

ANNEX I
SUMMARY OF PRODUCT CHARACTERISTICS

1. NAME OF THE MEDICINAL PRODUCT

Triumeq 50 mg/600 mg/300 mg film-coated tablets

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

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

For the full list of excipients see section 6.1.

3. PHARMACEUTICAL FORM

Film-coated tablet (tablet)

Purple, biconvex, film-coated oval tablets, approximately 22 x 11 mm, debossed with “572 Tr1” on one side.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Triumeq is indicated for the treatment of Human Immunodeficiency Virus type 1 (HIV-1) infected adults, adolescents and children weighing at least 25 kg (see sections 4.4 and 5.1).

Before initiating treatment with abacavir-containing products, screening for carriage of the HLA-B*5701 allele should be performed in any HIV-infected patient, irrespective of racial origin (see section 4.4). Abacavir should not be used in patients known to carry the HLA-B*5701 allele.

4.2 Posology and method of administration

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

Posology

Adults, adolescents and children (weighing at least 25kg)

The recommended dose is one tablet once daily.

Triumeq film-coated tablets should not be administered to adults, adolescents or children who weigh less than 25 kg because it is a fixed-dose tablet that cannot be dose reduced. Triumeq dispersible tablets should be administered to children of at least 3 months of age and weighing at least 6 kg to less than 25 kg.

Separate preparations of dolutegravir, abacavir or lamivudine are available in cases where discontinuation or dose adjustment of one of the active substances is indicated. In these cases the physician should refer to the individual product information for these medicinal products.

A separate dose of dolutegravir (film-coated tablets or dispersible tablets) is applicable where a dose adjustment is indicated due to drug-drug interactions, e.g. rifampicin, carbamazepine, oxcarbazepine, phenytoin, phenobarbital, St. John's wort, etravirine (without boosted protease inhibitors), efavirenz, nevirapine, or tipranavir/ritonavir (see sections 4.4 and 4.5).

Dispersible tablets

Triumeq is available as dispersible tablets for patients of at least 3 months of age and weighing at least 6 kg to less than 25 kg. The bioavailability of dolutegravir from film-coated tablets and dispersible tablets is not comparable; therefore, they must not be used as direct replacements (see section 5.2).

Missed doses

If the patient misses a dose of Triumeq, the patient should take it as soon as possible, providing the next dose is not due within 4 hours. If the next dose is due within 4 hours, the patient should not take the missed dose and simply resume the usual dosing schedule.

Special populations

Elderly

There are limited data available on the use of dolutegravir, abacavir and lamivudine in patients aged 65 years and over. There is no evidence that elderly patients require a different dose than younger adult patients (see section 5.2). Special care is advised in this age group due to age associated changes such as the decrease in renal function and alteration of haematological parameters.

Renal impairment

Triumeq is not recommended for use in patients with a creatinine clearance < 30 mL/min (see section 5.2). No dose adjustment is required in patients with mild or moderate renal impairment. However, the lamivudine exposure is significantly increased in patients with a creatinine clearance < 50 mL/min (see section 4.4).

Hepatic impairment

Abacavir is primarily metabolised by the liver. No clinical data are available in patients with moderate or severe hepatic impairment, therefore the use of Triumeq is not recommended unless judged necessary. In patients with mild hepatic impairment (Child-Pugh score 5-6) close monitoring is required, including monitoring of abacavir plasma levels if feasible (see sections 4.4 and 5.2).

Paediatric population

The safety and efficacy of Triumeq in children less than 3 months of age or weighing less than 6 kg have not yet been established.

Currently available data are described in section 4.8, 5.1 and 5.2, but no recommendation on a posology can be made.

Method of administration

Oral use

Triumeq can be taken with or without food (see section 5.2).

4.3 Contraindications

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

Co-administration with medicinal products with narrow therapeutic windows, that are substrates of organic cation transporter (OCT) 2, including but not limited to fampridine (also known as dalfampridine; see section 4.5).

4.4 Special warnings and precautions for use

<u>Hypersensitivity reactions (see section 4.8)</u>

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

Therefore, the following should always be adhered to:

- HLA-B*5701 status must always be documented prior to initiating therapy.
- Triumeq should never be initiated in patients with a positive HLA-B*5701 status, nor in patients with a negative HLA-B*5701 status who had a suspected abacavir HSR on a previous abacavir-containing regimen.
- **Triumeq must be stopped without delay**, even in the absence of the HLA-B*5701 allele, if an HSR is suspected. Delay in stopping treatment with Triumeq after the onset of hypersensitivity may result in an immediate and life-threatening reaction. Clinical status including liver aminotransferases and bilirubin should be monitored.
- After stopping treatment with Triumeq for reasons of a suspected HSR, **Triumeq or any other medicinal product containing abacavir or dolutegravir must never be re-initiated**.
- Restarting abacavir containing products following a suspected abacavir HSR can result in a prompt return of symptoms within hours. This recurrence is usually more severe than on initial presentation, and may include life-threatening hypotension and death.
- In order to avoid restarting abacavir and dolutegravir, patients who have experienced a suspected HSR should be instructed to dispose of their remaining Triumeq tablets.

Clinical description of HSRs

Hypersensitivity reactions have been reported in <1% of patients treated with dolutegravir in clinical studies, and were characterized by rash, constitutional findings, and sometimes, organ dysfunction, including severe liver reactions.

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

Almost all HSR to abacavir will include fever and/or rash. Other signs and symptoms that have been observed as part of abacavir HSR are described in detail in section 4.8 (Description of selected adverse reactions), including respiratory and gastrointestinal symptoms. Importantly, such symptoms **may lead to misdiagnosis of HSR as respiratory disease (pneumonia, bronchitis, pharyngitis), or gastroenteritis**. The symptoms related to this HSR worsen with continued therapy and **can be life-threatening**. These symptoms usually resolve upon discontinuation of abacavir.

Rarely, patients who have stopped abacavir for reasons other than symptoms of HSR have also experienced life-threatening reactions within hours of re-initiating abacavir therapy (see Section 4.8 Description of selected adverse reactions). Restarting abacavir in such patients must be done in a setting where medical assistance is readily available.

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 and weight, there is in some cases evidence for a treatment effect. For monitoring of blood lipids and glucose reference is made to established HIV treatment guidelines. Lipid disorders should be managed as clinically appropriate.

Liver disease

The safety and efficacy of Triumeq has not been established in patients with significant underlying liver disorders. Triumeq is not recommended in patients with moderate to severe hepatic impairment (see sections 4.2 and 5.2).

Patients with pre-existing liver dysfunction, including chronic active hepatitis have an increased frequency of liver function abnormalities during combination antiretroviral therapy, 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.

Patients with chronic hepatitis B or C

Patients with chronic hepatitis B or C and treated with combination antiretroviral therapy are at an increased risk of severe and potentially fatal hepatic adverse reactions. In case of concomitant antiviral therapy for hepatitis B or C, please refer also to the relevant product information for these medicinal products.

Triumeq includes lamivudine, which is active against hepatitis B. Abacavir and dolutegravir lack such activity. Lamivudine monotherapy is generally not considered an adequate treatment for hepatitis B, since the risk for hepatitis B resistance development is high. If Triumeq is used in patients co-infected with hepatitis B an additional antiviral is, therefore, generally needed. Reference should be made to treatment guidelines.

If Triumeq is discontinued in patients co-infected with hepatitis B virus, periodic monitoring of both liver function tests and markers of HBV replication is recommended, as withdrawal of lamivudine may result in an acute exacerbation of hepatitis.

Immune Reactivation Syndrome

In HIV-infected patients with severe immune deficiency at the time of institution of combination antiretroviral therapy (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 (often referred to as PCP). Any inflammatory symptoms should be evaluated and treatment instituted when necessary. Autoimmune disorders (such as Graves' disease and autoimmune hepatitis) 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.

Liver chemistry elevations consistent with immune reconstitution syndrome were observed in some hepatitis B and/or C co-infected patients at the start of dolutegravir therapy. Monitoring of liver chemistries is recommended in patients with hepatitis B and/or C co-infection. (See 'Patients with chronic hepatitis B or C' earlier in this section and also see section 4.8).

Mitochondrial dysfunction following exposure in utero

Nucleoside and nucleotide 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 post-natally 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 reactions have often been transitory. Some 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 nucleoside and nucleotide analogues, who presents with severe clinical findings of unknown aetiology, particularly neurologic findings. These findings do not affect current national recommendations to use antiretroviral therapy in pregnant women to prevent vertical transmission of HIV.

Cardiovascular events

Although the available data from clinical and observational studies with abacavir show inconsistent results, several studies suggest an increased risk of cardiovascular events (notably myocardial infarction) in patients treated with abacavir. Therefore, when prescribing Triumeq, action should be taken to minimise all modifiable risk factors (e.g. smoking, hypertension, and hyperlipidaemia). In addition, alternative treatment options to the abacavir containing regimen should be considered when treating patients with a high cardiovascular risk.

Osteonecrosis

Although the aetiology is considered to be multifactorial (including corticosteroid use, bisphosphonates, 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.

Opportunistic infections

Patients should be advised that Triumeq or any other antiretroviral therapy does not cure HIV infection and that they may still develop opportunistic infections and other complications of HIV infection. Therefore, patients should remain under close clinical observation by physicians experienced in the treatment of these associated HIV diseases.

Administration in subjects with moderate renal impairment

Patients with a creatinine clearance between 30 and 49 mL/min receiving Triumeq may experience a 1.6-to 3.3-fold higher lamivudine exposure (AUC) than patients with a creatinine clearance ≥ 50 mL/min. There are no safety data from randomised, controlled trials comparing Triumeq to the individual components in patients with a creatinine clearance between 30 and 49 mL/min who received dose-adjusted lamivudine. In the original lamivudine registrational trials in combination with zidovudine, higher lamivudine exposures were associated with higher rates of haematologic toxicities (neutropenia and anaemia), although discontinuations due to neutropenia or anaemia each occurred in $<1\%$ of subjects. Other lamivudine-related adverse events (such as gastro-intestinal and hepatic disorders) may occur.

Patients with a sustained creatinine clearance between 30 and 49 mL/min who receive Triumeq should be monitored for lamivudine-related adverse events, notably hematologic toxicities. If new or worsening neutropenia or anaemia develop, a dose adjustment of lamivudine, per lamivudine prescribing information, is indicated, which cannot be achieved with Triumeq. Triumeq should be discontinued and the individual components should be used to construct the treatment regimen.

Drug resistance

The use of Triumeq is not recommended for patients with integrase inhibitor resistance. This is because the recommended dose of dolutegravir is 50 mg twice daily for adult patients with resistance to integrase inhibitors and there are insufficient data to recommend a dose of dolutegravir in integrase inhibitor resistant adolescents, children and infants.

Drug interactions

The recommended dose of dolutegravir is 50 mg twice daily when co-administered with rifampicin, carbamazepine, oxcarbazepine, phenytoin, phenobarbital, St. John's wort, etravirine (without boosted protease inhibitors), efavirenz, nevirapine, or tipranavir/ritonavir (see section 4.5).

Triumeq should not be co-administered with polyvalent cation-containing antacids. Triumeq is recommended to be administered 2 hours before or 6 hours after these medicinal products (see section 4.5).

When taken with food, Triumeq and supplements or multivitamins containing calcium, iron or magnesium can be taken at the same time. If Triumeq is administered under fasting conditions, supplements or multivitamins containing calcium, iron or magnesium are recommended to be taken 2 hours after or 6 hours before Triumeq (see section 4.5).

Dolutegravir increased metformin concentrations. A dose adjustment of metformin should be considered when starting and stopping coadministration of dolutegravir with metformin, to maintain glycaemic control (see section 4.5). Metformin is eliminated renally and therefore it is of importance to monitor renal function when co-treated with dolutegravir. This combination may increase the risk for lactic acidosis in patients with moderate renal impairment (stage 3a creatinine clearance [CrCl] 45–59 mL/min) and a cautious approach is recommended. Reduction of the metformin dose should be highly considered.

The combination of lamivudine with cladribine is not recommended (see section 4.5).

Triumeq should not be taken with any other medicinal products containing dolutegravir, abacavir, lamivudine or emtricitabine, except where a dose adjustment of dolutegravir is indicated due to drug-drug interactions (see section 4.5).

Excipients

Triumeq contains less than 1 mmol sodium (23 mg) per tablet, that is to say is essentially 'sodium free'.

4.5 Interaction with other medicinal products and other forms of interaction

Triumeq contains dolutegravir, abacavir and lamivudine, therefore any interactions identified for these individually are relevant to Triumeq. No clinically significant drug interactions are expected between dolutegravir, abacavir and lamivudine.

Effect of other medicinal products on the pharmacokinetics of dolutegravir, abacavir and lamivudine

Dolutegravir is eliminated mainly through metabolism by uridine diphosphate glucuronosyl transferase (UGT) 1A1. Dolutegravir is also a substrate of UGT1A3, UGT1A9, CYP3A4, P-glycoprotein (P-gp), and breast cancer resistance protein (BCRP). Co-administration of Triumeq and other medicinal products that inhibit UGT1A1, UGT1A3, UGT1A9, CYP3A4, and/or P-gp may therefore increase dolutegravir plasma concentration. Medicinal products that induce those enzymes or

transporters may decrease dolutegravir plasma concentration and reduce the therapeutic effect of dolutegravir (see Table 1).

The absorption of dolutegravir is reduced by certain anti-acid medicinal products (see Table 1).

Abacavir is metabolised by UGT (UGT2B7) and alcohol dehydrogenase; co-administration of inducers (e.g. rifampicin, carbamazepine and phenytoin) or inhibitors (e.g. valproic acid) of UGT enzymes or with compounds eliminated through alcohol dehydrogenase could alter abacavir exposure.

Lamivudine is cleared renally. Active renal secretion of lamivudine in the urine is mediated through the OCT2 and multidrug and toxin extrusion transporters (MATE1 and MATE2-K). Trimethoprim (an inhibitor of these drug transporters) has been shown to increase lamivudine plasma concentrations, however the resulting increase was not clinically significant (see Table 1). Dolutegravir is an OCT2 and MATE1 inhibitor; however, lamivudine concentrations were similar with or without co-administration of dolutegravir based on a cross study analysis, indicating that dolutegravir has no effect on lamivudine exposure *in vivo*. Lamivudine is also substrate of the hepatic uptake transporter OCT1. As hepatic elimination plays a minor role in the clearance of lamivudine, drug interactions due to inhibition of OCT1 are unlikely to be of clinical significance.

Although abacavir and lamivudine are substrates of BCRP and P-gp *in vitro*, given the high absolute bioavailability of abacavir and lamivudine, (see section 5.2), inhibitors of these efflux transporters are unlikely to result in a clinically relevant impact on abacavir or lamivudine concentrations.

Effect of dolutegravir, abacavir and lamivudine on the pharmacokinetics of other medicinal products

In vivo, dolutegravir did not have an effect on midazolam, a CYP3A4 probe. Based on *in vivo* and/or *in vitro* data, dolutegravir is not expected to affect the pharmacokinetics of medicinal products that are substrates of any major enzyme or transporter such as CYP3A4, CYP2C9 and P-gp (for more information see section 5.2).

In vitro, dolutegravir inhibited the renal transporters OCT2 and MATE1. *In vivo*, a 10-14% decrease of creatinine clearance (secretory fraction is dependent on OCT2 and MATE1 transport) was observed in patients. *In vivo*, dolutegravir may increase plasma concentrations of medicinal products in which excretion is dependent upon OCT2 and/or MATE1 (e.g. fampridine [also known as dalfampridine], metformin) (see Table 1).

In vitro, dolutegravir inhibited the renal uptake organic anion transporters (OAT)1 and OAT3. Based on the lack of effect on the *in vivo* pharmacokinetics of the OAT substrate tenofovir, *in vivo* inhibition of OAT1 is unlikely. Inhibition of OAT3 has not been studied *in vivo*. Dolutegravir may increase plasma concentrations of medicinal products in which excretion is dependent upon OAT3.

In vitro, abacavir demonstrated the potential to inhibit CYP1A1 and limited potential to inhibit metabolism mediated by CYP3A4. Abacavir was an inhibitor of MATE1; the clinical consequences are not known.

In vitro, lamivudine was an inhibitor of OCT1 and OCT2; the clinical consequences are not known.

Established and theoretical interactions with selected antiretrovirals and non-antiretroviral medicinal products are listed in Table 1.

Interaction table

Interactions between dolutegravir, abacavir, lamivudine and co-administered medical products are listed in Table 1 (increase is indicated as “↑”, decrease as “↓”, no change as “↔”, area under the concentration versus time curve as “AUC”, maximum observed concentration as “C_{max}”, concentration

at end of dosing interval as “C_τ”). The table should not be considered exhaustive but is representative of the classes studied.

Table 1: Drug interactions

Medicinal products by therapeutic areas	Interaction geometric mean change (%)	Recommendations concerning co-administration
Antiretroviral medicinal products		
<i>Non-nucleoside reverse transcriptase inhibitors (Non-NRTIs)</i>		
Etravirine without boosted protease inhibitors / Dolutegravir	Dolutegravir ↓ AUC ↓ 71% C _{max} ↓ 52% C _τ ↓ 88% Etravirine ↔ (induction of UGT1A1 and CYP3A enzymes)	Etravirine without boosted protease inhibitors decreased plasma dolutegravir concentration. The recommended dose of dolutegravir is 50 mg twice daily for patients taking etravirine without boosted protease inhibitors. As Triumeq is a fixed dose tablet, an additional 50 mg tablet of dolutegravir should be administered, approximately 12 hours after Triumeq for the duration of the etravirine without boosted protease inhibitor co-administration (a separate preparation of dolutegravir is available for this dose adjustment, see section 4.2).
Lopinavir+ritonavir+etravirine/ Dolutegravir	Dolutegravir ↔ AUC ↑ 11% C _{max} ↑ 7% C _τ ↑ 28% Lopinavir ↔ Ritonavir ↔ Etravirine ↔	No dose adjustment is necessary.
Darunavir+ritonavir+etravirine/ Dolutegravir	Dolutegravir ↓ AUC ↓ 25% C _{max} ↓ 12% C _τ ↓ 36% Darunavir ↔ Ritonavir ↔ Etravirine ↔	No dose adjustment is necessary.
Efavirenz/Dolutegravir	Dolutegravir ↓ AUC ↓ 57% C _{max} ↓ 39% C _τ ↓ 75% Efavirenz ↔ (historical controls) (induction of UGT1A1 and CYP3A enzymes)	The recommended dose of dolutegravir is 50 mg twice daily when co-administered with efavirenz. As Triumeq is a fixed dose tablet, an additional 50 mg tablet of dolutegravir should be administered, approximately 12 hours after Triumeq for the duration of the efavirenz co-administration (a separate preparation of dolutegravir is available for this dose adjustment, see section 4.2).
Nevirapine/Dolutegravir	Dolutegravir ↓ (Not studied, a similar reduction in exposure as observed with efavirenz is	Co-administration with nevirapine may decrease dolutegravir plasma concentration due to enzyme induction and has not been studied. Effect of

	expected, due to induction)	nevirapine on dolutegravir exposure is likely similar to or less than that of efavirenz. The recommended dose of dolutegravir is 50 mg twice daily when co-administered with nevirapine. As Triumeq is a fixed dose tablet, an additional 50 mg tablet of dolutegravir should be administered, approximately 12 hours after Triumeq for the duration of the nevirapine co-administration (a separate preparation of dolutegravir is available for this dose adjustment, see section 4.2).
Rilpivirine	Dolutegravir ↔ AUC ↑ 12% C _{max} ↑ 13% C _τ ↑ 22% Rilpivirine ↔	No dose adjustment is necessary.
<i>Nucleoside reverse transcriptase inhibitors (NRTIs)</i>		
Tenofovir	Dolutegravir ↔ AUC ↑ 1% C _{max} ↓ 3% C _τ ↓ 8% Tenofovir ↔	No dose adjustment is necessary when Triumeq is combined with nucleoside reverse transcript inhibitors.
Emtricitabine, didanosine, stavudine, zidovudine.	Interaction not studied	Triumeq is not recommended for use in combination with emtricitabine containing products, since both lamivudine (in Triumeq) and emtricitabine are cytidine analogues (i.e. risk for intracellular interactions, (see section 4.4))
<i>Protease inhibitors</i>		
Atazanavir/Dolutegravir	Dolutegravir ↑ AUC ↑ 91% C _{max} ↑ 50% C _τ ↑ 180% Atazanavir ↔ (historical controls) (inhibition of UGT1A1 and CYP3A enzymes)	No dose adjustment is necessary.
Atazanavir+ ritonavir/ Dolutegravir	Dolutegravir ↑ AUC ↑ 62% C _{max} ↑ 34% C _τ ↑ 121% Atazanavir ↔ Ritonavir ↔	No dose adjustment is necessary.
Tipranavir+ritonavir/ Dolutegravir	Dolutegravir ↓ AUC ↓ 59% C _{max} ↓ 47% C _τ ↓ 76%	The recommended dose of dolutegravir is 50 mg twice daily when co-administered with tipranavir/ritonavir. As Triumeq is a fixed dose tablet, an additional 50 mg tablet of dolutegravir should be administered, approximately

	Tipranavir ↔ Ritonavir ↔ (induction of UGT1A1 and CYP3A enzymes)	12 hours after Triumeq for the duration of the tipranavir/ritonavir co- administration (a separate preparation of dolutegravir is available for this dose adjustment, see section 4.2).
Fosamprenavir+ritonavir/ Dolutegravir	Dolutegravir ↓ AUC ↓ 35% C _{max} ↓ 24% C _τ ↓ 49% Fosamprenavir ↔ Ritonavir ↔ (induction of UGT1A1 and CYP3A enzymes)	Fosamprenavir/ritonavir decreases dolutegravir concentrations, but based on limited data, did not result in decreased efficacy in Phase III studies. No dose adjustment is necessary.
Lopinavir+ritonavir/ Dolutegravir	Dolutegravir ↔ AUC ↓ 4% C _{max} ↔ 0% C ₂₄ ↓ 6% Lopinavir ↔ Ritonavir ↔	No dose adjustment is necessary.
Lopinavir+ritonavir/ Abacavir	Abacavir AUC ↓ 32%	
Darunavir+ritonavir/ Dolutegravir	Dolutegravir ↓ AUC ↓ 22% C _{max} ↓ 11% C _τ ↓ 38% Darunavir ↔ Ritonavir ↔ (induction of UGT1A1 and CYP3A enzymes)	No dose adjustment is necessary.
Other antiviral agents		
Daclatasvir/Dolutegravir	Dolutegravir ↔ AUC ↑ 33% C _{max} ↑ 29% C _τ ↑ 45% Daclatasvir ↔	Daclatasvir did not change dolutegravir plasma concentration to a clinically relevant extent. Dolutegravir did not change daclatasvir plasma concentration. No dose adjustment is necessary.
Anti-infective products		
Trimethoprim/sulfamethoxazole (Co-trimoxazole)/Abacavir	Interaction not studied	No Triumeq dose adjustment necessary, unless patient has renal impairment (See Section 4.2).
Trimethoprim/sulfamethoxazole (Co-trimoxazole)/Lamivudine (160mg/800mg once daily for 5 days/300mg single dose)	Lamivudine: AUC ↑ 43% C _{max} ↑ 7% Trimethoprim: AUC ↔ Sulfamethoxazole: AUC ↔ (organic cation transporter inhibition)	

Antimycobacterials		
Rifampicin/Dolutegravir	Dolutegravir ↓ AUC ↓ 54% C _{max} ↓ 43% C _τ ↓ 72% (induction of UGT1A1 and CYP3A enzymes)	The dose of dolutegravir is 50 mg twice daily when co-administered with rifampicin. As Triumeq is a fixed dose tablet, an additional 50 mg tablet of dolutegravir should be administered, approximately 12 hours after Triumeq for the duration of the rifampicin co-administration (a separate preparation of dolutegravir is available for this dose adjustment, see section 4.2).
Rifabutin	Dolutegravir ↔ AUC ↓ 5% C _{max} ↑ 16% C _τ ↓ 30% (induction of UGT1A1 and CYP3A enzymes)	No dose adjustment is necessary.
Anticonvulsants		
Carbamazepine/Dolutegravir	Dolutegravir ↓ AUC ↓ 49% C _{max} ↓ 33% C _τ ↓ 73%	The recommended dose of dolutegravir is 50 mg twice daily when co-administered with carbamazepine. As Triumeq is a fixed dose tablet, an additional 50 mg tablet of dolutegravir should be administered, approximately 12 hours after Triumeq for the duration of the carbamazepine co-administration (a separate preparation of dolutegravir is available for this dose adjustment, see section 4.2).
Phenobarbital/Dolutegravir Phenytoin/Dolutegravir Oxcarbazepine/Dolutegravir	Dolutegravir ↓ (Not studied, decrease expected due to induction of UGT1A1 and CYP3A enzymes, a similar reduction in exposure as observed with carbamazepine is expected)	The recommended dose of dolutegravir is 50 mg twice daily when co-administered with these metabolic inducers. As Triumeq is a fixed dose tablet, an additional 50 mg tablet of dolutegravir should be administered, approximately 12 hours after Triumeq for the duration of the co-administration with these metabolic inducers (a separate preparation of dolutegravir is available for this dose adjustment, see section 4.2).
Antihistamines (histamine H2 receptor antagonists)		
Ranitidine	Interaction not studied. Clinically significant interaction unlikely.	No dose adjustment necessary.
Cimetidine	Interaction not studied. Clinically significant interaction unlikely.	No dose adjustment necessary.
Cytotoxics		
Cladribine/Lamivudine	Interaction not studied. <i>In vitro</i> lamivudine inhibits the intracellular	Concomitant use of Triumeq with cladribine is not recommended (see section 4.4).

	phosphorylation of cladribine leading to a potential risk of cladribine loss of efficacy in case of combination in the clinical setting. Some clinical findings also support a possible interaction between lamivudine and cladribine	
Opioids		
Methadone/Abacavir (40 to 90mg once daily for 14 days/600mg single dose, then 600mg twice daily for 14 days)	Abacavir: AUC ↔ C _{max} ↓35% Methadone: CL/F ↑22%	Methadone dose adjustment likely not needed in majority of patients; occasionally methadone re-titration may be required.
Retinoids		
Retinoid compounds (e.g. Isotretinoin)	Interaction not studied Possible interaction given common pathway of elimination via alcohol dehydrogenase (abacavir-component).	Insufficient data to recommend dose adjustment.
Miscellaneous		
<i>Alcohol</i>		
Ethanol/Dolutegravir Ethanol/Lamivudine Ethanol/Abacavir (0.7 g/kg single dose/600mg single dose)	Interaction not studied (Inhibition of alcohol dehydrogenase) Abacavir: AUC ↑ 41% Ethanol: AUC ↔	No dose adjustment necessary.
<i>Sorbitol</i>		
Sorbitol solution (3.2 g, 10.2 g, 13.4 g)/Lamivudine	Single dose lamivudine oral solution 300 mg Lamivudine: AUC ↓ 14%; 32%; 36% C _{max} ↓ 28%; 52%, 55%.	When possible, avoid chronic coadministration of Triumeq with medicinal products containing sorbitol or other osmotic acting poly-alcohols or monosaccharide alcohols (eg: xylitol, mannitol, lactitol, maltitol). Consider more frequent monitoring of HIV-1 viral load when chronic coadministration cannot be avoided.
<i>Potassium channel blockers</i>		
Fampridine (also known as dalfampridine)/Dolutegravir	Fampridine ↑	Co-administration of dolutegravir has the potential to cause seizures due to increased fampridine plasma concentration via inhibition of OCT2 transporter; co-administration has not been studied. Fampridine co-administration with Triumeq is contraindicated (see section 4.3).
<i>Antacids and supplements</i>		

Magnesium/ aluminium-containing antacids/Dolutegravir	Dolutegravir ↓ AUC ↓ 74% C _{max} ↓ 72% (Complex binding to polyvalent ions)	Magnesium/ aluminium-containing antacids should be taken well separated in time from the administration of Triumeq (minimum 2 hours after or 6 hours before the intake of Triumeq).
Calcium supplements/Dolutegravir	Dolutegravir ↓ AUC ↓ 39% C _{max} ↓ 37% C ₂₄ ↓ 39% (Complex binding to polyvalent ions)	- When taken with food, Triumeq and supplements or multivitamins containing calcium, iron or magnesium can be taken at the same time. - If Triumeq is taken in a fasted state, such supplements should be taken a minimum 2 hours after or 6 hours before the intake of Triumeq.
Iron supplements/Dolutegravir	Dolutegravir ↓ AUC ↓ 54% C _{max} ↓ 57% C ₂₄ ↓ 56% (Complex binding to polyvalent ions)	The stated reductions in dolutegravir exposure were observed with the intake of dolutegravir and these supplements during fasted conditions. In fed state, the changes in exposure following intake together with calcium or iron supplements were modified by the food effect, resulting in an exposure similar to that obtained with dolutegravir administered in the fasted state.
Multivitamins (containing calcium, iron and magnesium) /Dolutegravir	Dolutegravir ↓ AUC ↓ 33% C _{max} ↓ 35% C ₂₄ ↓ 32%	
<i>Corticosteroids</i>		
Prednisone	Dolutegravir ↔ AUC ↑ 11% C _{max} ↑ 6% C _τ ↑ 17%	No dose adjustment is necessary.
<i>Antidiabetics</i>		
Metformin/Dolutegravir	Metformin ↑ Dolutegravir ↔ When co-administered with dolutegravir 50mg QD: Metformin AUC ↑ 79% C _{max} ↑ 66% When co-administered with dolutegravir 50mg BID: Metformin AUC ↑ 145 % C _{max} ↑ 111%	A dose adjustment of metformin should be considered when starting and stopping coadministration of dolutegravir with metformin, to maintain glycaemic control. In patients with moderate renal impairment a dose adjustment of metformin should be considered when coadministered with dolutegravir, because of the increased risk for lactic acidosis in patients with moderate renal impairment due to increased metformin concentration (section 4.4).
<i>Herbal products</i>		
St. John's wort/Dolutegravir	Dolutegravir ↓ (Not studied, decrease expected due to induction of UGT1A1 and CYP3A enzymes, a similar reduction in exposure as observed with carbamazepine is expected)	The recommended dose of dolutegravir is 50 mg twice daily when co- administered with St. John's wort. As Triumeq is a fixed dose tablet, an additional 50 mg tablet of dolutegravir should be administered, approximately 12 hours after Triumeq for the duration of the St John's wort co-administration (a separate preparation of dolutegravir is

		available for this dose adjustment, see section 4.2).
<i>Oral contraceptives</i>		
Ethinyl estradiol (EE) and Norgestromin (NGMN)/Dolutegravir	Effect of dolutegravir: EE ↔ AUC ↑ 3% C _{max} ↓ 1% Effect of dolutegravir: NGMN ↔ AUC ↓ 2% C _{max} ↓ 11%	Dolutegravir had no Pharmacodynamic effect on Luteinizing Hormone (LH), Follicle Stimulating Hormone (FSH) and progesterone. No dose adjustment of oral contraceptives is necessary when co-administered with Triumeq.
<i>Antihypertensive</i>		
Riociguat/Abacavir	Riociguat ↑ <i>In vitro</i> , abacavir inhibits CYP1A1. Concomitant administration of a single dose of riociguat (0.5 mg) to HIV patients receiving Triumeq led to an approximately three-fold higher riociguat AUC _(0-∞) when compared to historical riociguat AUC _(0-∞) reported in healthy subjects.	Riociguat dose may need to be reduced, consult the riociguat prescribing information for dosing recommendations.

Paediatric population

Interaction studies have only been performed in adults.

4.6 Fertility, pregnancy and lactation

Pregnancy

Triumeq can be used during pregnancy if clinically needed.

A large amount of data on pregnant women (more than 1000 exposed outcomes) indicate no malformative nor fetoneonatal toxicity associated with dolutegravir. In pregnant women treated with abacavir, a large amount of data (more than 1000 exposed outcomes) indicate no malformative nor fetoneonatal toxicity. In pregnant women treated with lamivudine, a large amount of data (more than 1000 exposed outcomes) indicate no malformative nor fetoneonatal toxicity.

There are no or limited amount of data (less than 300 pregnancy outcomes) on the use of this triple combination in pregnancy.

Two large birth outcome surveillance studies (more than 14,000 pregnancy outcomes) in Botswana (Tsepamo) and Eswatini, and other sources, do not indicate an increased risk for neural tube defects after dolutegravir exposure.

The incidence of neural tube defects in the general population ranges from 0.5-1 case per 1,000 live births (0.05-0.1%).

Data from the Tsepamo study show no significant difference in the prevalence of neural tube defects (0.11%) in infants whose mothers were taking dolutegravir at conception (more than 9,400 exposures)

compared to those taking non-dolutegravir containing antiretroviral regimens at conception (0.11%), or compared to women without HIV (0.07%).

Data from the Eswatini study show the same prevalence of neural tube defects (0.08%) in infants whose mothers were taking dolutegravir at conception (more than 4,800 exposures), as infants of women without HIV (0.08%).

Data analysed from the Antiretroviral Pregnancy Registry (APR) of more than 1000 pregnancies with first trimester dolutegravir treatment, more than 1000 pregnancies with first trimester abacavir treatment and more than 1000 pregnancies with first trimester lamivudine treatment do not indicate an increased risk of major birth defects with dolutegravir, lamivudine or abacavir compared to the background rate or women with HIV. There are no or limited amount of APR data (less than 300 first trimester exposures) from the use of dolutegravir + lamivudine + abacavir in pregnant women.

In animal reproductive toxicology studies with dolutegravir, no adverse development outcomes, including neural tube defects, were identified (see section 5.3).

Dolutegravir crosses the placenta in humans. In pregnant women living with HIV, the median foetal umbilical cord concentration of dolutegravir was approximately 1.3-fold greater compared with the maternal peripheral plasma concentration. Placental transfer of abacavir and/or its related metabolites has been shown to occur in humans. Placental transfer of lamivudine has been shown to occur in humans.

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

Animal studies with abacavir have shown toxicity to the developing embryo and foetus in rats, but not in rabbits. Animal studies with lamivudine showed an increase in early embryonic deaths in rabbits but not in rats (see section 5.3).

Abacavir and lamivudine may inhibit cellular DNA replication and abacavir has been shown to be carcinogenic in animal models (see section 5.3). The clinical relevance of these findings is unknown.

Mitochondrial dysfunction

Nucleoside and nucleotide analogues have been demonstrated *in vitro* and *in vivo* to cause a variable degree of mitochondrial damage. There have been reports of mitochondrial dysfunction in HIV-negative infants exposed *in utero* and/or post-natally to nucleoside analogues (see section 4.4).

Breast-feeding

Dolutegravir is excreted in human milk in small amounts (a median dolutegravir breast milk to maternal plasma ratio of 0.033 has been shown). There is insufficient information on the effects of dolutegravir in neonates/infants.

Abacavir and its metabolites are excreted into the milk of lactating rats. Abacavir is also excreted into human milk.

Based on more than 200 mother/child pairs treated for HIV, serum concentrations of lamivudine in breastfed infants of mothers treated for HIV are very low (< 4% of maternal serum concentrations) and progressively decrease to undetectable levels when breastfed infants reach 24 weeks of age. There are no data available on the safety of abacavir and lamivudine when administered to babies less than three months old.

It is recommended that women living with HIV do not breast-feed their infants in order to avoid transmission of HIV.

Fertility

There are no data on the effects of dolutegravir, abacavir or lamivudine on human male or female fertility. Animal studies indicate no effects of dolutegravir, abacavir or lamivudine on male or female fertility (see section 5.3).

4.7 Effects on ability to drive and use machines

Triumeq has no or negligible influence on the ability to drive and use machines. Patients should be informed that dizziness has been reported during treatment with dolutegravir. The clinical status of the patient and the adverse reaction profile of Triumeq should be borne in mind when considering the patient's ability to drive or operate machinery.

4.8 Undesirable effects

Summary of the safety profile

The most frequently reported adverse reactions related to dolutegravir and abacavir/lamivudine were nausea (12%), insomnia (7%), dizziness (6%) and headache (6%).

Many of the adverse reactions listed in the table below occur commonly (nausea, vomiting, diarrhoea, fever, lethargy, rash) in patients with abacavir hypersensitivity. Therefore, patients with any of these symptoms should be carefully evaluated for the presence of this hypersensitivity (see section 4.4). Very rarely cases of erythema multiforme, Stevens-Johnson syndrome or toxic epidermal necrolysis have been reported where abacavir hypersensitivity could not be ruled out. In such cases medicinal products containing abacavir should be permanently discontinued.

The most severe adverse reaction related to the treatment with dolutegravir and abacavir/lamivudine, seen in individual patients, was a hypersensitivity reaction that included rash and severe liver effects (see section 4.4 and Description of selected adverse reactions in this section).

Tabulated list of adverse reactions

The adverse reactions with the components of Triumeq from clinical study and post-marketing experience are listed in Table 2 by body system, organ class and absolute frequency. Frequencies are defined as very common ($\geq 1/10$), common ($\geq 1/100$ to $< 1/10$), uncommon ($\geq 1/1\ 000$ to $< 1/100$), rare ($\geq 1/10\ 000$ to $< 1/1\ 000$), very rare ($< 1/10\ 000$), and not known (cannot be estimated from the available data).

Table 2: Tabulated list of adverse reactions associated with the combination of dolutegravir + abacavir/lamivudine in an analysis of pooled data from: Phase IIb to Phase IIIb clinical studies or post-marketing experience; and adverse reactions to treatment with dolutegravir, abacavir and lamivudine from clinical studies and post-marketing experience when used with other antiretrovirals

Frequency	Adverse reaction
<i>Blood and lymphatic systems disorders:</i>	
Uncommon:	Neutropenia ¹ , anaemia ¹ , thrombocytopenia ¹
Very rare:	pure red cell aplasia ¹
Not known	sideroblastic anaemia ²
<i>Immune system disorders:</i>	
Common:	hypersensitivity (see section 4.4)
Uncommon:	immune reconstitution syndrome (see section 4.4)

<i>Metabolism and nutrition disorders:</i>	
Common:	anorexia ¹
Uncommon:	hypertriglyceridaemia, hyperglycaemia
Very rare:	lactic acidosis ¹
<i>Psychiatric disorders:</i>	
Very common:	insomnia
Common:	abnormal dreams, depression, anxiety ¹ , nightmare, sleep disorder
Uncommon:	suicidal ideation or suicide attempt (particularly in patients with a pre-existing history of depression or psychiatric illness), panic attack
Rare:	completed suicide (particularly in patients with a pre-existing history of depression or psychiatric illness)
<i>Nervous system disorders:</i>	
Very common:	headache
Common:	dizziness, somnolence, lethargy ¹
Very rare:	peripheral neuropathy ¹ , paraesthesia ¹
<i>Respiratory, thoracic and mediastinal disorders:</i>	
Common:	cough ¹ , nasal symptoms ¹
<i>Gastrointestinal disorders:</i>	
Very common:	nausea, diarrhoea
Common:	vomiting, flatulence, abdominal pain, abdominal pain upper, abdominal distension, abdominal discomfort, gastro-oesophageal reflux disease, dyspepsia
Rare:	pancreatitis ¹
<i>Hepatobiliary disorders:</i>	
Common:	alanine aminotransferase (ALT) and/or aspartate aminotransferase (AST) elevations
Uncommon:	hepatitis
Rare:	acute hepatic failure ¹ , increased bilirubin ³
<i>Skin and subcutaneous tissue disorders:</i>	
Common:	rash, pruritus, alopecia ¹
Very rare:	erythema multiform ¹ , Stevens-Johnson syndrome ¹ , toxic epidermal necrolysis ¹
<i>Musculoskeletal and connective tissue disorders:</i>	
Common:	Arthralgia ¹ , muscle disorders ¹ (including myalgia ¹)
Rare:	rhabdomyolysis ¹
<i>General disorders and administration site conditions:</i>	
Very common:	fatigue
Common:	asthenia, fever ¹ , malaise ¹

<i>Investigations:</i>	
Common:	CPK elevations, weight increased
Rare:	amylase elevations ¹
¹ This adverse reaction was identified from clinical studies or post-marketing experience for dolutegravir, abacavir or lamivudine when used with other antiretrovirals or post-marketing experience with Triumeq. ² Reversible sideroblastic anaemia has been reported with dolutegravir-containing regimens. The contribution of dolutegravir in these cases is unclear. ³ In combination with increased transaminases.	

Description of selected adverse reactions

Hypersensitivity reactions

Both abacavir and dolutegravir are associated with a risk for hypersensitivity reactions (HSR), which were observed more commonly with abacavir. Hypersensitivity reaction observed for each of these medicinal products (described below) share some common features such as fever and/or rash with other symptoms indicating multi-organ involvement. Time to onset was typically 10-14 days for both abacavir and dolutegravir-associated reactions, although reactions to abacavir may occur at any time during therapy. Treatment with Triumeq must be stopped without delay if HSR cannot be ruled out on clinical grounds, and therapy with Triumeq or other abacavir or dolutegravir containing products must never be re-initiated. Please refer to section 4.4 for further details on patient management in the event of a suspected HSR to Triumeq.

Dolutegravir hypersensitivity

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

Abacavir hypersensitivity

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

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

<i>Skin</i>	Rash (usually maculopapular or urticarial)
<i>Gastrointestinal tract</i>	Nausea, vomiting, diarrhoea, abdominal pain , mouth ulceration
<i>Respiratory tract</i>	Dyspnoea, cough , sore throat, adult respiratory distress syndrome, respiratory failure
<i>Miscellaneous</i>	Fever, lethargy, malaise , oedema, lymphadenopathy, hypotension, conjunctivitis, anaphylaxis
<i>Neurological/Psychiatry</i>	Headache , paraesthesia
<i>Haematological</i>	Lymphopenia
<i>Liver/pancreas</i>	Elevated liver function tests , hepatitis, hepatic failure

Musculoskeletal **Myalgia**, rarely myolysis, arthralgia, elevated creatine phosphokinase

Urology Elevated creatinine, renal failure

Symptoms related to this HSR worsen with continued therapy and can be life-threatening and in rare instance, have been fatal.

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

Metabolic parameters

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

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 and autoimmune hepatitis) 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).

Changes in laboratory chemistries

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

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

Co-infection with Hepatitis B or C

In dolutegravir Phase III studies patients with hepatitis B and/or C co-infection were permitted to enrol provided that baseline liver chemistry tests did not exceed 5 times the upper limit of normal (ULN). Overall, the safety profile in patients co-infected with hepatitis B and/or C was similar to that observed in patients without hepatitis B or C co-infection, although the rates of AST and ALT abnormalities were higher in the subgroup with hepatitis B and/or C co-infection for all treatment groups.

Paediatric population

Based on data from IMPAACT 2019 study in 57 HIV-1 infected children (aged less than 12 years and weighing at least 6 kg) who received the recommended doses of either the Triumeq film-coated tablet or dispersible tablets, there were no additional safety issues beyond those observed in the adult population.

Based on available data with dolutegravir used in combination with other antiretroviral agents to treat infants, children and adolescents, there were no additional safety issues identified beyond those observed in the adult population.

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

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

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

Further management should be as clinically indicated or as recommended by the national poisons centre, where available. There is no specific treatment for an overdose of Triumeq. If overdose occurs, the patient should be treated supportively with appropriate monitoring, as necessary. Since lamivudine is dialysable, continuous haemodialysis could be used in the treatment of overdose, although this has not been studied. It is not known whether abacavir can be removed by peritoneal dialysis or haemodialysis. As dolutegravir is highly bound to plasma proteins, it is unlikely that it will be significantly removed by dialysis.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

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

Mechanism of action

Dolutegravir inhibits HIV integrase by binding to the integrase active site and blocking the strand transfer step of retroviral Deoxyribonucleic acid (DNA) integration which is essential for the HIV replication cycle.

Abacavir and lamivudine are potent selective inhibitors of HIV-1 and HIV-2. Both abacavir and lamivudine are metabolised sequentially by intracellular kinases to the respective 5'-triphosphates (TP) which are the active moieties with extended intracellular half-lives supporting once daily dosing (see section 5.2). Lamivudine-TP (an analogue for cytidine) and carbociclovir-TP (the active triphosphate form of abacavir, an analogue for guanosine) are substrates for and competitive inhibitors of HIV reverse transcriptase (RT). However, their main antiviral activity is through incorporation of the monophosphate form into the viral DNA chain, resulting in chain termination. Abacavir and lamivudine triphosphates show significantly less affinity for host cell DNA polymerases.

Pharmacodynamic effects

Antiviral activity in vitro

Dolutegravir, abacavir and lamivudine have been shown to inhibit replication of lab-strains and clinical isolates of HIV in a number of cell types, including transformed T cell lines, monocyte/macrophage derived lines and primary cultures of activated peripheral blood mononuclear cells (PBMCs) and monocyte/macrophages. The concentration of active substance necessary to effect viral replication by 50% (IC₅₀ - half maximal inhibitory concentration) varied according to virus and host cell type.

The IC₅₀ for dolutegravir in various lab-strains using PBMC was 0.5 nM, and when using MT-4 cells it ranged from 0.7-2 nM. Similar IC₅₀s were seen for clinical isolates without any major difference between subtypes; in a panel of 24 HIV-1 isolates of clades A, B, C, D, E, F and G and group O the mean IC₅₀ value was 0.2 nM (range 0.02-2.14). The mean IC₅₀ for 3 HIV-2 isolates was 0.18 nM (range 0.09-0.61).

The mean IC₅₀ for abacavir against lab-strains of HIV-1IIB and HIV-1HXB2 ranged from 1.4 to 5.8 µM. The median or mean IC₅₀ values for lamivudine against lab-strains of HIV-1 ranged from 0.007 to 2.3 µM. The mean IC₅₀ against lab-strains of HIV-2 (LAV2 and EHO) ranged from 1.57 to 7.5 µM for abacavir and from 0.16 to 0.51 µM for lamivudine.

The IC₅₀ values of abacavir against HIV-1 Group M subtypes (A-G) ranged from 0.002 to 1.179 µM, against Group O from 0.022 to 1.21 µM, and against HIV-2 isolates, from 0.024 to 0.49 µM. For lamivudine, the IC₅₀ values against HIV-1 subtypes (A-G) ranged from 0.001 to 0.170 µM, against Group O from 0.030 to 0.160 µM and against HIV-2 isolates from 0.002 to 0.120 µM in peripheral blood mononuclear cells.

HIV-1 isolates (CRF01_AE, n=12; CRF02_AG, n=12; and Subtype C or CRF_AC, n=13) from 37 untreated patients in Africa and Asia were susceptible to abacavir (IC₅₀ fold changes < 2.5), and lamivudine (IC₅₀ fold changes < 3.0), except for two CRF02_AG isolates with fold changes of 2.9 and 3.4 for abacavir. Group O isolates from antiviral naïve patients tested for lamivudine activity were highly sensitive.

The combination of abacavir and lamivudine has demonstrated antiviral activity in cell culture against non-subtype B isolates and HIV-2 isolates with equivalent antiviral activity as for subtype B isolates.

Antiviral activity in combination with other antiviral agents

No antagonistic effects *in vitro* were seen with dolutegravir and other antiretrovirals (tested agents: stavudine, abacavir, efavirenz, nevirapine, lopinavir, amprenavir, enfuvirtide, maraviroc, adefovir and raltegravir). In addition, ribavirin had no apparent effect on dolutegravir activity.

The antiviral activity of abacavir in cell culture was not antagonized when combined with the nucleoside reverse transcriptase inhibitors (NRTIs) didanosine, emtricitabine, lamivudine, stavudine, tenofovir, zalcitabine or zidovudine, the non-nucleoside reverse transcriptase inhibitor (NNRTI) nevirapine, or the protease inhibitor (PI) amprenavir.

No antagonistic effects *in vitro* were seen with lamivudine and other antiretrovirals (tested agents: abacavir, didanosine, nevirapine, zalcitabine, and zidovudine).

Effect of human serum

In 100% human serum, the mean fold shift for dolutegravir activity was 75-fold, resulting in protein adjusted IC₉₀ of 0.064 µg/mL. Plasma protein binding studies *in vitro* indicate that abacavir binds only low to moderately (~49%) to human plasma proteins at therapeutic concentrations. Lamivudine exhibits linear pharmacokinetics over the therapeutic dose range and displays low plasma protein binding (less than 36%).

Resistance

Resistance in vitro: (dolutegravir)

Serial passage is used to study resistance evolution *in vitro*. When using the lab-strain HIVIII during passage over 112 days, mutations selected appeared slowly, with substitutions at positions S153Y and F. These mutations were not selected in patients treated with dolutegravir in the clinical studies. Using strain NL432 mutations E92Q (fold change 3) and G193E (fold change 3) were selected. These mutations have been selected in patients with pre-existing raltegravir resistance and who were then treated with dolutegravir (listed as secondary mutations for dolutegravir).

In further selection experiments using clinical isolates of subtype B, mutation R263K was seen in all five isolates (after 20 weeks and onwards). In subtype C (n=2) and A/G (n=2) isolates the integrase substitution R263K was selected in one isolate, and G118R in two isolates. R263K was reported from two individual patients with subtype B and subtype C in the clinical program for ART experienced, INI naïve subjects, but without effects on dolutegravir susceptibility *in vitro*. G118R lowers the susceptibility to dolutegravir in site directed mutants (fold change 10), but was not detected in patients receiving dolutegravir in the Phase III program.

Primary mutations for raltegravir/elvitegravir (Q148H/R/K, N155H, Y143R/H/C, E92Q, T66I) do not affect the *in vitro* susceptibility of dolutegravir as single mutations. When mutations listed as secondary integrase inhibitor associated mutations (for raltegravir/elvitegravir) are added to primary mutations (excluding at Q148) in experiments with site directed mutants, dolutegravir susceptibility remains at or near wildtype level. In the case of the Q148-mutation viruses, increasing dolutegravir fold change is seen as the number of secondary mutations increase. The effect of the Q148-based mutations (H/R/K) was also consistent with *in vitro* passage experiments with site directed mutants. In serial passage with strain NL432-based site directed mutants at N155H or E92Q, no further selection of resistance was seen (fold change unchanged around 1). In contrast, starting passage with mutants with mutation Q148H (fold change 1), a variety of raltegravir associated secondary mutations accumulated with a consequent increase of fold change to values >10. A clinically relevant phenotypic cut-off value (fold change vs wild type virus) has not been determined; genotypic resistance was a better predictor for outcome.

Seven hundred and five raltegravir resistant isolates from raltegravir experienced patients were analyzed for susceptibility to dolutegravir. Dolutegravir has a <10-fold change against 94% of the 705 clinical isolates.

Resistance in vivo: (dolutegravir)

In previously untreated patients receiving dolutegravir + 2 NRTIs in Phase IIb and Phase III, no development of resistance to the integrase class, or to the NRTI class was seen (n=876, follow-up of 48-96 weeks).

In patients with prior failed therapies, but naïve to the integrase class (SAILING study), integrase inhibitor substitutions were observed in 4/354 patients (follow-up 48 weeks) treated with dolutegravir, which was given in combination with an investigator selected background regimen (BR). Of these four, two subjects had a unique R263K integrase substitution, with a maximum fold change of 1.93, one subject had a polymorphic V151V/I integrase substitution, with maximum fold change of 0.92, and one subject had pre-existing integrase mutations and is assumed to have been integrase experienced or infected with integrase resistant virus by transmission. The R263K mutation was also selected *in vitro* (see above).

Resistance in vitro and in vivo: (abacavir and lamivudine)

Abacavir-resistant isolates of HIV-1 have been selected *in vitro* and *in vivo* and are associated with specific genotypic changes in the RT codon region (codons M184V, K65R, L74V and Y115F). During *in vitro* abacavir selection the M184V mutation occurred first and resulted in about a 2-fold increase in IC₅₀, below the abacavir clinical cut-off of 4.5-fold change. Continued passage in increasing concentrations of drug resulted in selection for double RT mutants 65R/184V and 74V/184V or triple

RT mutant 74V/115Y/184V. Two mutations conferred a 7 to 8-fold change in abacavir susceptibility and combinations of three mutations were required to confer more than an 8-fold change in susceptibility.

HIV-1 resistance to lamivudine involves the development of a M184I or M184V amino acid change close to the active site of the viral RT. This variant arises both *in vitro* and in HIV-1 infected patients treated with lamivudine-containing antiretroviral therapy. M184V mutants display greatly reduced susceptibility to lamivudine and show diminished viral replicative capacity *in vitro*. M184V is associated with about a 2-fold increase in abacavir resistance but does not confer clinical resistance for abacavir.

Isolates resistant to abacavir may also show reduced sensitivity to lamivudine. The combination of abacavir/lamivudine has demonstrated decreased susceptibility to viruses with the substitutions K65R with or without the M184V/I substitution, and to viruses with L74V plus the M184V/I substitution.

Cross-resistance between dolutegravir or abacavir or lamivudine and antiretrovirals from other classes e.g. PIs or NNRTIs is unlikely.

Effects on electrocardiogram

No relevant effects were seen on the QTc interval, with doses of dolutegravir exceeding the clinical dose by approximately 3-fold. Similar studies were not conducted with either abacavir or lamivudine.

Clinical efficacy and safety

The efficacy of Triumeq in HIV-infected, therapy naive subjects is based on the analyses of data from a number of trials. The analyses included two randomised, international, double-blind, active-controlled trials, SINGLE (ING114467) and SPRING-2 (ING113086), the international, open-label, active-controlled trial FLAMINGO (ING114915), and the randomised, open-label, active-controlled, multicentre, non-inferiority study ARIA (ING117172).

The STRIVING study (201147), was a randomised, open-label, active-controlled, multicentre, non-inferiority switch study in virologically suppressed subjects with no documented history of resistance to any class.

In SINGLE, 833 patients were treated with dolutegravir 50 mg film-coated tablets once daily plus fixed-dose abacavir-lamivudine (DTG + ABC/3TC) or fixed-dose efavirenz-tenofovir-emtricitabine (EFV/TDF/FTC). At baseline, median patient age was 35 years, 16% were female, 32% non-white, 7% had hepatitis C co-infection and 4% were CDC Class C, these characteristics were similar between treatment groups. Week 48 outcomes (including outcomes by key baseline covariates) are shown in Table 3.

Table 3: Virologic Outcomes of Randomised Treatment of SINGLE at 48 Weeks (Snapshot algorithm)

	48 weeks	
	DTG 50 mg + ABC/3TC once daily N=414	EFV/TDF/FTC once daily N=419
HIV-1 RNA <50 copies/mL	88%	81%
Treatment Difference*	7.4% (95% CI: 2.5%, 12.3%)	
Virologic non response†	5%	6%
No virologic data at Weeks 48 window	7%	13%
<u>Reasons</u>		

Discontinued study/study medicinal product due to adverse event or death†	2%	10%
Discontinued study/study medicinal product for other reasons§	5%	3%
Missing data during window but on study	0	<1%
HIV-1 RNA <50 copies/mL by baseline covariates		
Baseline Plasma Viral Load (copies/mL)	n / N (%)	n / N (%)
≤100,000	253 / 280 (90%)	238 / 288 (83%)
>100,000	111 / 134 (83%)	100 / 131 (76%)
Baseline CD4+ (cells/ mm³)		
<200	45 / 57 (79%)	48 / 62 (77%)
200 to <350	143 / 163 (88%)	126 / 159 (79%)
≥350	176 / 194 (91%)	164 / 198 (83%)
Gender		
Male	307 / 347 (88%)	291 / 356 (82%)
Female	57 / 67 (85%)	47 / 63 (75%)
Race		
White	255 / 284 (90%)	238 / 285 (84%)
African-American/African Heritage/Other	109 / 130 (84%)	99 / 133 (74%)
Age (years)		
<50	319 / 361 (88%)	302 / 375 (81%)
≥50	45 / 53 (85%)	36 / 44 (82%)
<p>* Adjusted for baseline stratification factors. † Includes subjects who discontinued prior to Week 48 for lack or loss of efficacy and subjects who are ≥50 copies in the 48 week window. ‡ Includes subjects who discontinued due to an adverse event or death at any time point from Day 1 through the Week 48 analysis window if this resulted in no virologic data on treatment during the analysis window. § Includes reasons such as withdrew consent, loss to follow-up, moved, protocol deviation. Notes: ABC/3TC = abacavir 600 mg, lamivudine 300 mg in the form of Kivexa/Epzicom fixed dose combination (FDC) EFV/TDF/FTC = efavirenz 600 mg, tenofovir disoproxil 245 mg, emtricitabine 200 mg in the form of Atripla FDC.</p>		

In the primary 48 weeks analysis, the proportion of patients with virologic suppression in the dolutegravir + ABC/3TC arm, was superior to the EFV/TDF/FTC arm, $p=0.003$, the same treatment difference was observed in subjects defined by baseline HIV RNA level ($<$ or $>$ 100,000 copies/mL). The median time to viral suppression was shorter with ABC/3TC + DTG (28 vs 84 days, $p<0.0001$). The adjusted mean change in CD4+ T cell count from baseline were 267 cells versus 208 cells/mm³, respectively ($p<0.001$). Both the time to viral suppression and change from baseline analyses were pre-specified and adjusted for multiplicity. At 96 weeks, the response was 80% vs 72%, respectively. The difference in the endpoint remained statistically significant ($p=0.006$). The statistically higher responses on DTG+ABC/3TC were driven by a higher rate of withdrawals due to AEs in the EFV/TDF/FTC arm, irrespective of viral load strata. Overall treatment differences at Week 96 are applicable to patients with high and low Baseline viral loads. At 144 weeks in the open-label phase of SINGLE, virologic suppression was maintained, the DTG +ABC/3TC arm (71%) was superior to the EFV/TDF/FTC arm (63%), treatment difference was 8.3% (2.0, 14.6).

In SPRING-2, 822 patients were treated with either dolutegravir 50 mg film-coated tablets once daily or raltegravir 400 mg twice daily (blinded), both with fixed-dose ABC/3TC (around 40%) or TDF/FTC (around 60%), given open label. Baseline demographics and outcomes are summarised in Table 4. Dolutegravir was non-inferior to raltegravir, including within the subset of patients with the abacavir/lamivudine background regimen.

Table 4: Demographics and virologic outcomes of randomised treatment of SPRING-2 (snapshot algorithm)

	DTG 50 mg once daily + 2 NRTI N=411	RAL 400mg twice daily + 2 NRTI N=411
Demographics		
Median Age (years)	37	35
Female	15%	14%
Non-white	16%	14%
Hepatitis B and/or C	13%	11%
CDC class C	2%	2%
ABC/3TC backbone	41%	40%
Week 48 efficacy results		
HIV-1 RNA <50 copies/mL	88%	85%
Treatment difference*	2.5% (95% CI: -2.2%, 7.1%)	
Virologic non response†	5%	8%
No virologic data at Weeks 48 window	7%	7%
Reasons		
Discontinued study/study medicinal product due to adverse event or death‡	2%	1%
Discontinued study/study medicinal product for other reasons§	5%	6%
HIV-1 RNA <50 copies/mL for those on ABC/3TC	86%	87%
Week 96 efficacy results		
HIV-1 RNA <50 copies/mL	81%	76%
Treatment difference*	4.5% (95% CI: -1.1%, 10.0%)	
HIV-1 RNA <50 copies/mL for those on ABC/3TC	74%	76%
* Adjusted for baseline stratification factors.		
† Includes subjects who discontinued prior to Week 48 for lack or loss of efficacy and subjects who are ≥50 copies in the 48 week window.		
‡ Includes subjects who discontinued due to an adverse event or death at any time point from Day 1 through the Week 48 analysis window if this resulted in no virologic data on treatment during the analysis window.		
§ Includes reasons such as protocol deviation, lost to follow up, and withdrew consent.		
Notes: DTG = dolutegravir, RAL = raltegravir.		

In FLAMINGO, 485 patients were treated with dolutegravir 50 mg film-coated tablets once daily or darunavir/ritonavir (DRV/r) 800 mg/100 mg once daily, both with ABC/3TC (around 33%) or TDF/FTC (around 67%). All treatments were given open-label. Main demographics and outcomes are summarised in Table 5.

Table 5: Demographics and Week 48 virologic outcomes of randomised treatment of FLAMINGO (snapshot algorithm)

	DTG 50 mg once daily + 2 NRTI N=242	DRV+RTV 800mg + 100mg once daily +2 NRTI N=242
Demographics		
Median Age (years)	34	34
Female	13%	17%
Non-white	28%	27%
Hepatitis B and/or C	11%	8%
CDC class C	4%	2%
ABC/3TC backbone	33%	33%
Week 48 Efficacy Results		
HIV-1 RNA <50 copies/mL	90%	83%
Treatment Difference*	7.1% (95% CI: 0.9%, 13.2%)	
Virologic non response†	6%	7%
No virologic data at Weeks 48 window	4%	10%
<u>Reasons</u>		
Discontinued study/study medicinal product due to adverse event or death‡	1%	4%
Discontinued study/study medicinal product for other reasons§	2%	5%
Missing data during window but on study	<1%	2%
HIV-1 RNA <50copies/mL for those on ABC/3TC	90%	85%
Median time to viral suppression**	28 days	85 days
* Adjusted for baseline stratification factors, p=0.025. † Includes subjects who discontinued prior to Week 48 for lack or loss of efficacy and subjects who are ≥50 copies in the 48 week window. ‡ Includes subjects who discontinued due to an adverse event or death at any time point from Day 1 through the Week 48 analysis window if this resulted in no virologic data on treatment during the analysis window. § Includes reasons such as withdrew consent, loss to follow-up, protocol deviation. ** p<0.001. Notes: DRV+RTV = darunavir + ritonavir, DTG = dolutegravir.		

At 96 weeks, virologic suppression in the dolutegravir group (80%) was superior to the DRV/r group (68%), (adjusted treatment difference [DTG-(DRV+RTV)]: 12.4%; 95% CI: [4.7, 20.2]). Response rates at 96 weeks were 82% for DTG+ABC/3TC and 75% for DRV/r+ABC/3TC.

In ARIA (ING117172), a randomised, open-label, active-controlled, multicentre, parallel group, non-inferiority study; 499 HIV-1 infected ART naïve adult women were randomised 1:1 to receive either; DTG/ABC/3TC FDC film-coated tablets 50 mg/600 mg/300 mg; or atazanavir 300 mg plus ritonavir 100 mg plus tenofovir disproxil / emtricitabine 245 mg/200 mg (ATV+RTV+TDF/FTC FDC), all administered once daily.

Table 6: Demographics and Week 48 virologic outcomes of randomised treatment of ARIA (snapshot algorithm)

	DTG/ABC/3TC FDC N=248	ATV+RTV+TDF/FTC FDC N=247
Demographics		
Median Age (years)	37	37
Female	100 %	100 %
Non-white	54 %	57 %
Hepatitis B and/ or C	6 %	9%
CDC class C	4 %	4 %
Week 48 Efficacy Results		
HIV-1 RNA <50 copies/mL	82 %	71 %
Treatment difference	10.5 (3.1% to 17.8%) [p=0.005].	
Virologic Failure	6 %	14 %
<u>Reasons</u>		
Data in window not below 50 c/mL threshold	2 %	6 %
Discontinued for lack of efficacy	2 %	<1 %
Discontinued for other reason while not below threshold	3 %	7 %
No Virologic Data	12 %	15 %
Discontinued due to AE or death	4 %	7 %
Discontinued for other reasons	6 %	6 %
Missing data during window but on study	2 %	2 %
AE = Adverse event. HIV-1 - human immunodeficiency virus type 1 DTG/ABC/3TC FDC - abacavir/dolutegravir/lamivudine fixed-dose combination ATV+RTV+TDF/FTC FDC -atazanavir plus ritonavir plus tenofovir disproxil/emtricitabine fixed-dose combination		

STRIIVING (201147) is a 48-week, randomised, open-label, active controlled, multicentre, non-inferiority study in patients without any prior treatment failure, and without any documented resistance to any class. Virologically suppressed (HIV-1 RNA <50 c/mL) subjects were randomly assigned (1:1) to continue their current ART regimen (2 NRTIs plus either a PI, NNRTI, or INI), or switch to ABC/DTG/3TC FDC film-coated tablets once daily (Early Switch). Hepatitis B co-infection was one of the main exclusion criteria.

Patients were mainly white (66%) or black (28%) of male sex (87%). Main prior transmission routes were homosexual (73%) or heterosexual (29%) contact. The proportion with a positive HCV serology was 7%. The median time from first starting ART was around 4.5 years.

Table 7: Outcomes of randomised treatment of STRIIVING (snapshot algorithm)

Study Outcomes (Plasma HIV-1 RNA <50 c/mL) at Week 24 and Week 48 – Snapshot Analysis (ITT-E Population)				
	ABC/DTG/3TC FDC N=275 n (%)	Current ART N=278 n (%)	Early Switch ABC/DTG/3TC FDC N=275 n (%)	Late Switch ABC/DTG/3TC FDC N=244 n (%)
Outcome Time Point	Day 1 to W 24	Day 1 to W 24	Day 1 to W48	W24 to W48
Virologic Success	85 %	88 %	83 %	92 %
Virologic Failure	1 %	1 %	<1 %	1 %
<u>Reasons</u>				
Data in window not below threshold	1 %	1 %	<1 %	1 %
No Virologic Data	14 %	10 %	17 %	7 %
Discontinued due to AE or death	4 %	0 %	4 %	2 %
Discontinued for other reasons	9 %	10 %	12 %	3 %
Missing data during window but on study	1 %	<1 %	2 %	2 %
ABC/DTG/3TC FDC = abacavir/dolutegravir/lamivudine fixed-dose combination; AE = adverse event; ART = antiretroviral therapy; HIV-1 = human immunodeficiency virus type 1; ITT-E = intent-to-treat exposed; W = week.				

Virologic suppression (HIV-1 RNA <50 copies/mL) in the ABC/DTG/3TC FDC group (85%) was statistically non-inferior to the current ART groups (88%) at 24 weeks. The adjusted difference in proportion and 95% CI [ABC/DTG/3TC vs current ART] were 3.4%; 95% CI: [-9.1, 2.4]. After 24 weeks all remaining subjects switched to ABC/DTG/3TC FDC (Late Switch). Similar levels of virologic suppression were maintained in both the Early and Late Switch groups at 48 weeks.

De novo resistance in patients failing therapy in SINGLE, SPRING-2 and FLAMINGO

De novo resistance was not detected to the integrase class or the NRTI class in any patients who were treated with dolutegravir + abacavir/lamivudine in the three studies mentioned.

For the comparators typical resistance was detected with TDF/FTC/EFV (SINGLE; six with NNRTI associated resistance and one with major NRTI resistance) and with 2 NRTIs + raltegravir (SPRING-2; four with major NRTI resistance and one with raltegravir resistance), while no *de novo* resistance was detected in patients treated with 2 NRTIs + DRV/RTV (FLAMINGO).

Paediatric population

In a Phase I/II 48 week, open-label, multicentre, dose-finding clinical study (IMPAACT P1093/ING112578), the pharmacokinetic parameters, safety, tolerability and efficacy of dolutegravir were evaluated in combination with other antiretroviral medicinal products in treatment naïve or treatment-experienced, INSTI-naïve, HIV-1–infected subjects aged ≥ 4 weeks to < 18 years. Subjects were stratified by age cohort; subjects aged 12 to less than 18 years were enrolled in Cohort I and subjects aged 6 to less than 12 years were enrolled in Cohort IIA. Across both cohorts, 67% (16/24) of subjects who received the recommended dose (determined by weight and age) achieved HIV-1 RNA less than 50 copies per mL at Week 48 (Snapshot algorithm).

DTG/ABC/3TC FDC film-coated tablets and dispersible tablets were evaluated in treatment naïve or treatment-experienced, HIV-1 infected subjects aged <12 years and weighing ≥6 to <40 kg in an open-label, multicentre, clinical trial (IMPAACT 2019). 57 subjects weighing at least 6 kg who received the recommended dose and formulation (determined by weight band) contributed to the efficacy analyses at Week 48. Overall, 79% (45/57) and 95% (54/57) of subjects weighing at least 6 kg achieved HIV-1

RNA less than 50 copies per mL and less than 200 copies per mL, respectively, at Week 48 (Snapshot algorithm).

Abacavir and lamivudine once daily, in combination with a third antiretroviral medicinal product, were evaluated in a randomised, multicentre trial (ARROW) in HIV-1–infected, treatment-naïve subjects. Subjects randomised to once-daily dosing (n = 331) and who weighed at least 25 kg received abacavir 600 mg and lamivudine 300 mg, as either the single entities or as FDC. At Week 96, 69% of subjects receiving abacavir and lamivudine once-daily in combination with a third antiretroviral medicinal product, had HIV-1 RNA less than 80 copies per mL.

5.2 Pharmacokinetic properties

Triumeq film-coated tablet has been shown to be bioequivalent to dolutegravir single entity film-coated tablet and abacavir/lamivudine fixed-dose combination tablet (ABC/3TC FDC) administered separately. This was demonstrated in a single dose, 2-way crossover bioequivalence study of Triumeq (fasted) versus 1 x 50 mg dolutegravir tablet, plus 1 x 600mg abacavir/300 mg lamivudine tablet (fasted) in healthy subjects (n=66).

The relative bioavailability of abacavir and lamivudine administered in dispersible tablet form is comparable to film-coated tablets. The relative bioavailability of dolutegravir administered in dispersible tablet form is approximately 1.7-fold higher as compared to film-coated tablets. Thus, the Triumeq dispersible tablets are not directly interchangeable with Triumeq film-coated tablets (see section 4.2).

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

Absorption

Dolutegravir, abacavir and lamivudine are rapidly absorbed following oral administration. The absolute bioavailability of dolutegravir has not been established. The absolute bioavailability of oral abacavir and lamivudine in adults is about 83% and 80-85% respectively. The mean time to maximal serum concentrations (t_{max}) is about 2 to 3 hours (post dose for tablet formulation), 1.5 hours and 1.0 hour for dolutegravir, abacavir and lamivudine, respectively.

Exposure to dolutegravir was generally similar between healthy subjects and HIV-1–infected subjects. In HIV-1–infected adult subjects following dolutegravir 50 mg film-coated tablets once daily, the steady-state pharmacokinetic parameters (geometric mean [%CV]) based on population pharmacokinetic analyses were $AUC_{(0-24)} = 53.6$ (27) $\mu\text{g}\cdot\text{h}/\text{mL}$, $C_{max} = 3.67$ (20) $\mu\text{g}/\text{mL}$, and $C_{min} = 1.11$ (46) $\mu\text{g}/\text{mL}$. Following a single dose of 600 mg of abacavir, the mean (CV) C_{max} is 4.26 $\mu\text{g}/\text{ml}$ (28%) and the mean (CV) AUC_{∞} is 11.95 $\mu\text{g}\cdot\text{h}/\text{ml}$ (21%). Following multiple-dose oral administration of lamivudine 300 mg once daily for seven days, the mean (CV) steady-state C_{max} is 2.04 $\mu\text{g}/\text{ml}$ (26%) and the mean (CV) AUC_{24} is 8.87 $\mu\text{g}\cdot\text{h}/\text{ml}$ (21%).

The effect of a high fat meal on Triumeq film-coated tablet was evaluated in a subgroup of subjects (n=12) of the single dose, 2-way crossover bioequivalence study. Plasma C_{max} and AUC of dolutegravir following administration of Triumeq film-coated tablets with a high fat meal were 37% and 48% higher, respectively, than those following administration of Triumeq film-coated tablets in the fasted state. For abacavir there was a decrease in C_{max} with 23% and AUC was unchanged. The exposure of lamivudine was similar with and without food. These results indicate that Triumeq film-coated tablets can be taken with or without food.

Distribution

The apparent volume of distribution of dolutegravir (following oral administration of suspension formulation, V_d/F) is estimated at 12.5 L. Intravenous studies with abacavir and lamivudine showed that the mean apparent volume of distribution is 0.8 and 1.3 l/kg respectively.

Dolutegravir is highly bound (> 99%) to human plasma proteins based on *in vitro* data. Binding of dolutegravir to plasma proteins is independent of dolutegravir concentration. Total blood and plasma drug-related radioactivity concentration ratios averaged between 0.441 to 0.535, indicating minimal association of radioactivity with blood cellular components. The unbound fraction of dolutegravir in plasma is increased at low levels of serum albumin (<35 g/L) as seen in subjects with moderate hepatic impairment. Plasma protein binding studies *in vitro* indicate that abacavir binds only low to moderately (~49%) to human plasma proteins at therapeutic concentrations. Lamivudine exhibits linear pharmacokinetics over the therapeutic dose range and displays limited plasma protein binding *in vitro* (< 36%).

Dolutegravir, abacavir and lamivudine are present in cerebrospinal fluid (CSF).

In 13 treatment-naïve subjects on a stable dolutegravir plus abacavir/lamivudine regimen, dolutegravir concentration in CSF averaged 18 ng/mL (comparable to unbound plasma concentration, and above the IC₅₀). Studies with abacavir demonstrate a CSF to plasma AUC ratio of between 30 to 44%. The observed values of the peak concentrations are 9-fold greater than the IC₅₀ of abacavir of 0.08 µg/ml or 0.26 µM when abacavir is given at 600 mg twice daily. The mean ratio of CSF/serum lamivudine concentrations 2-4 hours after oral administration was approximately 12%. The true extent of CNS penetration of lamivudine and its relationship with any clinical efficacy is unknown.

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

Biotransformation

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

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

Metabolism of lamivudine is a minor route of elimination. Lamivudine is predominately cleared by renal excretion of unchanged lamivudine. The likelihood of metabolic drug interactions with lamivudine is low due to the small extent of hepatic metabolism (5-10%).

Drug interactions

In vitro, dolutegravir demonstrated no direct, or weak inhibition (IC₅₀>50 µM) of the enzymes cytochrome P₄₅₀ (CYP)1A2, CYP2A6, CYP2B6, CYP2C8, CYP2C9, CYP2C19, CYP2D6, CYP3A, UGT1A1 or UGT2B7, or the transporters Pgp, BCRP, BSEP, organic anion transporting polypeptide 1B1 (OATP1B1), OATP1B3, OCT1, MATE2-K, multidrug resistance-associated protein 2 (MRP2) or MRP4. *In vitro*, dolutegravir did not induce CYP1A2, CYP2B6 or CYP3A4. Based on this data, dolutegravir is not expected to affect the pharmacokinetics of medicinal products that are substrates of major enzymes or transporters (see section 4.5).

In vitro, dolutegravir was not a substrate of human OATP 1B1, OATP 1B3 or OCT 1.

In vitro, abacavir did not inhibit or induce CYP enzymes (other than CYP1A1 and CYP3A4 [limited potential], see section 4.5) and demonstrates no or weak inhibition of OATP1B1, OAT1B3, OCT1, OCT2, BCRP and P-gp or MATE2-K. Abacavir is therefore not expected to affect the plasma concentrations of medicinal products that are substrates of these enzymes or transporters.

Abacavir was not significantly metabolised by CYP enzymes. *In vitro*, abacavir was not a substrate of OATP1B1, OATP1B3, OCT1, OCT2, OAT1, MATE1, MATE2-K, MRP2 or MRP4 therefore medicinal products that modulate these transporters are not expected to affect abacavir plasma concentrations.

In vitro, lamivudine did not inhibit or induce CYP enzymes (such as CYP3A4, CYP2C9 or CYP2D6) and demonstrated no or weak inhibition of OATP1B1, OAT1B3, OCT3, BCRP, P-gp, MATE1 or MATE2-K. Lamivudine is therefore not expected to affect the plasma concentrations of medicinal products that are substrates of these enzymes or transporters.

Lamivudine was not significantly metabolised by CYP enzymes.

Elimination

Dolutegravir has a terminal half-life of ~14 hours. The apparent oral clearance (CL/F) is approximately 1 L/hr in HIV-infected patients based on a population pharmacokinetic analysis.

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

The observed lamivudine half-life of elimination is 18 to 19 hours. For patients receiving lamivudine 300 mg once daily, the terminal intracellular half-life of lamivudine-TP was 16 to 19 hours. The mean systemic clearance of lamivudine is approximately 0.32 L/h/kg, predominantly by renal clearance (> 70%) via the organic cationic transport system. Studies in patients with renal impairment show lamivudine elimination is affected by renal dysfunction. Dose reduction is required for patients with creatinine clearance < 30 mL/min (see section 4.2).

Pharmacokinetic/pharmacodynamic relationship(s)

In a randomised, dose-ranging trial, HIV-1-infected subjects treated with dolutegravir monotherapy (ING111521) demonstrated rapid and dose-dependent antiviral activity with mean decline in HIV-1 RNA of 2.5 log₁₀ at day 11 for 50 mg dose. This antiviral response was maintained for 3 to 4 days after the last dose in the 50 mg group.

Intracellular pharmacokinetics

The geometric mean terminal carbovir-TP intracellular half-life at steady-state was 20.6 hours, compared to the geometric mean abacavir plasma half-life of 2.6 hours. The terminal intracellular half-life of lamivudine-TP was prolonged to 16-19 hours, supporting once daily dosing of ABC and 3TC.

Special populations

Hepatic impairment

Pharmacokinetic data has been obtained for dolutegravir, abacavir and lamivudine separately.

Dolutegravir is primarily metabolised and eliminated by the liver. A single dose of 50 mg of dolutegravir was administered to 8 subjects with moderate hepatic impairment (Child-Pugh class B) and to 8 matched healthy adult controls. While the total dolutegravir concentration in plasma was similar, a 1.5 to 2-fold increase in unbound exposure to dolutegravir was observed in subjects with moderate hepatic impairment compared to healthy controls. No dose adjustment is considered necessary for patients with mild to moderate hepatic impairment. The effect of severe hepatic impairment on the pharmacokinetics of dolutegravir has not been studied.

Abacavir is metabolised primarily by the liver. The pharmacokinetics of abacavir have been studied in patients with mild hepatic impairment (Child-Pugh score 5-6) receiving a single 600 mg dose. The results showed that there was a mean increase of 1.89-fold [1.32; 2.70] in the abacavir AUC, and 1.58 [1.22; 2.04] fold in the elimination half-life. No recommendation on dose reduction is possible in patients with mild hepatic impairment due to substantial variability of abacavir exposure.

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

Based on data obtained for abacavir, Triumeq is not recommended in patients with moderate or severe hepatic impairment.

Renal impairment

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

Renal clearance of unchanged active substance is a minor pathway of elimination for dolutegravir. A study of the pharmacokinetics of dolutegravir was performed in subjects with severe renal impairment ($\text{CrCl} < 30 \text{ mL/min}$). No clinically important pharmacokinetic differences between subjects with severe renal impairment ($\text{CrCl} < 30 \text{ mL/min}$) and matching healthy subjects were observed. Dolutegravir has not been studied in patients on dialysis, though differences in exposure are not expected.

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

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

Based on the lamivudine data, Triumeq is not recommended for patients with creatinine clearance of $< 30 \text{ mL/min}$.

Elderly

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

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

Paediatric population

The pharmacokinetics of dolutegravir film-coated and dispersible tablets in HIV-1 infected infants, children and adolescents aged ≥ 4 weeks to < 18 years were evaluated in two on-going studies (IMPAACT P1093/ING112578 and ODYSSEY/201296). Mean dolutegravir $\text{AUC}_{0-24\text{h}}$ and $\text{C}_{24\text{h}}$ in HIV-1-infected paediatric subjects weighing at least 6 kg were comparable to those in adults after 50 mg once daily or 50 mg twice daily. Mean C_{max} is higher in paediatrics, but the increase is not considered clinically significant as the safety profiles were similar in paediatric and adult subjects.

The pharmacokinetics of Triumeq film-coated and dispersible tablets in HIV-1 infected, treatment naïve or treatment-experienced, children aged < 12 years were evaluated in a study (IMPAACT 2019).

Mean dolutegravir, abacavir and lamivudine AUC_{0-24h}, C_{24h} and C_{max} at recommended doses for Triumeq film-coated and dispersible tablets in HIV-1 infected paediatric subjects weighing at least 6 kg to less than 40 kg were within the observed exposure ranges at the recommended doses of individual products in adults and paediatrics.

Pharmacokinetic data are available for abacavir and lamivudine in children and adolescents receiving recommended dose regimens of the oral solution and tablet formulations. Pharmacokinetic parameters are comparable to those reported in adults. In children and adolescents weighing 6 kg to less than 25 kg, at recommended doses, predicted exposures (AUC_{0-24h}) for abacavir and lamivudine with Triumeq dispersible tablets are within the predicted exposure range of the individual components based on population pharmacokinetic modelling and simulation.

Polymorphisms in drug metabolising enzymes

There is no evidence that common polymorphisms in drug metabolising enzymes alter dolutegravir pharmacokinetics to a clinically meaningful extent. In a meta-analysis using pharmacogenomics samples collected in clinical studies in healthy subjects, subjects with UGT1A1 (n=7) genotypes conferring poor dolutegravir metabolism had a 32% lower clearance of dolutegravir and 46% higher AUC compared with subjects with genotypes associated with normal metabolism via UGT1A1 (n=41).

Gender

Population PK analyses using pooled pharmacokinetic data from Phase IIb and Phase III adult trials revealed no clinically relevant effect of gender on the exposure of dolutegravir. There is no evidence that a dose adjustment of dolutegravir, abacavir or lamivudine would be required based on the effects of gender on PK parameters.

Race

Population PK analyses using pooled pharmacokinetic data from Phase IIb and Phase III adult trials revealed no clinically relevant effect of race on the exposure of dolutegravir. The pharmacokinetics of dolutegravir following single dose oral administration to Japanese subjects appear similar to observed parameters in Western (US) subjects. There is no evidence that a dose adjustment of dolutegravir, abacavir or lamivudine would be required based on the effects of race on PK parameters.

Co-infection with Hepatitis B or C

Population pharmacokinetic analysis indicated that hepatitis C virus co-infection had no clinically relevant effect on the exposure to dolutegravir. There are limited pharmacokinetic data on subjects with hepatitis B co-infection (see section 4.4).

5.3 Preclinical safety data

There are no data available on the effects of the combination of dolutegravir, abacavir and lamivudine in animals, except a negative *in vivo* rat micronucleus test which tested the effects of the combination of abacavir and lamivudine.

Mutagenicity and carcinogenicity

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

Neither abacavir nor lamivudine were mutagenic in bacterial tests, but consistent with other nucleoside analogues, inhibit cellular DNA replication in *in vitro* mammalian tests such as the mouse lymphoma assay. The results of an *in vivo* rat micronucleus test with abacavir and lamivudine in combination were negative.

Lamivudine has not shown any genotoxic activity in the *in vivo* studies. Abacavir has a weak potential to cause chromosomal damage both *in vitro* and *in vivo* at high tested concentrations.

The carcinogenic potential of a combination of dolutegravir, abacavir and lamivudine has not been tested. Dolutegravir was not carcinogenic in long term studies in the mouse and rat. In long-term oral carcinogenicity studies in rats and mice, lamivudine did not show any carcinogenic potential. Carcinogenicity studies with orally administered abacavir in mice and rats showed an increase in the incidence of malignant and non-malignant tumours. Malignant tumours occurred in the preputial gland of males and the clitoral gland of females of both species, and in rats in the thyroid gland of males and in the liver, urinary bladder, lymph nodes and the subcutis of females.

The majority of these tumours occurred at the highest abacavir dose of 330 mg/kg/day in mice and 600 mg/kg/day in rats. The exception was the preputial gland tumour which occurred at a dose of 110 mg/kg in mice. The systemic exposure at the no effect level in mice and rats was equivalent to 3 and 7 times the human systemic exposure during therapy. While the clinical relevance of these findings is unknown, these data suggest that a potential carcinogenic risk to humans is outweighed by the clinical benefit.

Repeat-dose toxicity

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

In toxicology studies abacavir was shown to increase liver weights in rats and monkeys. The clinical relevance of this is unknown. There is no evidence from clinical studies that abacavir is hepatotoxic. Additionally, autoinduction of abacavir metabolism or induction of the metabolism of other medicinal products hepatically metabolised has not been observed in humans.

Mild myocardial degeneration in the heart of mice and rats was observed following administration of abacavir for two years. The systemic exposures were equivalent to 7 to 21 times the expected systemic exposure in humans. The clinical relevance of this finding has not been determined.

Reproductive toxicology

In reproductive toxicity studies in animals, dolutegravir, lamivudine and abacavir were shown to cross the placenta.

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

Oral administration of dolutegravir to pregnant rabbits at doses up to 1000 mg/kg daily from days 6 to 18 of gestation did not elicit developmental toxicity or teratogenicity (0.74 times the 50mg human clinical exposure when administered in combination with abacavir and lamivudine based on AUC). In rabbits, maternal toxicity (decreased food consumption, scant/no faeces/urine, suppressed body weight gain) was observed at 1000 mg/kg (0.74 times the 50 mg human clinical exposure when administered in combination with abacavir and lamivudine based on AUC).

Lamivudine was not teratogenic in animal studies but there were indications of an increase in early embryonic deaths in rabbits at relatively low systemic exposures, comparable to those achieved in humans. A similar effect was not seen in rats even at very high systemic exposure.

Abacavir demonstrated toxicity to the developing embryo and foetus in rats, but not in rabbits. These findings included decreased foetal body weight, foetal oedema, and an increase in skeletal variations/malformations, early intra-uterine deaths and still births. No conclusion can be drawn with regard to the teratogenic potential of abacavir because of this embryo-foetal toxicity.

Fertility studies in rats have shown that dolutegravir, abacavir and lamivudine have no effect on male or female fertility.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Tablet core

Mannitol (E421)

Microcrystalline cellulose

Povidone (K29/32)

Sodium starch glycollate

Magnesium stearate

Tablet coating

Poly(vinyl) alcohol – partially hydrolysed

Titanium dioxide

Macrogol

Talc

Iron oxide black

Iron oxide red

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

3 years

6.4 Special precautions for storage

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

This medicinal product does not require any special temperature storage conditions.

6.5 Nature and contents of container

White HDPE (high density polyethylene) bottles closed with polypropylene child-resistant closures, with a polyethylene faced induction heat seal liner.

Each bottle contains 30 film-coated tablets and a desiccant.

Multipacks containing 90 (3 packs of 30) film-coated tablets. Each pack of 30 film-coated tablets contains a desiccant.

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

ViiV Healthcare BV
Van Asch van Wijckstraat 55H
3811 LP Amersfoort
Netherlands

8. MARKETING AUTHORISATION NUMBER(S)

EU/1/14/940/001
EU/1/14/940/002

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 1st September 2014
Date of latest renewal: 20th June 2019

10. DATE OF REVISION OF THE TEXT

Detailed information on this medicinal product is available on the website of the European Medicines Agency <https://www.ema.europa.eu>

1. NAME OF THE MEDICINAL PRODUCT

Triumeq 5 mg/60 mg/30 mg dispersible tablets

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each dispersible tablet contains 5 mg dolutegravir (as sodium), 60 mg of abacavir (as sulfate) and 30 mg of lamivudine.

For the full list of excipients see section 6.1.

3. PHARMACEUTICAL FORM

Dispersible tablet

Yellow, biconvex, capsule shaped, dispersible tablets, approximately 14 x 7 mm debossed with 'SV WTU' on one side.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Triumeq is indicated for the treatment of Human Immunodeficiency Virus type 1 (HIV-1) infected children of at least 3 months of age and weighing at least 6 kg to less than 25 kg (see sections 4.4 and 5.1).

Before initiating treatment with abacavir-containing products, screening for carriage of the HLA-B*5701 allele should be performed in any HIV-infected patient, irrespective of racial origin (see section 4.4). Abacavir should not be used in patients known to carry the HLA-B*5701 allele.

4.2 Posology and method of administration

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

Posology

Children (at least 3 months of age and weighing at least 6 kg to less than 25 kg)

The recommended dose of Triumeq dispersible tablets is determined according to weight (see Table 1).

Table 1: Dispersible tablet dose recommendations in children at least 3 months of age and weighing at least 6 kg to less than 25 kg

Body weight (kg)	Daily dose	Number of tablets
6 to less than 10	15 mg DTG, 180 mg ABC, 90 mg 3TC once daily	Three
10 to less than 14	20 mg DTG, 240 mg ABC, 120 mg 3TC once daily	Four

14 to less than 20	25 mg DTG, 300 mg ABC, 150 mg 3TC once daily	Five
20 to less than 25	30 mg DTG, 360 mg ABC, 180 mg 3TC once daily	Six

DTG= dolutegravir, ABC= abacavir, 3TC= lamivudine.

Children (at least 3 months of age and weighing at least 6 kg to less than 25 kg), concomitantly administered with strong enzyme inducers

The recommended dose of dolutegravir should be modified when Triumeq dispersible tablets are co-administered with etravirine (without boosted protease inhibitors), efavirenz, nevirapine, rifampicin, tipranavir/ritonavir, carbamazepine, phenytoin, phenobarbital and St. John's wort (see Table 2).

Table 2: Dispersible tablet dose recommendations in children at least 3 months of age and weighing at least 6 kg to less than 25 kg when administered concomitantly with strong enzyme inducers

Body weight (kg)	Daily dose	Number of tablets
6 to less than 10	15 mg DTG, 180 mg ABC, 90 mg 3TC once daily AND An extra dose of dolutegravir dispersible tablets administered approximately 12 hours after Triumeq.*	Three AND Refer to labelling for dolutegravir dispersible tablets.
10 to less than 14	20 mg DTG, 240 mg ABC, 120 mg 3TC once daily AND An extra 20 mg dose of dolutegravir dispersible tablets administered approximately 12 hours after Triumeq.*	Four AND Refer to labelling for dolutegravir dispersible tablets.
14 to less than 20	25 mg DTG, 300 mg ABC, 150 mg 3TC once daily AND An extra 25 mg dose of dolutegravir dispersible tablets administered approximately 12 hours after Triumeq.* OR An extra 40 mg dose of dolutegravir film-coated tablets administered approximately 12 hours after Triumeq.*	Five AND Refer to labelling for dolutegravir dispersible tablets. OR Refer to labelling for dolutegravir film-coated tablets.
20 to less than 25	30 mg DTG, 360 mg ABC, 180 mg 3TC once daily	Six

	<p>AND An extra 30 mg dose of dolutegravir dispersible tablets administered approximately 12 hours after Triumeq.*</p> <p>OR An extra 50 mg dose of dolutegravir film-coated tablets administered approximately 12 hours after Triumeq.*</p>	<p>AND Refer to labelling for dolutegravir dispersible tablets.</p> <p>OR Refer to labelling for dolutegravir film-coated tablets.</p>
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*In these cases the physician should refer to the individual product information for dolutegravir.

Separate preparations of dolutegravir, abacavir or lamivudine are available in cases where discontinuation or dose adjustment of one of the active substances is indicated. In these cases, the physician should refer to the individual product information for these medicinal products.

A separate dose of dolutegravir (film-coated tablets or dispersible tablets) is applicable where a dose adjustment is indicated due to drug-drug interactions, e.g. rifampicin, carbamazepine, oxcarbazepine, phenytoin, phenobarbital, St. John's wort, etravirine (without boosted protease inhibitors), efavirenz, nevirapine, or tipranavir/ritonavir (see Table 2 and section 4.5).

Film-coated tablets

Triumeq is available as film-coated tablets for patients who weigh at least 25 kg. The bioavailability of dolutegravir from film-coated tablets and dispersible tablets is not comparable; therefore, they must not be used as direct replacements (see section 5.2).

Missed doses

If the patient misses a dose of Triumeq, the patient should take it as soon as possible, providing the next dose is not due within 4 hours. If the next dose is due within 4 hours, the patient should not take the missed dose and simply resume the usual dosing schedule.

Special populations

Elderly

There are limited data available on the use of dolutegravir, abacavir and lamivudine in patients aged 65 years and over. There is no evidence that elderly patients require a different dose than younger adult patients (see section 5.2).

Renal impairment

There are no data available on the use of lamivudine in children with renal impairment who weigh less than 25 kg. Therefore, Triumeq is not recommended for use in adolescents or children weighing at least 6 kg to less than 25 kg with a creatinine clearance less than 50 mL/min (see section 5.2).

Hepatic impairment

Abacavir is primarily metabolised by the liver. No clinical data are available in patients with moderate or severe hepatic impairment, therefore the use of Triumeq in such patients is not recommended unless judged necessary. In patients with mild hepatic impairment (Child-Pugh score 5-6) close monitoring is required, including monitoring of abacavir plasma levels if feasible (see sections 4.4 and 5.2).

Paediatric population

The safety and efficacy of Triumeq in children less than 3 months of age or weighing less than 6 kg has not yet been established.

Currently available data are described in section 4.8, 5.1 and 5.2, but no recommendation on a posology can be made.

Method of administration

Oral use

Triumeq can be taken with or without food (see section 5.2). Triumeq must be dispersed in drinking water. The tablet(s) should be fully dispersed in 20 mL of drinking water (if using 4, 5 or 6 tablets) or 15 mL of drinking water (if using 3 tablets), in the supplied dosing cup, before swallowing. Do not chew, cut or crush the tablets. The dose of medicinal product must be given within 30 minutes of preparation. If it has been more than 30 minutes the dose should be washed away and a new dose should be prepared (see section 6.6 and Step-by-step instructions for use).

For children unable to use the supplied dosing cup, an appropriate-sized syringe may be used.

4.3 Contraindications

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

Co-administration with medicinal products with narrow therapeutic windows, that are substrates of organic cation transporter (OCT) 2, including but not limited to fampridine (also known as dalfampridine; see section 4.5).

4.4 Special warnings and precautions for use

Hypersensitivity reactions (see section 4.8)

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

Therefore, the following should always be adhered to:

- HLA-B*5701 status must always be documented prior to initiating therapy.
- Triumeq should never be initiated in patients with a positive HLA-B*5701 status, nor in patients with a negative HLA-B*5701 status who had a suspected abacavir HSR on a previous abacavir-containing regimen.
- **Triumeq must be stopped without delay**, even in the absence of the HLA-B*5701 allele, if an HSR is suspected. Delay in stopping treatment with Triumeq after the onset of hypersensitivity may result in an immediate and life-threatening reaction. Clinical status including liver aminotransferases and bilirubin should be monitored.
- After stopping treatment with Triumeq for reasons of a suspected HSR, **Triumeq or any other medicinal product containing abacavir or dolutegravir must never be re-initiated**.
- Restarting abacavir containing products following a suspected abacavir HSR can result in a prompt return of symptoms within hours. This recurrence is usually more severe than on initial presentation, and may include life-threatening hypotension and death.

- In order to avoid restarting abacavir and dolutegravir, patients who have experienced a suspected HSR should be instructed to dispose of their remaining Triumeq tablets.

Clinical description of HSRs

Hypersensitivity reactions have been reported in <1% of patients treated with dolutegravir in clinical studies, and were characterized by rash, constitutional findings, and sometimes, organ dysfunction, including severe liver reactions.

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

Almost all HSR to abacavir will include fever and/or rash. Other signs and symptoms that have been observed as part of abacavir HSR are described in detail in section 4.8 (Description of selected adverse reactions), including respiratory and gastrointestinal symptoms. Importantly, such symptoms **may lead to misdiagnosis of HSR as respiratory disease (pneumonia, bronchitis, pharyngitis), or gastroenteritis.** The symptoms related to this HSR worsen with continued therapy and **can be life-threatening.** These symptoms usually resolve upon discontinuation of abacavir.

Rarely, patients who have stopped abacavir for reasons other than symptoms of HSR have also experienced life-threatening reactions within hours of re- initiating abacavir therapy (see Section 4.8 Description of selected adverse reactions). Restarting abacavir in such patients must be done in a setting where medical assistance is readily available.

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 and weight, there is in some cases evidence for a treatment effect. For monitoring of blood lipids and glucose reference is made to established HIV treatment guidelines. Lipid disorders should be managed as clinically appropriate.

Liver disease

The safety and efficacy of Triumeq has not been established in patients with significant underlying liver disorders. Triumeq is not recommended in patients with moderate to severe hepatic impairment (see sections 4.2 and 5.2).

Patients with pre-existing liver dysfunction, including chronic active hepatitis have an increased frequency of liver function abnormalities during combination antiretroviral therapy, 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.

Patients with chronic hepatitis B or C

Patients with chronic hepatitis B or C and treated with combination antiretroviral therapy are at an increased risk of severe and potentially fatal hepatic adverse reactions. In case of concomitant antiviral therapy for hepatitis B or C, please refer also to the relevant product information for these medicinal products.

Triumeq includes lamivudine, which is active against hepatitis B. Abacavir and dolutegravir lack such activity. Lamivudine monotherapy is generally not considered an adequate treatment for hepatitis B,

since the risk for hepatitis B resistance development is high. If Triumeq is used in patients co-infected with hepatitis B an additional antiviral is, therefore, generally needed. Reference should be made to treatment guidelines.

If Triumeq is discontinued in patients co-infected with hepatitis B virus, periodic monitoring of both liver function tests and markers of HBV replication is recommended, as withdrawal of lamivudine may result in an acute exacerbation of hepatitis.

Immune Reactivation Syndrome

In HIV-infected patients with severe immune deficiency at the time of institution of combination antiretroviral therapy (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 (often referred to as PCP). Any inflammatory symptoms should be evaluated and treatment instituted when necessary. Autoimmune disorders (such as Graves' disease and autoimmune hepatitis) 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.

Liver chemistry elevations consistent with immune reconstitution syndrome were observed in some hepatitis B and/or C co-infected patients at the start of dolutegravir therapy. Monitoring of liver chemistries is recommended in patients with hepatitis B and/or C co-infection. (See 'Patients with chronic hepatitis B or C' earlier in this section and also see section 4.8).

Mitochondrial dysfunction following exposure in utero

Nucleoside and nucleotide 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 post-natally 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 reactions have often been transitory. Some 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 nucleoside and nucleotide analogues, who presents with severe clinical findings of unknown aetiology, particularly neurologic findings. These findings do not affect current national recommendations to use antiretroviral therapy in pregnant women to prevent vertical transmission of HIV.

Cardiovascular events

Although the available data from clinical and observational studies with abacavir show inconsistent results, several studies suggest an increased risk of cardiovascular events (notably myocardial infarction) in patients treated with abacavir. Therefore, when prescribing Triumeq, action should be taken to minimise all modifiable risk factors (e.g. smoking, hypertension, and hyperlipidaemia). In addition, alternative treatment options to the abacavir containing regimen should be considered when treating patients with a high cardiovascular risk.

Osteonecrosis

Although the aetiology is considered to be multifactorial (including corticosteroid use, bisphosphonates, 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.

Opportunistic infections

Patients should be advised that Triumeq or any other antiretroviral therapy does not cure HIV infection and that they may still develop opportunistic infections and other complications of HIV infection. Therefore, patients should remain under close clinical observation by physicians experienced in the treatment of these associated HIV diseases.

Drug resistance

The use of Triumeq is not recommended for patients with integrase inhibitor resistance because there are insufficient data to recommend a dose for dolutegravir in integrase inhibitor resistant adolescents, children and infants.

Drug interactions

The recommended dose of dolutegravir should be adjusted when co-administered with rifampicin, carbamazepine, oxcarbazepine, phenytoin, phenobarbital, St. John's wort, etravirine (without boosted protease inhibitors), efavirenz, nevirapine, or tipranavir/ritonavir (see section 4.5).

Triumeq should not be co-administered with polyvalent cation-containing antacids. Triumeq is recommended to be administered 2 hours before or 6 hours after these medicinal products (see section 4.5).

When taken with food, Triumeq and supplements or multivitamins containing calcium, iron or magnesium can be taken at the same time. If Triumeq is administered under fasting conditions, supplements or multivitamins containing calcium, iron or magnesium are recommended to be taken 2 hours after or 6 hours before Triumeq (see section 4.5).

Dolutegravir increased metformin concentrations. A dose adjustment of metformin should be considered when starting and stopping coadministration of dolutegravir with metformin, to maintain glycaemic control (see section 4.5). Metformin is eliminated renally and therefore it is of importance to monitor renal function when co-treated with dolutegravir. This combination may increase the risk for lactic acidosis in patients with moderate renal impairment (stage 3a creatinine clearance [CrCl] 45–59 mL/min) and a cautious approach is recommended. Reduction of the metformin dose should be highly considered.

The combination of lamivudine with cladribine is not recommended (see section 4.5).

Triumeq should not be taken with any other medicinal products containing dolutegravir, abacavir, lamivudine or emtricitabine, except where a dose adjustment of dolutegravir is indicated due to drug-drug interactions (see section 4.5).

Excipients

Triumeq contains less than 1 mmol sodium (23 mg) per tablet, that is to say is essentially 'sodium free'.

4.5 Interaction with other medicinal products and other forms of interaction

Triumeq contains dolutegravir, abacavir and lamivudine, therefore any interactions identified for these individually are relevant to Triumeq. No clinically significant drug interactions are expected between dolutegravir, abacavir and lamivudine.

Effect of other medicinal products on the pharmacokinetics of dolutegravir, abacavir and lamivudine

Dolutegravir is eliminated mainly through metabolism by uridine diphosphate glucuronosyl transferase (UGT) 1A1. Dolutegravir is also a substrate of UGT1A3, UGT1A9, CYP3A4, P-glycoprotein (P-gp), and breast cancer resistance protein (BCRP). Co-administration of Triumeq and other medicinal products that inhibit UGT1A1, UGT1A3, UGT1A9, CYP3A4, and/or P-gp may therefore increase dolutegravir plasma concentration. Medicinal products that induce those enzymes or transporters may decrease dolutegravir plasma concentration and reduce the therapeutic effect of dolutegravir (see Table 3).

The absorption of dolutegravir is reduced by certain anti-acid medicinal products (see Table 3).

Abacavir is metabolised by UGT (UGT2B7) and alcohol dehydrogenase; co-administration of inducers (e.g. rifampicin, carbamazepine and phenytoin) or inhibitors (e.g. valproic acid) of UGT enzymes or with compounds eliminated through alcohol dehydrogenase could alter abacavir exposure.

Lamivudine is cleared renally. Active renal secretion of lamivudine in the urine is mediated through the OCT2 and multidrug and toxin extrusion transporters (MATE1 and MATE2-K). Trimethoprim (an inhibitor of these drug transporters) has been shown to increase lamivudine plasma concentrations, however the resulting increase was not clinically significant (see Table 3). Dolutegravir is an OCT2 and MATE1 inhibitor; however, lamivudine concentrations were similar with or without co-administration of dolutegravir based on a cross study analysis, indicating that dolutegravir has no effect on lamivudine exposure *in vivo*. Lamivudine is also a substrate of the hepatic uptake transporter OCT1. As hepatic elimination plays a minor role in the clearance of lamivudine, drug interactions due to inhibition of OCT1 are unlikely to be of clinical significance.

Although abacavir and lamivudine are substrates of BCRP and P-gp *in vitro*, given the high absolute bioavailability of abacavir and lamivudine, (see section 5.2), inhibitors of these efflux transporters are unlikely to result in a clinically relevant impact on abacavir or lamivudine concentrations.

Effect of dolutegravir, abacavir and lamivudine on the pharmacokinetics of other medicinal products

In vivo, dolutegravir did not have an effect on midazolam, a CYP3A4 probe. Based on *in vivo* and/or *in vitro* data, dolutegravir is not expected to affect the pharmacokinetics of medicinal products that are substrates of any major enzyme or transporter such as CYP3A4, CYP2C9 and P-gp (for more information see section 5.2).

In vitro, dolutegravir inhibited the renal transporters OCT2 and MATE1. *In vivo*, a 10-14% decrease of creatinine clearance (secretory fraction is dependent on OCT2 and MATE1 transport) was observed in patients. *In vivo*, dolutegravir may increase plasma concentrations of medicinal products in which excretion is dependent upon OCT2 and/or MATE1 (e.g. fampridine [also known as dalfampridine], metformin) (see Table 3).

In vitro, dolutegravir inhibited the renal uptake organic anion transporters (OAT)1 and OAT3. Based on the lack of effect on the *in vivo* pharmacokinetics of the OAT substrate tenofovir, *in vivo* inhibition of OAT1 is unlikely. Inhibition of OAT3 has not been studied *in vivo*. Dolutegravir may increase plasma concentrations of medicinal products in which excretion is dependent upon OAT3.

In vitro, abacavir demonstrated the potential to inhibit CYP1A1 and limited potential to inhibit metabolism mediated by CYP3A4. Abacavir was an inhibitor of MATE1; the clinical consequences are not known.

In vitro, lamivudine was an inhibitor of OCT1 and OCT2; the clinical consequences are not known.

Established and theoretical interactions with selected antiretrovirals and non-antiretroviral medicinal products are listed in Table 3.

Interaction table

Interactions between dolutegravir, abacavir, lamivudine and co-administered medical products are listed in Table 3 (increase is indicated as “↑”, decrease as “↓”, no change as “↔”, area under the concentration versus time curve as “AUC”, maximum observed concentration as “C_{max}”, concentration at end of dosing interval as “C_τ”). The table should not be considered exhaustive but is representative of the classes studied.

Table 3: Drug interactions

Medicinal products by therapeutic areas	Interaction geometric mean change (%)	Recommendations concerning co-administration
Antiretroviral medicinal products		
<i>Non-nucleoside reverse transcriptase inhibitors (Non-NRTIs)</i>		
Etravirine without boosted protease inhibitors / Dolutegravir	Dolutegravir ↓ AUC ↓ 71% C _{max} ↓ 52% C _τ ↓ 88% Etravirine ↔ (induction of UGT1A1 and CYP3A enzymes)	Etravirine without boosted protease inhibitors decreased plasma dolutegravir concentration. The recommended dose of dolutegravir should be adjusted for patients taking etravirine without boosted protease inhibitors. Dosing recommendations are provided in Table 2 (see section 4.2)
Lopinavir+ritonavir+etravirine/ Dolutegravir	Dolutegravir ↔ AUC ↑ 11% C _{max} ↑ 7% C _τ ↑ 28% Lopinavir ↔ Ritonavir ↔ Etravirine ↔	No dose adjustment is necessary.
Darunavir+ritonavir+etravirine/ Dolutegravir	Dolutegravir ↓ AUC ↓ 25% C _{max} ↓ 12% C _τ ↓ 36% Darunavir ↔ Ritonavir ↔ Etravirine ↔	No dose adjustment is necessary.
Efavirenz/Dolutegravir	Dolutegravir ↓ AUC ↓ 57% C _{max} ↓ 39% C _τ ↓ 75% Efavirenz ↔ (historical controls) (induction of UGT1A1 and CYP3A enzymes)	The recommended dose of dolutegravir should be adjusted when co-administered with efavirenz. Dosing recommendations are provided in Table 2 (see section 4.2)
Nevirapine/Dolutegravir	Dolutegravir ↓ (Not studied, a similar reduction in exposure as observed with efavirenz is	Co-administration with nevirapine may decrease dolutegravir plasma concentration due to enzyme induction and has not been studied. Effect of nevirapine on dolutegravir exposure is

	expected, due to induction)	likely similar to or less than that of efavirenz. The recommended dose of dolutegravir should be adjusted when co-administered with nevirapine. Dosing recommendations are provided in Table 2 (see section 4.2)
Rilpivirine	Dolutegravir ↔ AUC ↑ 12% C _{max} ↑ 13% C _τ ↑ 22% Rilpivirine ↔	No dose adjustment is necessary.
<i>Nucleoside reverse transcriptase inhibitors (NRTIs)</i>		
Tenofovir	Dolutegravir ↔ AUC ↑ 1% C _{max} ↓ 3% C _τ ↓ 8% Tenofovir ↔	No dose adjustment is necessary when Triumeq is combined with nucleoside reverse transcript inhibitors.
Emtricitabine, didanosine, stavudine, zidovudine.	Interaction not studied	Triumeq is not recommended for use in combination with emtricitabine containing products, since both lamivudine (in Triumeq) and emtricitabine are cytidine analogues (i.e. risk for intracellular interactions, (see section 4.4))
<i>Protease inhibitors</i>		
Atazanavir/Dolutegravir	Dolutegravir ↑ AUC ↑ 91% C _{max} ↑ 50% C _τ ↑ 180% Atazanavir ↔ (historical controls) (inhibition of UGT1A1 and CYP3A enzymes)	No dose adjustment is necessary.
Atazanavir+ ritonavir/ Dolutegravir	Dolutegravir ↑ AUC ↑ 62% C _{max} ↑ 34% C _τ ↑ 121% Atazanavir ↔ Ritonavir ↔	No dose adjustment is necessary.
Tipranavir+ritonavir/ Dolutegravir	Dolutegravir ↓ AUC ↓ 59% C _{max} ↓ 47% C _τ ↓ 76% Tipranavir ↔ Ritonavir ↔ (induction of UGT1A1 and CYP3A enzymes)	The recommended dose of-dolutegravir should be adjusted when co-administered with tipranavir/ritonavir. Dosing recommendations are provided in Table 2 (see section 4.2)
Fosamprenavir+ritonavir/ Dolutegravir	Dolutegravir ↓ AUC ↓ 35%	Fosamprenavir/ritonavir decreases dolutegravir concentrations, but based

	C_{max} ↓ 24% C_{τ} ↓ 49% Fosamprenavir ↔ Ritonavir ↔ (induction of UGT1A1 and CYP3A enzymes)	on limited data, did not result in decreased efficacy in Phase III studies. No dose adjustment is necessary.
Lopinavir+ritonavir/ Dolutegravir	Dolutegravir ↔ AUC ↓ 4% C_{max} ↔ 0% C_{24} ↓ 6% Lopinavir ↔ Ritonavir ↔	No dose adjustment is necessary.
Lopinavir+ritonavir/ Abacavir	Abacavir AUC ↓ 32%	
Darunavir+ritonavir/ Dolutegravir	Dolutegravir ↓ AUC ↓ 22% C_{max} ↓ 11% C_{τ} ↓ 38% Darunavir ↔ Ritonavir ↔ (induction of UGT1A1 and CYP3A enzymes)	No dose adjustment is necessary.
Other antiviral agents		
Daclatasvir/Dolutegravir	Dolutegravir ↔ AUC ↑ 33% C_{max} ↑ 29% C_{τ} ↑ 45% Daclatasvir ↔	Daclatasvir did not change dolutegravir plasma concentration to a clinically relevant extent. Dolutegravir did not change daclatasvir plasma concentration. No dose adjustment is necessary.
Anti-infective products		
Trimethoprim/sulfamethoxazole (Co-trimoxazole)/Abacavir Trimethoprim/sulfamethoxazole (Co-trimoxazole)/Lamivudine (160mg/800mg once daily for 5 days/300mg single dose)	Interaction not studied Lamivudine: AUC ↑ 43% C_{max} ↑ 7% Trimethoprim: AUC ↔ Sulfamethoxazole: AUC ↔ (organic cation transporter inhibition)	No Triumeq dose adjustment necessary, unless patient has renal impairment (See Section 4.2).
Antimycobacterials		
Rifampicin/Dolutegravir	Dolutegravir ↓ AUC ↓ 54% C_{max} ↓ 43% C_{τ} ↓ 72% (induction of UGT1A1 and CYP3A enzymes)	The dose of dolutegravir should be adjusted when co-administered with rifampicin. Dosing recommendations are provided in Table 2 (see section 4.2)

Rifabutin	Dolutegravir ↔ AUC ↓ 5% C _{max} ↑ 16% C _τ ↓ 30% (induction of UGT1A1 and CYP3A enzymes)	No dose adjustment is necessary.
Anticonvulsants		
Carbamazepine/Dolutegravir	Dolutegravir ↓ AUC ↓ 49% C _{max} ↓ 33% C _τ ↓ 73%	The recommended dose of dolutegravir should be adjusted when co-administered with carbamazepine. Dosing recommendations are provided in Table 2 (see section 4.2)
Phenobarbital/Dolutegravir Phenytoin/Dolutegravir Oxcarbazepine/Dolutegravir	Dolutegravir ↓ (Not studied, decrease expected due to induction of UGT1A1 and CYP3A enzymes, a similar reduction in exposure as observed with carbamazepine is expected)	The recommended dose of dolutegravir should be adjusted when co-administered with these metabolic inducers. Dosing recommendations are provided in Table 2 (see section 4.2)
Antihistamines (histamine H2 receptor antagonists)		
Ranitidine	Interaction not studied. Clinically significant interaction unlikely.	No dose adjustment necessary.
Cimetidine	Interaction not studied. Clinically significant interaction unlikely.	No dose adjustment necessary.
Cytotoxics		
Cladribine/Lamivudine	Interaction not studied. <i>In vitro</i> lamivudine inhibits the intracellular phosphorylation of cladribine leading to a potential risk of cladribine loss of efficacy in case of combination in the clinical setting. Some clinical findings also support a possible interaction between lamivudine and cladribine	Concomitant use of Triumeq with cladribine is not recommended (see section 4.4).
Opioids		
Methadone/Abacavir (40 to 90mg once daily for 14 days/600mg single dose, then 600mg twice daily for 14 days)	Abacavir: AUC ↔ C _{max} ↓ 35% Methadone: CL/F ↑ 22%	Methadone dose adjustment likely not needed in majority of patients; occasionally methadone re-titration may be required.

Retinoids		
Retinoid compounds (e.g. Isotretinoin)	Interaction not studied Possible interaction given common pathway of elimination via alcohol dehydrogenase (abacavir-component).	Insufficient data to recommend dose adjustment.
Miscellaneous		
<i>Alcohol</i>		
Ethanol/Dolutegravir Ethanol/Lamivudine Ethanol/Abacavir (0.7 g/kg single dose/600mg single dose)	Interaction not studied (Inhibition of alcohol dehydrogenase) Abacavir: AUC ↑ 41% Ethanol: AUC ↔	No dose adjustment necessary.
<i>Sorbitol</i>		
Sorbitol solution (3.2 g, 10.2 g, 13.4 g)/Lamivudine	Single dose lamivudine oral solution 300 mg Lamivudine: AUC ↓ 14%; 32%; 36% C _{max} ↓ 28%; 52%, 55%.	When possible, avoid chronic coadministration of Triumeq with medicinal products containing sorbitol or other osmotic acting poly-alcohols or monosaccharide alcohols (eg: xylitol, mannitol, lactitol, maltitol). Consider more frequent monitoring of HIV-1 viral load when chronic coadministration cannot be avoided.
<i>Potassium channel blockers</i>		
Fampridine (also known as dalfampridine)/Dolutegravir	Fampridine ↑	Co-administration of dolutegravir has the potential to cause seizures due to increased fampridine plasma concentration via inhibition of OCT2 transporter; co-administration has not been studied. Fampridine co-administration with Triumeq is contraindicated (see section 4.3).
<i>Antacids and supplements</i>		
Magnesium/ aluminium-containing antacids/Dolutegravir	Dolutegravir ↓ AUC ↓ 74% C _{max} ↓ 72% (Complex binding to polyvalent ions)	Magnesium/ aluminium-containing antacids should be taken well separated in time from the administration of Triumeq (minimum 2 hours after or 6 hours before the intake of Triumeq).
Calcium supplements/Dolutegravir	Dolutegravir ↓ AUC ↓ 39% C _{max} ↓ 37% C ₂₄ ↓ 39% (Complex binding to polyvalent ions)	- When taken with food, Triumeq and supplements or multivitamins containing calcium, iron or magnesium can be taken at the same time. - If Triumeq is taken in a fasted state, such supplements should be taken a minimum 2 hours after or 6 hours before the intake of Triumeq.
Iron supplements/Dolutegravir	Dolutegravir ↓ AUC ↓ 54% C _{max} ↓ 57% C ₂₄ ↓ 56%	

	(Complex binding to polyvalent ions)	The stated reductions in dolutegravir exposure were observed with the intake of dolutegravir and these supplements during fasted conditions. In fed state, the changes in exposure following intake together with calcium or iron supplements were modified by the food effect, resulting in an exposure similar to that obtained with dolutegravir administered in the fasted state.
Multivitamins (containing calcium, iron and magnesium) /Dolutegravir	Dolutegravir ↓ AUC ↓ 33% C _{max} ↓ 35% C ₂₄ ↓ 32%	
<i>Corticosteroids</i>		
Prednisone	Dolutegravir ↔ AUC ↑ 11% C _{max} ↑ 6% C _t ↑ 17%	No dose adjustment is necessary.
<i>Antidiabetics</i>		
Metformin/Dolutegravir	Metformin ↑ Dolutegravir ↔ When co-administered with dolutegravir 50mg QD: Metformin AUC ↑ 79% C _{max} ↑ 66% When co-administered with dolutegravir 50mg BID: Metformin AUC ↑ 145 % C _{max} ↑ 111%	A dose adjustment of metformin should be considered when starting and stopping coadministration of dolutegravir with metformin, to maintain glycaemic control. In patients with moderate renal impairment a dose adjustment of metformin should be considered when coadministered with dolutegravir, because of the increased risk for lactic acidosis in patients with moderate renal impairment due to increased metformin concentration (section 4.4).
<i>Herbal products</i>		
St. John's wort/Dolutegravir	Dolutegravir ↓ (Not studied, decrease expected due to induction of UGT1A1 and CYP3A enzymes, a similar reduction in exposure as observed with carbamazepine is expected)	The recommended dose of dolutegravir should be adjusted when co-administered with St. John's wort. Dosing recommendations are provided in Table 2 (see section 4.2)
<i>Oral contraceptives</i>		
Ethinyl estradiol (EE) and Norgestromin (NGMN)/Dolutegravir	Effect of dolutegravir: EE ↔ AUC ↑ 3% C _{max} ↓ 1% Effect of dolutegravir: NGMN ↔ AUC ↓ 2% C _{max} ↓ 11%	Dolutegravir had no Pharmacodynamic effect on Luteinizing Hormone (LH), Follicle Stimulating Hormone (FSH) and progesterone. No dose adjustment of oral contraceptives is necessary when co-administered with Triumeq.
<i>Antihypertensive</i>		
Riociguat/Abacavir	Riociguat ↑ <i>In vitro</i> , abacavir inhibits CYP1A1. Concomitant administration of a single	Riociguat dose may need to be reduced, consult the riociguat prescribing information for dosing recommendations.

	dose of riociguat (0.5 mg) to HIV patients receiving Triumeq led to an approximately three-fold higher riociguat AUC _(0-∞) when compared to historical riociguat AUC _(0-∞) reported in healthy subjects.	
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Paediatric population

Interaction studies have only been performed in adults.

4.6 Fertility, pregnancy and lactation

Pregnancy

Triumeq can be used during pregnancy if clinically needed.

A large amount of data on pregnant women (more than 1000 exposed outcomes) indicate no malformative nor fetotoxicity associated with dolutegravir. In pregnant women treated with abacavir, a large amount of data (more than 1000 exposed outcomes) indicate no malformative nor fetotoxicity. In pregnant women treated with lamivudine, a large amount of data (more than 1000 exposed outcomes) indicate no malformative nor fetotoxicity.

There are no or limited amount of data (less than 300 pregnancy outcomes) on the use of this triple combination in pregnancy.

Two large birth outcome surveillance studies (more than 14,000 pregnancy outcomes) in Botswana (Tsepamo) and Eswatini, and other sources, do not indicate an increased risk for neural tube defects after dolutegravir exposure.

The incidence of neural tube defects in the general population ranges from 0.5-1 case per 1,000 live births (0.05-0.1%).

Data from the Tsepamo study show no significant difference in the prevalence of neural tube defects (0.11%) in infants whose mothers were taking dolutegravir at conception (more than 9,400 exposures) compared to those taking non-dolutegravir containing antiretroviral regimens at conception (0.11%), or compared to women without HIV (0.07%).

Data from the Eswatini study show the same prevalence of neural tube defects (0.08%) in infants whose mothers were taking dolutegravir at conception (more than 4,800 exposures), as infants of women without HIV (0.08%).

Data analysed from the Antiretroviral Pregnancy Registry (APR) of more than 1000 pregnancies with first trimester dolutegravir treatment, more than 1000 pregnancies with first trimester abacavir treatment and more than 1000 pregnancies with first trimester lamivudine treatment do not indicate an increased risk of major birth defects with dolutegravir, lamivudine or abacavir compared to the background rate or women with HIV. There are no or limited amount of APR data (less than 300 first trimester exposures) from the use of dolutegravir + lamivudine + abacavir in pregnant women..

In animal reproductive toxicology studies with dolutegravir, no adverse development outcomes, including neural tube defects, were identified (see section 5.3).

Dolutegravir crosses the placenta in humans. In pregnant women living with HIV, the median foetal umbilical cord concentration of dolutegravir was approximately 1.3-fold greater compared with the maternal peripheral plasma concentration. Placental transfer of abacavir and/or its related metabolites has been shown to occur in humans. Placental transfer of lamivudine has been shown to occur in humans.

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

Animal studies with abacavir have shown toxicity to the developing embryo and foetus in rats, but not in rabbits. Animal studies with lamivudine showed an increase in early embryonic deaths in rabbits but not in rats (see section 5.3).

Abacavir and lamivudine may inhibit cellular DNA replication and abacavir has been shown to be carcinogenic in animal models (see section 5.3). The clinical relevance of these findings is unknown.

Mitochondrial dysfunction

Nucleoside and nucleotide analogues have been demonstrated *in vitro* and *in vivo* to cause a variable degree of mitochondrial damage. There have been reports of mitochondrial dysfunction in HIV-negative infants exposed *in utero* and/or post-natally to nucleoside analogues (see section 4.4).

Breast-feeding

Dolutegravir is excreted in human milk in small amounts (a median dolutegravir breast milk to maternal plasma ratio of 0.033 has been shown). There is insufficient information on the effects of dolutegravir in neonates/infants.

Abacavir and its metabolites are excreted into the milk of lactating rats. Abacavir is also excreted into human milk.

Based on more than 200 mother/child pairs treated for HIV, serum concentrations of lamivudine in breastfed infants of mothers treated for HIV are very low (< 4% of maternal serum concentrations) and progressively decrease to undetectable levels when breastfed infants reach 24 weeks of age. There are no data available on the safety of abacavir and lamivudine when administered to babies less than three months old.

It is recommended that women living with HIV do not breast-feed their infants in order to avoid transmission of HIV.

Fertility

There are no data on the effects of dolutegravir, abacavir or lamivudine on human male or female fertility. Animal studies indicate no effects of dolutegravir, abacavir or lamivudine on male or female fertility (see section 5.3).

4.7 Effects on ability to drive and use machines

Triumeq has no or negligible influence on the ability to drive and use machines. Patients should be informed that dizziness has been reported during treatment with dolutegravir.

4.8 Undesirable effects

Summary of the safety profile

The most frequently reported adverse reactions related to dolutegravir and abacavir/lamivudine were nausea (12%), insomnia (7%), dizziness (6%) and headache (6%).

Many of the adverse reactions listed in the table below occur commonly (nausea, vomiting, diarrhoea, fever, lethargy, rash) in patients with abacavir hypersensitivity. Therefore, patients with any of these symptoms should be carefully evaluated for the presence of this hypersensitivity (see section 4.4). Very rarely cases of erythema multiforme, Stevens-Johnson syndrome or toxic epidermal necrolysis have been reported where abacavir hypersensitivity could not be ruled out. In such cases medicinal products containing abacavir should be permanently discontinued.

The most severe adverse reaction related to the treatment with dolutegravir and abacavir/lamivudine, seen in individual patients, was a hypersensitivity reaction that included rash and severe liver effects (see section 4.4 and Description of selected adverse reactions in this section).

Tabulated list of adverse reactions

The adverse reactions with the components of Triumeq from clinical study and post-marketing experience are listed in Table 4 by body system, organ class and absolute frequency. Frequencies are defined as very common ($\geq 1/10$), common ($\geq 1/100$ to $< 1/10$), uncommon ($\geq 1/1\ 000$ to $< 1/100$), rare ($\geq 1/10\ 000$ to $< 1/1\ 000$), very rare ($< 1/10\ 000$), and not known (cannot be estimated from the available data).

Table 4: Tabulated list of adverse reactions associated with the combination of dolutegravir + abacavir/lamivudine in an analysis of pooled data from: Phase IIb to Phase IIIb clinical studies or post-marketing experience; and adverse reactions to treatment with dolutegravir, abacavir and lamivudine from clinical studies and post-marketing experience when used with other antiretrovirals

Frequency	Adverse reaction
<i>Blood and lymphatic systems disorders:</i>	
Uncommon:	Neutropenia ¹ , anaemia ¹ , thrombocytopenia ¹
Very rare:	pure red cell aplasia ¹
Not known	sideroblastic anaemia ²
<i>Immune system disorders:</i>	
Common:	hypersensitivity (see section 4.4)
Uncommon:	immune reconstitution syndrome (see section 4.4)
<i>Metabolism and nutrition disorders:</i>	
Common:	anorexia ¹
Uncommon:	hypertriglyceridaemia, hyperglycaemia
Very rare:	lactic acidosis ¹
<i>Psychiatric disorders:</i>	
Very common:	insomnia
Common:	abnormal dreams, depression, anxiety ¹ , nightmare, sleep disorder
Uncommon:	suicidal ideation or suicide attempt (particularly in patients with a pre-existing history of depression or psychiatric illness), panic attack
Rare:	completed suicide (particularly in patients with a pre-existing history of depression or psychiatric illness)
<i>Nervous system disorders:</i>	

Very common:	headache
Common:	dizziness, somnolence, lethargy ¹
Very rare:	peripheral neuropathy ¹ , paraesthesia ¹
<i>Respiratory, thoracic and mediastinal disorders:</i>	
Common:	cough ¹ , nasal symptoms ¹
<i>Gastrointestinal disorders:</i>	
Very common:	nausea, diarrhoea
Common:	vomiting, flatulence, abdominal pain, abdominal pain upper, abdominal distension, abdominal discomfort, gastro-oesophageal reflux disease, dyspepsia
Rare:	pancreatitis ¹
<i>Hepatobiliary disorders:</i>	
Common:	alanine aminotransferase (ALT) and/or aspartate aminotransferase (AST) elevations
Uncommon:	hepatitis
Rare:	acute hepatic failure ¹ , increased bilirubin ³
<i>Skin and subcutaneous tissue disorders:</i>	
Common:	rash, pruritus, alopecia ¹
Very rare:	erythema multiform ¹ , Stevens-Johnson syndrome ¹ , toxic epidermal necrolysis ¹
<i>Musculoskeletal and connective tissue disorders:</i>	
Common:	Arthralgia ¹ , muscle disorders ¹ (including myalgia ¹)
Rare:	rhabdomyolysis ¹
<i>General disorders and administration site conditions:</i>	
Very common:	fatigue
Common:	asthenia, fever ¹ , malaise ¹
<i>Investigations:</i>	
Common:	CPK elevations, weight increased
Rare:	amylase elevations ¹
<p>¹This adverse reaction was identified from clinical studies or post-marketing experience for dolutegravir, abacavir or lamivudine when used with other antiretrovirals or post-marketing experience with Triumeq.</p> <p>²Reversible sideroblastic anaemia has been reported with dolutegravir-containing regimens. The contribution of dolutegravir in these cases is unclear.</p> <p>³In combination with increased transaminases.</p>	

Description of selected adverse reactions

Hypersensitivity reactions

Both abacavir and dolutegravir are associated with a risk for hypersensitivity reactions (HSR), which were observed more commonly with abacavir. Hypersensitivity reaction observed for each of these medicinal products (described below) share some common features such as fever and/or rash with

other symptoms indicating multi-organ involvement. Time to onset was typically 10-14 days for both abacavir and dolutegravir-associated reactions, although reactions to abacavir may occur at any time during therapy. Treatment with Triumeq must be stopped without delay if HSR cannot be ruled out on clinical grounds, and therapy with Triumeq or other abacavir or dolutegravir containing products must never be re-initiated. Please refer to section 4.4 for further details on patient management in the event of a suspected HSR to Triumeq.

Dolutegravir hypersensitivity

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

Abacavir hypersensitivity

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

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

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

Symptoms related to this HSR worsen with continued therapy and can be life-threatening and in rare instance, have been fatal.

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

Metabolic parameters

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

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 and autoimmune hepatitis) 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).

Changes in laboratory chemistries

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

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

Co-infection with Hepatitis B or C

In dolutegravir Phase III studies patients with hepatitis B and/or C co-infection were permitted to enrol provided that baseline liver chemistry tests did not exceed 5 times the upper limit of normal (ULN). Overall, the safety profile in patients co-infected with hepatitis B and/or C was similar to that observed in patients without hepatitis B or C co-infection, although the rates of AST and ALT abnormalities were higher in the subgroup with hepatitis B and/or C co-infection for all treatment groups.

Paediatric population

Based on data from IMPAACT 2019 study in 57 HIV-1 infected children (aged less than 12 years and weighing at least 6 kg) who received the recommended doses of either the Triumeq film-coated tablet or dispersible tablets, there were no additional safety issues beyond those observed in the adult population.

Based on available data with dolutegravir used in combination with other antiretroviral agents to treat infants, children and adolescents, there were no additional safety issues identified beyond those observed in the adult population.

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

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

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

Further management should be as clinically indicated or as recommended by the national poisons centre, where available. There is no specific treatment for an overdose of Triumeq. If overdose occurs, the patient should be treated supportively with appropriate monitoring, as necessary. Since lamivudine is dialysable, continuous haemodialysis could be used in the treatment of overdose, although this has not been studied. It is not known whether abacavir can be removed by peritoneal dialysis or haemodialysis. As dolutegravir is highly bound to plasma proteins, it is unlikely that it will be significantly removed by dialysis.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

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

Mechanism of action

Dolutegravir inhibits HIV integrase by binding to the integrase active site and blocking the strand transfer step of retroviral Deoxyribonucleic acid (DNA) integration which is essential for the HIV replication cycle.

Abacavir and lamivudine are potent selective inhibitors of HIV-1 and HIV-2. Both abacavir and lamivudine are metabolised sequentially by intracellular kinases to the respective 5'-triphosphates (TP) which are the active moieties with extended intracellular half-lives supporting once daily dosing (see section 5.2). Lamivudine-TP (an analogue for cytidine) and carbovir-TP (the active triphosphate form of abacavir, an analogue for guanosine) are substrates for and competitive inhibitors of HIV reverse transcriptase (RT). However, their main antiviral activity is through incorporation of the monophosphate form into the viral DNA chain, resulting in chain termination. Abacavir and lamivudine triphosphates show significantly less affinity for host cell DNA polymerases.

Pharmacodynamic effects

Antiviral activity in vitro

Dolutegravir, abacavir and lamivudine have been shown to inhibit replication of lab-strains and clinical isolates of HIV in a number of cell types, including transformed T cell lines, monocyte/macrophage derived lines and primary cultures of activated peripheral blood mononuclear cells (PBMCs) and monocyte/macrophages. The concentration of active substance necessary to effect viral replication by 50% (IC₅₀ - half maximal inhibitory concentration) varied according to virus and host cell type.

The IC₅₀ for dolutegravir in various lab-strains using PBMC was 0.5 nM, and when using MT-4 cells it ranged from 0.7-2 nM. Similar IC₅₀s were seen for clinical isolates without any major difference between subtypes; in a panel of 24 HIV-1 isolates of clades A, B, C, D, E, F and G and group O the mean IC₅₀ value was 0.2 nM (range 0.02-2.14). The mean IC₅₀ for 3 HIV-2 isolates was 0.18 nM (range 0.09-0.61).

The mean IC₅₀ for abacavir against lab-strains of HIV-1IIIIB and HIV-1HXB2 ranged from 1.4 to 5.8 µM. The median or mean IC₅₀ values for lamivudine against lab-strains of HIV-1 ranged from 0.007 to 2.3 µM. The mean IC₅₀ against lab-strains of HIV-2 (LAV2 and EHO) ranged from 1.57 to 7.5 µM for abacavir and from 0.16 to 0.51 µM for lamivudine.

The IC₅₀ values of abacavir against HIV-1 Group M subtypes (A-G) ranged from 0.002 to 1.179 µM, against Group O from 0.022 to 1.21 µM, and against HIV-2 isolates, from 0.024 to 0.49 µM. For lamivudine, the IC₅₀ values against HIV-1 subtypes (A-G) ranged from 0.001 to 0.170 µM, against Group O from 0.030 to 0.160 µM and against HIV-2 isolates from 0.002 to 0.120 µM in peripheral blood mononuclear cells.

HIV-1 isolates (CRF01_AE, n=12; CRF02_AG, n=12; and Subtype C or CRF_AC, n=13) from 37 untreated patients in Africa and Asia were susceptible to abacavir (IC₅₀ fold changes < 2.5), and lamivudine (IC₅₀ fold changes < 3.0), except for two CRF02_AG isolates with fold changes of 2.9 and 3.4 for abacavir. Group O isolates from antiviral naïve patients tested for lamivudine activity were highly sensitive.

The combination of abacavir and lamivudine has demonstrated antiviral activity in cell culture against non-subtype B isolates and HIV-2 isolates with equivalent antiviral activity as for subtype B isolates.

Antiviral activity in combination with other antiviral agents

No antagonistic effects *in vitro* were seen with dolutegravir and other antiretrovirals (tested agents: stavudine, abacavir, efavirenz, nevirapine, lopinavir, amprenavir, enfuvirtide, maraviroc, adefovir and raltegravir). In addition, ribavirin had no apparent effect on dolutegravir activity.

The antiviral activity of abacavir in cell culture was not antagonized when combined with the nucleoside reverse transcriptase inhibitors (NRTIs) didanosine, emtricitabine, lamivudine, stavudine, tenofovir, zalcitabine or zidovudine, the non-nucleoside reverse transcriptase inhibitor (NNRTI) nevirapine, or the protease inhibitor (PI) amprenavir.

No antagonistic effects *in vitro* were seen with lamivudine and other antiretrovirals (tested agents: abacavir, didanosine, nevirapine, zalcitabine, and zidovudine).

Effect of human serum

In 100% human serum, the mean fold shift for dolutegravir activity was 75-fold, resulting in protein adjusted IC₉₀ of 0.064 µg/mL. Plasma protein binding studies *in vitro* indicate that abacavir binds only low to moderately (~49%) to human plasma proteins at therapeutic concentrations. Lamivudine exhibits linear pharmacokinetics over the therapeutic dose range and displays low plasma protein binding (less than 36%).

Resistance

Resistance in vitro: (dolutegravir)

Serial passage is used to study resistance evolution *in vitro*. When using the lab-strain HIVIII during passage over 112 days, mutations selected appeared slowly, with substitutions at positions S153Y and F. These mutations were not selected in patients treated with dolutegravir in the clinical studies. Using strain NL432 mutations E92Q (fold change 3) and G193E (fold change 3) were selected. These mutations have been selected in patients with pre-existing raltegravir resistance and who were then treated with dolutegravir (listed as secondary mutations for dolutegravir).

In further selection experiments using clinical isolates of subtype B, mutation R263K was seen in all five isolates (after 20 weeks and onwards). In subtype C (n=2) and A/G (n=2) isolates the integrase substitution R263K was selected in one isolate, and G118R in two isolates. R263K was reported from two individual patients with subtype B and subtype C in the clinical program for ART experienced, INI naïve subjects, but without effects on dolutegravir susceptibility *in vitro*. G118R lowers the susceptibility to dolutegravir in site directed mutants (fold change 10), but was not detected in patients receiving dolutegravir in the Phase III program.

Primary mutations for raltegravir/elvitegravir (Q148H/R/K, N155H, Y143R/H/C, E92Q, T66I) do not affect the *in vitro* susceptibility of dolutegravir as single mutations. When mutations listed as secondary integrase inhibitor associated mutations (for raltegravir/elvitegravir) are added to primary

mutations (excluding at Q148) in experiments with site directed mutants, dolutegravir susceptibility remains at or near wildtype level. In the case of the Q148-mutation viruses, increasing dolutegravir fold change is seen as the number of secondary mutations increase. The effect of the Q148-based mutations (H/R/K) was also consistent with *in vitro* passage experiments with site directed mutants. In serial passage with strain NL432-based site directed mutants at N155H or E92Q, no further selection of resistance was seen (fold change unchanged around 1). In contrast, starting passage with mutants with mutation Q148H (fold change 1), a variety of raltegravir associated secondary mutations accumulated with a consequent increase of fold change to values >10. A clinically relevant phenotypic cut-off value (fold change vs wild type virus) has not been determined; genotypic resistance was a better predictor for outcome.

Seven hundred and five raltegravir resistant isolates from raltegravir experienced patients were analyzed for susceptibility to dolutegravir. Dolutegravir has a <10-fold change against 94% of the 705 clinical isolates.

Resistance in vivo: (dolutegravir)

In previously untreated patients receiving dolutegravir + 2 NRTIs in Phase IIb and Phase III, no development of resistance to the integrase class, or to the NRTI class was seen (n=876, follow-up of 48-96 weeks).

In patients with prior failed therapies, but naïve to the integrase class (SAILING study), integrase inhibitor substitutions were observed in 4/354 patients (follow-up 48 weeks) treated with dolutegravir, which was given in combination with an investigator selected background regimen (BR). Of these four, two subjects had a unique R263K integrase substitution, with a maximum fold change of 1.93, one subject had a polymorphic V151V/I integrase substitution, with maximum fold change of 0.92, and one subject had pre-existing integrase mutations and is assumed to have been integrase experienced or infected with integrase resistant virus by transmission. The R263K mutation was also selected *in vitro* (see above).

Resistance in vitro and in vivo: (abacavir and lamivudine)

Abacavir-resistant isolates of HIV-1 have been selected *in vitro* and *in vivo* and are associated with specific genotypic changes in the RT codon region (codons M184V, K65R, L74V and Y115F). During *in vitro* abacavir selection the M184V mutation occurred first and resulted in about a 2-fold increase in IC₅₀, below the abacavir clinical cut-off of 4.5-fold change. Continued passage in increasing concentrations of drug resulted in selection for double RT mutants 65R/184V and 74V/184V or triple RT mutant 74V/115Y/184V. Two mutations conferred a 7 to 8-fold change in abacavir susceptibility and combinations of three mutations were required to confer more than an 8-fold change in susceptibility.

HIV-1 resistance to lamivudine involves the development of a M184I or M184V amino acid change close to the active site of the viral RT. This variant arises both *in vitro* and in HIV-1 infected patients treated with lamivudine-containing antiretroviral therapy. M184V mutants display greatly reduced susceptibility to lamivudine and show diminished viral replicative capacity *in vitro*. M184V is associated with about a 2-fold increase in abacavir resistance but does not confer clinical resistance for abacavir.

Isolates resistant to abacavir may also show reduced sensitivity to lamivudine. The combination of abacavir/lamivudine has demonstrated decreased susceptibility to viruses with the substitutions K65R with or without the M184V/I substitution, and to viruses with L74V plus the M184V/I substitution.

Cross-resistance between dolutegravir or abacavir or lamivudine and antiretrovirals from other classes e.g. PIs or NNRTIs is unlikely.

Effects on electrocardiogram

No relevant effects were seen on the QTc interval, with doses of dolutegravir exceeding the clinical

dose by approximately 3-fold. Similar studies were not conducted with either abacavir or lamivudine.

Clinical efficacy and safety

The efficacy of Triumeq in HIV-infected, therapy naive subjects is based on the analyses of data from a number of trials. The analyses included two randomised, international, double-blind, active-controlled trials, SINGLE (ING114467) and SPRING-2 (ING113086), the international, open-label, active-controlled trial FLAMINGO (ING114915), and the randomised, open-label, active-controlled, multicentre, non-inferiority study ARIA (ING117172).

The STRIVING study (201147), was a randomised, open-label, active-controlled, multicentre, non-inferiority switch study in virologically suppressed subjects with no documented history of resistance to any class.

In SINGLE, 833 patients were treated with dolutegravir 50 mg film-coated tablets once daily plus fixed-dose abacavir-lamivudine (DTG + ABC/3TC) or fixed-dose efavirenz-tenofovir-emtricitabine (EFV/TDF/FTC). At baseline, median patient age was 35 years, 16% were female, 32% non-white, 7% had hepatitis C co-infection and 4% were CDC Class C, these characteristics were similar between treatment groups. Week 48 outcomes (including outcomes by key baseline covariates) are shown in Table 5.

Table 5: Virologic Outcomes of Randomised Treatment of SINGLE at 48 Weeks (Snapshot algorithm)

	48 weeks	
	DTG 50 mg + ABC/3TC once daily N=414	EFV/TDF/FTC once daily N=419
HIV-1 RNA <50 copies/mL	88%	81%
Treatment Difference*	7.4% (95% CI: 2.5%, 12.3%)	
Virologic non response†	5%	6%
No virologic data at Weeks 48 window	7%	13%
Reasons		
Discontinued study/study medicinal product due to adverse event or death‡	2%	10%
Discontinued study/study medicinal product for other reasons§	5%	3%
Missing data during window but on study	0	<1%
HIV-1 RNA <50 copies/mL by baseline covariates		
Baseline Plasma Viral Load (copies/mL)	n / N (%)	n / N (%)
≤100,000	253 / 280 (90%)	238 / 288 (83%)
>100,000	111 / 134 (83%)	100 / 131 (76%)
Baseline CD4+ (cells/ mm³)		
<200	45 / 57 (79%)	48 / 62 (77%)
200 to <350	143 / 163 (88%)	126 / 159 (79%)
≥350	176 / 194 (91%)	164 / 198 (83%)
Gender		
Male	307 / 347 (88%)	291 / 356 (82%)
Female	57 / 67 (85%)	47 / 63 (75%)
Race		
White	255 / 284 (90%)	238 / 285 (84%)

African-American/African Heritage/Other	109 / 130 (84%)	99 / 133 (74%)
Age (years)		
<50	319 / 361 (88%)	302 / 375 (81%)
≥50	45 / 53 (85%)	36 / 44 (82%)
<p>* Adjusted for baseline stratification factors. † Includes subjects who discontinued prior to Week 48 for lack or loss of efficacy and subjects who are ≥50 copies in the 48 week window. ‡ Includes subjects who discontinued due to an adverse event or death at any time point from Day 1 through the Week 48 analysis window if this resulted in no virologic data on treatment during the analysis window. § Includes reasons such as withdrew consent, loss to follow-up, moved, protocol deviation. Notes: ABC/3TC = abacavir 600 mg, lamivudine 300 mg in the form of Kivexa/Epzicom fixed dose combination (FDC) EFV/TDF/FTC = efavirenz 600 mg, tenofovir disoproxil 245 mg, emtricitabine 200 mg in the form of Atripla FDC.</p>		

In the primary 48 weeks analysis, the proportion of patients with virologic suppression in the dolutegravir + ABC/3TC arm, was superior to the EFV/TDF/FTC arm, $p=0.003$, the same treatment difference was observed in subjects defined by baseline HIV RNA level ($<$ or $>$ 100,000 copies/mL). The median time to viral suppression was shorter with ABC/3TC + DTG (28 vs 84 days, $p<0.0001$). The adjusted mean change in CD4+ T cell count from baseline were 267 cells versus 208 cells/mm³, respectively ($p<0.001$). Both the time to viral suppression and change from baseline analyses were pre-specified and adjusted for multiplicity. At 96 weeks, the response was 80% vs 72%, respectively. The difference in the endpoint remained statistically significant ($p=0.006$). The statistically higher responses on DTG+ABC/3TC were driven by a higher rate of withdrawals due to AEs in the EFV/TDF/FTC arm, irrespective of viral load strata. Overall treatment differences at Week 96 are applicable to patients with high and low Baseline viral loads. At 144 weeks in the open-label phase of SINGLE, virologic suppression was maintained, the DTG +ABC/3TC arm (71%) was superior to the EFV/TDF/FTC arm (63%), treatment difference was 8.3% (2.0, 14.6).

In SPRING-2, 822 patients were treated with either dolutegravir 50 mg film-coated tablets once daily or raltegravir 400 mg twice daily (blinded), both with fixed-dose ABC/3TC (around 40%) or TDF/FTC (around 60%), given open label. Baseline demographics and outcomes are summarised in Table 6. Dolutegravir was non-inferior to raltegravir, including within the subset of patients with the abacavir/lamivudine background regimen.

Table 6: Demographics and virologic outcomes of randomised treatment of SPRING-2 (snapshot algorithm)

	DTG 50 mg once daily + 2 NRTI N=411	RAL 400mg twice daily + 2 NRTI N=411
Demographics		
Median Age (years)	37	35
Female	15%	14%
Non-white	16%	14%
Hepatitis B and/or C	13%	11%
CDC class C	2%	2%
ABC/3TC backbone	41%	40%
Week 48 efficacy results		
HIV-1 RNA <50 copies/mL	88%	85%
Treatment difference*	2.5% (95% CI: -2.2%, 7.1%)	
Virologic non response†	5%	8%
No virologic data at Weeks 48 window	7%	7%
Reasons		
Discontinued study/study medicinal product due to adverse event or death‡	2%	1%
Discontinued study/study medicinal product for other reasons§	5%	6%
HIV-1 RNA <50 copies/mL for those on ABC/3TC	86%	87%
Week 96 efficacy results		
HIV-1 RNA <50 copies/mL	81%	76%
Treatment difference*	4.5% (95% CI: -1.1%, 10.0%)	
HIV-1 RNA <50 copies/mL for those on ABC/3TC	74%	76%
* Adjusted for baseline stratification factors.		
† Includes subjects who discontinued prior to Week 48 for lack or loss of efficacy and subjects who are ≥50 copies in the 48 week window.		
‡ Includes subjects who discontinued due to an adverse event or death at any time point from Day 1 through the Week 48 analysis window if this resulted in no virologic data on treatment during the analysis window.		
§ Includes reasons such as protocol deviation, lost to follow up, and withdrew consent.		
Notes: DTG = dolutegravir, RAL = raltegravir.		

In FLAMINGO, 485 patients were treated with dolutegravir 50 mg film-coated tablets once daily or darunavir/ritonavir (DRV/r) 800 mg/100 mg once daily, both with ABC/3TC (around 33%) or TDF/FTC (around 67%). All treatments were given open-label. Main demographics and outcomes are summarised in Table 7.

Table 7: Demographics and Week 48 virologic outcomes of randomised treatment of FLAMINGO (snapshot algorithm)

	DTG 50 mg once daily + 2 NRTI N=242	DRV+RTV 800mg + 100mg once daily +2 NRTI N=242
Demographics		
Median Age (years)	34	34
Female	13%	17%
Non-white	28%	27%
Hepatitis B and/or C	11%	8%
CDC class C	4%	2%
ABC/3TC backbone	33%	33%
Week 48 Efficacy Results		
HIV-1 RNA <50 copies/mL	90%	83%
Treatment Difference*	7.1% (95% CI: 0.9%, 13.2%)	
Virologic non response†	6%	7%
No virologic data at Weeks 48 window	4%	10%
<u>Reasons</u>		
Discontinued study/study medicinal product due to adverse event or death‡	1%	4%
Discontinued study/study medicinal product for other reasons§	2%	5%
Missing data during window but on study	<1%	2%
HIV-1 RNA <50copies/mL for those on ABC/3TC	90%	85%
Median time to viral suppression**	28 days	85 days
* Adjusted for baseline stratification factors, p=0.025. † Includes subjects who discontinued prior to Week 48 for lack or loss of efficacy and subjects who are ≥50 copies in the 48 week window. ‡ Includes subjects who discontinued due to an adverse event or death at any time point from Day 1 through the Week 48 analysis window if this resulted in no virologic data on treatment during the analysis window. § Includes reasons such as withdrew consent, loss to follow-up, protocol deviation. ** p<0.001. Notes: DRV+RTV = darunavir + ritonavir, DTG = dolutegravir.		

At 96 weeks, virologic suppression in the dolutegravir group (80%) was superior to the DRV/r group (68%), (adjusted treatment difference [DTG-(DRV+RTV)]: 12.4%; 95% CI: [4.7, 20.2]). Response rates at 96 weeks were 82% for DTG+ABC/3TC and 75% for DRV/r+ABC/3TC.

In ARIA (ING117172), a randomised, open-label, active-controlled, multicentre, parallel group, non-inferiority study; 499 HIV-1 infected ART naïve adult women were randomised 1:1 to receive either; DTG/ABC/3TC FDC film-coated tablets 50 mg/600 mg/300 mg; or atazanavir 300 mg plus ritonavir 100 mg plus tenofovir disproxil / emtricitabine 245 mg/200 mg (ATV+RTV+TDF/FTC FDC), all administered once daily.

Table 8: Demographics and Week 48 virologic outcomes of randomised treatment of ARIA (snapshot algorithm)

	DTG/ABC/3TC FDC N=248	ATV+RTV+TDF/FTC FDC N=247
Demographics		
Median Age (years)	37	37
Female	100 %	100 %
Non-white	54 %	57 %
Hepatitis B and/ or C	6 %	9%
CDC class C	4 %	4 %
Week 48 Efficacy Results		
HIV-1 RNA <50 copies/mL	82 %	71 %
Treatment difference	10.5 (3.1% to 17.8%) [p=0.005].	
Virologic Failure	6 %	14 %
<u>Reasons</u>		
Data in window not below 50 c/mL threshold	2 %	6 %
Discontinued for lack of efficacy	2 %	<1 %
Discontinued for other reason while not below threshold	3 %	7 %
No Virologic Data	12 %	15 %
Discontinued due to AE or death	4 %	7 %
Discontinued for other reasons	6 %	6 %
Missing data during window but on study	2 %	2 %
AE = Adverse event. HIV-1 - human immunodeficiency virus type 1 DTG/ABC/3TC FDC - abacavir/dolutegravir/lamivudine fixed-dose combination ATV+RTV+TDF/FTC FDC -atazanavir plus ritonavir plus tenofovir disproxil/emtricitabine fixed-dose combination		

STRIIVING (201147) is a 48-week, randomised, open-label, active controlled, multicentre, non-inferiority study in patients without any prior treatment failure, and without any documented resistance to any class. Virologically suppressed (HIV-1 RNA <50 c/mL) subjects were randomly assigned (1:1) to continue their current ART regimen (2 NRTIs plus either a PI, NNRTI, or INI), or switch to ABC/DTG/3TC FDC film-coated tablets once daily (Early Switch). Hepatitis B co-infection was one of the main exclusion criteria.

Patients were mainly white (66%) or black (28%) of male sex (87%). Main prior transmission routes were homosexual (73%) or heterosexual (29%) contact. The proportion with a positive HCV serology was 7%. The median time from first starting ART was around 4.5 years.

Table 9: Outcomes of randomised treatment of STRIIVING (snapshot algorithm)

Study Outcomes (Plasma HIV-1 RNA <50 c/mL) at Week 24 and Week 48 – Snapshot Analysis (ITT-E Population)				
	ABC/DTG/3TC FDC N=275 n (%)	Current ART N=278 n (%)	Early Switch ABC/DTG/3TC FDC N=275 n (%)	Late Switch ABC/DTG/3TC FDC N=244 n (%)
Outcome Time Point	Day 1 to W 24	Day 1 to W 24	Day 1 to W48	W24 to W48
Virologic Success	85 %	88 %	83 %	92 %
Virologic Failure	1 %	1 %	<1 %	1 %
<u>Reasons</u>				
Data in window not below threshold	1 %	1 %	<1 %	1 %
No Virologic Data	14 %	10 %	17 %	7 %
Discontinued due to AE or death	4 %	0 %	4 %	2 %
Discontinued for other reasons	9 %	10 %	12 %	3 %
Missing data during window but on study	1 %	<1 %	2 %	2 %
ABC/DTG/3TC FDC = abacavir/dolutegravir/lamivudine fixed-dose combination; AE = adverse event; ART = antiretroviral therapy; HIV-1 = human immunodeficiency virus type 1; ITT-E = intent-to-treat exposed; W = week.				

Virologic suppression (HIV-1 RNA <50 copies/mL) in the ABC/DTG/3TC FDC group (85%) was statistically non-inferior to the current ART groups (88%) at 24 weeks. The adjusted difference in proportion and 95% CI [ABC/DTG/3TC vs current ART] were 3.4%; 95% CI: [-9.1, 2.4]. After 24 weeks all remaining subjects switched to ABC/DTG/3TC FDC (Late Switch). Similar levels of virologic suppression were maintained in both the Early and Late Switch groups at 48 weeks.

De novo resistance in patients failing therapy in SINGLE, SPRING-2 and FLAMINGO

De novo resistance was not detected to the integrase class or the NRTI class in any patients who were treated with dolutegravir + abacavir/lamivudine in the three studies mentioned.

For the comparators typical resistance was detected with TDF/FTC/EFV (SINGLE; six with NNRTI associated resistance and one with major NRTI resistance) and with 2 NRTIs + raltegravir (SPRING-2; four with major NRTI resistance and one with raltegravir resistance), while no *de novo* resistance was detected in patients treated with 2 NRTIs + DRV/RTV (FLAMINGO).

Paediatric population

In a Phase I/II 48 week, open-label, multicentre, dose-finding clinical study (IMPAACT P1093/ING112578), the pharmacokinetic parameters, safety, tolerability and efficacy of dolutegravir were evaluated in combination with other antiretroviral medicinal products in treatment naïve or treatment-experienced, INSTI-naïve, HIV-1–infected subjects aged ≥ 4 weeks to < 18 years. Subjects were stratified by age cohort; subjects aged 12 to less than 18 years were enrolled in Cohort I and subjects aged 6 to less than 12 years were enrolled in Cohort IIA. Across both cohorts, 67% (16/24) of subjects who received the recommended dose (determined by weight and age) achieved HIV-1 RNA less than 50 copies per mL at Week 48 (Snapshot algorithm).

DTG/ABC/3TC FDC film-coated tablets and dispersible tablets were evaluated in treatment naïve or treatment-experienced, HIV-1 infected subjects aged <12 years and weighing ≥6 to <40 kg in an open-label, multicentre, clinical trial (IMPAACT 2019). 57 subjects weighing at least 6 kg who received the recommended dose and formulation (determined by weight band) contributed to the efficacy analyses at Week 48. Overall, 79% (45/57) and 95% (54/57) of subjects weighing at least 6 kg achieved HIV-1

RNA less than 50 copies per mL and less than 200 copies per mL, respectively, at Week 48 (Snapshot algorithm).

Abacavir and lamivudine once daily, in combination with a third antiretroviral medicinal product, were evaluated in a randomised, multicentre trial (ARROW) in HIV-1–infected, treatment-naïve subjects. Subjects randomised to once-daily dosing (n = 331) and who weighed at least 25 kg received abacavir 600 mg and lamivudine 300 mg, as either the single entities or as FDC. At Week 96, 69% of subjects receiving abacavir and lamivudine once-daily in combination with a third antiretroviral medicinal product, had HIV-1 RNA less than 80 copies per mL.

5.2 Pharmacokinetic properties

Triumeq film-coated tablet has been shown to be bioequivalent to dolutegravir single entity film-coated tablet and abacavir/lamivudine fixed-dose combination tablet (ABC/3TC FDC) administered separately. This was demonstrated in a single dose, 2-way crossover bioequivalence study of Triumeq (fasted) versus 1 x 50 mg dolutegravir tablet, plus 1 x 600mg abacavir/300 mg lamivudine tablet (fasted) in healthy subjects (n=66).

The relative bioavailability of abacavir and lamivudine administered in dispersible tablet form is comparable to film-coated tablets. The relative bioavailability of dolutegravir administered in dispersible tablet form is approximately 1.7-fold higher as compared to film-coated tablets. Thus, the Triumeq dispersible tablets are not directly interchangeable with Triumeq film-coated tablets (see section 4.2).

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

Absorption

Dolutegravir, abacavir and lamivudine are rapidly absorbed following oral administration. The absolute bioavailability of dolutegravir has not been established. The absolute bioavailability of oral abacavir and lamivudine in adults is about 83% and 80-85% respectively. The mean time to maximal serum concentrations (t_{max}) is about 2 to 3 hours (post dose for tablet formulation), 1.5 hours and 1.0 hour for dolutegravir, abacavir and lamivudine, respectively.

Exposure to dolutegravir was generally similar between healthy subjects and HIV-1–infected subjects. In HIV-1–infected adult subjects following dolutegravir 50 mg film-coated tablets once daily, the steady-state pharmacokinetic parameters (geometric mean [%CV]) based on population pharmacokinetic analyses were $AUC_{(0-24)} = 53.6$ (27) $\mu\text{g}\cdot\text{h}/\text{mL}$, $C_{max} = 3.67$ (20) $\mu\text{g}/\text{mL}$, and $C_{min} = 1.11$ (46) $\mu\text{g}/\text{mL}$. Following a single dose of 600 mg of abacavir, the mean (CV) C_{max} is 4.26 $\mu\text{g}/\text{ml}$ (28%) and the mean (CV) AUC_{∞} is 11.95 $\mu\text{g}\cdot\text{h}/\text{ml}$ (21%). Following multiple-dose oral administration of lamivudine 300 mg once daily for seven days, the mean (CV) steady-state C_{max} is 2.04 $\mu\text{g}/\text{ml}$ (26%) and the mean (CV) AUC_{24} is 8.87 $\mu\text{g}\cdot\text{h}/\text{ml}$ (21%).

The effect of a high fat meal on Triumeq dispersible tablet was evaluated in a single dose, 2-cohort, crossover study. Plasma C_{max} decreased for dolutegravir (29%), abacavir (55%), and lamivudine (36%) following administration of Triumeq dispersible tablets with a high fat meal. AUCs for all 3 components were not affected by food. These results indicate that Triumeq dispersible tablets can be taken with or without food.

Distribution

The apparent volume of distribution of dolutegravir (following oral administration of suspension formulation, V_d/F) is estimated at 12.5 L. Intravenous studies with abacavir and lamivudine showed that the mean apparent volume of distribution is 0.8 and 1.3 l/kg respectively.

Dolutegravir is highly bound (> 99%) to human plasma proteins based on *in vitro* data. Binding of dolutegravir to plasma proteins is independent of dolutegravir concentration. Total blood and plasma drug-related radioactivity concentration ratios averaged between 0.441 to 0.535, indicating minimal association of radioactivity with blood cellular components. The unbound fraction of dolutegravir in plasma is increased at low levels of serum albumin (<35 g/L) as seen in subjects with moderate hepatic impairment. Plasma protein binding studies *in vitro* indicate that abacavir binds only low to moderately (~49%) to human plasma proteins at therapeutic concentrations. Lamivudine exhibits linear pharmacokinetics over the therapeutic dose range and displays limited plasma protein binding *in vitro* (< 36%).

Dolutegravir, abacavir and lamivudine are present in cerebrospinal fluid (CSF).

In 13 treatment-naïve subjects on a stable dolutegravir plus abacavir/lamivudine regimen, dolutegravir concentration in CSF averaged 18 ng/mL (comparable to unbound plasma concentration, and above the IC₅₀). Studies with abacavir demonstrate a CSF to plasma AUC ratio of between 30 to 44%. The observed values of the peak concentrations are 9-fold greater than the IC₅₀ of abacavir of 0.08 µg/ml or 0.26 µM when abacavir is given at 600 mg twice daily. The mean ratio of CSF/serum lamivudine concentrations 2-4 hours after oral administration was approximately 12%. The true extent of CNS penetration of lamivudine and its relationship with any clinical efficacy is unknown.

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

Biotransformation

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

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

Metabolism of lamivudine is a minor route of elimination. Lamivudine is predominately cleared by renal excretion of unchanged lamivudine. The likelihood of metabolic drug interactions with lamivudine is low due to the small extent of hepatic metabolism (5-10%).

Drug interactions

In vitro, dolutegravir demonstrated no direct, or weak inhibition (IC₅₀>50 µM) of the enzymes cytochrome P₄₅₀ (CYP)1A2, CYP2A6, CYP2B6, CYP2C8, CYP2C9, CYP2C19, CYP2D6, CYP3A, UGT1A1 or UGT2B7, or the transporters Pgp, BCRP, BSEP, organic anion transporting polypeptide 1B1 (OATP1B1), OATP1B3, OCT1, MATE2-K, multidrug resistance-associated protein 2 (MRP2) or MRP4. *In vitro*, dolutegravir did not induce CYP1A2, CYP2B6 or CYP3A4. Based on this data, dolutegravir is not expected to affect the pharmacokinetics of medicinal products that are substrates of major enzymes or transporters (see section 4.5).

In vitro, dolutegravir was not a substrate of human OATP 1B1, OATP 1B3 or OCT 1.

In vitro, abacavir did not inhibit or induce CYP enzymes (other than CYP1A1 and CYP3A4 [limited potential], see section 4.5) and demonstrates no or weak inhibition of OATP1B1, OAT1B3, OCT1, OCT2, BCRP and P-gp or MATE2-K. Abacavir is therefore not expected to affect the plasma concentrations of medicinal products that are substrates of these enzymes or transporters.

Abacavir was not significantly metabolised by CYP enzymes. *In vitro*, abacavir was not a substrate of OATP1B1, OATP1B3, OCT1, OCT2, OAT1, MATE1, MATE2-K, MRP2 or MRP4 therefore medicinal products that modulate these transporters are not expected to affect abacavir plasma concentrations.

In vitro, lamivudine did not inhibit or induce CYP enzymes (such as CYP3A4, CYP2C9 or CYP2D6) and demonstrated no or weak inhibition of OATP1B1, OAT1B3, OCT3, BCRP, P-gp, MATE1 or MATE2-K. Lamivudine is therefore not expected to affect the plasma concentrations of medicinal products that are substrates of these enzymes or transporters.

Lamivudine was not significantly metabolised by CYP enzymes.

Elimination

Dolutegravir has a terminal half-life of ~14 hours. The apparent oral clearance (CL/F) is approximately 1 L/hr in HIV-infected patients based on a population pharmacokinetic analysis.

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

The observed lamivudine half-life of elimination is 18 to 19 hours. For patients receiving lamivudine 300 mg once daily, the terminal intracellular half-life of lamivudine-TP was 16 to 19 hours. The mean systemic clearance of lamivudine is approximately 0.32 L/h/kg, predominantly by renal clearance (> 70%) via the organic cationic transport system. Studies in patients with renal impairment show lamivudine elimination is affected by renal dysfunction. Dose reduction is required for patients with creatinine clearance < 30 mL/min (see section 4.2).

Pharmacokinetic/pharmacodynamic relationship(s)

In a randomised, dose-ranging trial, HIV-1-infected subjects treated with dolutegravir monotherapy (ING111521) demonstrated rapid and dose-dependent antiviral activity with mean decline in HIV-1 RNA of 2.5 log₁₀ at day 11 for 50 mg dose. This antiviral response was maintained for 3 to 4 days after the last dose in the 50 mg group.

Intracellular pharmacokinetics

The geometric mean terminal carbovir-TP intracellular half-life at steady-state was 20.6 hours, compared to the geometric mean abacavir plasma half-life of 2.6 hours. The terminal intracellular half-life of lamivudine-TP was prolonged to 16-19 hours, supporting once daily dosing of ABC and 3TC.

Special populations

Hepatic impairment

Pharmacokinetic data has been obtained for dolutegravir, abacavir and lamivudine separately.

Dolutegravir is primarily metabolised and eliminated by the liver. A single dose of 50 mg of dolutegravir was administered to 8 subjects with moderate hepatic impairment (Child-Pugh class B) and to 8 matched healthy adult controls. While the total dolutegravir concentration in plasma was similar, a 1.5 to 2-fold increase in unbound exposure to dolutegravir was observed in subjects with moderate hepatic impairment compared to healthy controls. No dose adjustment is considered necessary for patients with mild to moderate hepatic impairment. The effect of severe hepatic impairment on the pharmacokinetics of dolutegravir has not been studied.

Abacavir is metabolised primarily by the liver. The pharmacokinetics of abacavir have been studied in patients with mild hepatic impairment (Child-Pugh score 5-6) receiving a single 600 mg dose. The results showed that there was a mean increase of 1.89-fold [1.32; 2.70] in the abacavir AUC, and 1.58 [1.22; 2.04] fold in the elimination half-life. No recommendation on dose reduction is possible in patients with mild hepatic impairment due to substantial variability of abacavir exposure.

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

Based on data obtained for abacavir, Triumeq is not recommended in patients with moderate or severe hepatic impairment.

Renal impairment

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

Renal clearance of unchanged active substance is a minor pathway of elimination for dolutegravir. A study of the pharmacokinetics of dolutegravir was performed in subjects with severe renal impairment ($\text{CrCl} < 30 \text{ mL/min}$). No clinically important pharmacokinetic differences between subjects with severe renal impairment ($\text{CrCl} < 30 \text{ mL/min}$) and matching healthy subjects were observed. Dolutegravir has not been studied in patients on dialysis, though differences in exposure are not expected.

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

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

Based on the lamivudine data, Triumeq dispersible tablets are not recommended for patients with creatinine clearance of $< 50 \text{ mL/min}$ (see section 4.2).

Elderly

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

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

Paediatric population

The pharmacokinetics of dolutegravir film-coated and dispersible tablets in HIV-1 infected infants, children and adolescents aged ≥ 4 weeks to < 18 years were evaluated in two on-going studies (IMPACT P1093/ING112578 and ODYSSEY/201296). Mean dolutegravir $\text{AUC}_{0-24\text{h}}$ and $\text{C}_{24\text{h}}$ in HIV-1-infected paediatric subjects weighing at least 6 kg were comparable to those in adults after 50 mg once daily or 50 mg twice daily. Mean C_{max} is higher in paediatrics, but the increase is not considered clinically significant as the safety profiles were similar in paediatric and adult subjects.

The pharmacokinetics of Triumeq film-coated and dispersible tablets in HIV-1 infected, treatment naïve or treatment-experienced, children aged < 12 years were evaluated in a study (IMPACT 2019).

Mean dolutegravir, abacavir and lamivudine AUC_{0-24h}, C_{24h} and C_{max} at recommended doses for Triumeq film-coated and dispersible tablets in HIV-1 infected paediatric subjects weighing at least 6 kg to less than 40 kg were within the observed exposure ranges at the recommended doses of individual products in adults and paediatrics.

Pharmacokinetic data are available for abacavir and lamivudine in children and adolescents receiving recommended dose regimens of the oral solution and tablet formulations. Pharmacokinetic parameters are comparable to those reported in adults. In children and adolescents weighing 6 kg to less than 25 kg, at recommended doses, predicted exposures (AUC_{0-24h}) for abacavir and lamivudine with Triumeq dispersible tablets are within the predicted exposure range of the individual components based on population pharmacokinetic modelling and simulation.

Polymorphisms in drug metabolising enzymes

There is no evidence that common polymorphisms in drug metabolising enzymes alter dolutegravir pharmacokinetics to a clinically meaningful extent. In a meta-analysis using pharmacogenomics samples collected in clinical studies in healthy subjects, subjects with UGT1A1 (n=7) genotypes conferring poor dolutegravir metabolism had a 32% lower clearance of dolutegravir and 46% higher AUC compared with subjects with genotypes associated with normal metabolism via UGT1A1 (n=41).

Gender

Population PK analyses using pooled pharmacokinetic data from Phase IIb and Phase III adult trials revealed no clinically relevant effect of gender on the exposure of dolutegravir. There is no evidence that a dose adjustment of dolutegravir, abacavir or lamivudine would be required based on the effects of gender on PK parameters.

Race

Population PK analyses using pooled pharmacokinetic data from Phase IIb and Phase III adult trials revealed no clinically relevant effect of race on the exposure of dolutegravir. The pharmacokinetics of dolutegravir following single dose oral administration to Japanese subjects appear similar to observed parameters in Western (US) subjects. There is no evidence that a dose adjustment of dolutegravir, abacavir or lamivudine would be required based on the effects of race on PK parameters.

Co-infection with Hepatitis B or C

Population pharmacokinetic analysis indicated that hepatitis C virus co-infection had no clinically relevant effect on the exposure to dolutegravir. There are limited pharmacokinetic data on subjects with hepatitis B co-infection (see section 4.4).

5.3 Preclinical safety data

There are no data available on the effects of the combination of dolutegravir, abacavir and lamivudine in animals, except a negative *in vivo* rat micronucleus test which tested the effects of the combination of abacavir and lamivudine.

Mutagenicity and carcinogenicity

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

Neither abacavir nor lamivudine were mutagenic in bacterial tests, but consistent with other nucleoside analogues, inhibit cellular DNA replication in *in vitro* mammalian tests such as the mouse lymphoma assay. The results of an *in vivo* rat micronucleus test with abacavir and lamivudine in combination were negative.

Lamivudine has not shown any genotoxic activity in the *in vivo* studies. Abacavir has a weak potential to cause chromosomal damage both *in vitro* and *in vivo* at high tested concentrations.

The carcinogenic potential of a combination of dolutegravir, abacavir and lamivudine has not been tested. Dolutegravir was not carcinogenic in long term studies in the mouse and rat. In long-term oral carcinogenicity studies in rats and mice, lamivudine did not show any carcinogenic potential. Carcinogenicity studies with orally administered abacavir in mice and rats showed an increase in the incidence of malignant and non-malignant tumours. Malignant tumours occurred in the preputial gland of males and the clitoral gland of females of both species, and in rats in the thyroid gland of males and in the liver, urinary bladder, lymph nodes and the subcutis of females.

The majority of these tumours occurred at the highest abacavir dose of 330 mg/kg/day in mice and 600 mg/kg/day in rats. The exception was the preputial gland tumour which occurred at a dose of 110 mg/kg in mice. The systemic exposure at the no effect level in mice and rats was equivalent to 3 and 7 times the human systemic exposure during therapy. While the clinical relevance of these findings is unknown, these data suggest that a potential carcinogenic risk to humans is outweighed by the clinical benefit.

Repeat-dose toxicity

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

In toxicology studies abacavir was shown to increase liver weights in rats and monkeys. The clinical relevance of this is unknown. There is no evidence from clinical studies that abacavir is hepatotoxic. Additionally, autoinduction of abacavir metabolism or induction of the metabolism of other medicinal products hepatically metabolised has not been observed in humans.

Mild myocardial degeneration in the heart of mice and rats was observed following administration of abacavir for two years. The systemic exposures were equivalent to 7 to 21 times the expected systemic exposure in humans. The clinical relevance of this finding has not been determined.

Reproductive toxicology

In reproductive toxicity studies in animals, dolutegravir, lamivudine and abacavir were shown to cross the placenta.

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

Oral administration of dolutegravir to pregnant rabbits at doses up to 1000 mg/kg daily from days 6 to 18 of gestation did not elicit developmental toxicity or teratogenicity (0.74 times the 50mg human clinical exposure when administered in combination with abacavir and lamivudine based on AUC). In rabbits, maternal toxicity (decreased food consumption, scant/no faeces/urine, suppressed body weight gain) was observed at 1000 mg/kg (0.74 times the 50 mg human clinical exposure when administered in combination with abacavir and lamivudine based on AUC).

Lamivudine was not teratogenic in animal studies but there were indications of an increase in early embryonic deaths in rabbits at relatively low systemic exposures, comparable to those achieved in humans. A similar effect was not seen in rats even at very high systemic exposure.

Abacavir demonstrated toxicity to the developing embryo and foetus in rats, but not in rabbits. These findings included decreased foetal body weight, foetal oedema, and an increase in skeletal variations/malformations, early intra-uterine deaths and still births. No conclusion can be drawn with regard to the teratogenic potential of abacavir because of this embryo-foetal toxicity.

Fertility studies in rats have shown that dolutegravir, abacavir and lamivudine have no effect on male or female fertility.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Tablet core

Acesulfame Potassium

Crospovidone

Mannitol (E421)

Microcrystalline Cellulose

Povidone

Silicified Microcrystalline Cellulose (cellulose, microcrystalline; silica, colloidal anhydrous)

Sodium Starch Glycolate

Sodium Stearyl Fumarate

Strawberry Cream Flavour

Sucralose

Tablet coating

Iron Oxide Yellow (E172)

Macrogol

Polyvinyl Alcohol-Part Hydrolyzed

Talc

Titanium Dioxide (E171)

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

4 years

6.4 Special precautions for storage

Store in the original package in order to protect from moisture. Keep the bottle tightly closed. Do not remove the desiccant. Do not swallow the desiccant.

This medicinal product does not require any special temperature storage conditions.

6.5 Nature and contents of container

Opaque, white HDPE (high density polyethylene) bottles closed with polypropylene child-resistant closures, with a polyethylene faced induction heat seal liner.

Each bottle contains 90 dispersible tablets and a desiccant.

A plastic dosing cup with graduation marks at 5 mL intervals, between 15 mL and 40 mL, is supplied with the pack.

6.6 Special precautions for disposal and other handling

The dispersible tablet must be dispersed in drinking water. The tablet(s) should be fully dispersed in 20 mL of drinking water (if using 4, 5 or 6 tablets) or 15 mL of drinking water (if using 3 tablets), in the supplied dosing cup, before swallowing and must be given within 30 minutes of preparation (see section 4.2 and Step-by-step instructions for use).

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

7. MARKETING AUTHORISATION HOLDER

ViiV Healthcare BV
Van Asch van Wijckstraat 55H
3811 LP Amersfoort
Netherlands

8. MARKETING AUTHORISATION NUMBER(S)

EU/1/14/940/003

9. DATE OF FIRST AUTHORISATION/RENEWAL OF THE AUTHORISATION

Date of first authorisation: 1st September 2014
Date of latest renewal: 20th June 2019

10. DATE OF REVISION OF THE TEXT

Detailed information on this medicinal product is available on the website of the European Medicines Agency <https://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

Film-coated Tablets:

GLAXO WELLCOME, S.A.,
Avda. Extremadura, 3
Pol. Ind. Allendeduero
Aranda de Duero
Burgos, 09400
Spain

Or

Delpharm Poznań Spółka Akcyjna
UL.Grunwaldzka 189
60-322 Poznan
Poland

Dispersible Tablets:

GLAXO WELLCOME, S.A.,
Avda. Extremadura, 3
Pol. Ind. Allendeduero
Aranda de Duero
Burgos, 09400
Spain

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 (PSURs)**

The requirements for submission of PSURs 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 marketing authorisation holder (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.

ANNEX III
LABELLING AND PACKAGE LEAFLET

A. LABELLING

PARTICULARS TO APPEAR ON THE OUTER PACKAGING

BOTTLE CARTON (INDIVIDUAL PACKS ONLY)

1. NAME OF THE MEDICINAL PRODUCT

Triumeq 50 mg/600 mg/300 mg film-coated tablets
dolutegravir/abacavir/lamivudine

2. STATEMENT OF ACTIVE SUBSTANCE(S)

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

3. LIST OF EXCIPIENTS

4. PHARMACEUTICAL FORM AND CONTENTS

30 film-coated 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

Detach enclosed Alert Card, it contains important safety information.

WARNING

In case of any symptoms suggesting hypersensitivity reactions, contact your doctor IMMEDIATELY.

Push here (with Alert card attached)

8. EXPIRY DATE

EXP

9. SPECIAL STORAGE CONDITIONS

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

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**

ViiV Healthcare BV
Van Asch van Wijckstraat 55H
3811 LP Amersfoort
Netherlands

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/14/940/001

13. BATCH NUMBER

Lot

14. GENERAL CLASSIFICATION FOR SUPPLY**15. INSTRUCTIONS ON USE****16. INFORMATION IN BRAILLE**

Triumeq 50 mg:600 mg:300 mg

17. UNIQUE IDENTIFIER – 2D BARCODE

2D barcode carrying the unique identifier included.

18. UNIQUE IDENTIFIER – HUMAN READABLE DATA

PC
SN
NN

PARTICULARS TO APPEAR ON THE IMMEDIATE PACKAGING

BOTTLE LABEL

1. NAME OF THE MEDICINAL PRODUCT

Triumeq 50 mg/600 mg/300 mg tablets
dolutegravir/abacavir/lamivudine

2. STATEMENT OF ACTIVE SUBSTANCE(S)

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

3. LIST OF EXCIPIENTS

4. PHARMACEUTICAL FORM AND CONTENTS

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

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

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

ViiV Healthcare BV

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/14/940/001

EU/1/14/940/002

13. BATCH NUMBER

Lot

14. GENERAL CLASSIFICATION FOR SUPPLY

15. INSTRUCTIONS ON USE

16. INFORMATION IN BRAILLE

17. UNIQUE IDENTIFIER – 2D BARCODE

18. UNIQUE IDENTIFIER – HUMAN READABLE DATA

PARTICULARS TO APPEAR ON THE OUTER PACKAGING

BOTTLE CARTON (MULTIPACKS ONLY – WITH BLUE BOX)

1. NAME OF THE MEDICINAL PRODUCT

Triumeq 50 mg/600 mg/300 mg film-coated tablets
dolutegravir/abacavir/lamivudine

2. STATEMENT OF ACTIVE SUBSTANCE(S)

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

3. LIST OF EXCIPIENTS

4. PHARMACEUTICAL FORM AND CONTENTS

Multipack: 90 (3 packs of 30) film-coated 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

WARNING! In case of any symptoms suggesting hypersensitivity reactions, contact your doctor IMMEDIATELY.

8. EXPIRY DATE

EXP

9. SPECIAL STORAGE CONDITIONS

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

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

ViiV Healthcare BV
Van Asch van Wijckstraat 55H
3811 LP Amersfoort
Netherlands

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/14/940/002

13. BATCH NUMBER

Lot

14. GENERAL CLASSIFICATION FOR SUPPLY

15. INSTRUCTIONS ON USE

16. INFORMATION IN BRAILLE

Triumeq 50 mg:600 mg:300 mg

17. UNIQUE IDENTIFIER – 2D BARCODE

2D barcode carrying the unique identifier included.

18. UNIQUE IDENTIFIER – HUMAN READABLE DATA

PC
SN
NN

PARTICULARS TO APPEAR ON THE INTERMEDIATE PACKAGING

INTERMEDIATE CARTON (WITHOUT BLUE BOX – COMPONENT OF MULTIPACK)

1. NAME OF THE MEDICINAL PRODUCT

Triumeq 50 mg/600 mg/300 mg film-coated tablets
dolutegravir/abacavir/lamivudine

2. STATEMENT OF ACTIVE SUBSTANCE(S)

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

3. LIST OF EXCIPIENTS

4. PHARMACEUTICAL FORM AND CONTENTS

30 film-coated tablets. Component of a multipack, can't be sold separately.

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

Detach enclosed Alert Card, it contains important safety information.

WARNING

In case of any symptoms suggesting hypersensitivity reactions, contact your doctor IMMEDIATELY.

Push here (with Alert card attached)

8. EXPIRY DATE

EXP

9. SPECIAL STORAGE CONDITIONS

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

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**

ViiV Healthcare BV
Van Asch van Wijckstraat 55H
3811 LP Amersfoort
Netherlands

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/14/940/002

13. BATCH NUMBER

Lot

14. GENERAL CLASSIFICATION FOR SUPPLY**15. INSTRUCTIONS ON USE****16. INFORMATION IN BRAILLE**

Triumeq 50 mg:600 mg:300 mg

17. UNIQUE IDENTIFIER – 2D BARCODE**18. UNIQUE IDENTIFIER – HUMAN READABLE DATA**

PARTICULARS TO APPEAR ON THE OUTER PACKAGING

OUTER CARTON 5 mg/60 mg/30 mg dispersible tablets

1. NAME OF THE MEDICINAL PRODUCT

Triumeq 5 mg/60 mg/30 mg dispersible tablets
dolutegravir/abacavir/lamivudine

2. STATEMENT OF ACTIVE SUBSTANCE(S)

Each dispersible tablet contains 5 mg dolutegravir (as sodium), 60 mg abacavir (as sulfate), 30 mg lamivudine.

3. LIST OF EXCIPIENTS

4. PHARMACEUTICAL FORM AND CONTENTS

Dispersible tablet
90 dispersible tablets

This pack contains a dosing cup.

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

Detach enclosed Alert Card, it contains important safety information.

WARNING

In case of any symptoms suggesting hypersensitivity reactions, contact your doctor IMMEDIATELY.

Push here (with Alert card attached)

8. EXPIRY DATE

EXP

9. SPECIAL STORAGE CONDITIONS

Store in the original package in order to protect from moisture. Keep the bottle tightly closed. Do not remove the desiccant. Do not swallow the desiccant.

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

ViiV Healthcare BV
Van Asch van Wijckstraat 55H
3811 LP Amersfoort
Netherlands

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/14/940/003

13. BATCH NUMBER

Lot

14. GENERAL CLASSIFICATION FOR SUPPLY

15. INSTRUCTIONS ON USE

16. INFORMATION IN BRAILLE

triumeq 5 mg:60 mg:30 mg

17. UNIQUE IDENTIFIER – 2D BARCODE

2D barcode carrying the unique identifier included.

18. UNIQUE IDENTIFIER - HUMAN READABLE DATA

PC
SN
NN

PARTICULARS TO APPEAR ON THE IMMEDIATE PACKAGING

BOTTLE LABEL 5 mg/60 mg/30 mg dispersible tablets

1. NAME OF THE MEDICINAL PRODUCT

Triumeq 5 mg/60 mg/30 mg dispersible tablets
dolutegravir/abacavir/lamivudine

2. STATEMENT OF ACTIVE SUBSTANCE(S)

Each dispersible tablet contains 5 mg dolutegravir (as sodium), 60 mg abacavir (as sulfate), 30 mg lamivudine.

3. LIST OF EXCIPIENTS

4. PHARMACEUTICAL FORM AND CONTENTS

Dispersible tablet
90 dispersible 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

Store in the original package in order to protect from moisture.
Keep the bottle tightly closed.
Do not remove the desiccant.
Do not swallow the desiccant.

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

ViiV Healthcare BV

12. MARKETING AUTHORISATION NUMBER(S)

EU/1/14/940/003

13. BATCH NUMBER

Lot

14. GENERAL CLASSIFICATION FOR SUPPLY

15. INSTRUCTIONS ON USE

16. INFORMATION IN BRAILLE

17. UNIQUE IDENTIFIER – 2D BARCODE

18. UNIQUE IDENTIFIER - HUMAN READABLE DATA

TRIUMEQ TABLETS AND DISPERSIBLE TABLETS PATIENT ALERT CARD

SIDE 1

IMPORTANT - PATIENT ALERT CARD
Triumeq (dolutegravir / abacavir / lamivudine) tablets and
dispersible tablets
Carry this card with you at all times

Since Triumeq contains abacavir some patients taking Triumeq may develop a hypersensitivity reaction (serious allergic reaction). This reaction **can be life-threatening** if treatment with Triumeq is continued. **CONTACT YOUR DOCTOR IMMEDIATELY for advice on whether you should stop taking Triumeq if:**

- 1) **you get a skin rash OR**
- 2) **you get one or more symptoms from at least TWO of the following groups**
 - fever
 - shortness of breath, sore throat or cough
 - nausea or vomiting or diarrhoea or abdominal pain
 - severe tiredness or achiness or generally feeling ill

If you have discontinued Triumeq due to this reaction, **YOU MUST NEVER TAKE** Triumeq, or any medicine containing abacavir again as **within hours** you may experience a life-threatening lowering of your blood pressure or death.

(see reverse of card)

SIDE 2

You should immediately contact your doctor if you think you are having a hypersensitivity reaction to Triumeq. Write your doctor's details below:

Doctor:..... Tel:.....

If your doctor is not available, you must urgently seek alternative medical advice (e.g. the emergency unit of the nearest hospital).

For general Triumeq information enquiries, contact:

B. PACKAGE LEAFLET

Package leaflet: Information for the patient

Triumeq 50 mg/600 mg/300 mg film-coated tablets dolutegravir/abacavir/lamivudine

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 Triumeq is and what it is used for
2. What you need to know before you take Triumeq
3. How to take Triumeq
4. Possible side effects
5. How to store Triumeq
6. Contents of the pack and other information

1. What Triumeq is and what it is used for

Triumeq is a medicine that contains three active substances used to treat HIV infection: abacavir, lamivudine and dolutegravir. Abacavir and lamivudine belong to a group of anti-retroviral medicines (medicines used to treat HIV infection) called *nucleoside analogue reverse transcriptase inhibitors (NRTIs)*, and dolutegravir belongs to a group of anti-retroviral medicines called *integrase inhibitors (INIs)*.

Triumeq is used to treat **HIV (human immunodeficiency virus) infection** in adults, adolescents and children who weigh at least 25 kg.

Before you are prescribed Triumeq your doctor will arrange a test to find out whether you carry a particular type of gene called HLA-B*5701. Triumeq should not be used in patients who are known to carry the HLA-B*5701 gene. Patients with this gene are at a high risk of developing a serious hypersensitivity (allergic) reaction if they use Triumeq (see ‘hypersensitivity reactions’ in section 4).

Triumeq does not cure HIV infection; it reduces the amount of virus in your body, and keeps it at a low level. It also increases the number of CD4 cells in your blood. CD4 cells are a type of white blood cells that are important in helping your body to fight infection.

Not everyone responds to treatment with Triumeq in the same way. Your doctor will monitor the effectiveness of your treatment.

2. What you need to know before you take Triumeq

Do not take Triumeq

- if you are **allergic (hypersensitive)** to dolutegravir, abacavir (or any other medicine containing abacavir), or lamivudine, or any of the other ingredients of this medicine (listed in section 6).

Carefully read all the information about hypersensitivity reactions in Section 4.

- If you are taking a medicine called **fampridine** (also known as dalfampridine; used in multiple sclerosis).
→ If you think any of these apply to you, tell your doctor.

Warnings and precautions

IMPORTANT — Hypersensitivity reactions

Triumeq contains abacavir and dolutegravir. Both of these active substances can cause a serious allergic reaction known as a hypersensitivity reaction. You should never take abacavir or abacavir-containing products again if you have a hypersensitivity reaction: it can be life threatening.

You must carefully read all the information under ‘Hypersensitivity reactions’ in the panel in Section 4.

The Triumeq pack includes an **Alert Card** to remind you and medical staff about hypersensitivity. **Detach this card and keep it with you at all times.**

Take special care with Triumeq

Some people taking Triumeq or other combination treatments for HIV are more at risk of serious side effects than others. You need to be aware of the extra risks:

- if you have moderate or severe liver disease
- if you have ever had **liver disease**, including hepatitis B or C (if you have hepatitis B infection, don't stop Triumeq without your doctor's advice, as your hepatitis may come back)
- if you have a kidney problem
→ **Talk to your doctor if any of these apply to you before using Triumeq.** You may need extra check-ups, including blood tests, while you're taking your medicine. See Section 4 for more information.

Abacavir hypersensitivity reactions

Even patients who don't have the HLA-B*5701 gene may still develop a **hypersensitivity reaction** (a serious allergic reaction).

→ **Carefully read all the information about hypersensitivity reactions in Section 4 of this leaflet.**

Risk of cardiovascular events

It cannot be excluded that abacavir may increase the risk of having cardiovascular events.

→ **Tell your doctor** if you have cardiovascular problems, if you smoke, or have other illnesses that may increase your risk of cardiovascular diseases such as high blood pressure or diabetes. Don't stop taking Triumeq unless your doctor advises you to do so.

Look out for important symptoms

Some people taking medicines for HIV infection develop other conditions, which can be serious. These include:

- symptoms of infections and inflammation
- joint pain, stiffness and bone problems

You need to know about important signs and symptoms to look out for while you're taking Triumeq.

→ **Read the information ‘Other possible side effects of combination therapy for HIV’ in Section 4 of this leaflet.**

Children

This medicine is not for children weighing less than 25 kg because the dose of each component of this medicine cannot be adjusted to their weight.

Other medicines and Triumeq

Tell your doctor if you are taking, have recently taken or might take any other medicines.

Don't take Triumeq with the following medicine:

- fampridine (also known as dalfampridine), used in **multiple sclerosis**.

Some medicines can affect how Triumeq works, or make it more likely that you will have side effects. Triumeq can also affect how some other medicines work.

Tell your doctor if you are taking any of the medicines *in the following list*:

- metformin, to treat **diabetes**
- medicines called **antacids**, to treat **indigestion** and **heartburn**. **Do not take an antacid** during the 6 hours before you take Triumeq, or for at least 2 hours after you take it. (*See also Section 3*).
- supplements or multivitamins containing calcium, iron or magnesium. **If you take Triumeq with food**, you can take supplements or multivitamins containing calcium, iron or magnesium at the same time as Triumeq. **If you do not take Triumeq with food, do not take supplements or multivitamins containing calcium, iron or magnesium** during the 6 hours before you take Triumeq, or for at least 2 hours after you take it (*see also Section 3*).
- emtricitabine, etravirine, efavirenz, nevirapine or tipranavir/ritonavir, to treat **HIV infection**
- medicines (usually liquids) containing sorbitol and other sugar alcohols (such as xylitol, mannitol, lactitol or maltitol), if taken regularly
- other medicines containing lamivudine, used to treat **HIV infection** or **hepatitis B infection**
- cladribine, used to treat **hairy cell leukaemia**
- rifampicin, to treat tuberculosis (TB) and other **bacterial infections**
- trimethoprim/sulfamethoxazole, an antibiotic to treat **bacterial infections**
- phenytoin and phenobarbital, to treat **epilepsy**
- oxcarbazepine and carbamazepine, to treat **epilepsy** and **bipolar disorder**
- **St. John's wort** (*Hypericum perforatum*), a herbal remedy to treat **depression**
- **methadone**, used as a **heroin substitute**. Abacavir increases the rate at which methadone is removed from the body. If you are taking methadone, you will be checked for any withdrawal symptoms. Your methadone dose may need to be changed
- Riociguat, used to treat **high blood pressure in the blood vessels** (the pulmonary arteries) that carry blood from the heart to the lungs. Your doctor may need to reduce your riociguat dose, as abacavir may increase riociguat blood levels.

→ **Tell your doctor or pharmacist** if you are taking any of these. Your doctor may decide to adjust your dose or that you need extra checkups.

Pregnancy

If you are pregnant, think you may be pregnant, or if you are planning to have a baby:

→ **Talk to your doctor** about the risks and benefits of taking Triumeq.

Tell your doctor immediately if you become pregnant or are planning to become pregnant. Your doctor will review your treatment. Do not stop taking Triumeq without consulting your doctor, as this may harm you and your unborn child.

Breast-feeding

Breast-feeding is **not recommended** in women living with HIV because HIV infection can be passed on to the baby in breast milk.

A small amount of the ingredients in Triumeq can also pass into your breast milk.

If you are breast-feeding, or thinking about breast-feeding, you should **discuss it with your doctor as soon as possible**.

Driving and using machines

Triumeq can make you dizzy and have other side effects that make you less alert.

→ **Don't drive or operate machinery** unless you are sure your alertness has not been affected.

Triumeq contains sodium.

This medicine contains less than 1 mmol sodium (23 mg) per film-coated tablet, that is to say essentially 'sodium-free'.

3. How to take Triumeq

Always take this medicine exactly as your doctor has told you. Check with your doctor or pharmacist if you are not sure.

- **The usual dose is one tablet once a day**

Swallow the tablet with some liquid. Triumeq can be taken with or without food.

Use in children and adolescents

Children and adolescents weighing at least 25 kg can take the adult dose of one tablet once a day.

If you weigh less than 25 kg, you cannot take Triumeq film-coated tablets, because the dose of each component of this medicine cannot be adjusted to your weight. Your doctor should prescribe Triumeq dispersible tablets or the components separately for you.

Triumeq is available as film-coated and dispersible tablets. Film-coated tablets and dispersible tablets are not the same. Therefore, you should not switch between film-coated tablets and dispersible tablets without first talking to your doctor.

Do not take an antacid during the 6 hours before you take Triumeq, or for at least 2 hours after you take it. Other acid-lowering medicines like ranitidine and omeprazole can be taken at the same time as Triumeq.

→ Talk to your doctor for further advice on taking antacid medicines with Triumeq.

If you take Triumeq with food, you can take supplements or multivitamins containing calcium, iron or magnesium at the same time as Triumeq. **If you do not take Triumeq with food**, do not take a supplement or multivitamin containing calcium, iron or magnesium during the 6 hours before you take Triumeq, or for at least 2 hours after you take it.

→ Talk to your doctor for further advice on taking supplements or multivitamins containing calcium, iron or magnesium with Triumeq.

If you take more Triumeq than you should

If you take too many tablets of Triumeq, **contact your doctor or pharmacist for advice**. If possible, show them the Triumeq pack.

If you forget to take Triumeq

If you miss a dose, take it as soon as you remember. But if your next dose is due within 4 hours, skip the dose you missed and take the next one at the usual time. Then continue your treatment as before.

→ **Don't take a double dose** to make up for a missed dose.

If you have stopped taking Triumeq

If you have stopped taking Triumeq for any reason — especially because you think you are having side effects, or because you have another illness:

→ **Talk to your doctor before you start taking it again**. Your doctor will check whether your symptoms were related to a hypersensitivity reaction. If the doctor thinks they may be related to a

hypersensitivity reaction, **you will be told never again to take Triumeq, or any other medicine containing abacavir or dolutegravir.** It is important that you follow this advice. If your doctor advises that you can start taking Triumeq again, you may be asked to take your first doses in a place where you will have ready access to medical care if you need it.

4. Possible side effects

Like all medicines, this medicine can cause side effects, although not everybody gets them.

When you're being treated for HIV, it can be hard to tell whether a symptom is a side effect of Triumeq or other medicines you are taking, or an effect of the HIV disease itself. **So it is very important to talk to your doctor about any changes in your health.**

Abacavir can cause a hypersensitivity reaction (a serious allergic reaction), especially in people who carry a particular type of gene called HLA-B*5701. Even patients who don't have the HLA-B*5701 gene may still develop a **hypersensitivity reaction**, described in this leaflet in the panel headed 'Hypersensitivity reactions'. **It is very important that you read and understand the information about this serious reaction.**

As well as the side effects listed below for Triumeq, other conditions can develop during combination therapy for HIV.

→ It is important to read the information in this section under the heading 'Other possible side effects of combination therapy for HIV'.

Hypersensitivity reactions

Triumeq contains abacavir and dolutegravir. Both of these active substances can cause a serious allergic reaction known as a hypersensitivity reaction.

These hypersensitivity reactions have been seen more frequently in people taking medicines that contain abacavir.

Who gets these reactions?

Anyone taking Triumeq could develop a hypersensitivity reaction, which could be life threatening if they continue to take Triumeq.

You are more likely to develop this reaction if you have a gene called HLA-B*5701 (but you can get a reaction even if you don't have this gene). You should have been tested for this gene before Triumeq was prescribed for you. If you know you have this gene, tell your doctor.

What are the symptoms?

The most common symptoms are:

fever (high temperature) and **skin rash**.

Other common symptoms are:

nausea (feeling sick), vomiting (being sick), diarrhoea, abdominal (stomach) pain, severe tiredness.

Other symptoms include:

pains in the joints or muscles, swelling of the neck, shortness of breath, sore throat, cough, occasional headaches, inflammation of the eye (conjunctivitis), mouth ulcers, low blood pressure, tingling or numbness of the hands or feet.

When do these reactions happen?

Hypersensitivity reactions can start at any time during treatment with Triumeq, but are more likely during the first 6 weeks of treatment.

Contact your doctor immediately:

- 1 if you get a skin rash, OR
- 2 if you get symptoms from at least 2 of the following groups:
 - fever
 - shortness of breath, sore throat or cough
 - nausea or vomiting, diarrhoea or abdominal pain
 - severe tiredness or aches and pains, or generally feeling ill.

Your doctor may advise you to stop taking Triumeq.

If you have stopped taking Triumeq

If you have stopped taking Triumeq because of a hypersensitivity reaction, **you must NEVER AGAIN take Triumeq, or any other medicine containing abacavir.** If you do, within hours, your blood pressure could fall dangerously low, which could result in death. You should also never again take medicines containing dolutegravir.

If you have stopped taking Triumeq for any reason — especially because you think you are having side effects, or because you have other illness:

Talk to your doctor before you start again. Your doctor will check whether your symptoms were related to a hypersensitivity reaction. If the doctor thinks they may have been, **you will then be told never again to take Triumeq, or any other medicine containing abacavir.** You may also be told never again to take any other medicine containing dolutegravir. It is important that you follow this advice.

Occasionally, hypersensitivity reactions have developed in people who start taking abacavir containing products again, but who had only one symptom on the Alert Card before they stopped taking it.

Very rarely, patients who have taken medicines containing abacavir in the past without any symptoms of hypersensitivity have developed a hypersensitivity reaction when they start taking these medicines again.

If your doctor advises that you can start taking Triumeq again, you may be asked to take your first doses in a place where you will have ready access to medical care if you need it.

If you are hypersensitive to Triumeq, return all your unused Triumeq tablets for safe disposal. Ask your doctor or pharmacist for advice.

The Triumeq pack includes an **Alert Card**, to remind you and medical staff about hypersensitivity reactions. **Detach this card and keep it with you at all times.**

Very common side effects

These may affect **more than 1 in 10 people**:

- headache
- diarrhoea
- feeling sick (*nausea*)
- difficulty in sleeping (*insomnia*)
- lack of energy (*fatigue*)

Common side effects

These may affect **up to 1 in 10 people**:

- hypersensitivity reaction (*see 'Hypersensitivity reactions' earlier in this section*)
- loss of appetite
- rash
- itching (*pruritus*)
- being sick (*vomiting*)
- stomach (*abdominal*) pain
- stomach (*abdominal*) discomfort
- weight gain
- indigestion
- wind (*flatulence*)
- dizziness
- abnormal dreams
- nightmares
- depression (feelings of deep sadness and unworthiness)
- anxiety
- tiredness
- feeling drowsy
- fever (*high temperature*)
- cough
- irritated or runny nose
- hair loss
- muscle pain and discomfort
- joint pain
- feeling weak
- general feeling of being unwell

Common side effects that may show up in blood tests are:

- an increase in the level of liver enzymes
- increase in the level of enzymes produced in the muscles (*creatine phosphokinase*)

Uncommon side effects

These may affect **up to 1 in 100 people**:

- inflammation of the liver (*hepatitis*)
- suicidal thoughts and behaviours (particularly in patients who have had depression or mental health problems before)
- panic attack

Uncommon side effects that may show up in blood tests are:

- a decreased number of cells involved in blood clotting (*thrombocytopenia*).
- a low red blood cell count (*anaemia*) or low white blood cell count (*neutropenia*)
- an increase in sugar (glucose) in the blood
- an increase in triglycerides (type of fat) in the blood

Rare side effects

These may affect **up to 1 in 1000 people**:

- inflammation of the pancreas (*pancreatitis*)
- breakdown of muscle tissue
- liver failure (signs may include yellowing of the skin and the whites of the eyes or unusually dark urine).
- suicide (particularly in patients who have had depression or mental health problems before)

→ **Tell your doctor immediately** if you experience any mental health problems (see also other mental health problems above).

Rare side effects that may show up in blood tests are:

- increase in bilirubin (a test of liver function)
- increase in an enzyme called *amylase*.

Very rare side effects

These may affect **up to 1 in 10,000 people**:

- numbness, tingly feelings in the skin (pins and needles)
- sensation of weakness in the limbs
- skin rash, which may form blisters and looks like small targets (central dark spots surrounded by a paler area, with a dark ring around the edge) (*erythema multiforme*)
- a widespread rash with blisters and peeling skin, particularly around the mouth, nose, eyes and genitals (*Stevens–Johnson syndrome*), and a more severe form causing skin peeling in more than 30% of the body surface (*toxic epidermal necrolysis*)
- lactic acidosis (excess lactic acid in the blood).

Very rare side effects that may show up in blood tests are:

- a failure of the bone marrow to produce new red blood cells (*pure red cell aplasia*).

Frequency not known

Cannot be estimated from the available data:

- a condition where red blood cells do not form properly (*sideroblastic anaemia*).

If you get any side effects

→ **Talk to your doctor**. This includes any possible side effects not listed in this leaflet.

Other possible side effects of combination therapy for HIV

Combination therapy such as Triumeq may cause other conditions to develop during HIV treatment.

Symptoms of infection and inflammation

People with advanced HIV infection or AIDS have weak immune systems, and are more likely to develop serious infections (*opportunistic infections*). Such infections may have been “silent” and not detected by the weak immune system before treatment was started. After starting treatment, the immune system becomes stronger, and may attack the infections, which can cause symptoms of infection or inflammation. Symptoms usually include **fever**, plus some of the following:

- headache
- stomach ache
- difficulty breathing

In rare cases, as the immune system becomes stronger, it can also attack healthy body tissue (*autoimmune disorders*). The symptoms of autoimmune disorders may develop many months after you start taking medicine to treat your HIV infection. Symptoms may include:

- palpitations (rapid or irregular heartbeat) or tremor
- hyperactivity (excessive restlessness and movement)
- weakness beginning in the hands and feet and moving up towards the trunk of the body.

If you get any symptoms of infection and inflammation or if you notice any of the symptoms above:

→ **Tell your doctor immediately**. Don't take other medicines for the infection without your doctor's advice.

Joint pain, stiffness and bone problems

Some people taking combination therapy for HIV develop a condition called *osteonecrosis*. In this condition, parts of the bone tissue die because of reduced blood supply to the bone. People may be more likely to get this condition:

- if they have been taking combination therapy for a long time
- if they are also taking anti-inflammatory medicines called corticosteroids
- if they drink alcohol
- if their immune systems are very weak
- if they are overweight.

Signs of osteonecrosis include:

- stiffness in the joints
- aches and pains (especially in the hip, knee or shoulder)
- difficulty moving.

If you notice any of these symptoms:

→ **Tell your doctor.**

Weight, blood lipid and blood glucose 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 sometimes to the HIV medicines themselves. Your doctor will test for these changes.

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 Triumeq

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 carton and bottle after EXP. The expiry date refers to the last day of that month.

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

This medicine does not require any special temperature 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 Triumeq contains

- The active substances are dolutegravir, abacavir and lamivudine. Each tablet contains dolutegravir sodium equivalent to 50 mg dolutegravir, 600 mg abacavir (as sulfate) and 300 mg lamivudine.
- The other ingredients are mannitol (E421), microcrystalline cellulose, povidone (K29/32), sodium starch glycolate, magnesium stearate, poly(vinyl) alcohol – partially hydrolysed, titanium dioxide, macrogol/PEG, talc, iron oxide black and iron oxide red).
- This medicine contains less than 1 mmol sodium (23 mg) per tablet, that is to say essentially ‘sodium-free’.

What Triumeq looks like and contents of the pack

Triumeq film-coated tablets are purple, biconvex, oval tablets, debossed with “572 Tri” on one side.

The film-coated tablets are provided in bottles containing 30 tablets.

The bottle contains a desiccant to reduce moisture. Once the bottle has been opened keep the desiccant in the bottle, do not remove it.

Multipacks containing 90 film-coated tablets (3 packs of 30 film-coated tablets) are also available. Not all pack sizes may be available in your country.

Marketing Authorisation Holder

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Manufacturer

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This leaflet was last revised in {month YYYY}.

Other sources of information

Detailed information on this medicine is available on the European Medicines Agency web site:
<https://www.ema.europa.eu>.

Package leaflet: Information for the patient

Triumeq 5 mg/60 mg/30 mg dispersible tablets dolutegravir/abacavir/lamivudine

Read all of this leaflet carefully before you start using 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 a child in your care. Do not pass it on to others. It may harm them, even if their signs of illness are the same as those of the child you are caring for.
- If the child gets 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 Triumeq is and what it is used for
2. What you need to know before you use Triumeq
3. How to take Triumeq
4. Possible side effects
5. How to store Triumeq
6. Contents of the pack and other information
7. Step-by-step instructions for use

1. What Triumeq is and what it is used for

Triumeq is a medicine that contains three active substances used to treat HIV infection: abacavir, lamivudine and dolutegravir. Abacavir and lamivudine belong to a group of anti-retroviral medicines (medicines used to treat HIV infection) called *nucleoside analogue reverse transcriptase inhibitors (NRTIs)*, and dolutegravir belongs to a group of anti-retroviral medicines called *integrase inhibitors (INIs)*.

Triumeq is used to treat **HIV (human immunodeficiency virus) infection** in children of 3 months of age or older, and who weigh at least 6 kg and less than 25 kg.

Before the child you are caring for is prescribed Triumeq your doctor will arrange a test to find out whether they carry a particular type of gene called HLA-B*5701. Triumeq should not be used in patients who are known to carry the HLA-B*5701 gene. Patients with this gene are at a high risk of developing a serious hypersensitivity (allergic) reaction if they use Triumeq (see 'hypersensitivity reactions' in section 4).

Triumeq does not cure HIV infection; it reduces the amount of virus in your body, and keeps it at a low level. It also increases the number of CD4 cells in your blood. CD4 cells are a type of white blood cells that are important in helping your body to fight infection.

Not everyone responds to treatment with Triumeq in the same way. Your doctor will monitor the effectiveness of the child's treatment.

2. What you need to know before you use Triumeq

Do not use Triumeq

- if the child you are caring for is **allergic** (*hypersensitive*) to dolutegravir, abacavir (or any other medicine containing abacavir), or lamivudine, or any of the other ingredients of this medicine (listed in section 6).

Carefully read all the information about hypersensitivity reactions in Section 4.

- If the child you are caring for is taking a medicine called **fampridine** (also known as dalfampridine; used in multiple sclerosis).
→ If you think any of these apply to the child, tell your doctor.

Warnings and precautions

IMPORTANT — Hypersensitivity reactions

Triumeq contains abacavir and dolutegravir. Both of these active substances can cause a serious allergic reaction known as a hypersensitivity reaction. The child you are caring for should never take abacavir or abacavir-containing products again if they have a hypersensitivity reaction: it can be life threatening.

You must carefully read all the information under ‘Hypersensitivity reactions’ in the panel in Section 4.

The Triumeq pack includes an **Alert Card** to remind you and medical staff about hypersensitivity. **Detach this card and keep it with you at all times.**

Take special care with Triumeq

Some people taking Triumeq or other combination treatments for HIV are more at risk of serious side effects than others. You need to be aware of the extra risks:

- if the child you are caring for has moderate or severe liver disease
- if the child you are caring for has ever had **liver disease**, including hepatitis B or C (if the child has hepatitis B infection, don't stop Triumeq without your doctor's advice, as their hepatitis may come back)
- if the child you are caring for has a kidney problem
→ **Talk to your doctor if any of these apply to the child before using Triumeq.** They may need extra check-ups, including blood tests, while they are taking the medicine. See Section 4 for more information.

Abacavir hypersensitivity reactions

Even patients who don't have the HLA-B*5701 gene may still develop a **hypersensitivity reaction** (a serious allergic reaction).

→ **Carefully read all the information about hypersensitivity reactions in Section 4 of this leaflet.**

Risk of cardiovascular events

It cannot be excluded that abacavir may increase the risk of having cardiovascular events.

→ **Tell your doctor** if the child you are caring for has cardiovascular problems, if they smoke, or have other illnesses that may increase their risk of cardiovascular diseases such as high blood pressure or diabetes. Don't stop giving Triumeq unless your doctor advises you to do so.

Look out for important symptoms

Some people taking medicines for HIV infection develop other conditions, which can be serious. These include:

- symptoms of infections and inflammation
- joint pain, stiffness and bone problems

You need to know about important signs and symptoms to look out for while you're giving Triumeq.

→ Read the information ‘Other possible side effects of combination therapy for HIV’ in Section 4 of this leaflet.

Children

Triumeq is not for use in children less than 3 months of age or weighing less than 6 kg because lower doses of this medicine have not been evaluated in these groups.

Children must **keep planned doctor’s appointments** (see Section 3, *How to give Triumeq, for more information*).

Other medicines and Triumeq

Tell your doctor if the child you are caring for is taking, has recently taken or might take any other medicines.

Some medicines can affect how Triumeq works, or make it more likely that you will have side effects. Triumeq can also affect how some other medicines work.

Tell your doctor if you are taking any of the medicines *in the following list*:

- metformin, to treat **diabetes**
- medicines called **antacids**, to treat **indigestion** and **heartburn**. **Do not take an antacid** during the 6 hours before you take Triumeq, or for at least 2 hours after you take it. (*See also Section 3*).
- supplements or multivitamins containing calcium, iron or magnesium. **If you take Triumeq with food**, you can take supplements or multivitamins containing calcium, iron or magnesium at the same time as Triumeq. **If you do not take Triumeq with food, do not take supplements or multivitamins containing calcium, iron or magnesium** during the 6 hours before you take Triumeq, or for at least 2 hours after you take it (*see also Section 3*).
- emtricitabine, etravirine, efavirenz, nevirapine or tipranavir/ritonavir, to treat **HIV infection**
- medicines (usually liquids) containing sorbitol and other sugar alcohols (such as xylitol, mannitol, lactitol or maltitol), if taken regularly
- other medicines containing lamivudine, used to treat **HIV infection** or **hepatitis B infection**
- cladribine, used to treat **hairy cell leukaemia**
- rifampicin, to treat tuberculosis (TB) and other **bacterial infections**
- trimethoprim/sulfamethoxazole, an antibiotic to treat **bacterial infections**
- phenytoin and phenobarbital, to treat **epilepsy**
- oxcarbazepine and carbamazepine, to treat **epilepsy** and **bipolar disorder**
- **St. John’s wort** (*Hypericum perforatum*), a herbal remedy to treat **depression**
- **methadone**, used as a **heroin substitute**. Abacavir increases the rate at which methadone is removed from the body. If you are taking methadone, you will be checked for any withdrawal symptoms. Your methadone dose may need to be changed
- Riociguat, used to treat **high blood pressure in the blood vessels** (the pulmonary arteries) that carry blood from the heart to the lungs. Your doctor may need to reduce your riociguat dose, as abacavir may increase riociguat blood levels.

→ **Tell your doctor or pharmacist** if the child you are caring for is taking any of these. Your doctor may decide to adjust the child’s dose or that the child needs extra checkups.

Pregnancy

Patients who are pregnant, think they may be pregnant, or are planning to have a baby:

→ **Talk to your doctor** about the risks and benefits of taking Triumeq.

Tell your doctor immediately if you become pregnant or are planning to become pregnant. Your doctor will review your treatment. Do not stop taking Triumeq without consulting your doctor, as this may harm you and your unborn child.

Breast-feeding

Breast-feeding is **not recommended** in women living with HIV because HIV infection can be passed on to the baby in breast milk.

A small amount of the ingredients in Triumeq can also pass into your breast milk.

If you are breast-feeding, or thinking about breast-feeding, you should **discuss it with your doctor as soon as possible**.

Driving and using machines

Triumeq can make you dizzy and have other side effects that make you less alert.

→ **Don't drive or operate machinery** unless you are sure your alertness has not been affected.

Triumeq contains sodium

This medicine contains less than 1 mmol sodium (23 mg) per dispersible tablet, that is to say essentially 'sodium-free'.

3. How to give Triumeq

Always give this medicine exactly as your doctor has told you. Check with your doctor or pharmacist if you are not sure.

Your doctor will decide on the correct dose of Triumeq for the child you are caring for, depending on the weight of the child.

If the child you are caring for is less than 3 months of age or weighs less than 6 kg, Triumeq is not suitable for the child, because it is not known if Triumeq is safe and effective. Your doctor should prescribe the components separately for the child.

Triumeq can be given **with or without food**.

The dispersible tablets must be dispersed in drinking water. The tablets should be fully dispersed in the supplied dosing cup before swallowing. Do not chew, cut or crush the tablets. If the child you are caring for is unable to use the supplied dosing cup, you may also need an oral syringe to give the medicine. Talk to your healthcare provider for advice.

Children's dose of Triumeq needs to be adjusted as they gain weight.

→ It is important therefore that children **keep planned doctor's appointments**.

Triumeq is available as film-coated and dispersible tablets. Film-coated tablets and dispersible tablets are not the same. Therefore, you should not switch between film-coated tablets and dispersible tablets without first talking to your doctor.

Do not give an antacid during the 6 hours before you give Triumeq, or for at least 2 hours after you give it. Other acid-lowering medicines like ranitidine and omeprazole can be taken at the same time as Triumeq.

→ Talk to your doctor for further advice on taking antacid medicines with Triumeq.

If you give Triumeq with food, you can give supplements or multivitamins containing calcium, iron or magnesium at the same time as Triumeq. **If you do not give Triumeq with food**, do not give a supplement or multivitamin containing calcium, iron or magnesium during the 6 hours before you give Triumeq, or for at least 2 hours after you give it.

→ Talk to your doctor for further advice on taking supplements or multivitamins containing calcium, iron or magnesium with Triumeq.

If you give more Triumeq than you should

If you give too many dispersible tablets of Triumeq, **contact your doctor or pharmacist for advice**. If possible, show them the Triumeq pack.

If you forget to give Triumeq

If you miss a dose, give it as soon as you remember. But if the next dose is due within 4 hours, skip the dose you missed and give the next one at the usual time. Then continue the child's treatment as before.

→ **Don't give a double dose** to make up for a missed dose.

If you have stopped giving Triumeq

If you have stopped giving Triumeq to the child for any reason — especially because you think they are having side effects, or because they have another illness:

→ **Talk to your doctor before you start giving it again**. Your doctor will check whether the child's symptoms were related to a hypersensitivity reaction. If the doctor thinks they may be related to a hypersensitivity reaction, **you will be told never again to give Triumeq, or any other medicine containing abacavir or dolutegravir**. It is important that you follow this advice.

If your doctor advises that you can start giving Triumeq again, you may be asked to give the first doses in a place where the child will have ready access to medical care if they need it.

4. Possible side effects

Like all medicines, this medicine can cause side effects, although not everybody gets them.

When the child is being treated for HIV, it can be hard to tell whether a symptom is a side effect of Triumeq or other medicines they are taking, or an effect of the HIV disease itself. **So it is very important to talk to your doctor about any changes in the child's health.**

Abacavir can cause a hypersensitivity reaction (a serious allergic reaction), especially in people who carry a particular type of gene called HLA-B*5701. Even patients who don't have the HLA-B*5701 gene may still develop a **hypersensitivity reaction**, described in this leaflet in the panel headed 'Hypersensitivity reactions'. **It is very important that you read and understand the information about this serious reaction.**

As well as the side effects listed below for Triumeq, other conditions can develop during combination therapy for HIV.

→ It is important to read the information in this section under the heading 'Other possible side effects of combination therapy for HIV'.

Hypersensitivity reactions

Triumeq contains abacavir and dolutegravir. Both of these active substances can cause a serious allergic reaction known as a hypersensitivity reaction.

These hypersensitivity reactions have been seen more frequently in people taking medicines that contain abacavir.

Who gets these reactions?

Anyone taking Triumeq could develop a hypersensitivity reaction, which could be life threatening if they continue to take Triumeq.

The child is more likely to develop this reaction if they have a gene called HLA-B*5701 (but they can get a reaction even if they don't have this gene). The child you are caring for should have been tested

for this gene before Triumeq was prescribed for them. If you know they have this gene, tell your doctor.

What are the symptoms?

The most common symptoms are:

fever (high temperature) and **skin rash**.

Other common symptoms are:

nausea (feeling sick), vomiting (being sick), diarrhoea, abdominal (stomach) pain, severe tiredness.

Other symptoms include:

pains in the joints or muscles, swelling of the neck, shortness of breath, sore throat, cough, occasional headaches, inflammation of the eye (conjunctivitis), mouth ulcers, low blood pressure, tingling or numbness of the hands or feet.

When do these reactions happen?

Hypersensitivity reactions can start at any time during treatment with Triumeq, but are more likely during the first 6 weeks of treatment.

Contact your doctor immediately:

- 1 if the child gets a skin rash, OR**
- 2 if the child gets symptoms from at least 2 of the following groups:**
 - **fever**
 - **shortness of breath, sore throat or cough**
 - **nausea or vomiting, diarrhoea or abdominal pain**
 - **severe tiredness or aches and pains, or generally feeling ill.**

Your doctor may advise you to stop giving Triumeq.

If you have stopped giving Triumeq

If you have stopped giving Triumeq to the child because of a hypersensitivity reaction, **they must NEVER AGAIN take Triumeq, or any other medicine containing abacavir**. If they do, within hours, their blood pressure could fall dangerously low, which could result in death. They should also never again take medicines containing dolutegravir.

If the child has stopped taking Triumeq for any reason — especially because you think they are having side effects, or because they have other illness:

Talk to your doctor before you start again. Your doctor will check whether the child's symptoms were related to a hypersensitivity reaction. If the doctor thinks they may have been, **you will then be told never again to give Triumeq, or any other medicine containing abacavir**. You may also be

told never again to give any other medicine containing dolutegravir. It is important that you follow this advice.

Occasionally, hypersensitivity reactions have developed in people who start taking abacavir containing products again, but who had only one symptom on the Alert Card before they stopped taking it.

Very rarely, patients who have taken medicines containing abacavir in the past without any symptoms of hypersensitivity have developed a hypersensitivity reaction when they start taking these medicines again.

If your doctor advises that you can start giving Triumeq again, you may be asked to give the first doses in a place where the child will have ready access to medical care if you need it.

If the child is hypersensitive to Triumeq, return all the unused Triumeq tablets for safe disposal. Ask your doctor or pharmacist for advice.

The Triumeq pack includes an **Alert Card**, to remind you and medical staff about hypersensitivity reactions. **Detach this card and keep it with you at all times.**

Very common side effects

These may affect **more than 1 in 10 people**:

- headache
- diarrhoea
- feeling sick (*nausea*)
- difficulty in sleeping (*insomnia*)
- lack of energy (*fatigue*)

Common side effects

These may affect **up to 1 in 10 people**:

- hypersensitivity reaction (*see 'Hypersensitivity reactions' earlier in this section*)
- loss of appetite
- rash
- itching (*pruritus*)
- being sick (*vomiting*)
- stomach (*abdominal*) pain
- stomach (*abdominal*) discomfort
- weight gain
- indigestion
- wind (*flatulence*)
- dizziness
- abnormal dreams
- nightmares
- depression (feelings of deep sadness and unworthiness)
- anxiety
- tiredness
- feeling drowsy
- fever (*high temperature*)
- cough
- irritated or runny nose
- hair loss
- muscle pain and discomfort
- joint pain
- feeling weak
- general feeling of being unwell

Common side effects that may show up in blood tests are:

- an increase in the level of liver enzymes
- increase in the level of enzymes produced in the muscles (*creatine phosphokinase*)

Uncommon side effects

These may affect **up to 1 in 100 people**:

- inflammation of the liver (*hepatitis*)
- suicidal thoughts and behaviours (particularly in patients who have had depression or mental health problems before)
- panic attack

Uncommon side effects that may show up in blood tests are:

- a decreased number of cells involved in blood clotting (*thrombocytopenia*).
- a low red blood cell count (*anaemia*) or low white blood cell count (*neutropenia*)
- an increase in sugar (glucose) in the blood
- an increase in triglycerides (type of fat) in the blood

Rare side effects

These may affect **up to 1 in 1000 people**:

- inflammation of the pancreas (*pancreatitis*)
- breakdown of muscle tissue
- liver failure (signs may include yellowing of the skin and the whites of the eyes or unusually dark urine).
- suicide (particularly in patients who have had depression or mental health problems before)

→ **Tell your doctor immediately** if you experience any mental health problems (see also other mental health problems above).

Rare side effects that may show up in blood tests are:

- increase in bilirubin (a test of liver function)
- increase in an enzyme called *amylase*.

Very rare side effects

These may affect **up to 1 in 10,000 people**:

- numbness, tingly feelings in the skin (pins and needles)
- sensation of weakness in the limbs
- skin rash, which may form blisters and looks like small targets (central dark spots surrounded by a paler area, with a dark ring around the edge) (*erythema multiforme*)
- a widespread rash with blisters and peeling skin, particularly around the mouth, nose, eyes and genitals (*Stevens–Johnson syndrome*), and a more severe form causing skin peeling in more than 30% of the body surface (*toxic epidermal necrolysis*)
- lactic acidosis (excess lactic acid in the blood).

Very rare side effects that may show up in blood tests are:

- a failure of the bone marrow to produce new red blood cells (*pure red cell aplasia*).

Frequency not known

Cannot be estimated from the available data:

- a condition where red blood cells do not form properly (*sideroblastic anaemia*).

If the child you are caring for gets any side effects

→ **Talk to your doctor**. This includes any possible side effects not listed in this leaflet.

Other possible side effects of combination therapy for HIV

Combination therapy such as Triumeq may cause other conditions to develop during HIV treatment.

Symptoms of infection and inflammation

People with advanced HIV infection or AIDS have weak immune systems, and are more likely to develop serious infections (*opportunistic infections*). Such infections may have been “silent” and not detected by the weak immune system before treatment was started. After starting treatment, the immune system becomes stronger, and may attack the infections, which can cause symptoms of infection or inflammation. Symptoms usually include **fever**, plus some of the following:

- headache
- stomach ache
- difficulty breathing

In rare cases, as the immune system becomes stronger, it can also attack healthy body tissue (*autoimmune disorders*). The symptoms of autoimmune disorders may develop many months after the child starts taking medicine to treat their HIV infection. Symptoms may include:

- palpitations (rapid or irregular heartbeat) or tremor
- hyperactivity (excessive restlessness and movement)
- weakness beginning in the hands and feet and moving up towards the trunk of the body.

If the child gets any symptoms of infection and inflammation or if you notice any of the symptoms above:

→ **Tell your doctor immediately.** Don't give other medicines for the infection without your doctor's advice.

Joint pain, stiffness and bone problems

Some people taking combination therapy for HIV develop a condition called *osteonecrosis*. In this condition, parts of the bone tissue die because of reduced blood supply to the bone. People may be more likely to get this condition:

- if they have been taking combination therapy for a long time
- if they are also taking anti-inflammatory medicines called corticosteroids
- if they drink alcohol
- if their immune systems are very weak
- if they are overweight.

Signs of osteonecrosis include:

- stiffness in the joints
- aches and pains (especially in the hip, knee or shoulder)
- difficulty moving.

If you notice any of these symptoms:

→ **Tell your doctor.**

Weight, blood lipid and blood glucose 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 sometimes to the HIV medicines themselves. Your doctor will test for these changes.

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 Triumeq

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 carton and bottle label after EXP. The expiry date refers to the last day of that month.

Store in the original package in order to protect from moisture. Keep the bottle tightly closed. Do not remove the desiccant. Do not swallow the desiccant.

This medicine does not require any special temperature 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 Triumeq contains

- The active substances are dolutegravir, abacavir and lamivudine. Each tablet contains dolutegravir sodium equivalent to 5 mg dolutegravir, 60 mg abacavir (as sulfate) and 30 mg lamivudine.
- The other ingredients are acesulfame potassium, crospovidone, mannitol (E421), microcrystalline cellulose, povidone, silicified microcrystalline cellulose (cellulose, microcrystalline; silica, colloidal anhydrous), sodium starch glycolate, sodium stearyl fumarate, strawberry cream flavour, sucralose, polyvinyl alcohol-part hydrolyzed, macrogol, talc, titanium dioxide (E171) and iron oxide yellow (E172).
- This medicine contains less than 1 mmol sodium (23 mg) per dispersible tablet, that is to say essentially 'sodium-free'.

What Triumeq looks like and contents of the pack

Triumeq dispersible tablets are yellow, biconvex, capsule shaped tablets, debossed with "SV WTU" on one side.

The dispersible tablets are provided in bottles containing 90 tablets.

The bottle contains a desiccant to reduce moisture. Once the bottle has been opened keep the desiccant in the bottle, do not remove it.

A dosing cup is supplied with the pack

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Manufacturer

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This leaflet was last revised in {month YYYY}.

Other sources of information

Detailed information on this medicine is available on the European Medicines Agency web site:
<https://www.ema.europa.eu>.

7. Step-by-step instructions

Read the Instructions for Use before giving a dose of medicine.

Follow the steps, using clean drinking water to prepare and give a dose to a child.

Important information

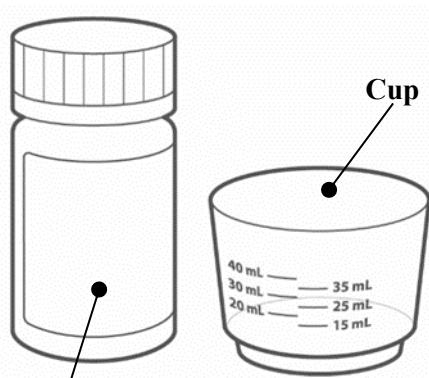
Always give this medicine exactly as your healthcare provider tells you. Talk to your healthcare provider if you are not sure.

Do not chew, cut, or crush the tablets.

If you forget to give a dose of medicine, give it as soon as you remember. But if your next dose is due within 4 hours, skip the dose you missed and take the next one at the usual time. Then continue your treatment as before. Do not give 2 doses at the same time or give more than your healthcare provider has prescribed.

If your child does not or cannot take the full dose call your healthcare provider.

If you give too much medicine, get emergency medical help right away.



Bottle

Your pack contains:

- A bottle containing 90 tablets.
- Dosing cup.

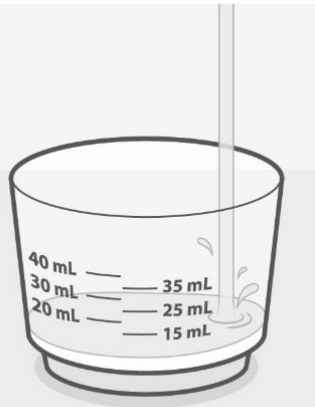
You will also need:

- Clean drinking water.
- If your child is unable to use the dosing cup, you may also need an oral syringe to give the medicine. Talk to your healthcare provider for advice.

Getting ready

1. Pour water

Water Volume Guide	
Number of tablets	Volume of water
3	15 mL
4	20 mL
5	
6	

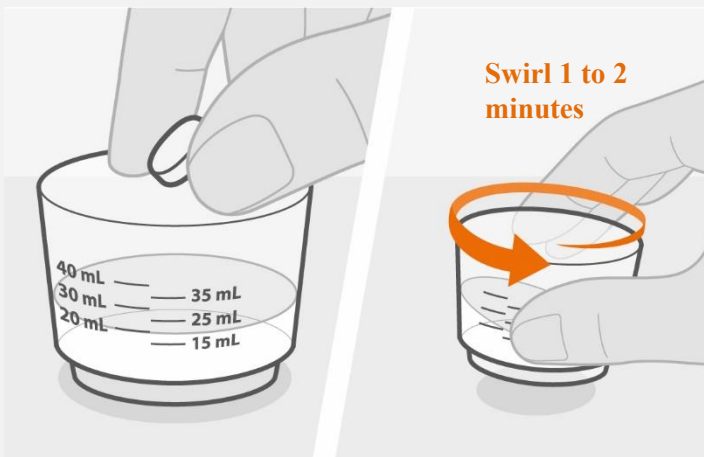


- Pour clean drinking water into the cup.
The Water Volume Guide above shows the amount of water needed for the prescribed dose.

Use drinking water only.

- **Do not** use any other drink or food to prepare the dose

2. Prepare the medicine



- Add the prescribed number of tablet(s) to the water.
- Swirl the cup gently for 1 to 2 minutes to disperse the tablet(s). The medicine will become cloudy. Take care not to spill any of the medicine.
- Check that the medicine is ready. If there are any lumps of tablet swirl the cup until they have gone.

If you spill any medicine, clean up the spill.

Throw away the rest of the prepared medicine and make a new dose.

You must give the dose of medicine within 30 minutes of preparing the dose. If it has been more than 30 minutes wash away all the dose in the cup using water and prepare a new dose of medicine.

Giving the medicine

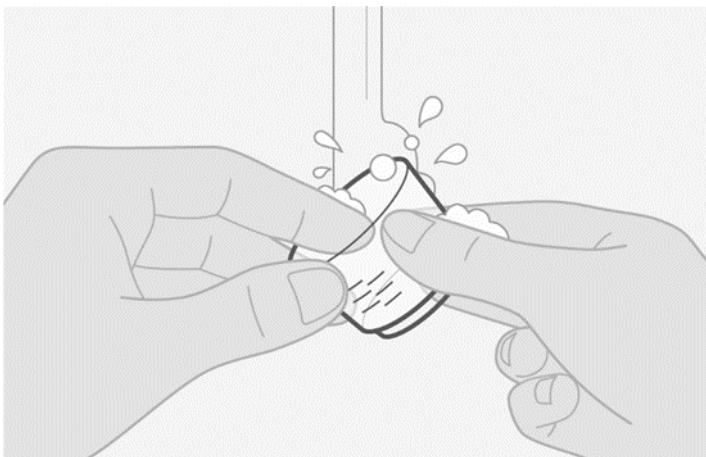
3. Give the medicine



- Make sure that the child is upright. Give all the prepared medicine to the child.
- Add another 15 mL or less of drinking water to the cup, swirl and give it all to the child.
- **Repeat if any medicine remains to make sure the child gets the full dose.**

Cleaning

4. Clean the dosing items



- Wash the cup with water.
- The cup will need to be cleaned before preparing the next dose.

Storage information

Keep the tablets in the bottle. Keep the bottle tightly closed.

The bottle contains a desiccant canister which helps to keep the tablets dry. **Do not** eat the desiccant. **Do not** remove the desiccant.

Keep all medicines out of reach of children.

Disposal information

When all the tablets in the bottle have been taken or are no longer needed, throw away the bottle and cup. Dispose of them using your local household waste guidelines.

You will get a new cup in your next pack.