

SUMMARY OF PRODUCT CHARACTERISTICS

This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions.

1. NAME OF THE MEDICINAL PRODUCT

INBEC: 50 mg/600 mg/300 mg film-coated tablets.

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains 50 mg dolutegravir, 600 mg of abacavir and 300 mg of lamivudine.

For the full list of excipients see section 6.1

3. PHARMACEUTICAL FORM

Film-coated tablet (tablet)

4. CLINICAL PARTICULARS

4.1. Therapeutic indications.

INBEC is indicated for the treatment of Human Immunodeficiency Virus (HIV) infected adults and adolescents above 12 years of age weighing at least 40 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 and adolescents (weighing at least 40kg)

The recommended dose of INBEC in adults and adolescents is one tablet once daily. INBEC should not be administered to adults or adolescents who weigh less than 40 kg because it is a fixed-dose tablet that cannot be dose reduced.

INBEC is a fixed-dose tablet and should not be prescribed for patients requiring dose adjustments. 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.

Missed doses

If the patient misses a dose of INBEC, the patient should take INBEC 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.

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

INBEC is not recommended for use in patients with a creatinine clearance < 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 INBEC 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 INBEC in children less than 12 years of age has not yet been established. No data are available.

Method of administration

Oral use

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

4.3. Contraindications

Hypersensitivity to dolutegravir, abacavir or lamivudine or to any of the excipients listed in section 6.1. See sections 4.4 and 4.8.

Co-administration with dofetilide (see section 4.5).

4.4. Special warnings and precautions for use

Transmission of HIV:

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

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 INBEC 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.
- INBEC 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.
- INBEC 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 INBEC 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 INBEC for reasons of a suspected HSR, INBEC 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 INBEC tablets.

Clinical description of HSRs

Hypersensitivity reactions have been reported in <1% of patients treated with dolutegravir in clinical studies, and was 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.

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 life style. For lipids, there is in some cases evidence for a treatment effect, while for weight gain there is no strong evidence relating this to any particular treatment. For monitoring of blood lipids and glucose reference is made to established HIV treatment guidelines. Lipid disorders should be managed as clinically appropriate.

Liver disease

The safety and efficacy of INBEC has not been established in patients with significant underlying liver disorders. INBEC 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.

INBEC 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 INBEC is used in patients co-infected with hepatitis B an additional antiviral is therefore generally needed. Reference should be made to treatment guidelines.

If INBEC 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 carinii* pneumonia. Any inflammatory symptoms should be evaluated and treatment instituted when necessary. Autoimmune disorders (such as Graves' disease) have also been reported to occur in the setting of immune reactivation; however, the reported time to onset is more variable and these events can occur many months after initiation of treatment.

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 etiology, particularly neurologic findings. These findings do not affect current national recommendations to use antiretroviral therapy in pregnant women to prevent vertical transmission of HIV.

Myocardial infarction

Observational studies have shown an association between myocardial infarction and the use of abacavir. Those studied were mainly antiretroviral experienced patients. Data from clinical trials showed limited numbers of myocardial infarction and could not exclude a small increase in risk. Overall the available data from observational cohorts and from randomised trials show some inconsistency so can neither confirm nor refute a causal relationship between abacavir treatment and the risk of myocardial infarction. To date, there is no established biological mechanism to explain a potential increase in risk. When prescribing INBEC, action should be taken to try to minimize all modifiable risk factors (e.g. smoking, hypertension, and hyperlipidaemia).

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 INBEC 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

Since the recommended dose of dolutegravir is 50 mg twice daily for patients with resistance to integrase inhibitors, the use of INBEC is not recommended for patients with integrase inhibitor resistance.

Drug interactions

Since the recommended dose of dolutegravir is 50 mg twice daily when co-administered with etravirine (without boosted protease inhibitors), efavirenz, nevirapine, rifampicin, tipranavir/ritonavir, carbamazepine, phenytoin, phenobarbital and St. John's wort, the use of INBEC is not recommended for patients taking these medicines (see section 4.5).

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

INBEC is recommended to be administered 2 hours before or 6 hours after taking calcium or iron supplements (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).

INBEC should not be taken with any other medicinal products containing dolutegravir, abacavir, lamivudine or emtricitabine.

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

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

Effect of other agents on the pharmacokinetics of dolutegravir, abacavir and lamivudine

Dolutegravir is eliminated mainly through metabolism by UGT1A1. Dolutegravir is also a substrate of UGT1A3, UGT1A9, CYP3A4, P-gp, and BCRP. Co-administration of INBEC and other drugs that inhibit UGT1A1, UGT1A3, UGT1A9, CYP3A4, and/or P-gp may therefore increase dolutegravir plasma concentration. Drugs 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 agents (see Table 1).

Abacavir is metabolised by UDP-glucuronyltransferase (UGT) enzymes and alcohol dehydrogenase; co-administration of inducers or inhibitors 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 organic cation transporter (OCT2) and multidrug and toxin extrusion transporters (MATE1 and MATE2-K). Co-administration of lamivudine with OCT and MATE inhibitors could increase lamivudine exposure. 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*.

Abacavir and lamivudine are not significantly metabolised by CYP enzymes.

Effect of dolutegravir, abacavir and lamivudine on the pharmacokinetics of other agents

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 MATE-1 transport) was observed in patients. *In vivo*, dolutegravir may increase plasma concentrations of medicinal products in which excretion is dependent upon OCT2 or MATE-1 (e.g. dofetilide, metformin) (see Table 1 and section 4.3).

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 medical products in which excretion is dependent upon OAT3.

Abacavir and lamivudine do not inhibit or induce CYP enzymes (such as CYP 3A4, CYP 2C9 or CYP 2D6). *In vitro* data indicate that inhibition of P-gp and BCRP by abacavir cannot be excluded at intestinal level. *In vitro*, lamivudine inhibited OCT1 and OCT2.

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}”). 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</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. Since the recommended dose of dolutegravir is 50 mg twice daily for patients taking etravirine without boosted protease inhibitors, INBEC is not recommended for patients taking etravirine without co-administration of atazanavir/ritonavir, darunavir/ritonavir or lopinavir/ritonavir (see further below in table).
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)	Since the dose of dolutegravir is 50 mg twice daily when co-administered with efavirenz, the co-administration of efavirenz with INBEC is not recommended (see section 4.4).
Nevirapine/Dolutegravir	Dolutegravir ↓ (Not studied, a similar reduction in exposure as observed with efavirenz is expected, due to induction)	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 likely similar to or less than that of efavirenz. Since the dose of dolutegravir is 50 mg twice daily when co-administered with nevirapine, the co-administration of nevirapine with INBEC is not recommended.
Rilpivirine	Dolutegravir ↔ AUC ↑ 12% C _{max} ↑ 13% C _τ ↑ 22% Rilpivirine ↔	No dose adjustment is necessary.

<i>Nucleoside reverse transcriptase inhibitors (NRTIs)</i>		
Tenofovir Emtricitabine, didanosine, stavudine, zidovudine.	Dolutegravir ↔ AUC ↑ 1% C _{max} ↓ 3% C _τ ↓ 8% Tenofovir ↔ Interaction not studied	No dose adjustment is necessary when INBEC is combined with nucleoside reverse transcriptase inhibitors. INBEC is not recommended for use in combination with emtricitabine containing products, since both lamivudine (in INBEC) 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%	Since the recommended dose of dolutegravir is 50 mg twice daily when co-administered with

	<p>C_{τ} ↓ 76%</p> <p>Tipranavir ↔</p> <p>Ritonavir ↔</p> <p>(induction of UGT1A1 and CYP3A enzymes)</p>	<p>tipranavir/ritonavir, the co-administration of tipranavir/ritonavir with INBEC is not recommended.</p>
Fosamprenavir+ritonavir/ Dolutegravir	<p>Dolutegravir ↓</p> <p>AUC ↓ 35%</p> <p>C_{\max} ↓ 24%</p> <p>C_{τ} ↓ 49%</p> <p>Fosamprenavir ↔</p> <p>Ritonavir ↔</p> <p>(induction of UGT1A1 and CYP3A enzymes)</p>	<p>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.</p>
Nelfinavir/Dolutegravir	<p>Dolutegravir ↔</p> <p>(Not studied)</p>	<p>No dose adjustment is necessary.</p>
Lopinavir+ritonavir/ Dolutegravir	<p>Dolutegravir ↔</p> <p>AUC ↓ 4%</p> <p>C_{\max} ↔ 0%</p> <p>C_{24} ↓ 6%</p> <p>Lopinavir ↔</p> <p>Ritonavir ↔</p>	<p>No dose adjustment is necessary.</p>
Darunavir+ritonavir/ Dolutegravir	<p>Dolutegravir ↓</p> <p>AUC ↓ 22%</p> <p>C_{\max} ↓ 11%</p> <p>C_{τ} ↓ 38%</p> <p>Darunavir ↔</p> <p>Ritonavir ↔</p> <p>(induction of UGT1A1 and CYP3A enzymes)</p>	<p>No dose adjustment is necessary.</p>
Other antiviral agents		
Telaprevir	<p>Dolutegravir ↑</p> <p>AUC ↑ 25%</p>	<p>No dose adjustment is necessary.</p>

	C_{max} ↑ 19% C_t ↑ 37% Telaprevir ↔ (historical controls) (inhibition of CYP3A enzyme)	
Boceprevir	Dolutegravir ↔ AUC ↑ 7% C_{max} ↑ 5% C_t ↑ 8% Boceprevir ↔ (historical controls)	No dose adjustment is necessary.
Daclatasvir/Dolutegravir	Dolutegravir ↔ AUC ↑ 33% C_{max} ↑ 29% C_t ↑ 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 INBEC dosage adjustment necessary, unless patient has renal impairment (See Section 4.2).
Antimycobacterials		
Rifampicin/Dolutegravir	Dolutegravir ↓ AUC ↓ 54%	Since the dose of dolutegravir is 50 mg twice daily when co-

	C_{max} ↓ 43% C_T ↓ 72% (induction of UGT1A1 and CYP3A enzymes)	administered with rifampicin, the co-administration of rifampicin with INBEC is not recommended.
Rifabutin	Dolutegravir ↔ AUC ↓ 5% C_{max} ↑ 16% C_T ↓ 30% (induction of UGT1A1 and CYP3A enzymes)	No dose adjustment is necessary.
Anticonvulsants		
Carbamazepine/Dolutegravir	Dolutegravir ↓ AUC ↓ 49% C_{max} ↓ 33% C_T ↓ 73%	Since the recommended dose of dolutegravir is 50 mg twice daily when co-administered with carbamazepine, DTG/ABC/3TC FDC is not recommended for patients taking carbamazepine.
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)	Since the recommended dose of dolutegravir is 50 mg twice daily when co-administered with these metabolic inducers, DTG/ABC/3TC FDC is not recommended for patients taking these metabolic inducers.
Antihistamines (histamine H2 receptor antagonists)		
Ranitidine	Interaction not studied. Clinically significant interaction unlikely.	No dosage adjustment necessary.
Cimetidine	Interaction not studied. Clinically significant	No dosage adjustment necessary.

	interaction unlikely.	
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 INBEC 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 dosage 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 dosage 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 dosage adjustment necessary.
<i>Antiarrhythmics</i>		
Dofetilide/Dolutegravir	Dofetilide ↑ (Not studied, potential increase via inhibition of OCT2 transporter)	INBEC and dofetilide co-administration is contraindicated due to potential life-threatening toxicity caused by high dofetilide concentration (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 INBEC (minimum 2 hours after or 6 hours before).
Calcium supplements/Dolutegravir	Dolutegravir ↓ AUC ↓ 39% C _{max} ↓ 37% C ₂₄ ↓ 39% (Complex binding to polyvalent ions)	Calcium supplements, iron supplements or multivitamins should be taken well separated in time from the administration of INBEC (minimum 2 hours after or 6 hours before).
Iron supplements/Dolutegravir	Dolutegravir ↓ AUC ↓ 54% C _{max} ↓ 57% C ₂₄ ↓ 56% (Complex binding to polyvalent ions)	
Multivitamins/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	Since the recommended dose of dolutegravir is 50 mg twice daily when co-administered with St. John's wort, DTG/ABC/3TC FDC is not recommended.

	with carbamazepine is expected)	
<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 INBEC.

Paediatric population

Interaction studies have only been performed in adults.

4.6. Fertility, pregnancy and lactation

Pregnancy

As a general rule, when deciding to use antiretroviral agents for the treatment of HIV infection in pregnant women and consequently for reducing the risk of HIV vertical transmission to the newborn, the animal data as well as the clinical experience in pregnant women should be taken into account.

There are no data on the use of INBEC in pregnancy.

There are no or limited amount of data from the use of dolutegravir in pregnant women. The effect of dolutegravir on human pregnancy is unknown. A moderate amount of data on pregnant women taking the individual actives abacavir and lamivudine in combination indicates no malformative toxicity (more than 400 outcomes from first trimester exposures). Concerning lamivudine, a large amount of data (more than 3000 outcomes from first trimester) indicates no malformative toxicity. Moderate amount of data (more than 600 outcomes from first trimester) indicates no malformative toxicity for abacavir.

In reproductive toxicity studies in animals, dolutegravir was shown to cross the placenta. Animal studies do not indicate direct or indirect harmful effects with respect

to reproductive toxicity (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.

INBEC should be used during pregnancy only if the expected benefit justifies the potential risk to the foetus.

For patients co-infected with hepatitis B who are being treated with a lamivudine containing medicinal product such as INBEC and subsequently become pregnant, consideration should be given to the possibility of a recurrence of hepatitis on discontinuation of lamivudine.

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

It is unknown whether dolutegravir is excreted in human milk. Available toxicological data in animals has shown excretion of dolutegravir in milk. In lactating rats that received a single oral dose of 50 mg/kg at 10 days postpartum, dolutegravir was detected in milk at concentrations typically higher than blood.

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 HIV infected women do not breast-feed their infants under any circumstances 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

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 INBEC 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

Clinical safety data with INBEC are limited. The most frequently reported adverse reactions considered possibly or probably related to dolutegravir and abacavir/lamivudine [pooled data from 679 anti-retroviral naïve subjects receiving this combination in the Phase IIb to IIIb clinical trials, see section 5.1], 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 event possibly 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 considered at least possibly related to treatment with the components of INBEC 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 ($\geq 1/1000$ to $< 1/100$), rare ($\geq 1/10,000$ to $< 1/1000$), very rare ($< 1/10,000$).

The adverse reactions observed for the combination of dolutegravir + abacavir/lamivudine in an analysis of pooled data from Phase IIb to Phase IIIb clinical trials were generally consistent with the adverse reaction profiles for the individual components dolutegravir, abacavir and lamivudine.

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

Table 2: Tabulated summary of adverse reactions associated with the combination of dolutegravir + abacavir/lamivudine in an analysis of pooled data from: Phase IIb to Phase IIIb clinical trials; and adverse reactions to treatment with abacavir and lamivudine from clinical studies and post-marketing experience or dolutegravir from 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
<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, nightmare, sleep disorder
Uncommon	suicidal ideation or suicide attempt (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>	
Uncommon:	hepatitis
<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 ^{1,2} , muscle disorders ¹ (including myalgia ²)
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, ALT/AST elevations
Rare:	amylase elevations ¹

¹This adverse reaction was not identified from the Phase 3 clinical studies for either the combination of dolutegravir + abacavir/lamivudine or dolutegravir, but from clinical studies or post-marketing experience for abacavir or lamivudine when used with other antiretrovirals.

²This adverse reaction was not identified from the Phase 3 clinical studies for either combination of dolutegravir + abacavir/lamivudine or dolutegravir, but from post-marketing experience for dolutegravir when used with other antiretrovirals. The highest frequency category observed from the label of the individual components was used (i.e., lamivudine).

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 INBEC must be stopped without delay if HSR cannot be ruled out on clinical grounds, and therapy with INBEC 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 INBEC .

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) 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

There are no clinical study data on the effects of INBEC in the paediatric population. Individual components have been investigated in adolescents (12 to 17 years).

Based on limited available data with the dolutegravir single entity used in combination with other antiretroviral agents to treat adolescents (12 to 17 years), there were no additional types of adverse reactions 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.

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 INBEC. 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 (PMBCs) and monocyte/macrophages. The concentration of drug 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 ug/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 naive 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 triple fixed-dose combination (DTG + ABC/3TC) in HIV-infected, therapy naive subjects is based on the analyses of data from a number of trials. The analyses included two randomized, international, double-blind, active-controlled trials, SINGLE (ING114467) and SPRING-2 (ING113086), the international, open-label, active-controlled trial FLAMINGO (ING114915), and the randomized, open-label, active-controlled, multicentre, non-inferiority study ARIA (ING117172).

The STRIVING study (201147), was a randomized, 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 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 Randomized 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	2%	10%

drug due to adverse event or death†		
Discontinued study/study drug for other reasons§	5%	3%
Missing data during window but on study	0	<1%
HIV-1 RNA <50 copies/mL by baseline covariates		
Baseline Plasma Viral Load (copies/mL)	n / N (%)	n / N (%)
≤100,000	253 / 280 (90%)	238 / 288 (83%)
>100,000	111 / 134 (83%)	100 / 131 (76%)
Baseline CD4+ (cells/mm³)		
<200	45 / 57 (79%)	48 / 62 (77%)
200 to <350	143 / 163 (88%)	126 / 159 (79%)
≥350	176 / 194 (91%)	164 / 198 (83%)
Gender		
Male	307 / 347 (88%)	291 / 356 (82%)
Female	57 / 67 (85%)	47 / 63 (75%)
Race		
White	255 / 284 (90%)	238 / 285 (84%)
African-American/African Heritage/Other	109 / 130 (84%)	99 / 133 (74%)
Age (years)		
<50	319 / 361 (88%)	302 / 375 (81%)
≥50	45 / 53 (85%)	36 / 44 (82%)
* 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 300 mg, emtricitabine 200 mg in the form of Atripla FDC.

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 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 randomized 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%
<u>Reasons</u>		
Discontinued study/study drug due to adverse event or death‡	2%	1%
Discontinued study/study drug 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%
<p>* Adjusted for baseline stratification factors.</p> <p>† 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.</p> <p>‡ 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.</p> <p>§ Includes reasons such as protocol deviation, lost to follow up, and withdrew consent.</p> <p>Notes: DTG = dolutegravir, RAL = raltegravir.</p>		

In FLAMINGO, 485 patients were treated with dolutegravir 50 mg 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 randomized 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 drug due to adverse event or death‡	1%	4%
Discontinued study/study drug 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
<p>* Adjusted for baseline stratification factors, p=0.025.</p> <p>† 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.</p> <p>‡ 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.</p> <p>§ Includes reasons such as withdrew consent, loss to follow-up, protocol deviation.</p> <p>** p<0.001.</p> <p>Notes: DRV+RTV = darunavir + ritonavir, DTG = dolutegravir.</p>		

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 randomized, open-label, active-controlled, multicenter, parallel group, non-inferiority study; 499 HIV-1 infected ART naïve adult women were randomized 1:1 to receive either; DTG/ABC/3TC FDC 50 mg/600 mg/300 mg; or atazanavir 300 mg plus ritonavir 100 mg plus tenofovir disoproxil fumarate/emtricitabine 300 mg/200 mg (ATV+RTV+TDF/FTC FDC), all administered once daily.

Table 6: Demographics and Week 48 virologic outcomes of randomized 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.

STRIIVING (201147) is a 48-week, randomized, open-label, active controlled, multicenter, 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 once daily (Early Switch). Hepatitis B co-infection was one of 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 randomized 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 %
<p>ABC/DTG/3TC FDC = abacavir/dolutegravir/lamivudine fixed-dose combination; AE = adverse event;</p> <p>ART = antiretroviral therapy; HIV-1 = human immunodeficiency virus type 1; ITT-E = intent-to-treat exposed;</p> <p>W = week.</p>				

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 multicentre, open-label study (P1093/ING112578), the pharmacokinetic parameters, safety, tolerability and efficacy of dolutegravir was

evaluated in combination regimens in HIV-1 infected infants, children and adolescents.

At 24 weeks, 16 of 23 (69%) adolescents (12 to 17 years of age) treated with dolutegravir once daily (35 mg n=4; 50 mg n=19) plus OBR achieved viral load less than 50 copies/mL.

Twenty out of 23 children and adolescents (87%) had $>1 \log_{10} \text{c/mL}$ decrease from Baseline in HIV-1 RNA or HIV-1 RNA $<400 \text{ c/mL}$ at Week 24. Four subjects had virologic failure none of which had INI resistance at the time of virologic failure.

5.2. Pharmacokinetic properties

The triple fixed-dose combination tablet has been shown to be bioequivalent to dolutegravir single entity 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 triple fixed-dose combination (fasted) versus 1 x 50 mg dolutegravir tablet, plus 1 x 600mg abacavir/300 mg lamivudine tablet (fasted) in healthy subjects (n=66). The effect of a high fat meal on the triple fixed-dose combination tablet was evaluated in a subgroup of subjects in this study (n=12). Plasma C_{max} and AUC of dolutegravir following administration of triple fixed-dose combination tablet with a high fat meal were 37% and 48% higher, respectively, than those following administration of triple fixed-dose combination tablet in the fasted state. This is not considered clinically significant (see Absorption). The effect of food on plasma exposures of abacavir and lamivudine following administration of triple fixed-dose combination tablet with a high fat meal were very similar to prior food effects observed with ABC/3TC FDC. These results indicate that the triple fixed-dose combination can be taken with or without food.

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 once daily, the steady-state pharmacokinetic parameters (geometric mean [%CV]) based on population pharmacokinetic analyses were $AUC_{(0-24)} = 53.6$ (27) $\mu\text{g}\cdot\text{h}/\text{mL}$, $C_{\text{max}} = 3.67$ (20) $\mu\text{g}/\text{mL}$, and $C_{\text{min}} = 1.11$ (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%).

Plasma C_{max} and AUC of dolutegravir following administration of triple fixed-dose combination with a high fat meal were 37% and 48% higher, respectively, than those following administration of triple fixed-dose combination 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 INBEC 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 metabolized 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 ($IC_{50} > 50 \mu M$) of the enzymes cytochrome P₄₅₀ (CYP)1A2, CYP2A6, CYP2B6, CYP2C8, CYP2C9, CYP2C19, CYP2D6 CYP3A, uridine diphosphate glucuronosyl transferase (UGT)1A1 or UGT2B7, or the transporters Pgp, BCRP, BSEP, OATP1B1, OATP1B3, OCT1, MATE2-K, 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.

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 5 to 7 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 < 50 ml/min (see section 4.2).

Pharmacokinetic/pharmacodynamic relationship(s)

In a randomized, 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, compared to the plasma lamivudine half-life of 5-7 hours, supporting once daily dosing of ABC and 3TC.

Special patient populations

Hepatic impairment

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

Dolutegravir is primarily metabolized 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 dosage 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, INBEC is not recommended in patients with moderate and 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 (CL_{Cr} <30 mL/min). No clinically important pharmacokinetic differences between subjects with severe renal impairment (CL_{Cr} <30 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, INBEC is not recommended for patients with creatinine clearance of < 50 ml/min.

Elderly

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

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

Paediatric population

The pharmacokinetics of dolutegravir in 10 antiretroviral treatment-experienced HIV-1 infected adolescents (12 to 17 years) showed that dolutegravir 50 mg once daily dosage resulted in dolutegravir exposure comparable to that observed in adults who received dolutegravir 50 mg once daily.

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

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 kg 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

Mannitol

Microcrystalline cellulose

Povidone K30

Sodium starch Glycolate

Croscarmellose sodium

Magnesium stearate

Opadry II Blue 85F505121

Composition of Opadry II Blue

Polyvinyl alcohol- part hydrolyzed, Macrogol/PEG, Talc, Titanium dioxide, Indigo Carmine Aluminum Lake.

6.2. Incompatibilities

None known.

6.3. Shelf life

24 Months

6.4. Special precautions for storage

Store at room temperature, 20°C to 25°C, (68°F to 77°F).
Keep all medicines out of the reach of children.

6.5. Nature and contents of container

30 tablets are packed in HDPE bottle container.

6.6. Special precautions for disposal

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.

7. Marketing Authorisation Holder

Emcure Pharmaceuticals Limited

8. Marketing Authorisation Number(S)

To be assigned

9. Date of First Authorisation/Renewal of The Authorisation

Not Applicable

10. Date of Revision of the Text

28/06/2017