔ C\text{max}: ↔ C\text{min}: ↑ 42% Velpatasvir: AUC: ↑ 142% C\text{max}: ↑ 55% C\text{min}: ↑ 301% Atazanavir: AUC: ↔ C\text{max}: ↔ C\text{min}: ↑ 39% Ritonavir: AUC: ↔ C\text{max}: ↔ C\text{min}: ↑ 29% Emtricitabine: AUC: ↔ C\text{max}: ↔ C\text{min}: ↔ Tenofovir: AUC: ↔ C\text{max}: ↑ 55% C\text{min}: ↑ 39%</td>
<td>Increased plasma concentrations of tenofovir resulting from co-administration of tenofovir disoproxil fumarate, sofosbuvir/velpatasvir and atazanavir/ritonavir may increase adverse reactions related to tenofovir disoproxil fumarate, including renal disorders. The safety of tenofovir disoproxil fumarate when used with sofosbuvir/velpatasvir and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established. The combination should be used with caution with frequent renal monitoring (see section 4.4).</td>
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<tr>
<td>Medicinal product by therapeutic areas (dose in mg)</td>
<td>Effects on drug levels Mean percent change in AUC, C&lt;sub&gt;max&lt;/sub&gt;, C&lt;sub&gt;min&lt;/sub&gt;</td>
<td>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Darunavir/Ritonavir (800 mg q.d./100 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.) | Sofosbuvir:  
AUC: ↓28%  
C<sub>max</sub>: ↓38%  
GS-331007<sup>2</sup>:  
AUC: ↔  
C<sub>max</sub>: ↔  
C<sub>min</sub>: ↔  
Velpatasvir:  
AUC: ↔  
C<sub>max</sub>: ↓24%  
C<sub>min</sub>: ↔  
Darunavir:  
AUC: ↔  
C<sub>max</sub>: ↔  
C<sub>min</sub>: ↔  
Ritonavir:  
AUC: ↔  
C<sub>max</sub>: ↔  
C<sub>min</sub>: ↔  
Emtricitabine:  
AUC: ↔  
C<sub>max</sub>: ↔  
C<sub>min</sub>: ↔  
Tenofovir:  
AUC: ↑39%  
C<sub>max</sub>: ↑55%  
C<sub>min</sub>: ↑52% | Increased plasma concentrations of tenofovir resulting from co-administration of tenofovir disoproxil fumarate, sofosbuvir/velpatasvir and darunavir/ritonavir may increase adverse reactions related to tenofovir disoproxil fumarate, including renal disorders. The safety of tenofovir disoproxil fumarate when used with sofosbuvir/velpatasvir and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established. The combination should be used with caution with frequent renal monitoring (see section 4.4). |
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<th>Medicinal product by therapeutic areas (dose in mg)</th>
<th>Effects on drug levels Mean percent change in AUC, $C_{\text{max}}$, $C_{\text{min}}$</th>
<th>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</th>
</tr>
</thead>
</table>
| Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Lopinavir/Ritonavir (800 mg/200 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.) | Sofosbuvir:  
AUC: ↓ 29%  
$C_{\text{max}}$: ↓ 41%  
GS-331007²:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Velpatasvir:  
AUC: ↔  
$C_{\text{max}}$: ↓ 30%  
$C_{\text{min}}$: ↑ 63%  
Lopinavir:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Ritonavir:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Emtricitabine:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Tenofovir:  
AUC: ↔  
$C_{\text{max}}$: ↑ 42%  
$C_{\text{min}}$: ↔ | Increased plasma concentrations of tenofovir resulting from co-administration of tenofovir disoproxil fumarate, sofosbuvir/velpatasvir and lopinavir/ritonavir may increase adverse reactions related to tenofovir disoproxil fumarate, including renal disorders. The safety of tenofovir disoproxil fumarate when used with sofosbuvir/velpatasvir and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established.  
The combination should be used with caution with frequent renal monitoring (see section 4.4). |
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<tr>
<td>Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Raltegravir (400 mg b.i.d) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.)</td>
<td>Sofosbuvir: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔ GS-331007$^2$: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔ Velpatasvir: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔ Raltegravir: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↓ 21% Emtricitabine: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔ Tenofovir: AUC: ↑ 40% $C_{\text{max}}$: ↑ 46% $C_{\text{min}}$: ↑ 70%</td>
<td>No dose adjustment is recommended. The increased exposure of tenofovir could potentiate adverse reactions associated with tenofovir disoproxil fumarate, including renal disorders. Renal function should be closely monitored (see section 4.4).</td>
</tr>
<tr>
<td>Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Efavirenz/Emtricitabine/ Tenofovir disoproxil fumarate (600 mg/200 mg/300 mg q.d.)</td>
<td>Sofosbuvir: AUC: ↔ $C_{\text{max}}$: ↑ 38% GS-331007$^2$: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔ Velpatasvir: AUC: ↓ 53% $C_{\text{max}}$: ↓ 47% $C_{\text{min}}$: ↓ 57% Efavirenz: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔ Emtricitabine: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔ Tenofovir: AUC: ↑ 81% $C_{\text{max}}$: ↑ 77% $C_{\text{min}}$: ↑ 121%</td>
<td>Concomitant administration of sofosbuvir/velpatasvir and efavirenz is expected to decrease plasma concentrations of velpatasvir. Co-administration of sofosbuvir/velpatasvir with efavirenz-containing regimens is not recommended.</td>
</tr>
<tr>
<td>Medicinal product by therapeutic areas (dose in mg)</td>
<td>Effects on drug levels</td>
<td>Recommendation concerning co-administration with 245 mg tenofovir disoproxil fumarate (as fumarate)</td>
</tr>
<tr>
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<td>---</td>
</tr>
</tbody>
</table>
| Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Emtricitabine/Rilpivirine/Tenofovir disoproxil fumarate (200 mg/25 mg/300 mg q.d.) | Sofosbuvir:  
AUC: ↔  
C_{max}: ↔  
C_{min}: ↔  
GS-331007\(^2\):  
AUC: ↔  
C_{max}: ↔  
C_{min}: ↔  
Velpatasvir:  
AUC: ↔  
C_{max}: ↔  
C_{min}: ↔  
Emtricitabine:  
AUC: ↔  
C_{max}: ↔  
C_{min}: ↔  
Rilpivirine:  
AUC: ↔  
C_{max}: ↔  
C_{min}: ↔  
Tenofovir:  
AUC: ↑ 40%  
C_{max}: ↑ 44%  
C_{min}: ↑ 84% | No dose adjustment is recommended. The increased exposure of tenofovir could potentiate adverse reactions associated with tenofovir disoproxil fumarate, including renal disorders. Renal function should be closely monitored (see section 4.4). |
| Sofosbuvir (400 mg q.d.) + Efavirenz/Emtricitabine/Tenofovir disoproxil fumarate (600 mg/200 mg/300 mg q.d.) | Sofosbuvir:  
AUC: ↔  
C_{max}: ↓ 19%  
GS-331007\(^2\):  
AUC: ↔  
C_{max}: ↓ 23%  
Efavirenz:  
AUC: ↔  
C_{max}: ↔  
C_{min}: ↔  
Emtricitabine:  
AUC: ↔  
C_{max}: ↔  
C_{min}: ↔  
Tenofovir:  
AUC: ↔  
C_{max}: ↑ 25%  
C_{min}: ↔ | No dose adjustment is required. |

\(^1\) Data generated from simultaneous dosing with ledipasvir/sofosbuvir. Staggered administration (12 hours apart) provided similar results.

\(^2\) The predominant circulating metabolite of sofosbuvir.

**Studies conducted with other medicinal products**  
There were no clinically significant pharmacokinetic interactions when tenofovir disoproxil fumarate was co-administered with emtricitabine, lamivudine, indinavir, efavirenz, nelfinavir, saquinavir.
(ritonavir boosted), methadone, ribavirin, rifampicin, tacrolimus, or the hormonal contraceptive norgestimate/ethinyl oestradiol.

Tenofovir disoproxil fumarate must be taken with food, as food enhances the bioavailability of tenofovir (see section 5.2).

4.6 Fertility, pregnancy and lactation

Pregnancy

A moderate amount of data on pregnant women (between 300-1,000 pregnancy outcomes) indicate no malformations or foetal/neonatal toxicity associated with tenofovir disoproxil fumarate. Animal studies do not indicate reproductive toxicity (see section 5.3). The use of tenofovir disoproxil fumarate may be considered during pregnancy, if necessary.

Breast-feeding

Tenofovir has been shown to be excreted in human milk. There is insufficient information on the effects of tenofovir in newborns/infants. Therefore Viread should not be used during breast-feeding.

As a general rule, it is recommended that HIV infected women do not breast-feed their infants in order to avoid transmission of HIV to the infant.

Fertility

There are limited clinical data with respect to the effect of tenofovir disoproxil fumarate on fertility. Animal studies do not indicate harmful effects of tenofovir disoproxil fumarate on fertility.

4.7 Effects on ability to drive and use machines

No studies on the effects on the ability to drive and use machines have been performed. However, patients should be informed that dizziness has been reported during treatment with tenofovir disoproxil fumarate.

4.8 Undesirable effects

Summary of the safety profile

In patients receiving tenofovir disoproxil fumarate, rare events of renal impairment, renal failure and uncommon events of proximal renal tubulopathy (including Fanconi syndrome) sometimes leading to bone abnormalities (infrequently contributing to fractures) have been reported. Monitoring of renal function is recommended for patients receiving Viread (see section 4.4).

Approximately one third of patients can be expected to experience adverse reactions following treatment with tenofovir disoproxil fumarate in combination with other antiretroviral agents. These reactions are usually mild to moderate gastrointestinal events. Approximately 1% of tenofovir disoproxil fumarate-treated adult patients discontinued treatment due to the gastrointestinal events.

Co-administration of Viread and didanosine is not recommended as this may result in an increased risk of adverse reactions (see section 4.5). Rarely, pancreatitis and lactic acidosis, sometimes fatal, have been reported (see section 4.4).

Discontinuation of Viread in patients co-infected with HIV and HBV may be associated with severe acute exacerbations of hepatitis (see section 4.4).

Tabulated summary of adverse reactions

Assessment of adverse reactions for tenofovir disoproxil fumarate is based on safety data from clinical studies and post-marketing experience. All adverse reactions are presented in Table 2.

Assessment of adverse reactions from HIV-1 clinical study data is based on experience in two studies in 653 treatment-experienced adult patients receiving treatment with tenofovir disoproxil fumarate
(n = 443) or placebo (n = 210) in combination with other antiretroviral medicinal products for 24 weeks and also in a double-blind comparative controlled study in which 600 treatment-naïve adult patients received treatment with tenofovir disoproxil 245 mg (as fumarate) (n = 299) or stavudine (n = 301) in combination with lamivudine and efavirenz for 144 weeks.

The adverse reactions with suspected (at least possible) relationship to treatment are listed below by body system organ class and frequency. Within each frequency grouping, undesirable effects are presented in order of decreasing seriousness. Frequencies are defined as very common (≥ 1/10), common (≥ 1/100 to < 1/10), uncommon (≥ 1/1,000 to < 1/100) or rare (≥ 1/10,000 to < 1/1,000).

Table 2: Tabulated summary of adverse reactions associated with tenofovir disoproxil fumarate based on clinical study and post-marketing experience

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Tenofovir disoproxil fumarate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metabolism and nutrition disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Very common:</td>
<td>hypophosphataemia¹</td>
</tr>
<tr>
<td>Uncommon:</td>
<td>hypokalaemia¹</td>
</tr>
<tr>
<td>Rare:</td>
<td>lactic acidosis</td>
</tr>
<tr>
<td><strong>Nervous system disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Very common:</td>
<td>dizziness</td>
</tr>
<tr>
<td><strong>Gastrointestinal disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Very common:</td>
<td>diarrhoea, vomiting, nausea</td>
</tr>
<tr>
<td>Common:</td>
<td>flatulence</td>
</tr>
<tr>
<td>Uncommon:</td>
<td>pancreatitis</td>
</tr>
<tr>
<td><strong>Hepatobiliary disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Common:</td>
<td>increased transaminases</td>
</tr>
<tr>
<td>Rare:</td>
<td>hepatic steatosis, hepatitis</td>
</tr>
<tr>
<td><strong>Skin and subcutaneous tissue disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Very common:</td>
<td>rash</td>
</tr>
<tr>
<td>Rare:</td>
<td>angioedema</td>
</tr>
<tr>
<td><strong>Musculoskeletal and connective tissue disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Uncommon:</td>
<td>rhabdomyolysis¹, muscular weakness¹</td>
</tr>
<tr>
<td>Rare:</td>
<td>osteomalacia (manifested as bone pain and infrequently contributing to fractures)¹,², myopathy¹</td>
</tr>
<tr>
<td><strong>Renal and urinary disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Uncommon:</td>
<td>increased creatinine, proximal renal tubulopathy (including Fanconi syndrome)</td>
</tr>
<tr>
<td>Rare:</td>
<td>acute renal failure, renal failure, acute tubular necrosis, nephritis (including acute interstitial nephritis)², nephrogenic diabetes insipidus</td>
</tr>
<tr>
<td><strong>General disorders and administration site conditions:</strong></td>
<td></td>
</tr>
<tr>
<td>Very common:</td>
<td>asthenia</td>
</tr>
</tbody>
</table>

¹ This adverse reaction may occur as a consequence of proximal renal tubulopathy. It is not considered to be causally associated with tenofovir disoproxil fumarate in the absence of this condition.
² This adverse reaction was identified through post-marketing surveillance but not observed in randomised controlled clinical trials or the tenofovir disoproxil fumarate expanded access program. The frequency category was estimated from a statistical calculation based on the total number of patients exposed to tenofovir disoproxil fumarate in randomised controlled clinical trials and the expanded access program (n = 7,319).
Description of selected adverse reactions

Renal impairment
As Viread may cause renal damage monitoring of renal function is recommended (see sections 4.4 and 4.8 Summary of the safety profile). Proximal renal tubulopathy generally resolved or improved after tenofovir disoproxil fumarate discontinuation. However, in some patients, declines in creatinine clearance did not completely resolve despite tenofovir disoproxil fumarate discontinuation. Patients at risk of renal impairment (such as patients with baseline renal risk factors, advanced HIV disease, or patients receiving concomitant nephrotoxic medications) are at increased risk of experiencing incomplete recovery of renal function despite tenofovir disoproxil fumarate discontinuation (see section 4.4).

Interaction with didanosine
Co-administration of tenofovir disoproxil fumarate and didanosine is not recommended as it results in a 40-60% increase in systemic exposure to didanosine that may increase the risk of didanosine-related adverse reactions (see section 4.5). Rarely, pancreatitis and lactic acidosis, sometimes fatal, have been reported.

Metabolic parameters
Weight and levels of blood lipids and glucose may increase during antiretroviral therapy (see section 4.4).

Immune reactivation syndrome
In HIV infected patients with severe immune deficiency at the time of initiation of CART, an inflammatory reaction to asymptomatic or residual opportunistic infections may arise. Autoimmune disorders (such as Graves’ disease) have also been reported; however, the reported time to onset is more variable and these events can occur many months after initiation of treatment (see section 4.4).

Osteonecrosis
Cases of osteonecrosis have been reported, particularly in patients with generally acknowledged risk factors, advanced HIV disease or long-term exposure to CART. The frequency of this is unknown (see section 4.4).

Paediatric population
Assessment of adverse reactions is based on two randomised trials (studies GS-US-104-0321 and GS-US-104-0352) in 184 HIV-1 infected paediatric patients (aged 2 to < 18 years) who received treatment with tenofovir disoproxil fumarate (n = 93) or placebo/active comparator (n = 91) in combination with other antiretroviral agents for 48 weeks (see section 5.1). The adverse reactions observed in paediatric patients who received treatment with tenofovir disoproxil fumarate were consistent with those observed in clinical studies of tenofovir disoproxil fumarate in adults (see section 4.8 Tabulated summary of adverse reactions and 5.1).

Reductions in BMD have been reported in paediatric patients. In HIV-1 infected adolescents, the BMD Z-scores observed in subjects who received tenofovir disoproxil fumarate were lower than those observed in subjects who received placebo. In HIV-1 infected children, the BMD Z-scores observed in subjects who switched to tenofovir disoproxil fumarate were lower than those observed in subjects who remained on their stavudine- or zidovudine-containing regimen (see sections 4.4 and 5.1).

In study GS-US-104-0352, 4 out of 89 paediatric patients exposed to tenofovir disoproxil fumarate (median tenofovir disoproxil fumarate exposure 312 weeks) discontinued due to adverse reactions consistent with proximal renal tubulopathy. Seven patients had estimated glomerular filtration rate (GFR) values between 70 and 90 mL/min/1.73 m². Among them, two patients experienced a clinically meaningful decline in estimated GFR which improved after discontinuation of tenofovir disoproxil fumarate.
Other special population(s)

Patients with renal impairment

The use of tenofovir disoproxil fumarate is not recommended in paediatric patients with renal impairment (see sections 4.2 and 4.4).

Exacerbations of hepatitis after discontinuation of treatment

In HIV infected patients co-infected with HBV, clinical and laboratory evidence of hepatitis have occurred after discontinuation of tenofovir disoproxil fumarate (see section 4.4).

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via the national reporting system listed in Appendix V.

4.9 Overdose

Symptoms

If overdose occurs the patient must be monitored for evidence of toxicity (see sections 4.8 and 5.3), and standard supportive treatment applied as necessary.

Management

Tenofovir can be removed by haemodialysis; the median haemodialysis clearance of tenofovir is 134 ml/min. It is not known whether tenofovir can be removed by peritoneal dialysis.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antiviral for systemic use; nucleoside and nucleotide reverse transcriptase inhibitors, ATC code: J05AF07

Mechanism of action and pharmacodynamic effects

Tenofovir disoproxil fumarate is the fumarate salt of the prodrug tenofovir disoproxil. Tenofovir disoproxil is absorbed and converted to the active substance tenofovir, which is a nucleoside monophosphate (nucleotide) analogue. Tenofovir is then converted to the active metabolite, tenofovir diphosphate, an obligate chain terminator, by constitutively expressed cellular enzymes. Tenofovir diphosphate has an intracellular half-life of 10 hours in activated and 50 hours in resting peripheral blood mononuclear cells (PBMCs). Tenofovir diphosphate inhibits HIV-1 reverse transcriptase and the HBV polymerase by direct binding competition with the natural deoxyribonucleotide substrate and, after incorporation into DNA, by DNA chain termination. Tenofovir diphosphate is a weak inhibitor of cellular polymerases α, β, and γ. At concentrations of up to 300 µmol/l, tenofovir has also shown no effect on the synthesis of mitochondrial DNA or the production of lactic acid in in vitro assays.

Data pertaining to HIV

HIV antiviral activity in vitro: The concentration of tenofovir required for 50% inhibition (EC₅₀) of the wild-type laboratory strain HIV-1mm is 1.6 µmol/l in lymphoid cell lines and 1.1 µmol/l against primary HIV-1 subtype B isolates in PBMCs. Tenofovir is also active against HIV-1 subtypes A, C, D, E, F, G, and O and against HIVBal in primary monocyte/macrophage cells. Tenofovir shows activity in vitro against HIV-2, with an EC₅₀ of 4.9 µmol/l in MT-4 cells.
**Resistance:** Strains of HIV-1 with reduced susceptibility to tenofovir and a K65R mutation in reverse transcriptase have been selected in vitro and in some patients (see Clinical efficacy and safety). Tenofovir disoproxil fumarate should be avoided in antiretroviral-experienced patients with strains harbouring the K65R mutation (see section 4.4). In addition, a K70E substitution in HIV-1 reverse transcriptase has been selected by tenofovir and results in low-level reduced susceptibility to tenofovir.

Clinical studies in treatment-experienced patients have assessed the anti-HIV activity of tenofovir disoproxil 245 mg (as fumarate) against strains of HIV-1 with resistance to nucleoside inhibitors. The results indicate that patients whose HIV expressed 3 or more thymidine-analogue associated mutations (TAMs) that included either the M41L or L210W reverse transcriptase mutation showed reduced response to tenofovir disoproxil 245 mg (as fumarate) therapy.

**Clinical efficacy and safety**
The effects of tenofovir disoproxil fumarate in treatment-experienced and treatment-naive HIV-1 infected adults have been demonstrated in trials of 48 weeks and 144 weeks duration, respectively.

In study GS-99-907, 550 treatment-experienced adult patients were treated with placebo or tenofovir disoproxil 245 mg (as fumarate) for 24 weeks. The mean baseline CD4 cell count was 427 cells/mm³, the mean baseline plasma HIV-1 RNA was 3.4 log₁₀ copies/ml (78% of patients had a viral load of < 5,000 copies/ml) and the mean duration of prior HIV treatment was 5.4 years. Baseline genotypic analysis of HIV isolates from 253 patients revealed that 94% of patients had HIV-1 resistance mutations associated with nucleoside reverse transcriptase inhibitors, 58% had mutations associated with protease inhibitors and 48% had mutations associated with non-nucleoside reverse transcriptase inhibitors.

At week 24 the time-weighted average change from baseline in log₁₀ plasma HIV-1 RNA levels (DAVG₂₄) was -0.03 log₁₀ copies/ml and -0.61 log₁₀ copies/ml for the placebo and tenofovir disoproxil 245 mg (as fumarate) recipients (p < 0.0001). A statistically significant difference in favour of tenofovir disoproxil 245 mg (as fumarate) was seen in the time-weighted average change from baseline at week 24 (DAVG₂₄) for CD4 count (+13 cells/mm³ for tenofovir disoproxil 245 mg (as fumarate) versus -11 cells/mm³ for placebo, p-value = 0.0008). The antiviral response to tenofovir disoproxil fumarate was durable through 48 weeks (DAVG₄₈ was -0.57 log₁₀ copies/ml, proportion of patients with HIV-1 RNA below 400 or 50 copies/ml was 41% and 18% respectively). Eight (2%) tenofovir disoproxil 245 mg (as fumarate) treated patients developed the K65R mutation within the first 48 weeks.

The 144-week, double-blind, active controlled phase of study GS-99-903 evaluated the efficacy and safety of tenofovir disoproxil 245 mg (as fumarate) versus stavudine when used in combination with lamivudine and efavirenz in HIV-1 infected adult patients naïve to antiretroviral therapy. The mean baseline CD4 cell count was 279 cells/mm³, the mean baseline plasma HIV-1 RNA was 4.91 log₁₀ copies/ml, 19% of patients had symptomatic HIV-1 infection and 18% had AIDS. Patients were stratified by baseline HIV-1 RNA and CD4 count. Forty-three percent of patients had baseline viral loads > 100,000 copies/ml and 39% had CD4 cell counts < 200 cells/ml.

By intent to treat analysis (missing data and switch in antiretroviral therapy (ART) considered as failure), the proportion of patients with HIV-1 RNA below 400 copies/ml and 50 copies/ml at 48 weeks of treatment was 80% and 76% respectively in the tenofovir disoproxil 245 mg (as fumarate) arm, compared to 84% and 80% in the stavudine arm. At 144 weeks, the proportion of patients with HIV-1 RNA below 400 copies/ml and 50 copies/ml was 71% and 68% respectively in the tenofovir disoproxil 245 mg (as fumarate) arm, compared to 64% and 63% in the stavudine arm.

The average change from baseline for HIV-1 RNA and CD4 count at 48 weeks of treatment was similar in both treatment groups (-3.09 and -3.09 log₁₀ copies/ml; +169 and 167 cells/mm³ in the tenofovir disoproxil 245 mg (as fumarate) and stavudine groups, respectively). At 144 weeks of treatment, the average change from baseline remained similar in both treatment groups (-3.07 and -3.03 log₁₀ copies/ml; +263 and +283 cells/mm³ in the tenofovir disoproxil 245 mg (as fumarate)
and stavudine groups, respectively). A consistent response to treatment with tenofovir disoproxil 245 mg (as fumarate) was seen regardless of baseline HIV-1 RNA and CD4 count.

The K65R mutation occurred in a slightly higher percentage of patients in the tenofovir disoproxil fumarate group than the active control group (2.7% versus 0.7%). Efavirenz or lamivudine resistance either preceded or was coincident with the development of K65R in all cases. Eight patients had HIV that expressed K65R in the tenofovir disoproxil 245 mg (as fumarate) arm, 7 of these occurred during the first 48 weeks of treatment and the last one at week 96. No further K65R development was observed up to week 144. One patient in the tenofovir disoproxil (as fumarate) arm developed the K70E substitution in the virus. From both the genotypic and phenotypic analyses there was no evidence for other pathways of resistance to tenofovir.

Data pertaining to HBV
The antiviral activity of tenofovir disoproxil fumarate against hepatitis B virus (HBV) has been demonstrated in vitro and clinically in adults and adolescents. Please refer to the Summaries of Product Characteristics for Viread 245 mg film-coated tablets and Viread 33 mg/g granules.

Paediatric population
In study GS-US-104-0321, 87 HIV-1 infected treatment-experienced patients 12 to < 18 years of age were treated with tenofovir disoproxil fumarate (n = 45) or placebo (n = 42) in combination with an optimised background regimen (OBR) for 48 weeks. Due to limitations of the study, a benefit of tenofovir disoproxil fumarate over placebo was not demonstrated based on plasma HIV-1 RNA levels at week 24. However, a benefit is expected for the adolescent population based on extrapolation of adult data and comparative pharmacokinetic data (see section 5.2).

In patients who received treatment with tenofovir disoproxil fumarate or placebo, mean lumbar spine BMD Z-score was -1.004 and -0.809, and mean total body BMD Z-score was -0.866 and -0.584, respectively, at baseline. Mean changes at week 48 (end of double-blind phase) were -0.215 and -0.165 in lumbar spine BMD Z-score, and -0.254 and -0.179 in total body BMD Z-score for the tenofovir disoproxil fumarate and placebo groups, respectively. The mean rate of BMD gain was less in the tenofovir disoproxil fumarate group compared to the placebo group. At week 48, six adolescents in the tenofovir disoproxil fumarate group and one adolescent in the placebo group had significant lumbar spine BMD loss (defined as > 4% loss). Among 28 patients receiving 96 weeks of treatment with tenofovir disoproxil fumarate, BMD Z-scores declined by -0.341 for lumbar spine and -0.458 for total body.

In study GS-US-104-0352, 97 treatment-experienced patients 2 to < 12 years of age with stable, virologic suppression on stavudine- or zidovudine-containing regimens were randomised to either replace stavudine or zidovudine with tenofovir disoproxil fumarate (n = 48) or continue on their original regimen (n = 49) for 48 weeks. At week 48, 83% of patients in the tenofovir disoproxil fumarate treatment group and 92% of patients in the stavudine or zidovudine treatment group had HIV-1 RNA concentrations < 400 copies/ml. The difference in the proportion of patients who maintained < 400 copies/ml at week 48 was mainly influenced by the higher number of discontinuations in the tenofovir disoproxil fumarate treatment group. When missing data were excluded, 91% of patients in the tenofovir disoproxil fumarate treatment group and 94% of patients in the stavudine or zidovudine treatment group had HIV-1 RNA concentrations < 400 copies/ml at week 48.

Reductions in BMD have been reported in paediatric patients. In patients who received treatment with tenofovir disoproxil fumarate, or stavudine or zidovudine, mean lumbar spine BMD Z-score was -1.034 and -0.498, and mean total body BMD Z-score was -0.471 and -0.386, respectively, at baseline. Mean changes at week 48 (end of randomised phase) were 0.032 and 0.087 in lumbar spine BMD Z-score, and -0.184 and -0.027 in total body BMD Z-score for the tenofovir disoproxil fumarate and stavudine or zidovudine groups, respectively. The mean rate of lumbar spine bone gain at week 48 was similar between the tenofovir disoproxil fumarate treatment group and the stavudine or zidovudine treatment group. Total body bone gain was less in the tenofovir disoproxil fumarate treatment group compared to the stavudine or zidovudine treatment group. One tenofovir disoproxil
fumarate treated subject and no stavudine or zidovudine treated subjects experienced significant (> 4%) lumbar spine BMD loss at week 48. BMD Z-scores declined by -0.012 for lumbar spine and by -0.338 for total body in the 64 subjects who were treated with tenofovir disoproxil fumarate for 96 weeks. BMD Z-scores were not adjusted for height and weight.

In study GS-US-104-0352, 4 out of 89 paediatric patients exposed to tenofovir disoproxil fumarate discontinued due to adverse reactions consistent with proximal renal tubulopathy (median tenofovir disoproxil fumarate exposure 104 weeks).

The European Medicines Agency has deferred the obligation to submit the results of studies with Viread in one or more subsets of the paediatric population in HIV and chronic hepatitis B (see section 4.2 for information on paediatric use).

5.2 Pharmacokinetic properties

Tenofovir disoproxil fumarate is a water soluble ester prodrug which is rapidly converted in vivo to tenofovir and formaldehyde.

Tenofovir is converted intracellularly to tenofovir monophosphate and to the active component, tenofovir diphosphate.

Absorption

Following oral administration of tenofovir disoproxil fumarate to HIV infected patients, tenofovir disoproxil fumarate is rapidly absorbed and converted to tenofovir. Administration of multiple doses of tenofovir disoproxil fumarate with a meal to HIV infected patients resulted in mean (%CV) tenofovir C_{max}, AUC, and C_{min} values of 326 (36.6%) ng/ml, 3,324 (41.2%) ng·h/ml and 64.4 (39.4%) ng/ml, respectively. Maximum tenofovir concentrations are observed in serum within one hour of dosing in the fasted state and within two hours when taken with food. The oral bioavailability of tenofovir from tenofovir disoproxil fumarate in fasted patients was approximately 25%. Administration of tenofovir disoproxil fumarate with a high fat meal enhanced the oral bioavailability, with an increase in tenofovir AUC by approximately 40% and C_{max} by approximately 14%. Following the first dose of tenofovir disoproxil fumarate in fed patients, the median C_{max} in serum ranged from 213 to 375 ng/ml. However, administration of tenofovir disoproxil fumarate with a light meal did not have a significant effect on the pharmacokinetics of tenofovir.

Distribution

Following intravenous administration the steady-state volume of distribution of tenofovir was estimated to be approximately 800 ml/kg. After oral administration of tenofovir disoproxil fumarate, tenofovir is distributed to most tissues with the highest concentrations occurring in the kidney, liver and the intestinal contents (preclinical studies). In vitro protein binding of tenofovir to plasma or serum protein was less than 0.7 and 7.2%, respectively, over the tenofovir concentration range 0.01 to 25 µg/ml.

Biotransformation

In vitro studies have determined that neither tenofovir disoproxil fumarate nor tenofovir are substrates for the CYP450 enzymes. Moreover, at concentrations substantially higher (approximately 300-fold) than those observed in vivo, tenofovir did not inhibit in vitro drug metabolism mediated by any of the major human CYP450 isoforms involved in drug biotransformation (CYP3A4, CYP2D6, CYP2C9, CYP2E1, or CYP1A1/2). Tenofovir disoproxil fumarate at a concentration of 100 µmol/l had no effect on any of the CYP450 isoforms, except CYP1A1/2, where a small (6%) but statistically significant reduction in metabolism of CYP1A1/2 substrate was observed. Based on these data, it is unlikely that clinically significant interactions involving tenofovir disoproxil fumarate and medicinal products metabolised by CYP450 would occur.
Elimination

Tenofovir is primarily excreted by the kidney by both filtration and an active tubular transport system with approximately 70-80% of the dose excreted unchanged in urine following intravenous administration. Total clearance has been estimated to be approximately 230 ml/h/kg (approximately 300 ml/min). Renal clearance has been estimated to be approximately 160 ml/h/kg (approximately 210 ml/min), which is in excess of the glomerular filtration rate. This indicates that active tubular secretion is an important part of the elimination of tenofovir. Following oral administration the terminal half-life of tenofovir is approximately 12 to 18 hours.

Studies have established the pathway of active tubular secretion of tenofovir to be influx into proximal tubule cell by the human organic anion transporters (hOAT) 1 and 3 and efflux into the urine by the multidrug resistant protein 4 (MRP 4).

Linearity/non-linearity

The pharmacokinetics of tenofovir were independent of tenofovir disoproxil fumarate dose over the dose range 75 to 600 mg and were not affected by repeated dosing at any dose level.

Gender

Limited data on the pharmacokinetics of tenofovir in women indicate no major gender effect.

Ethnicity

Pharmacokinetics have not been specifically studied in different ethnic groups.

Paediatric population

Steady-state pharmacokinetics of tenofovir were evaluated in 8 HIV-1 infected adolescent patients (aged 12 to < 18 years) with body weight ≥ 35 kg and in 23 HIV-1 infected children aged 2 to < 12 years (see Table 3 below). Tenofovir exposure achieved in these paediatric patients receiving oral daily doses of tenofovir disoproxil 245 mg (as fumarate) or 6.5 mg/kg body weight tenofovir disoproxil (as fumarate) up to a maximum dose of 245 mg was similar to exposures achieved in adults receiving once-daily doses of tenofovir disoproxil 245 mg (as fumarate).

Table 3: Mean (± SD) tenofovir pharmacokinetic parameters by age groups for paediatric patients

<table>
<thead>
<tr>
<th>Dose and formulation</th>
<th>245 mg film-coated tablet 12 to &lt; 18 years (n = 8)</th>
<th>6.5 mg/kg granules 2 to &lt; 12 years (n = 23)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C_{max} (μg/ml)</td>
<td>0.38 ± 0.13</td>
<td>0.24 ± 0.13</td>
</tr>
<tr>
<td>AUC_{tau} (μg·h/ml)</td>
<td>3.39 ± 1.22</td>
<td>2.59 ± 1.06</td>
</tr>
</tbody>
</table>

Pharmacokinetic studies have not been performed in children under 2 years.

Renal impairment

Pharmacokinetic parameters of tenofovir were determined following administration of a single dose of tenofovir disoproxil 245 mg to 40 non-HIV infected adult patients with varying degrees of renal impairment defined according to baseline creatinine clearance (CrCl) (normal renal function when CrCl > 80 ml/min; mild with CrCl = 50-79 ml/min; moderate with CrCl = 30-49 ml/min and severe with CrCl = 10-29 ml/min). Compared with patients with normal renal function, the mean (%CV) tenofovir exposure increased from 2,185 (12%) ng·h/ml in subjects with CrCl > 80 ml/min to respectively 3,064 (30%) ng·h/ml, 6,009 (42%) ng·h/ml and 15,985 (45%) ng·h/ml in patients with mild, moderate and severe renal impairment.

The pharmacokinetics of tenofovir in non-haemodialysis adult patients with creatinine clearance < 10 ml/min and in patients with ESRD managed by peritoneal or other forms of dialysis have not been studied.

The pharmacokinetics of tenofovir in paediatric patients with renal impairment have not been studied. No data are available to make dose recommendations (see sections 4.2 and 4.4).
Hepatic impairment
A single 245 mg dose of tenofovir disoproxil was administered to non-HIV infected adult patients with varying degrees of hepatic impairment defined according to Child-Pugh-Turcotte (CPT) classification. Tenofovir pharmacokinetics were not substantially altered in subjects with hepatic impairment suggesting that no dose adjustment is required in these subjects. The mean (%CV) tenofovir \( C_{\text{max}} \) and \( \text{AUC}_{0-\infty} \) values were 223 (34.8%) ng/ml and 2,050 (50.8%) ng·h/ml, respectively, in normal subjects compared with 289 (46.0%) ng/ml and 2,310 (43.5%) ng·h/ml in subjects with moderate hepatic impairment, and 305 (24.8%) ng/ml and 2,740 (44.0%) ng·h/ml in subjects with severe hepatic impairment.

Intracellular pharmacokinetics
In non-proliferating human peripheral blood mononuclear cells (PBMCs) the half-life of tenofovir diphosphate was found to be approximately 50 hours, whereas the half-life in phytohaemagglutinin-stimulated PBMCs was found to be approximately 10 hours.

5.3 Preclinical safety data
Non-clinical safety pharmacology studies reveal no special hazard for humans. Findings in repeated dose toxicity studies in rats, dogs and monkeys at exposure levels greater than or equal to clinical exposure levels and with possible relevance to clinical use include renal and bone toxicity and a decrease in serum phosphate concentration. Bone toxicity was diagnosed as osteomalacia (monkeys) and reduced bone mineral density (BMD) (rats and dogs). The bone toxicity in young adult rats and dogs occurred at exposures \( \geq 5 \)-fold the exposure in paediatric or adult patients; bone toxicity occurred in juvenile infected monkeys at very high exposures following subcutaneous dosing \( \geq 40 \)-fold the exposure in patients). Findings in the rat and monkey studies indicated that there was a substance-related decrease in intestinal absorption of phosphate with potential secondary reduction in BMD.

Genotoxicity studies revealed positive results in the \textit{in vitro} mouse lymphoma assay, equivocal results in one of the strains used in the Ames test, and weakly positive results in an UDS test in primary rat hepatocytes. However, it was negative in an \textit{in vivo} mouse bone marrow micronucleus assay.

Oral carcinogenicity studies in rats and mice only revealed a low incidence of duodenal tumours at an extremely high dose in mice. These tumours are unlikely to be of relevance to humans.

Reproductive studies in rats and rabbits showed no effects on mating, fertility, pregnancy or foetal parameters. However, tenofovir disoproxil fumarate reduced the viability index and weight of pups in peri-postnatal toxicity studies at maternally toxic doses.

The active substance tenofovir disoproxil fumarate and its main transformation products are persistent in the environment.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

\textit{Tablet core}
Croscarmellose sodium
Lactose monohydrate
Magnesium stearate (E572)
Microcrystalline cellulose (E460)
Starch pregelatinised
Film-coating
Glycerol triacetate (E1518)
Hypermellose (E464)
Lactose monohydrate
Titanium dioxide (E171)

6.2 Incompatibilities
Not applicable.

6.3 Shelf life
3 years.

6.4 Special precautions for storage
This medicinal product does not require any special storage conditions.

6.5 Nature and contents of container
High density polyethylene (HDPE) bottle with a polypropylene child-resistant closure containing 30 film-coated tablets and a silica gel desiccant.

The following pack sizes are available: outer cartons containing 1 bottle of 30 film-coated tablets and outer cartons containing 90 (3 bottles of 30) film-coated tablets. Not all pack sizes may be marketed.

6.6 Special precautions for disposal
Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

7. MARKETING AUTHORISATION HOLDER
Gilead Sciences International Limited
Cambridge
CB21 6GT
United Kingdom

8. MARKETING AUTHORISATION NUMBER(S)
EU/1/01/200/006
EU/1/01/200/007

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION
Date of first authorisation: 5 February 2002
Date of latest renewal: 14 December 2011

10. DATE OF REVISION OF THE TEXT
Detailed information on this medicinal product is available on the website of the European Medicines Agency http://www.ema.europa.eu
1. **NAME OF THE MEDICINAL PRODUCT**

Viread 204 mg film-coated tablets

2. **QUALITATIVE AND QUANTITATIVE COMPOSITION**

Each film-coated tablet contains 204 mg of tenofovir disoproxil (as fumarate).

*Excipient with known effect*
Each tablet contains 137 mg lactose (as monohydrate).

For the full list of excipients, see section 6.1.

3. **PHARMACEUTICAL FORM**

Film-coated tablet (tablet).

White, capsule-shaped, film-coated tablets, of dimensions 15.4 mm x 7.3 mm, debossed on one side with “GSI” and on the other side with “250”.

4. **CLINICAL PARTICULARS**

4.1 **Therapeutic indications**

Viread 204 mg film-coated tablets are indicated in combination with other antiretroviral medicinal products for the treatment of HIV-1 infected paediatric patients, with NRTI resistance or toxicities precluding the use of first line agents, aged 6 to < 12 years who weigh from 28 kg to less than 35 kg.

The choice of Viread to treat antiretroviral-experienced patients with HIV-1 infection should be based on individual viral resistance testing and/or treatment history of patients.

4.2 **Posology and method of administration**

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

*Posology*

The recommended dose for HIV-1 infected paediatric patients aged 6 to < 12 years weighing 28 kg to < 35 kg who are able to swallow film-coated tablets is one 204 mg tablet once daily taken orally with food.

Please refer to the Summaries of Product Characteristics for Viread 123 mg and 163 mg film-coated tablets for the treatment of HIV-1 infected paediatric patients aged 6 to < 12 years weighing 17 kg to < 22 kg and 22 kg to < 28 kg, respectively.

Viread is also available as 33 mg/g granules for use in HIV-1 infected paediatric patients aged 2 to < 12 years who weigh < 17 kg or who are unable to swallow film-coated tablets. Please refer to the Summary of Product Characteristics for Viread 33 mg/g granules.

*Missed dose*

If a patient misses a dose of Viread within 12 hours of the time it is usually taken, the patient should take Viread with food as soon as possible and resume their normal dosing schedule. If a patient misses a dose of Viread by more than 12 hours and it is almost time for their next dose, the patient should not take the missed dose and simply resume the usual dosing schedule.
If the patient vomits within 1 hour of taking Viread, another tablet should be taken. If the patient vomits more than 1 hour after taking Viread they do not need to take another dose.

Special populations
Renal impairment
The use of tenofovir disoproxil fumarate is not recommended in paediatric patients with renal impairment (see section 4.4).

Hepatic impairment
No dose adjustment is required in patients with hepatic impairment (see sections 4.4 and 5.2).

If Viread 204 mg film-coated tablets are discontinued in patients co-infected with HIV and hepatitis B virus (HBV), these patients should be closely monitored for evidence of exacerbation of hepatitis (see section 4.4).

Paediatric population
The safety and efficacy of tenofovir disoproxil fumarate in HIV-1 infected children under 2 years of age have not been established. No data are available.

The safety and efficacy of tenofovir disoproxil fumarate in children with chronic hepatitis B aged 2 to < 12 years or weighing < 35 kg have not been established. No data are available.

Method of administration
Viread 204 mg film-coated tablets should be taken once daily, orally with food.

4.3 Contraindications
Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.

4.4 Special warnings and precautions for use
General
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.

Co-administration of other medicinal products
- Viread should not be administered concomitantly with other medicinal products containing tenofovir disoproxil fumarate or tenofovir alafenamide.
- Viread should not be administered concomitantly with adefovir dipivoxil.
- Co-administration of tenofovir disoproxil fumarate and didanosine is not recommended. Co-administration of tenofovir disoproxil fumarate and didanosine results in a 40-60% increase in systemic exposure to didanosine that may increase the risk of didanosine-related adverse reactions (see section 4.5). Rarely, pancreatitis and lactic acidosis, sometimes fatal, have been reported. Co-administration of tenofovir disoproxil fumarate and didanosine at a dose of 400 mg daily has been associated with a significant decrease in CD4 cell count, possibly due to an intracellular interaction increasing phosphorylated (i.e. active) didanosine. A decreased dosage of 250 mg didanosine co-administered with tenofovir disoproxil fumarate therapy has been associated with reports of high rates of virological failure within several tested combinations for the treatment of HIV-1 infection.

Triple therapy with nucleosides/nucleotides
There have been reports of a high rate of virological failure and of emergence of resistance at an early stage in HIV patients when tenofovir disoproxil fumarate was combined with lamivudine and abacavir as well as with lamivudine and didanosine as a once-daily regimen.
Renal and bone effects in adult population

Renal effects
Tenofovir is principally eliminated via the kidney. Renal failure, renal impairment, elevated creatinine, hypophosphataemia and proximal tubulopathy (including Fanconi syndrome) have been reported with the use of tenofovir disoproxil fumarate in clinical practice (see section 4.8).

Renal impairment
Renal safety with tenofovir has only been studied to a very limited degree in adult patients with impaired renal function (creatinine clearance < 80 ml/min).

Bone effects
In HIV infected patients, in a 144-week controlled clinical study that compared tenofovir disoproxil fumarate with stavudine in combination with lamivudine and efavirenz in antiretroviral-naïve adult patients, small decreases in bone mineral density (BMD) of the hip and spine were observed in both treatment groups. Decreases in BMD of spine and changes in bone biomarkers from baseline were significantly greater in the tenofovir disoproxil fumarate treatment group at 144 weeks. Decreases in BMD of hip were significantly greater in this group until 96 weeks. However, there was no increased risk of fractures or evidence for clinically relevant bone abnormalities over 144 weeks.

In other studies (prospective and cross-sectional), the most pronounced decreases in BMD were seen in patients treated with tenofovir disoproxil fumarate as part of a regimen containing a boosted protease inhibitor. Alternative treatment regimens should be considered for patients with osteoporosis that are at a high risk for fractures.

Bone abnormalities (infrequently contributing to fractures) may be associated with proximal renal tubulopathy (see section 4.8).

Renal and bone effects in paediatric population
There are uncertainties associated with the long term effects of bone and renal toxicity. Moreover, the reversibility of renal toxicity cannot be fully ascertained. Therefore, a multidisciplinary approach is recommended to adequately weigh on a case by case basis the benefit/risk balance of treatment, decide the appropriate monitoring during treatment (including decision for treatment withdrawal) and consider the need for supplementation.

Renal effects
Renal adverse reactions consistent with proximal renal tubulopathy have been reported in HIV-1 infected paediatric patients aged 2 to < 12 years in clinical study GS-US-104-0352 (see sections 4.8 and 5.1).

Renal monitoring
It is recommended that renal function (creatinine clearance and serum phosphate) is assessed in all patients prior to initiating therapy with tenofovir disoproxil fumarate and that it is also monitored after two to four weeks of treatment, after three months of treatment and every three to six months thereafter in patients without renal risk factors. In patients at risk for renal impairment, a more frequent monitoring of renal function is required.

Renal management
If serum phosphate is confirmed to be < 3.0 mg/dl (0.96 mmol/l) in any paediatric patient receiving tenofovir disoproxil fumarate, renal function should be re-evaluated within one week, including measurements of blood glucose, blood potassium and urine glucose concentrations (see section 4.8, proximal tubulopathy). If renal abnormalities are suspected or detected then consultation with a nephrologist should be obtained to consider interruption of tenofovir disoproxil fumarate treatment. Interrupting treatment with tenofovir disoproxil fumarate should also be considered in case of progressive decline of renal function when no other cause has been identified.
Co-administration and risk of renal toxicity

Use of tenofovir disoproxil fumarate should be avoided with concurrent or recent use of a nephrotoxic medicinal product (e.g. aminoglycosides, amphotericin B, foscarnet, ganciclovir, pentamidine, vancomycin, cidofovir or interleukin-2). If concomitant use of tenofovir disoproxil fumarate and nephrotoxic agents is unavoidable, renal function should be monitored weekly.

Cases of acute renal failure after initiation of high dose or multiple non-steroidal anti-inflammatory drugs (NSAIDs) have been reported in patients treated with tenofovir disoproxil fumarate and with risk factors for renal dysfunction. If tenofovir disoproxil fumarate is co-administered with an NSAID, renal function should be monitored adequately.

A higher risk of renal impairment has been reported in patients receiving tenofovir disoproxil fumarate in combination with a ritonavir or cobicistat boosted protease inhibitor. A close monitoring of renal function is required in these patients (see section 4.5). In patients with renal risk factors, the co-administration of tenofovir disoproxil fumarate with a boosted protease inhibitor should be carefully evaluated.

Tenofovir disoproxil fumarate has not been clinically evaluated in patients receiving medicinal products which are secreted by the same renal pathway, including the transport proteins human organic anion transporter (hOAT) 1 and 3 or MRP 4 (e.g. cidofovir, a known nephrotoxic medicinal product). These renal transport proteins may be responsible for tubular secretion and in part, renal elimination of tenofovir and cidofovir. Consequently, the pharmacokinetics of these medicinal products, which are secreted by the same renal pathway including transport proteins hOAT 1 and 3 or MRP 4, might be modified if they are co-administered. Unless clearly necessary, concomitant use of these medicinal products which are secreted by the same renal pathway is not recommended, but if such use is unavoidable, renal function should be monitored weekly (see section 4.5).

Renal impairment

The use of tenofovir disoproxil fumarate is not recommended in paediatric patients with renal impairment (see section 4.2). Tenofovir disoproxil fumarate should not be initiated in paediatric patients with renal impairment and should be discontinued in paediatric patients who develop renal impairment during tenofovir disoproxil fumarate therapy.

Bone effects

Viread may cause a reduction in BMD. The effects of tenofovir disoproxil fumarate-associated changes in BMD on long-term bone health and future fracture risk are currently unknown (see section 5.1).

If bone abnormalities are detected or suspected in paediatric patients, consultation with an endocrinologist and/or nephrologist should be obtained.

Patients with HIV and hepatitis B or C virus co-infection

Patients with chronic hepatitis B or C and treated with antiretroviral therapy are at an increased risk for severe and potentially fatal hepatic adverse reactions.

Physicians should refer to current HIV treatment guidelines for the optimal management of HIV infection in patients co-infected with hepatitis B virus (HBV).

In case of concomitant antiviral therapy for hepatitis B or C, please refer also to the relevant Summary of Product Characteristics for these medicinal products.

Discontinuation of Viread therapy in patients co-infected with HIV and HBV may be associated with severe acute exacerbations of hepatitis. Patients co-infected with HIV and HBV who discontinue Viread should be closely monitored with both clinical and laboratory follow-up for at least 6 months after stopping treatment. In patients with advanced liver disease or cirrhosis, treatment discontinuation is not recommended since post-treatment exacerbation of hepatitis may lead to hepatic decompensation.
Use with certain hepatitis C virus antiviral agents
Co-administration of tenofovir disoproxil fumarate with ledipasvir/sofosbuvir or sofosbuvir/velpatasvir has been shown to increase plasma concentrations of tenofovir, especially when used together with an HIV regimen containing tenofovir disoproxil fumarate and a pharmacokinetic enhancer (ritonavir or cobicistat). The safety of tenofovir disoproxil fumarate in the setting of ledipasvir/sofosbuvir or sofosbuvir/velpatasvir and a pharmacokinetic enhancer has not been established. The potential risks and benefits associated with co-administration of ledipasvir/sofosbuvir or sofosbuvir/velpatasvir with tenofovir disoproxil fumarate given in conjunction with a boosted HIV protease inhibitor (e.g. atazanavir or darunavir) should be considered, particularly in patients at increased risk of renal dysfunction. Patients receiving ledipasvir/sofosbuvir or sofosbuvir/velpatasvir concomitantly with tenofovir disoproxil fumarate and a boosted HIV protease inhibitor should be monitored for adverse reactions related to tenofovir disoproxil fumarate.

Liver disease
Tenofovir and tenofovir disoproxil fumarate are not metabolised by liver enzymes. A pharmacokinetic study has been performed in non-HIV infected adult patients with various degrees of hepatic impairment. No significant pharmacokinetic alteration has been observed in these patients (see section 5.2).

Patients with pre-existing liver dysfunction, including chronic active hepatitis, have an increased frequency of liver function abnormalities during combination antiretroviral therapy (CART) and should be monitored according to standard practice. If there is evidence of worsening liver disease in such patients, interruption or discontinuation of treatment must be considered.

Weight and metabolic parameters
An increase in weight and in levels of blood lipids and glucose may occur during antiretroviral therapy. Such changes may in part be linked to disease control and life style. For lipids, there is in some cases evidence for a treatment effect, while for weight gain there is no strong evidence relating this to any particular treatment. For monitoring of blood lipids and glucose reference is made to established HIV treatment guidelines. Lipid disorders should be managed as clinically appropriate.

Mitochondrial dysfunction following exposure in utero
Nucleos(t)ide analogues may impact mitochondrial function to a variable degree, which is most pronounced with stavudine, didanosine and zidovudine. There have been reports of mitochondrial dysfunction in HIV negative infants exposed in utero and/or postnatally to nucleoside analogues; these have predominantly concerned treatment with regimens containing zidovudine. The main adverse reactions reported are haematological disorders (anaemia, neutropenia) and metabolic disorders (hyperlactatemia, hyperlipasemia). These events have often been transitory. Late onset neurological disorders have been reported rarely (hypertonia, convulsion, abnormal behaviour). Whether such neurological disorders are transient or permanent is currently unknown. These findings should be considered for any child exposed in utero to nucleos(t)ide analogues, who present with severe clinical findings of unknown etiology, particularly neurologic findings. These findings do not affect current national recommendations to use antiretroviral therapy in pregnant women to prevent vertical transmission of HIV.

Immune reactivation syndrome
In HIV infected patients with severe immune deficiency at the time of institution of CART, an inflammatory reaction to asymptomatic or residual opportunistic pathogens 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 CART. Relevant examples are cytomegalovirus retinitis, generalised and/or focal mycobacterial infections, and Pneumocystis jirovecii pneumonia. Any inflammatory symptoms should be evaluated and treatment instituted when necessary.

Autoimmune disorders (such as Graves’ disease) have also been reported to occur in the setting of immune reactivation; however, the reported time to onset is more variable and these events can occur many months after initiation of treatment.
Osteonecrosis
Although the aetiology is considered to be multifactorial (including corticosteroid use, alcohol consumption, severe immunosuppression, higher body mass index), cases of osteonecrosis have been reported, particularly in patients with advanced HIV disease and/or long-term exposure to CART. Patients should be advised to seek medical advice if they experience joint aches and pain, joint stiffness or difficulty in movement.

Viread 204 mg film-coated tablets contain lactose monohydrate. Consequently, patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency, or glucose-galactose malabsorption should not take this medicinal product.

4.5 Interaction with other medicinal products and other forms of interaction

Interaction studies have only been performed in adults.

Based on the results of in vitro experiments and the known elimination pathway of tenofovir, the potential for CYP450-mediated interactions involving tenofovir with other medicinal products is low.

Concomitant use not recommended
Viread should not be administered concomitantly with other medicinal products containing tenofovir disoproxil fumarate or tenofovir alafenamide.

Viread should not be administered concomitantly with adefovir dipivoxil.

Didanosine
Co-administration of tenofovir disoproxil fumarate and didanosine is not recommended (see section 4.4 and Table 1).

Renally eliminated medicinal products
Since tenofovir is primarily eliminated by the kidneys, co-administration of tenofovir disoproxil fumarate with medicinal products that reduce renal function or compete for active tubular secretion via transport proteins hOAT 1, hOAT 3 or MRP 4 (e.g. cidofovir) may increase serum concentrations of tenofovir and/or the co-administered medicinal products.

Use of tenofovir disoproxil fumarate should be avoided with concurrent or recent use of a nephrotoxic medicinal product. Some examples include, but are not limited to, aminoglycosides, amphotericin B, foscarnet, ganciclovir, pentamidine, vancomycin, cidofovir or interleukin-2 (see section 4.4).

Given that tacrolimus can affect renal function, close monitoring is recommended when it is co-administered with tenofovir disoproxil fumarate.

Other interactions
Interactions between tenofovir disoproxil fumarate and other medicinal products are listed in Table 1 below (increase is indicated as “↑”, decrease as “↓”, no change as “↔”, twice daily as “b.i.d.”, and once daily as “q.d.”).
Table 1: Interactions between tenofovir disoproxil fumarate and other medicinal products

<table>
<thead>
<tr>
<th>Medicinal product by therapeutic areas (dose in mg)</th>
<th>Effects on drug levels Mean percent change in AUC, (C_{\text{max}}), (C_{\text{min}})</th>
<th>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANTI-INFECTIVES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antiretrovirals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protease inhibitors</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Atazanavir/Ritonavir (300 q.d./100 q.d./300 q.d.) | Atazanavir: AUC: ↓ 25%  
\(C_{\text{max}}\): ↓ 28%  
\(C_{\text{min}}\): ↓ 26%  
Tenofovir: AUC: ↑ 37%  
\(C_{\text{max}}\): ↑ 34%  
\(C_{\text{min}}\): ↑ 29% | No dose adjustment is recommended. The increased exposure of tenofovir could potentiate tenofovir-associated adverse events, including renal disorders. Renal function should be closely monitored (see section 4.4). |
| Lopinavir/Ritonavir (400 b.i.d./100 b.i.d./300 q.d.) | Lopinavir/ritonavir: No significant effect on lopinavir/ritonavir PK parameters.  
Tenofovir: AUC: ↑ 32%  
\(C_{\text{max}}\): ↔  
\(C_{\text{min}}\): ↑ 51% | No dose adjustment is recommended. The increased exposure of tenofovir could potentiate tenofovir-associated adverse events, including renal disorders. Renal function should be closely monitored (see section 4.4). |
| Darunavir/Ritonavir (300/100 b.i.d./300 q.d.) | Darunavir: No significant effect on darunavir/ritonavir PK parameters.  
Tenofovir: AUC: ↑ 22%  
\(C_{\text{min}}\): ↑ 37% | No dose adjustment is recommended. The increased exposure of tenofovir could potentiate tenofovir-associated adverse events, including renal disorders. Renal function should be closely monitored (see section 4.4). |
<p>| <strong>NRTIs</strong>                                         |                                                 |                                      |
| Didanosine                                        | Co-administration of tenofovir disoproxil fumarate and didanosine results in a 40-60% increase in systemic exposure to didanosine that may increase the risk for didanosine-related adverse reactions. Rarely, pancreatitis and lactic acidosis, sometimes fatal, have been reported. Co-administration of tenofovir disoproxil fumarate and didanosine at a dose of 400 mg daily has been associated with a significant decrease in CD4 cell count, possibly due to an intracellular interaction increasing phosphorylated (i.e. active) didanosine. A decreased dosage of 250 mg didanosine co-administered with tenofovir disoproxil fumarate therapy has been associated with reports of high rates of virological failure within several tested combinations for the treatment of HIV-1 infection. | Co-administration of tenofovir disoproxil fumarate and didanosine is not recommended (see section 4.4). |</p>
<table>
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<th>Medicinal product by therapeutic areas (dose in mg)</th>
<th>Effects on drug levels Mean percent change in AUC, $C_{\text{max}}$, $C_{\text{min}}$</th>
<th>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</th>
</tr>
</thead>
</table>
| Adefovir dipivoxil                                | AUC: $\leftrightarrow$  
$C_{\text{max}}$: $\leftrightarrow$ | Tenofovir disoproxil fumarate should not be administered concurrently with adefovir dipivoxil (see section 4.4). |

**Hepatitis C virus antiviral agents**

<table>
<thead>
<tr>
<th>Medicinal product</th>
<th>Effects on drug levels Mean percent change in AUC, $C_{\text{max}}$, $C_{\text{min}}$</th>
<th>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</th>
</tr>
</thead>
</table>
|Ledipasvir/Sofosbuvir (90 mg/400 mg q.d.) + Atazanavir/Ritonavir (300 mg q.d./100 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.)¹ | Ledipasvir:  
AUC: ↑ 96% 
$C_{\text{max}}$: ↑ 68% 
$C_{\text{min}}$: ↑ 118%  
Sofosbuvir:  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: $\leftrightarrow$  
GS-331007²:  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: $\leftrightarrow$  
$C_{\text{min}}$: ↑ 42%  
Atazanavir:  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: $\leftrightarrow$  
$C_{\text{min}}$: ↑ 63%  
Ritonavir:  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: $\leftrightarrow$  
$C_{\text{min}}$: ↑ 45%  
Emtricitabine:  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: $\leftrightarrow$  
$C_{\text{min}}$: $\leftrightarrow$  
Tenofovir:  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: ↑ 47%  
$C_{\text{min}}$: ↑ 47% | Increased plasma concentrations of tenofovir resulting from co-administration of tenofovir disoproxil fumarate, ledipasvir/sofosbuvir and atazanavir/ritonavir may increase adverse reactions related to tenofovir disoproxil fumarate, including renal disorders. The safety of tenofovir disoproxil fumarate when used with ledipasvir/sofosbuvir and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established. The combination should be used with caution with frequent renal monitoring, if other alternatives are not available (see section 4.4). |
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<tr>
<th>Medicinal product by therapeutic areas (dose in mg)</th>
<th>Effects on drug levels Mean percent change in AUC, C_{max}, C_{min}</th>
<th>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</th>
</tr>
</thead>
</table>
| Ledipasvir/Sofosbuvir (90 mg/400 mg q.d.) + Darunavir/Ritonavir (800 mg q.d./100 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.)¹ | Ledipasvir:  
AUC: ↔  
C_{max}: ↔  
C_{min}: ↔  
Sofosbuvir:  
AUC: ↓ 27%  
C_{max}: ↓ 37%  
GS-331007²:  
AUC: ↔  
C_{max}: ↔  
C_{min}: ↔  
Darunavir:  
AUC: ↔  
C_{max}: ↔  
C_{min}: ↔  
Ritonavir:  
AUC: ↔  
C_{max}: ↔  
C_{min}: ↑ 48%  
Emtricitabine:  
AUC: ↔  
C_{max}: ↔  
C_{min}: ↔  
Tenofovir:  
AUC: ↑ 50%  
C_{max}: ↑ 64%  
C_{min}: ↑ 59%  | Increased plasma concentrations of tenofovir resulting from co-administration of tenofovir disoproxil fumarate, ledipasvir/sofosbuvir and darunavir/ritonavir may increase adverse reactions related to tenofovir disoproxil fumarate, including renal disorders. The safety of tenofovir disoproxil fumarate when used with ledipasvir/sofosbuvir and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established. The combination should be used with caution with frequent renal monitoring, if other alternatives are not available (see section 4.4). |
| Ledipasvir/Sofosbuvir (90 mg/400 mg q.d.) + Efavirenz/Emtricitabine/Tenofovir disoproxil fumarate (600 mg/200 mg/300 mg q.d.) | Ledipasvir:  
AUC: ↓ 34%  
C_{max}: ↓ 34%  
C_{min}: ↓ 34%  
Sofosbuvir:  
AUC: ↔  
C_{max}: ↔  
GS-331007²:  
AUC: ↔  
C_{max}: ↔  
C_{min}: ↔  
Efavirenz:  
AUC: ↔  
C_{max}: ↔  
C_{min}: ↔  
Emtricitabine:  
AUC: ↔  
C_{max}: ↔  
C_{min}: ↔  | No dose adjustment is recommended. The increased exposure of tenofovir could potentiate adverse reactions associated with tenofovir disoproxil fumarate, including renal disorders. Renal function should be closely monitored (see section 4.4). |
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<tbody>
<tr>
<td>Tenofovir:</td>
<td></td>
<td>No dose adjustment is recommended. The increased exposure of tenofovir could potentiate adverse reactions associated with tenofovir disoproxil fumarate, including renal disorders. Renal function should be closely monitored (see section 4.4).</td>
</tr>
<tr>
<td>AUC: ↑ 98%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$C_{\text{max}}$: ↑ 79%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$C_{\text{min}}$: ↑ 163%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ledipasvir/Sofosbuvir (90 mg/400 mg q.d.) + Emtricitabine/Rilpivirine/Tenofovir disoproxil fumarate (200 mg/25 mg/300 mg q.d.)</td>
<td>Ledipasvir:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>AUC: ↔</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$C_{\text{max}}$: ↔</td>
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<tr>
<td></td>
<td>$C_{\text{min}}$: ↔</td>
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<tr>
<td></td>
<td>Sofosbuvir:</td>
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<tr>
<td></td>
<td>AUC: ↔</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$C_{\text{max}}$: ↔</td>
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<td></td>
<td>$C_{\text{min}}$: ↔</td>
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<tr>
<td></td>
<td>GS-331007²:</td>
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<tr>
<td></td>
<td>AUC: ↔</td>
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<td></td>
<td>$C_{\text{max}}$: ↔</td>
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<td>$C_{\text{min}}$: ↔</td>
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<td></td>
<td>Emtricitabine:</td>
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<tr>
<td></td>
<td>AUC: ↔</td>
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<td></td>
<td>$C_{\text{max}}$: ↔</td>
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<td>$C_{\text{min}}$: ↔</td>
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<td>Rilpivirine:</td>
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<tr>
<td></td>
<td>AUC: ↔</td>
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<tr>
<td></td>
<td>$C_{\text{max}}$: ↔</td>
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<tr>
<td></td>
<td>$C_{\text{min}}$: ↔</td>
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<tr>
<td></td>
<td>Tenofovir:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>AUC: ↑ 40%</td>
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</tr>
<tr>
<td></td>
<td>$C_{\text{max}}$: ↔</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$C_{\text{min}}$: ↑ 91%</td>
<td></td>
</tr>
<tr>
<td>Medicinal product by therapeutic areas (dose in mg)</td>
<td>Effects on drug levels Mean percent change in AUC, $C_{\text{max}}$, $C_{\text{min}}$</td>
<td>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Ledipasvir/Sofosbuvir (90 mg/400 mg q.d.) + Dolutegravir (50 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.)</td>
<td>Sofosbuvir: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔ GS-331007$^2$ AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔ Ledipasvir: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔ Dolutegravir AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔ Emtricitabine: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔ Tenofovir: AUC: ↑ 65% $C_{\text{max}}$: ↑ 61% $C_{\text{min}}$: ↑ 115%</td>
<td>No dose adjustment is recommended. The increased exposure of tenofovir could potentiate adverse reactions associated with tenofovir disoproxil fumarate, including renal disorders. Renal function should be closely monitored (see section 4.4).</td>
</tr>
<tr>
<td>Medicinal product by therapeutic areas (dose in mg)</td>
<td>Effects on drug levels Mean percent change in AUC, $C_{\text{max}}$, $C_{\text{min}}$</td>
<td>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
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<td>----------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Atazanavir/Ritonavir (300 mg q.d./100 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.) | Sofosbuvir: 
AUC: ↔ 
$C_{\text{max}}$: ↔ 
GS-331007: 
$C_{\text{max}}$: ↔ 
$C_{\text{min}}$: ↑ 42% 
Velpatasvir: 
AUC: ↑ 142% 
$C_{\text{max}}$: ↑ 55% 
$C_{\text{min}}$: ↑ 301% 
Atazanavir: 
AUC: ↔ 
$C_{\text{max}}$: ↔ 
$C_{\text{min}}$: ↑ 39% 
Ritonavir: 
AUC: ↔ 
$C_{\text{max}}$: ↔ 
$C_{\text{min}}$: ↑ 29% 
Emtricitabine: 
AUC: ↔ 
$C_{\text{max}}$: ↔ 
$C_{\text{min}}$: ↔ 
Tenofovir: 
AUC: ↔ 
$C_{\text{max}}$: ↑ 55% 
$C_{\text{min}}$: ↑ 39% | Increased plasma concentrations of tenofovir resulting from co-administration of tenofovir disoproxil fumarate, sofosbuvir/velpatasvir and atazanavir/ritonavir may increase adverse reactions related to tenofovir disoproxil fumarate, including renal disorders. The safety of tenofovir disoproxil fumarate when used with sofosbuvir/velpatasvir and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established. The combination should be used with caution with frequent renal monitoring (see section 4.4). |
<table>
<thead>
<tr>
<th>Medicinal product by therapeutic areas (dose in mg)</th>
<th>Effects on drug levels Mean percent change in AUC, $C_{\text{max}}$, $C_{\text{min}}$</th>
<th>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</th>
</tr>
</thead>
</table>
| Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Darunavir/Ritonavir (800 mg q.d./100 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.) | Sofosbuvir:  
- AUC: ↓28%  
- $C_{\text{max}}$: ↓38%  
- GS-331007:  
  - AUC: ↔  
  - $C_{\text{max}}$: ↔  
  - $C_{\text{min}}$: ↔  
- Velpatasvir:  
  - AUC: ↔  
  - $C_{\text{max}}$: ↓24%  
  - $C_{\text{min}}$: ↔  
- Darunavir:  
  - AUC: ↔  
  - $C_{\text{max}}$: ↔  
  - $C_{\text{min}}$: ↔  
- Ritonavir:  
  - AUC: ↔  
  - $C_{\text{max}}$: ↔  
  - $C_{\text{min}}$: ↔  
- Emtricitabine:  
  - AUC: ↔  
  - $C_{\text{max}}$: ↔  
  - $C_{\text{min}}$: ↔  
- Tenofovir:  
  - AUC: ↑39%  
  - $C_{\text{max}}$: ↑55%  
  - $C_{\text{min}}$: ↑52% | Increased plasma concentrations of tenofovir resulting from co-administration of tenofovir disoproxil fumarate, sofosbuvir/velpatasvir and darunavir/ritonavir may increase adverse reactions related to tenofovir disoproxil fumarate, including renal disorders. The safety of tenofovir disoproxil fumarate when used with sofosbuvir/velpatasvir and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established.  
The combination should be used with caution with frequent renal monitoring (see section 4.4). |
<table>
<thead>
<tr>
<th>Medicinal product by therapeutic areas (dose in mg)</th>
<th>Effects on drug levels Mean percent change in AUC, $C_{\text{max}}$, $C_{\text{min}}$</th>
<th>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</th>
</tr>
</thead>
</table>
| Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Lopinavir/Ritonavir (800 mg/200 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.) | Sofosbuvir:  
AUC: ↓ 29%  
$C_{\text{max}}$: ↓ 41%  
GS-331007²:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Velpatasvir:  
AUC: ↔  
$C_{\text{max}}$: ↓ 30%  
$C_{\text{min}}$: ↑ 63%  
Lopinavir:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Ritonavir:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Emtricitabine:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Tenofovir:  
AUC: ↔  
$C_{\text{max}}$: ↑ 42%  
$C_{\text{min}}$: ↔  | Increased plasma concentrations of tenofovir resulting from co-administration of tenofovir disoproxil fumarate, sofosbuvir/velpatasvir and lopinavir/ritonavir may increase adverse reactions related to tenofovir disoproxil fumarate, including renal disorders. The safety of tenofovir disoproxil fumarate when used with sofosbuvir/velpatasvir and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established.  
The combination should be used with caution with frequent renal monitoring (see section 4.4). |
<table>
<thead>
<tr>
<th>Medicinal product by therapeutic areas (dose in mg)</th>
<th>Effects on drug levels</th>
<th>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Raltegravir (400 mg b.i.d) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.)</td>
<td></td>
<td>No dose adjustment is recommended. The increased exposure of tenofovir could potentiate adverse reactions associated with tenofovir disoproxil fumarate, including renal disorders. Renal function should be closely monitored (see section 4.4).</td>
</tr>
<tr>
<td></td>
<td>Sofosbuvir: AUC: ↔ C&lt;sub&gt;max&lt;/sub&gt;: ↔ C&lt;sub&gt;min&lt;/sub&gt;: ↔ GS-331007: AUC: ↔ C&lt;sub&gt;max&lt;/sub&gt;: ↔ C&lt;sub&gt;min&lt;/sub&gt;: ↔ Velpatasvir: AUC: ↔ C&lt;sub&gt;max&lt;/sub&gt;: ↔ C&lt;sub&gt;min&lt;/sub&gt;: ↔ Raltegravir: AUC: ↔ C&lt;sub&gt;max&lt;/sub&gt;: ↔ C&lt;sub&gt;min&lt;/sub&gt;: ↓ 21% Emtricitabine: AUC: ↔ C&lt;sub&gt;max&lt;/sub&gt;: ↔ C&lt;sub&gt;min&lt;/sub&gt;: ↔ Tenofovir: AUC: ↑ 40% C&lt;sub&gt;max&lt;/sub&gt;: ↑ 46% C&lt;sub&gt;min&lt;/sub&gt;: ↑ 70%</td>
<td></td>
</tr>
<tr>
<td>Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Efavirenz/Emtricitabine/ Tenofovir disoproxil fumarate (600 mg/200 mg/300 mg q.d.)</td>
<td></td>
<td>Concomitant administration of sofosbuvir/velpatasvir and efavirenz is expected to decrease plasma concentrations of velpatasvir. Co-administration of sofosbuvir/velpatasvir with efavirenz-containing regimens is not recommended.</td>
</tr>
<tr>
<td></td>
<td>Sofosbuvir: AUC: ↔ C&lt;sub&gt;max&lt;/sub&gt;: ↑ 38% GS-331007: AUC: ↔ C&lt;sub&gt;max&lt;/sub&gt;: ↔ C&lt;sub&gt;min&lt;/sub&gt;: ↔ Velpatasvir: AUC: ↓ 53% C&lt;sub&gt;max&lt;/sub&gt;: ↓ 47% C&lt;sub&gt;min&lt;/sub&gt;: ↓ 57% Efavirenz: AUC: ↔ C&lt;sub&gt;max&lt;/sub&gt;: ↔ C&lt;sub&gt;min&lt;/sub&gt;: ↔ Emtricitabine: AUC: ↔ C&lt;sub&gt;max&lt;/sub&gt;: ↔ C&lt;sub&gt;min&lt;/sub&gt;: ↔ Tenofovir: AUC: ↑ 81% C&lt;sub&gt;max&lt;/sub&gt;: ↑ 77% C&lt;sub&gt;min&lt;/sub&gt;: ↑ 121%</td>
<td></td>
</tr>
<tr>
<td>Medicinal product by therapeutic areas (dose in mg)</td>
<td>Effects on drug levels Mean percent change in AUC, C_{max}, C_{min}</td>
<td>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Emtricitabine/Rilpivirine/ Tenofovir disoproxil fumarate (200 mg/25 mg/300 mg q.d.) | **Sofosbuvir:**
AUC: ↔
C_{max}: ↔
GS-331007²:
AUC: ↔
C_{max}: ↔
C_{min}: ↔
**Velpatasvir:**
AUC: ↔
C_{max}: ↔
C_{min}: ↔
**Emtricitabine:**
AUC: ↔
C_{max}: ↔
C_{min}: ↔
**Rilpivirine:**
AUC: ↔
C_{max}: ↔
C_{min}: ↔
**Tenofovir:**
AUC: ↑ 40%
C_{max}: ↑ 44%
C_{min}: ↑ 84% | No dose adjustment is recommended. The increased exposure of tenofovir could potentiate adverse reactions associated with tenofovir disoproxil fumarate, including renal disorders. Renal function should be closely monitored (see section 4.4). |
| Sofosbuvir (400 mg q.d.) + Efavirenz/Emtricitabine/Tenofovir disoproxil fumarate (600 mg/200 mg/300 mg q.d.) | **Sofosbuvir:**
AUC: ↔
C_{max}: ↓ 19%
GS-331007²:
AUC: ↔
C_{max}: ↓ 23%
**Efavirenz:**
AUC: ↔
C_{max}: ↔
C_{min}: ↔
**Emtricitabine:**
AUC: ↔
C_{max}: ↔
C_{min}: ↔
**Tenofovir:**
AUC: ↔
C_{max}: ↑ 25%
C_{min}: ↔ | No dose adjustment is required. |

¹ Data generated from simultaneous dosing with ledipasvir/sofosbuvir. Staggered administration (12 hours apart) provided similar results.
² The predominant circulating metabolite of sofosbuvir.

**Studies conducted with other medicinal products**

There were no clinically significant pharmacokinetic interactions when tenofovir disoproxil fumarate was co-administered with emtricitabine, lamivudine, indinavir, efavirenz, nelfinavir, saquinavir
(ritonavir boosted), methadone, ribavirin, rifampicin, tacrolimus, or the hormonal contraceptive norgestimate/ethinyl oestradiol.

Tenofovir disoproxil fumarate must be taken with food, as food enhances the bioavailability of tenofovir (see section 5.2).

4.6 Fertility, pregnancy and lactation

Pregnancy
A moderate amount of data on pregnant women (between 300-1,000 pregnancy outcomes) indicate no malformations or foetal/neonatal toxicity associated with tenofovir disoproxil fumarate. Animal studies do not indicate reproductive toxicity (see section 5.3). The use of tenofovir disoproxil fumarate may be considered during pregnancy, if necessary.

Breast-feeding
Tenofovir has been shown to be excreted in human milk. There is insufficient information on the effects of tenofovir in newborns/infants. Therefore Viread should not be used during breast-feeding.

As a general rule, it is recommended that HIV infected women do not breast-feed their infants in order to avoid transmission of HIV to the infant.

Fertility
There are limited clinical data with respect to the effect of tenofovir disoproxil fumarate on fertility. Animal studies do not indicate harmful effects of tenofovir disoproxil fumarate on fertility.

4.7 Effects on ability to drive and use machines

No studies on the effects on the ability to drive and use machines have been performed. However, patients should be informed that dizziness has been reported during treatment with tenofovir disoproxil fumarate.

4.8 Undesirable effects

Summary of the safety profile
In patients receiving tenofovir disoproxil fumarate, rare events of renal impairment, renal failure and uncommon events of proximal renal tubulopathy (including Fanconi syndrome) sometimes leading to bone abnormalities (infrequently contributing to fractures) have been reported. Monitoring of renal function is recommended for patients receiving Viread (see section 4.4).

Approximately one third of patients can be expected to experience adverse reactions following treatment with tenofovir disoproxil fumarate in combination with other antiretroviral agents. These reactions are usually mild to moderate gastrointestinal events. Approximately 1% of tenofovir disoproxil fumarate-treated adult patients discontinued treatment due to the gastrointestinal events.

Co-administration of Viread and didanosine is not recommended as this may result in an increased risk of adverse reactions (see section 4.5). Rarely, pancreatitis and lactic acidosis, sometimes fatal, have been reported (see section 4.4).

Discontinuation of Viread in patients co-infected with HIV and HBV may be associated with severe acute exacerbations of hepatitis (see section 4.4).

Tabulated summary of adverse reactions
Assessment of adverse reactions for tenofovir disoproxil fumarate is based on safety data from clinical studies and post-marketing experience. All adverse reactions are presented in Table 2.

Assessment of adverse reactions from HIV-1 clinical study data is based on experience in two studies in 653 treatment-experienced adult patients receiving treatment with tenofovir disoproxil fumarate
(n = 443) or placebo (n = 210) in combination with other antiretroviral medicinal products for 24 weeks and also in a double-blind comparative controlled study in which 600 treatment-naïve adult patients received treatment with tenofovir disoproxil 245 mg (as fumarate) (n = 299) or stavudine (n = 301) in combination with lamivudine and efavirenz for 144 weeks.

The adverse reactions with suspected (at least possible) relationship to treatment are listed below by body system organ class and frequency. Within each frequency grouping, undesirable effects are presented in order of decreasing seriousness. Frequencies are defined as very common (≥ 1/10), common (≥ 1/100 to < 1/10), uncommon (≥ 1/1,000 to < 1/100) or rare (≥ 1/10,000 to < 1/1,000).

Table 2: Tabulated summary of adverse reactions associated with tenofovir disoproxil fumarate based on clinical study and post-marketing experience

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Tenofovir disoproxil fumarate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metabolism and nutrition disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Very common:</td>
<td>hypophosphataemia¹</td>
</tr>
<tr>
<td>Uncommon:</td>
<td>hypokalaemia¹</td>
</tr>
<tr>
<td>Rare:</td>
<td>lactic acidosis</td>
</tr>
<tr>
<td><strong>Nervous system disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Very common:</td>
<td>dizziness</td>
</tr>
<tr>
<td><strong>Gastrointestinal disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Very common:</td>
<td>diarrhoea, vomiting, nausea</td>
</tr>
<tr>
<td>Common:</td>
<td>flatulence</td>
</tr>
<tr>
<td>Uncommon:</td>
<td>pancreatitis</td>
</tr>
<tr>
<td><strong>Hepatobiliary disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Common:</td>
<td>increased transaminases</td>
</tr>
<tr>
<td>Rare:</td>
<td>hepatic steatosis, hepatitis</td>
</tr>
<tr>
<td><strong>Skin and subcutaneous tissue disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Very common:</td>
<td>rash</td>
</tr>
<tr>
<td>Rare:</td>
<td>angioedema</td>
</tr>
<tr>
<td><strong>Musculoskeletal and connective tissue disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Uncommon:</td>
<td>rhabdomyolysis¹, muscular weakness¹</td>
</tr>
<tr>
<td>Rare:</td>
<td>osteomalacia (manifested as bone pain and infrequently contributing to fractures)¹², myopathy¹</td>
</tr>
<tr>
<td><strong>Renal and urinary disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Uncommon:</td>
<td>increased creatinine, proximal renal tubulopathy (including Fanconi syndrome)</td>
</tr>
<tr>
<td>Rare:</td>
<td>acute renal failure, renal failure, acute tubular necrosis, nephritis (including acute interstitial nephritis)², nephrogenic diabetes insipidus</td>
</tr>
<tr>
<td><strong>General disorders and administration site conditions:</strong></td>
<td></td>
</tr>
<tr>
<td>Very common:</td>
<td>asthenia</td>
</tr>
</tbody>
</table>

¹ This adverse reaction may occur as a consequence of proximal renal tubulopathy. It is not considered to be causally associated with tenofovir disoproxil fumarate in the absence of this condition.
² This adverse reaction was identified through post-marketing surveillance but not observed in randomised controlled clinical trials or the tenofovir disoproxil fumarate expanded access program. The frequency category was estimated from a statistical calculation based on the total number of patients exposed to tenofovir disoproxil fumarate in randomised controlled clinical trials and the expanded access program (n = 7,319).
Description of selected adverse reactions

Renal impairment
As Viread may cause renal damage monitoring of renal function is recommended (see sections 4.4 and 4.8 Summary of the safety profile). Proximal renal tubulopathy generally resolved or improved after tenofovir disoproxil fumarate discontinuation. However, in some patients, declines in creatinine clearance did not completely resolve despite tenofovir disoproxil fumarate discontinuation. Patients at risk of renal impairment (such as patients with baseline renal risk factors, advanced HIV disease, or patients receiving concomitant nephrotoxic medications) are at increased risk of experiencing incomplete recovery of renal function despite tenofovir disoproxil fumarate discontinuation (see section 4.4).

Interaction with didanosine
Co-administration of tenofovir disoproxil fumarate and didanosine is not recommended as it results in a 40-60% increase in systemic exposure to didanosine that may increase the risk of didanosine-related adverse reactions (see section 4.5). Rarely, pancreatitis and lactic acidosis, sometimes fatal, have been reported.

Metabolic parameters
Weight and levels of blood lipids and glucose may increase during antiretroviral therapy (see section 4.4).

Immune reactivation syndrome
In HIV infected patients with severe immune deficiency at the time of initiation of CART, an inflammatory reaction to asymptomatic or residual opportunistic infections may arise. Autoimmune disorders (such as Graves’ disease) have also been reported; however, the reported time to onset is more variable and these events can occur many months after initiation of treatment (see section 4.4).

Osteonecrosis
Cases of osteonecrosis have been reported, particularly in patients with generally acknowledged risk factors, advanced HIV disease or long-term exposure to CART. The frequency of this is unknown (see section 4.4).

Paediatric population
Assessment of adverse reactions is based on two randomised trials (studies GS-US-104-0321 and GS-US-104-0352) in 184 HIV-1 infected paediatric patients (aged 2 to <18 years) who received treatment with tenofovir disoproxil fumarate (n = 93) or placebo/active comparator (n = 91) in combination with other antiretroviral agents for 48 weeks (see section 5.1). The adverse reactions observed in paediatric patients who received treatment with tenofovir disoproxil fumarate were consistent with those observed in clinical studies of tenofovir disoproxil fumarate in adults (see section 4.8 Tabulated summary of adverse reactions and 5.1).

Reductions in BMD have been reported in paediatric patients. In HIV-1 infected adolescents, the BMD Z-scores observed in subjects who received tenofovir disoproxil fumarate were lower than those observed in subjects who received placebo. In HIV-1 infected children, the BMD Z-scores observed in subjects who switched to tenofovir disoproxil fumarate were lower than those observed in subjects who remained on their stavudine- or zidovudine-containing regimen (see sections 4.4 and 5.1).

In study GS-US-104-0352, 4 out of 89 paediatric patients exposed to tenofovir disoproxil fumarate (median tenofovir disoproxil fumarate exposure 312 weeks) discontinued due to adverse reactions consistent with proximal renal tubulopathy. Seven patients had estimated glomerular filtration rate (GFR) values between 70 and 90 mL/min/1.73 m². Among them, two patients experienced a clinically meaningful decline in estimated GFR which improved after discontinuation of tenofovir disoproxil fumarate.
Other special population(s)

Patients with renal impairment
The use of tenofovir disoproxil fumarate is not recommended in paediatric patients with renal impairment (see sections 4.2 and 4.4).

Exacerbations of hepatitis after discontinuation of treatment
In HIV infected patients co-infected with HBV, clinical and laboratory evidence of hepatitis have occurred after discontinuation of tenofovir disoproxil fumarate (see section 4.4).

Reporting of suspected adverse reactions
Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via the national reporting system listed in Appendix V.

4.9 Overdose

Symptoms
If overdose occurs the patient must be monitored for evidence of toxicity (see sections 4.8 and 5.3), and standard supportive treatment applied as necessary.

Management
Tenofovir can be removed by haemodialysis; the median haemodialysis clearance of tenofovir is 134 ml/min. It is not known whether tenofovir can be removed by peritoneal dialysis.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antiviral for systemic use; nucleoside and nucleotide reverse transcriptase inhibitors, ATC code: J05AF07

Mechanism of action and pharmacodynamic effects
Tenofovir disoproxil fumarate is the fumarate salt of the prodrug tenofovir disoproxil. Tenofovir disoproxil is absorbed and converted to the active substance tenofovir, which is a nucleoside monophosphate (nucleotide) analogue. Tenofovir is then converted to the active metabolite, tenofovir diphosphate, an obligate chain terminator, by constitutively expressed cellular enzymes. Tenofovir diphosphate has an intracellular half-life of 10 hours in activated and 50 hours in resting peripheral blood mononuclear cells (PBMCs). Tenofovir diphosphate inhibits HIV-1 reverse transcriptase and the HBV polymerase by direct binding competition with the natural deoxyribonucleotide substrate and, after incorporation into DNA, by DNA chain termination. Tenofovir diphosphate is a weak inhibitor of cellular polymerases α, β, and γ. At concentrations of up to 300 µmol/l, tenofovir has also shown no effect on the synthesis of mitochondrial DNA or the production of lactic acid in in vitro assays.

Data pertaining to HIV
HIV antiviral activity in vitro: The concentration of tenofovir required for 50% inhibition (EC$_{50}$) of the wild-type laboratory strain HIV-1$_{HIV}$ is 1.6 µmol/l in lymphoid cell lines and 1.1 µmol/l against primary HIV-1 subtype B isolates in PBMCs. Tenofovir is also active against HIV-1 subtypes A, C, D, E, F, G, and O and against HIV$_{RLA}$ in primary monocyte/macrophage cells. Tenofovir shows activity in vitro against HIV-2, with an EC$_{50}$ of 4.9 µmol/l in MT-4 cells.
Resistance: Strains of HIV-1 with reduced susceptibility to tenofovir and a K65R mutation in reverse transcriptase have been selected in vitro and in some patients (see Clinical efficacy and safety). Tenofovir disoproxil fumarate should be avoided in antiretroviral-experienced patients with strains harbouring the K65R mutation (see section 4.4). In addition, a K70E substitution in HIV-1 reverse transcriptase has been selected by tenofovir and results in low-level reduced susceptibility to tenofovir.

Clinical studies in treatment-experienced patients have assessed the anti-HIV activity of tenofovir disoproxil 245 mg (as fumarate) against strains of HIV-1 with resistance to nucleoside inhibitors. The results indicate that patients whose HIV expressed 3 or more thymidine-analogue associated mutations (TAMs) that included either the M41L or L210W reverse transcriptase mutation showed reduced response to tenofovir disoproxil 245 mg (as fumarate) therapy.

Clinical efficacy and safety
The effects of tenofovir disoproxil fumarate in treatment-experienced and treatment-naïve HIV-1 infected adults have been demonstrated in trials of 48 weeks and 144 weeks duration, respectively.

In study GS-99-907, 550 treatment-experienced adult patients were treated with placebo or tenofovir disoproxil 245 mg (as fumarate) for 24 weeks. The mean baseline CD4 cell count was 427 cells/mm³, the mean baseline plasma HIV-1 RNA was 3.4 log₁₀ copies/ml (78% of patients had a viral load of < 5,000 copies/ml) and the mean duration of prior HIV treatment was 5.4 years. Baseline genotypic analysis of HIV isolates from 253 patients revealed that 94% of patients had HIV-1 resistance mutations associated with nucleoside reverse transcriptase inhibitors, 58% had mutations associated with protease inhibitors and 48% had mutations associated with non-nucleoside reverse transcriptase inhibitors.

At week 24 the time-weighted average change from baseline in log₁₀ plasma HIV-1 RNA levels (DAVG₂₄) was -0.03 log₁₀ copies/ml and -0.61 log₁₀ copies/ml for the placebo and tenofovir disoproxil 245 mg (as fumarate) recipients (p < 0.0001). A statistically significant difference in favour of tenofovir disoproxil 245 mg (as fumarate) was seen in the time-weighted average change from baseline at week 24 (DAVG₂₄) for CD4 count (+13 cells/mm³ for tenofovir disoproxil 245 mg (as fumarate) versus -11 cells/mm³ for placebo, p-value = 0.0008). The antiviral response to tenofovir disoproxil fumarate was durable through 48 weeks (DAVG₄₈ was -0.57 log₁₀ copies/ml, proportion of patients with HIV-1 RNA below 400 or 50 copies/ml was 41% and 18% respectively). Eight (2%) tenofovir disoproxil 245 mg (as fumarate) treated patients developed the K65R mutation within the first 48 weeks.

The 144-week, double-blind, active controlled phase of study GS-99-903 evaluated the efficacy and safety of tenofovir disoproxil 245 mg (as fumarate) versus stavudine when used in combination with lamivudine and efavirenz in HIV-1 infected adult patients naïve to antiretroviral therapy. The mean baseline CD4 cell count was 279 cells/mm³, the mean baseline plasma HIV-1 RNA was 4.91 log₁₀ copies/ml, 19% of patients had symptomatic HIV-1 infection and 18% had AIDS. Patients were stratified by baseline HIV-1 RNA and CD4 count. Forty-three percent of patients had baseline viral loads > 100,000 copies/ml and 39% had CD4 cell counts < 200 cells/ml.

By intent to treat analysis (missing data and switch in antiretroviral therapy (ART) considered as failure), the proportion of patients with HIV-1 RNA below 400 copies/ml and 50 copies/ml at 48 weeks of treatment was 80% and 76% respectively in the tenofovir disoproxil 245 mg (as fumarate) arm, compared to 84% and 80% in the stavudine arm. At 144 weeks, the proportion of patients with HIV-1 RNA below 400 copies/ml and 50 copies/ml was 71% and 68% respectively in the tenofovir disoproxil 245 mg (as fumarate) arm, compared to 64% and 63% in the stavudine arm.

The average change from baseline for HIV-1 RNA and CD4 count at 48 weeks of treatment was similar in both treatment groups (-3.09 and -3.09 log₁₀ copies/ml; +169 and 167 cells/mm³ in the tenofovir disoproxil 245 mg (as fumarate) and stavudine groups, respectively). At 144 weeks of treatment, the average change from baseline remained similar in both treatment groups (-3.07 and -3.03 log₁₀ copies/ml; +263 and +283 cells/mm³ in the tenofovir disoproxil 245 mg (as fumarate))
and stavudine groups, respectively). A consistent response to treatment with tenofovir disoproxil 245 mg (as fumarate) was seen regardless of baseline HIV-1 RNA and CD4 count.

The K65R mutation occurred in a slightly higher percentage of patients in the tenofovir disoproxil fumarate group than the active control group (2.7% versus 0.7%). Efavirenz or lamivudine resistance either preceded or was coincident with the development of K65R in all cases. Eight patients had HIV that expressed K65R in the tenofovir disoproxil 245 mg (as fumarate) arm, 7 of these occurred during the first 48 weeks of treatment and the last one at week 96. No further K65R development was observed up to week 144. One patient in the tenofovir disoproxil (as fumarate) arm developed the K70E substitution in the virus. From both the genotypic and phenotypic analyses there was no evidence for other pathways of resistance to tenofovir.

Data pertaining to HBV
The antiviral activity of tenofovir disoproxil fumarate against hepatitis B virus (HBV) has been demonstrated in vitro and clinically in adults and adolescents. Please refer to the Summaries of Product Characteristics for Viread 245 mg film-coated tablets and Viread 33 mg/g granules.

Paediatric population
In study GS-US-104-0321, 87 HIV-1 infected treatment-experienced patients 12 to < 18 years of age were treated with tenofovir disoproxil fumarate (n = 45) or placebo (n = 42) in combination with an optimised background regimen (OBR) for 48 weeks. Due to limitations of the study, a benefit of tenofovir disoproxil fumarate over placebo was not demonstrated based on plasma HIV-1 RNA levels at week 24. However, a benefit is expected for the adolescent population based on extrapolation of adult data and comparative pharmacokinetic data (see section 5.2).

In patients who received treatment with tenofovir disoproxil fumarate or placebo, mean lumbar spine BMD Z-score was -1.004 and -0.809, and mean total body BMD Z-score was -0.866 and -0.584, respectively, at baseline. Mean changes at week 48 (end of double-blind phase) were -0.215 and -0.165 in lumbar spine BMD Z-score, and -0.254 and -0.179 in total body BMD Z-score for the tenofovir disoproxil fumarate and placebo groups, respectively. The mean rate of BMD gain was less in the tenofovir disoproxil fumarate group compared to the placebo group. At week 48, six adolescents in the tenofovir disoproxil fumarate group and one adolescent in the placebo group had significant lumbar spine BMD loss (defined as > 4% loss). Among 28 patients receiving 96 weeks of treatment with tenofovir disoproxil fumarate, BMD Z-scores declined by -0.341 for lumbar spine and -0.458 for total body.

In study GS-US-104-0352, 97 treatment-experienced patients 2 to < 12 years of age with stable, virologic suppression on stavudine- or zidovudine-containing regimens were randomised to either replace stavudine or zidovudine with tenofovir disoproxil fumarate (n = 48) or continue on their original regimen (n = 49) for 48 weeks. At week 48, 83% of patients in the tenofovir disoproxil fumarate treatment group and 92% of patients in the stavudine or zidovudine treatment group had HIV-1 RNA concentrations < 400 copies/ml. The difference in the proportion of patients who maintained < 400 copies/ml at week 48 was mainly influenced by the higher number of discontinuations in the tenofovir disoproxil fumarate treatment group. When missing data were excluded, 91% of patients in the tenofovir disoproxil fumarate treatment group and 94% of patients in the stavudine or zidovudine treatment group had HIV-1 RNA concentrations < 400 copies/ml at week 48.

Reductions in BMD have been reported in paediatric patients. In patients who received treatment with tenofovir disoproxil fumarate, or stavudine or zidovudine, mean lumbar spine BMD Z-score was -1.034 and -0.498, and mean total body BMD Z-score was -0.471 and -0.386, respectively, at baseline. Mean changes at week 48 (end of randomised phase) were 0.032 and 0.087 in lumbar spine BMD Z-score, and -0.184 and -0.027 in total body BMD Z-score for the tenofovir disoproxil fumarate and stavudine or zidovudine groups, respectively. The mean rate of lumbar spine bone gain at week 48 was similar between the tenofovir disoproxil fumarate treatment group and the stavudine or zidovudine treatment group. Total body bone gain was less in the tenofovir disoproxil fumarate treatment group compared to the stavudine or zidovudine treatment group. One tenofovir disoproxil
fumarate treated subject and no stavudine or zidovudine treated subjects experienced significant (> 4%) lumbar spine BMD loss at week 48. BMD Z-scores declined by -0.012 for lumbar spine and by -0.338 for total body in the 64 subjects who were treated with tenofovir disoproxil fumarate for 96 weeks. BMD Z-scores were not adjusted for height and weight.

In study GS-US-104-0352, 4 out of 89 paediatric patients exposed to tenofovir disoproxil fumarate discontinued due to adverse reactions consistent with proximal renal tubulopathy (median tenofovir disoproxil fumarate exposure 104 weeks).

The European Medicines Agency has deferred the obligation to submit the results of studies with Viread in one or more subsets of the paediatric population in HIV and chronic hepatitis B (see section 4.2 for information on paediatric use).

5.2 Pharmacokinetic properties

Tenofovir disoproxil fumarate is a water soluble ester prodrug which is rapidly converted in vivo to tenofovir and formaldehyde.

Tenofovir is converted intracellularly to tenofovir monophosphate and to the active component, tenofovir diphosphate.

Absorption

Following oral administration of tenofovir disoproxil fumarate to HIV infected patients, tenofovir disoproxil fumarate is rapidly absorbed and converted to tenofovir. Administration of multiple doses of tenofovir disoproxil fumarate with a meal to HIV infected patients resulted in mean (%CV) tenofovir C\text{max}, AUC, and C\text{min} values of 326 (36.6%) ng/ml, 3,324 (41.2%) ng·h/ml and 64.4 (39.4%) ng/ml, respectively. Maximum tenofovir concentrations are observed in serum within one hour of dosing in the fasted state and within two hours when taken with food. The oral bioavailability of tenofovir from tenofovir disoproxil fumarate in fasted patients was approximately 25%. Administration of tenofovir disoproxil fumarate with a high fat meal enhanced the oral bioavailability, with an increase in tenofovir AUC by approximately 40% and C\text{max} by approximately 14%. Following the first dose of tenofovir disoproxil fumarate in fed patients, the median C\text{max} in serum ranged from 213 to 375 ng/ml. However, administration of tenofovir disoproxil fumarate with a light meal did not have a significant effect on the pharmacokinetics of tenofovir.

Distribution

Following intravenous administration the steady-state volume of distribution of tenofovir was estimated to be approximately 800 ml/kg. After oral administration of tenofovir disoproxil fumarate, tenofovir is distributed to most tissues with the highest concentrations occurring in the kidney, liver and the intestinal contents (preclinical studies). In vitro protein binding of tenofovir to plasma or serum protein was less than 0.7 and 7.2%, respectively, over the tenofovir concentration range 0.01 to 25 µg/ml.

Biotransformation

In vitro studies have determined that neither tenofovir disoproxil fumarate nor tenofovir are substrates for the CYP450 enzymes. Moreover, at concentrations substantially higher (approximately 300-fold) than those observed in vivo, tenofovir did not inhibit in vitro drug metabolism mediated by any of the major human CYP450 isoforms involved in drug biotransformation (CYP3A4, CYP2D6, CYP2C9, CYP2E1, or CYP1A1/2). Tenofovir disoproxil fumarate at a concentration of 100 µmol/l had no effect on any of the CYP450 isoforms, except CYP1A1/2, where a small (6%) but statistically significant reduction in metabolism of CYP1A1/2 substrate was observed. Based on these data, it is unlikely that clinically significant interactions involving tenofovir disoproxil fumarate and medicinal products metabolised by CYP450 would occur.
Elimination
Tenofovir is primarily excreted by the kidney by both filtration and an active tubular transport system with approximately 70-80% of the dose excreted unchanged in urine following intravenous administration. Total clearance has been estimated to be approximately 230 ml/h/kg (approximately 300 ml/min). Renal clearance has been estimated to be approximately 160 ml/h/kg (approximately 210 ml/min), which is in excess of the glomerular filtration rate. This indicates that active tubular secretion is an important part of the elimination of tenofovir. Following oral administration the terminal half-life of tenofovir is approximately 12 to 18 hours.

Studies have established the pathway of active tubular secretion of tenofovir to be influx into proximal tubule cell by the human organic anion transporters (hOAT) 1 and 3 and efflux into the urine by the multidrug resistant protein 4 (MRP 4).

Linearity/non-linearity
The pharmacokinetics of tenofovir were independent of tenofovir disoproxil fumarate dose over the dose range 75 to 600 mg and were not affected by repeated dosing at any dose level.

Gender
Limited data on the pharmacokinetics of tenofovir in women indicate no major gender effect.

Ethnicity
Pharmacokinetics have not been specifically studied in different ethnic groups.

Paediatric population
Steady-state pharmacokinetics of tenofovir were evaluated in 8 HIV-1 infected adolescent patients (aged 12 to < 18 years) with body weight ≥ 35 kg and in 23 HIV-1 infected children aged 2 to < 12 years (see Table 3 below). Tenofovir exposure achieved in these paediatric patients receiving oral daily doses of tenofovir disoproxil 245 mg (as fumarate) or 6.5 mg/kg body weight tenofovir disoproxil (as fumarate) up to a maximum dose of 245 mg was similar to exposures achieved in adults receiving once-daily doses of tenofovir disoproxil 245 mg (as fumarate).

Table 3: Mean (± SD) tenofovir pharmacokinetic parameters by age groups for paediatric patients

<table>
<thead>
<tr>
<th>Dose and formulation</th>
<th>245 mg film-coated tablet</th>
<th>6.5 mg/kg granules</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12 to &lt; 18 years (n = 8)</td>
<td>2 to &lt; 12 years (n = 23)</td>
</tr>
<tr>
<td>C_{max} (μg/ml)</td>
<td>0.38 ± 0.13</td>
<td>0.24 ± 0.13</td>
</tr>
<tr>
<td>AUC_{tau} (μg·h/ml)</td>
<td>3.39 ± 1.22</td>
<td>2.59 ± 1.06</td>
</tr>
</tbody>
</table>

Pharmacokinetic studies have not been performed in children under 2 years.

Renal impairment
Pharmacokinetic parameters of tenofovir were determined following administration of a single dose of tenofovir disoproxil 245 mg to 40 non-HIV infected adult patients with varying degrees of renal impairment defined according to baseline creatinine clearance (CrCl) (normal renal function when CrCl > 80 ml/min; mild with CrCl = 50-79 ml/min; moderate with CrCl = 30-49 ml/min and severe with CrCl = 10-29 ml/min). Compared with patients with normal renal function, the mean (%CV) tenofovir exposure increased from 2,185 (12%) ng·h/ml in subjects with CrCl > 80 ml/min to respectively 3,064 (30%) ng·h/ml, 6,009 (42%) ng·h/ml and 15,985 (45%) ng·h/ml in patients with mild, moderate and severe renal impairment.

The pharmacokinetics of tenofovir in non-haemodialysis adult patients with creatinine clearance < 10 ml/min and in patients with ESRD managed by peritoneal or other forms of dialysis have not been studied.

The pharmacokinetics of tenofovir in paediatric patients with renal impairment have not been studied. No data are available to make dose recommendations (see sections 4.2 and 4.4).
Hepatic impairment
A single 245 mg dose of tenofovir disoproxil was administered to non-HIV infected adult patients with varying degrees of hepatic impairment defined according to Child-Pugh-Turcotte (CPT) classification. Tenofovir pharmacokinetics were not substantially altered in subjects with hepatic impairment suggesting that no dose adjustment is required in these subjects. The mean (%CV) tenofovir C\textsubscript{max} and AUC\textsubscript{0-∞} values were 223 (34.8%) ng/ml and 2,050 (50.8%) ng·h/ml, respectively, in normal subjects compared with 289 (46.0%) ng/ml and 2,310 (43.5%) ng·h/ml in subjects with moderate hepatic impairment, and 305 (24.8%) ng/ml and 2,740 (44.0%) ng·h/ml in subjects with severe hepatic impairment.

Intracellular pharmacokinetics
In non-proliferating human peripheral blood mononuclear cells (PBMCs) the half-life of tenofovir diphosphate was found to be approximately 50 hours, whereas the half-life in phytohaemagglutinin-stimulated PBMCs was found to be approximately 10 hours.

5.3 Preclinical safety data
Non-clinical safety pharmacology studies reveal no special hazard for humans. Findings in repeated dose toxicity studies in rats, dogs and monkeys at exposure levels greater than or equal to clinical exposure levels and with possible relevance to clinical use include renal and bone toxicity and a decrease in serum phosphate concentration. Bone toxicity was diagnosed as osteomalacia (monkeys) and reduced bone mineral density (BMD) (rats and dogs). The bone toxicity in young adult rats and dogs occurred at exposures ≥ 5-fold the exposure in paediatric or adult patients; bone toxicity occurred in juvenile infected monkeys at very high exposures following subcutaneous dosing (≥ 40-fold the exposure in patients). Findings in the rat and monkey studies indicated that there was a substance-related decrease in intestinal absorption of phosphate with potential secondary reduction in BMD.

Genotoxicity studies revealed positive results in the in vitro mouse lymphoma assay, equivocal results in one of the strains used in the Ames test, and weakly positive results in an UDS test in primary rat hepatocytes. However, it was negative in an in vivo mouse bone marrow micronucleus assay.

Oral carcinogenicity studies in rats and mice only revealed a low incidence of duodenal tumours at an extremely high dose in mice. These tumours are unlikely to be of relevance to humans.

Reproductive studies in rats and rabbits showed no effects on mating, fertility, pregnancy or foetal parameters. However, tenofovir disoproxil fumarate reduced the viability index and weight of pups in peri-postnatal toxicity studies at maternally toxic doses.

The active substance tenofovir disoproxil fumarate and its main transformation products are persistent in the environment.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

*Tablet core*
- Croscarmellose sodium
- Lactose monohydrate
- Magnesium stearate (E572)
- Microcrystalline cellulose (E460)
- Starch pregelatinised
**Film-coating**
Glycerol triacetate (E1518)
Hypromellose (E464)
Lactose monohydrate
Titanium dioxide (E171)

6.2 **Incompatibilities**

Not applicable.

6.3 **Shelf life**

3 years.

6.4 **Special precautions for storage**

This medicinal product does not require any special storage conditions.

6.5 **Nature and contents of container**

High density polyethylene (HDPE) bottle with a polypropylene child-resistant closure containing 30 film-coated tablets and a silica gel desiccant.

The following pack sizes are available: outer cartons containing 1 bottle of 30 film-coated tablets and outer cartons containing 90 (3 bottles of 30) film-coated tablets. Not all pack sizes may be marketed.

6.6 **Special precautions for disposal**

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

7. **MARKETING AUTHORISATION HOLDER**

Gilead Sciences International Limited
Cambridge
CB21 6GT
United Kingdom

8. **MARKETING AUTHORISATION NUMBER(S)**

EU/1/01/200/008
EU/1/01/200/009

9. **DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION**

Date of first authorisation: 5 February 2002
Date of latest renewal: 14 December 2011

10. **DATE OF REVISION OF THE TEXT**

Detailed information on this medicinal product is available on the website of the European Medicines Agency http://www.ema.europa.eu
1. **NAME OF THE MEDICINAL PRODUCT**

Viread 245 mg film-coated tablets

2. **QUALITATIVE AND QUANTITATIVE COMPOSITION**

Each film-coated tablet contains 245 mg of tenofovir disoproxil (as fumarate).

**Excipient with known effect**

Each tablet contains 164 mg lactose (as monohydrate).

For the full list of excipients, see section 6.1.

3. **PHARMACEUTICAL FORM**

Film-coated tablet (tablet).

Light blue, almond-shaped, film-coated tablets, of dimensions 16.8 mm x 10.3 mm, debossed on one side with “GILEAD” and “4331” and on the other side with “300”.

4. **CLINICAL PARTICULARS**

4.1 Therapeutic indications

*HIV-1 infection*

Viread 245 mg film-coated tablets are indicated in combination with other antiretroviral medicinal products for the treatment of HIV-1 infected adults.

In adults, the demonstration of the benefit of Viread in HIV-1 infection is based on results of one study in treatment-naïve patients, including patients with a high viral load (> 100,000 copies/ml) and studies in which Viread was added to stable background therapy (mainly tritherapy) in antiretroviral pre-treated patients experiencing early virological failure (< 10,000 copies/ml, with the majority of patients having < 5,000 copies/ml).

Viread 245 mg film-coated tablets are also indicated for the treatment of HIV-1 infected adolescents, with NRTI resistance or toxicities precluding the use of first line agents, aged 12 to < 18 years.

The choice of Viread to treat antiretroviral-experienced patients with HIV-1 infection should be based on individual viral resistance testing and/or treatment history of patients.

*Hepatitis B infection*

Viread 245 mg film-coated tablets are indicated for the treatment of chronic hepatitis B in adults with:

- compensated liver disease, with evidence of active viral replication, persistently elevated serum alanine aminotransferase (ALT) levels and histological evidence of active inflammation and/or fibrosis (see section 5.1).

- evidence of lamivudine-resistant hepatitis B virus (see sections 4.8 and 5.1).

- decompensated liver disease (see sections 4.4, 4.8 and 5.1).
Viread 245 mg film-coated tablets are indicated for the treatment of chronic hepatitis B in adolescents 12 to < 18 years of age with:

- compensated liver disease and evidence of immune active disease, i.e. active viral replication, persistently elevated serum ALT levels and histological evidence of active inflammation and/or fibrosis (see sections 4.4, 4.8 and 5.1).

4.2 Posology and method of administration

Therapy should be initiated by a physician experienced in the management of HIV infection and/or treatment of chronic hepatitis B.

Posology

Adults

The recommended dose of Viread for the treatment of HIV or for the treatment of chronic hepatitis B is 245 mg (one tablet) once daily taken orally with food.

Chronic hepatitis B

The optimal duration of treatment is unknown. Treatment discontinuation may be considered as follows:

- In HBeAg positive patients without cirrhosis, treatment should be administered for at least 6-12 months after HBe seroconversion (HBeAg loss and HBV DNA loss with anti-HBe detection) is confirmed or until HBs seroconversion or there is loss of efficacy (see section 4.4). Serum ALT and HBV DNA levels should be followed regularly after treatment discontinuation to detect any late virological relapse.

- In HBeAg negative patients without cirrhosis, treatment should be administered at least until HBs seroconversion or there is evidence of loss of efficacy. With prolonged treatment for more than 2 years, regular reassessment is recommended to confirm that continuing the selected therapy remains appropriate for the patient.

Viread is also available as 33 mg/g granules for the treatment of HIV-1 infection and chronic hepatitis B in adults for whom a solid dosage form is not appropriate.

Paediatric population

HIV-1: In adolescents aged 12 to < 18 years and weighing ≥ 35 kg, the recommended dose of Viread is 245 mg (one tablet) once daily taken orally with food (see sections 4.8 and 5.1).

Viread is also available as granules for use in HIV-1 infected paediatric patients aged 2 to < 12 years and as reduced tablet strengths for use in HIV-1 infected paediatric patients aged 6 to < 12 years (see section 5.1). Please refer to the Summaries of Product Characteristics for Viread 33 mg/g granules and Viread 123 mg, 163 mg and 204 mg film-coated tablets.

The safety and efficacy of tenofovir disoproxil fumarate in HIV-1 infected children under 2 years of age have not been established. No data are available.

Chronic hepatitis B: In adolescents aged 12 to < 18 years and weighing ≥ 35 kg, the recommended dose of Viread is 245 mg (one tablet) once daily, taken orally with food (see sections 4.8 and 5.1). The optimal duration of treatment is currently unknown.

The safety and efficacy of tenofovir disoproxil fumarate in children with chronic hepatitis B aged 2 to < 12 years or weighing < 35 kg have not been established. No data are available.

Viread is also available as 33 mg/g granules for the treatment of HIV-1 infection and chronic hepatitis B in adolescents aged 12 to < 18 years for whom a solid dosage form is not appropriate.
Missed dose
If a patient misses a dose of Viread within 12 hours of the time it is usually taken, the patient should take Viread with food as soon as possible and resume their normal dosing schedule. If a patient misses a dose of Viread by more than 12 hours and it is almost time for their next dose, the patient should not take the missed dose and simply resume the usual dosing schedule.

If the patient vomits within 1 hour of taking Viread, another tablet should be taken. If the patient vomits more than 1 hour after taking Viread they do not need to take another dose.

Special populations
Elderly
No data are available on which to make a dose recommendation for patients over the age of 65 years (see section 4.4).

Renal impairment
Tenofovir is eliminated by renal excretion and the exposure to tenofovir increases in patients with renal dysfunction.

Adults
There are limited data on the safety and efficacy of tenofovir disoproxil fumarate in adult patients with moderate and severe renal impairment (creatinine clearance < 50 ml/min) and long-term safety data has not been evaluated for mild renal impairment (creatinine clearance 50-80 ml/min). Therefore, in adult patients with renal impairment tenofovir disoproxil fumarate should only be used if the potential benefits of treatment are considered to outweigh the potential risks. Administration of Viread 33 mg/g granules to provide a reduced daily dose of tenofovir disoproxil fumarate is recommended for adult patients with creatinine clearance < 50 ml/min, including haemodialysis patients. Please refer to the Summary of Product Characteristics for Viread 33 mg/g granules.

Mild renal impairment (creatinine clearance 50-80 ml/min)
Limited data from clinical studies support once daily dosing of 245 mg tenofovir disoproxil (as fumarate) in patients with mild renal impairment.

Moderate renal impairment (creatinine clearance 30-49 ml/min)
For patients unable to take the granule formulation of tenofovir disoproxil fumarate, prolonged dose intervals using the 245 mg film-coated tablets may be used. Administration of 245 mg tenofovir disoproxil (as fumarate) every 48 hours can be used based on modelling of single-dose pharmacokinetic data in HIV negative and non-HBV infected subjects with varying degrees of renal impairment, including end-stage renal disease requiring haemodialysis, but has not been confirmed in clinical studies. Therefore, clinical response to treatment and renal function should be closely monitored in these patients (see sections 4.4 and 5.2).

Severe renal impairment (creatinine clearance < 30 ml/min) and haemodialysis patients
For patients unable to take the granule formulation of tenofovir disoproxil fumarate and with no alternative treatment available, prolonged dose intervals using the 245 mg film-coated tablets may be used as follows:

Severe renal impairment: 245 mg tenofovir disoproxil (as fumarate) may be administered every 72-96 hours (dosing twice a week).

Haemodialysis patients: 245 mg tenofovir disoproxil (as fumarate) may be administered every 7 days following completion of a haemodialysis session*.

These dose interval adjustments have not been confirmed in clinical studies. Simulations suggest that the prolonged dose interval using Viread 245 mg film-coated tablets is not optimal and could result in increased toxicity and possibly inadequate response. Therefore, clinical response to treatment and renal function should be closely monitored (see sections 4.4 and 5.2).
* Generally, once weekly dosing assuming three haemodialysis sessions per week, each of approximately 4 hours duration or after 12 hours cumulative haemodialysis.

No dosing recommendations can be given for non-haemodialysis patients with creatinine clearance < 10 ml/min.

**Paediatrics**
The use of tenofovir disoproxil fumarate is not recommended in paediatric patients with renal impairment (see section 4.4).

**Hepatic impairment**
No dose adjustment is required in patients with hepatic impairment (see sections 4.4 and 5.2).

If Viread is discontinued in patients with chronic hepatitis B with or without HIV co-infection, these patients should be closely monitored for evidence of exacerbation of hepatitis (see section 4.4).

**Method of administration**
Viread tablets should be taken once daily, orally with food.

A granules formulation of tenofovir disoproxil fumarate is available for patients having difficulty in swallowing film-coated tablets. However, in exceptional circumstances Viread 245 mg film-coated tablets can be administered following disintegration of the tablet in at least 100 ml of water, orange juice or grape juice.

### 4.3 Contraindications

Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.

### 4.4 Special warnings and precautions for use

**General**
HIV antibody testing should be offered to all HBV infected patients before initiating tenofovir disoproxil fumarate therapy (see below Co-infection with HIV-1 and hepatitis B).

**HIV-1**
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.

**Chronic hepatitis B**
Patients must be advised that tenofovir disoproxil fumarate has not been proven to prevent the risk of transmission of HBV to others through sexual contact or contamination with blood. Appropriate precautions must continue to be used.

**Co-administration of other medicinal products**
- Viread should not be administered concomitantly with other medicinal products containing tenofovir disoproxil fumarate or tenofovir alafenamide.
- Viread should not be administered concomitantly with adefovir dipivoxil.
- Co-administration of tenofovir disoproxil fumarate and didanosine is not recommended. Co-administration of tenofovir disoproxil fumarate and didanosine results in a 40-60% increase in systemic exposure to didanosine that may increase the risk of didanosine-related adverse reactions (see section 4.5). Rarely, pancreatitis and lactic acidosis, sometimes fatal, have been reported. Co-administration of tenofovir disoproxil fumarate and didanosine results in an intracellular interaction increasing phosphorylated (i.e. active) didanosine. A decreased dosage of 250 mg didanosine co-administered with tenofovir disoproxil fumarate therapy has
been associated with reports of high rates of virological failure within several tested combinations for the treatment of HIV-1 infection.

**Triple therapy with nucleosides/nucleotides**

There have been reports of a high rate of virological failure and of emergence of resistance at an early stage in HIV patients when tenofovir disoproxil fumarate was combined with lamivudine and abacavir as well as with lamivudine and didanosine as a once-daily regimen.

**Renal and bone effects in adult population**

**Renal effects**

Tenofovir is principally eliminated via the kidney. Renal failure, renal impairment, elevated creatinine, hypophosphataemia and proximal tubulopathy (including Fanconi syndrome) have been reported with the use of tenofovir disoproxil fumarate in clinical practice (see section 4.8).

**Renal monitoring**

It is recommended that creatinine clearance is calculated in all patients prior to initiating therapy with tenofovir disoproxil fumarate and renal function (creatinine clearance and serum phosphate) is also monitored after two to four weeks of treatment, after three months of treatment and every three to six months thereafter in patients without renal risk factors. In patients at risk for renal impairment, a more frequent monitoring of renal function is required.

**Renal management**

If serum phosphate is < 1.5 mg/dl (0.48 mmol/l) or creatinine clearance is decreased to < 50 ml/min in any adult patient receiving tenofovir disoproxil fumarate, renal function should be re-evaluated within one week, including measurements of blood glucose, blood potassium and urine glucose concentrations (see section 4.8, proximal tubulopathy). Consideration should also be given to interrupting treatment with tenofovir disoproxil fumarate in adult patients with creatinine clearance decreased to < 50 ml/min or decreases in serum phosphate to < 1.0 mg/dl (0.32 mmol/l). Interrupting treatment with tenofovir disoproxil fumarate should also be considered in case of progressive decline of renal function when no other cause has been identified.

**Co-administration and risk of renal toxicity**

Use of tenofovir disoproxil fumarate should be avoided with concurrent or recent use of a nephrotoxic medicinal product (e.g. aminoglycosides, amphotericin B, foscarin, ganciclovir, pentamidine, vancomycin, cidofovir or interleukin-2). If concomitant use of tenofovir disoproxil fumarate and nephrotoxic agents is unavoidable, renal function should be monitored weekly.

Cases of acute renal failure after initiation of high dose or multiple non-steroidal anti-inflammatory drugs (NSAIDs) have been reported in patients treated with tenofovir disoproxil fumarate and with risk factors for renal dysfunction. If tenofovir disoproxil fumarate is co-administered with an NSAID, renal function should be monitored adequately.

A higher risk of renal impairment has been reported in patients receiving tenofovir disoproxil fumarate in combination with a ritonavir or cobicistat boosted protease inhibitor. A close monitoring of renal function is required in these patients (see section 4.5). In patients with renal risk factors, the co-administration of tenofovir disoproxil fumarate with a boosted protease inhibitor should be carefully evaluated.

Tenofovir disoproxil fumarate has not been clinically evaluated in patients receiving medicinal products which are secreted by the same renal pathway, including the transport proteins human organic anion transporter (hOAT) 1 and 3 or MRP 4 (e.g. cidofovir, a known nephrotoxic medicinal product). These renal transport proteins may be responsible for tubular secretion and in part, renal elimination of tenofovir and cidofovir. Consequently, the pharmacokinetics of these medicinal products, which are secreted by the same renal pathway including transport proteins hOAT 1 and 3 or MRP 4, might be modified if they are co-administered. Unless clearly necessary, concomitant use of these medicinal products which are secreted by the same renal pathway is not recommended, but if such use is unavoidable, renal function should be monitored weekly (see section 4.5).
Renal impairment

Renal safety with tenofovir disoproxil fumarate has only been studied to a very limited degree in adult patients with impaired renal function (creatinine clearance < 80 ml/min).

Adult patients with creatinine clearance < 50 ml/min, including haemodialysis patients:

There are limited data on the safety and efficacy of tenofovir disoproxil fumarate in patients with impaired renal function. Therefore, tenofovir disoproxil fumarate should only be used if the potential benefits of treatment are considered to outweigh the potential risks. In patients with severe renal impairment (creatinine clearance < 30 ml/min) and in patients who require haemodialysis use of tenofovir disoproxil fumarate is not recommended. If no alternative treatment is available, the dosing interval must be adjusted and renal function should be closely monitored (see sections 4.2 and 5.2).

Bone effects

In HIV infected patients, in a 144-week controlled clinical study that compared tenofovir disoproxil fumarate with stavudine in combination with lamivudine and efavirenz in antiretroviral-naive adult patients, small decreases in bone mineral density (BMD) of the hip and spine were observed in both treatment groups. Decreases in BMD of spine and changes in bone biomarkers from baseline were significantly greater in the tenofovir disoproxil fumarate treatment group at 144 weeks. Decreases in BMD of hip were significantly greater in this group until 96 weeks. However, there was no increased risk of fractures or evidence for clinically relevant bone abnormalities over 144 weeks.

In other studies (prospective and cross-sectional), the most pronounced decreases in BMD were seen in patients treated with tenofovir disoproxil fumarate as part of a regimen containing a boosted protease inhibitor. Alternative treatment regimens should be considered for patients with osteoporosis that are at a high risk for fractures.

Bone abnormalities (infrequently contributing to fractures) may be associated with proximal renal tubulopathy (see section 4.8).

If bone abnormalities are suspected or detected then appropriate consultation should be obtained.

Renal and bone effects in paediatric population

There are uncertainties associated with the long term effects of bone and renal toxicity. Moreover, the reversibility of renal toxicity cannot be fully ascertained. Therefore, a multidisciplinary approach is recommended to adequately weigh on a case by case basis the benefit/risk balance of treatment, decide the appropriate monitoring during treatment (including decision for treatment withdrawal) and consider the need for supplementation.

Renal effects

Renal adverse reactions consistent with proximal renal tubulopathy have been reported in HIV-1 infected paediatric patients aged 2 to < 12 years in clinical study GS-US-104-0352 (see sections 4.8 and 5.1).

Renal monitoring

Renal function (creatinine clearance and serum phosphate) should be evaluated prior to treatment, and monitored during treatment as in adults (see above).

Renal management

If serum phosphate is confirmed to be < 3.0 mg/dl (0.96 mmol/l) in any paediatric patient receiving tenofovir disoproxil fumarate, renal function should be re-evaluated within one week, including measurements of blood glucose, blood potassium and urine glucose concentrations (see section 4.8, proximal tubulopathy). If renal abnormalities are suspected or detected then consultation with a nephrologist should be obtained to consider interruption of tenofovir disoproxil fumarate treatment. Interrupting treatment with tenofovir disoproxil fumarate should also be considered in case of progressive decline of renal function when no other cause has been identified.
**Co-administration and risk of renal toxicity**

The same recommendations apply as in adults (see above).

**Renal impairment**

The use of tenofovir disoproxil fumarate is not recommended in paediatric patients with renal impairment (see section 4.2). Tenofovir disoproxil fumarate should not be initiated in paediatric patients with renal impairment and should be discontinued in paediatric patients who develop renal impairment during tenofovir disoproxil fumarate therapy.

**Bone effects**

Viread may cause a reduction in BMD. The effects of tenofovir disoproxil fumarate-associated changes in BMD on long-term bone health and future fracture risk are currently unknown (see section 5.1).

If bone abnormalities are detected or suspected in paediatric patients, consultation with an endocrinologist and/or nephrologist should be obtained.

**Liver disease**

Safety and efficacy data are very limited in liver transplant patients.

There are limited data on the safety and efficacy of tenofovir disoproxil fumarate in HBV infected patients with decompensated liver disease and who have a Child-Pugh-Turcotte (CPT) score $> 9$. These patients may be at higher risk of experiencing serious hepatic or renal adverse reactions. Therefore, hepatobiliary and renal parameters should be closely monitored in this patient population.

**Exacerbations of hepatitis**

**Flares on treatment:** Spontaneous exacerbations in chronic hepatitis B are relatively common and are characterised by transient increases in serum ALT. After initiating antiviral therapy, serum ALT may increase in some patients (see section 4.8). In patients with compensated liver disease, these increases in serum ALT are generally not accompanied by an increase in serum bilirubin concentrations or hepatic decompensation. Patients with cirrhosis may be at a higher risk for hepatic decompensation following hepatitis exacerbation, and therefore should be monitored closely during therapy.

**Flares after treatment discontinuation:** Acute exacerbation of hepatitis has also been reported in patients who have discontinued hepatitis B therapy. Post-treatment exacerbations are usually associated with rising HBV DNA, and the majority appears to be self-limited. However, severe exacerbations, including fatalities, have been reported. Hepatic function should be monitored at repeated intervals with both clinical and laboratory follow-up for at least 6 months after discontinuation of hepatitis B therapy. If appropriate, resumption of hepatitis B therapy may be warranted. In patients with advanced liver disease or cirrhosis, treatment discontinuation is not recommended since post-treatment exacerbation of hepatitis may lead to hepatic decompensation.

Liver flares are especially serious, and sometimes fatal in patients with decompensated liver disease.

**Co-infection with hepatitis C or D:** There are no data on the efficacy of tenofovir in patients co-infected with hepatitis C or D virus.

**Co-infection with HIV-1 and hepatitis B:** Due to the risk of development of HIV resistance, tenofovir disoproxil fumarate should only be used as part of an appropriate antiretroviral combination regimen in HIV/HBV co-infected patients. Patients with pre-existing liver dysfunction, including chronic active hepatitis, have an increased frequency of liver function abnormalities during combination antiretroviral therapy (CART) and should be monitored according to standard practice. If there is evidence of worsening liver disease in such patients, interruption or discontinuation of treatment must be considered. However, it should be noted that increases of ALT can be part of HBV clearance during therapy with tenofovir, see above *Exacerbations of hepatitis.*
Use with certain hepatitis C virus antiviral agents
Co-administration of tenofovir disoproxil fumarate with ledipasvir/sofosbuvir or sofosbuvir/velpatasvir has been shown to increase plasma concentrations of tenofovir, especially when used together with an HIV regimen containing tenofovir disoproxil fumarate and a pharmacokinetic enhancer (ritonavir or cobicistat). The safety of tenofovir disoproxil fumarate in the setting of ledipasvir/sofosbuvir or sofosbuvir/velpatasvir and a pharmacokinetic enhancer has not been established. The potential risks and benefits associated with co-administration of ledipasvir/sofosbuvir or sofosbuvir/velpatasvir with tenofovir disoproxil fumarate given in conjunction with a boosted HIV protease inhibitor (e.g. atazanavir or darunavir) should be considered, particularly in patients at increased risk of renal dysfunction. Patients receiving ledipasvir/sofosbuvir or sofosbuvir/velpatasvir concomitantly with tenofovir disoproxil fumarate and a boosted HIV protease inhibitor should be monitored for adverse reactions related to tenofovir disoproxil fumarate.

Weight and metabolic parameters
An increase in weight and in levels of blood lipids and glucose may occur during antiretroviral therapy. Such changes may in part be linked to disease control and life style. For lipids, there is in some cases evidence for a treatment effect, while for weight gain there is no strong evidence relating this to any particular treatment. For monitoring of blood lipids and glucose reference is made to established HIV treatment guidelines. Lipid disorders should be managed as clinically appropriate.

Mitochondrial dysfunction following exposure in utero
Nucleos(t)ide analogues may impact mitochondrial function to a variable degree, which is most pronounced with stavudine, didanosine and zidovudine. There have been reports of mitochondrial dysfunction in HIV negative infants exposed in utero and/or postnatally to nucleoside analogues; these have predominantly concerned treatment with regimens containing zidovudine. The main adverse reactions reported are haematological disorders (anaemia, neutropenia) and metabolic disorders (hyperlactatemia, hyperlipasemia). These events have often been transitory. Late onset neurological disorders have been reported rarely (hypertonia, convulsion, abnormal behaviour). Whether such neurological disorders are transient or permanent is currently unknown. These findings should be considered for any child exposed in utero to nucleos(t)ide analogues, who present with severe clinical findings of unknown etiology, particularly neurologic findings. These findings do not affect current national recommendations to use antiretroviral therapy in pregnant women to prevent vertical transmission of HIV.

Immune reactivation syndrome
In HIV infected patients with severe immune deficiency at the time of institution of CART, an inflammatory reaction to asymptomatic or residual opportunistic pathogens 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 CART. Relevant examples are cytomegalovirus retinitis, generalised and/or focal mycobacterial infections, and Pneumocystis jirovecii pneumonia. Any inflammatory symptoms should be evaluated and treatment instituted when necessary.

Autoimmune disorders (such as Graves’ disease) have also been reported to occur in the setting of immune reactivation; however, the reported time to onset is more variable and these events can occur many months after initiation of treatment.

Osteonecrosis
Although the aetiology is considered to be multifactorial (including corticosteroid use, alcohol consumption, severe immunosuppression, higher body mass index), cases of osteonecrosis have been reported, particularly in patients with advanced HIV disease and/or long-term exposure to CART. Patients should be advised to seek medical advice if they experience joint aches and pain, joint stiffness or difficulty in movement.

Elderly
Tenofovir disoproxil fumarate has not been studied in patients over the age of 65. Elderly patients are more likely to have decreased renal function; therefore caution should be exercised when treating elderly patients with tenofovir disoproxil fumarate.
Viread 245 mg film-coated tablets contain lactose monohydrate. Consequently, patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency, or glucose-galactose malabsorption should not take this medicinal product.

4.5 Interaction with other medicinal products and other forms of interaction

Interaction studies have only been performed in adults.

Based on the results of in vitro experiments and the known elimination pathway of tenofovir, the potential for CYP450-mediated interactions involving tenofovir with other medicinal products is low.

Concomitant use not recommended
Viread should not be administered concomitantly with other medicinal products containing tenofovir disoproxil fumarate or tenofovir alafenamide.

Viread should not be administered concomitantly with adeovir dipivoxil.

Didanosine
Co-administration of tenofovir disoproxil fumarate and didanosine is not recommended (see section 4.4 and Table 1).

Renally eliminated medicinal products
Since tenofovir is primarily eliminated by the kidneys, co-administration of tenofovir disoproxil fumarate with medicinal products that reduce renal function or compete for active tubular secretion via transport proteins hOAT 1, hOAT 3 or MRP 4 (e.g. cidofovir) may increase serum concentrations of tenofovir and/or the co-administered medicinal products.

Use of tenofovir disoproxil fumarate should be avoided with concurrent or recent use of a nephrotoxic medicinal product. Some examples include, but are not limited to, aminoglycosides, amphotericin B, foscarnet, ganciclovir, pentamidine, vancomycin, cidofovir or interleukin-2 (see section 4.4).

Given that tacrolimus can affect renal function, close monitoring is recommended when it is co-administered with tenofovir disoproxil fumarate.

Other interactions
Interactions between tenofovir disoproxil fumarate and other medicinal products are listed in Table 1 below (increase is indicated as “↑”, decrease as “↓”, no change as “↔”, twice daily as “b.i.d.”, and once daily as “q.d.”).
Table 1: Interactions between tenofovir disoproxil fumarate and other medicinal products

<table>
<thead>
<tr>
<th>Medicinal product by therapeutic areas (dose in mg)</th>
<th>Effects on drug levels Mean percent change in AUC, $C_{\text{max}}$, $C_{\text{min}}$</th>
<th>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</th>
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</thead>
<tbody>
<tr>
<td><strong>ANTI-INFECTIVES</strong></td>
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<td><strong>Antiretrovirals</strong></td>
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<tr>
<td><strong>Protease inhibitors</strong></td>
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</tbody>
</table>
| Atazanavir/Ritonavir (300 q.d./100 q.d./300 q.d.)   | Atazanavir: AUC: ↓ 25%  
C_{\text{max}}: ↓ 28%  
C_{\text{min}}: ↓ 26%  
Tenofovir: AUC: ↑ 37%  
C_{\text{max}}: ↑ 34%  
C_{\text{min}}: ↑ 29% | No dose adjustment is recommended. The increased exposure of tenofovir could potentiate tenofovir-associated adverse events, including renal disorders. Renal function should be closely monitored (see section 4.4). |
| Lopinavir/Ritonavir (400 b.i.d./100 b.i.d./300 q.d.)| Lopinavir/ritonavir: No significant effect on lopinavir/ritonavir PK parameters.  
Tenofovir: AUC: ↑ 32%  
C_{\text{max}}: ↔  
C_{\text{min}}: ↑ 51% | No dose adjustment is recommended. The increased exposure of tenofovir could potentiate tenofovir-associated adverse events, including renal disorders. Renal function should be closely monitored (see section 4.4). |
| Darunavir/Ritonavir (300/100 b.i.d./300 q.d.)       | Darunavir: No significant effect on darunavir/ritonavir PK parameters.  
Tenofovir: AUC: ↑ 22%  
C_{\text{min}}: ↑ 37% | No dose adjustment is recommended. The increased exposure of tenofovir could potentiate tenofovir-associated adverse events, including renal disorders. Renal function should be closely monitored (see section 4.4). |
| **NRTIs**                                           |                                                                                 |                                                                                       |
| Didanosine                                          | Co-administration of tenofovir disoproxil fumarate and didanosine results in a 40-60% increase in systemic exposure to didanosine that may increase the risk for didanosine-related adverse reactions. Rarely, pancreatitis and lactic acidosis, sometimes fatal, have been reported.  
Co-administration of tenofovir disoproxil fumarate and didanosine at a dose of 400 mg daily has been associated with a significant decrease in CD4 cell count, possibly due to an intracellular interaction increasing phosphorylated (i.e. active) didanosine. A decreased dosage of 250 mg didanosine co-administered with tenofovir disoproxil fumarate therapy has been associated with reports of high rates of virological failure within several tested combinations for the treatment of HIV-1 infection. | Co-administration of tenofovir disoproxil fumarate and didanosine is not recommended (see section 4.4). |
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</thead>
<tbody>
<tr>
<td>Adefovir dipivoxil</td>
<td>AUC: $\leftrightarrow$ $C_{\text{max}}$: $\leftrightarrow$</td>
<td>Tenofovir disoproxil fumarate should not be administered concurrently with adefovir dipivoxil (see section 4.4).</td>
</tr>
<tr>
<td>Entecavir</td>
<td>AUC: $\leftrightarrow$ $C_{\text{max}}$: $\leftrightarrow$</td>
<td>No clinically significant pharmacokinetic interactions when tenofovir disoproxil fumarate was co-administered with entecavir.</td>
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<tr>
<td><strong>Hepatitis C virus antiviral agents</strong></td>
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<tr>
<td>Ledipasvir/Sofosbuvir (90 mg/400 mg q.d.) +</td>
<td>Ledipasvir: AUC: ↑ 96% $C_{\text{max}}$: ↑ 68% $C_{\text{min}}$: ↑ 118%</td>
<td>Increased plasma concentrations of tenofovir resulting from co-administration of tenofovir disoproxil fumarate, ledipasvir/sofosbuvir and atazanavir/ritonavir may increase adverse reactions related to tenofovir disoproxil fumarate, including renal disorders. The safety of tenofovir disoproxil fumarate when used with ledipasvir/sofosbuvir and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established.</td>
</tr>
<tr>
<td>Atazanavir/Ritonavir (300 mg q.d./100 mg q.d.) +</td>
<td>Sofosbuvir: AUC: $\leftrightarrow$ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↑ 42%</td>
<td>The combination should be used with caution with frequent renal monitoring, if other alternatives are not available (see section 4.4).</td>
</tr>
<tr>
<td>Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.)</td>
<td>GS-331007: AUC: $\leftrightarrow$ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↑ 42%</td>
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<tr>
<td>Levetiracetam: AUC: $\leftrightarrow$</td>
<td>$C_{\text{max}}$: ↔ $C_{\text{min}}$: ↑ 42%</td>
<td></td>
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<tr>
<td>Atazanavir: AUC: $\leftrightarrow$</td>
<td>$C_{\text{max}}$: ↔ $C_{\text{min}}$: ↑ 63%</td>
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<tr>
<td>Ritonavir: AUC: $\leftrightarrow$</td>
<td>$C_{\text{max}}$: ↔ $C_{\text{min}}$: ↑ 45%</td>
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<tr>
<td>Emtricitabine: AUC: $\leftrightarrow$</td>
<td>$C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔</td>
<td></td>
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<tr>
<td>Tenofovir: AUC: $\leftrightarrow$</td>
<td>$C_{\text{max}}$: ↑ 47% $C_{\text{min}}$: ↑ 47%</td>
<td></td>
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<tr>
<td>Medicinal product by therapeutic areas (dose in mg)</td>
<td>Effects on drug levels Mean percent change in AUC, C&lt;sub&gt;max&lt;/sub&gt;, C&lt;sub&gt;min&lt;/sub&gt;</td>
<td>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</td>
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<td>--------------------------------------------------</td>
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<tr>
<td>Ledipasvir/Sofosbuvir (90 mg/400 mg q.d.) + Darunavir/Ritonavir (800 mg q.d./100 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.)&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Ledipasvir: AUC: ↔ C&lt;sub&gt;max&lt;/sub&gt;: ↔ C&lt;sub&gt;min&lt;/sub&gt;: ↔</td>
<td>Increased plasma concentrations of tenofovir resulting from co-administration of tenofovir disoproxil fumarate, ledipasvir/sofosbuvir and darunavir/ritonavir may increase adverse reactions related to tenofovir disoproxil fumarate, including renal disorders. The safety of tenofovir disoproxil fumarate when used with ledipasvir/sofosbuvir and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established. The combination should be used with caution with frequent renal monitoring, if other alternatives are not available (see section 4.4).</td>
</tr>
<tr>
<td>Sofosbuvir: AUC: ↓ 27% C&lt;sub&gt;max&lt;/sub&gt;: ↓ 37%</td>
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<tr>
<td>GS-331007&lt;sup&gt;2&lt;/sup&gt;: AUC: ↔ C&lt;sub&gt;max&lt;/sub&gt;: ↔ C&lt;sub&gt;min&lt;/sub&gt;: ↔</td>
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<tr>
<td>Darunavir: AUC: ↔ C&lt;sub&gt;max&lt;/sub&gt;: ↔ C&lt;sub&gt;min&lt;/sub&gt;: ↔</td>
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<tr>
<td>Ritonavir: AUC: ↔ C&lt;sub&gt;max&lt;/sub&gt;: ↔ C&lt;sub&gt;min&lt;/sub&gt;: ↑ 48%</td>
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<tr>
<td>Emtricitabine: AUC: ↔ C&lt;sub&gt;max&lt;/sub&gt;: ↔ C&lt;sub&gt;min&lt;/sub&gt;: ↔</td>
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<tr>
<td>Tenofovir: AUC: ↑ 50% C&lt;sub&gt;max&lt;/sub&gt;: ↑ 64% C&lt;sub&gt;min&lt;/sub&gt;: ↑ 59%</td>
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<tr>
<td>Ledipasvir/Sofosbuvir (90 mg/400 mg q.d.) + Efavirenz/Emtricitabine/Tenofovir disoproxil fumarate (600 mg/200 mg/300 mg q.d.)</td>
<td>Ledipasvir: AUC: ↓ 34% C&lt;sub&gt;max&lt;/sub&gt;: ↓ 34% C&lt;sub&gt;min&lt;/sub&gt;: ↓ 34%</td>
<td>No dose adjustment is recommended. The increased exposure of tenofovir could potentiate adverse reactions associated with tenofovir disoproxil fumarate, including renal disorders. Renal function should be closely monitored (see section 4.4).</td>
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<tr>
<td>Sofosbuvir: AUC: ↔ C&lt;sub&gt;max&lt;/sub&gt;: ↔</td>
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<tr>
<td>GS-331007&lt;sup&gt;2&lt;/sup&gt;: AUC: ↔ C&lt;sub&gt;max&lt;/sub&gt;: ↔ C&lt;sub&gt;min&lt;/sub&gt;: ↔</td>
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<tr>
<td>Efavirenz: AUC: ↔ C&lt;sub&gt;max&lt;/sub&gt;: ↔ C&lt;sub&gt;min&lt;/sub&gt;: ↔</td>
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<tr>
<td>Emtricitabine: AUC: ↔ C&lt;sub&gt;max&lt;/sub&gt;: ↔ C&lt;sub&gt;min&lt;/sub&gt;: ↔</td>
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<tr>
<td>Tenofovir:</td>
<td>$\text{AUC: } \uparrow 98%$ $\text{C}<em>{\text{max}}: \uparrow 79%$ $\text{C}</em>{\text{min}}: \uparrow 163%$</td>
<td>No dose adjustment is recommended. The increased exposure of tenofovir could potentiate adverse reactions associated with tenofovir disoproxil fumarate, including renal disorders. Renal function should be closely monitored (see section 4.4).</td>
</tr>
<tr>
<td>Ledipasvir/Sofosbuvir (90 mg/400 mg q.d.) + Emtricitabine/Rilpivirine/Tenofovir disoproxil fumarate (200 mg/25 mg/300 mg q.d.)</td>
<td>- Ledipasvir: $\text{AUC: } \leftrightarrow$ $\text{C}<em>{\text{max}}: \leftrightarrow$ $\text{C}</em>{\text{min}}: \leftrightarrow$ - Sofosbuvir: $\text{AUC: } \leftrightarrow$ $\text{C}<em>{\text{max}}: \leftrightarrow$ $\text{C}</em>{\text{min}}: \leftrightarrow$ - GS-331007²: $\text{AUC: } \leftrightarrow$ $\text{C}<em>{\text{max}}: \leftrightarrow$ $\text{C}</em>{\text{min}}: \leftrightarrow$ - Emtricitabine: $\text{AUC: } \leftrightarrow$ $\text{C}<em>{\text{max}}: \leftrightarrow$ $\text{C}</em>{\text{min}}: \leftrightarrow$ - Rilpivirine: $\text{AUC: } \leftrightarrow$ $\text{C}<em>{\text{max}}: \leftrightarrow$ $\text{C}</em>{\text{min}}: \leftrightarrow$ - Tenofovir: $\text{AUC: } \uparrow 40%$ $\text{C}<em>{\text{max}}: \leftrightarrow$ $\text{C}</em>{\text{min}}: \uparrow 91%$</td>
<td></td>
</tr>
<tr>
<td>Medicinal product by therapeutic areas (dose in mg)</td>
<td>Effects on drug levels Mean percent change in AUC, $C_{\text{max}}$, $C_{\text{min}}$</td>
<td>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Ledipasvir/Sofosbuvir (90 mg/400 mg q.d.) + Dolutegravir (50 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.)</td>
<td>Sofosbuvir: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔ GS-331007² AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔</td>
<td>No dose adjustment is recommended. The increased exposure of tenofovir could potentiate adverse reactions associated with tenofovir disoproxil fumarate, including renal disorders. Renal function should be closely monitored (see section 4.4).</td>
</tr>
<tr>
<td></td>
<td>Ledipasvir: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔</td>
<td></td>
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<tr>
<td></td>
<td>Dolutegravir AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔</td>
<td></td>
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<tr>
<td></td>
<td>Emtricitabine: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tenofovir: AUC: ↑ 65% $C_{\text{max}}$: ↑ 61% $C_{\text{min}}$: ↑ 115%</td>
<td></td>
</tr>
<tr>
<td>Medicinal product by therapeutic areas (dose in mg)</td>
<td>Effects on drug levels Mean percent change in AUC, $C_{\text{max}}$, $C_{\text{min}}$</td>
<td>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Atazanavir/Ritonavir (300 mg q.d./100 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.) | Sofosbuvir:  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: $\leftrightarrow$  
GS-331007:  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: $\leftrightarrow$  
$C_{\text{min}}$: $\uparrow$ 42%  
Velpatasvir:  
AUC: $\uparrow$ 142%  
$C_{\text{max}}$: $\uparrow$ 55%  
$C_{\text{min}}$: $\uparrow$ 301%  
Atazanavir:  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: $\leftrightarrow$  
$C_{\text{min}}$: $\uparrow$ 39%  
Ritonavir:  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: $\leftrightarrow$  
$C_{\text{min}}$: $\uparrow$ 29%  
Emtricitabine:  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: $\leftrightarrow$  
$C_{\text{min}}$: $\leftrightarrow$  
Tenofovir:  
AUC: $\leftrightarrow$  
$C_{\text{max}}$: $\uparrow$ 55%  
$C_{\text{min}}$: $\uparrow$ 39% | Increased plasma concentrations of tenofovir resulting from co-administration of tenofovir disoproxil fumarate, sofosbuvir/velpatasvir and atazanavir/ritonavir may increase adverse reactions related to tenofovir disoproxil fumarate, including renal disorders. The safety of tenofovir disoproxil fumarate when used with sofosbuvir/velpatasvir and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established. The combination should be used with caution with frequent renal monitoring (see section 4.4). |
<table>
<thead>
<tr>
<th>Medicinal product by therapeutic areas (dose in mg)</th>
<th>Effects on drug levels</th>
<th>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Darunavir/Ritonavir (800 mg q.d./100 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.)</td>
<td>Sofosbuvir: AUC: ↓28% $C_{\text{max}}$: ↓38% GS-331007: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔ Velpatasvir: AUC: ↔ $C_{\text{max}}$: ↓24% $C_{\text{min}}$: ↔ Darunavir: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔ Ritonavir: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔ Emtricitabine: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔ Tenofovir: AUC: ↑39% $C_{\text{max}}$: ↑55% $C_{\text{min}}$: ↑52%</td>
<td>Increased plasma concentrations of tenofovir resulting from co-administration of tenofovir disoproxil fumarate, sofosbuvir/velpatasvir and darunavir/ritonavir may increase adverse reactions related to tenofovir disoproxil fumarate, including renal disorders. The safety of tenofovir disoproxil fumarate when used with sofosbuvir/velpatasvir and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established. The combination should be used with caution with frequent renal monitoring (see section 4.4).</td>
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<td>Effects on drug levels Mean percent change in AUC, $C_{\text{max}}$, $C_{\text{min}}$</td>
<td>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>----------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Lopinavir/Ritonavir (800 mg/200 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.) | Sofosbuvir:  
AUC: ↓29%  
$C_{\text{max}}$: ↓41%  
GS-331007:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Velpatasvir:  
AUC: ↔  
$C_{\text{max}}$: ↓30%  
$C_{\text{min}}$: ↑63%  
Lopinavir:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Ritonavir:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Emtricitabine:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Tenofovir:  
AUC: ↔  
$C_{\text{max}}$: ↑42%  
$C_{\text{min}}$: ↔ | Increased plasma concentrations of tenofovir resulting from co-administration of tenofovir disoproxil fumarate, sofosbuvir/velpatasvir and lopinavir/ritonavir may increase adverse reactions related to tenofovir disoproxil fumarate, including renal disorders. The safety of tenofovir disoproxil fumarate when used with sofosbuvir/velpatasvir and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established.  
The combination should be used with caution with frequent renal monitoring (see section 4.4). |
<table>
<thead>
<tr>
<th>Medicinal product by therapeutic areas (dose in mg)</th>
<th>Effects on drug levels Mean percent change in AUC, $C_{\text{max}}$, $C_{\text{min}}$</th>
<th>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</th>
</tr>
</thead>
</table>
| Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Raltegravir (400 mg b.i.d) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.) | Sofosbuvir:  
AUC: ↔  
$C_{\text{max}}$: ↔  
GS-331007²:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Velpatasvir:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Raltegravir:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↓ 21%  
Emtricitabine:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Tenofovir:  
AUC: ↑ 40%  
$C_{\text{max}}$: ↑ 46%  
$C_{\text{min}}$: ↑ 70%  | No dose adjustment is recommended. The increased exposure of tenofovir could potentiate adverse reactions associated with tenofovir disoproxil fumarate, including renal disorders. Renal function should be closely monitored (see section 4.4). |
| Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Efavirenz/Emtricitabine/ Tenofovir disoproxil fumarate (600 mg/200 mg/300 mg q.d.) | Sofosbuvir:  
AUC: ↔  
$C_{\text{max}}$: ↑ 38%  
GS-331007²:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Velpatasvir:  
AUC: ↓ 53%  
$C_{\text{max}}$: ↓ 47%  
$C_{\text{min}}$: ↓ 57%  
Efavirenz:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Emtricitabine:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Tenofovir:  
AUC: ↑ 81%  
$C_{\text{max}}$: ↑ 77%  
$C_{\text{min}}$: ↑ 121%  | Concomitant administration of sofosbuvir/velpatasvir and efavirenz is expected to decrease plasma concentrations of velpatasvir. Co-administration of sofosbuvir/velpatasvir with efavirenz-containing regimens is not recommended. |
<table>
<thead>
<tr>
<th>Medicinal product by therapeutic areas (dose in mg)</th>
<th>Effects on drug levels</th>
<th>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Emtricitabine/Rilpivirine/Tenofovir disoproxil fumarate (200 mg/25 mg/300 mg q.d.)</td>
<td>Sofosbuvir: AUC: ↔ ; C&lt;sub&gt;max&lt;/sub&gt;: ↔; C&lt;sub&gt;min&lt;/sub&gt;: ↔; GS-331007&lt;sup&gt;2&lt;/sup&gt;: AUC: ↔; C&lt;sub&gt;max&lt;/sub&gt;: ↔; C&lt;sub&gt;min&lt;/sub&gt;: ↔; Velpatasvir: AUC: ↔; C&lt;sub&gt;max&lt;/sub&gt;: ↔; C&lt;sub&gt;min&lt;/sub&gt;: ↔; Emtricitabine: AUC: ↔; C&lt;sub&gt;max&lt;/sub&gt;: ↔; C&lt;sub&gt;min&lt;/sub&gt;: ↔; Rilpivirine: AUC: ↔; C&lt;sub&gt;max&lt;/sub&gt;: ↔; C&lt;sub&gt;min&lt;/sub&gt;: ↔; Tenofovir: AUC: ↑ 40%; C&lt;sub&gt;max&lt;/sub&gt;: ↑ 44%; C&lt;sub&gt;min&lt;/sub&gt;: ↑ 84%</td>
<td>No dose adjustment is recommended. The increased exposure of tenofovir could potentiate adverse reactions associated with tenofovir disoproxil fumarate, including renal disorders. Renal function should be closely monitored (see section 4.4).</td>
</tr>
<tr>
<td>Sofosbuvir (400 mg q.d.) + Efavirenz/Emtricitabine/Tenofovir disoproxil fumarate (600 mg/200 mg/300 mg q.d.)</td>
<td>Sofosbuvir: AUC: ↔; C&lt;sub&gt;max&lt;/sub&gt;: ↓ 19%; GS-331007&lt;sup&gt;2&lt;/sup&gt;: AUC: ↓ 23%; Efavirenz: AUC: ↔; C&lt;sub&gt;max&lt;/sub&gt;: ↔; C&lt;sub&gt;min&lt;/sub&gt;: ↔; Emtricitabine: AUC: ↔; C&lt;sub&gt;max&lt;/sub&gt;: ↔; C&lt;sub&gt;min&lt;/sub&gt;: ↔; Tenofovir: AUC: ↔; C&lt;sub&gt;max&lt;/sub&gt;: ↑ 25%; C&lt;sub&gt;min&lt;/sub&gt;: ↔</td>
<td>No dose adjustment is required.</td>
</tr>
</tbody>
</table>

<sup>1</sup> Data generated from simultaneous dosing with ledipasvir/sofosbuvir. Staggered administration (12 hours apart) provided similar results.

<sup>2</sup> The predominant circulating metabolite of sofosbuvir.

**Studies conducted with other medicinal products**

There were no clinically significant pharmacokinetic interactions when tenofovir disoproxil fumarate was co-administered with emtricitabine, lamivudine, indinavir, efavirenz, nelfinavir, saquinavir.
(ritonavir boosted), methadone, ribavirin, rifampicin, tacrolimus, or the hormonal contraceptive norgestimate/ethinyl oestradiol.

Tenofovir disoproxil fumarate must be taken with food, as food enhances the bioavailability of tenofovir (see section 5.2).

4.6 Fertility, pregnancy and lactation

Pregnancy
A moderate amount of data on pregnant women (between 300-1,000 pregnancy outcomes) indicate no malformations or foetal/neonatal toxicity associated with tenofovir disoproxil fumarate. Animal studies do not indicate reproductive toxicity (see section 5.3). The use of tenofovir disoproxil fumarate may be considered during pregnancy, if necessary.

Breast-feeding
Tenofovir has been shown to be excreted in human milk. There is insufficient information on the effects of tenofovir in newborns/infants. Therefore Viread should not be used during breast-feeding.

As a general rule, it is recommended that HIV and HBV infected women do not breast-feed their infants in order to avoid transmission of HIV and HBV to the infant.

Fertility
There are limited clinical data with respect to the effect of tenofovir disoproxil fumarate on fertility. Animal studies do not indicate harmful effects of tenofovir disoproxil fumarate on fertility.

4.7 Effects on ability to drive and use machines

No studies on the effects on the ability to drive and use machines have been performed. However, patients should be informed that dizziness has been reported during treatment with tenofovir disoproxil fumarate.

4.8 Undesirable effects

Summary of the safety profile

HIV-1 and hepatitis B: In patients receiving tenofovir disoproxil fumarate, rare events of renal impairment, renal failure and uncommon events of proximal renal tubulopathy (including Fanconi syndrome) sometimes leading to bone abnormalities (infrequently contributing to fractures) have been reported. Monitoring of renal function is recommended for patients receiving Viread (see section 4.4).

HIV-1: Approximately one third of patients can be expected to experience adverse reactions following treatment with tenofovir disoproxil fumarate in combination with other antiretroviral agents. These reactions are usually mild to moderate gastrointestinal events. Approximately 1% of tenofovir disoproxil fumarate-treated adult patients discontinued treatment due to the gastrointestinal events.

Co-administration of Viread and didanosine is not recommended as this may result in an increased risk of adverse reactions (see section 4.5). Rarely, pancreatitis and lactic acidosis, sometimes fatal, have been reported (see section 4.4).

Hepatitis B: Approximately one quarter of patients can be expected to experience adverse reactions following treatment with tenofovir disoproxil fumarate, most of which are mild. In clinical trials of HBV infected patients, the most frequently occurring adverse reaction to tenofovir disoproxil fumarate was nausea (5.4%).

Acute exacerbation of hepatitis has been reported in patients on treatment as well as in patients who have discontinued hepatitis B therapy (see section 4.4).
Tabulated summary of adverse reactions

Assessment of adverse reactions for tenofovir disoproxil fumarate is based on safety data from clinical studies and post-marketing experience. All adverse reactions are presented in Table 2.

**HIV-1 clinical studies:** Assessment of adverse reactions from HIV-1 clinical study data is based on experience in two studies in 653 treatment-experienced patients receiving treatment with tenofovir disoproxil fumarate (n = 443) or placebo (n = 210) in combination with other antiretroviral medicinal products for 24 weeks and also in a double-blind comparative controlled study in which 600 treatment-naïve patients received treatment with tenofovir disoproxil fumarate 245 mg (as fumarate) (n = 299) or stavudine (n = 301) in combination with lamivudine and efavirenz for 144 weeks.

**Hepatitis B clinical studies:** Assessment of adverse reactions from HBV clinical study data is primarily based on experience in two double-blind comparative controlled studies in which 641 adult patients with chronic hepatitis B and compensated liver disease received treatment with tenofovir disoproxil fumarate 245 mg (as fumarate) daily (n = 426) or adefovir dipivoxil 10 mg daily (n = 215) for 48 weeks. The adverse reactions observed with continued treatment for 384 weeks were consistent with the safety profile of tenofovir disoproxil fumarate. After an initial decline of approximately -4.9 ml/min (using Cockcroft-Gault equation) or -3.9 ml/min/1.73 m² (using modification of diet in renal disease [MDRD] equation) after the first 4 weeks of treatment, the rate of annual decline post baseline of renal function reported in tenofovir disoproxil fumarate treated patients was -1.41 ml/min per year (using Cockcroft-Gault equation) and -0.74 ml/min/1.73 m² per year (using MDRD equation).

**Patients with decompensated liver disease:** The safety profile of tenofovir disoproxil fumarate in patients with decompensated liver disease was assessed in a double-blind active controlled study (GS-US-174-0108) in which adult patients received treatment with tenofovir disoproxil fumarate (n = 45) or emtricitabine plus tenofovir disoproxil fumarate (n = 45) or entecavir (n = 22) for 48 weeks.

In the tenofovir disoproxil fumarate treatment arm, 7% of patients discontinued treatment due to an adverse event; 9% of patients experienced a confirmed increase in serum creatinine of ≥ 0.5 mg/dl or confirmed serum phosphate of < 2 mg/dl through week 48; there were no statistically significant differences between the combined tenofovir-containing arms and the entecavir arm. After 168 weeks, 16% (7/45) of the tenofovir disoproxil fumarate group, 4% (2/45) of the emtricitabine plus tenofovir disoproxil fumarate group, and 14% (3/22) of the entecavir group experienced tolerability failure. Thirteen percent (6/45) of the tenofovir disoproxil fumarate group, 13% (6/45) of the emtricitabine plus tenofovir disoproxil fumarate group, and 9% (2/22) of the entecavir group had a confirmed increase in serum creatinine ≥ 0.5 mg/dl or confirmed serum phosphate of < 2 mg/dl.

At week 168, in this population of patients with decompensated liver disease, the rate of death was of 13% (6/45) in the tenofovir disoproxil fumarate group, 11% (5/45) in the emtricitabine plus tenofovir disoproxil fumarate group and 14% (3/22) in the entecavir group. The rate of hepatocellular carcinoma was 18% (8/45) in the tenofovir disoproxil fumarate group, 7% (3/45) in the emtricitabine plus tenofovir disoproxil fumarate group and 9% (2/22) in the entecavir group.

Subjects with a high baseline CPT score were at higher risk of developing serious adverse events (see section 4.4).

**Patients with lamivudine-resistant chronic hepatitis B:** No new adverse reactions to tenofovir disoproxil fumarate were identified from a randomised, double-blind study (GS-US-174-0121) in which 280 lamivudine-resistant patients received treatment with tenofovir disoproxil fumarate (n = 141) or emtricitabine/tenofovir disoproxil fumarate (n = 139) for 240 weeks.
The adverse reactions with suspected (at least possible) relationship to treatment are listed below by body system organ class and frequency. Within each frequency grouping, undesirable effects are presented in order of decreasing seriousness. Frequencies are defined as very common (≥ 1/10), common (≥ 1/100 to < 1/10), uncommon (≥ 1/1,000 to < 1/100) or rare (≥ 1/10,000 to < 1/1,000).

Table 2: Tabulated summary of adverse reactions associated with tenofovir disoproxil fumarate based on clinical study and post-marketing experience

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Tenofovir disoproxil fumarate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metabolism and nutrition disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Very common:</td>
<td>hypophosphataemia&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Uncommon:</td>
<td>hypokalaemia&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Rare:</td>
<td>lactic acidosis</td>
</tr>
<tr>
<td><strong>Nervous system disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Very common:</td>
<td>dizziness</td>
</tr>
<tr>
<td>Common:</td>
<td>headache</td>
</tr>
<tr>
<td><strong>Gastrointestinal disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Very common:</td>
<td>diarrhoea, vomiting, nausea</td>
</tr>
<tr>
<td>Common:</td>
<td>abdominal pain, abdominal distension, flatulence</td>
</tr>
<tr>
<td>Uncommon:</td>
<td>pancreatitis</td>
</tr>
<tr>
<td><strong>Hepatobiliary disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Common:</td>
<td>increased transaminases</td>
</tr>
<tr>
<td>Rare:</td>
<td>hepatic steatosis, hepatitis</td>
</tr>
<tr>
<td><strong>Skin and subcutaneous tissue disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Very common:</td>
<td>rash</td>
</tr>
<tr>
<td>Rare:</td>
<td>angioedema</td>
</tr>
<tr>
<td><strong>Musculoskeletal and connective tissue disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Uncommon:</td>
<td>rhabdomyolysis&lt;sup&gt;1, 1&lt;/sup&gt;, muscular weakness&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Rare:</td>
<td>osteomalacia (manifested as bone pain and infrequently contributing to fractures)&lt;sup&gt;1, 2&lt;/sup&gt;, myopathy&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Renal and urinary disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Uncommon:</td>
<td>increased creatinine, proximal renal tubulopathy (including Fanconi syndrome)</td>
</tr>
<tr>
<td>Rare:</td>
<td>acute renal failure, renal failure, acute tubular necrosis, nephritis (including acute interstitial nephritis)&lt;sup&gt;2&lt;/sup&gt;, nephrogenic diabetes insipidus</td>
</tr>
<tr>
<td><strong>General disorders and administration site conditions:</strong></td>
<td></td>
</tr>
<tr>
<td>Very common:</td>
<td>asthenia</td>
</tr>
<tr>
<td>Common:</td>
<td>fatigue</td>
</tr>
</tbody>
</table>

<sup>1</sup> This adverse reaction may occur as a consequence of proximal renal tubulopathy. It is not considered to be causally associated with tenofovir disoproxil fumarate in the absence of this condition.

<sup>2</sup> This adverse reaction was identified through post-marketing surveillance but not observed in randomised controlled clinical trials or the tenofovir disoproxil fumarate expanded access program. The frequency category was estimated from a statistical calculation based on the total number of patients exposed to tenofovir disoproxil fumarate in randomised controlled clinical trials and the expanded access program (n = 7,319).

Description of selected adverse reactions

**HIV-1 and hepatitis B:**

**Renal impairment**

As Viread may cause renal damage monitoring of renal function is recommended (see sections 4.4 and 4.8 *Summary of the safety profile*). Proximal renal tubulopathy generally resolved or improved after tenofovir disoproxil fumarate discontinuation. However, in some patients, declines in creatinine clearance did not completely resolve despite tenofovir disoproxil fumarate discontinuation. Patients at risk of renal impairment (such as patients with baseline renal risk factors, advanced HIV disease, or patients receiving concomitant nephrotoxic medications) are at increased risk of experiencing incomplete recovery of renal function despite tenofovir disoproxil fumarate discontinuation (see section 4.4).
**HIV-1:**

*Interaction with didanosine*

Co-administration of tenofovir disoproxil fumarate and didanosine is not recommended as it results in a 40-60% increase in systemic exposure to didanosine that may increase the risk of didanosine-related adverse reactions (see section 4.5). Rarely, pancreatitis and lactic acidosis, sometimes fatal, have been reported.

**Metabolic parameters**

Weight and levels of blood lipids and glucose may increase during antiretroviral therapy (see section 4.4).

**Immune reactivation syndrome**

In HIV infected patients with severe immune deficiency at the time of initiation of CART, an inflammatory reaction to asymptomatic or residual opportunistic infections may arise. Autoimmune disorders (such as Graves’ disease) have also been reported; however, the reported time to onset is more variable and these events can occur many months after initiation of treatment (see section 4.4).

**Osteonecrosis**

Cases of osteonecrosis have been reported, particularly in patients with generally acknowledged risk factors, advanced HIV disease or long-term exposure to CART. The frequency of this is unknown (see section 4.4).

**Hepatitis B:**

*Exacerbations of hepatitis during treatment*

In studies with nucleoside-naïve patients, on-treatment ALT elevations > 10 times ULN (upper limit of normal) and > 2 times baseline occurred in 2.6% of tenofovir disoproxil fumarate-treated patients. ALT elevations had a median time to onset of 8 weeks, resolved with continued treatment, and, in a majority of cases, were associated with a ≥ 2 log_{10} copies/ml reduction in viral load that preceded or coincided with the ALT elevation. Periodic monitoring of hepatic function is recommended during treatment (see section 4.4).

*Exacerbations of hepatitis after discontinuation of treatment*

In HBV infected patients, clinical and laboratory evidence of exacerbations of hepatitis have occurred after discontinuation of HBV therapy (see section 4.4).

**Paediatric population**

**HIV-1**

Assessment of adverse reactions is based on two randomised trials (studies GS-US-104-0321 and GS-US-104-0352) in 184 HIV-1 infected paediatric patients (aged 2 to < 18 years) who received treatment with tenofovir disoproxil fumarate (n = 93) or placebo/active comparator (n = 91) in combination with other antiretroviral agents for 48 weeks (see section 5.1). The adverse reactions observed in paediatric patients who received treatment with tenofovir disoproxil fumarate were consistent with those observed in clinical studies of tenofovir disoproxil fumarate in adults (see section 4.8 Tabulated summary of adverse reactions and 5.1).

Reductions in BMD have been reported in paediatric patients. In HIV-1 infected adolescents, the BMD Z-scores observed in subjects who received tenofovir disoproxil fumarate were lower than those observed in subjects who received placebo. In HIV-1 infected children, the BMD Z-scores observed in subjects who switched to tenofovir disoproxil fumarate were lower than those observed in subjects who remained on their stavudine- or zidovudine-containing regimen (see sections 4.4 and 5.1).

In study GS-US-104-0352, 4 out of 89 paediatric patients exposed to tenofovir disoproxil fumarate (median tenofovir disoproxil fumarate exposure 312 weeks) discontinued due to adverse reactions consistent with proximal renal tubulopathy. Seven patients had estimated glomerular filtration rate (GFR) values between 70 and 90 mL/min/1.73 m^2. Among them, two patients experienced a clinically meaningful decline in estimated GFR which improved after discontinuation of tenofovir disoproxil fumarate.
Chronic hepatitis B
Assessment of adverse reactions is based on one randomised study (study GS-US-174-0115) in 106 adolescent patients (12 to < 18 years of age) with chronic hepatitis B receiving treatment with tenofovir disoproxil 245 mg (as fumarate) (n = 52) or placebo (n = 54) for 72 weeks. The adverse reactions observed in adolescent patients who received treatment with tenofovir disoproxil fumarate were consistent with those observed in clinical studies of tenofovir disoproxil fumarate in adults (see section 4.8 Tabulated summary of adverse reactions and 5.1).

Reductions in BMD have been observed in HBV infected adolescents. The BMD Z-scores observed in subjects who received tenofovir disoproxil fumarate were lower than those observed in subjects who received placebo (see sections 4.4 and 5.1).

Other special population(s)
Elderly
Tenofovir disoproxil fumarate has not been studied in patients over the age of 65. Elderly patients are more likely to have decreased renal function, therefore caution should be exercised when treating elderly patients with tenofovir disoproxil fumarate (see section 4.4).

Patients with renal impairment
Since tenofovir disoproxil fumarate can cause renal toxicity, close monitoring of renal function is recommended in adult patients with renal impairment treated with Viread (see sections 4.2, 4.4 and 5.2). The use of tenofovir disoproxil fumarate is not recommended in paediatric patients with renal impairment (see sections 4.2 and 4.4).

Reporting of suspected adverse reactions
Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via the national reporting system listed in Appendix V.

4.9 Overdose
Symptoms
If overdose occurs the patient must be monitored for evidence of toxicity (see sections 4.8 and 5.3), and standard supportive treatment applied as necessary.

Management
Tenofovir can be removed by haemodialysis; the median haemodialysis clearance of tenofovir is 134 ml/min. It is not known whether tenofovir can be removed by peritoneal dialysis.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties
Pharmacotherapeutic group: Antiviral for systemic use; nucleoside and nucleotide reverse transcriptase inhibitors, ATC code: J05AF07

Mechanism of action and pharmacodynamic effects
Tenofovir disoproxil fumarate is the fumarate salt of the prodrug tenofovir disoproxil. Tenofovir disoproxil is absorbed and converted to the active substance tenofovir, which is a nucleoside monophosphate (nucleotide) analogue. Tenofovir is then converted to the active metabolite, tenofovir diphosphate, an obligate chain terminator, by constitutively expressed cellular enzymes. Tenofovir diphosphate has an intracellular half-life of 10 hours in activated and 50 hours in resting peripheral blood mononuclear cells (PBMCs). Tenofovir diphosphate inhibits HIV-1 reverse transcriptase and the HBV polymerase by direct binding competition with the natural deoxyribonucleotide substrate
and, after incorporation into DNA, by DNA chain termination. Tenofovir diphosphate is a weak inhibitor of cellular polymerases α, β, and γ. At concentrations of up to 300 μmol/l, tenofovir has also shown no effect on the synthesis of mitochondrial DNA or the production of lactic acid in in vitro assays.

Data pertaining to HIV

**HIV antiviral activity in vitro:** The concentration of tenofovir required for 50% inhibition (EC₅₀) of the wild-type laboratory strain HIV-1ₜₐₙ is 1-6 μmol/l in lymphoid cell lines and 1.1 μmol/l against primary HIV-1 subtype B isolates in PBMCs. Tenofovir is also active against HIV-1 subtypes A, C, D, E, F, G, and O and against HIVₜₐₙ in primary monocyte/macrophage cells. Tenofovir shows activity in vitro against HIV-2, with an EC₅₀ of 4.9 μmol/l in MT-4 cells.

**Resistance:** Strains of HIV-1 with reduced susceptibility to tenofovir and a K65R mutation in reverse transcriptase have been selected in vitro and in some patients (see Clinical efficacy and safety). Tenofovir disoproxil fumarate should be avoided in antiretroviral-experienced patients with strains harbouring the K65R mutation (see section 4.4). In addition, a K70E substitution in HIV-1 reverse transcriptase has been selected by tenofovir and results in low-level reduced susceptibility to tenofovir.

Clinical studies in treatment-experienced patients have assessed the anti-HIV activity of tenofovir disoproxil 245 mg (as fumarate) against strains of HIV-1 with resistance to nucleoside inhibitors. The results indicate that patients whose HIV expressed 3 or more thymidine-analogue associated mutations (TAMs) that included either the M41L or L210W reverse transcriptase mutation showed reduced response to tenofovir disoproxil 245 mg (as fumarate) therapy.

**Clinical efficacy and safety**

The effects of tenofovir disoproxil fumarate in treatment-experienced and treatment-naïve HIV-1 infected adults have been demonstrated in trials of 48 weeks and 144 weeks duration, respectively.

In study GS-99-907, 550 treatment-experienced adult patients were treated with placebo or tenofovir disoproxil 245 mg (as fumarate) for 24 weeks. The mean baseline CD4 cell count was 427 cells/mm³; the mean baseline plasma HIV-1 RNA was 3.4 log₁₀ copies/ml (78% of patients had a viral load of < 5,000 copies/ml) and the mean duration of prior HIV treatment was 5.4 years. Baseline genotypic analysis of HIV isolates from 253 patients revealed that 94% of patients had HIV-1 resistance mutations associated with nucleoside reverse transcriptase inhibitors, 58% had mutations associated with protease inhibitors and 48% had mutations associated with non-nucleoside reverse transcriptase inhibitors.

At week 24 the time-weighted average change from baseline in log₁₀ plasma HIV-1 RNA levels (DAVG₃₂) was -0.03 log₁₀ copies/ml and -0.61 log₁₀ copies/ml for the placebo and tenofovir disoproxil 245 mg (as fumarate) recipients (p < 0.0001). A statistically significant difference in favour of tenofovir disoproxil 245 mg (as fumarate) was seen in the time-weighted average change from baseline at week 24 (DAVG₃₂) for CD4 count (+13 cells/mm³ for tenofovir disoproxil 245 mg (as fumarate) versus -11 cells/mm³ for placebo, p-value = 0.0008). The antiviral response to tenofovir disoproxil fumarate was durable through 48 weeks (DAVG₄₈ was -0.57 log₁₀ copies/ml, proportion of patients with HIV-1 RNA below 400 or 50 copies/ml was 41% and 18% respectively). Eight (2%) tenofovir disoproxil 245 mg (as fumarate) treated patients developed the K65R mutation within the first 48 weeks.

The 144-week, double-blind, active controlled phase of study GS-99-903 evaluated the efficacy and safety of tenofovir disoproxil 245 mg (as fumarate) versus stavudine when used in combination with lamivudine and efavirenz in HIV-1 infected adult patients naïve to antiretroviral therapy. The mean baseline CD4 cell count was 279 cells/mm³, the mean baseline plasma HIV-1 RNA was 4.91 log₁₀ copies/ml, 19% of patients had symptomatic HIV-1 infection and 18% had AIDS. Patients were stratified by baseline HIV-1 RNA and CD4 count. Forty-three percent of patients had baseline viral loads > 100,000 copies/ml and 39% had CD4 cell counts < 200 cells/ml.
By intent to treat analysis (missing data and switch in antiretroviral therapy (ART) considered as failure), the proportion of patients with HIV-1 RNA below 400 copies/ml and 50 copies/ml at 48 weeks of treatment was 80% and 76% respectively in the tenofovir disoproxil 245 mg (as fumarate) arm, compared to 84% and 80% in the stavudine arm. At 144 weeks, the proportion of patients with HIV-1 RNA below 400 copies/ml and 50 copies/ml was 71% and 68% respectively in the tenofovir disoproxil 245 mg (as fumarate) arm, compared to 64% and 63% in the stavudine arm.

The average change from baseline for HIV-1 RNA and CD4 count at 48 weeks of treatment was similar in both treatment groups (-3.09 and -3.09 log_{10} copies/ml; +169 and 167 cells/mm^3 in the tenofovir disoproxil 245 mg (as fumarate) and stavudine groups, respectively). At 144 weeks of treatment, the average change from baseline remained similar in both treatment groups (-3.07 and -3.03 log_{10} copies/ml; +263 and +283 cells/mm^3 in the tenofovir disoproxil 245 mg (as fumarate) and stavudine groups, respectively). A consistent response to treatment with tenofovir disoproxil 245 mg (as fumarate) arm was seen regardless of baseline HIV-1 RNA and CD4 count.

The K65R mutation occurred in a slightly higher percentage of patients in the tenofovir disoproxil fumarate group than the active control group (2.7% versus 0.7%). Efavirenz or lamivudine resistance either preceded or was coincident with the development of K65R in all cases. Eight patients had HIV that expressed K65R in the tenofovir disoproxil 245 mg (as fumarate) arm, 7 of these occurred during the first 48 weeks of treatment and the last one at week 96. No further K65R development was observed up to week 144. One patient in the tenofovir disoproxil (as fumarate) arm developed the K70E substitution in the virus. From both the genotypic and phenotypic analyses there was no evidence for other pathways of resistance to tenofovir.

Data pertaining to HBV

HBV antiviral activity in vitro: The in vitro antiviral activity of tenofovir against HBV was assessed in the HepG2 2.2.15 cell line. The EC_{50} values for tenofovir were in the range of 0.14 to 1.5 µmol/l, with CC_{50} (50% cytotoxicity concentration) values > 100 µmol/l.

Resistance: No HBV mutations associated with tenofovir disoproxil fumarate resistance have been identified (see Clinical efficacy and safety). In cell based assays, HBV strains expressing the rtV173L, rtL180M, and rtM204I/V mutations associated with resistance to lamivudine and telbivudine showed a susceptibility to tenofovir ranging from 0.7- to 3.4-fold that of wild-type virus. HBV strains expressing the rtL180M, rtT184G, rtS202G/I, rtM204V and rtM250V mutations associated with resistance to entecavir showed a susceptibility to tenofovir ranging from 0.6- to 6.9-fold that of wild-type virus. HBV strains expressing the adefovir-associated resistance mutations rtA181V and rtN236T showed a susceptibility to tenofovir ranging from 2.9- to 10-fold that of wild-type virus. Viruses containing the rtA181T mutation remained susceptible to tenofovir with EC_{50} values 1.5-fold that of wild-type virus.

Clinical efficacy and safety

The demonstration of benefit of tenofovir disoproxil fumarate in compensated and decompensated disease is based on virological, biochemical and serological responses in adults with HBeAg positive and HBeAg negative chronic hepatitis B. Treated patients included those who were treatment-naïve, lamivudine-experienced, adefovir dipivoxil-experienced and patients with lamivudine and/or adefovir dipivoxil resistance mutations at baseline. Benefit has also been demonstrated based on histological responses in compensated patients.


Results through 48 weeks from two randomised, phase 3 double-blind studies comparing tenofovir disoproxil fumarate to adefovir dipivoxil in adult patients with compensated liver disease are presented in Table 3 below. Study GS-US-174-0103 was conducted in 266 (randomised and treated) HBeAg positive patients while study GS-US-174-0102 was conducted in 375 (randomised and treated) patients negative for HBeAg and positive for HBeAb.
In both of these studies tenofovir disoproxil fumarate was significantly superior to adefovir dipivoxil for the primary efficacy endpoint of complete response (defined as HBV DNA levels < 400 copies/ml and Knodell necroinflammatory score improvement of at least 2 points without worsening in Knodell fibrosis). Treatment with tenofovir disoproxil 245 mg (as fumarate) was also associated with significantly greater proportions of patients with HBV DNA < 400 copies/ml, when compared to adefovir dipivoxil 10 mg treatment. Both treatments produced similar results with regard to histological response (defined as Knodell necroinflammatory score improvement of at least 2 points without worsening in Knodell fibrosis) at week 48 (see Table 3 below).

In study GS-US-174-0103 a significantly greater proportion of patients in the tenofovir disoproxil fumarate group than in the adefovir dipivoxil group had normalised ALT and achieved HBsAg loss at week 48 (see Table 3 below).

Table 3: Efficacy parameters in compensated HBeAg negative and HBeAg positive patients at week 48

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Study 174-0102 (HBeAg negative)</th>
<th>Study 174-0103 (HBeAg positive)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tenofovir disoproxil 245 mg (as fumarate) n = 250</td>
<td>Adefovir dipivoxil 10 mg n = 125</td>
</tr>
<tr>
<td>Complete response (%)</td>
<td>71*</td>
<td>49</td>
</tr>
<tr>
<td>Histology</td>
<td>Histological response (%)</td>
<td>72</td>
</tr>
<tr>
<td>Median HBV DNA reduction from baseline (log_{10} copies/ml)</td>
<td>-4.7*</td>
<td>-4.0</td>
</tr>
<tr>
<td>HBV DNA (%) &lt; 400 copies/ml (&lt; 69 IU/ml)</td>
<td>93*</td>
<td>63</td>
</tr>
<tr>
<td>ALT (%) Normalised ALT</td>
<td>76</td>
<td>77</td>
</tr>
<tr>
<td>Serology (%)</td>
<td>HBeAg loss/seroconversion</td>
<td>n/a</td>
</tr>
<tr>
<td>HBsAg loss/seroconversion</td>
<td>0/0</td>
<td>0/0</td>
</tr>
</tbody>
</table>

* p-value versus adefovir dipivoxil < 0.05.
* Complete response defined as HBV DNA levels < 400 copies/ml and Knodell necroinflammatory score improvement of at least 2 points without worsening in Knodell fibrosis.
* Knodell necroinflammatory score improvement of at least 2 points without worsening in Knodell fibrosis.
* Median change from baseline HBV DNA merely reflects the difference between baseline HBV DNA and the limit of detection (LOD) of the assay.
* The population used for analysis of ALT normalisation included only patients with ALT above ULN at baseline. n/a = not applicable.

Tenofovir disoproxil fumarate was associated with significantly greater proportions of patients with undetectable HBV DNA (< 169 copies/ml [< 29 IU/ml]; the limit of quantification of the Roche Cobas Taqman HBV assay), when compared to adefovir dipivoxil (study GS-US-174-0102; 91%, 56% and study GS-US-174-0103; 69%, 9%), respectively.
Response to treatment with tenofovir disoproxil fumarate was comparable in nucleoside-experienced (n = 51) and nucleoside-naïve (n = 375) patients and in patients with normal ALT (n = 21) and abnormal ALT (n = 405) at baseline when studies GS-US-174-0102 and GS-US-174-0103 were combined. Forty-nine of the 51 nucleoside-experienced patients were previously treated with lamivudine. Seventy-three percent of nucleoside-experienced and 69% of nucleoside-naïve patients achieved complete response to treatment; 90% of nucleoside-experienced and 88% of nucleoside-naïve patients achieved HBV DNA suppression < 400 copies/ml. All patients with normal ALT at baseline and 88% of patients with abnormal ALT at baseline achieved HBV DNA suppression < 400 copies/ml.

In studies GS-US-174-0102 and GS-US-174-0103, after receiving double-blind treatment for 48 weeks (either tenofovir disoproxil 245 mg (as fumarate) or adefovir dipivoxil 10 mg), patients rolled over with no interruption in treatment to open-label tenofovir disoproxil fumarate. In studies GS-US-174-0102 and GS-US-174-0103, 77% and 61% of patients continued in the study through to 384 weeks, respectively. At weeks 96, 144, 192, 240, 288 and 384, viral suppression, biochemical and serological responses were maintained with continued tenofovir disoproxil fumarate treatment (see Tables 4 and 5 below).

Table 4: Efficacy parameters in compensated HBeAg negative patients at week 96, 144, 192, 240, 288 and 384 open-label treatment

<table>
<thead>
<tr>
<th>Parameter(^a)</th>
<th>Study 174-0102 (HBeAg negative)</th>
<th>Study 174-0102 (HBeAg negative)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tenofovir disoproxil 245 mg (as fumarate) n = 250</td>
<td>Adefovir dipivoxil 10 mg roll over to tenofovir disoproxil 245 mg (as fumarate) n = 125</td>
</tr>
<tr>
<td>Week</td>
<td>96(^b) 144(^c) 192(^d) 240(^e) 288(^f) 384(^g)</td>
<td>96(^h) 144(^i) 192(^j) 240(^k) 288(^l) 384(^m)</td>
</tr>
<tr>
<td>HBV DNA (%)</td>
<td>90 87 84 83 80 74</td>
<td>89 88 87 84 84 76</td>
</tr>
<tr>
<td>&lt; 400 copies/ml (&lt; 69 IU/ml)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALT (%) Normalised ALT(^d)</td>
<td>72 73 67 70 68 64</td>
<td>68 70 77 76 74 69</td>
</tr>
<tr>
<td>Serology (%)</td>
<td>HBeAg loss/seroconversion</td>
<td>HBeAg loss/seroconversion</td>
</tr>
<tr>
<td></td>
<td>n/a n/a n/a n/a n/a n/a</td>
<td>n/a n/a n/a n/a n/a n/a</td>
</tr>
<tr>
<td></td>
<td>HBSAg loss/seroconversion</td>
<td>HBSAg loss/seroconversion</td>
</tr>
<tr>
<td></td>
<td>0/0 0/0 0/0 0/0 0/0 1/1(^n)</td>
<td>0/0 0/0 0/0 0/0 1/1(^o) 1/1(^p)</td>
</tr>
</tbody>
</table>

\(^a\) Based upon Long Term Evaluation algorithm (LTE Analysis) - Patients who discontinued the study at any time prior to week 384 due to a protocol defined endpoint, as well as those completing week 384, are included in the denominator.

\(^b\) 48 weeks of double-blind tenofovir disoproxil fumarate followed by 48 weeks open-label.

\(^c\) 48 weeks of double-blind adefovir dipivoxil followed by 48 weeks open-label tenofovir disoproxil fumarate.

\(^d\) The population used for analysis of ALT normalisation included only patients with ALT above ULN at baseline.

\(^e\) 48 weeks of double-blind tenofovir disoproxil fumarate followed by 96 weeks open-label.

\(^f\) 48 weeks of double-blind adefovir dipivoxil followed by 96 weeks open-label tenofovir disoproxil fumarate.

\(^g\) 48 weeks of double-blind tenofovir disoproxil fumarate followed by 144 weeks open-label.

\(^h\) 48 weeks of double-blind adefovir dipivoxil followed by 144 weeks open-label tenofovir disoproxil fumarate.

\(^i\) 48 weeks of double-blind tenofovir disoproxil fumarate followed by 192 weeks open-label.

\(^j\) 48 weeks of double-blind adefovir dipivoxil followed by 192 weeks open-label tenofovir disoproxil fumarate.

\(^k\) 48 weeks of double-blind tenofovir disoproxil fumarate followed by 240 weeks open-label.

\(^l\) 48 weeks of double-blind adefovir dipivoxil followed by 240 weeks open-label tenofovir disoproxil fumarate.

\(^m\) 48 weeks of double-blind tenofovir disoproxil fumarate followed by 336 weeks open-label.

\(^n\) Figures presented are cumulative percentages based upon a Kaplan Meier analysis excluding data collected after the addition of emtricitabine to open-label tenofovir disoproxil fumarate (KM-TDF).

\(^o\) 48 weeks of double-blind tenofovir disoproxil fumarate followed by 336 weeks open-label.

\(^p\) 48 weeks of double-blind adefovir dipivoxil followed by 336 weeks open-label tenofovir disoproxil fumarate.

n/a = not applicable.
Table 5: Efficacy parameters in compensated HBeAg positive patients at week 96, 144, 192, 240, 288 and 384 open-label treatment

<table>
<thead>
<tr>
<th>Study 174-0103 (HBeAg positive)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Parameter</strong></td>
<td><strong>Tenofovir disoproxil 245 mg (as fumarate) n = 176</strong></td>
</tr>
<tr>
<td><strong>Week</strong></td>
<td>96(^{b}) 144(^{c}) 192(^{a}) 240(^{d}) 288(^{d}) 384(^{d})</td>
</tr>
<tr>
<td>HBV DNA (%) (&lt; 400 copies/ml (&lt; 69 IU/ml)</td>
<td>76</td>
</tr>
<tr>
<td>ALT (%) Normalised ALT(^{d})</td>
<td>60</td>
</tr>
<tr>
<td>Serology (%)</td>
<td>26/ 34/ 38/ 37/ 30/ 24/ 33/ 36/ 38/ 40/ 35/</td>
</tr>
</tbody>
</table>

* Based upon Long Term Evaluation algorithm (LTE Analysis) - Patients who discontinued the study at any time prior to week 384 due to a protocol defined endpoint, as well as those completing week 384, are included in the denominator.

\(^{a}\) 48 weeks of double-blind tenofovir disoproxil fumarate followed by 48 weeks open-label.

\(^{b}\) 48 weeks of double-blind adefovir dipivoxil followed by 48 weeks open-label tenofovir disoproxil fumarate.

\(^{c}\) The population used for analysis of ALT normalisation included only patients with ALT above ULN at baseline.

\(^{d}\) 48 weeks of double-blind tenofovir disoproxil fumarate followed by 96 weeks open-label.

\(^{e}\) 48 weeks of double-blind adefovir dipivoxil followed by 96 weeks open-label tenofovir disoproxil fumarate.

\(^{f}\) Figures presented are cumulative percentages based upon a Kaplan Meier analysis including data collected after the addition of emtricitabine to open-label tenofovir disoproxil fumarate (KM-ITT).

\(^{g}\) 48 weeks of double-blind tenofovir disoproxil fumarate followed by 144 weeks open-label.

\(^{h}\) 48 weeks of double-blind adefovir dipivoxil followed by 144 weeks open-label tenofovir disoproxil fumarate.

\(^{i}\) 48 weeks of double-blind tenofovir disoproxil fumarate followed by 192 weeks open-label.

\(^{j}\) 48 weeks of double-blind adefovir dipivoxil followed by 192 weeks open-label tenofovir disoproxil fumarate.

\(^{k}\) Figures presented are cumulative percentages based upon a Kaplan Meier analysis excluding data collected after the addition of emtricitabine to open-label tenofovir disoproxil fumarate (KM-TDF).

\(^{l}\) 48 weeks of double-blind tenofovir disoproxil fumarate followed by 240 weeks open-label.

\(^{m}\) 48 weeks of double-blind adefovir dipivoxil followed by 240 weeks open-label tenofovir disoproxil fumarate.

\(^{n}\) 48 weeks of double-blind tenofovir disoproxil fumarate followed by 336 weeks open-label.

\(^{o}\) 48 weeks of double-blind adefovir dipivoxil followed by 336 weeks open-label tenofovir disoproxil fumarate.

Paired baseline and week 240 liver biopsy data were available for 331/489 patients who remained in studies GS-US-174-0102 and GS-US-174-0103 at week 240 (see Table 6 below). Ninety-five percent (225/237) of patients without cirrhosis at baseline and 99% (93/94) of patients with cirrhosis at baseline had either no change or an improvement in fibrosis (Ishak fibrosis score). Of the 94 patients with cirrhosis at baseline (Ishak fibrosis score: 5 - 6), 26% (24) experienced no change in Ishak fibrosis score and 72% (68) experienced regression of cirrhosis by week 240 with a reduction in Ishak fibrosis score of at least 2 points.

Table 6: Histological response (%) in compensated HBeAg negative and HBeAg positive subjects at week 240 compared to baseline

<table>
<thead>
<tr>
<th>Study 174-0102 (HBeAg negative)</th>
<th>Study 174-0103 (HBeAg positive)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tenofovir disoproxil 245 mg (as fumarate) n = 250(^{a})</strong></td>
<td><strong>Tenofovir disoproxil 245 mg (as fumarate) n = 176(^{b})</strong></td>
</tr>
<tr>
<td><strong>Histological response (%)</strong></td>
<td>88/ 85/ 90/ 92</td>
</tr>
</tbody>
</table>

* The population used for analysis of histology included only patients with available liver biopsy data (Missing = Excluded) by week 240. Response after addition of emtricitabine is excluded (total of 17 subjects across both studies).

\(^{a}\) Knodell necroinflammatory score improvement of at least 2 points.

\(^{b}\) Knodell necroinflammatory score improvement of at least 2 points.

\(^{c}\) 48 weeks double-blind tenofovir disoproxil fumarate followed by 192 weeks open-label.

\(^{d}\) 48 weeks double-blind adefovir dipivoxil followed by 192 weeks open-label tenofovir disoproxil fumarate.
Experience in patients with HIV co-infection and prior lamivudine experience

In a randomised, 48-week double-blind, controlled study of tenofovir disoproxil 245 mg (as fumarate) in adult patients co-infected with HIV-1 and chronic hepatitis B with prior lamivudine experience (study ACTG 5127), the mean serum HBV DNA levels at baseline in patients randomised to the tenofovir arm were 9.45 log_{10} copies/ml (n = 27). Treatment with tenofovir disoproxil 245 mg (as fumarate) was associated with a mean change in serum HBV DNA from baseline, in the patients for whom there was 48-week data, of -5.74 log_{10} copies/ml (n = 18). In addition, 61% of patients had normal ALT at week 48.

Experience in patients with persistent viral replication (study GS-US-174-0106)

The efficacy and safety of tenofovir disoproxil 245 mg (as fumarate) or tenofovir disoproxil 245 mg (as fumarate) plus 200 mg emtricitabine has been evaluated in a randomised, double-blind study (study GS-US-174-0106), in HBeAg positive and HBeAg negative adult patients who had persistent viraemia (HBV DNA ≥ 1,000 copies/ml) while receiving adefovir dipivoxil 10 mg for more than 24 weeks. At baseline, 57% of patients randomised to tenofovir disoproxil fumarate versus 60% of patients randomised to emtricitabine plus tenofovir disoproxil fumarate treatment group had previously been treated with lamivudine. Overall at week 24, treatment with tenofovir disoproxil fumarate resulted in 66% (35/53) of patients with HBV DNA < 400 copies/ml (< 69 IU/ml) versus 69% (36/52) of patients treated with emtricitabine plus tenofovir disoproxil fumarate (p = 0.672). In addition 55% (29/53) of patients treated with tenofovir disoproxil fumarate had undetectable HBV DNA (< 169 copies/ml [< 29 IU/ml]; the limit of quantification of the Roche Cobas TaqMan HBV assay) versus 60% (31/52) of patients treated with emtricitabine plus tenofovir disoproxil fumarate (p = 0.504). Comparisons between treatment groups beyond week 24 are difficult to interpret since investigators had the option to intensify treatment to open-label emtricitabine plus tenofovir disoproxil. Long-term studies to evaluate the benefit/risk of bitherapy with emtricitabine plus tenofovir disoproxil fumarate in HBV mono-infected patients are ongoing.

Experience in patients with decompensated liver disease at 48 weeks (study GS-US-174-0108)

Study GS-US-174-0108 is a randomised, double-blind, active controlled study evaluating the safety and efficacy of tenofovir disoproxil fumarate (n = 45), emtricitabine plus tenofovir disoproxil fumarate (n = 45), and entecavir (n = 22), in patients with decompensated liver disease. In the tenofovir disoproxil fumarate treatment arm, patients had a mean CPT score of 7.2, mean HBV DNA of 5.8 log_{10} copies/ml and mean serum ALT of 61 U/l at baseline. Forty-two percent (19/45) of patients had at least 6 months of prior lamivudine experience, 20% (9/45) of patients had prior adefovir dipivoxil experience and 9 of 45 patients (20%) had lamivudine and/or adefovir dipivoxil resistance mutations at baseline. The co-primary safety endpoints were discontinuation due to an adverse event and confirmed increase in serum creatinine ≥ 0.5 mg/dl or confirmed serum phosphate of < 2 mg/dl.

In patients with CPT scores ≤ 9, 74% (29/39) of tenofovir disoproxil fumarate, and 94% (33/35) of emtricitabine plus tenofovir disoproxil fumarate treatment groups achieved HBV DNA < 400 copies/ml after 48 weeks of treatment.

Overall, the data derived from this study are too limited to draw any definitive conclusions on the comparison of emtricitabine plus tenofovir disoproxil fumarate versus tenofovir disoproxil fumarate, (see Table 7 below).
Table 7: Safety and efficacy parameters in decompensated patients at week 48

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Tenofovir disoproxil 245 mg (as fumarate) (n = 45)</th>
<th>Emtricitabine 200 mg/tenofovir disoproxil 245 mg (as fumarate) (n = 45)</th>
<th>Entecavir (0.5 mg or 1 mg) n = 22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tolerability failure (permanent discontinuation of study drug due to a treatment emergent AE) n (%)</td>
<td>3 (7%)</td>
<td>2 (4%)</td>
<td>2 (9%)</td>
</tr>
<tr>
<td>Confirmed increase in serum creatinine ≥ 0.5 mg/dl from baseline or confirmed serum phosphate of &lt; 2 mg/dl n (%)</td>
<td>4 (9%)</td>
<td>3 (7%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>HBV DNA n (%) &lt; 400 copies/ml n (%)</td>
<td>31/44 (70%)</td>
<td>36/41 (88%)</td>
<td>16/22 (73%)</td>
</tr>
<tr>
<td>ALT n (%) Normal ALT</td>
<td>25/44 (57%)</td>
<td>31/41 (76%)</td>
<td>12/22 (55%)</td>
</tr>
<tr>
<td>≥ 2 point decrease in CPT from baseline n (%)</td>
<td>7/27 (26%)</td>
<td>12/25 (48%)</td>
<td>5/12 (42%)</td>
</tr>
<tr>
<td>Mean change from baseline in CPT score</td>
<td>-0.8</td>
<td>-0.9</td>
<td>-1.3</td>
</tr>
<tr>
<td>Mean change from baseline in MELD score</td>
<td>-1.8</td>
<td>-2.3</td>
<td>-2.6</td>
</tr>
</tbody>
</table>

*p-value comparing the combined tenofovir-containing arms versus the entecavir arm = 0.622.

*p-value comparing the combined tenofovir-containing arms versus the entecavir arm = 1.000.

Experience beyond 48 weeks in study GS-US-174-0108
Using a noncompleter/switch = failure analysis, 50% (21/42) of subjects receiving tenofovir disoproxil fumarate, 76% (28/37) of subjects receiving emtricitabine plus tenofovir disoproxil fumarate and 52% (11/21) of subjects receiving entecavir achieved HBV DNA < 400 copies/ml at week 168.

Experience in patients with lamivudine-resistant HBV at 240 weeks (study GS-US-174-0121)
The efficacy and safety of 245 mg tenofovir disoproxil (as fumarate) was evaluated in a randomised, double-blind study (GS-US-174-0121) in HBeAg positive and HBeAg negative patients (n = 280) with compensated liver disease, viraemia (HBV DNA ≥ 1,000 IU/ml), and genotypic evidence of lamivudine resistance (rtM204I/V +/− rtL180M). Only five had adefovir-associated resistance mutations at baseline. One hundred forty-one and 139 adult subjects were randomised to a tenofovir disoproxil fumarate and emtricitabine plus tenofovir disoproxil fumarate treatment arm, respectively. Baseline demographics were similar between the two treatment arms: At baseline, 52.5% of subjects were HBeAg negative, 47.5% were HBeAg positive, mean HBV DNA level was 6.5 log_{10} copies/ml, and mean ALT was 79 U/l, respectively.

After 240 weeks of treatment, 117 of 141 subjects (83%) randomised to tenofovir disoproxil fumarate had HBV DNA < 400 copies/ml, and 51 of 79 subjects (65%) had ALT normalisation. After 240 weeks of treatment with emtricitabine plus tenofovir disoproxil fumarate, 115 of 139 subjects (83%) had HBV DNA < 400 copies/ml, and 59 of 83 subjects (71%) had ALT normalisation. Among the HBeAg positive subjects randomised to tenofovir disoproxil fumarate, 16 of 65 subjects (25%) experienced HBeAg loss, and 8 of 65 subjects (12%) experienced anti-HBe seroconversion through week 240. In the HBeAg positive subjects randomised to emtricitabine plus tenofovir disoproxil fumarate, 13 of 68 subjects (19%) experienced HBeAg loss, and 7 of 68 subjects (10%) experienced
anti-HBe seroconversion through week 240. Two subjects randomised to tenofovir disoproxil fumarate experienced HBsAg loss by Week 240, but not seroconversion to anti-HBs. Five subjects randomised to emtricitabine plus tenofovir disoproxil fumarate experienced HBsAg loss, with 2 of these 5 subjects experiencing seroconversion to anti-HBs.

Clinical resistance
Four hundred and twenty-six HBeAg negative (GS-US-174-0102, n = 250) and HBeAg positive (GS-US-174-0103, n = 176) patients initially randomised to double-blind tenofovir disoproxil fumarate treatment and then switched to open-label tenofovir disoproxil fumarate treatment were evaluated for genotypic changes in HBV polymerase from baseline. Genotypic evaluations performed on all patients with HBV DNA > 400 copies/ml at week 48 (n = 39), 96 (n = 24), 144 (n = 6), 192 (n = 5), 240 (n = 4), 288 (n = 6) and 384 (n = 2) of tenofovir disoproxil fumarate monotherapy showed that no mutations associated with tenofovir disoproxil fumarate resistance have developed.

Two hundred and fifteen HBeAg negative (GS-US-174-0102, n = 125) and HBeAg positive (GS-US-174-0103, n = 90) patients initially randomised to double-blind adefovir dipivoxil treatment and then switched to open-label tenofovir disoproxil fumarate treatment were evaluated for genotypic changes in HBV polymerase from baseline. Genotypic evaluations performed on all patients with HBV DNA > 400 copies/ml at week 48 (n = 16), 96 (n = 5), 144 (n = 1), 192 (n = 2), 240 (n = 1), 288 (n = 1) and 384 (n = 2) of tenofovir disoproxil fumarate monotherapy showed that no mutations associated with tenofovir disoproxil fumarate resistance have developed.

In study GS-US-174-0108, 45 patients (including 9 patients with lamivudine and/or adefovir dipivoxil resistance mutations at baseline) received tenofovir disoproxil fumarate for up to 168 weeks. Genotypic data from paired baseline and on treatment HBV isolates were available for 6/8 patients with HBV DNA > 400 copies/ml at week 48. No amino acid substitutions associated with resistance to tenofovir disoproxil fumarate were identified in these isolates. Genotypic analysis was conducted for 5 subjects in the tenofovir disoproxil fumarate arm post week 48. No amino acid substitutions associated with tenofovir disoproxil fumarate resistance were detected in any subject.

In study GS-US-174-0121, 141 patients with lamivudine resistance substitutions at baseline received tenofovir disoproxil fumarate for up to 240 weeks. Cumulatively, there were 4 patients who experienced a viremic episode (HBV DNA > 400 copies/ml) at their last timepoint on TDF. Among them, sequence data from paired baseline and on treatment HBV isolates were available for 2 of 4 patients. No amino acid substitutions associated with resistance to tenofovir disoproxil fumarate were identified in these isolates.

In a paediatric study (GS-US-174-0115), 52 patients (including 6 patients with lamivudine resistance mutations at baseline) initially received blinded tenofovir disoproxil fumarate for up to 72 weeks and then 51/52 patients switched to open-label tenofovir disoproxil fumarate (TDF-TDF group). Genotypic evaluations were performed on all patients within this group with HBV DNA > 400 copies/ml at week 48 (n = 6), week 72 (n = 5), week 96 (n = 4), week 144 (n = 2), and week 192 (n = 3). Fifty-four patients (including 2 patients with lamivudine resistance mutations at baseline) initially received blinded placebo treatment for 72 weeks, and 52/54 patients followed with tenofovir disoproxil fumarate (PLB-TDF group). Genotypic evaluations were performed on all patients within this group with HBV DNA > 400 copies/ml at week 96 (n = 17), week 144 (n = 7), and week 192 (n = 8). No amino acid substitutions associated with resistance to tenofovir disoproxil fumarate were identified in these isolates.

Paediatric population
HIV-1: In study GS-US-104-0321, 87 HIV-1 infected treatment-experienced patients 12 to < 18 years of age were treated with tenofovir disoproxil fumarate (n = 45) or placebo (n = 42) in combination with an optimised background regimen (OBR) for 48 weeks. Due to limitations of the study, a benefit of tenofovir disoproxil fumarate over placebo was not demonstrated based on plasma HIV-1 RNA levels at week 24. However, a benefit is expected for the adolescent population based on extrapolation of adult data and comparative pharmacokinetic data (see section 5.2).
In patients who received treatment with tenofovir disoproxil fumarate or placebo, mean lumbar spine BMD Z-score was -1.004 and -0.809, and mean total body BMD Z-score was -0.866 and -0.584, respectively, at baseline. Mean changes at week 48 (end of double-blind phase) were -0.215 and -0.165 in lumbar spine BMD Z-score, and -0.254 and -0.179 in total body BMD Z-score for the tenofovir disoproxil fumarate and placebo groups, respectively. The mean rate of BMD gain was less in the tenofovir disoproxil fumarate group compared to the placebo group. At week 48, six adolescents in the tenofovir disoproxil fumarate group and one adolescent in the placebo group had significant lumbar spine BMD loss (defined as > 4% loss). Among 28 patients receiving 96 weeks of treatment with tenofovir disoproxil fumarate, BMD Z-scores declined by -0.341 for lumbar spine and -0.458 for total body.

In study GS-US-104-0352, 97 treatment-experienced patients 2 to < 12 years of age with stable, virologic suppression on stavudine- or zidovudine-containing regimens were randomised to either replace stavudine or zidovudine with tenofovir disoproxil fumarate (n = 48) or continue on their original regimen (n = 49) for 48 weeks. At week 48, 83% of patients in the tenofovir disoproxil fumarate treatment group and 92% of patients in the stavudine or zidovudine treatment group had HIV-1 RNA concentrations < 400 copies/ml. The difference in the proportion of patients who maintained < 400 copies/ml at week 48 was mainly influenced by the higher number of discontinuations in the tenofovir disoproxil fumarate treatment group. When missing data were excluded, 91% of patients in the tenofovir disoproxil fumarate treatment group and 94% of patients in the stavudine or zidovudine treatment group had HIV-1 RNA concentrations < 400 copies/ml at week 48.

Reductions in BMD have been reported in paediatric patients. In patients who received treatment with tenofovir disoproxil fumarate, or stavudine or zidovudine, mean lumbar spine BMD Z-score was -1.034 and -0.498, and mean total body BMD Z-score was -0.471 and -0.386, respectively, at baseline. Mean changes at week 48 (end of randomised phase) were 0.032 and 0.087 in lumbar spine BMD Z-score, and -0.184 and -0.027 in total body BMD Z-score for the tenofovir disoproxil fumarate and stavudine or zidovudine groups, respectively. The mean rate of lumbar spine bone gain at week 48 was similar between the tenofovir disoproxil fumarate treatment group and the stavudine or zidovudine treatment group. Total body bone gain was less in the tenofovir disoproxil fumarate treatment group compared to the stavudine or zidovudine treatment group. One tenofovir disoproxil fumarate treated subject and no stavudine or zidovudine treated subjects experienced significant (> 4%) lumbar spine BMD loss at week 48. BMD Z-scores declined by -0.012 for lumbar spine and by -0.338 for total body in the 64 subjects who were treated with tenofovir disoproxil fumarate for 96 weeks. BMD Z-scores were not adjusted for height and weight.

In study GS-US-104-0352, 4 out of 89 paediatric patients exposed to tenofovir disoproxil fumarate discontinued due to adverse reactions consistent with proximal renal tubulopathy (median tenofovir disoproxil fumarate exposure 104 weeks).

Chronic hepatitis B: In study GS-US-174-0115, 106 HBeAg negative and HBeAg positive patients aged 12 to < 18 years with chronic HBV infection [HBV DNA ≥ 10^5 copies/ml, elevated serum ALT (≥ 2 x ULN) or a history of elevated serum ALT levels in the past 24 months] were treated with tenofovir disoproxil 245 mg (as fumarate) (n = 52) or placebo (n = 54) for 72 weeks. Subjects must have been naïve to tenofovir disoproxil fumarate, but could have received interferon based regimens (> 6 months prior to screening) or any other non-tenofovir disoproxil fumarate containing oral anti-HBV nucleoside/nucleotide therapy (> 16 weeks prior to screening). At week 72, overall 88% (46/52) of patients in the tenofovir disoproxil fumarate treatment group and 0% (0/54) of patients in the placebo group had HBV DNA < 400 copies/ml. Seventy-four percent (26/35) of patients in the tenofovir disoproxil fumarate group had normalised ALT at week 72 compared to 31% (13/42) in the placebo group. Response to treatment with tenofovir disoproxil fumarate was comparable in nucleos(t)ide-naïve (n = 20) and nucleos(t)ide-experienced (n = 32) patients, including lamivudine-resistant patients (n = 6). Ninety-five percent of nucleos(t)ide-naïve patients, 84% of nucleos(t)ide-experienced patients, and 83% of lamivudine-resistant patients achieved HBV DNA < 400 copies/ml at week 72. Thirty-one of the 32 nucleos(t)ide-experienced patients had prior lamivudine experience. At week 72, 96% (27/28) of immune-active patients (HBV DNA ≥ 10^5 copies/ml, serum ALT
> 1.5 x ULN) in the tenofovir disoproxil fumarate treatment group and 0% (0/32) of patients in the placebo group had HBV DNA < 400 copies/ml. Seventy-five percent (21/28) of immune-active patients in the tenofovir disoproxil fumarate group had normal ALT at week 72 compared to 34% (11/32) in the placebo group.

After 72 weeks of blinded randomized treatment, each subject could switch to open-label tenofovir disoproxil fumarate treatment up to week 192. After week 72, virologic suppression was maintained for those receiving double-blind tenofovir disoproxil fumarate followed by open-label tenofovir disoproxil fumarate (TDF-TDF group): 86.5% (45/52) of subjects in the TDF-TDF group had HBV DNA < 400 copies/ml at week 192. Among the subjects who received placebo during the double-blind period, the proportion of subjects with HBV DNA < 400 copies/mL rose sharply after they began treatment with open-label TDF (PLB-TDF group): 74.1% (40/54) of subjects in the PLB-TDF group had HBV DNA < 400 copies/ml at week 192. The proportion of subjects with ALT normalization at week 192 in the TDF-TDF group was 75.8% (25/33) among those who were HBeAg positive at baseline and 100.0% (2 of 2 subjects) among those who were HBeAg negative at baseline. Similar percentages of subjects in the TDF-TDF and PLB-TDF groups (37.5% and 41.7%, respectively) experienced seroconversion to anti-HBe through week 192.

Bone Mineral Density (BMD) data from Study GS-US-174-0115 are summarized in Table 8:

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Week 72</th>
<th>Week 192</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>TDF-TDF</td>
<td>PLB-TDF</td>
<td>TDF-TDF</td>
</tr>
<tr>
<td>Lumbar spine mean (SD) BMD Z-score(^a)</td>
<td>-0.42 (0.762)</td>
<td>-0.26 (0.806)</td>
<td>-0.49 (0.852)</td>
</tr>
<tr>
<td>Lumbar spine mean (SD) change from baseline BMD Z-score(^a)</td>
<td>NA</td>
<td>NA</td>
<td>-0.06 (0.320)</td>
</tr>
<tr>
<td>Whole body mean (SD) BMD Z-score(^a)</td>
<td>-0.19 (1.110)</td>
<td>-0.23 (0.859)</td>
<td>-0.36 (1.077)</td>
</tr>
<tr>
<td>Whole body mean (SD) change from baseline BMD Z-score(^a)</td>
<td>NA</td>
<td>NA</td>
<td>-0.16 (0.355)</td>
</tr>
<tr>
<td>Lumbar spine BMD at least 6% decrease(^b)</td>
<td>NA</td>
<td>NA</td>
<td>1.9% (1 subject)</td>
</tr>
<tr>
<td>Whole body BMD at least 6% decrease(^b)</td>
<td>NA</td>
<td>NA</td>
<td>0%</td>
</tr>
<tr>
<td>Lumbar spine BMD mean % increase</td>
<td>NA</td>
<td>NA</td>
<td>5.14%</td>
</tr>
<tr>
<td>Whole body BMD mean % increase</td>
<td>NA</td>
<td>NA</td>
<td>3.07%</td>
</tr>
</tbody>
</table>

\(^a\) BMD Z-scores not adjusted for height and weight
\(^b\) Primary safety endpoint through week 72

The European Medicines Agency has deferred the obligation to submit the results of studies with Viread in one or more subsets of the paediatric population in HIV and chronic hepatitis B (see section 4.2 for information on paediatric use).

5.2 Pharmacokinetic properties

Tenofovir disoproxil fumarate is a water soluble ester prodrug which is rapidly converted \textit{in vivo} to tenofovir and formaldehyde.
Tenofovir is converted intracellularly to tenofovir monophosphate and to the active component, tenofovir diphosphate.

Absorption
Following oral administration of tenofovir disoproxil fumarate to HIV infected patients, tenofovir disoproxil fumarate is rapidly absorbed and converted to tenofovir. Administration of multiple doses of tenofovir disoproxil fumarate with a meal to HIV infected patients resulted in mean (\%CV) tenofovir C_{\text{max}}, \text{AUC}, and C_{\text{min}} values of 326 (36.6\%) ng/ml, 3,324 (41.2\%) ng·h/ml and 64.4 (39.4\%) ng/ml, respectively. Maximum tenofovir concentrations are observed in serum within one hour of dosing in the fasted state and within two hours when taken with food. The oral bioavailability of tenofovir from tenofovir disoproxil fumarate in fasted patients was approximately 25\%. Administration of tenofovir disoproxil fumarate with a high fat meal enhanced the oral bioavailability, with an increase in tenofovir \text{AUC} by approximately 40\% and \text{C}_{\text{max}} by approximately 14\%. Following the first dose of tenofovir disoproxil fumarate in fed patients, the median \text{C}_{\text{max}} in serum ranged from 213 to 375 ng/ml. However, administration of tenofovir disoproxil fumarate with a light meal did not have a significant effect on the pharmacokinetics of tenofovir.

Distribution
Following intravenous administration the steady-state volume of distribution of tenofovir was estimated to be approximately 800 ml/kg. After oral administration of tenofovir disoproxil fumarate, tenofovir is distributed to most tissues with the highest concentrations occurring in the kidney, liver and the intestinal contents (preclinical studies). In vitro protein binding of tenofovir to plasma or serum protein was less than 0.7 and 7.2\%, respectively, over the tenofovir concentration range 0.01 to 25 \text{µg/ml}.

Biotransformation
In vitro studies have determined that neither tenofovir disoproxil fumarate nor tenofovir are substrates for the CYP450 enzymes. Moreover, at concentrations substantially higher (approximately 300-fold) than those observed in vivo, tenofovir did not inhibit in vitro drug metabolism mediated by any of the major human CYP450 isoforms involved in drug biotransformation (CYP3A4, CYP2D6, CYP2C9, CYP2E1, or CYP1A1/2). Tenofovir disoproxil fumarate at a concentration of 100 \text{µmol/l} had no effect on any of the CYP450 isoforms, except CYP1A1/2, where a small (6\%) but statistically significant reduction in metabolism of CYP1A1/2 substrate was observed. Based on these data, it is unlikely that clinically significant interactions involving tenofovir disoproxil fumarate and medicinal products metabolised by CYP450 would occur.

Elimination
Tenofovir is primarily excreted by the kidney by both filtration and an active tubular transport system with approximately 70-80\% of the dose excreted unchanged in urine following intravenous administration. Total clearance has been estimated to be approximately 230 ml/h/kg (approximately 300 ml/min). Renal clearance has been estimated to be approximately 160 ml/h/kg (approximately 210 ml/min), which is in excess of the glomerular filtration rate. This indicates that active tubular secretion is an important part of the elimination of tenofovir. Following oral administration the terminal half-life of tenofovir is approximately 12 to 18 hours.

Studies have established the pathway of active tubular secretion of tenofovir to be influx into proximal tubule cell by the human organic anion transporters (hOAT) 1 and 3 and efflux into the urine by the multidrug resistant protein 4 (MRP 4).

Linearity/non-linearity
The pharmacokinetics of tenofovir were independent of tenofovir disoproxil fumarate dose over the dose range 75 to 600 mg and were not affected by repeated dosing at any dose level.

Age
Pharmacokinetic studies have not been performed in the elderly (over 65 years of age).
Gender
Limited data on the pharmacokinetics of tenofovir in women indicate no major gender effect.

Ethnicity
Pharmacokinetics have not been specifically studied in different ethnic groups.

Paediatric population
HIV-1: Steady-state pharmacokinetics of tenofovir were evaluated in 8 HIV-1 infected adolescent patients (aged 12 to < 18 years) with body weight ≥ 35 kg. Mean (± SD) $C_{\text{max}}$ and AUC$_{\text{tau}}$ are 0.38 ± 0.13 μg/ml and 3.39 ± 1.22 μg·h/ml, respectively. Tenofovir exposure achieved in adolescent patients receiving oral daily doses of tenofovir disoproxil 245 mg (as fumarate) was similar to exposures achieved in adults receiving once-daily doses of tenofovir disoproxil 245 mg (as fumarate).

Chronic hepatitis B: Steady-state tenofovir exposure in HBV infected adolescent patients (12 to < 18 years of age) receiving an oral daily dose of tenofovir disoproxil 245 mg (as fumarate) was similar to exposures achieved in adults receiving once-daily doses of tenofovir disoproxil 245 mg (as fumarate).

Pharmacokinetic studies have not been performed with tenofovir disoproxil (as fumarate) 245 mg tablets in children under 12 years or with renal impairment.

Renal impairment
Pharmacokinetic parameters of tenofovir were determined following administration of a single dose of tenofovir disoproxil 245 mg to 40 non-HIV, non-HBV infected adult patients with varying degrees of renal impairment defined according to baseline creatinine clearance (CrCl) (normal renal function when CrCl > 80 ml/min; mild with CrCl = 50-79 ml/min; moderate with CrCl = 30-49 ml/min and severe with CrCl = 10-29 ml/min). Compared with patients with normal renal function, the mean (%CV) tenofovir exposure increased from 2,185 (12%) ng·h/ml in subjects with CrCl > 80 ml/min to respectively 3,064 (30%) ng·h/ml, 6,009 (42%) ng·h/ml and 15,985 (45%) ng·h/ml in patients with mild, moderate and severe renal impairment. The dosing recommendations in patients with renal impairment, with increased dosing interval, are expected to result in higher peak plasma concentrations and lower $C_{\text{min}}$ levels in patients with renal impairment compared with patients with normal renal function. The clinical implications of this are unknown.

In patients with end-stage renal disease (ESRD) (CrCl < 10 ml/min) requiring haemodialysis, between dialysis tenofovir concentrations substantially increased over 48 hours achieving a mean $C_{\text{max}}$ of 1,032 ng/ml and a mean AUC$_{0-48h}$ of 42,857 ng·h/ml.

It is recommended that the dosing interval for tenofovir disoproxil 245 mg (as fumarate) is modified in adult patients with creatinine clearance < 50 ml/min or in patients who already have ESRD and require dialysis (see section 4.2).

The pharmacokinetics of tenofovir in non-haemodialysis patients with creatinine clearance < 10 ml/min and in patients with ESRD managed by peritoneal or other forms of dialysis have not been studied.

The pharmacokinetics of tenofovir in paediatric patients with renal impairment have not been studied. No data are available to make dose recommendations (see sections 4.2 and 4.4).

Hepatic impairment
A single 245 mg dose of tenofovir disoproxil was administered to non-HIV, non-HBV infected adult patients with varying degrees of hepatic impairment defined according to Child-Pugh-Turcotte (CPT) classification. Tenofovir pharmacokinetics were not substantially altered in subjects with hepatic impairment suggesting that no dose adjustment is required in these subjects. The mean (%CV) tenofovir $C_{\text{max}}$ and AUC$_{0-\infty}$ values were 223 (34.8%) ng/ml and 2,050 (50.8%) ng·h/ml, respectively, in normal subjects compared with 289 (46.0%) ng/ml and 2,310 (43.5%) ng·h/ml in subjects with
moderate hepatic impairment, and 305 (24.8%) ng/ml and 2,740 (44.0%) ng·h/ml in subjects with severe hepatic impairment.

**Intracellular pharmacokinetics**
In non-proliferating human peripheral blood mononuclear cells (PBMCs) the half-life of tenofovir diphosphate was found to be approximately 50 hours, whereas the half-life in phytohaemagglutinin-stimulated PBMCs was found to be approximately 10 hours.

### 5.3 Preclinical safety data

Non-clinical safety pharmacology studies reveal no special hazard for humans. Findings in repeated dose toxicity studies in rats, dogs and monkeys at exposure levels greater than or equal to clinical exposure levels and with possible relevance to clinical use include renal and bone toxicity and a decrease in serum phosphate concentration. Bone toxicity was diagnosed as osteomalacia (monkeys) and reduced bone mineral density (BMD) (rats and dogs). The bone toxicity in young adult rats and dogs occurred at exposures ≥ 5-fold the exposure in paediatric or adult patients; bone toxicity occurred in juvenile infected monkeys at very high exposures following subcutaneous dosing (≥ 40-fold the exposure in patients). Findings in the rat and monkey studies indicated that there was a substance-related decrease in intestinal absorption of phosphate with potential secondary reduction in BMD.

Genotoxicity studies revealed positive results in the in vitro mouse lymphoma assay, equivocal results in one of the strains used in the Ames test, and weakly positive results in an UDS test in primary rat hepatocytes. However, it was negative in an in vivo mouse bone marrow micronucleus assay.

Oral carcinogenicity studies in rats and mice only revealed a low incidence of duodenal tumours at an extremely high dose in mice. These tumours are unlikely to be of relevance to humans.

Reproductive studies in rats and rabbits showed no effects on mating, fertility, pregnancy or foetal parameters. However, tenofovir disoproxil fumarate reduced the viability index and weight of pups in peri-postnatal toxicity studies at maternally toxic doses.

The active substance tenofovir disoproxil fumarate and its main transformation products are persistent in the environment.

### 6. PHARMACEUTICAL PARTICULARS

#### 6.1 List of excipients

**Tablet core**
- Croscarmellose sodium
- Lactose monohydrate
- Magnesium stearate (E572)
- Microcrystalline cellulose (E460)
- Starch pregelatinised

**Film-coating**
- Glycerol triacetate (E1518)
- Hypromellose (E464)
- Indigo carmine aluminium lake (E132)
- Lactose monohydrate
- Titanium dioxide (E171)

#### 6.2 Incompatibilities

Not applicable.
6.3 Shelf life

5 years.

6.4 Special precautions for storage

This medicinal product does not require any special storage conditions.

6.5 Nature and contents of container

High density polyethylene (HDPE) bottle with a polypropylene child-resistant closure containing 30 film-coated tablets and a silica gel desiccant.

The following pack sizes are available: outer cartons containing 1 bottle of 30 film-coated tablets and outer cartons containing 90 (3 bottles of 30) film-coated tablets. Not all pack sizes may be marketed.

6.6 Special precautions for disposal

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

7. MARKETING AUTHORITY

Gilead Sciences International Limited
Cambridge
CB21 6GT
United Kingdom

8. MARKETING AUTHORITY NUMBER(S)

EU/1/01/200/001
EU/1/01/200/002

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORITY

Date of first authorisation: 5 February 2002
Date of latest renewal: 14 December 2011

10. DATE OF REVISION OF THE TEXT

Detailed information on this medicinal product is available on the website of the European Medicines Agency http://www.ema.europa.eu
1. **NAME OF THE MEDICINAL PRODUCT**

Viread 33 mg/g granules

2. **QUALITATIVE AND QUANTITATIVE COMPOSITION**

Each scoop delivers one gram of granules which contains 33 mg of tenofovir disoproxil (as fumarate).

**Excipient with known effect**

One gram of granules contains 622 mg mannitol.

For the full list of excipients, see section 6.1.

3. **PHARMACEUTICAL FORM**

Granules.

White, taste masked, coated granules.

4. **CLINICAL PARTICULARS**

4.1 **Therapeutic indications**

**HIV-1 infection**

Viread 33 mg/g granules are indicated in combination with other antiretroviral medicinal products for the treatment of HIV-1 infected paediatric patients, with NRTI resistance or toxicities precluding the use of first line agents, from 2 to < 6 years of age, and above 6 years of age for whom a solid dosage form is not appropriate.

Viread 33 mg/g granules are also indicated in combination with other antiretroviral medicinal products for the treatment of HIV-1 infected adults for whom a solid dosage form is not appropriate.

In adults, the demonstration of the benefit of Viread in HIV-1 infection is based on results of one study in treatment-naïve patients, including patients with a high viral load (> 100,000 copies/ml) and studies in which Viread was added to stable background therapy (mainly tritherapy) in antiretroviral pre-treated patients experiencing early virological failure (< 10,000 copies/ml, with the majority of patients having < 5,000 copies/ml).

The choice of Viread to treat antiretroviral-experienced patients with HIV-1 infection should be based on individual viral resistance testing and/or treatment history of patients.

**Hepatitis B infection**

Viread 33 mg/g granules are indicated for the treatment of chronic hepatitis B in adults for whom a solid dosage form is not appropriate with:

- compensated liver disease, with evidence of active viral replication, persistently elevated serum alanine aminotransferase (ALT) levels and histological evidence of active inflammation and/or fibrosis (see section 5.1).
- evidence of lamivudine-resistant hepatitis B virus (see sections 4.8 and 5.1).
- decompensated liver disease (see sections 4.4, 4.8 and 5.1).
Viread 33 mg/g granules are also indicated for the treatment of chronic hepatitis B in adolescents 12 to < 18 years of age for whom a solid dosage form is not appropriate with:

- compensated liver disease and evidence of immune active disease, i.e. active viral replication, persistently elevated serum ALT levels and histological evidence of active inflammation and/or fibrosis (see sections 4.4, 4.8 and 5.1).

### 4.2 Posology and method of administration

Therapy should be initiated by a physician experienced in the management of HIV infection and/or treatment of chronic hepatitis B.

**Posology**

**HIV-1:** The recommended dose is 6.5 mg of tenofovir disoproxil (as fumarate) per kilogram of body weight once daily taken with food. Refer to Table 1.

Limited clinical data are available at the 6.5 mg/kg dose of the granules. Therefore, close monitoring of efficacy and safety is needed.

**Table 1: Dosing for paediatric patients aged 2 to < 12 years**

<table>
<thead>
<tr>
<th>Body weight (kg)</th>
<th>Once daily Scoops of granules</th>
<th>Total dose (mg) tenofovir disoproxil (as fumarate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 to &lt; 12</td>
<td>2</td>
<td>65</td>
</tr>
<tr>
<td>12 to &lt; 14</td>
<td>2.5</td>
<td>82</td>
</tr>
<tr>
<td>14 to &lt; 17</td>
<td>3</td>
<td>98</td>
</tr>
<tr>
<td>17 to &lt; 19</td>
<td>3.5</td>
<td>114</td>
</tr>
<tr>
<td>19 to &lt; 22</td>
<td>4</td>
<td>131</td>
</tr>
<tr>
<td>22 to &lt; 24</td>
<td>4.5</td>
<td>147</td>
</tr>
<tr>
<td>24 to &lt; 27</td>
<td>5</td>
<td>163</td>
</tr>
<tr>
<td>27 to &lt; 29</td>
<td>5.5</td>
<td>180</td>
</tr>
<tr>
<td>29 to &lt; 32</td>
<td>6</td>
<td>196</td>
</tr>
<tr>
<td>32 to &lt; 34</td>
<td>6.5</td>
<td>212</td>
</tr>
<tr>
<td>34 to &lt; 35</td>
<td>7</td>
<td>229</td>
</tr>
<tr>
<td>≥ 35</td>
<td>7.5</td>
<td>245</td>
</tr>
</tbody>
</table>

Viread is also available as 123 mg, 163 mg, 204 mg film-coated tablets for use in HIV-1 infected paediatric patients aged 6 to < 12 years who weigh ≥ 17 and < 35 kg for whom a solid dosage form is appropriate. Please refer to the Summaries of Product Characteristics for these medicinal products.

Viread is also available as 245 mg film-coated tablets for the treatment of HIV-1 infection and chronic hepatitis B in adolescents aged 12 to < 18 years who weigh ≥ 35 kg.

**Adults and adolescents aged 12 to < 18 years and weighing ≥ 35 kg:** The recommended dose of Viread for the treatment of HIV or for the treatment of chronic hepatitis B is 245 mg, equivalent to 7.5 scoops of granules, once daily taken orally with food.

Viread is also available as 245 mg film-coated tablets for the treatment of HIV-1 infection and chronic hepatitis B in adults.

**Chronic hepatitis B:** The optimal duration of treatment is unknown. Treatment discontinuation may be considered as follows:

- In HBeAg positive patients without cirrhosis, treatment should be administered for at least 6-12 months after HBe seroconversion (HBeAg loss and HBV DNA loss with anti-HBe detection) is confirmed or until HBs seroconversion or there is loss of efficacy
Serum ALT and HBV DNA levels should be followed regularly after treatment discontinuation to detect any late virological relapse.

- In HBeAg negative patients without cirrhosis, treatment should be administered at least until HBs seroconversion or there is evidence of loss of efficacy. With prolonged treatment for more than 2 years, regular reassessment is recommended to confirm that continuing the selected therapy remains appropriate for the patient.

**Missed dose**

If a patient misses a dose of Viread within 12 hours of the time it is usually taken, the patient should take Viread with food as soon as possible and resume their normal dosing schedule. If a patient misses a dose of Viread by more than 12 hours and it is almost time for their next dose, the patient should not take the missed dose and simply resume the usual dosing schedule.

If the patient vomits within 1 hour of taking Viread, another dose should be taken. If the patient vomits more than 1 hour after taking Viread they do not need to take another dose.

**Special populations**

**Elderly**

No data are available on which to make a dose recommendation for patients over the age of 65 years (see section 4.4).

**Renal impairment**

Tenofovir is eliminated by renal excretion and the exposure to tenofovir increases in patients with renal dysfunction.

**Adults**

There are limited data on the safety and efficacy of tenofovir disoproxil fumarate in adult patients with moderate and severe renal impairment (creatinine clearance < 50 ml/min) and long-term safety data has not been evaluated for mild renal impairment (creatinine clearance 50-80 ml/min). Therefore, in adult patients with renal impairment tenofovir disoproxil fumarate should only be used if the potential benefits of treatment are considered to outweigh the potential risks. Dose adjustments using tenofovir disoproxil (as fumarate) 33 mg/g granules are recommended for patients with creatinine clearance < 50 ml/min.

**Mild renal impairment (creatinine clearance 50-80 ml/min)**

Limited data from clinical studies support once daily dosing of 245 mg tenofovir disoproxil (as fumarate), equivalent to 7.5 scoops of granules, in patients with mild renal impairment.

Adjustments of the daily dose of tenofovir disoproxil (as fumarate) 33 mg/g granules are recommended in patients with moderate (creatinine clearance 30-49 ml/min) or severe (creatinine clearance < 30 ml/min) renal impairment based on modelling of single-dose pharmacokinetic data in HIV negative and non-HBV infected subjects with varying degrees of renal impairment, including end-stage renal disease requiring haemodialysis. These pharmacokinetic modelling data have not been confirmed in clinical studies. Therefore, clinical response to treatment and renal function should be closely monitored in these patients (see sections 4.4 and 5.2).

**Moderate renal impairment (creatinine clearance 30-49 ml/min)**

Administration of 132 mg (4 scoops) tenofovir disoproxil (as fumarate) 33 mg/g granules once daily is recommended.

**Severe renal impairment (creatinine clearance < 30 ml/min) and haemodialysis patients**

For patients with creatinine clearance 20-29 ml/min: Administration of 65 mg (2 scoops) tenofovir disoproxil (as fumarate) 33 mg/g granules once daily is recommended.

For patients with creatinine clearance 10-19 ml/min: Administration of 33 mg (1 scoop) tenofovir disoproxil (as fumarate) 33 mg/g granules once daily is recommended.
Haemodialysis patients: 16.5 mg (0.5 scoop) tenofovir disoproxil (as fumarate) 33 mg/g granules may be administered following completion of each 4-hour haemodialysis session.

These dose adjustments have not been confirmed in clinical studies. Therefore, clinical response to treatment and renal function should be closely monitored (see sections 4.4 and 5.2).

No dosing recommendations can be given for non-haemodialysis patients with creatinine clearance < 10 ml/min.

Paediatric patients
The use of tenofovir disoproxil fumarate is not recommended in paediatric patients with renal impairment (see section 4.4).

Hepatic impairment
No dose adjustment is required in patients with hepatic impairment (see sections 4.4 and 5.2).

If Viread is discontinued in patients with chronic hepatitis B with or without HIV co-infection, these patients should be closely monitored for evidence of exacerbation of hepatitis (see section 4.4).

Paediatric population
The safety and efficacy of tenofovir disoproxil fumarate in HIV-1 infected children under 2 years of age have not been established. No data are available.

The safety and efficacy of tenofovir disoproxil fumarate in children with chronic hepatitis B aged 2 to < 12 years or weighing < 35 kg have not been established. No data are available.

Method of administration
Viread granules should be measured with the supplied dosing scoop. One level scoop delivers 1 g of granules which contains 33 mg of tenofovir disoproxil (as fumarate). Viread granules should be mixed in a container with soft food not requiring chewing, for example yoghurt, applesauce or baby food. One tablespoon (15 ml) of soft food per one level scoop of granules is required. The entire mixture should be ingested immediately. Viread granules must not be mixed with liquids.

Viread should be taken once daily, orally with food.

4.3 Contraindications
Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.

4.4 Special warnings and precautions for use

General
HIV antibody testing should be offered to all HBV infected patients before initiating tenofovir disoproxil fumarate therapy (see below Co-infection with HIV-1 and hepatitis B).

HIV-1
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.

Chronic hepatitis B
Patients must be advised that tenofovir disoproxil fumarate has not been proven to prevent the risk of transmission of HBV to others through sexual contact or contamination with blood. Appropriate precautions must continue to be used.
Co-administration of other medicinal products
- Viread should not be administered concomitantly with other medicinal products containing tenofovir disoproxil fumarate or tenofovir alafenamide.
- Viread should not be administered concomitantly with adefovir dipivoxil.
- Co-administration of tenofovir disoproxil fumarate and didanosine is not recommended. Co-administration of tenofovir disoproxil fumarate and didanosine results in a 40-60% increase in systemic exposure to didanosine that may increase the risk of didanosine-related adverse reactions (see section 4.5). Rarely, pancreatitis and lactic acidosis, sometimes fatal, have been reported. Co-administration of tenofovir disoproxil fumarate and didanosine at a dose of 400 mg daily has been associated with a significant decrease in CD4 cell count, possibly due to an intracellular interaction increasing phosphorylated (i.e. active) didanosine. A decreased dosage of 250 mg didanosine co-administered with tenofovir disoproxil fumarate therapy has been associated with reports of high rates of virological failure within several tested combinations for the treatment of HIV-1 infection.

Triple therapy with nucleosides/nucleotides
There have been reports of a high rate of virological failure and of emergence of resistance at an early stage in HIV patients when tenofovir disoproxil fumarate was combined with lamivudine and abacavir as well as with lamivudine and didanosine as a once-daily regimen.

Renal and bone effects in adult population
**Renal effects**
Tenofovir is principally eliminated via the kidney. Renal failure, renal impairment, elevated creatinine, hypophosphataemia and proximal tubulopathy (including Fanconi syndrome) have been reported with the use of tenofovir disoproxil fumarate in clinical practice (see section 4.8).

**Renal monitoring**
It is recommended that creatinine clearance is calculated in all patients prior to initiating therapy with tenofovir disoproxil fumarate and renal function (creatinine clearance and serum phosphate) is also monitored after two to four weeks of treatment, after three months of treatment and every three to six months thereafter in patients without renal risk factors. In patients at risk for renal impairment, a more frequent monitoring of renal function is required.

**Renal management**
If serum phosphate is < 1.5 mg/dl (0.48 mmol/l) or creatinine clearance is decreased to < 50 ml/min in any adult patient receiving tenofovir disoproxil fumarate, renal function should be re-evaluated within one week, including measurements of blood glucose, blood potassium and urine glucose concentrations (see section 4.8, proximal tubulopathy). Consideration should also be given to interrupting treatment with tenofovir disoproxil fumarate in adult patients with creatinine clearance decreased to < 50 ml/min or decreases in serum phosphate to < 1.0 mg/dl (0.32 mmol/l). Interrupting treatment with tenofovir disoproxil fumarate should also be considered in case of progressive decline of renal function when no other cause has been identified.

**Co-administration and risk of renal toxicity**
Use of tenofovir disoproxil fumarate should be avoided with concurrent or recent use of a nephrotoxic medicinal product (e.g. aminoglycosides, amphotericin B, foscarnet, ganciclovir, pentamidine, vancomycin, cidofovir or interleukin-2). If concomitant use of tenofovir disoproxil fumarate and nephrotoxic agents is unavoidable, renal function should be monitored weekly.

Cases of acute renal failure after initiation of high dose or multiple non-steroidal anti-inflammatory drugs (NSAIDs) have been reported in patients treated with tenofovir disoproxil fumarate and with risk factors for renal dysfunction. If tenofovir disoproxil fumarate is co-administered with an NSAID, renal function should be monitored adequately.
A higher risk of renal impairment has been reported in patients receiving tenofovir disoproxil fumarate in combination with a ritonavir or cobicistat boosted protease inhibitor. A close monitoring of renal function is required in these patients (see section 4.5). In patients with renal risk factors, the co-administration of tenofovir disoproxil fumarate with a boosted protease inhibitor should be carefully evaluated.

Tenofovir disoproxil fumarate has not been clinically evaluated in patients receiving medicinal products which are secreted by the same renal pathway, including the transport proteins human organic anion transporter (hOAT) 1 and 3 or MRP 4 (e.g. cidofovir, a known nephrotoxic medicinal product). These renal transport proteins may be responsible for tubular secretion and in part, renal elimination of tenofovir and cidofovir. Consequently, the pharmacokinetics of these medicinal products, which are secreted by the same renal pathway including transport proteins hOAT 1 and 3 or MRP 4, might be modified if they are co-administered. Unless clearly necessary, concomitant use of these medicinal products which are secreted by the same renal pathway is not recommended, but if such use is unavoidable, renal function should be monitored weekly (see section 4.5).

Renal impairment
Renal safety with tenofovir disoproxil fumarate has only been studied to a very limited degree in adult patients with impaired renal function (creatinine clearance < 80 ml/min).

Adult patients with creatinine clearance < 50 ml/min, including haemodialysis patients
There are limited data on the safety and efficacy of tenofovir disoproxil fumarate in patients with impaired renal function. Therefore, tenofovir disoproxil fumarate should only be used if the potential benefits of treatment are considered to outweigh the potential risks. In patients with moderate or severe renal impairment (creatinine clearance < 50 ml/min) the daily dose must be adjusted and renal function should be closely monitored (see sections 4.2 and 5.2).

Bone effects
In HIV infected patients, in a 144-week controlled clinical study that compared tenofovir disoproxil fumarate with stavudine in combination with lamivudine and efavirenz in antiretroviral-naïve adult patients, small decreases in bone mineral density (BMD) of the hip and spine were observed in both treatment groups. Decreases in BMD of spine and changes in bone biomarkers from baseline were significantly greater in the tenofovir disoproxil fumarate treatment group at 144 weeks. Decreases in BMD of hip were significantly greater in this group until 96 weeks. However, there was no increased risk of fractures or evidence for clinically relevant bone abnormalities over 144 weeks.

In other studies (prospective and cross-sectional), the most pronounced decreases in BMD were seen in patients treated with tenofovir disoproxil fumarate as part of a regimen containing a boosted protease inhibitor. Alternative treatment regimens should be considered for patients with osteoporosis that are at a high risk for fractures.

Bone abnormalities (infrequently contributing to fractures) may be associated with proximal renal tubulopathy (see section 4.8).

If bone abnormalities are suspected or detected then appropriate consultation should be obtained.

Renal and bone effects in paediatric population
There are uncertainties associated with the long term effects of bone and renal toxicity. Moreover, the reversibility of renal toxicity cannot be fully ascertained. Therefore, a multidisciplinary approach is recommended to adequately weigh on a case by case basis the benefit/risk balance of treatment, decide the appropriate monitoring during treatment (including decision for treatment withdrawal) and consider the need for supplementation.

Renal effects
Renal adverse reactions consistent with proximal renal tubulopathy have been reported in HIV-1 infected paediatric patients aged 2 to < 12 years in clinical study GS-US-104-0352 (see sections 4.8 and 5.1).
Renal monitoring
Renal function (creatinine clearance and serum phosphate) should be evaluated prior to treatment, and monitored during treatment as in adults (see above).

Renal management
If serum phosphate is confirmed to be < 3.0 mg/dl (0.96 mmol/l) in any paediatric patient receiving tenofovir disoproxil fumarate, renal function should be re-evaluated within one week, including measurements of blood glucose, blood potassium and urine glucose concentrations (see section 4.8, proximal tubulopathy). If renal abnormalities are suspected or detected then consultation with a nephrologist should be obtained to consider interruption of tenofovir disoproxil fumarate treatment. Interrupting treatment with tenofovir disoproxil fumarate should also be considered in case of progressive decline of renal function when no other cause has been identified.

Co-administration and risk of renal toxicity
The same recommendations apply as in adults (see above).

Renal impairment
The use of tenofovir disoproxil fumarate is not recommended in paediatric patients with renal impairment (see section 4.2). Tenofovir disoproxil fumarate should not be initiated in paediatric patients with renal impairment and should be discontinued in paediatric patients who develop renal impairment during tenofovir disoproxil fumarate therapy.

Bone effects
Viread may cause a reduction in BMD. The effects of tenofovir disoproxil fumarate-associated changes in BMD on long-term bone health and future fracture risk are currently unknown (see section 5.1).

If bone abnormalities are detected or suspected in paediatric patients, consultation with an endocrinologist and/or nephrologist should be obtained.

Liver disease
Safety and efficacy data are very limited in liver transplant patients.

There are limited data on the safety and efficacy of tenofovir disoproxil fumarate in HBV infected patients with decompensated liver disease and who have a Child-Pugh-Turcotte (CPT) score > 9. These patients may be at higher risk of experiencing serious hepatic or renal adverse reactions. Therefore, hepatobiliary and renal parameters should be closely monitored in this patient population.

Exacerbations of hepatitis
Flares on treatment: Spontaneous exacerbations in chronic hepatitis B are relatively common and are characterised by transient increases in serum ALT. After initiating antiviral therapy, serum ALT may increase in some patients (see section 4.8). In patients with compensated liver disease, these increases in serum ALT are generally not accompanied by an increase in serum bilirubin concentrations or hepatic decompensation. Patients with cirrhosis may be at a higher risk for hepatic decompensation following hepatitis exacerbation, and therefore should be monitored closely during therapy.

Flares after treatment discontinuation: Acute exacerbation of hepatitis has also been reported in patients who have discontinued hepatitis B therapy. Post-treatment exacerbations are usually associated with rising HBV DNA, and the majority appears to be self-limited. However, severe exacerbations, including fatalities, have been reported. Hepatic function should be monitored at repeated intervals with both clinical and laboratory follow-up for at least 6 months after discontinuation of hepatitis B therapy. If appropriate, resumption of hepatitis B therapy may be warranted. In patients with advanced liver disease or cirrhosis, treatment discontinuation is not recommended since post-treatment exacerbation of hepatitis may lead to hepatic decompensation.

Liver flares are especially serious, and sometimes fatal in patients with decompensated liver disease.
**Co-infection with hepatitis C or D:** There are no data on the efficacy of tenofovir in patients co-infected with hepatitis C or D virus.

**Co-infection with HIV-1 and hepatitis B:** Due to the risk of development of HIV resistance, tenofovir disoproxil fumarate should only be used as part of an appropriate antiretroviral combination regimen in HIV/HBV co-infected patients. Patients with pre-existing liver dysfunction, including chronic active hepatitis, have an increased frequency of liver function abnormalities during combination antiretroviral therapy (CART) and should be monitored according to standard practice. If there is evidence of worsening liver disease in such patients, interruption or discontinuation of treatment must be considered. However, it should be noted that increases of ALT can be part of HBV clearance during therapy with tenofovir, see above *Exacerbations of hepatitis*.

**Use with certain hepatitis C virus antiviral agents**

Co-administration of tenofovir disoproxil fumarate with ledipasvir/sofosbuvir or sofosbuvir/velpatasvir has been shown to increase plasma concentrations of tenofovir, especially when used together with an HIV regimen containing tenofovir disoproxil fumarate and a pharmacokinetic enhancer (ritonavir or cobicistat). The safety of tenofovir disoproxil fumarate in the setting of ledipasvir/sofosbuvir or sofosbuvir/velpatasvir and a pharmacokinetic enhancer has not been established. The potential risks and benefits associated with co-administration of ledipasvir/sofosbuvir or sofosbuvir/velpatasvir with tenofovir disoproxil fumarate given in conjunction with a boosted HIV protease inhibitor (e.g. atazanavir or darunavir) should be considered, particularly in patients at increased risk of renal dysfunction. Patients receiving ledipasvir/sofosbuvir or sofosbuvir/velpatasvir concomitantly with tenofovir disoproxil fumarate and a boosted HIV protease inhibitor should be monitored for adverse reactions related to tenofovir disoproxil fumarate.

**Weight and metabolic parameters**

An increase in weight and in levels of blood lipids and glucose may occur during antiretroviral therapy. Such changes may in part be linked to disease control and life style. For lipids, there is in some cases evidence for a treatment effect, while for weight gain there is no strong evidence relating this to any particular treatment. For monitoring of blood lipids and glucose reference is made to established HIV treatment guidelines. Lipid disorders should be managed as clinically appropriate.

**Mitochondrial dysfunction following exposure *in utero***

Nucleos(t)ide analogues may impact mitochondrial function to a variable degree, which is most pronounced with stavudine, didanosine and zidovudine. There have been reports of mitochondrial dysfunction in HIV negative infants exposed *in utero* and/or postnatally to nucleoside analogues; these have predominantly concerned treatment with regimens containing zidovudine. The main adverse reactions reported are haematological disorders (anaemia, neutropenia) and metabolic disorders (hyperlactatemia, hyperlipasemia). These events have often been transitory. Late onset neurological disorders have been reported rarely (hypertonia, convulsion, abnormal behaviour). Whether such neurological disorders are transient or permanent is currently unknown. These findings should be considered for any child exposed *in utero* to nucleos(t)ide analogues, who present with severe clinical findings of unknown etiology, particularly neurologic findings. These findings do not affect current national recommendations to use antiretroviral therapy in pregnant women to prevent vertical transmission of HIV.

**Immune reactivation syndrome**

In HIV infected patients with severe immune deficiency at the time of institution of CART, an inflammatory reaction to asymptomatic or residual opportunistic pathogens 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 CART. Relevant examples are cytomegalovirus retinitis, generalised and/or focal mycobacterial infections, and *Pneumocystis jiroveci* pneumonia. Any inflammatory symptoms should be evaluated and treatment instituted when necessary.
Autoimmune disorders (such as Graves’ disease) have also been reported to occur in the setting of immune reactivation; however, the reported time to onset is more variable and these events can occur many months after initiation of treatment.

**Osteonecrosis**
Although the aetiology is considered to be multifactorial (including corticosteroid use, alcohol consumption, severe immunosuppression, higher body mass index), cases of osteonecrosis have been reported, particularly in patients with advanced HIV disease and/or long-term exposure to CART. Patients should be advised to seek medical advice if they experience joint aches and pain, joint stiffness or difficulty in movement.

**Elderly**
Tenofovir disoproxil fumarate has not been studied in patients over the age of 65. Elderly patients are more likely to have decreased renal function; therefore caution should be exercised when treating elderly patients with tenofovir disoproxil fumarate.

Viread granules contain mannitol which may have a mild laxative effect.

**4.5 Interaction with other medicinal products and other forms of interaction**

Interaction studies have only been performed in adults. Based on the results of *in vitro* experiments and the known elimination pathway of tenofovir, the potential for CYP450-mediated interactions involving tenofovir with other medicinal products is low.

**Concomitant use not recommended**
Viread should not be administered concomitantly with other medicinal products containing tenofovir disoproxil fumarate or tenofovir alafenamide.

Viread should not be administered concomitantly with adefovir dipivoxil.

**Didanosine**
Co-administration of tenofovir disoproxil fumarate and didanosine is not recommended (see section 4.4 and Table 2).

**Renally eliminated medicinal products**
Since tenofovir is primarily eliminated by the kidneys, co-administration of tenofovir disoproxil fumarate with medicinal products that reduce renal function or compete for active tubular secretion via transport proteins hOAT 1, hOAT 3 or MRP 4 (e.g. cidofovir) may increase serum concentrations of tenofovir and/or the co-administered medicinal products.

Use of tenofovir disoproxil fumarate should be avoided with concurrent or recent use of a nephrotoxic medicinal product. Some examples include, but are not limited to, aminoglycosides, amphotericin B, foscarnet, ganciclovir, pentamidine, vancomycin, cidofovir or interleukin-2 (see section 4.4).

Given that tacrolimus can affect renal function, close monitoring is recommended when it is co-administered with tenofovir disoproxil fumarate.

**Other interactions**
Interactions between tenofovir disoproxil fumarate and other medicinal products are listed in Table 2 below (increase is indicated as “↑”, decrease as “↓”, no change as “↔”, twice daily as “b.i.d.”, and once daily as “q.d.”).
Table 2: Interactions between tenofovir disoproxil fumarate and other medicinal products

<table>
<thead>
<tr>
<th>Medicinal product by therapeutic areas (dose in mg)</th>
<th>Effects on drug levels</th>
<th>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANTI-INFECTIVES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Antiretrovirals</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Protease inhibitors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atazanavir/Ritonavir (300 q.d./100 q.d./300 q.d.)</td>
<td>Atazanavir: AUC: ↓ 25% C_{max}: ↓ 28% C_{min}: ↓ 26% Tenofovir: AUC: ↑ 37% C_{max}: ↑ 34% C_{min}: ↑ 29%</td>
<td>No dose adjustment is recommended. The increased exposure of tenofovir could potentiate tenofovir-associated adverse events, including renal disorders. Renal function should be closely monitored (see section 4.4).</td>
</tr>
<tr>
<td>Lopinavir/Ritonavir (400 b.i.d./100 b.i.d./300 q.d.)</td>
<td>Lopinavir/ritonavir: No significant effect on lopinavir/ritonavir PK parameters. Tenofovir: AUC: ↑ 32% C_{max}: ↔ C_{min}: ↑ 51%</td>
<td>No dose adjustment is recommended. The increased exposure of tenofovir could potentiate tenofovir-associated adverse events, including renal disorders. Renal function should be closely monitored (see section 4.4).</td>
</tr>
<tr>
<td>Darunavir/Ritonavir (300/100 b.i.d./300 q.d.)</td>
<td>Darunavir: No significant effect on darunavir/ritonavir PK parameters. Tenofovir: AUC: ↑ 22% C_{min}: ↑ 37%</td>
<td>No dose adjustment is recommended. The increased exposure of tenofovir could potentiate tenofovir-associated adverse events, including renal disorders. Renal function should be closely monitored (see section 4.4).</td>
</tr>
<tr>
<td><strong>NRTIs</strong></td>
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<tr>
<td>Didanosine</td>
<td>Co-administration of tenofovir disoproxil fumarate and didanosine results in a 40-60% increase in systemic exposure to didanosine that may increase the risk for didanosine-related adverse reactions. Rarely, pancreatitis and lactic acidosis, sometimes fatal, have been reported. Co-administration of tenofovir disoproxil fumarate and didanosine at a dose of 400 mg daily has been associated with a significant decrease in CD4 cell count, possibly due to an intracellular interaction increasing phosphorylated (i.e. active) didanosine. A decreased dosage of 250 mg didanosine co-administered with tenofovir disoproxil fumarate therapy has been associated with reports of high rates of virological failure within several tested combinations for the treatment of HIV-1 infection.</td>
<td>Co-administration of tenofovir disoproxil fumarate and didanosine is not recommended (see section 4.4).</td>
</tr>
<tr>
<td>Medicinal product by therapeutic areas (dose in mg)</td>
<td>Effects on drug levels Mean percent change in AUC, $C_{\text{max}}$, $C_{\text{min}}$</td>
<td>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</td>
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<tr>
<td>---------------------------------------------------</td>
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<tr>
<td>Adefovir dipivoxil</td>
<td>AUC: ↔ $C_{\text{max}}$: ↔</td>
<td>Tenofovir disoproxil fumarate should not be administered concurrently with adefovir dipivoxil (see section 4.4).</td>
</tr>
<tr>
<td>Entecavir</td>
<td>AUC: ↔ $C_{\text{max}}$: ↔</td>
<td>No clinically significant pharmacokinetic interactions when tenofovir disoproxil fumarate was co-administered with entecavir.</td>
</tr>
<tr>
<td><strong>Hepatitis C virus antiviral agents</strong></td>
<td></td>
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<tr>
<td>Ledipasvir/Sofosbuvir (90 mg/400 mg q.d.) +</td>
<td>Ledipasvir: AUC: ↑ 96% $C_{\text{max}}$: ↑ 68% $C_{\text{min}}$: ↑ 118%</td>
<td>Increased plasma concentrations of tenofovir resulting from co-administration of tenofovir disoproxil fumarate, ledipasvir/sofosbuvir and atazanavir/ritonavir may increase adverse reactions related to tenofovir disoproxil fumarate, including renal disorders. The safety of tenofovir disoproxil fumarate when used with ledipasvir/sofosbuvir and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established.</td>
</tr>
<tr>
<td>Atazanavir/Ritonavir (300 mg q.d./100 mg q.d.) +</td>
<td>Sofosbuvir: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↑ 42%</td>
<td>The combination should be used with caution with frequent renal monitoring, if other alternatives are not available (see section 4.4).</td>
</tr>
<tr>
<td>Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.)</td>
<td>GS-331007$^2$: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↑ 42%</td>
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<td></td>
<td>Atazanavir: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↑ 63%</td>
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<td></td>
<td>Ritonavir: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↑ 45%</td>
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<td></td>
<td>Emtricitabine: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔</td>
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<tr>
<td></td>
<td>Tenofovir: AUC: ↔ $C_{\text{max}}$: ↑ 47% $C_{\text{min}}$: ↑ 47%</td>
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<tr>
<td>Medicinal product by therapeutic areas (dose in mg)</td>
<td>Effects on drug levels Mean percent change in AUC, $C_{\text{max}}$, $C_{\text{min}}$</td>
<td>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</td>
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<td>--------------------------------------------------</td>
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<tr>
<td>Ledipasvir/Sofosbuvir (90 mg/400 mg q.d.) + Darunavir/Ritonavir (800 mg q.d./100 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.)¹</td>
<td></td>
<td>Increased plasma concentrations of tenofovir resulting from co-administration of tenofovir disoproxil fumarate, ledipasvir/sofosbuvir and darunavir/ritonavir may increase adverse reactions related to tenofovir disoproxil fumarate, including renal disorders. The safety of tenofovir disoproxil fumarate when used with ledipasvir/sofosbuvir and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established. The combination should be used with caution with frequent renal monitoring, if other alternatives are not available (see section 4.4).</td>
</tr>
<tr>
<td>Ledipasvir: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sofosbuvir: AUC: ↓ 27% $C_{\text{max}}$: ↓ 37% $C_{\text{min}}$: ↔</td>
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<tr>
<td>GS-331007²: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔</td>
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<tr>
<td>Darunavir: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔</td>
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<tr>
<td>Ritonavir: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↑ 48%</td>
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<tr>
<td>Emtricitabine: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔</td>
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<tr>
<td>Tenofovir: AUC: ↑ 50% $C_{\text{max}}$: ↑ 64% $C_{\text{min}}$: ↑ 59%</td>
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<tr>
<td>Medicinal product by therapeutic areas (dose in mg)</td>
<td>Effects on drug levels Mean percent change in AUC, $C_{\text{max}}, C_{\text{min}}$</td>
<td>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</td>
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<td>---------------------------------------------------</td>
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</tbody>
</table>
| Ledipasvir/Sofosbuvir (90 mg/400 mg q.d.) + Efavirenz/Emtricitabine/Tenofovir disoproxil fumarate (600 mg/200 mg/300 mg q.d.) | Ledipasvir: 
AUC: ↓ 34% 
$C_{\text{max}}$: ↓ 34% 
$C_{\text{min}}$: ↓ 34% 
Sofosbuvir: 
AUC: ↔ 
$C_{\text{max}}$: ↔ 
$C_{\text{min}}$: ↔ 
GS-331007²: 
AUC: ↔ 
$C_{\text{max}}$: ↔ 
$C_{\text{min}}$: ↔ 
Efavirenz: 
AUC: ↔ 
$C_{\text{max}}$: ↔ 
$C_{\text{min}}$: ↔ 
Emtricitabine: 
AUC: ↔ 
$C_{\text{max}}$: ↔ 
$C_{\text{min}}$: ↔ 
Tenofovir: 
AUC: ↑ 98% 
$C_{\text{max}}$: ↑ 79% 
$C_{\text{min}}$: ↑ 163% | No dose adjustment is recommended. The increased exposure of tenofovir could potentiate adverse reactions associated with tenofovir disoproxil fumarate, including renal disorders. Renal function should be closely monitored (see section 4.4). |
| Ledipasvir/Sofosbuvir (90 mg/400 mg q.d.) + Emtricitabine/Rilpivirine/Tenofovir disoproxil fumarate (200 mg/25 mg/300 mg q.d.) | Ledipasvir: 
AUC: ↔ 
$C_{\text{max}}$: ↔ 
$C_{\text{min}}$: ↔ 
Sofosbuvir: 
AUC: ↔ 
$C_{\text{max}}$: ↔ 
$C_{\text{min}}$: ↔ 
GS-331007²: 
AUC: ↔ 
$C_{\text{max}}$: ↔ 
$C_{\text{min}}$: ↔ 
Emtricitabine: 
AUC: ↔ 
$C_{\text{max}}$: ↔ 
$C_{\text{min}}$: ↔ 
Rilpivirine: 
AUC: ↔ 
$C_{\text{max}}$: ↔ 
$C_{\text{min}}$: ↔ 
Tenofovir: 
AUC: ↑ 40% 
$C_{\text{max}}$: ↔ 
$C_{\text{min}}$: ↑ 91% | No dose adjustment is recommended. The increased exposure of tenofovir could potentiate adverse reactions associated with tenofovir disoproxil fumarate, including renal disorders. Renal function should be closely monitored (see section 4.4). |
<table>
<thead>
<tr>
<th>Medicinal product by therapeutic areas (dose in mg)</th>
<th>Effects on drug levels Mean percent change in AUC, $C_{max}$ $C_{min}$</th>
<th>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ledipasvir/Sofosbuvir (90 mg/400 mg q.d.) + Dolutegravir (50 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.)</td>
<td>Sofosbuvir: AUC: ↔ $C_{max}$: ↔ GS-331007$^2$ AUC: ↔ $C_{max}$: ↔ $C_{min}$: ↔</td>
<td>No dose adjustment is recommended. The increased exposure of tenofovir could potentiate adverse reactions associated with tenofovir disoproxil fumarate, including renal disorders. Renal function should be closely monitored (see section 4.4).</td>
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<td></td>
<td>Ledipasvir: AUC: ↔ $C_{max}$: ↔ $C_{min}$: ↔</td>
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<td></td>
<td>Dolutegravir AUC: ↔ $C_{max}$: ↔ $C_{min}$: ↔</td>
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<td></td>
<td>Emtricitabine: AUC: ↔ $C_{max}$: ↔ $C_{min}$: ↔</td>
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<td></td>
<td>Tenofovir: AUC: ↑ 65% $C_{max}$: ↑ 61% $C_{min}$: ↑ 115%</td>
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<td>Medicinal product by therapeutic areas (dose in mg)</td>
<td>Effects on drug levels</td>
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<tr>
<td>Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Atazanavir/Ritonavir (300 mg q.d./100 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.)</td>
<td>Mean percent change in AUC, ( C_{\text{max}}, C_{\text{min}} )</td>
<td></td>
</tr>
<tr>
<td>Sofosbuvir: AUC: ↔</td>
<td>GS-331007: AUC: ↔</td>
<td></td>
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<tr>
<td>C(_{\text{max}}): ↔</td>
<td>( C_{\text{max}}: \uparrow 42% )</td>
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<tr>
<td>Velpatasvir: AUC: ↑ 142%</td>
<td>( C_{\text{max}}: ↑ 55% )</td>
<td></td>
</tr>
<tr>
<td>C(_{\text{min}}): ↑ 301%</td>
<td>( C_{\text{min}}: ↑ 39% )</td>
<td></td>
</tr>
<tr>
<td>Atazanavir: AUC: ↔</td>
<td>( C_{\text{max}}: \uparrow 39% )</td>
<td></td>
</tr>
<tr>
<td>Ritonavir: AUC: ↔</td>
<td>( C_{\text{max}}: ↑ 29% )</td>
<td></td>
</tr>
<tr>
<td>Emtricitabine: AUC: ↔</td>
<td>( C_{\text{max}}: \downarrow )</td>
<td></td>
</tr>
<tr>
<td>Tenofovir: AUC: ↔</td>
<td>( C_{\text{max}}: ↑ 55% )</td>
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<tr>
<td></td>
<td>( C_{\text{min}}: ↑ 39% )</td>
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</tbody>
</table>

Increased plasma concentrations of tenofovir resulting from co-administration of tenofovir disoproxil fumarate, sofosbuvir/velpatasvir and atazanavir/ritonavir may increase adverse reactions related to tenofovir disoproxil fumarate, including renal disorders. The safety of tenofovir disoproxil fumarate when used with sofosbuvir/velpatasvir and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established.

The combination should be used with caution with frequent renal monitoring (see section 4.4).
<table>
<thead>
<tr>
<th>Medicinal product by therapeutic areas (dose in mg)</th>
<th>Effects on drug levels Mean percent change in AUC, $C_{\text{max}}, C_{\text{min}}$</th>
<th>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Darunavir/Ritonavir (800 mg q.d./100 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.)</td>
<td>Sofosbuvir: AUC: ↓28% $C_{\text{max}}$: ↓38% GS-331007$^2$: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔ Velpatasvir: AUC: ↔ $C_{\text{max}}$: ↓24% $C_{\text{min}}$: ↔ Darunavir: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔ Ritonavir: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔ Emtricitabine: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔ Tenofovir: AUC: ↑39% $C_{\text{max}}$: ↑55% $C_{\text{min}}$: ↑52%</td>
<td>Increased plasma concentrations of tenofovir resulting from co-administration of tenofovir disoproxil fumarate, sofosbuvir/velpatasvir and darunavir/ritonavir may increase adverse reactions related to tenofovir disoproxil fumarate, including renal disorders. The safety of tenofovir disoproxil fumarate when used with sofosbuvir/velpatasvir and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established. The combination should be used with caution with frequent renal monitoring (see section 4.4).</td>
</tr>
<tr>
<td>Medicinal product by therapeutic areas (dose in mg)</td>
<td>Effects on drug levels Mean percent change in AUC, $C_{\text{max}}$, $C_{\text{min}}$</td>
<td>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</td>
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</tr>
<tr>
<td>Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Lopinavir/Ritonavir (800 mg/200 mg q.d.) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.)</td>
<td>Sofosbuvir: AUC: ↓ 29% $C_{\text{max}}$: ↓ 41% GS-331007: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔</td>
<td>Increased plasma concentrations of tenofovir resulting from co-administration of tenofovir disoproxil fumarate, sofosbuvir/velpatasvir and lopinavir/ritonavir may increase adverse reactions related to tenofovir disoproxil fumarate, including renal disorders. The safety of tenofovir disoproxil fumarate when used with sofosbuvir/velpatasvir and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established. The combination should be used with caution with frequent renal monitoring (see section 4.4).</td>
</tr>
<tr>
<td>Velpatasvir: AUC: ↔ $C_{\text{max}}$: ↓ 30% $C_{\text{min}}$: ↑ 63%</td>
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<tr>
<td>Lopinavir: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔</td>
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<td>Ritonavir: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔</td>
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<tr>
<td>Emtricitabine: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\text{min}}$: ↔</td>
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<tr>
<td>Tenofovir: AUC: ↔ $C_{\text{max}}$: ↑ 42% $C_{\text{min}}$: ↔</td>
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<td>Medicinal product by therapeutic areas (dose in mg)</td>
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</tr>
<tr>
<td>Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Raltegravir (400 mg b.i.d) + Emtricitabine/Tenofovir disoproxil fumarate (200 mg/300 mg q.d.)</td>
<td>Sofosbuvir: AUC: ↔ $C_{\text{max}}$: ↔ $GS$-331007$^2$: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\min}$: ↔ Velpatasvir: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\min}$: ↔ Raltegravir: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\min}$: ↓ 21% Emtricitabine: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\min}$: ↔ Tenofovir: AUC: ↑ 40% $C_{\text{max}}$: ↑ 46% $C_{\min}$: ↑ 70%</td>
<td>No dose adjustment is recommended. The increased exposure of tenofovir could potentiate adverse reactions associated with tenofovir disoproxil fumarate, including renal disorders. Renal function should be closely monitored (see section 4.4).</td>
</tr>
<tr>
<td>Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Efavirenz/Emtricitabine/Tenofovir disoproxil fumarate (600 mg/200 mg/300 mg q.d.)</td>
<td>Sofosbuvir: AUC: ↔ $C_{\text{max}}$: ↑ 38% $GS$-331007$^2$: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\min}$: ↔ Velpatasvir: AUC: ↓ 53% $C_{\text{max}}$: ↓ 47% $C_{\min}$: ↓ 57% Efavirenz: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\min}$: ↔ Emtricitabine: AUC: ↔ $C_{\text{max}}$: ↔ $C_{\min}$: ↔ Tenofovir: AUC: ↑ 81% $C_{\text{max}}$: ↑ 77% $C_{\min}$: ↑ 121%</td>
<td>Concomitant administration of sofosbuvir/velpatasvir and efavirenz is expected to decrease plasma concentrations of velpatasvir. Co-administration of sofosbuvir/velpatasvir with efavirenz-containing regimens is not recommended.</td>
</tr>
<tr>
<td>Medicinal product by therapeutic areas (dose in mg)</td>
<td>Effects on drug levels Mean percent change in AUC, $C_{\text{max}}$, $C_{\text{min}}$</td>
<td>Recommendation concerning co-administration with 245 mg tenofovir disoproxil (as fumarate)</td>
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</table>
| Sofosbuvir/Velpatasvir (400 mg/100 mg q.d.) + Emtricitabine/Rilpivirine/Tenofovir disoproxil fumarate (200 mg/25 mg/300 mg q.d.) | Sofosbuvir:  
AUC: ↔  
$C_{\text{max}}$: ↔  
GS-331007$^2$:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Velpatasvir:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Emtricitabine:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Rilpivirine:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Tenofovir:  
AUC: ↑ 40%  
$C_{\text{max}}$: ↑ 44%  
$C_{\text{min}}$: ↑ 84% | No dose adjustment is recommended. The increased exposure of tenofovir could potentiate adverse reactions associated with tenofovir disoproxil fumarate, including renal disorders. Renal function should be closely monitored (see section 4.4). |
| Sofosbuvir (400 mg q.d.) + Efavirenz/Emtricitabine/Tenofovir disoproxil fumarate (600 mg/200 mg/300 mg q.d.) | Sofosbuvir:  
AUC: ↔  
$C_{\text{max}}$: ↓ 19%  
GS-331007$^2$:  
AUC: ↔  
$C_{\text{max}}$: ↓ 23%  
Efavirenz:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Emtricitabine:  
AUC: ↔  
$C_{\text{max}}$: ↔  
$C_{\text{min}}$: ↔  
Tenofovir:  
AUC: ↔  
$C_{\text{max}}$: ↑ 25%  
$C_{\text{min}}$: ↔ | No dose adjustment is required. |

$^1$ Data generated from simultaneous dosing with ledipasvir/sofosbuvir. Staggered administration (12 hours apart) provided similar results.

$^2$ The predominant circulating metabolite of sofosbuvir.

**Studies conducted with other medicinal products**
There were no clinically significant pharmacokinetic interactions when tenofovir disoproxil fumarate was co-administered with emtricitabine, lamivudine, indinavir, efavirenz, nelfinavir, saquinavir
(ritonavir boosted), methadone, ribavirin, rifampicin, tacrolimus, or the hormonal contraceptive norgestimate/ethinyl oestradiol.

Tenofovir disoproxil fumarate must be taken with food, as food enhances the bioavailability of tenofovir (see section 5.2).

4.6 Fertility, pregnancy and lactation

Pregnancy
A moderate amount of data on pregnant women (between 300-1,000 pregnancy outcomes) indicate no malformations or foetal/neonatal toxicity associated with tenofovir disoproxil fumarate. Animal studies do not indicate reproductive toxicity (see section 5.3). The use of tenofovir disoproxil fumarate may be considered during pregnancy, if necessary.

Breast-feeding
Tenofovir has been shown to be excreted in human milk. There is insufficient information on the effects of tenofovir in newborns/infants. Therefore Viread should not be used during breast-feeding.

As a general rule, it is recommended that HIV and HBV infected women do not breast-feed their infants in order to avoid transmission of HIV and HBV to the infant.

Fertility
There are limited clinical data with respect to the effect of tenofovir disoproxil fumarate on fertility. Animal studies do not indicate harmful effects of tenofovir disoproxil fumarate on fertility.

4.7 Effects on ability to drive and use machines

No studies on the effects on the ability to drive and use machines have been performed. However, patients should be informed that dizziness has been reported during treatment with tenofovir disoproxil fumarate.

4.8 Undesirable effects

Summary of the safety profile

HIV-1 and hepatitis B: In patients receiving tenofovir disoproxil fumarate, rare events of renal impairment, renal failure and uncommon events of proximal renal tubulopathy (including Fanconi syndrome) sometimes leading to bone abnormalities (infrequently contributing to fractures) have been reported. Monitoring of renal function is recommended for patients receiving Viread (see section 4.4).

HIV-1: Approximately one third of patients can be expected to experience adverse reactions following treatment with tenofovir disoproxil fumarate in combination with other antiretroviral agents. These reactions are usually mild to moderate gastrointestinal events. Approximately 1% of tenofovir disoproxil fumarate-treated adult patients discontinued treatment due to the gastrointestinal events.

Co-administration of Viread and didanosine is not recommended as this may result in an increased risk of adverse reactions (see section 4.5). Rarely, pancreatitis and lactic acidosis, sometimes fatal, have been reported (see section 4.4).

Hepatitis B: Approximately one quarter of patients can be expected to experience adverse reactions following treatment with tenofovir disoproxil fumarate, most of which are mild. In clinical trials of HBV infected patients, the most frequently occurring adverse reaction to tenofovir disoproxil fumarate was nausea (5.4%).

Acute exacerbation of hepatitis has been reported in patients on treatment as well as in patients who have discontinued hepatitis B therapy (see section 4.4).
Tabulated summary of adverse reactions
Assessment of adverse reactions for tenofovir disoproxil fumarate is based on safety data from clinical studies and post-marketing experience. All adverse reactions are presented in Table 3.

**HIV-1 clinical studies:** Assessment of adverse reactions from HIV-1 clinical study data is based on experience in two studies in 653 treatment-experienced adult patients receiving treatment with tenofovir disoproxil fumarate (n = 443) or placebo (n = 210) in combination with other antiretroviral medicinal products for 24 weeks and also in a double-blind comparative controlled study in which 600 treatment-naïve adult patients received treatment with tenofovir disoproxil 245 mg (as fumarate) (n = 299) or stavudine (n = 301) in combination with lamivudine and efavirenz for 144 weeks.

**Hepatitis B clinical studies:** Assessment of adverse reactions from HBV clinical study data is primarily based on experience in two double-blind comparative controlled studies in which 641 adult patients with chronic hepatitis B and compensated liver disease received treatment with tenofovir disoproxil 245 mg (as fumarate) daily (n = 426) or adefovir dipivoxil 10 mg daily (n = 215) for 48 weeks. The adverse reactions observed with continued treatment for 384 weeks were consistent with the safety profile of tenofovir disoproxil fumarate. After an initial decline of approximately -4.9 ml/min (using Cockcroft-Gault equation) or -3.9 ml/min/1.73 m² (using modification of diet in renal disease [MDRD] equation) after the first 4 weeks of treatment, the rate of annual decline post baseline of renal function reported in tenofovir disoproxil fumarate treated patients was -1.41 ml/min per year (using Cockcroft-Gault equation) and -0.74 ml/min/1.73 m² per year (using MDRD equation).

**Patients with decompensated liver disease:** The safety profile of tenofovir disoproxil fumarate in patients with decompensated liver disease was assessed in a double-blind active controlled study (GS-US-174-0108) in which adult patients received treatment with tenofovir disoproxil fumarate (n = 45) or emtricitabine plus tenofovir disoproxil fumarate (n = 45) or entecavir (n = 22) for 48 weeks.

In the tenofovir disoproxil fumarate treatment arm, 7% of patients discontinued treatment due to an adverse event; 9% of patients experienced a confirmed increase in serum creatinine of ≥ 0.5 mg/dl or confirmed serum phosphate of < 2 mg/dl through week 48; there were no statistically significant differences between the combined tenofovir-containing arms and the entecavir arm. After 168 weeks, 16% (7/45) of the tenofovir disoproxil fumarate group, 4% (2/45) of the emtricitabine plus tenofovir disoproxil fumarate group, and 14% (3/22) of the entecavir group experienced tolerability failure. Thirteen percent (6/45) of the tenofovir disoproxil fumarate group, 13% (6/45) of the emtricitabine plus tenofovir disoproxil fumarate group, and 9% (2/22) of the entecavir group had a confirmed increase in serum creatinine ≥ 0.5 mg/dl or confirmed serum phosphate of < 2 mg/dl.

At week 168, in this population of patients with decompensated liver disease, the rate of death was of 13% (6/45) in the tenofovir disoproxil fumarate group, 11% (5/45) in the emtricitabine plus tenofovir disoproxil fumarate group and 14% (3/22) in the entecavir group. The rate of hepatocellular carcinoma was 18% (8/45) in the tenofovir disoproxil fumarate group, 7% (3/45) in the emtricitabine plus tenofovir disoproxil fumarate group and 9% (2/22) in the entecavir group.

Subjects with a high baseline CPT score were at higher risk of developing serious adverse events (see section 4.4).

**Patients with lamivudine-resistant chronic hepatitis B:** No new adverse reactions to tenofovir disoproxil fumarate were identified from a randomised, double-blind study (GS-US-174-0121) in which 280 lamivudine-resistant patients received treatment with tenofovir disoproxil fumarate (n = 141) or emtricitabine/tenofovir disoproxil fumarate (n = 139) for 240 weeks.
The adverse reactions with suspected (at least possible) relationship to treatment are listed below by
body syste organ class and frequency. Within each frequency grouping, undesirable effects are
presented in order of decreasing seriousness. Frequencies are defined as very common (≥ 1/10),
common (≥ 1/100 to < 1/10), uncommon (≥ 1/1,000 to < 1/100) or rare (≥ 1/10,000 to < 1/1,000).

Table 3: Tabulated summary of adverse reactions associated with tenofovir disoproxil fumarate
based on clinical study and post-marketing experience

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Tenofovir disoproxil fumarate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metabolism and nutrition disorders:</td>
<td></td>
</tr>
</tbody>
</table>
| Very common: | hypophosphataemia  
| Uncommon: | hypokalaemia  
| Rare: | lactic acidosis  |
| Nervous system disorders: | |
| Very common: | dizziness  
| Common: | headache  |
| Gastrointestinal disorders: | |
| Very common: | diarrhoea, vomiting, nausea  
| Common: | abdominal pain, abdominal distension, flatulence  
| Uncommon: | pancreatitis  |
| Hepatobiliary disorders: | |
| Common: | increased transaminases  
| Rare: | hepatic steatosis, hepatitis  |
| Skin and subcutaneous tissue disorders: | |
| Very common: | rash  
| Rare: | angioedema  |
| Musculoskeletal and connective tissue disorders: | |
| Uncommon: | rhabdomyolysis, muscular weakness  
| Rare: | osteomalacia (manifested as bone pain and infrequently contributing to fractures), myopathy  |
| Renal and urinary disorders: | |
| Uncommon: | increased creatinine, proximal renal tubulopathy (including Fanconi syndrome)  
| Rare: | acute renal failure, renal failure, acute tubular necrosis, nephritis (including acute interstitial nephritis), nephrogenic diabetes insipidus  |
| General disorders and administration site conditions: | |
| Very common: | asthenia  
| Common: | fatigue  |

1 This adverse reaction may occur as a consequence of proximal renal tubulopathy. It is not considered to be causally
associated with tenofovir disoproxil fumarate in the absence of this condition.
2 This adverse reaction was identified through post-marketing surveillance but not observed in randomised controlled clinical
trials or the tenofovir disoproxil fumarate expanded access program. The frequency category was estimated from a statistical
calculation based on the total number of patients exposed to tenofovir disoproxil fumarate in randomised controlled clinical
trials and the expanded access program (n = 7,319).

Description of selected adverse reactions

HIV-1 and hepatitis B:

Renal impairment

As Viread may cause renal damage monitoring of renal function is recommended (see sections 4.4 and
4.8 Summary of the safety profile). Proximal renal tubulopathy generally resolved or improved after
tenofovir disoproxil fumarate discontinuation. However, in some patients, declines in creatinine
clearance did not completely resolve despite tenofovir disoproxil fumarate discontinuation. Patients at
risk of renal impairment (such as patients with baseline renal risk factors, advanced HIV disease, or
patients receiving concomitant nephrotoxic medications) are at increased risk of experiencing
incomplete recovery of renal function despite tenofovir disoproxil fumarate discontinuation (see
section 4.4).
HIV-1:
Interaction with didanosine
Co-administration of tenofovir disoproxil fumarate and didanosine is not recommended as it results in a 40-60% increase in systemic exposure to didanosine that may increase the risk of didanosine-related adverse reactions (see section 4.5). Rarely, pancreatitis and lactic acidosis, sometimes fatal, have been reported.

Metabolic parameters
Weight and levels of blood lipids and glucose may increase during antiretroviral therapy (see section 4.4).

Immune reactivation syndrome
In HIV infected patients with severe immune deficiency at the time of initiation of CART, an inflammatory reaction to asymptomatic or residual opportunistic infections may arise. Autoimmune disorders (such as Graves’ disease) have also been reported; however, the reported time to onset is more variable and these events can occur many months after initiation of treatment (see section 4.4).

Osteonecrosis
Cases of osteonecrosis have been reported, particularly in patients with generally acknowledged risk factors, advanced HIV disease or long-term exposure to CART. The frequency of this is unknown (see section 4.4).

Hepatitis B:
Exacerbations of hepatitis during treatment
In studies with nucleoside-naïve patients, on-treatment ALT elevations > 10 times ULN (upper limit of normal) and > 2 times baseline occurred in 2.6% of tenofovir disoproxil fumarate-treated patients. ALT elevations had a median time to onset of 8 weeks, resolved with continued treatment, and, in a majority of cases, were associated with a ≥ 2 log_{10} copies/ml reduction in viral load that preceded or coincided with the ALT elevation. Periodic monitoring of hepatic function is recommended during treatment (see section 4.4).

Exacerbations of hepatitis after discontinuation of treatment
In HBV infected patients, clinical and laboratory evidence of exacerbations of hepatitis have occurred after discontinuation of HBV therapy (see section 4.4).

Paediatric population
HIV-1
Assessment of adverse reactions is based on two randomised trials (studies GS-US-104-0321 and GS-US-104-0352) in 184 HIV-1 infected paediatric patients (aged 2 to < 18 years) who received treatment with tenofovir disoproxil fumarate (n = 93) or placebo/active comparator (n = 91) in combination with other antiretroviral agents for 48 weeks (see section 5.1). The adverse reactions observed in paediatric patients who received treatment with tenofovir disoproxil fumarate were consistent with those observed in clinical studies of tenofovir disoproxil fumarate in adults (see section 4.8 Tabulated summary of adverse reactions and 5.1).

Reductions in BMD have been reported in paediatric patients. In HIV-1 infected adolescents, the BMD Z-scores observed in subjects who received tenofovir disoproxil fumarate were lower than those observed in subjects who received placebo. In HIV-1 infected children, the BMD Z-scores observed in subjects who switched to tenofovir disoproxil fumarate were lower than those observed in subjects who remained on their stavudine- or zidovudine-containing regimen (see sections 4.4 and 5.1).

In study GS-US-104-0352, 4 out of 89 paediatric patients exposed to tenofovir disoproxil fumarate (median tenofovir disoproxil fumarate exposure 312 weeks) discontinued due to adverse reactions consistent with proximal renal tubulopathy. Seven patients had estimated glomerular filtration rate (GFR) values between 70 and 90 mL/min/1.73 m^2. Among them, two patients experienced a clinically meaningful decline in estimated GFR which improved after discontinuation of tenofovir disoproxil fumarate.
Chronic hepatitis B
Assessment of adverse reactions is based on one randomised study (study GS-US-174-0115) in 106 adolescent patients (12 to ≤18 years of age) with chronic hepatitis B receiving treatment with tenofovir disoproxil 245 mg (as fumarate) (n = 52) or placebo (n = 54) for 72 weeks. The adverse reactions observed in adolescent patients who received treatment with tenofovir disoproxil fumarate were consistent with those observed in clinical studies of tenofovir disoproxil fumarate in adults (see section 4.8 Tabulated summary of adverse reactions and 5.1).

Reductions in BMD have been observed in HBV infected adolescents. The BMD Z-scores observed in subjects who received tenofovir disoproxil fumarate were lower than those observed in subjects who received placebo (see sections 4.4 and 5.1).

Other special population(s)
Elderly
Tenofovir disoproxil fumarate has not been studied in patients over the age of 65. Elderly patients are more likely to have decreased renal function, therefore caution should be exercised when treating elderly patients with tenofovir disoproxil fumarate (see section 4.4).

Patients with renal impairment
Since tenofovir disoproxil fumarate can cause renal toxicity, close monitoring of renal function is recommended in adult patients with renal impairment treated with Viread (see sections 4.2, 4.4 and 5.2). The use of tenofovir disoproxil fumarate is not recommended in paediatric patients with renal impairment (see sections 4.2 and 4.4).

Reporting of suspected adverse reactions
Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via the national reporting system listed in Appendix V.

4.9 Overdose
Symptoms
If overdose occurs the patient must be monitored for evidence of toxicity (see sections 4.8 and 5.3), and standard supportive treatment applied as necessary.

Management
Tenofovir can be removed by haemodialysis; the median haemodialysis clearance of tenofovir is 134 ml/min. It is not known whether tenofovir can be removed by peritoneal dialysis.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties
Pharmacotherapeutic group: Antiviral for systemic use; nucleoside and nucleotide reverse transcriptase inhibitors, ATC code: J05AF07

Mechanism of action and pharmacodynamic effects
Tenofovir disoproxil fumarate is the fumarate salt of the prodrug tenofovir disoproxil. Tenofovir disoproxil is absorbed and converted to the active substance tenofovir, which is a nucleoside monophosphate (nucleotide) analogue. Tenofovir is then converted to the active metabolite, tenofovir diphosphate, an obligate chain terminator, by constitutively expressed cellular enzymes. Tenofovir diphosphate has an intracellular half-life of 10 hours in activated and 50 hours in resting peripheral blood mononuclear cells (PBMCs). Tenofovir diphosphate inhibits HIV-1 reverse transcriptase and the HBV polymerase by direct binding competition with the natural deoxyribonucleotide substrate.
and, after incorporation into DNA, by DNA chain termination. Tenofovir diphosphate is a weak inhibitor of cellular polymerases α, β, and γ. At concentrations of up to 300 µmol/l, tenofovir has also shown no effect on the synthesis of mitochondrial DNA or the production of lactic acid in \textit{in vitro} assays.

\textbf{Data pertaining to HIV}

\textbf{HIV antiviral activity in vitro:} The concentration of tenofovir required for 50\% inhibition (EC$_{50}$) of the wild-type laboratory strain HIV-1$_{\text{IM}}$ is 1-6 µmol/l in lymphoid cell lines and 1.1 µmol/l against primary HIV-1 subtype B isolates in PBMCs. Tenofovir is also active against HIV-1 subtypes A, C, D, E, F, G, and O and against HIV$_{\text{HIV}}$ in primary monocyte/macrophage cells. Tenofovir shows activity \textit{in vitro} against HIV-2, with an EC$_{50}$ of 4.9 µmol/l in MT-4 cells.

\textbf{Resistance:} Strains of HIV-1 with reduced susceptibility to tenofovir and a K65R mutation in reverse transcriptase have been selected \textit{in vitro} and in some patients (see Clinical efficacy and safety). Tenofovir disoproxil fumarate should be avoided in antiretroviral-experienced patients with strains harbouring the K65R mutation (see section 4.4). In addition, a K70E substitution in HIV-1 reverse transcriptase has been selected by tenofovir and results in low-level reduced susceptibility to tenofovir.

Clinical studies in treatment-experienced patients have assessed the anti-HIV activity of tenofovir disoproxil 245 mg (as fumarate) against strains of HIV-1 with resistance to nucleoside inhibitors. The results indicate that patients whose HIV expressed 3 or more thymidine-analogue associated mutations (TAMs) that included either the M41L or L210W reverse transcriptase mutation showed reduced response to tenofovir disoproxil 245 mg (as fumarate) therapy.

\textbf{Clinical efficacy and safety}

The effects of tenofovir disoproxil fumarate in treatment-experienced and treatment-naïve HIV-1 infected adults have been demonstrated in trials of 48 weeks and 144 weeks duration, respectively.

In study GS-99-907, 550 treatment-experienced adult patients were treated with placebo or tenofovir disoproxil 245 mg (as fumarate) for 24 weeks. The mean baseline CD4 cell count was 427 cells/mm$^3$, the mean baseline plasma HIV-1 RNA was 3.4 log$_{10}$ copies/ml (78\% of patients had a viral load of < 5,000 copies/ml) and the mean duration of prior HIV treatment was 5.4 years. Baseline genotypic analysis of HIV isolates from 253 patients revealed that 94\% of patients had HIV-1 resistance mutations associated with nucleoside reverse transcriptase inhibitors, 58\% had mutations associated with protease inhibitors and 48\% had mutations associated with non-nucleoside reverse transcriptase inhibitors.

At week 24 the time-weighted average change from baseline in log$_{10}$ plasma HIV-1 RNA levels (DAVG$_{24}$) was -0.03 log$_{10}$ copies/ml and -0.61 log$_{10}$ copies/ml for the placebo and tenofovir disoproxil 245 mg (as fumarate) recipients (p < 0.0001). A statistically significant difference in favour of tenofovir disoproxil 245 mg (as fumarate) was seen in the time-weighted average change from baseline at week 24 (DAVG$_{24}$) for CD4 count (+13 cells/mm$^3$ for tenofovir disoproxil 245 mg (as fumarate) versus -11 cells/mm$^3$ for placebo, p-value = 0.0008). The antiviral response to tenofovir disoproxil fumarate was durable through 48 weeks (DAVG$_{48}$ was -0.57 log$_{10}$ copies/ml, proportion of patients with HIV-1 RNA below 400 or 50 copies/ml was 41\% and 18\% respectively). Eight (2\%) tenofovir disoproxil 245 mg (as fumarate) treated patients developed the K65R mutation within the first 48 weeks.

The 144-week, double-blind, active controlled phase of study GS-99-903 evaluated the efficacy and safety of tenofovir disoproxil 245 mg (as fumarate) \textit{versus} stavudine when used in combination with lamivudine and efavirenz in HIV-1 infected adult patients naive to antiretroviral therapy. The mean baseline CD4 cell count was 279 cells/mm$^3$, the mean baseline plasma HIV-1 RNA was 4.91 log$_{10}$ copies/ml, 19\% of patients had symptomatic HIV-1 infection and 18\% had AIDS. Patients were stratified by baseline HIV-1 RNA and CD4 count. Forty-three percent of patients had baseline viral loads > 100,000 copies/ml and 39\% had CD4 cell counts < 200 cells/ml.
By intent to treat analysis (missing data and switch in antiretroviral therapy (ART) considered as failure), the proportion of patients with HIV-1 RNA below 400 copies/ml and 50 copies/ml at 48 weeks of treatment was 80% and 76% respectively in the tenofovir disoproxil 245 mg (as fumarate) arm, compared to 84% and 80% in the stavudine arm. At 144 weeks, the proportion of patients with HIV-1 RNA below 400 copies/ml and 50 copies/ml was 71% and 68% respectively in the tenofovir disoproxil 245 mg (as fumarate) arm, compared to 64% and 63% in the stavudine arm.

The average change from baseline for HIV-1 RNA and CD4 count at 48 weeks of treatment was similar in both treatment groups (-3.09 and -3.09 log_{10} copies/ml; +169 and 167 cells/mm^3 in the tenofovir disoproxil 245 mg (as fumarate) and stavudine groups, respectively). At 144 weeks of treatment, the average change from baseline remained similar in both treatment groups (-3.07 and -3.03 log_{10} copies/ml; +263 and +283 cells/mm^3 in the tenofovir disoproxil 245 mg (as fumarate) and stavudine groups, respectively). A consistent response to treatment with tenofovir disoproxil 245 mg (as fumarate) arm was seen regardless of baseline HIV-1 RNA and CD4 count.

The K65R mutation occurred in a slightly higher percentage of patients in the tenofovir disoproxil fumarate group than the active control group (2.7% versus 0.7%). Efavirenz or lamivudine resistance either preceded or was coincident with the development of K65R in all cases. Eight patients had HIV that expressed K65R in the tenofovir disoproxil 245 mg (as fumarate) arm, 7 of these occurred during the first 48 weeks of treatment and the last one at week 96. No further K65R development was observed up to week 144. One patient in the tenofovir disoproxil (as fumarate) arm developed the K70E substitution in the virus. From both the genotypic and phenotypic analyses there was no evidence for other pathways of resistance to tenofovir.

**Data pertaining to HBV**

**HBV antiviral activity in vitro:** The in vitro antiviral activity of tenofovir against HBV was assessed in the HepG2 2.2.15 cell line. The EC_{50} values for tenofovir were in the range of 0.14 to 1.5 µmol/l, with CC_{50} (50% cytotoxicity concentration) values > 100 µmol/l.

**Resistance:** No HBV mutations associated with tenofovir disoproxil fumarate resistance have been identified (see Clinical efficacy and safety). In cell based assays, HBV strains expressing the rtV173L, rtL180M, and rtM204I/V mutations associated with resistance to lamivudine and telbivudine showed a susceptibility to tenofovir ranging from 0.7- to 3.4-fold that of wild-type virus. HBV strains expressing the rtL180M, rtT184G, rtS202G/I, rtM204V and rtM250V mutations associated with resistance to entecavir showed a susceptibility to tenofovir ranging from 0.6- to 6.9-fold that of wild-type virus. HBV strains expressing the adeovir-associated resistance mutations rtA181V and rtN236T showed a susceptibility to tenofovir ranging from 2.9- to 10-fold that of wild-type virus. Viruses containing the rtA181T mutation remained susceptible to tenofovir with EC_{50} values 1.5-fold that of wild-type virus.

**Clinical efficacy and safety**

The demonstration of benefit of tenofovir disoproxil fumarate in compensated and decompensated disease is based on virological, biochemical and serological responses in adults with HBeAg positive and HBeAg negative chronic hepatitis B. Treated patients included those who were treatment-naïve, lamivudine-experienced, adeovir dipivoxil-experienced and patients with lamivudine and/or adeovir dipivoxil resistance mutations at baseline. Benefit has also been demonstrated based on histological responses in compensated patients.


Results through 48 weeks from two randomised, phase 3 double-blind studies comparing tenofovir disoproxil fumarate to adeovir dipivoxil in adult patients with compensated liver disease are presented in Table 4 below. Study GS-US-174-0103 was conducted in 266 (randomised and treated) HBeAg positive patients while study GS-US-174-0102 was conducted in 375 (randomised and treated) patients negative for HBeAg and positive for HBeAb.
In both of these studies tenofovir disoproxil fumarate was significantly superior to adefovir dipivoxil for the primary efficacy endpoint of complete response (defined as HBV DNA levels < 400 copies/ml and Knodell necroinflammatory score improvement of at least 2 points without worsening in Knodell fibrosis). Treatment with tenofovir disoproxil 245 mg (as fumarate) was also associated with significantly greater proportions of patients with HBV DNA < 400 copies/ml, when compared to adefovir dipivoxil 10 mg treatment. Both treatments produced similar results with regard to histological response (defined as Knodell necroinflammatory score improvement of at least 2 points without worsening in Knodell fibrosis) at week 48 (see Table 4 below).

In study GS-US-174-0103 a significantly greater proportion of patients in the tenofovir disoproxil fumarate group than in the adefovir dipivoxil group had normalised ALT and achieved HBsAg loss at week 48 (see Table 4 below).

**Table 4: Efficacy parameters in compensated HBeAg negative and HBeAg positive patients at week 48**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Study 174-0102 (HBeAg negative)</th>
<th>Study 174-0103 (HBeAg positive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parameter</td>
<td>Tenofovir disoproxil 245 mg (as fumarate) n = 250</td>
<td>Adefovir dipivoxil 10 mg n = 125</td>
</tr>
<tr>
<td>Complete response (%)a</td>
<td>71*</td>
<td>49</td>
</tr>
<tr>
<td>Histology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Histological response (%)b</td>
<td>72</td>
<td>69</td>
</tr>
<tr>
<td>Median HBV DNA reduction from baselinec</td>
<td>-4.7*</td>
<td>-4.0</td>
</tr>
<tr>
<td>HBV DNA (%)</td>
<td>93*</td>
<td>63</td>
</tr>
<tr>
<td>ALT (%)</td>
<td>76</td>
<td>77</td>
</tr>
<tr>
<td>Serology (%)</td>
<td>22/21</td>
<td>18/18</td>
</tr>
<tr>
<td>Normalised ALTd</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

*a p-value versus adefovir dipivoxil < 0.05.
*b Complete response defined as HBV DNA levels < 400 copies/ml and Knodell necroinflammatory score improvement of at least 2 points without worsening in Knodell fibrosis.
*c Knodell necroinflammatory score improvement of at least 2 points without worsening in Knodell fibrosis.
*d Median change from baseline HBV DNA merely reflects the difference between baseline HBV DNA and the limit of detection (LOD) of the assay.
*e The population used for analysis of ALT normalisation included only patients with ALT above ULN at baseline.

Tenofovir disoproxil fumarate was associated with significantly greater proportions of patients with undetectable HBV DNA (< 169 copies/ml [< 29 IU/ml]; the limit of quantification of the Roche Cobas Taqman HBV assay), when compared to adefovir dipivoxil (study GS-US-174-0102; 91%, 56% and study GS-US-174-0103; 69%, 9%), respectively.

Response to treatment with tenofovir disoproxil fumarate was comparable in nucleoside-experienced (n = 51) and nucleoside-naïve (n = 375) patients and in patients with normal ALT (n = 21) and abnormal ALT (n = 405) at baseline when studies GS-US-174-0102 and GS-US-174-0103 were combined. Forty-nine of the 51 nucleoside-experienced patients were previously treated with lamivudine. Seventy-three percent of nucleoside-experienced and 69% of nucleoside-naïve patients achieved complete response to treatment; 90% of nucleoside-experienced and 88% of
nucleoside-naïve patients achieved HBV DNA suppression < 400 copies/ml. All patients with normal ALT at baseline and 88% of patients with abnormal ALT at baseline achieved HBV DNA suppression < 400 copies/ml.


In studies GS-US-174-0102 and GS-US-174-0103, after receiving double-blind treatment for 48 weeks (either tenofovir disoproxil 245 mg (as fumarate) or adefovir didoxivoxil 10 mg), patients rolled over with no interruption in treatment to open-label tenofovir disoproxil fumarate. In studies GS-US-174-0102 and GS-US-174-0103, 77% and 61% of patients continued in the study through to 384 weeks, respectively. At weeks 96, 144, 192, 240, 288 and 384, viral suppression, biochemical and serological responses were maintained with continued tenofovir disoproxil fumarate treatment (see Tables 5 and 6 below).

**Table 5: Efficacy parameters in compensated HBeAg negative patients at week 96, 144, 192, 240, 288 and 384 open-label treatment**

<table>
<thead>
<tr>
<th>Parameter&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Study 174-0102 (HBeAg negative)</th>
<th>Study 174-0102 (HBeAg negative)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tenofovir disoproxil 245 mg (as fumarate) n = 250</td>
<td>Tenofovir disoproxil 245 mg (as fumarate) n = 125</td>
</tr>
<tr>
<td><strong>Week</strong></td>
<td>96&lt;sup&gt;b&lt;/sup&gt;</td>
<td>144&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>HBV DNA (%)</strong> (&lt; 400 copies/ml)</td>
<td>90</td>
<td>87</td>
</tr>
<tr>
<td><strong>ALT (%)</strong>&lt;sup&gt;n&lt;/sup&gt;</td>
<td>Normalised ALT&lt;sup&gt;d&lt;/sup&gt;</td>
<td>72</td>
</tr>
<tr>
<td><strong>Serology (%)</strong>&lt;sup&gt;n&lt;/sup&gt;</td>
<td>0/0</td>
<td>0/0</td>
</tr>
</tbody>
</table>

<sup>a</sup> Based upon Long Term Evaluation algorithm (LTE Analysis) - Patients who discontinued the study at any time prior to week 384 due to a protocol defined endpoint, as well as those completing week 384, are included in the denominator.

<sup>b</sup> 48 weeks of double-blind tenofovir disoproxil fumarate followed by 48 weeks open-label.

<sup>c</sup> 48 weeks of double-blind adefovir dipivoxil followed by 48 weeks open-label tenofovir disoproxil fumarate.

<sup>d</sup> The population used for analysis of ALT normalisation included only patients with ALT above ULN at baseline.

<sup>e</sup> 48 weeks of double-blind tenofovir disoproxil fumarate followed by 96 weeks open-label.

<sup>f</sup> 48 weeks of double-blind tenofovir disoproxil fumarate followed by 96 weeks open-label tenofovir disoproxil fumarate.

<sup>g</sup> 48 weeks of double-blind tenofovir disoproxil fumarate followed by 192 weeks open-label.

<sup>h</sup> 48 weeks of double-blind tenofovir disoproxil fumarate followed by 144 weeks open-label.

<sup>i</sup> 48 weeks of double-blind adefovir dipivoxil followed by 144 weeks open-label tenofovir disoproxil fumarate.

<sup>j</sup> 48 weeks of double-blind tenofovir disoproxil fumarate followed by 192 weeks open-label.

<sup>k</sup> 48 weeks of double-blind adefovir dipivoxil followed by 192 weeks open-label tenofovir disoproxil fumarate.

<sup>r</sup> One patient in this group became HBsAg negative for the first time at the 240 week visit and was ongoing in the study at the time of the data cut-off. However, the subject’s HBsAg loss was ultimately confirmed at the subsequent visit.

<sup>s</sup> 48 weeks of double-blind tenofovir disoproxil fumarate followed by 240 weeks open-label.

<sup>t</sup> 48 weeks of double-blind adefovir dipivoxil followed by 240 weeks open-label tenofovir disoproxil fumarate.

<sup>u</sup> Figures presented are cumulative percentages based upon a Kaplan Meier analysis excluding data collected after the addition of entecavir to open-label tenofovir disoproxil fumarate (KM-TDF).

<sup>v</sup> 48 weeks of double-blind tenofovir disoproxil fumarate followed by 336 weeks open-label.

<sup>w</sup> 48 weeks of double-blind adefovir dipivoxil followed by 336 weeks open-label tenofovir disoproxil fumarate.

n/a = not applicable.
### Table 6: Efficacy parameters in compensated HBeAg positive patients at week 96, 144, 192, 240, 288 and 384 open-label treatment

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Tenoforv disoproxil 245 mg (as fumarate) n = 176</th>
<th>Adefovir dipivoxil 10 mg roll over to tenoforv disoproxil 245 mg (as fumarate) n = 90</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week</td>
<td>96(^b) 144(^c) 192(^b) 240(^l) 288(^a) 384(^a)</td>
<td>96(^c) 144(^l) 192(^b) 240(^b) 288(^9) 384(^9)</td>
</tr>
<tr>
<td>HBV DNA (%) &lt; 400 copies/ml (&lt; 69 IU/ml)</td>
<td>76 72 68 64 61 56</td>
<td>74 71 72 66 65 61</td>
</tr>
<tr>
<td>ALT (%) Normalised ALT(^d)</td>
<td>60 55 56 46 47 47</td>
<td>65 61 59 56 57 56</td>
</tr>
<tr>
<td>Serology (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HBeAg loss/ seroconversion</td>
<td>26/ 29/ 34/ 38/ 37/ 30/ 24/ 33/ 36/ 38/ 40/ 35/</td>
<td></td>
</tr>
<tr>
<td>HBsAg loss/ seroconversion</td>
<td>23 23 25 30 25 20 20 26 30 31 31 31 24</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5/ 8/ 11/ 12/ 12/ 15/ 6/ 8/ 8/ 10/ 11/ 13/</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 6(^f) 8(^f) 8(^f) 8(^f) 12(^f) 5 7(^f) 7(^f) 10(^l) 10(^l) 11(^l)</td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) Based upon Long Term Evaluation algorithm (LTE Analysis) - Patients who discontinued the study at any time prior to week 384 due to a protocol defined endpoint, as well as those completing week 384, are included in the denominator.  
\(^b\) 48 weeks of double-blind tenoforv disoproxil fumarate followed by 48 weeks open-label.  
\(^c\) 48 weeks of double-blind adefovir dipivoxil followed by 48 weeks open-label tenoforv disoproxil fumarate.  
\(^d\) The population used for analysis of ALT normalisation included only patients with ALT above ULN at baseline.  
\(^e\) 48 weeks of double-blind tenoforv disoproxil fumarate followed by 96 weeks open-label.  
\(^f\) 48 weeks of double-blind adefovir dipivoxil followed by 96 weeks open-label tenoforv disoproxil fumarate.  
\(^g\) Figures presented are cumulative percentages based upon a Kaplan Meier analysis including data collected after the addition of emtricitabine to open-label tenoforv disoproxil fumarate (KM-ITT).  
\(^h\) 48 weeks of double-blind tenoforv disoproxil fumarate followed by 144 weeks open-label.  
\(^i\) 48 weeks of double-blind adefovir dipivoxil followed by 144 weeks open-label tenoforv disoproxil fumarate.  
\(^j\) Figures presented are cumulative percentages based upon a Kaplan Meier analysis including data collected after the addition of emtricitabine to open-label tenoforv disoproxil fumarate (KM-TDF).  
\(^k\) 48 weeks of double-blind tenoforv disoproxil fumarate followed by 240 weeks open-label.  
\(^l\) 48 weeks of double-blind adefovir dipivoxil followed by 240 weeks open-label tenoforv disoproxil fumarate.  
\(^m\) 48 weeks of double-blind tenoforv disoproxil fumarate followed by 336 weeks open-label.  
\(^n\) 48 weeks of double-blind adefovir dipivoxil followed by 336 weeks open-label tenoforv disoproxil fumarate.  

Paired baseline and week 240 liver biopsy data were available for 331/489 patients who remained in studies GS-US-174-0102 and GS-US-174-0103 at week 240 (see Table 7 below). Ninety-five percent (225/237) of patients without cirrhosis at baseline and 99% (93/94) of patients with cirrhosis at baseline had either no change or an improvement in fibrosis (Ishak fibrosis score). Of the 94 patients with cirrhosis at baseline (Ishak fibrosis score: 5 - 6), 26% (24) experienced no change in Ishak fibrosis score and 72% (68) experienced regression of cirrhosis by week 240 with a reduction in Ishak fibrosis score of at least 2 points.

### Table 7: Histological response (%) in compensated HBeAg negative and HBeAg positive subjects at week 240 compared to baseline

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Study 174-0102 (HBeAg negative)</th>
<th>Study 174-0103 (HBeAg positive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tenofovor disoproxil 245 mg (as fumarate) n = 250(^e)</td>
<td>Adefovor dipivoxil 10 mg roll over to tenoforv disoproxil 245 mg (as fumarate) n = 125(^f)</td>
<td>Tenofovor disoproxil 245 mg (as fumarate) n = 176(^c)</td>
</tr>
<tr>
<td>Histological response(^h) (%)</td>
<td>[88/130(148)]</td>
<td>[85/63(74)]</td>
</tr>
</tbody>
</table>

\(^e\) The population used for analysis of histology included only patients with available liver biopsy data (Missing = Excluded) by week 240. Response after addition of emtricitabine is excluded (total of 17 subjects across both studies).  
\(^f\) Knodell necroinflammatory score improvement of at least 2 points without worsening in Knodell fibrosis score.  
\(^g\) 48 weeks double-blind tenoforv disoproxil fumarate followed by up to 192 weeks open-label.  
\(^h\) 48 weeks double-blind adefovir dipivoxil followed by up to 192 weeks open-label tenoforv disoproxil fumarate.
Experience in patients with HIV co-infection and prior lamivudine experience
In a randomised, 48-week double-blind, controlled study of tenofovir disoproxil 245 mg (as fumarate) in adult patients co-infected with HIV-1 and chronic hepatitis B with prior lamivudine experience (study ACTG 5127), the mean serum HBV DNA levels at baseline in patients randomised to the tenofovir arm were 9.45 log_{10} copies/ml (n = 27). Treatment with tenofovir disoproxil 245 mg (as fumarate) was associated with a mean change in serum HBV DNA from baseline, in the patients for whom there was 48-week data, of \(-5.74\) log_{10} copies/ml (n = 18). In addition, 61% of patients had normal ALT at week 48.

Experience in patients with persistent viral replication (study GS-US-174-0106)
The efficacy and safety of tenofovir disoproxil 245 mg (as fumarate) or tenofovir disoproxil 245 mg (as fumarate) plus 200 mg emtricitabine has been evaluated in a randomised, double-blind study (study GS-US-174-0106), in HBeAg positive and HBeAg negative adult patients who had persistent viraemia (HBV DNA \(\geq 1,000\) copies/ml) while receiving adefovir dipivoxil 10 mg for more than 24 weeks. At baseline, 57% of patients randomised to tenofovir disoproxil fumarate versus 60% of patients randomised to emtricitabine plus tenofovir disoproxil fumarate treatment group had previously been treated with lamivudine. Overall at week 24, treatment with tenofovir disoproxil fumarate resulted in 66% (35/53) of patients with HBV DNA < 400 copies/ml (< 69 IU/ml) versus 69% (36/52) of patients treated with emtricitabine plus tenofovir disoproxil fumarate (p = 0.672). In addition 55% (29/53) of patients treated with tenofovir disoproxil fumarate had undetectable HBV DNA (< 169 copies/ml [< 29 IU/ml]; the limit of quantification of the Roche Cobas TaqMan HBV assay) versus 60% (31/52) of patients treated with emtricitabine plus tenofovir disoproxil fumarate (p = 0.504). Comparisons between treatment groups beyond week 24 are difficult to interpret since investigators had the option to intensify treatment to open-label emtricitabine plus tenofovir disoproxil. Long-term studies to evaluate the benefit/risk of bitherapy with emtricitabine plus tenofovir disoproxil fumarate in HBV monoinfected patients are ongoing.

Experience in patients with decompensated liver disease at 48 weeks (study GS-US-174-0108)
Study GS-US-174-0108 is a randomised, double-blind, active controlled study evaluating the safety and efficacy of tenofovir disoproxil fumarate (n = 45), emtricitabine plus tenofovir disoproxil fumarate (n = 45), and entecavir (n = 22), in patients with decompensated liver disease. In the tenofovir disoproxil fumarate treatment arm, patients had a mean CPT score of 7.2, mean HBV DNA of 5.8 log_{10} copies/ml and mean serum ALT of 61 U/l at baseline. Forty-two percent (19/45) of patients had at least 6 months of prior lamivudine experience, 20% (9/45) of patients had prior adefovir dipivoxil experience and 9 of 45 patients (20%) had lamivudine and/or adefovir dipivoxil resistance mutations at baseline. The co-primary safety endpoints were discontinuation due to an adverse event and confirmed increase in serum creatinine \(\geq 0.5\) mg/dl or confirmed serum phosphate of < 2 mg/dl.

In patients with CPT scores \(\leq 9\), 74% (29/39) of tenofovir disoproxil fumarate, and 94% (33/35) of emtricitabine plus tenofovir disoproxil fumarate treatment groups achieved HBV DNA < 400 copies/ml after 48 weeks of treatment.

Overall, the data derived from this study are too limited to draw any definitive conclusions on the comparison of emtricitabine plus tenofovir disoproxil fumarate versus tenofovir disoproxil fumarate, (see Table 8 below).
Table 8: Safety and efficacy parameters in decompensated patients at week 48

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Tenofovir disoproxil 245 mg (as fumarate) (n = 45)</th>
<th>Emtricitabine 200 mg/ tenofovir disoproxil 245 mg (as fumarate) (n = 45)</th>
<th>Entecavir (0.5 mg or 1 mg) n = 22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tolerability failure (permanent discontinuation of study drug due to a treatment emergent AE) n (%)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>3 (7%)</td>
<td>2 (4%)</td>
<td>2 (9%)</td>
</tr>
<tr>
<td>Confirmed increase in serum creatinine ≥ 0.5 mg/dl from baseline or confirmed serum phosphate of &lt; 2 mg/dl n (%)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>4 (9%)</td>
<td>3 (7%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>HBV DNA n (%) &lt; 400 copies/ml n (%)</td>
<td>31/44 (70%)</td>
<td>36/41 (88%)</td>
<td>16/22 (73%)</td>
</tr>
<tr>
<td>ALT n (%) Normal ALT</td>
<td>25/44 (57%)</td>
<td>31/41 (76%)</td>
<td>12/22 (55%)</td>
</tr>
<tr>
<td>≥ 2 point decrease in CPT from baseline n (%)</td>
<td>7/27 (26%)</td>
<td>12/25 (48%)</td>
<td>5/12 (42%)</td>
</tr>
<tr>
<td>Mean change from baseline in CPT score</td>
<td>-0.8</td>
<td>-0.9</td>
<td>-1.3</td>
</tr>
<tr>
<td>Mean change from baseline in MELD score</td>
<td>-1.8</td>
<td>-2.3</td>
<td>-2.6</td>
</tr>
</tbody>
</table>

<sup>a</sup> p-value comparing the combined tenofovir-containing arms versus the entecavir arm = 0.622,

<sup>b</sup> p-value comparing the combined tenofovir-containing arms versus the entecavir arm = 1.000.

Experience beyond 48 weeks in study GS-US-174-0108

Using a noncompleter/switch = failure analysis, 50% (21/42) of subjects receiving tenofovir disoproxil fumarate, 76% (28/37) of subjects receiving emtricitabine plus tenofovir disoproxil fumarate and 52% (11/21) of subjects receiving entecavir achieved HBV DNA < 400 copies/ml at week 168.

Experience in patients with lamivudine-resistant HBV at 240 weeks (study GS-US-174-0121)

The efficacy and safety of 245 mg tenofovir disoproxil (as fumarate) was evaluated in a randomised, double-blind study (GS-US-174-0121) in HBeAg positive and HBeAg negative patients (n = 280) with compensated liver disease, viraemia (HBV DNA ≥ 1,000 IU/ml), and genotypic evidence of lamivudine resistance (rtM204I/V +/- rtL180M). Only five had adefovir-associated resistance mutations at baseline. One hundred forty-one and 139 adult subjects were randomised to a tenofovir disoproxil fumarate and emtricitabine plus tenofovir disoproxil fumarate treatment arm, respectively. Baseline demographics were similar between the two treatment arms: At baseline, 52.5% of subjects were HBeAg negative, 47.5% were HBeAg positive, mean HBV DNA level was 6.5 log<sub>10</sub> copies/ml, and mean ALT was 79 U/l, respectively.

After 240 weeks of treatment, 117 of 141 subjects (83%) randomised to tenofovir disoproxil fumarate had HBV DNA < 400 copies/ml, and 51 of 79 subjects (65%) had ALT normalisation. After 240 weeks of treatment with emtricitabine plus tenofovir disoproxil fumarate, 115 of 139 subjects (83%) had HBV DNA < 400 copies/ml, and 59 of 83 subjects (71%) had ALT normalisation. Among the HBeAg positive subjects randomised to tenofovir disoproxil fumarate, 16 of 65 subjects (25%) experienced HBeAg loss, and 8 of 65 subjects (12%) experienced anti-HBe seroconversion through week 240. In the HBeAg positive subjects randomised to emtricitabine plus tenofovir disoproxil fumarate, 13 of 68 subjects (19%) experienced HBeAg loss, and 7 of 68 subjects (10%) experienced...
anti-HBe seroconversion through week 240. Two subjects randomised to tenofovir disoproxil fumarate experienced HBsAg loss by Week 240, but not seroconversion to anti-HBs. Five subjects randomised to emtricitabine plus tenofovir disoproxil fumarate experienced HBsAg loss, with 2 of these 5 subjects experiencing seroconversion to anti-HBs.

Clinical resistance
Four hundred and twenty-six HBeAg negative (GS-US-174-0102, n = 250) and HBeAg positive (GS-US-174-0103, n = 176) patients initially randomised to double-blind tenofovir disoproxil fumarate treatment and then switched to open-label tenofovir disoproxil fumarate treatment were evaluated for genotypic changes in HBV polymerase from baseline. Genotypic evaluations performed on all patients with HBV DNA > 400 copies/ml at week 48 (n = 39), 96 (n = 24), 144 (n = 6), 192 (n = 5), 240 (n = 4), 288 (n = 6) and 384 (n = 2) of tenofovir disoproxil fumarate monotherapy showed that no mutations associated with tenofovir disoproxil fumarate resistance have developed.

Two hundred and fifteen HBeAg negative (GS-US-174-0102, n = 125) and HBeAg positive (GS-US-174-0103, n = 90) patients initially randomised to double-blind adefovir dipivoxil treatment and then switched to open-label tenofovir disoproxil fumarate treatment were evaluated for genotypic changes in HBV polymerase from baseline. Genotypic evaluations performed on all patients with HBV DNA > 400 copies/ml at week 48 (n = 16), 96 (n = 5), 144 (n = 1), 192 (n = 2), 240 (n = 1), 288 (n = 1) and 384 (n = 2) of tenofovir disoproxil fumarate monotherapy showed that no mutations associated with tenofovir disoproxil fumarate resistance have developed.

In study GS-US-174-0108, 45 patients (including 9 patients with lamivudine and/or adefovir dipivoxil resistance mutations at baseline) received tenofovir disoproxil fumarate for up to 168 weeks. Genotypic data from paired baseline and on treatment HBV isolates were available for 6/8 patients with HBV DNA > 400 copies/ml at week 48. No amino acid substitutions associated with resistance to tenofovir disoproxil fumarate were identified in these isolates. Genotypic analysis was conducted for 5 subjects in the tenofovir disoproxil fumarate arm post week 48. No amino acid substitutions associated with tenofovir disoproxil fumarate resistance were detected in any subject.

In study GS-US-174-0121, 141 patients with lamivudine resistance substitutions at baseline received tenofovir disoproxil fumarate for up to 240 weeks. Cumulatively, there were 4 patients who experienced a viremic episode (HBV DNA>400 copies/ml) at their last timepoint on TDF. Among them, sequence data from paired baseline and on treatment HBV isolates were available for 2 of 4 patients. No amino acid substitutions associated with resistance to tenofovir disoproxil fumarate were identified in these isolates.

In a paediatric study (GS-US-174-0115), 52 patients (including 6 patients with lamivudine resistance mutations at baseline) initially received blinded tenofovir disoproxil fumarate for up to 72 weeks and then 51/52 patients switched to open-label tenofovir disoproxil fumarate (TDF-TDF group). Genotypic evaluations were performed on all patients within this group with HBV DNA > 400 copies/ml at week 48 (n = 6), week 72 (n = 5), week 96 (n = 4), week 144 (n = 2), and week 192 (n = 3). Fifty-four patients (including 2 patients with lamivudine resistance mutations at baseline) initially received blinded placebo treatment for 72 weeks, and 52/54 patients followed with tenofovir disoproxil fumarate (PLB-TDF group). Genotypic evaluations were performed on all patients within this group with HBV DNA > 400 copies/ml at week 96 (n = 17), week 144 (n = 7), and week 192 (n = 8). No amino acid substitutions associated with resistance to tenofovir disoproxil fumarate were identified in these isolates.

Paediatric population
HIV-1: In study GS-US-104-0321, 87 HIV-1 infected treatment-experienced patients 12 to < 18 years of age were treated with tenofovir disoproxil fumarate (n = 45) or placebo (n = 42) in combination with an optimised background regimen (OBR) for 48 weeks. Due to limitations of the study, a benefit of tenofovir disoproxil fumarate over placebo was not demonstrated based on plasma HIV-1 RNA levels at week 24. However, a benefit is expected for the adolescent population based on extrapolation of adult data and comparative pharmacokinetic data (see section 5.2).
In patients who received treatment with tenofovir disoproxil fumarate or placebo, mean lumbar spine BMD Z-score was -1.004 and -0.809, and mean total body BMD Z-score was -0.866 and -0.584, respectively, at baseline. Mean changes at week 48 (end of double-blind phase) were -0.215 and -0.165 in lumbar spine BMD Z-score, and -0.254 and -0.179 in total body BMD Z-score for the tenofovir disoproxil fumarate and placebo groups, respectively. The mean rate of BMD gain was less in the tenofovir disoproxil fumarate group compared to the placebo group. At week 48, six adolescents in the tenofovir disoproxil fumarate group and one adolescent in the placebo group had significant lumbar spine BMD loss (defined as > 4% loss). Among 28 patients receiving 96 weeks of treatment with tenofovir disoproxil fumarate, BMD Z-scores declined by -0.341 for lumbar spine and -0.458 for total body.

In study GS-US-104-0352, 97 treatment-experienced patients 2 to <12 years of age with stable, virologic suppression on stavudine- or zidovudine-containing regimens were randomised to either replace stavudine or zidovudine with tenofovir disoproxil fumarate (n = 48) or continue on their original regimen (n = 49) for 48 weeks. At week 48, 83% of patients in the tenofovir disoproxil fumarate treatment group and 92% of patients in the stavudine or zidovudine treatment group had HIV-1 RNA concentrations < 400 copies/ml. The difference in the proportion of patients who maintained < 400 copies/ml at week 48 was mainly influenced by the higher number of discontinuations in the tenofovir disoproxil fumarate treatment group. When missing data were excluded, 91% of patients in the tenofovir disoproxil fumarate treatment group and 94% of patients in the stavudine or zidovudine treatment group had HIV-1 RNA concentrations < 400 copies/ml at week 48.

Reductions in BMD have been reported in paediatric patients. In patients who received treatment with tenofovir disoproxil fumarate, or stavudine or zidovudine, mean lumbar spine BMD Z-score was -1.034 and -0.498, and mean total body BMD Z-score was -0.471 and -0.386, respectively, at baseline. Mean changes at week 48 (end of randomised phase) were 0.032 and 0.087 in lumbar spine BMD Z-score, and -0.184 and -0.027 in total body BMD Z-score for the tenofovir disoproxil fumarate and stavudine or zidovudine groups, respectively. The mean rate of lumbar spine bone gain at week 48 was similar between the tenofovir disoproxil fumarate treatment group and the stavudine or zidovudine treatment group. Total body bone gain was less in the tenofovir disoproxil fumarate treatment group compared to the stavudine or zidovudine treatment group. One tenofovir disoproxil fumarate treated subject and no stavudine or zidovudine treated subjects experienced significant (> 4%) lumbar spine BMD loss at week 48. BMD Z-scores declined by -0.012 for lumbar spine and by -0.338 for total body in the 64 subjects who were treated with tenofovir disoproxil fumarate for 96 weeks. BMD Z-scores were not adjusted for height and weight.

In study GS-US-104-0352, 4 out of 89 paediatric patients exposed to tenofovir disoproxil fumarate discontinued due to adverse reactions consistent with proximal renal tubulopathy (median tenofovir disoproxil fumarate exposure 104 weeks).

**Chronic hepatitis B:** In study GS-US-174-0115, 106 HBeAg negative and HBeAg positive patients aged 12 to < 18 years with chronic HBV infection [HBV DNA ≥ 10^5 copies/ml, elevated serum ALT (≥ 2 x ULN) or a history of elevated serum ALT levels in the past 24 months] were treated with tenofovir disoproxil 245 mg (as fumarate) (n = 52) or placebo (n = 54) for 72 weeks. Subjects must have been naïve to tenofovir disoproxil fumarate, but could have received interferon based regimens (> 6 months prior to screening) or any other non-tenofovir disoproxil fumarate containing oral anti-HBV nucleoside/nucleotide therapy (> 16 weeks prior to screening). At week 72, overall 88% (46/52) of patients in the tenofovir disoproxil fumarate treatment group and 0% (0/54) of patients in the placebo group had HBV DNA < 400 copies/ml. Seventy-four percent (26/35) of patients in the tenofovir disoproxil fumarate group had normalised ALT at week 72 compared to 31% (13/42) in the placebo group. Response to treatment with tenofovir disoproxil fumarate was comparable in nucleos(t)ide-naïve (n = 20) and nucleos(t)ide-experienced (n = 32) patients, including lamivudine-resistant patients (n = 6). Ninety-five percent of nucleos(t)ide-naïve patients, 84% of nucleos(t)ide-experienced patients, and 83% of lamivudine-resistant patients achieved HBV DNA < 400 copies/ml at week 72. Thirty-one of the 32 nucleos(t)ide-experienced patients had prior lamivudine experience. At week 72, 96% (27/28) of immune-active patients (HBV DNA ≥ 10^5 copies/ml, serum ALT 150
> 1.5 x ULN) in the tenofovir disoproxil fumarate treatment group and 0% (0/32) of patients in the placebo group had HBV DNA < 400 copies/ml. Seventy-five percent (21/28) of immune-active patients in the tenofovir disoproxil fumarate group had normal ALT at week 72 compared to 34% (11/32) in the placebo group.

After 72 weeks of blinded randomized treatment, each subject could switch to open-label tenofovir disoproxil fumarate treatment up to week 192. After week 72, virologic suppression was maintained for those receiving double-blind tenofovir disoproxil fumarate followed by open-label tenofovir disoproxil fumarate (TDF-TDF group): 86.5% (45/52) of subjects in the TDF-TDF group had HBV DNA < 400 copies/ml at week 192. Among the subjects who received placebo during the double-blind period, the proportion of subjects with HBV DNA < 400 copies/mL rose sharply after they began treatment with open-label TDF (PLB-TDF group): 74.1% (40/54) of subjects in the PLB-TDF group had HBV DNA < 400 copies/ml at week 192. The proportion of subjects with ALT normalization at week 192 in the TDF-TDF group was 75.8% (25/33) among those who were HBeAg positive at baseline and 100.0% (2 of 2 subjects) among those who were HBeAg negative at baseline. Similar percentages of subjects in the TDF-TDF and PLB-TDF groups (37.5% and 41.7%, respectively) experienced seroconversion to anti-HBe through week 192.

Bone Mineral Density (BMD) data from Study GS-US-174-0115 are summarized in Table 9:

| Table 9: Bone Mineral Density Evaluation at Baseline, Week 72 and 192 |
|----------------------|----------------------|----------------------|----------------------|----------------------|
|                      | Baseline            | Week 72              | Week 192             |                      |
|                      | TDF-TDF             | TDF-TDF              | TDF-TDF              | TDF-TDF             |
|                      | (SD) BMD Z-score    | (SD) BMD Z-score     | (SD) BMD Z-score     | (SD) BMD Z-score    |
| Lumbar spine mean    | −0.42 (0.762)       | −0.26 (0.806)        | −0.49 (0.852)        | −0.37 (0.946)       |
| (SD) BMD Z-score     |                      |                      | (0.893)              | (0.946)             |
| Lumbar spine mean    | NA                   | NA                   | −0.06 (0.320)        | 0.10 (0.378)        |
| (SD) change from     |                      |                      |                      | 0.02 (0.548)        |
| baseline BMD Z-score |                      |                      |                      | (0.548)             |
| Whole body mean      | −0.19 (1.110)       | −0.23 (0.859)        | −0.36 (1.077)        | −0.38 (0.934)       |
| (SD) BMD Z-score     |                      |                      | (0.916)              | (0.934)             |
| Whole body mean      | NA                   | NA                   | −0.16 (0.355)        | −0.16 (0.521)       |
| (SD) change from     |                      |                      | (0.349)              | (0.521)             |
| baseline BMD Z-score |                      |                      |                      | (0.504)             |
| Lumbar spine BMD at  | NA                   | NA                   | 1.9% (1 subject)     | 3.8% (2 subjects)   |
| least 6% decreaseb   |                      |                      | 0%                   | 3.7% (2 subjects)   |
| Whole body BMD at     | NA                   | NA                   | 0%                   | 0%                  |
| least 6% decreaseb   |                      |                      |                      | 1.9% (1 subject)    |
| Lumbar spine BMD     | NA                   | NA                   | 5.14%                | 10.05%              |
| mean % increase      |                      |                      |                      | 11.21%              |
| Whole body BMD       | NA                   | NA                   | 3.07%                | 6.09%               |
| mean % increase      |                      |                      |                      | 7.22%               |

NA = Not Applicable

a BMD Z-scores not adjusted for height and weight
b Primary safety endpoint through week 72

The European Medicines Agency has deferred the obligation to submit the results of studies with Viread in one or more subsets of the paediatric population in HIV and chronic hepatitis B (see section 4.2 for information on paediatric use).

5.2 Pharmacokinetic properties

Tenofovir disoproxil fumarate is a water soluble ester prodrug which is rapidly converted in vivo to tenofovir and formaldehyde.
Tenofovir is converted intracellularly to tenofovir monophosphate and to the active component, tenofovir diphosphate.

**Absorption**

Following oral administration of tenofovir disoproxil fumarate to HIV infected patients, tenofovir disoproxil fumarate is rapidly absorbed and converted to tenofovir. Administration of multiple doses of tenofovir disoproxil fumarate with a meal to HIV infected patients resulted in mean (%CV) tenofovir $C_{max}$, AUC, and $C_{min}$ values of 326 (36.6%) ng/ml, 3,324 (41.2%) ng·h/ml and 64.4 (39.4%) ng/ml, respectively. Maximum tenofovir concentrations are observed in serum within one hour of dosing in the fasted state and within two hours when taken with food. The oral bioavailability of tenofovir from tenofovir disoproxil fumarate in fasted patients was approximately 25%. Administration of tenofovir disoproxil fumarate with a high fat meal enhanced the oral bioavailability, with an increase in tenofovir AUC by approximately 40% and $C_{max}$ by approximately 14%. Following the first dose of tenofovir disoproxil fumarate in fed patients, the median $C_{max}$ in serum ranged from 213 to 375 ng/ml. However, administration of tenofovir disoproxil fumarate with a light meal did not have a significant effect on the pharmacokinetics of tenofovir.

**Distribution**

Following intravenous administration the steady-state volume of distribution of tenofovir was estimated to be approximately 800 ml/kg. After oral administration of tenofovir disoproxil fumarate, tenofovir is distributed to most tissues with the highest concentrations occurring in the kidney, liver and the intestinal contents (preclinical studies). *In vitro* protein binding of tenofovir to plasma or serum protein was less than 0.7 and 7.2%, respectively, over the tenofovir concentration range 0.01 to 25 µg/ml.

**Biotransformation**

*In vitro* studies have determined that neither tenofovir disoproxil fumarate nor tenofovir are substrates for the CYP450 enzymes. Moreover, at concentrations substantially higher (approximately 300-fold) than those observed *in vivo*, tenofovir did not inhibit *in vitro* drug metabolism mediated by any of the major human CYP450 isoforms involved in drug biotransformation (CYP3A4, CYP2D6, CYP2C9, CYP2E1, or CYP1A1/2). Tenofovir disoproxil fumarate at a concentration of 100 µmol/l had no effect on any of the CYP450 isoforms, except CYP1A1/2, where a small (6%) but statistically significant reduction in metabolism of CYP1A1/2 substrate was observed. Based on these data, it is unlikely that clinically significant interactions involving tenofovir disoproxil fumarate and medicinal products metabolised by CYP450 would occur.

**Elimination**

Tenofovir is primarily excreted by the kidney by both filtration and an active tubular transport system with approximately 70-80% of the dose excreted unchanged in urine following intravenous administration. Total clearance has been estimated to be approximately 230 ml/h/kg (approximately 300 ml/min). Renal clearance has been estimated to be approximately 160 ml/h/kg (approximately 210 ml/min), which is in excess of the glomerular filtration rate. This indicates that active tubular secretion is an important part of the elimination of tenofovir. Following oral administration the terminal half-life of tenofovir is approximately 12 to 18 hours.

Studies have established the pathway of active tubular secretion of tenofovir to be influx into proximal tubule cell by the human organic anion transporters (hOAT) 1 and 3 and efflux into the urine by the multidrug resistant protein 4 (MRP 4).

**Linearity/non-linearity**

The pharmacokinetics of tenofovir were independent of tenofovir disoproxil fumarate dose over the dose range 75 to 600 mg and were not affected by repeated dosing at any dose level.

**Age**

Pharmacokinetic studies have not been performed in the elderly (over 65 years of age).
Gender
Limited data on the pharmacokinetics of tenofovir in women indicate no major gender effect.

Ethnicity
Pharmacokinetics have not been specifically studied in different ethnic groups.

Paediatric population
HIV-1: Steady-state pharmacokinetics of tenofovir were evaluated in 8 HIV-1 infected adolescent patients (aged 12 to < 18 years) with body weight ≥ 35 kg and in 23 HIV-1 infected children aged 2 to < 12 years (see Table 10 below). Tenofovir exposure achieved in these paediatric patients receiving oral daily doses of tenofovir disoproxil 245 mg (as fumarate) or 6.5 mg/kg body weight tenofovir disoproxil (as fumarate) up to a maximum dose of 245 mg was similar to exposures achieved in adults receiving once-daily doses of tenofovir disoproxil 245 mg (as fumarate).

Table 10: Mean (± SD) tenofovir pharmacokinetic parameters by age groups for paediatric patients

<table>
<thead>
<tr>
<th>Dose and formulation</th>
<th>245 mg film-coated tablet 12 to &lt; 18 years (n = 8)</th>
<th>6.5 mg/kg granules 2 to &lt; 12 years (n = 23)</th>
</tr>
</thead>
<tbody>
<tr>
<td>( C_{max} ) (μg/ml)</td>
<td>0.38 ± 0.13</td>
<td>0.24 ± 0.13</td>
</tr>
<tr>
<td>( AUC_{tau} ) (μg·h/ml)</td>
<td>3.39 ± 1.22</td>
<td>2.59 ± 1.06</td>
</tr>
</tbody>
</table>

Chronic hepatitis B: Steady-state tenofovir exposure in HBV infected adolescent patients (12 to < 18 years of age) receiving an oral daily dose of tenofovir disoproxil 245 mg (as fumarate) was similar to exposures achieved in adults receiving once-daily doses of tenofovir disoproxil 245 mg (as fumarate).

Pharmacokinetic studies have not been performed in children under 2 years.

Renal impairment
Pharmacokinetic parameters of tenofovir were determined following administration of a single dose of tenofovir disoproxil 245 mg to 40 non-HIV, non-HBV infected adult patients with varying degrees of renal impairment defined according to baseline adult creatinine clearance (CrCl) (normal renal function when CrCl > 80 ml/min; mild with CrCl = 50-79 ml/min; moderate with CrCl = 30-49 ml/min and severe with CrCl = 10-29 ml/min). Compared with patients with normal renal function, the mean (%CV) tenofovir exposure increased from 2,185 (12%) ng·h/ml in subjects with CrCl > 80 ml/min to respectively 3,064 (30%) ng·h/ml, 6,009 (42%) ng·h/ml and 15,985 (45%) ng·h/ml in patients with mild, moderate and severe renal impairment.

Pharmacokinetic modelling of single-dose pharmacokinetic data in non-HIV and non-HBV infected adult subjects with varying degrees of renal impairment was used to determine dose and dosing interval recommendations for adult subjects with varying degrees of renal impairment (see section 4.2).

Doses of 132 mg, 65 mg and 33 mg tenofovir disoproxil (as fumarate) granules once daily are recommended in adult patients with calculated creatinine clearance (CrCl) of 30 to 49 ml/min, 20 to 29 ml/min or 10 to 19 ml/min, respectively. Although these doses are not expected to exactly reproduce the pharmacokinetic profile of tenofovir in patients with normal renal function receiving tenofovir disoproxil (as fumarate) 245 mg film-coated tablets, they are considered to represent the best balance of benefit and risk for patients with renal impairment.

In subjects with end-stage renal disease (ESRD) (CrCl < 10 ml/min) requiring haemodialysis, a dose of 16.5 mg tenofovir disoproxil following completion of haemodialysis is predicted to limit tenofovir systemic accumulation to exposures approximately 2-fold compared to those observed in patients with normal renal function receiving tenofovir disoproxil (as fumarate) 245 mg film-coated tablets. This dosing recommendation balances the need to limit drug accumulation while attempting to maintain sufficient tenofovir concentrations over the dosing interval similar to trough concentrations observed
in patients with normal renal function receiving tenofovir disoproxil (as fumarate) 245 mg film-coated tablets.

The pharmacokinetics of tenofovir in non-haemodialysis patients with creatinine clearance < 10 ml/min and in patients with ESRD managed by peritoneal or other forms of dialysis have not been studied.

The pharmacokinetics of tenofovir in paediatric patients with renal impairment have not been studied. No data are available to make dose recommendations (see sections 4.2 and 4.4).

**Hepatic impairment**

A single 245 mg dose of tenofovir disoproxil was administered to non-HIV, non-HBV infected adult patients with varying degrees of hepatic impairment defined according to Child-Pugh-Turcotte (CPT) classification. Tenofovir pharmacokinetics were not substantially altered in subjects with hepatic impairment suggesting that no dose adjustment is required in these subjects. The mean (%CV) tenofovir $C_{\text{max}}$ and $AUC_{0-\infty}$ values were 223 (34.8%) ng/ml and 2,050 (50.8%) ng·h/ml, respectively, in normal subjects compared with 289 (46.0%) ng/ml and 2,310 (43.5%) ng·h/ml in subjects with moderate hepatic impairment, and 305 (24.8%) ng/ml and 2,740 (44.0%) ng·h/ml in subjects with severe hepatic impairment.

**Intracellular pharmacokinetics**

In non-proliferating human peripheral blood mononuclear cells (PBMCs) the half-life of tenofovir diphosphate was found to be approximately 50 hours, whereas the half-life in phytohaemagglutinin-stimulated PBMCs was found to be approximately 10 hours.

**5.3 Preclinical safety data**

Non-clinical safety pharmacology studies reveal no special hazard for humans. Findings in repeated dose toxicity studies in rats, dogs and monkeys at exposure levels greater than or equal to clinical exposure levels and with possible relevance to clinical use include renal and bone toxicity and a decrease in serum phosphate concentration. Bone toxicity was diagnosed as osteomalacia (monkeys) and reduced bone mineral density (BMD) (rats and dogs). The bone toxicity in young adult rats and dogs occurred at exposures ≥ 5-fold the exposure in paediatric or adult patients; bone toxicity occurred in juvenile infected monkeys at very high exposures following subcutaneous dosing (≥ 40-fold the exposure in patients). Findings in the rat and monkey studies indicated that there was a substance-related decrease in intestinal absorption of phosphate with potential secondary reduction in BMD.

Genotoxicity studies revealed positive results in the *in vitro* mouse lymphoma assay, equivocal results in one of the strains used in the Ames test, and weakly positive results in an UDS test in primary rat hepatocytes. However, it was negative in an *in vivo* mouse bone marrow micronucleus assay.

Oral carcinogenicity studies in rats and mice only revealed a low incidence of duodenal tumours at an extremely high dose in mice. These tumours are unlikely to be of relevance to humans.

Reproductive studies in rats and rabbits showed no effects on mating, fertility, pregnancy or foetal parameters. However, tenofovir disoproxil fumarate reduced the viability index and weight of pups in peri-postnatal toxicity studies at maternally toxic doses.

The active substance tenofovir disoproxil fumarate and its main transformation products are persistent in the environment.
6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Ethylcellulose (E462)
Hydroxypropyl cellulose (E463)
Mannitol (E421)
Silicon dioxide (E551)

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

3 years.

6.4 Special precautions for storage

Do not store above 25°C.

6.5 Nature and contents of container

High density polyethylene (HDPE) bottle with a polypropylene child-resistant closure containing 60 g of granules and a dosing scoop.

6.6 Special precautions for disposal

Any unused medicinal product or waste material should be disposed of in accordance with local requirements.

7. MARKETING AUTHORISATION HOLDER

Gilead Sciences International Limited
Cambridge
CB21 6GT
United Kingdom

8. MARKETING AUTHORISATION NUMBER(S)

EU/1/01/200/003

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 5 February 2002
Date of latest renewal: 14 December 2011

10. DATE OF REVISION OF THE TEXT

Detailed information on this medicinal product is available on the website of the European Medicines Agency http://www.ema.europa.eu
ANNEX II

A. MANUFACTURER(S) RESPONSIBLE FOR BATCH RELEASE

B. CONDITIONS OR RESTRICTIONS REGARDING SUPPLY AND USE

C. OTHER CONDITIONS AND REQUIREMENTS OF THE MARKETING AUTHORISATION

D. CONDITIONS OR RESTRICTIONS WITH REGARD TO THE SAFE AND EFFECTIVE USE OF THE MEDICINAL PRODUCT
A. MANUFACTURER(S) RESPONSIBLE FOR BATCH RELEASE

Name and address of the manufacturer(s) responsible for batch release

Takeda GmbH
Lehnitzstrasse 70-98
D-16515 Oranienburg
Germany

Gilead Sciences Ireland UC
IDA Business & Technology Park
Carrigtohill
County Cork
Ireland

The printed package leaflet of the medicinal product must state the name and address of the manufacturer responsible for the release of the concerned batch.

B. CONDITIONS OR RESTRICTIONS REGARDING SUPPLY AND USE

Medicinal product subject to restricted medical prescription (see Annex I: Summary of Product Characteristics, section 4.2).

C. OTHER CONDITIONS AND REQUIREMENTS OF THE MARKETING AUTHORISATION

• Periodic Safety Update Reports

The requirements for submission of periodic safety update reports for this medicinal product are set out in the list of Union reference dates (EURD list) provided for under Article 107c(7) of Directive 2001/83/EC and any subsequent updates published on the European medicines web-portal.

D. CONDITIONS OR RESTRICTIONS WITH REGARD TO THE SAFE AND EFFECTIVE USE OF THE MEDICINAL PRODUCT

• Risk Management Plan (RMP)

The MAH shall perform the required pharmacovigilance activities and interventions detailed in the agreed RMP presented in Module 1.8.2 of the Marketing Authorisation and any agreed subsequent updates of the RMP.

An updated RMP should be submitted:
• At the request of the European Medicines Agency;
• Whenever the risk management system is modified, especially as the result of new information being received that may lead to a significant change to the benefit/risk profile or as the result of an important (pharmacovigilance or risk minimisation) milestone being reached.
**Additional risk minimisation measures**

The Marketing Authorisation Holder (MAH) shall ensure that all physicians who are expected to prescribe/use Viread in adults and/or paediatric patients are provided with a physician educational pack containing the Summary of Product Characteristics and an appropriate educational brochure, as detailed below:

- HIV renal educational brochure, including the creatinine clearance slide ruler
- HBV renal educational brochure, including the creatinine clearance slide ruler
- HIV paediatric educational brochure
- HBV paediatric educational brochure

The HIV and HBV renal educational brochures should contain the following key messages:

- That there is an increased risk of renal disease in HIV and HBV infected patients associated with tenofovir disoproxil fumarate-containing products such as Viread
- That Viread should only be used in patients with impaired renal function if the potential benefits of treatment are considered to outweigh the potential risks
- The importance of daily dose adjustment using Viread 33 mg/g granules, or alternatively dose interval adjustment using Viread 245 mg film-coated tablets, in adult patients with creatinine clearance of 30-49 ml/min
- Daily dose adjustment using Viread 33 mg/g granules is recommended for patients with severe renal impairment (creatinine clearance < 30 ml/min). For patients unable to use the granules formulation and with no alternative treatment available, prolonged dose intervals using Viread 245 mg film-coated tablets may be used
- That use of Viread should be avoided with concomitant or recent use of nephrotoxic medicinal products. If Viread is used with nephrotoxic medicinal products, renal function should be closely monitored according to the recommended schedule
- That patients should have their baseline renal function assessed prior to initiating Viread therapy
- The importance of regular monitoring of renal function during Viread therapy
- Recommended schedule for monitoring renal function considering the presence or absence of additional risk factors for renal impairment
- That if serum phosphate is < 1.5 mg/dl or creatinine clearance decreases during therapy to < 50 ml/min then renal function should be re-evaluated within one week. If creatinine clearance is confirmed as < 50 ml/min or serum phosphate decreases to < 1.0 mg/dl then consideration should be given to interrupting Viread therapy. Interrupting treatment with Viread should also be considered in case of progressive decline of renal function when no other cause has been identified.
- Instructions on the use of the creatinine clearance slide ruler

The HIV and HBV paediatric educational brochures should contain the following key messages:

- That a multidisciplinary approach is recommended for the management of paediatric patients
- That there is an increased risk of renal disease in HIV and HBV infected patients associated with tenofovir disoproxil fumarate-containing products such as Viread
- That Viread is not recommended for use in paediatric patients with renal impairment
- That use of Viread should be avoided with concomitant or recent use of nephrotoxic medicinal products. If Viread is used with nephrotoxic medicinal products, renal function should be closely monitored according to the recommended schedule
- That patients should have their baseline renal function assessed prior to initiating Viread therapy
- The importance of regular monitoring of renal function during Viread therapy
- Recommended schedule for monitoring renal function considering the presence or absence of additional risk factors for renal impairment
- That if serum phosphate is confirmed to be < 3.0 mg/dl (0.96 mmol/l) in any paediatric patient receiving tenofovir disoproxil fumarate, renal function should be re-evaluated within one week. If renal abnormalities are detected or suspected then consultation with a nephrologist should be obtained to consider interruption of Viread treatment. Interrupting treatment with Viread should also be considered in case of progressive decline of renal function when no other cause has been identified.
- That Viread may cause a reduction in BMD and the effects of Viread associated changes in BMD on long term bone health and future fracture risk are currently unknown in paediatric patients
- That if bone abnormalities are detected or suspected then consultation with an endocrinologist and/or nephrologist should be obtained
ANNEX III

LABELLING AND PACKAGE LEAFLET
A. LABELLING
PARTICULARS TO APPEAR ON THE OUTER PACKAGING AND THE IMMEDIATE PACKAGING

BOTTLE AND CARTON LABELLING

1.  NAME OF THE MEDICINAL PRODUCT

Viread 123 mg film-coated tablets
Tenofovir disoproxil

2.  STATEMENT OF ACTIVE SUBSTANCE(S)

Each film-coated tablet contains 123 mg of tenofovir disoproxil (as fumarate).

3.  LIST OF EXCIPIENTS

Contains lactose monohydrate.

4.  PHARMACEUTICAL FORM AND CONTENTS

30 film-coated tablets.
30 tablets.
90 (3 bottles of 30) film-coated tablets.
90 (3 bottles of 30) tablets.

5.  METHOD AND ROUTE(S) OF ADMINISTRATION

Read the package leaflet before use.
Oral use.

6.  SPECIAL WARNING THAT THE MEDICINAL PRODUCT MUST BE STORED OUT OF THE SIGHT AND REACH OF CHILDREN

Keep out of the sight and reach of children.

7.  OTHER SPECIAL WARNING(S), IF NECESSARY

8.  EXPIRY DATE

EXP
9. **SPECIAL STORAGE CONDITIONS**

10. **SPECIAL PRECAUTIONS FOR DISPOSAL OF UNUSED MEDICINAL PRODUCTS OR WASTE MATERIALS DERIVED FROM SUCH MEDICINAL PRODUCTS, IF APPROPRIATE**

11. **NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER**

   Gilead Sciences Intl Ltd  
   Cambridge  
   CB21 6GT  
   United Kingdom

12. **MARKETING AUTHORISATION NUMBER(S)**

   EU/1/01/200/004 30 film-coated tablets  
   EU/1/01/200/005 90 (3 bottles of 30) film-coated tablets

13. **BATCH NUMBER**

   Lot

14. **GENERAL CLASSIFICATION FOR SUPPLY**

15. **INSTRUCTIONS ON USE**

16. **INFORMATION IN BRAILLE**

   Viread 123 mg [outer packaging only]

17. **UNIQUE IDENTIFIER – 2D BARCODE**

   2D barcode carrying the unique identifier included.

18. **UNIQUE IDENTIFIER - HUMAN READABLE DATA**

   PC: {number}  
   SN: {number}  
   NN: {number}
PARTICULARS TO APPEAR ON THE OUTER PACKAGING AND THE IMMEDIATE PACKAGING

BOTTLE AND CARTON LABELLING

1. **NAME OF THE MEDICINAL PRODUCT**

Viread 163 mg film-coated tablets
Tenofovir disoproxil

2. **STATEMENT OF ACTIVE SUBSTANCE(S)**

Each film-coated tablet contains 163 mg of tenofovir disoproxil (as fumarate).

3. **LIST OF EXCIPIENTS**

Contains lactose monohydrate.

4. **PHARMACEUTICAL FORM AND CONTENTS**

30 film-coated tablets.
30 tablets.

90 (3 bottles of 30) film-coated tablets.
90 (3 bottles of 30) tablets.

5. **METHOD AND ROUTE(S) OF ADMINISTRATION**

Read the package leaflet before use.
Oral use.

6. **SPECIAL WARNING THAT THE MEDICINAL PRODUCT MUST BE STORED OUT OF THE SIGHT AND REACH OF CHILDREN**

Keep out of the sight and reach of children.

7. **OTHER SPECIAL WARNING(S), IF NECESSARY**

8. **EXPIRY DATE**

EXP
9. SPECIAL STORAGE CONDITIONS

10. SPECIAL PRECAUTIONS FOR DISPOSAL OF UNUSED MEDICINAL PRODUCTS OR WASTE MATERIALS DERIVED FROM SUCH MEDICINAL PRODUCTS, IF APPROPRIATE

11. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER

Gilead Sciences Intl Ltd
Cambridge
CB21 6GT
United Kingdom

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/01/200/006 30 film-coated tablets
EU/1/01/200/007 90 (3 bottles of 30) film-coated tablets

13. BATCH NUMBER

Lot

14. GENERAL CLASSIFICATION FOR SUPPLY

15. INSTRUCTIONS ON USE

16. INFORMATION IN BRAILLE

Viread 163 mg [outer packaging only]

17. UNIQUE IDENTIFIER – 2D BARCODE

2D barcode carrying the unique identifier included.

18. UNIQUE IDENTIFIER - HUMAN READABLE DATA

PC: {number}
SN: {number}
NN: {number}
### PARTICULARS TO APPEAR ON THE OUTER PACKAGING AND THE IMMEDIATE PACKAGING

#### BOTTLE AND CARTON LABELLING

1. **NAME OF THE MEDICINAL PRODUCT**

   Viread 204 mg film-coated tablets  
   Tenofovir disoproxil

2. **STATEMENT OF ACTIVE SUBSTANCE(S)**

   Each film-coated tablet contains 204 mg of tenofovir disoproxil (as fumarate).

3. **LIST OF EXCIPIENTS**

   Contains lactose monohydrate.

4. **PHARMACEUTICAL FORM AND CONTENTS**

   - 30 film-coated tablets.  
   - 30 tablets.  
   - 90 (3 bottles of 30) film-coated tablets.  
   - 90 (3 bottles of 30) tablets.

5. **METHOD AND ROUTE(S) OF ADMINISTRATION**

   Read the package leaflet before use.  
   Oral use.

6. **SPECIAL WARNING THAT THE MEDICINAL PRODUCT MUST BE STORED OUT OF THE SIGHT AND REACH OF CHILDREN**

   Keep out of the sight and reach of children.

7. **OTHER SPECIAL WARNING(S), IF NECESSARY**

8. **EXPIRY DATE**

   EXP
9. SPECIAL STORAGE CONDITIONS

10. SPECIAL PRECAUTIONS FOR DISPOSAL OF UNUSED MEDICINAL PRODUCTS OR WASTE MATERIALS DERIVED FROM SUCH MEDICINAL PRODUCTS, IF APPROPRIATE

11. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER

Gilead Sciences Intl Ltd
Cambridge
CB2 16GT
United Kingdom

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/01/200/008 30 film-coated tablets
EU/1/01/200/009 90 (3 bottles of 30) film-coated tablets

13. BATCH NUMBER

Lot

14. GENERAL CLASSIFICATION FOR SUPPLY

15. INSTRUCTIONS ON USE

16. INFORMATION IN BRAILLE

Viread 204 mg [outer packaging only]

17. UNIQUE IDENTIFIER – 2D BARCODE

2D barcode carrying the unique identifier included.

18. UNIQUE IDENTIFIER - HUMAN READABLE DATA

PC: {number}
SN: {number}
NN: {number}
PARTICULARS TO APPEAR ON THE OUTER PACKAGING AND THE IMMEDIATE PACKAGING
BOTTLE AND CARTON LABELLING

1. **NAME OF THE MEDICINAL PRODUCT**

Viread 245 mg film-coated tablets
Tenofovir disoproxil

2. **STATEMENT OF ACTIVE SUBSTANCE(S)**

Each film-coated tablet contains 245 mg of tenofovir disoproxil (as fumarate).

3. **LIST OF EXCIPIENTS**

Contains lactose monohydrate.

4. **PHARMACEUTICAL FORM AND CONTENTS**

30 film-coated tablets.
30 tablets.
90 (3 bottles of 30) film-coated tablets.
90 (3 bottles of 30) tablets.

5. **METHOD AND ROUTE(S) OF ADMINISTRATION**

Read the package leaflet before use.

Oral use.

6. **SPECIAL WARNING THAT THE MEDICINAL PRODUCT MUST BE STORED OUT OF THE SIGHT AND REACH OF CHILDREN**

Keep out of the sight and reach of children.

7. **OTHER SPECIAL WARNING(S), IF NECESSARY**

8. **EXPIRY DATE**

EXP
<table>
<thead>
<tr>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. SPECIAL STORAGE CONDITIONS</td>
</tr>
<tr>
<td>10. SPECIAL PRECAUTIONS FOR DISPOSAL OF UNUSED MEDICINAL PRODUCTS OR WASTE MATERIALS DERIVED FROM SUCH MEDICINAL PRODUCTS, IF APPROPRIATE</td>
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<td>13. BATCH NUMBER</td>
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<td>Lot</td>
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<td>14. GENERAL CLASSIFICATION FOR SUPPLY</td>
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<tr>
<td>15. INSTRUCTIONS ON USE</td>
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<tr>
<td>16. INFORMATION IN BRAILLE</td>
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<td>Viread 245 mg [outer packaging only]</td>
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<td>2D barcode carrying the unique identifier included.</td>
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<td>18. UNIQUE IDENTIFIER - HUMAN READABLE DATA</td>
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<td>SN: {number}</td>
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<tr>
<td>NN: {number}</td>
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</table>
### PARTICULARS TO APPEAR ON THE OUTER PACKAGING AND THE IMMEDIATE PACKAGING

#### BOTTLE AND CARTON LABELLING

1. **NAME OF THE MEDICINAL PRODUCT**

Viread 33 mg/g granules  
Tenofovir disoproxil

2. **STATEMENT OF ACTIVE SUBSTANCE(S)**

Each scoop delivers one gram of granules which contains 33 mg of tenofovir disoproxil (as fumarate).

3. **LIST OF EXCIPIENTS**

Contains mannitol.

4. **PHARMACEUTICAL FORM AND CONTENTS**

60 g granules.  
Use with the supplied dosing scoop.

5. **METHOD AND ROUTE(S) OF ADMINISTRATION**

Read the package leaflet before use.  
Oral use.

6. **SPECIAL WARNING THAT THE MEDICINAL PRODUCT MUST BE STORED OUT OF THE SIGHT AND REACH OF CHILDREN**

Keep out of the sight and reach of children.

7. **OTHER SPECIAL WARNING(S), IF NECESSARY**

8. **EXPIRY DATE**

EXP

9. **SPECIAL STORAGE CONDITIONS**

Do not store above 25°C.
10. SPECIAL PRECAUTIONS FOR DISPOSAL OF UNUSED MEDICINAL PRODUCTS OR WASTE MATERIALS DERIVED FROM SUCH MEDICINAL PRODUCTS, IF APPROPRIATE

11. NAME AND ADDRESS OF THE MARKETING AUTHORISATION HOLDER

Gilead Sciences Intl Ltd
Cambridge
CB21 6GT
United Kingdom

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/01/200/003

13. BATCH NUMBER

Lot

14. GENERAL CLASSIFICATION FOR SUPPLY

15. INSTRUCTIONS ON USE

16. INFORMATION IN BRAILLE

Viread granules [outer packaging only]

17. UNIQUE IDENTIFIER – 2D BARCODE

2D barcode carrying the unique identifier included.

18. UNIQUE IDENTIFIER - HUMAN READABLE DATA

PC: {number}
SN: {number}
NN: {number}
B. PACKAGE LEAFLET
Package leaflet: Information for the user

Viread 123 mg film-coated tablets
Tenofovir disoproxil

Read all of this leaflet carefully before your child starts taking this medicine because it contains important information for you.
- Keep this leaflet. You may need to read it again.
- If you have any further questions, ask your child’s doctor or pharmacist.
- This medicine has been prescribed for your child only. Do not pass it on to others. It may harm them, even if their signs of illness are the same as your child’s.
- If your child gets any side effects, talk to your child’s doctor or pharmacist. This includes any possible side effects not listed in this leaflet. See section 4.

What is in this leaflet
1. What Viread is and what it is used for
2. What you need to know before your child takes Viread
3. How to take Viread
4. Possible side effects
5. How to store Viread
6. Contents of the pack and other information

1. What Viread is and what it is used for

Viread contains the active substance tenofovir disoproxil. This active substance is an antiretroviral or antiviral medicine which is used to treat HIV infection. Tenofovir is a nucleotide reverse transcriptase inhibitor, generally known as an NRTI and works by interfering with the normal working of an enzyme (reverse transcriptase) that is essential for the virus to reproduce itself. Viread should always be used combined with other medicines to treat HIV infection.

Viread 123 mg tablets are a treatment for HIV (Human Immunodeficiency Virus) infection.

Viread 123 mg tablets are for use in children. They are only suitable for:
- children aged 6 to less than 12 years
- who weigh from 17 kg to less than 22 kg
- who have already been treated with other HIV medicines which are no longer fully effective due to development of resistance, or have caused side effects.

This medicine is not a cure for HIV infection. While taking Viread your child may still develop infections or other illnesses associated with HIV infection. Your child can also pass on HIV to others, so it is important to take precautions to avoid infecting other people.

2. What you need to know before your child takes Viread

Do not give Viread

- If your child is allergic to tenofovir, tenofovir disoproxil fumarate or any of the other ingredients of this medicine listed in section 6.

⇒ If this applies to your child, tell their doctor immediately and don’t give Viread.
Warnings and precautions

- Viread 123 mg tablets are only suitable for children who have already been treated with other HIV medicines which are no longer fully effective due to development of resistance, or have caused side effects.

- Check your child’s age and weight to see if Viread 123 mg tablets are suitable, see Children and adolescents.

Talk to your child’s doctor or pharmacist before giving Viread.

- Take care not to infect other people. Your child can still pass on HIV when taking this medicine, although the risk is lowered by effective antiretroviral therapy. Discuss with your child’s doctor the precautions needed to avoid infecting other people.

- Talk to your child’s doctor or pharmacist if your child has had kidney disease or if tests have shown problems with their kidneys. Viread should not be given to children with existing kidney problems. Viread may affect your child’s kidneys during treatment. Before starting treatment, your child’s doctor may order blood tests to assess your child’s kidney function. Your child’s doctor may also order blood tests during treatment to monitor how your child’s kidneys work.

Viread is not usually taken with other medicines that can damage your child’s kidneys (see Other medicines and Viread). If this is unavoidable, your child’s doctor will monitor your child’s kidney function once a week.

- Bone problems. Some adult patients with HIV taking combination antiretroviral therapy may develop a bone disease called osteonecrosis (death of bone tissue caused by loss of blood supply to the bone). The length of combination antiretroviral therapy, corticosteroid use, alcohol consumption, severe immunosuppression, higher body mass index, among others, may be some of the many risk factors for developing this disease. Signs of osteonecrosis are joint stiffness, aches and pains (especially of the hip, knee and shoulder) and difficulty in movement. If you notice any of these symptoms tell your child’s doctor.

Bone problems (sometimes resulting in fractures) may also occur due to damage to kidney tubule cells (see section 4, Possible side effects).

- Talk to your child’s doctor if your child has a history of liver disease, including hepatitis. Patients with liver disease including chronic hepatitis B or C, who are treated with antiretrovirals, have a higher risk of severe and potentially fatal liver complications. If your child has hepatitis B infection, your child’s doctor will carefully consider the best treatment for them. If your child has a history of liver disease or chronic hepatitis B infection your child’s doctor may conduct blood tests to monitor their liver function.

- Look out for infections. If your child has advanced HIV infection (AIDS) and has an infection, they may develop symptoms of infection and inflammation or worsening of the symptoms of an existing infection once treatment with Viread is started. These symptoms may indicate that your child’s body’s improved immune system is fighting infection. Look out for signs of inflammation or infection soon after your child starts taking Viread. If you notice signs of inflammation or infection, tell your child’s doctor at once.

In addition to the opportunistic infections, autoimmune disorders (a condition that occurs when the immune system attacks healthy body tissue) may also occur after your child starts taking medicines for the treatment of their HIV infection. Autoimmune disorders may occur many months after the start of treatment. If you notice that your child has any symptoms of infection or other symptoms such as muscle weakness, weakness beginning in the hands and feet and...
moving up towards the trunk of the body, palpitations, tremor or hyperactivity, please inform your child’s doctor immediately to seek necessary treatment.

Children and adolescents

Viread 123 mg tablets are only suitable for:

- children aged 6 to less than 12 years
- who weigh from 17 kg to less than 22 kg
- who have already been treated with other HIV medicines which are no longer fully effective due to development of resistance, or have caused side effects.

Viread 123 mg tablets are not suitable for the following groups:

- Not for children who weigh under 17 kg or 22 kg and over. Contact your child’s doctor if your child is outside the permitted weight.
- Not for children and adolescents under 6 years or 12 years and over.
- Not for HBV (Hepatitis B virus) infected children and adolescents of any age.

For dosage see section 3, How to take Viread.

Other medicines and Viread

Tell your child’s doctor or pharmacist if they are taking, have recently taken or might take any other medicines.

- Do not give Viread if your child is already taking other medicines containing tenofovir disoproxil fumarate or tenofovir alafenamide. Do not give Viread together with medicines containing adefovir dipivoxil (a medicine used to treat chronic hepatitis B).

- It is very important to tell your child’s doctor if your child is taking other medicines that may damage their kidneys. These include:
  - aminoglycosides, pentamidine or vancomycin (for bacterial infection),
  - amphotericin B (for fungal infection),
  - foscarnet, ganciclovir, or cidofovir (for viral infection),
  - interleukin-2 (to treat cancer),
  - adefovir dipivoxil (for HBV),
  - tacrolimus (for suppression of the immune system),
  - non-steroidal anti-inflammatory drugs (NSAIDs, to relieve bone or muscle pains).

- Other medicines containing didanosine (for HIV infection): Taking Viread with other antiviral medicines that contain didanosine can raise the levels of didanosine in the blood and may reduce CD4 cell counts. Rarely, inflammation of the pancreas and lactic acidosis (excess lactic acid in the blood), which sometimes caused death, have been reported when medicines containing tenofovir disoproxil fumarate and didanosine were taken together. Your child’s doctor will carefully consider whether to treat your child with combinations of tenofovir and didanosine.

- It is also important to tell your doctor if your child is taking ledipasvir/sofosbuvir or sofosbuvir/velpatasvir to treat hepatitis C infection.

Viread with food and drink

Give Viread with food (for example, a meal or a snack).
Pregnancy and breast-feeding

If your child is pregnant or breast-feeding, or they think they may be pregnant, ask your child’s doctor or pharmacist for advice before they take this medicine.

- **Your child must not take Viread during pregnancy** unless specifically discussed with your child’s doctor. Although there are limited clinical data on the use of Viread in pregnant women, it is not usually used unless absolutely necessary.

- **Your child should try to avoid getting pregnant** during treatment with Viread. Your child must use an effective method of contraception to avoid becoming pregnant if they are sexually active.

- **If your child becomes pregnant**, ask your child’s doctor about the potential benefits and risks of the antiretroviral therapy to your child and your child’s baby.

- **If your child has taken Viread** during their pregnancy, your child’s doctor may request regular blood tests and other diagnostic tests to monitor the development of the baby. In children whose mothers took medicines like Viread (NRTIs) during pregnancy, the benefit from the protection against the virus outweighed the risk of side effects.

- **Your child must not breast-feed during treatment with Viread.** This is because the active substance in this medicine passes into human breast milk.

- Your child must not breast-feed, to avoid passing the virus to the baby in breast milk.

Driving and using machines

Viread can cause dizziness. If your child feels dizzy while taking Viread, they must **not drive or ride a bicycle** and must not use any tools or machines.

Viread contains lactose

Tell your child’s doctor before giving Viread if your child cannot tolerate lactose or if they have an intolerance to any other sugars.

3. How to take Viread

**Your child must always take this medicine exactly as their doctor or pharmacist has told you.** Check with your child’s doctor or pharmacist if you are not sure.

**The recommended dose is:**

- **Children aged 6 to less than 12 years who weigh from 17 kg to less than 22 kg:**
  1 tablet each day with food (for example, a meal or a snack).

Your child’s doctor will monitor their weight.

**Your child must always take the dose recommended by their doctor.** This is to make sure that their medicine is fully effective, and to reduce the risk of developing resistance to the treatment. Do not change the dose unless your child’s doctor tells you to.

Your child’s doctor will prescribe Viread with other antiretroviral medicines.

Refer to the patient information leaflets of the other antiretrovirals for guidance on how to take those medicines.
If your child takes more Viread than they should

If your child accidentally takes too many Viread tablets, they may be at increased risk of experiencing possible side effects with this medicine (see section 4, Possible side effects). Contact your child’s doctor or nearest emergency department for advice. Keep the tablet bottle with you so that you can easily describe what your child has taken.

If your child forgets to take Viread

It is important not to miss a dose of Viread. If your child misses a dose, work out how long since they should have taken it.

- **If it is less than 12 hours** after it is usually taken, they should take it as soon as they can, and then take their next dose at its regular time.

- **If it is more than 12 hours** since your child should have taken it, forget about the missed dose. Wait and give the next dose at the regular time. Do not give a double dose to make up for a forgotten tablet.

If your child throws up less than 1 hour after taking Viread, give your child another tablet. Your child does not need to take another tablet if they were sick more than 1 hour after taking Viread.

If your child stops taking Viread

Your child must not stop taking Viread without their doctor’s advice. Stopping treatment with Viread may reduce the effectiveness of the treatment recommended by your child’s doctor.

If your child has HIV and hepatitis B it is very important not to stop their Viread treatment without talking to your child’s doctor first. Some patients have had blood tests or symptoms indicating that their hepatitis has got worse after stopping Viread. Your child may require blood tests for several months after stopping treatment. In some patients with advanced liver disease or cirrhosis, stopping treatment is not recommended as this may lead to worsening of your child’s hepatitis.

- Talk to your child’s doctor before your child stops taking Viread for any reason, particularly if your child is experiencing any side effects or they have another illness.

- Tell your child’s doctor immediately about new or unusual symptoms after your child stops treatment, particularly symptoms you associate with hepatitis B infection.

- Contact your child’s doctor before your child restarts taking Viread tablets.

If you have any further questions on the use of this medicine, ask your child’s doctor or pharmacist.

4. **Possible side effects**

During HIV therapy there may be an increase in weight and in levels of blood lipids and glucose. This is partly linked to restored health and life style, and in the case of blood lipids sometimes to the HIV medicines themselves. Your child’s doctor will test for these changes.

Like all medicines, this medicine can cause side effects, although not everybody gets them.
Possible serious side effects: tell your child’s doctor immediately

- **Lactic acidosis** (excess lactic acid in the blood) is a *rare* (can affect up to 1 in every 1,000 patients) but serious side effect that can be fatal. The following side effects may be signs of lactic acidosis:
  - deep, rapid breathing
  - drowsiness
  - feeling sick (nausea), being sick (vomiting) and stomach pain

➤ If you think that your child may have **lactic acidosis**, contact your child’s doctor immediately.

Other possible serious side effects

The following side effects are *uncommon* (this can affect up to 1 in every 100 patients):

- **pain in the tummy** (abdomen) caused by inflammation of the pancreas
- damage to kidney tubule cells

The following side effects are *rare* (these can affect up to 1 in every 1,000 patients):

- inflammation of the kidney, **passing a lot of urine and feeling thirsty**
- **changes to** your child’s **urine** and **back pain** caused by kidney problems, including kidney failure
- softening of the bones (with **bone pain** and sometimes resulting in fractures), which may occur due to damage to kidney tubule cells
- **fatty liver**

➤ If you think that your child may have any of these serious side effects, talk to your child’s doctor.

Most frequent side effects

The following side effects are *very common* (these can affect at least 10 in every 100 patients):

- diarrhoea, being sick (vomiting), feeling sick (nausea), dizziness, rash, feeling weak

*Tests may also show:*

- decreases in phosphate in the blood

Other possible side effects

The following side effects are *common* (these can affect up to 10 in every 100 patients):

- flatulence
Tests may also show:

- liver problems

The following side effects are uncommon (these can affect up to 1 in every 100 patients):

- breakdown of muscle, muscle pain or weakness

Tests may also show:

- decreases in potassium in the blood
- increased creatinine in your child’s blood
- pancreas problems

The breakdown of muscle, softening of the bones (with bone pain and sometimes resulting in fractures), muscle pain, muscle weakness and decreases in potassium or phosphate in the blood may occur due to damage to kidney tubule cells.

The following side effects are rare (these can affect up to 1 in every 1,000 patients):

- pain in the tummy (abdomen) caused by inflammation of the liver
- swelling of the face, lips, tongue or throat

Reporting of side effects

If your child gets any side effects, talk to your child’s doctor or pharmacist. This includes any possible side effects not listed in this leaflet. You can also report side effects directly via the national reporting system listed in Appendix V. By reporting side effects you can help provide more information on the safety of this medicine.

5. How to store Viread

Keep this medicine out of the sight and reach of children.

Do not use this medicine after the expiry date which is stated on the bottle and carton after {EXP}. The expiry date refers to the last day of that month.

This medicine does not require any special storage conditions.

Do not throw away any medicines via wastewater or household waste. Ask your pharmacist how to throw away medicines you no longer use. These measures will help protect the environment.

6. Contents of the pack and other information

What Viread contains

- The active substance is tenofovir. Each Viread tablet contains 123 mg of tenofovir disoproxil (as fumarate).
- The other ingredients are microcrystalline cellulose (E460), starch pregelatinised, croscarmellose sodium, lactose monohydrate, and magnesium stearate (E572) which make up the tablet core, and lactose monohydrate, hypromellose (E464), titanium dioxide (E171) and glycerol triacetate (E1518) which make up the tablet coating. Refer to section 2 “Viread contains lactose”.

What Viread looks like and contents of the pack

Viread 123 mg film-coated tablets are white, triangle-shaped, film-coated tablets, 8.5 mm in diameter, debossed on one side with “GSI” and on the other side with “150”. Viread 123 mg film-coated tablets are supplied in bottles containing 30 tablets. Each bottle contains a silica gel desiccant that must be kept in the bottle to help protect your tablets. The silica gel desiccant is contained in a separate sachet or canister and should not be swallowed.

The following pack sizes are available: outer cartons containing 1 bottle of 30 film-coated tablets and 3 bottles of 30 film-coated tablets. Not all pack sizes may be marketed.

Marketing Authorisation Holder and Manufacturer

Marketing Authorisation Holder:
Gilead Sciences International Limited
Cambridge
CB21 6GT
United Kingdom

Manufacturer:
Gilead Sciences Ireland UC
IDA Business & Technology Park
Carrigtwohill
County Cork
Ireland

For any information about this medicine, please contact the local representative of the Marketing Authorisation Holder:
This leaflet was last revised in {MM/YYYY}.

Detailed information on this medicine is available on the European Medicines Agency web site:
http://www.ema.europa.eu
Package leaflet: Information for the user

Viread 163 mg film-coated tablets
Tenofovir disoproxil

Read all of this leaflet carefully before your child starts taking this medicine because it contains important information for you.
- Keep this leaflet. You may need to read it again.
- If you have any further questions, ask your child’s doctor or pharmacist.
- This medicine has been prescribed for your child only. Do not pass it on to others. It may harm them, even if their signs of illness are the same as your child’s.
- If your child gets any side effects, talk to your child’s doctor or pharmacist. This includes any possible side effects not listed in this leaflet. See section 4.

What is in this leaflet
1. What Viread is and what it is used for
2. What you need to know before your child takes Viread
3. How to take Viread
4. Possible side effects
5. How to store Viread
6. Contents of the pack and other information

1. What Viread is and what it is used for

Viread contains the active substance tenofovir disoproxil. This active substance is an antiretroviral or antiviral medicine which is used to treat HIV infection. Tenofovir is a nucleotide reverse transcriptase inhibitor, generally known as an NRTI and works by interfering with the normal working of an enzyme (reverse transcriptase) that is essential for the virus to reproduce itself. Viread should always be used combined with other medicines to treat HIV infection.

Viread 163 mg tablets are a treatment for HIV (Human Immunodeficiency Virus) infection.

Viread 163 mg tablets are for use in children. They are only suitable for:
- children aged 6 to less than 12 years
- who weigh from 22 kg to less than 28 kg
- who have already been treated with other HIV medicines which are no longer fully effective due to development of resistance, or have caused side effects.

This medicine is not a cure for HIV infection. While taking Viread your child may still develop infections or other illnesses associated with HIV infection. Your child can also pass on HIV to others, so it is important to take precautions to avoid infecting other people.

2. What you need to know before your child takes Viread

Do not give Viread

- If your child is allergic to tenofovir, tenofovir disoproxil fumarate or any of the other ingredients of this medicine listed in section 6.

→ If this applies to your child, tell their doctor immediately and don’t give Viread.
Warnings and precautions

- Viread 163 mg tablets are only suitable for children who have already been treated with other HIV medicines which are no longer fully effective due to development of resistance, or have caused side effects.

- Check your child’s age and weight to see if Viread 163 mg tablets are suitable, see Children and adolescents.

Talk to your child’s doctor or pharmacist before giving Viread.

- Take care not to infect other people. Your child can still pass on HIV when taking this medicine, although the risk is lowered by effective antiretroviral therapy. Discuss with your child’s doctor the precautions needed to avoid infecting other people.

- Talk to your child’s doctor or pharmacist if your child has had kidney disease or if tests have shown problems with their kidneys. Viread should not be given to children with existing kidney problems. Viread may affect your child’s kidneys during treatment. Before starting treatment, your child’s doctor may order blood tests to assess your child’s kidney function. Your child’s doctor may also order blood tests during treatment to monitor how your child’s kidneys work.

Viread is not usually taken with other medicines that can damage your child’s kidneys (see Other medicines and Viread). If this is unavoidable, your child’s doctor will monitor your child’s kidney function once a week.

- Bone problems. Some adult patients with HIV taking combination antiretroviral therapy may develop a bone disease called osteonecrosis (death of bone tissue caused by loss of blood supply to the bone). The length of combination antiretroviral therapy, corticosteroid use, alcohol consumption, severe immunosuppression, higher body mass index, among others, may be some of the many risk factors for developing this disease. Signs of osteonecrosis are joint stiffness, aches and pains (especially of the hip, knee and shoulder) and difficulty in movement. If you notice any of these symptoms tell your child’s doctor.

Bone problems (sometimes resulting in fractures) may also occur due to damage to kidney tubule cells (see section 4, Possible side effects).

- Talk to your child’s doctor if your child has a history of liver disease, including hepatitis. Patients with liver disease including chronic hepatitis B or C, who are treated with antiretrovirals, have a higher risk of severe and potentially fatal liver complications. If your child has hepatitis B infection, your child’s doctor will carefully consider the best treatment for them. If your child has a history of liver disease or chronic hepatitis B infection your child’s doctor may conduct blood tests to monitor their liver function.

- Look out for infections. If your child has advanced HIV infection (AIDS) and has an infection, they may develop symptoms of infection and inflammation or worsening of the symptoms of an existing infection once treatment with Viread is started. These symptoms may indicate that your child’s body’s improved immune system is fighting infection. Look out for signs of inflammation or infection soon after your child starts taking Viread. If you notice signs of inflammation or infection, tell your child’s doctor at once.

In addition to the opportunistic infections, autoimmune disorders (a condition that occurs when the immune system attacks healthy body tissue) may also occur after your child starts taking medicines for the treatment of their HIV infection. Autoimmune disorders may occur many months after the start of treatment. If you notice that your child has any symptoms of infection or other symptoms such as muscle weakness, weakness beginning in the hands and feet and
moving up towards the trunk of the body, palpitations, tremor or hyperactivity, please inform your child’s doctor immediately to seek necessary treatment.

Children and adolescents

Viread 163 mg tablets are only suitable for:
- children aged 6 to less than 12 years
- who weigh from 22 kg to less than 28 kg
- who have already been treated with other HIV medicines which are no longer fully effective due to development of resistance, or have caused side effects.

Viread 163 mg tablets are not suitable for the following groups:
- Not for children who weigh under 22 kg or 28 kg and over. Contact your child’s doctor if your child is outside the permitted weight.
- Not for children and adolescents under 6 years or 12 years and over.
- Not for HBV (Hepatitis B virus) infected children and adolescents of any age.

For dosage see section 3, How to take Viread.

Other medicines and Viread

Tell your child’s doctor or pharmacist if they are taking, have recently taken or might take any other medicines.

- Do not give Viread if your child is already taking other medicines containing tenofovir disoproxil fumarate or tenofovir alafenamide. Do not give Viread together with medicines containing adefovir dipivoxil (a medicine used to treat chronic hepatitis B).

- It is very important to tell your child’s doctor if your child is taking other medicines that may damage their kidneys.

These include:
- aminoglycosides, pentamidine or vancomycin (for bacterial infection),
- amphotericin B (for fungal infection),
- fosfomycin, ganciclovir, or cidofovir (for viral infection),
- interleukin-2 (to treat cancer),
- adefovir dipivoxil (for HBV),
- tacrolimus (for suppression of the immune system),
- non-steroidal anti-inflammatory drugs (NSAIDs, to relieve bone or muscle pains).

- Other medicines containing didanosine (for HIV infection): Taking Viread with other antiviral medicines that contain didanosine can raise the levels of didanosine in the blood and may reduce CD4 cell counts. Rarely, inflammation of the pancreas and lactic acidosis (excess lactic acid in the blood), which sometimes caused death, have been reported when medicines containing tenofovir disoproxil fumarate and didanosine were taken together. Your child’s doctor will carefully consider whether to treat your child with combinations of tenofovir and didanosine.

- It is also important to tell your doctor if your child is taking ledipasvir/sofosbuvir or sofosbuvir/velpatasvir to treat hepatitis C infection.

Viread with food and drink

Give Viread with food (for example, a meal or a snack).
Pregnancy and breast-feeding

If your child is pregnant or breast-feeding, or they think they may be pregnant, ask your child’s doctor or pharmacist for advice before they take this medicine.

- **Your child must not take Viread during pregnancy** unless specifically discussed with your child’s doctor. Although there are limited clinical data on the use of Viread in pregnant women, it is not usually used unless absolutely necessary.

- **Your child should try to avoid getting pregnant** during treatment with Viread. Your child must use an effective method of contraception to avoid becoming pregnant if they are sexually active.

- **If your child becomes pregnant**, ask your child’s doctor about the potential benefits and risks of the antiretroviral therapy to your child and your child’s baby.

- **If your child has taken Viread** during their pregnancy, your child’s doctor may request regular blood tests and other diagnostic tests to monitor the development of the baby. In children whose mothers took medicines like Viread (NRTIs) during pregnancy, the benefit from the protection against the virus outweighed the risk of side effects.

- **Your child must not breast-feed during treatment with Viread.** This is because the active substance in this medicine passes into human breast milk.

- Your child must not breast-feed, to avoid passing the virus to the baby in breast milk.

Driving and using machines

Viread can cause dizziness. If your child feels dizzy while taking Viread, they must not drive or ride a bicycle and must not use any tools or machines.

**Viread contains lactose**

Tell your child’s doctor before giving Viread if your child cannot tolerate lactose or if they have an intolerance to any other sugars.

3. **How to take Viread**

Your child must always take this medicine exactly as their doctor or pharmacist has told you. Check with your child’s doctor or pharmacist if you are not sure.

The recommended dose is:

- **Children aged 6 to less than 12 years who weigh from 22 kg to less than 28 kg:**
  1 tablet each day with food (for example, a meal or a snack).

Your child’s doctor will monitor their weight.

Your child must always take the dose recommended by their doctor. This is to make sure that their medicine is fully effective, and to reduce the risk of developing resistance to the treatment. Do not change the dose unless your child’s doctor tells you to.

Your child’s doctor will prescribe Viread with other antiretroviral medicines.

Refer to the patient information leaflets of the other antiretrovirals for guidance on how to take those medicines.
If your child takes more Viread than they should

If your child accidentally takes too many Viread tablets, they may be at increased risk of experiencing possible side effects with this medicine (see section 4, Possible side effects). Contact your child’s doctor or nearest emergency department for advice. Keep the tablet bottle with you so that you can easily describe what your child has taken.

If your child forgets to take Viread

It is important not to miss a dose of Viread. If your child misses a dose, work out how long since they should have taken it.

- **If it is less than 12 hours** after it is usually taken, they should take it as soon as they can, and then take their next dose at its regular time.

- **If it is more than 12 hours** since your child should have taken it, forget about the missed dose. Wait and give the next dose at the regular time. Do not give a double dose to make up for a forgotten tablet.

If your child throws up less than 1 hour after taking Viread, give your child another tablet. Your child does not need to take another tablet if they were sick more than 1 hour after taking Viread.

If your child stops taking Viread

Your child must not stop taking Viread without their doctor’s advice. Stopping treatment with Viread may reduce the effectiveness of the treatment recommended by your child’s doctor.

If your child has HIV and hepatitis B it is very important not to stop their Viread treatment without talking to your child’s doctor first. Some patients have had blood tests or symptoms indicating that their hepatitis has got worse after stopping Viread. Your child may require blood tests for several months after stopping treatment. In some patients with advanced liver disease or cirrhosis, stopping treatment is not recommended as this may lead to worsening of your child’s hepatitis.

- Talk to your child’s doctor before your child stops taking Viread for any reason, particularly if your child is experiencing any side effects or they have another illness.

- Tell your child’s doctor immediately about new or unusual symptoms after your child stops treatment, particularly symptoms you associate with hepatitis B infection.

- Contact your child’s doctor before your child restarts taking Viread tablets.

If you have any further questions on the use of this medicine, ask your child’s doctor or pharmacist.

4. Possible side effects

During HIV therapy there may be an increase in weight and in levels of blood lipids and glucose. This is partly linked to restored health and lifestyle, and in the case of blood lipids sometimes to the HIV medicines themselves. Your child’s doctor will test for these changes.

Like all medicines, this medicine can cause side effects, although not everybody gets them.
Possible serious side effects: tell your child’s doctor immediately

- **Lactic acidosis** (excess lactic acid in the blood) is a **rare** (can affect up to 1 in every 1,000 patients) but serious side effect that can be fatal. The following side effects may be signs of lactic acidosis:
  - deep, rapid breathing
  - drowsiness
  - feeling sick (nausea), being sick (vomiting) and stomach pain

➤ If you think that your child may have **lactic acidosis**, contact your child’s doctor immediately.

Other possible serious side effects

The following side effects are **uncommon** (this can affect up to 1 in every 100 patients):

- **pain in the tummy** (abdomen) caused by inflammation of the pancreas
- damage to kidney tubule cells

The following side effects are **rare** (these can affect up to 1 in every 1,000 patients):

- inflammation of the kidney, **passing a lot of urine and feeling thirsty**
- **changes to** your child’s **urine** and **back pain** caused by kidney problems, including kidney failure
- softening of the bones (with **bone pain** and sometimes resulting in fractures), which may occur due to damage to kidney tubule cells
- fatty liver

➤ If you think that your child may have any of these serious side effects, talk to your child’s doctor.

Most frequent side effects

The following side effects are **very common** (these can affect at least 10 in every 100 patients):

- diarrhoea, being sick (vomiting), feeling sick (nausea), dizziness, rash, feeling weak

Tests may also show:

- decreases in phosphate in the blood

Other possible side effects

The following side effects are **common** (these can affect up to 10 in every 100 patients):

- flatulence
Tests may also show:

- liver problems

The following side effects are uncommon (these can affect up to 1 in every 100 patients):

- breakdown of muscle, muscle pain or weakness

Tests may also show:

- decreases in potassium in the blood
- increased creatinine in your child’s blood
- pancreas problems

The breakdown of muscle, softening of the bones (with bone pain and sometimes resulting in fractures), muscle pain, muscle weakness and decreases in potassium or phosphate in the blood may occur due to damage to kidney tubule cells.

The following side effects are rare (these can affect up to 1 in every 1,000 patients):

- pain in the tummy (abdomen) caused by inflammation of the liver
- swelling of the face, lips, tongue or throat

**Reporting of side effects**

*If your child gets any side effects, talk to your child’s doctor or pharmacist.* This includes any possible side effects not listed in this leaflet. You can also report side effects directly via the national reporting system listed in Appendix V. By reporting side effects you can help provide more information on the safety of this medicine.

5. **How to store Viread**

Keep this medicine out of the sight and reach of children.

Do not use this medicine after the expiry date which is stated on the bottle and carton after {EXP}. The expiry date refers to the last day of that month.

This medicine does not require any special storage conditions.

Do not throw away any medicines via wastewater or household waste. Ask your pharmacist how to throw away medicines you no longer use. These measures will help protect the environment.

6. **Contents of the pack and other information**

**What Viread contains**

- The active substance is tenofovir. Each Viread tablet contains 163 mg of tenofovir disoproxil (as fumarate).
- The other ingredients are microcrystalline cellulose (E460), starch pregelatinised, croscarmellose sodium, lactose monohydrate, and magnesium stearate (E572) which make up the tablet core, and lactose monohydrate, hypromellose (E464), titanium dioxide (E171) and glycerol triacetate (E1518) which make up the tablet coating. Refer to section 2 “Viread contains lactose”.

What Viread looks like and contents of the pack

Viread 163 mg film-coated tablets are white, round-shaped, film-coated tablets, 10.7 mm in diameter, debossed on one side with “GSI” and on the other side with “200”. Viread 163 mg film-coated tablets are supplied in bottles containing 30 tablets. Each bottle contains a silica gel desiccant that must be kept in the bottle to help protect your tablets. The silica gel desiccant is contained in a separate sachet or canister and should not be swallowed.

The following pack sizes are available: outer cartons containing 1 bottle of 30 film-coated tablets and 3 bottles of 30 film-coated tablets. Not all pack sizes may be marketed.

Marketing Authorisation Holder and Manufacturer

Marketing Authorisation Holder:
Gilead Sciences International Limited
Cambridge
CB21 6GT
United Kingdom

Manufacturer:
Gilead Sciences Ireland UC
IDA Business & Technology Park
Carrigtohill
County Cork
Ireland

For any information about this medicine, please contact the local representative of the Marketing Authorisation Holder:

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<th>Address</th>
<th>Telephone</th>
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<tr>
<td>België/Belgique/Belgien</td>
<td>Gilead Sciences Belgium SPRL-BVBA</td>
<td>+ 32 (0) 24 01 35 50</td>
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<tr>
<td>Litouva</td>
<td>Gilead Sciences Poland Sp. z o.o.</td>
<td>+ 48 22 262 8702</td>
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<tr>
<td>България</td>
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<tr>
<td>Nederland</td>
<td>Gilead Sciences Netherlands B.V.</td>
<td>+ 31 (0) 20 718 36 98</td>
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<td>+ 39 02 439201</td>
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<td>United Kingdom</td>
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This leaflet was last revised in {MM/YYYY}.

Detailed information on this medicine is available on the European Medicines Agency web site: http://www.ema.europa.eu
Viread contains the active substance tenofovir disoproxil. This active substance is an antiretroviral or antiviral medicine which is used to treat HIV infection. Tenofovir is a nucleotide reverse transcriptase inhibitor, generally known as an NRTI and works by interfering with the normal working of an enzyme (reverse transcriptase) that is essential for the virus to reproduce itself. Viread should always be used combined with other medicines to treat HIV infection.

Viread 204 mg tablets are a treatment for HIV (Human Immunodeficiency Virus) infection.

Viread 204 mg tablets are for use in children. They are only suitable for:
- children aged 6 to less than 12 years
- who weigh from 28 kg to less than 35 kg
- who have already been treated with other HIV medicines which are no longer fully effective due to development of resistance, or have caused side effects.

This medicine is not a cure for HIV infection. While taking Viread your child may still develop infections or other illnesses associated with HIV infection. Your child can also pass on HIV to others, so it is important to take precautions to avoid infecting other people.

2. **What you need to know before your child takes Viread**

Do not give Viread

- If your child is allergic to tenofovir, tenofovir disoproxil fumarate or any of the other ingredients of this medicine listed in section 6.

  ➔ If this applies to your child, **tell their doctor immediately and don’t give Viread.**
Warnings and precautions

- Viread 204 mg tablets are only suitable for children who have already been treated with other HIV medicines which are no longer fully effective due to development of resistance, or have caused side effects.

- Check your child’s age and weight to see if Viread 204 mg tablets are suitable, see Children and adolescents.

Talk to your child’s doctor or pharmacist before giving Viread.

- Take care not to infect other people. Your child can still pass on HIV when taking this medicine, although the risk is lowered by effective antiretroviral therapy. Discuss with your child’s doctor the precautions needed to avoid infecting other people.

- Talk to your child’s doctor or pharmacist if your child has had kidney disease or if tests have shown problems with their kidneys. Viread should not be given to children with existing kidney problems. Viread may affect your child’s kidneys during treatment. Before starting treatment, your child’s doctor may order blood tests to assess your child’s kidney function. Your child’s doctor may also order blood tests during treatment to monitor how your child’s kidneys work.

Viread is not usually taken with other medicines that can damage your child’s kidneys (see Other medicines and Viread). If this is unavoidable, your child’s doctor will monitor your child’s kidney function once a week.

- Bone problems. Some adult patients with HIV taking combination antiretroviral therapy may develop a bone disease called osteonecrosis (death of bone tissue caused by loss of blood supply to the bone). The length of combination antiretroviral therapy, corticosteroid use, alcohol consumption, severe immunosuppression, higher body mass index, among others, may be some of the many risk factors for developing this disease. Signs of osteonecrosis are joint stiffness, aches and pains (especially of the hip, knee and shoulder) and difficulty in movement. If you notice any of these symptoms, tell your child’s doctor.

Bone problems (sometimes resulting in fractures) may also occur due to damage to kidney tubule cells (see section 4, Possible side effects).

- Talk to your child’s doctor if your child has a history of liver disease, including hepatitis. Patients with liver disease including chronic hepatitis B or C, who are treated with antiretrovirals, have a higher risk of severe and potentially fatal liver complications. If your child has hepatitis B infection, your child’s doctor will carefully consider the best treatment for them. If your child has a history of liver disease or chronic hepatitis B infection, your child’s doctor may conduct blood tests to monitor their liver function.

- Look out for infections. If your child has advanced HIV infection (AIDS) and has an infection, they may develop symptoms of infection and inflammation or worsening of the symptoms of an existing infection once treatment with Viread is started. These symptoms may indicate that your child’s body’s improved immune system is fighting infection. Look out for signs of inflammation or infection soon after your child starts taking Viread. If you notice signs of inflammation or infection, tell your child’s doctor at once.

In addition to the opportunistic infections, autoimmune disorders (a condition that occurs when the immune system attacks healthy body tissue) may also occur after your child starts taking medicines for the treatment of their HIV infection. Autoimmune disorders may occur many months after the start of treatment. If you notice that your child has any symptoms of infection or other symptoms such as muscle weakness, weakness beginning in the hands and feet and
moving up towards the trunk of the body, palpitations, tremor or hyperactivity, please inform your child’s doctor immediately to seek necessary treatment.

**Children and adolescents**

Viread 204 mg tablets are only suitable for:
- children aged 6 to less than 12 years
- who weigh from 28 kg to less than 35 kg
- who have already been treated with other HIV medicines which are no longer fully effective due to development of resistance, or have caused side effects.

Viread 204 mg tablets are not suitable for the following groups:
- Not for children who weigh under 28 kg or 35 kg and over. Contact your child’s doctor if your child is outside the permitted weight.
- Not for children and adolescents under 6 years or 12 years and over.
- Not for HBV (Hepatitis B virus) infected children and adolescents of any age.

For dosage see section 3, *How to take Viread*.

**Other medicines and Viread**

Tell your child’s doctor or pharmacist if they are taking, have recently taken or might take any other medicines.

- **Do not give Viread** if your child is already taking other medicines containing tenofovir disoproxil fumarate or tenofovir alafenamide. Do not give Viread together with medicines containing adefovir dipivoxil (a medicine used to treat chronic hepatitis B).

- **It is very important to tell your child’s doctor if your child is taking other medicines that may damage their kidneys.**

  These include:
  - aminoglycosides, pentamidine or vancomycin (for bacterial infection),
  - amphotericin B (for fungal infection),
  - fosfocarnet, ganciclovir, or cidofovir (for viral infection),
  - interleukin-2 (to treat cancer),
  - adefovir dipivoxil (for HBV),
  - tacrolimus (for suppression of the immune system),
  - non-steroidal anti-inflammatory drugs (NSAIDs, to relieve bone or muscle pains).

- **Other medicines containing didanosine (for HIV infection):** Taking Viread with other antiviral medicines that contain didanosine can raise the levels of didanosine in the blood and may reduce CD4 cell counts. Rarely, inflammation of the pancreas and lactic acidosis (excess lactic acid in the blood), which sometimes caused death, have been reported when medicines containing tenofovir disoproxil fumarate and didanosine were taken together. Your child’s doctor will carefully consider whether to treat your child with combinations of tenofovir and didanosine.

  - **It is also important to tell your doctor** if your child is taking ledipasvir/sofosbuvir or sofosbuvir/velpatasvir to treat hepatitis C infection.

**Viread with food and drink**

Give **Viread with food** (for example, a meal or a snack).
Pregnancy and breast-feeding

If your child is pregnant or breast-feeding, or they think they may be pregnant, ask your child’s doctor or pharmacist for advice before they take this medicine.

- **Your child must not take Viread during pregnancy** unless specifically discussed with your child’s doctor. Although there are limited clinical data on the use of Viread in pregnant women, it is not usually used unless absolutely necessary.

- **Your child should try to avoid getting pregnant** during treatment with Viread. Your child must use an effective method of contraception to avoid becoming pregnant if they are sexually active.

- **If your child becomes pregnant**, ask your child’s doctor about the potential benefits and risks of the antiretroviral therapy to your child and your child’s baby.

- **If your child has taken Viread** during their pregnancy, your child’s doctor may request regular blood tests and other diagnostic tests to monitor the development of the baby. In children whose mothers took medicines like Viread (NRTIs) during pregnancy, the benefit from the protection against the virus outweighed the risk of side effects.

- **Your child must not breast-feed during treatment with Viread.** This is because the active substance in this medicine passes into human breast milk.

- Your child must not breast-feed, to avoid passing the virus to the baby in breast milk.

Driving and using machines

Viread can cause dizziness. If your child feels dizzy while taking Viread, they must **not drive or ride a bicycle** and must not use any tools or machines.

Viread contains lactose

Tell your child’s doctor before giving Viread if your child cannot tolerate lactose or if they have an intolerance to any other sugars.

3. **How to take Viread**

**Your child must always take this medicine exactly as their doctor or pharmacist has told you.** Check with your child’s doctor or pharmacist if you are not sure.

The recommended dose is:
- **Children aged 6 to less than 12 years who weigh from 28 kg to less than 35 kg:** 1 tablet each day with food (for example, a meal or a snack).

Your child’s doctor will monitor their weight.

**Your child must always take the dose recommended by their doctor.** This is to make sure that their medicine is fully effective, and to reduce the risk of developing resistance to the treatment. Do not change the dose unless your child’s doctor tells you to.

Your child’s doctor will prescribe Viread with other antiretroviral medicines.

Refer to the patient information leaflets of the other antiretrovirals for guidance on how to take those medicines.
If your child takes more Viread than they should

If your child accidentally takes too many Viread tablets, they may be at increased risk of experiencing possible side effects with this medicine (see section 4, Possible side effects). Contact your child’s doctor or nearest emergency department for advice. Keep the tablet bottle with you so that you can easily describe what your child has taken.

If your child forgets to take Viread

It is important not to miss a dose of Viread. If your child misses a dose, work out how long since they should have taken it.

- If it is less than 12 hours after it is usually taken, they should take it as soon as they can, and then take their next dose at its regular time.

- If it is more than 12 hours since your child should have taken it, forget about the missed dose. Wait and give the next dose at the regular time. Do not give a double dose to make up for a forgotten tablet.

If your child throws up less than 1 hour after taking Viread, give your child another tablet. Your child does not need to take another tablet if they were sick more than 1 hour after taking Viread.

If your child stops taking Viread

Your child must not stop taking Viread without their doctor’s advice. Stopping treatment with Viread may reduce the effectiveness of the treatment recommended by your child’s doctor.

If your child has HIV and hepatitis B it is very important not to stop their Viread treatment without talking to your child’s doctor first. Some patients have had blood tests or symptoms indicating that their hepatitis has got worse after stopping Viread. Your child may require blood tests for several months after stopping treatment. In some patients with advanced liver disease or cirrhosis, stopping treatment is not recommended as this may lead to worsening of your child’s hepatitis.

- Talk to your child’s doctor before your child stops taking Viread for any reason, particularly if your child is experiencing any side effects or they have another illness.

- Tell your child’s doctor immediately about new or unusual symptoms after your child stops treatment, particularly symptoms you associate with hepatitis B infection.

- Contact your child’s doctor before your child restarts taking Viread tablets.

If you have any further questions on the use of this medicine, ask your child’s doctor or pharmacist.

4. Possible side effects

During HIV therapy there may be an increase in weight and in levels of blood lipids and glucose. This is partly linked to restored health and lifestyle, and in the case of blood lipids sometimes to the HIV medicines themselves. Your child’s doctor will test for these changes.

Like all medicines, this medicine can cause side effects, although not everybody gets them.
Possible serious side effects: tell your child’s doctor immediately

- **Lactic acidosis** (excess lactic acid in the blood) is a **rare** (can affect up to 1 in every 1,000 patients) but serious side effect that can be fatal. The following side effects may be signs of lactic acidosis:
  - deep, rapid breathing
  - drowsiness
  - feeling sick (nausea), being sick (vomiting) and stomach pain

➤ If you think that your child may have **lactic acidosis, contact your child’s doctor immediately.**

Other possible serious side effects

The following side effects are **uncommon** (this can affect up to 1 in every 100 patients):

- pain in the tummy (abdomen) caused by inflammation of the pancreas
- damage to kidney tubule cells

The following side effects are **rare** (these can affect up to 1 in every 1,000 patients):

- inflammation of the kidney, **passing a lot of urine and feeling thirsty**
- changes to your child’s **urine** and **back pain** caused by kidney problems, including kidney failure
- softening of the bones (with **bone pain** and sometimes resulting in fractures), which may occur due to damage to kidney tubule cells
- fatty liver

➤ If you think that your child may have any of these serious side effects, talk to your child’s doctor.

Most frequent side effects

The following side effects are **very common** (these can affect at least 10 in every 100 patients):

- diarrhoea, being sick (vomiting), feeling sick (nausea), dizziness, rash, feeling weak

Tests may also show:

- decreases in phosphate in the blood

Other possible side effects

The following side effects are **common** (these can affect up to 10 in every 100 patients):

- flatulence
Tests may also show:

- liver problems

The following side effects are uncommon (these can affect up to 1 in every 100 patients):

- breakdown of muscle, muscle pain or weakness

Tests may also show:

- decreases in potassium in the blood
- increased creatinine in your child’s blood
- pancreas problems

The breakdown of muscle, softening of the bones (with bone pain and sometimes resulting in fractures), muscle pain, muscle weakness and decreases in potassium or phosphate in the blood may occur due to damage to kidney tubule cells.

The following side effects are rare (these can affect up to 1 in every 1,000 patients):

- pain in the tummy (abdomen) caused by inflammation of the liver
- swelling of the face, lips, tongue or throat

**Reporting of side effects**

*If your child gets any side effects, talk to your child’s doctor or pharmacist.* This includes any possible side effects not listed in this leaflet. You can also report side effects directly via the national reporting system listed in Appendix V. By reporting side effects you can help provide more information on the safety of this medicine.

5. **How to store Viread**

Keep this medicine out of the sight and reach of children.

Do not use this medicine after the expiry date which is stated on the bottle and carton after {EXP}. The expiry date refers to the last day of that month.

This medicine does not require any special storage conditions.

Do not throw away any medicines via wastewater or household waste. Ask your pharmacist how to throw away medicines you no longer use. These measures will help protect the environment.

6. **Contents of the pack and other information**

**What Viread contains**

- The active substance is tenofovir. Each Viread tablet contains 204 mg of tenofovir disoproxil (as fumarate).
- **The other ingredients are** microcrystalline cellulose (E460), starch pregelatinised, croscarmellose sodium, lactose monohydrate, and magnesium stearate (E572) which make up the tablet core, and lactose monohydrate, hypromellose (E464), titanium dioxide (E171) and glycerol triacetate (E1518) which make up the tablet coating. Refer to section 2 “Viread contains lactose”.

**What Viread looks like and contents of the pack**

Viread 204 mg film-coated tablets are white, capsule-shaped, film-coated tablets, of dimensions 15.4 mm x 7.3 mm, debossed on one side with “GSI” and on the other side with “250”. Viread 204 mg film-coated tablets are supplied in bottles containing 30 tablets. Each bottle contains a silica gel desiccant that must be kept in the bottle to help protect your tablets. The silica gel desiccant is contained in a separate sachet or canister and should not be swallowed.

The following pack sizes are available: outer cartons containing 1 bottle of 30 film-coated tablets and 3 bottles of 30 film-coated tablets. Not all pack sizes may be marketed.

**Marketing Authorisation Holder and Manufacturer**

Marketing Authorisation Holder:
Gilead Sciences International Limited
Cambridge
CB21 6GT
United Kingdom

Manufacturer:
Gilead Sciences Ireland UC
IDA Business & Technology Park
Carrigtøhill
County Cork
Ireland

For any information about this medicine, please contact the local representative of the Marketing Authorisation Holder:

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**Nederland**
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This leaflet was last revised in {MM/YYYY}.

Detailed information on this medicine is available on the European Medicines Agency web site: http://www.ema.europa.eu
Read all of this leaflet carefully before you start taking this medicine because it contains important information for you.
- Keep this leaflet. You may need to read it again.
- If you have any further questions, ask your doctor or pharmacist.
- This medicine has been prescribed for you only. Do not pass it on to others. It may harm them, even if their signs of illness are the same as yours.
- If you get any side effects, talk to your doctor or pharmacist. This includes any possible side effects not listed in this leaflet. See section 4.

What is in this leaflet
1. What Viread is and what it is used for
2. What you need to know before you take Viread
3. How to take Viread
4. Possible side effects
5. How to store Viread
6. Contents of the pack and other information

If Viread has been prescribed for your child, please note that all the information in this leaflet is addressed to your child (in this case please read “your child” instead of “you”).

1. What Viread is and what it is used for

Viread contains the active substance tenofovir disoproxil. This active substance is an antiretroviral or antiviral medicine which is used to treat HIV or HBV infection or both. Tenofovir is a nucleotide reverse transcriptase inhibitor, generally known as an NRTI and works by interfering with the normal working of enzymes (in HIV reverse transcriptase; in hepatitis B DNA polymerase) that are essential for the viruses to reproduce themselves. In HIV Viread should always be used combined with other medicines to treat HIV infection.

**Viread 245 mg tablets are a treatment for HIV** (Human Immunodeficiency Virus) infection. The tablets are suitable for:
- **adults**
- **adolescents aged 12 to less than 18 years who have already been treated** with other HIV medicines which are no longer fully effective due to development of resistance, or have caused side effects.

**Viread 245 mg tablets are also a treatment for chronic hepatitis B, an infection with HBV** (hepatitis B virus). The tablets are suitable for:
- **adults**
- **adolescents aged 12 to less than 18 years.**

You do not have to have HIV to be treated with Viread for HBV.

This medicine is not a cure for HIV infection. While taking Viread you may still develop infections or other illnesses associated with HIV infection. You can also pass on HIV or HBV to others, so it is important to take precautions to avoid infecting other people.
2. What you need to know before you take Viread

Do not take Viread

- **If you are allergic** to tenofovir, tenofovir disoproxil fumarate or any of the other ingredients of this medicine listed in section 6.

  ➔ If this applies to you, **tell your doctor immediately and don’t take Viread.**

**Warnings and precautions**

Talk to your doctor or pharmacist before taking Viread.

- **Take care not to infect other people.** You can still pass on HIV when taking this medicine, although the risk is lowered by effective antiretroviral therapy. Discuss with your doctor the precautions needed to avoid infecting other people. Viread does not reduce the risk of passing on HBV to others through sexual contact or blood contamination. You must continue to take precautions to avoid this.

- **Talk to your doctor or pharmacist if you have had kidney disease or if tests have shown problems with your kidneys.** Viread should not be given to adolescents with existing kidney problems. Before starting treatment, your doctor may order blood tests to assess your kidney function. Viread may affect your kidneys during treatment. Your doctor may order blood tests during treatment to monitor how your kidneys work. If you are an adult, your doctor may advise you to take the tablets less often. Do not reduce the prescribed dose, unless your doctor has told you to do so.

  Viread is not usually taken with other medicines that can damage your kidneys (see Other medicines and Viread). If this is unavoidable, your doctor will monitor your kidney function once a week.

- **Bone problems.** Some adult patients with HIV taking combination antiretroviral therapy may develop a bone disease called osteonecrosis (death of bone tissue caused by loss of blood supply to the bone). The length of combination antiretroviral therapy, corticosteroid use, alcohol consumption, severe immunosuppression, higher body mass index, among others, may be some of the many risk factors for developing this disease. Signs of osteonecrosis are joint stiffness, aches and pains (especially of the hip, knee and shoulder) and difficulty in movement. If you notice any of these symptoms tell your doctor.

  Bone problems (sometimes resulting in fractures) may also occur due to damage to kidney tubule cells (see section 4, Possible side effects).

- **Talk to your doctor if you have a history of liver disease, including hepatitis.** Patients with liver disease including chronic hepatitis B or C, who are treated with antiretrovirals, have a higher risk of severe and potentially fatal liver complications. If you have hepatitis B infection, your doctor will carefully consider the best treatment for you. If you have a history of liver disease or chronic hepatitis B infection your doctor may conduct blood tests to monitor your liver function.

- **Look out for infections.** If you have advanced HIV infection (AIDS) and have an infection, you may develop symptoms of infection and inflammation or worsening of the symptoms of an existing infection once treatment with Viread is started. These symptoms may indicate that your body’s improved immune system is fighting infection. Look out for signs of inflammation or infection soon after you start taking Viread. If you notice signs of inflammation or infection, **tell your doctor at once.**
In addition to the opportunistic infections, autoimmune disorders (a condition that occurs when the immune system attacks healthy body tissue) may also occur after you start taking medicines for the treatment of your HIV infection. Autoimmune disorders may occur many months after the start of treatment. If you notice any symptoms of infection or other symptoms such as muscle weakness, weakness beginning in the hands and feet and moving up towards the trunk of the body, palpitations, tremor or hyperactivity, please inform your doctor immediately to seek necessary treatment.

- **Talk to your doctor or pharmacist if you are over 65.** Viread has not been studied in patients over 65 years of age. If you are older than this and are prescribed Viread, your doctor will monitor you carefully.

**Children and adolescents**

Viread 245 mg tablets are **suitable** for:

- **HIV-1 infected adolescents aged 12 to less than 18 years who weigh at least 35 kg and who have already been treated** with other HIV medicines which are no longer fully effective due to development of resistance, or have caused side effects
- **HBV infected adolescents aged 12 to less than 18 years who weigh at least 35 kg.**

Viread 245 mg tablets are **not** suitable for the following groups:

- **Not for HIV-1 infected children** under 12 years of age
- **Not for HBV infected children** under 12 years of age.

For dosage see section 3, *How to take Viread.*

**Other medicines and Viread**

Tell your doctor or pharmacist if you are taking, have recently taken or might take any other medicines.

- **Don’t stop any anti-HIV medicines** prescribed by your doctor when you start Viread if you have both HBV and HIV.

- **Do not take Viread** if you are already taking other medicines containing tenofovir disoproxil fumarate or tenofovir alafenamide. Do not take Viread together with medicines containing adefovir dipivoxil (a medicine used to treat chronic hepatitis B).

- **It is very important to tell your doctor if you are taking other medicines that may damage your kidneys.**

These include:

- aminoglycosides, pentamidine or vancomycin (for bacterial infection),
- amphotericin B (for fungal infection),
- foscarnet, ganciclovir, or cidofovir (for viral infection),
- interleukin-2 (to treat cancer),
- adefovir dipivoxil (for HBV),
- tacrolimus (for suppression of the immune system),
- non-steroidal anti-inflammatory drugs (NSAIDs, to relieve bone or muscle pains).
Other medicines containing didanosine (for HIV infection): Taking Viread with other antiviral medicines that contain didanosine can raise the levels of didanosine in your blood and may reduce CD4 cell counts. Rarely, inflammation of the pancreas and lactic acidosis (excess lactic acid in the blood), which sometimes caused death, have been reported when medicines containing tenofovir disoproxil fumarate and didanosine were taken together. Your doctor will carefully consider whether to treat you with combinations of tenofovir and didanosine.

It is also important to tell your doctor if you are taking ledipasvir/sofosbuvir or sofosbuvir/velpatasvir to treat hepatitis C infection.

Viread with food and drink

Take Viread with food (for example, a meal or a snack).

Pregnancy and breast-feeding

If you are pregnant or breast-feeding, think you may be pregnant or are planning to have a baby, ask your doctor or pharmacist for advice before taking this medicine.

You must not take Viread during pregnancy unless specifically discussed with your doctor. Although there are limited clinical data on the use of Viread in pregnant women, it is not usually used unless absolutely necessary.

Try to avoid getting pregnant during treatment with Viread. You must use an effective method of contraception to avoid becoming pregnant.

If you become pregnant, or plan to become pregnant, ask your doctor about the potential benefits and risks of your antiretroviral therapy to you and your child.

If you have taken Viread during your pregnancy, your doctor may request regular blood tests and other diagnostic tests to monitor the development of your child. In children whose mothers took NRTIs during pregnancy, the benefit from the protection against HIV outweighed the risk of side effects.

Do not breast-feed during treatment with Viread. This is because the active substance in this medicine passes into human breast milk.

If you are a woman with HIV or HBV do not breast-feed, to avoid passing the virus to the baby in breast milk.

Driving and using machines

Viread can cause dizziness. If you feel dizzy while taking Viread, do not drive or ride a bicycle and do not use any tools or machines.

Viread contains lactose

Tell your doctor before taking Viread if you cannot tolerate lactose or if you have an intolerance to any other sugars.

3. How to take Viread

Always take this medicine exactly as your doctor or pharmacist has told you. Check with your doctor or pharmacist if you are not sure.
The recommended dose is:

- **Adults:** 1 tablet each day with food (for example, a meal or a snack).
- **Adolescents aged 12 to less than 18 years who weigh at least 35 kg:** 1 tablet each day with food (for example, a meal or a snack).

If you have particular difficulty swallowing, you can use the tip of a spoon to crush the tablet. Then mix the powder with about 100 ml (half a glass) of water, orange juice or grape juice and drink immediately.

- **Always take the dose recommended by your doctor.** This is to make sure that your medicine is fully effective, and to reduce the risk of developing resistance to the treatment. Do not change the dose unless your doctor tells you to.
- **If you are an adult and have problems with your kidneys,** your doctor may advise you to take Viread less frequently.
- **If you have HBV your doctor may offer you an HIV test to see if you have both HBV and HIV.**

Refer to the patient information leaflets of the other antiretrovirals for guidance on how to take those medicines.

**If you take more Viread than you should**

If you accidentally take too many Viread tablets, you may be at increased risk of experiencing possible side effects with this medicine (see section 4, Possible side effects). Contact your doctor or nearest emergency department for advice. Keep the tablet bottle with you so that you can easily describe what you have taken.

**If you forget to take Viread**

It is important not to miss a dose of Viread. If you miss a dose, work out how long since you should have taken it.

- **If it is less than 12 hours** after it is usually taken, take it as soon as you can, and then take your next dose at its regular time.
- **If it is more than 12 hours** since you should have taken it, forget about the missed dose. Wait and take the next dose at the regular time. Do not take a double dose to make up for a forgotten tablet.

**If you throw up less than 1 hour after taking Viread,** take another tablet. You do not need to take another tablet if you were sick more than 1 hour after taking Viread.

**If you stop taking Viread**

Don’t stop taking Viread without your doctor’s advice. Stopping treatment with Viread may reduce the effectiveness of the treatment recommended by your doctor.

**If you have hepatitis B or HIV and hepatitis B together (co-infection),** it is very important not to stop your Viread treatment without talking to your doctor first. Some patients have had blood tests or symptoms indicating that their hepatitis has got worse after stopping Viread. You may require blood tests for several months after stopping treatment. In some patients with advanced liver disease or cirrhosis, stopping treatment is not recommended as this may lead to worsening of your hepatitis.

- **Talk to your doctor before you stop taking Viread for any reason, particularly if you are experiencing any side effects or you have another illness.**
• Tell your doctor immediately about new or unusual symptoms after you stop treatment, particularly symptoms you associate with hepatitis B infection.

• Contact your doctor before you restart taking Viread tablets.

If you have any further questions on the use of this medicine, ask your doctor or pharmacist.

4. Possible side effects

During HIV therapy there may be an increase in weight and in levels of blood lipids and glucose. This is partly linked to restored health and lifestyle, and in the case of blood lipids sometimes to the HIV medicines themselves. Your doctor will test for these changes.

Like all medicines, this medicine can cause side effects, although not everybody gets them.

Possible serious side effects: tell your doctor immediately

• **Lactic acidosis** (excess lactic acid in the blood) is a **rare** (can affect up to 1 in every 1,000 patients) but serious side effect that can be fatal. The following side effects may be signs of lactic acidosis:
  • deep, rapid breathing
  • drowsiness
  • feeling sick (nausea), being sick (vomiting) and stomach pain

  ➔ If you think that you may have **lactic acidosis**, **contact your doctor immediately**.

Other possible serious side effects

The following side effects are **uncommon** (this can affect up to 1 in every 100 patients):

• **pain in the tummy** (abdomen) caused by inflammation of the pancreas

• damage to kidney tubule cells

The following side effects are **rare** (these can affect up to 1 in every 1,000 patients):

• inflammation of the kidney, **passing a lot of urine and feeling thirsty**

• **changes to your urine** and back pain caused by kidney problems, including kidney failure

• softening of the bones (with **bone pain** and sometimes resulting in fractures), which may occur due to damage to kidney tubule cells

• fatty liver

  ➔ If you think that you may have any of these serious side effects, **talk to your doctor**.
Most frequent side effects

The following side effects are **very common** (these can affect at least 10 in every 100 patients):

- diarrhoea, being sick (vomiting), feeling sick (nausea), dizziness, rash, feeling weak

*Tests may also show:*

- decreases in phosphate in the blood

Other possible side effects

The following side effects are **common** (these can affect up to 10 in every 100 patients):

- headache, stomach pain, feeling tired, feeling bloated, flatulence

*Tests may also show:*

- liver problems

The following side effects are **uncommon** (these can affect up to 1 in every 100 patients):

- breakdown of muscle, muscle pain or weakness

*Tests may also show:*

- decreases in potassium in the blood
- increased creatinine in your blood
- pancreas problems

The breakdown of muscle, softening of the bones (with bone pain and sometimes resulting in fractures), muscle pain, muscle weakness and decreases in potassium or phosphate in the blood may occur due to damage to kidney tubule cells.

The following side effects are **rare** (these can affect up to 1 in every 1,000 patients):

- pain in the tummy (abdomen) caused by inflammation of the liver
- swelling of the face, lips, tongue or throat

**Reporting of side effects**

*If you get any side effects, talk to your doctor or pharmacist.* This includes any possible side effects not listed in this leaflet. You can also report side effects directly via the national reporting system listed in Appendix V. By reporting side effects you can help provide more information on the safety of this medicine.

5. **How to store Viread**

Keep this medicine out of the sight and reach of children.

Do not use this medicine after the expiry date which is stated on the bottle and carton after {EXP}. The expiry date refers to the last day of that month.
This medicine does not require any special storage conditions.

Do not throw away any medicines via wastewater or household waste. Ask your pharmacist how to throw away medicines you no longer use. These measures will help protect the environment.

6. Contents of the pack and other information

What Viread contains

- **The active substance** is tenofovir. Each Viread tablet contains 245 mg of tenofovir disoproxil (as fumarate).

- **The other ingredients are** microcrystalline cellulose (E460), starch pregelatinised, croscarmellose sodium, lactose monohydrate, and magnesium stearate (E572) which make up the tablet core, and lactose monohydrate, hypromellose (E464), titanium dioxide (E171), glycerol triacetate (E1518) and indigo carmine aluminium lake (E132) which make up the tablet coating. Refer to section 2 “Viread contains lactose”.

What Viread looks like and contents of the pack

Viread 245 mg film-coated tablets are light blue, almond-shaped, film-coated tablets, of dimensions 16.8 mm x 10.3 mm, debossed on one side with “GILEAD” and “4331” and on the other side with “300”. Viread 245 mg film-coated tablets are supplied in bottles containing 30 tablets. Each bottle contains a silica gel desiccant that must be kept in the bottle to help protect your tablets. The silica gel desiccant is contained in a separate sachet or canister and should not be swallowed.

The following pack sizes are available: outer cartons containing 1 bottle of 30 film-coated tablets and 3 bottles of 30 film-coated tablets. Not all pack sizes may be marketed.

Marketing Authorisation Holder and Manufacturer

Marketing Authorisation Holder:
Gilead Sciences International Limited
Cambridge
CB21 6GT
United Kingdom

Manufacturer:
Takeda GmbH
Lehnitzstrasse 70-98
D-16515 Oranienburg
Germany

or

Gilead Sciences Ireland UC
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Carrigtwohill
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For any information about this medicine, please contact the local representative of the Marketing Authorisation Holder:

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This leaflet was last revised in {MM/YYYY}.

Detailed information on this medicine is available on the European Medicines Agency web site: http://www.ema.europa.eu
Package leaflet: Information for the patient

Viread 33 mg/g granules
Tenofovir disoproxil

Read all of this leaflet carefully before you start taking this medicine because it contains important information for you.
- Keep this leaflet. You may need to read it again.
- If you have any further questions, ask your doctor or pharmacist.
- This medicine has been prescribed for you only. Do not pass it on to others. It may harm them, even if their signs of illness are the same as yours.
- If you get any side effects, talk to your doctor or pharmacist. This includes any possible side effects not listed in this leaflet. See section 4.

What is in this leaflet
1. What Viread is and what it is used for
2. What you need to know before you take Viread
3. How to take Viread
4. Possible side effects
5. How to store Viread
6. Contents of the pack and other information

If Viread has been prescribed for your child, please note that all the information in this leaflet is addressed to your child (in this case please read “your child” instead of “you”).

1. What Viread is and what it is used for

Viread contains the active substance tenofovir disoproxil. This active substance is an antiretroviral or antiviral medicine which is used to treat HIV or HBV infection or both. Tenofovir is a nucleotide reverse transcriptase inhibitor, generally known as an NRTI and works by interfering with the normal working of enzymes (in HIV reverse transcriptase; in hepatitis B DNA polymerase) that are essential for the viruses to reproduce themselves. In HIV Viread should always be used combined with other medicines to treat HIV infection.

Viread 33 mg/g granules are a treatment for HIV (Human Immunodeficiency Virus) infection. They are suitable for:
- adults
- children and adolescents aged 2 to less than 18 years who have already been treated with other HIV medicines which are no longer fully effective due to development of resistance, or have caused side effects.

Viread 33 mg/g granules are also a treatment for chronic hepatitis B, an infection with HBV (hepatitis B virus). They are suitable for:
- adults
- adolescents aged 12 to less than 18 years.

You do not have to have HIV to be treated with Viread for HBV.

This medicine is not a cure for HIV infection. While taking Viread you may still develop infections or other illnesses associated with HIV infection. You can also pass on HIV or HBV to others, so it is important to take precautions to avoid infecting other people.
2. What you need to know before you take Viread

Do not take Viread

- **If you are allergic** to tenofovir, tenofovir disoproxil fumarate or any of the other ingredients of this medicine listed in section 6.

  ➔ If this applies to you, **tell your doctor immediately and don’t take Viread.**

Warnings and precautions

Talk to your doctor or pharmacist before taking Viread.

- **Take care not to infect other people.** You can still pass on HIV when taking this medicine, although the risk is lowered by effective antiretroviral therapy. Discuss with your doctor the precautions needed to avoid infecting other people. Viread does not reduce the risk of passing on HBV to others through sexual contact or blood contamination. You must continue to take precautions to avoid this.

- **Talk to your doctor or pharmacist if you have had kidney disease or if tests have shown problems with your kidneys.** Viread should not be given to children with existing kidney problems. Before starting treatment, your doctor may order blood tests to assess your kidney function. Viread may affect your kidneys during treatment. Your doctor may order blood tests during treatment to monitor how your kidneys work. If you are an adult, your doctor may advise you to reduce your daily dose of the granules. Do not reduce the prescribed dose, unless your doctor has told you to do so.

  Viread is not usually taken with other medicines that can damage your kidneys (see *Other medicines and Viread*). If this is unavoidable, your doctor will monitor your kidney function once a week.

- **Bone problems.** Some adult patients with HIV taking combination antiretroviral therapy may develop a bone disease called osteonecrosis (death of bone tissue caused by loss of blood supply to the bone). The length of combination antiretroviral therapy, corticosteroid use, alcohol consumption, severe immunosuppression, higher body mass index, among others, may be some of the many risk factors for developing this disease. Signs of osteonecrosis are joint stiffness, aches and pains (especially of the hip, knee and shoulder) and difficulty in movement. If you notice any of these symptoms tell your doctor.

  Bone problems (sometimes resulting in fractures) may also occur due to damage to kidney tubule cells (see section 4, *Possible side effects*).

- **Talk to your doctor if you have a history of liver disease, including hepatitis.** Patients with liver disease including chronic hepatitis B or C, who are treated with antiretrovirals, have a higher risk of severe and potentially fatal liver complications. If you have hepatitis B infection, your doctor will carefully consider the best treatment for you. If you have a history of liver disease or chronic hepatitis B infection your doctor may conduct blood tests to monitor your liver function.

- **Look out for infections.** If you have advanced HIV infection (AIDS) and have an infection, you may develop symptoms of infection and inflammation or worsening of the symptoms of an existing infection once treatment with Viread is started. These symptoms may indicate that your body’s improved immune system is fighting infection. Look out for signs of inflammation or infection soon after you start taking Viread. If you notice signs of inflammation or infection, **tell your doctor at once.**
In addition to the opportunistic infections, autoimmune disorders (a condition that occurs when the immune system attacks healthy body tissue) may also occur after you start taking medicines for the treatment of your HIV infection. Autoimmune disorders may occur many months after the start of treatment. If you notice any symptoms of infection or other symptoms such as muscle weakness, weakness beginning in the hands and feet and moving up towards the trunk of the body, palpitations, tremor or hyperactivity, please inform your doctor immediately to seek necessary treatment.

- **Talk to your doctor or pharmacist if you are over 65.** Viread has not been studied in patients over 65 years of age. If you are older than this and are prescribed Viread, your doctor will monitor you carefully.

**Children and adolescents**

Viread 33 mg/g granules are **only suitable** for:

- **HIV-infected children and adolescents aged 2 to less than 18 years who have already been treated** with other HIV medicines which are no longer fully effective due to development of resistance, or have caused side effects
- **HBV infected adolescents aged 12 to less than 18 years.**

Viread 33 mg/g granules are **not suitable** for the following groups:

- **Not for HIV-infected children under 2 years**
- **Not for HBV (Hepatitis B virus) infected children under 12 years.**

For dosage see section 3, *How to take Viread.*

**Other medicines and Viread**

Tell your doctor or pharmacist if you are taking, have recently taken or might take any other medicines.

- **Don’t stop any anti-HIV medicines** prescribed by your doctor when you start Viread if you have both HBV and HIV.

- **Do not take Viread** if you are already taking other medicines containing tenofovir disoproxil fumarate or tenofovir alafenamide. Do not take Viread together with medicines containing adefovir dipivoxil (a medicine used to treat chronic hepatitis B).

- **It is very important to tell your doctor if you are taking other medicines that may damage your kidneys.**

These include:

- aminoglycosides, pentamidine or vancomycin (for bacterial infection),
- amphotericin B (for fungal infection),
- foscarin, ganciclovir, or cidofovir (for viral infection),
- interleukin-2 (to treat cancer),
- adefovir dipivoxil (for HBV),
- tacrolimus (for suppression of the immune system),
- non-steroidal anti-inflammatory drugs (NSAIDs, to relieve bone or muscle pains).
Other medicines containing didanosine (for HIV infection): Taking Viread with other antiviral medicines that contain didanosine can raise the levels of didanosine in your blood and may reduce CD4 cell counts. Rarely, inflammation of the pancreas and lactic acidosis (excess lactic acid in the blood), which sometimes caused death, have been reported when medicines containing tenofovir disoproxil fumarate and didanosine were taken together. Your doctor will carefully consider whether to treat you with combinations of tenofovir and didanosine.

It is also important to tell your doctor if you are taking ledipasvir/sofosbuvir or sofosbuvir/velpatasvir to treat hepatitis C infection.

Viread with food and drink

Viread granules should be mixed with soft food which does not require chewing (for example, yoghurt, applesauce or baby food). If the granules mixture is chewed, it will taste very bitter.

Pregnancy and breast-feeding

If you are pregnant or breast-feeding, think you may be pregnant or are planning to have a baby, ask your doctor or pharmacist for advice before taking this medicine.

You must not take Viread during pregnancy unless specifically discussed with your doctor. Although there are limited clinical data on the use of Viread in pregnant women, it is not usually used unless absolutely necessary.

Try to avoid getting pregnant during treatment with Viread. You must use an effective method of contraception to avoid becoming pregnant.

If you become pregnant, or plan to become pregnant, ask your doctor about the potential benefits and risks of your antiretroviral therapy to you and your child.

If you have taken Viread during your pregnancy, your doctor may request regular blood tests and other diagnostic tests to monitor the development of your child. In children whose mothers took NRTIs during pregnancy, the benefit from the protection against HIV outweighted the risk of side effects.

Do not breast-feed during treatment with Viread. This is because the active substance in this medicine passes into human breast milk.

If you are a woman with HIV or HBV do not breast-feed, to avoid passing the virus to the baby in breast milk.

Driving and using machines

Viread can cause dizziness. If you feel dizzy while taking Viread, do not drive or ride a bicycle and do not use any tools or machines.

Viread granules contain mannitol

Mannitol may have a mild laxative effect.

How to take Viread

Always take this medicine exactly as your doctor or pharmacist has told you. Check with your doctor or pharmacist if you are not sure.
The recommended dose is:

- **Adults and adolescents aged 12 to less than 18 years and weighing at least 35 kg:** 245 mg, equivalent to 7.5 scoops of granules, once a day.
- **Children aged 2 to less than 12 years:** The daily dose in children depends on their weight. Your child’s doctor will determine the right dose of Viread granules based on your child’s weight.

Viread granules should be measured with the supplied dosing scoop (see Figure A):

Each level dosing scoop provides 1 g of the granules which contains 33 mg tenofovir disoproxil (as fumarate).

- Fill the dosing scoop to the top.
- Use the flat edge of clean knife to make the granules even with the top of the scoop (see Figure B).

- For ½ scoop:
  - Fill the dosing scoop up to the “½ line” on the side (see Figure C).

- Measure out the correct number of level scoops of granules into a container.
- You must mix the granules with soft food which does not require chewing, for example yoghurt, applesauce or baby food. One tablespoon (15 ml) of soft food per one level scoop of granules is required. Do not mix the granules with liquids.
- You must take the granules mixed with food immediately.
- Take all of the mixture you make each time.

- **Always take the dose recommended by your doctor.** This is to make sure that your medicine is fully effective, and to reduce the risk of developing resistance to the treatment. Do not change the dose unless your doctor tells you to.

- **If you are an adult and have problems with your kidneys,** your doctor may advise you to reduce your daily dose of the granules.

- If you have HBV your doctor may offer you an HIV test to see if you have both HBV and HIV.

Refer to the patient information leaflets of the other antiretrovirals for guidance on how to take those medicines.
If you take more Viread than you should

If you accidentally take too much Viread, you may be at increased risk of experiencing possible side effects with this medicine (see section 4, Possible side effects). Contact your doctor or nearest emergency department for advice. Keep the granules bottle with you so that you can easily describe what you have taken.

If you forget to take Viread

It is important not to miss a dose of Viread. If you miss a dose, work out how long since you should have taken it.

- If it is less than 12 hours after it is usually taken, take it as soon as you can, and then take your next dose at its regular time.
- If it is more than 12 hours since you should have taken it, forget about the missed dose. Wait and take the next dose at the regular time. Do not take a double dose to make up for a forgotten dose.

If you throw up less than 1 hour after taking Viread, take another dose. You do not need to take another dose if you were sick more than 1 hour after taking Viread.

If you stop taking Viread

Don't stop taking Viread without your doctor’s advice. Stopping treatment with Viread may reduce the effectiveness of the treatment recommended by your doctor.

If you have hepatitis B or HIV and hepatitis B together (co-infection), it is very important not to stop your Viread treatment without talking to your doctor first. Some patients have had blood tests or symptoms indicating that their hepatitis has got worse after stopping Viread. You may require blood tests for several months after stopping treatment. In some patients with advanced liver disease or cirrhosis, stopping treatment is not recommended as this may lead to worsening of your hepatitis.

- Talk to your doctor before you stop taking Viread for any reason, particularly if you are experiencing any side effects or you have another illness.
- Tell your doctor immediately about new or unusual symptoms after you stop treatment, particularly symptoms you associate with hepatitis B infection.
- Contact your doctor before you restart taking Viread granules.

If you have any further questions on the use of this medicine, ask your doctor or pharmacist.

4. Possible side effects

During HIV therapy there may be an increase in weight and in levels of blood lipids and glucose. This is partly linked to restored health and life style, and in the case of blood lipids sometimes to the HIV medicines themselves. Your doctor will test for these changes.

Like all medicines, this medicine can cause side effects, although not everybody gets them.
Possible serious side effects: tell your doctor immediately

- **Lactic acidosis** (excess lactic acid in the blood) is a **rare** (can affect up to 1 in every 1,000 patients) but serious side effect that can be fatal. The following side effects may be signs of lactic acidosis:
  - deep, rapid breathing
  - drowsiness
  - feeling sick (nausea), being sick (vomiting) and stomach pain

➤ If you think that you may have lactic acidosis, contact your doctor immediately.

Other possible serious side effects

The following side effects are **uncommon** (this can affect up to 1 in every 100 patients):

- **pain in the tummy** (abdomen) caused by inflammation of the pancreas
- damage to kidney tubule cells

The following side effects are **rare** (these can affect up to 1 in every 1,000 patients):

- inflammation of the kidney, **passing a lot of urine and feeling thirsty**
- **changes to your urine** and back pain caused by kidney problems, including kidney failure
- softening of the bones (with **bone pain** and sometimes resulting in fractures), which may occur due to damage to kidney tubule cells
- fatty liver

➤ If you think that you may have any of these serious side effects, talk to your doctor.

Most frequent side effects

The following side effects are **very common** (these can affect at least 10 in every 100 patients):

- diarrhoea, being sick (vomiting), feeling sick (nausea), dizziness, rash, feeling weak

*Tests may also show:*

- decreases in phosphate in the blood

Other possible side effects

The following side effects are **common** (these can affect up to 10 in every 100 patients):

- headache, stomach pain, feeling tired, feeling bloated, flatulence

*Tests may also show:*

- liver problems
The following side effects are **uncommon** (these can affect up to 1 in every 100 patients):

- breakdown of muscle, muscle pain or weakness

*Tests may also show:*

- decreases in potassium in the blood
- increased creatinine in your blood
- pancreas problems

The breakdown of muscle, softening of the bones (with bone pain and sometimes resulting in fractures), muscle pain, muscle weakness and decreases in potassium or phosphate in the blood may occur due to damage to kidney tubule cells.

The following side effects are **rare** (these can affect up to 1 in every 1,000 patients):

- pain in the tummy (abdomen) caused by inflammation of the liver
- swelling of the face, lips, tongue or throat

**Reporting of side effects**

*If you get any side effects, talk to your doctor or pharmacist.* This includes any possible side effects not listed in this leaflet. You can also report side effects directly via the national reporting system listed in Appendix V. By reporting side effects you can help provide more information on the safety of this medicine.

5. **How to store Viread**

Keep this medicine out of the sight and reach of children.

Do not use this medicine after the expiry date which is stated on the bottle and carton after {EXP}. The expiry date refers to the last day of that month.

Do not store above 25°C.

Do not throw away any medicines via wastewater or household waste. Ask your pharmacist how to throw away medicines you no longer use. These measures will help protect the environment.

6. **Contents of the pack and other information**

**What Viread contains**

- The **active substance** is tenofovir. One gram of Viread granules contains 33 mg of tenofovir disoproxil (as fumarate).

- The **other ingredients** are ethylcellulose (E462), hydroxypropyl cellulose (E463), mannitol (E421) and silicon dioxide (E551). Refer to section 2 “Viread granules contain mannitol”.

**What Viread looks like and contents of the pack**

This medicine consists of white coated granules. The granules are supplied in a bottle containing 60 g of granules and are packaged with a dosing scoop.
Marketing Authorisation Holder and Manufacturer

Marketing Authorisation Holder:
Gilead Sciences International Limited
Cambridge
CB21 6GT
United Kingdom

Manufacturer:
Gilead Sciences Ireland UC
IDA Business & Technology Park
Carrigtohill
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For any information about this medicine, please contact the local representative of the Marketing Authorisation Holder:

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Detailed information on this medicine is available on the European Medicines Agency web site: http://www.ema.europa.eu