ATRIPLA® (efavirenz/emtricitabine/tenofovir disoproxil fumarate) tablets, for oral use

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**RECENT MAJOR CHANGES**
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• Warnings and Precautions, Lactic Acidosis/Severe Hepatomegaly with Steatosis (5.3) 04/2017
• Warnings and Precautions, Coadministration with Related Products (5.4) 04/2017
• Warnings and Precautions, QTc Prolongation (5.5) 04/2017
• Warnings and Precautions, Psychiatric Symptoms (5.6) 04/2017
• Warnings and Precautions, Fat Redistribution (5.15) 04/2017

**INDICATIONS AND USAGE**
ATRIPLA, a combination of 2 nucleoside analog HIV-1 reverse transcriptase inhibitors and 1 non-nucleoside HIV-1 reverse transcriptase inhibitor, is indicated for use alone as a complete regimen or in combination with other antiretroviral agents for the treatment of HIV-1 infection in adults and pediatric patients 12 years of age and older. (1)

**Dosage and Administration**
Recommended dose in adults and pediatric patients (12 years of age and older and weighing at least 40 kg): One tablet once daily taken orally on an empty stomach, preferably at bedtime. (2)

Dose in renal impairment: Should not be administered in patients with estimated creatinine clearance below 50 mL/min. (2)

With rifampin coadministration, an additional 200 mg/day of efavirenz is recommended for patients weighing 50 kg or more. (2)

**DOSAGE FORMS AND STRENGTHS**
Tablet containing 600 mg of efavirenz, 200 mg of emtricitabine, and 300 mg of tenofovir disoproxil fumarate. (3)

**CONTRAINDICATIONS**
• Previously demonstrated hypersensitivity (e.g., Stevens-Johnson syndrome, erythema multiforme, or toxic skin eruptions) to efavirenz, a component of ATRIPLA. (4.1)
• Coadministration with voriconazole due to a significant drug interaction with efavirenz, a component of ATRIPLA, that may decrease the therapeutic effectiveness of voriconazole and increase the risk of efavirenz-associated side effects. (4.2)

**WARNINGS AND PRECAUTIONS**
• Lactic acidosis/severe hepatomegaly with steatosis: Discontinue treatment in patients who develop symptoms or laboratory findings suggestive of lactic acidosis or pronounced hepatotoxicity. (5.3)
• QTc prolongation: Consider alternatives to ATRIPLA in patients taking other medications with a known risk of torsade de pointes or in patients at higher risk of torsade de pointes. (5.5)
• Serious psychiatric symptoms: Immediate medical evaluation is recommended. (5.6)
• Nervous system symptoms (NSS): NSS are frequent, usually begin 1–2 days after initiating therapy, and resolve in 2–4 weeks. Dosing at bedtime may improve tolerability. NSS are not predictive of onset of psychiatric symptoms. (2, 5.7)
• New onset or worsening renal impairment: Can include acute renal failure and Fanconi syndrome. Assess estimated creatinine clearance before initiating treatment with ATRIPLA (efavirenz/emtricitabine/tenofovir disoproxil fumarate). In patients at risk for renal dysfunction, assess estimated creatinine clearance, serum phosphorus, uric acid, and urine protein before initiating treatment with ATRIPLA and periodically during treatment. Avoid administering ATRIPLA with concurrent or recent use of nephrotoxic drugs. (5.8)
• Pregnancy: Fetal harm may occur when administered to a pregnant woman during the first trimester. Women should be apprised of the potential harm to the fetus. A pregnancy registry is available. (5.9, 8.1)
• Rash: Discontinue if severe rash develops. (5.10, 6.1)
• Hepatotoxicity: Monitor liver function tests before and during treatment of patients taking other medications with a known risk of hepatic toxicity. (5.11)
• Coadministration with other products: Do not use with drugs containing emtricitabine, tenofovir disoproxil fumarate, or tenofovir alafenamide, including COMPLERA, DESCovy, EMTRIVA, GENVOYA, ODEFSEY, STRIBILD, TRIUMVIRA, VEMULIVY, or VIREAD; or with drugs containing lamivudine. SUSTIVA (efavirenz) should not be coadministered with ATRIPLA unless required for dose-adjustment when coadministered with rifampin. (5.4)

**ADVERSE REACTIONS**
Most common adverse reactions (incidence greater than or equal to 10%) observed in an active-controlled clinical trial of efavirenz, emtricitabine, and tenofovir disoproxil fumarate are diarrhea, nausea, fatigue, headache, dizziness, depression, insomnia, abnormal dreams, and rash. (6)

To report SUSPECTED ADVERSE REACTIONS, contact Gilead Sciences, Inc. at 1-800-GILEAD-5 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch

**DRUG INTERACTIONS**
• Efavirenz: Coadministration of efavirenz can alter the concentrations of other drugs, and other drugs may alter the concentrations of efavirenz. The potential for drug-drug interactions must be considered before and during therapy. (4.2, 7.1, 12.3)
• Didanosine: Tenofovir disoproxil fumarate increases didanosine concentrations. Use with caution and monitor for evidence of didanosine toxicity (e.g., pancreatitis, neuropathy) when coadministered. Consider dose reductions or discontinuations of didanosine if warranted. (7.2)
• HIV-1 protease inhibitors: Coadministration of ATRIPLA with either lopinavir/ritonavir or darunavir and ritonavir increases tenofovir concentrations. Monitor for evidence of tenofovir toxicity. Coadministration of ATRIPLA with either atazanavir or azatavir is not recommended. (7.3)

**USE IN SPECIFIC POPULATIONS**
• Pregnancy: Women should avoid pregnancy while receiving ATRIPLA and for 12 weeks after discontinuation. (5.9)
• Nursing mothers: Women infected with HIV should be instructed not to breastfeed. (8.3)
• Hepatic impairment: ATRIPLA is not recommended for patients with moderate or severe hepatic impairment. Use caution in patients with mild hepatic impairment. (5.11, 8.6)
• Pediatrics: The incidence of rash was higher than in adults. (5.10, 6.1)

See 17 for PATIENT COUNSELING INFORMATION and FDA-approved patient labeling.

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(Continued)
ATRIPLA® (efavirenz/emtricitabine/tenofovir disoproxil fumarate) has been reported in patients who are coinfected with HBV and HIV-1 and have discontinued emtricitabine or tenofovir DF, two of the components of ATRIPLA. In some patients infected with HBV and treated with emtricitabine, the exacerbations of hepatitis B were associated with liver decompensation and liver failure. Patients who are coinfected with HIV-1 and HBV should be closely monitored, with both clinical and laboratory follow-up for at least several months in patients who are coinfected with HIV-1 and HBV and discontinue ATRIPLA. If appropriate, initiation of anti-hepatitis B therapy may be warranted [See Warnings and Precautions (5.1)].

5.4 Coadministration with Related Products

ATRIPLA® is a fixed-dose combination of efavirenz, emtricitabine, and tenofovir DF. Do not coadminister ATRIPLA® with other drugs containing emtricitabine, tenofovir DF, or tenofovir alafenamide, including COMPLERA®, DESCovy®, EMTRIVA®, GENVOYA®, OD/F/®STRIVL®, STRIVECTIN®, VEM/VLID®, or VIREAD®. SUSTIVA® (efavirenz) should not be coadministered with ATRIPLA® unless needed for dose-adjustment (e.g., with rifampin) [See Dosage and Administration (2), Drug Interactions (7.1)]. Due to similarities between emtricitabine and lamivudine, ATRIPLA® should not be coadministered with drugs containing lamivudine, including Combivir® (lamivudine/zidovudine), Epivir® or Epivir®-HBV (lamivudine), Epzicom® (abacavir sulfate/lamivudine), or Trizivir® (abacavir sulfate/lamivudine/zidovudine).

5.5 QTc Prolongation

QTc prolongation has been observed with the use of efavirenz [See Drug Interactions (7.1) and Clinical Pharmacology (12.2)]. Consider alternatives to ATRIPLA® when coadministered with a drug with a known risk of Torsade de Points or when administered to patients at higher risk of Torsade de Points.

5.6 Psychiatric Symptoms

Serious psychiatric adverse experiences have been reported in patients treated with efavirenz. In controlled trials of 1008 subjects treated with regimens containing efavirenz for a mean of 2.1 years and 635 subjects treated with control regimens for a mean of 1.5 years, the frequency (regardless of causality) of specific serious psychiatric events among subjects who received efavirenz or control regimens, respectively, were: severe depression (2.4%, 0.9%), suicidal ideation (0.7%, 0.3%), nonfatal suicide attempts (0.5%, 0%), aggressive behavior (0.4%, 0.5%), paranoid reactions (0.4%, 0.3%), and manic reactions (0.2%, 0.3%). When psychiatric symptoms similar to those noted above were combined and evaluated as a group in a multifactorial analysis of data from Study A256006 (006), treatment with efavirenz was associated with an increase in the occurrence of these selected psychiatric symptoms. Other factors associated with an increase in the occurrence of these psychiatric symptoms were history of injection drug use, psychiatric history, and receipt of psychiatric medication at trial entry; similar associations were observed in both the efavirenz and control treatment groups. In Study 006, onset of new serious psychiatric symptoms occurred throughout the trial for both efavirenz-treated and control-treated subjects. One percent of efavirenz-treated

8.6 Hepatic Impairment

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WARNING: POSTTREATMENT EXACERBATION OF HEPATITIS B

ATRIPLA® (efavirenz/emtricitabine/tenofovir disoproxil fumarate) is not approved for the treatment of chronic hepatitis B virus (HBV) infection, and the safety and efficacy of ATRIPLA® have not been established in patients coinfected with HBV and HIV-1. Severe acute exacerbations of hepatitis B have been reported in patients who have discontinued EMTRIVA® or VIREAD®, which are components of ATRIPLA®. Hepatic function should be monitored closely with both clinical and laboratory follow-up for at least several months in patients who are coinfected with HIV-1 and HBV and discontinue ATRIPLA®. If appropriate, initiation of anti-hepatitis B therapy may be warranted.
5.7 Nervous System Symptoms

Fifty-three percent (531/1008) of subjects receiving efavirenz in controlled trials reported central nervous system symptoms (any grade, regardless of causality) compared to 25% (156/635) of subjects receiving control regimens. These symptoms included dizziness (28.1% of the 1008 subjects), insomnia (16.3%), impaired concentration (8.3%), somnolence (7.0%), abnormal dreams (6.2%), and hallucinations (1.2%). Other reported symptoms were euphoria, confusion, agitation, amnesia, stupor, abnormal thinking, and depersonalization. The majority of these symptoms were mild to moderate (50.7%); symptoms were severe in 2.0% of subjects. Overall, 2.1% of subjects discontinued therapy as a result. These symptoms usually begin during the first or second day of therapy and generally resolve after the first 2–4 weeks of therapy. After 4 weeks of therapy, the prevalence of nervous system symptoms of at least moderate severity ranged from 5% to 9% in subjects treated with regimens containing efavirenz and from 3% to 5% in subjects treated with a control regimen. Patients should be informed that these common symptoms were likely to improve with continued therapy and were not predictive of subsequent onset of the less frequent psychiatric symptoms [See Warnings and Precautions (5.6)]. Dosing at bedtime may improve the tolerability of these nervous system symptoms [See Dosage and Administration (2)].

Analysis of long-term data from Study 006 (median follow-up 180 weeks, 102 weeks, and 76 weeks for subjects treated with efavirenz + zidovudine + lamivudine, efavirenz + indinavir, and indinavir + zidovudine + lamivudine, respectively) showed that, beyond 24 weeks of therapy, the incidences of new-onset nervous system symptoms among efavirenz-treated subjects were generally similar to those in the indinavir-containing control arm.

Patients receiving ATRIPLA should be alerted to the potential for additive central nervous system effects when ATRIPLA is used concomitantly with alcohol or psychoactive drugs. Patients who experience central nervous system symptoms such as dizziness, impaired concentration, and/or drowsiness should avoid potentially hazardous tasks such as driving or operating machinery.

5.8 New Onset or Worsening Renal Impairment

Emtricitabine and tenofovir are principally eliminated by the kidney; however, efavirenz is not. Since ATRIPLA is a combination product and the dose of the individual components cannot be altered, patients with estimated creatinine clearance below 50 mL/min should not receive ATRIPLA.

Renal impairment, including cases of acute renal failure and Fanconi syndrome (renal tubular injury with severe hypophosphatemia) has been reported with the use of tenofovir DF [See Adverse Reactions (6.6)]. It is recommended that estimated creatinine clearance be assessed in all patients prior to initiating therapy and as clinically appropriate during therapy with ATRIPLA. In patients at risk of renal dysfunction, including patients who have previously experienced renal events while receiving Hepsera, it is recommended that estimated creatinine clearance, serum phosphorus, urine glucose, and urine protein be assessed prior to initiation of ATRIPLA and periodically during ATRIPLA therapy.

ATRIPLA should be avoided with concurrent or recent use of a nephrotoxic agent (e.g., high-dose or multiple non-steroidal anti-inflammatory drugs [NSAIDs]) [See Drug Interactions (7.2)]. Cases of acute renal failure after initiation of high-dose or multiple NSAIDs have been reported in HIV-infected patients with risk factors for renal dysfunction who appeared stable on tenofovir DF. Some patients required hospitalization and renal replacement therapy. Alternatives to NSAIDs should be considered, if needed, in patients at risk for renal dysfunction.

Persistent or worsening bone pain, pain in extremities, fractures, and/or muscular pain or weakness may be manifestations of proximal renal tubulopathy and should prompt an evaluation of renal function in at-risk patients.

5.9 Reproductive Risk Potential

Pregnancy Category D: Efavirenz may cause fetal harm when administered during the first trimester to a pregnant woman. Pregnancy should be avoided in women receiving ATRIPLA. Barrier contraception must always be used in combination with other methods of contraception (e.g., oral or other hormonal contraceptives). Because of the long half-life of efavirenz, use of adequate contraceptive measures for 12 weeks after discontinuation of ATRIPLA is recommended. Women of childbearing potential should undergo pregnancy testing before initiation of ATRIPLA. If this drug is used during the first trimester of pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential harm to the fetus.

There are no adequate and well-controlled trials of ATRIPLA in pregnant women. ATRIPLA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus, such as in pregnant women without other therapeutic options [See Use in Specific Populations (8.1)].

5.10 Rash

In controlled clinical trials, 26% (266/1008) of adult subjects treated with 600 mg efavirenz experienced new-onset skin rash compared with 17% (111/635) of those treated in control groups. Rash associated with blistering, moist desquamation, or ulceration occurred in 0.9% (9/1008) of subjects treated with efavirenz. The incidence of Grade 4 rash (e.g., erythema multiforme, Stevens-Johnson syndrome) in adult subjects treated with efavirenz in all trials and expanded access was 0.1%. Rashes are usually mild-to-moderate maculopapular skin eruptions that occur within the first 2 weeks of initiating therapy with efavirenz (median time to onset of rash in adults was 11 days) and, in most subjects continuing therapy with efavirenz, rash resolves within 1 month (median duration, 16 days). The discontinuation rate for rash in adult clinical trials was 1.7% (17/1008). ATRIPLA can be reintitated in patients interrupting therapy because of rash. ATRIPLA should be discontinued in patients developing severe rash associated with blistering, desquamation, mucosal involvement, or fever. Appropriate antihistamines and/or corticosteroids may improve the tolerability and hasten the resolution of rash. For patients who have had a life-threatening cutaneous reaction (e.g., Stevens-Johnson syndrome), alternative therapy should be considered [See Contraindications (4.1)].

Experience with efavirenz in subjects who discontinued other antiretroviral agents of the NNRTI class is limited. Nineteen subjects who discontinued nevirapine because of rash have been treated with efavirenz. Nine of these subjects developed mild-to-moderate rash while receiving therapy with efavirenz, and two of these subjects discontinued because of rash.

Rash was reported in 59 of 182 pediatric subjects (32%) treated with efavirenz [See Adverse Reactions (6.1)]. Two pediatric subjects experienced Grade 3 rash (confluent rash with fever, generalized rash), and four subjects had Grade 4 rash (erythema multiforme). The median time to onset of rash in pediatric subjects was 28 days (range 3–1642 days). Prophylaxis with appropriate antihistamines before initiating therapy with ATRIPLA in pediatric patients should be considered.

5.11 Hepatotoxicity

Monitoring of liver enzymes before and during treatment is recommended for patients with underlying hepatic disease, including hepatitis B or C infection; patients with marked transaminase elevations; and patients treated with other medications associated with liver toxicity [See Warnings and Precautions (5.1)]. A few of the postmarketing reports of hepatic failure occurred in patients with no pre-existing hepatic disease or other identifiable risk factors [See Adverse Reactions (6.3)]. Liver enzyme monitoring should also be considered for patients without pre-existing hepatic dysfunction or other risk factors. In patients with persistent elevations of serum transaminases to greater than five times the upper limit of the normal range, the benefit of continued therapy with ATRIPLA needs to be weighed against the unknown risks of significant liver toxicity [See Adverse Reactions (6.2)].

5.12 Bone Effects of Tenofovir DF

Bone Mineral Density

In clinical trials in HIV-1 infected adults, tenofovir DF was associated with slightly greater decreases in bone mineral density (BMD) and increases in biochemical markers of bone metabolism, suggesting increased bone turnover relative to comparators. Serum parathyroid hormone levels and 1,25 Vitamin D levels were also higher in subjects receiving tenofovir DF.

Clinical trials evaluating tenofovir DF in pediatric and adolescent subjects were conducted. Under normal circumstances, BMD increases rapidly in pediatric patients. In HIV-infected subjects aged 2 years to less than 18 years, bone effects were similar to those observed in adult subjects and suggest increased bone turnover. Total body BMD gain was less in the tenofovir DF treated HIV-1 infected pediatric subjects as compared to the control groups. Similar trends were observed in chronic hepatitis-B infected adolescent subjects aged 12 years to less than 18 years. In all pediatric trials, skeletal growth (height) appeared to be unaffected. For more information, consult the WREAP prescribing information.

The effects of tenofovir DF-associated changes in BMD and biochemical markers on long-term bone health and future fracture risk are unknown. Assessment of BMD should be considered for adult and pediatric patients who have a history of pathologic bone fracture or other risk factors for osteoporosis or bone loss. Although the effect of supplementation with calcium and vitamin D was not studied, such supplementation may be beneficial for all patients. If bone abnormalities are suspected, then appropriate consultation should be obtained.

Mineralization Defects

Cases of osteomalacia associated with proximal renal tubulopathy, manifested as bone pain or pain in extremities and which may contribute to fractures, have been reported in association with the use of tenofovir DF [See Adverse Reactions (6.3)]. Arthralgias and muscle pain or weakness have also been reported in cases of proximal renal tubulopathy. Hypophosphatemia and osteomalacia should be considered in patients at risk of renal dysfunction who present with persistent or worsening bone or muscle symptoms while receiving products containing tenofovir DF [See Warnings and Precautions (5.8)].

5.13 Convolutions

Convolutions have been observed in adult and pediatric patients receiving efavirenz, generally in the presence of known medical history of seizures. Caution must be taken in any patient with a history of seizures.
Patients who are receiving concomitant anticonvulsant medications primarily metabolized by the liver, such as phenytoin and phenobarbital, may require periodic monitoring of plasma levels [See Drug Interactions (7.3)].

5.14 Immune Reconstitution Syndrome

Immune reconstitution syndrome has been reported in patients treated with combination antiretroviral therapy, including the components of ATRIPLA. During the initial phase of combination antiretroviral treatment, patients whose immune system responds may develop an inflammatory response to indolent or residual opportunistic infections (such as Mycobacterium avium infection, cytomegalovirus, Pneumocystis jiroveci pneumonia [PCP], or tuberculosis), which may necessitate further evaluation and treatment.

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

5.15 Fat Redistribution

Redistribution/accumulation of body fat, including central obesity, dorsocervical fat enlargement (buffalo hump), peripheral wasting, facial wasting, breast enlargement, and “cushinoid appearance,” has been observed in patients receiving antiretroviral therapy, including efavirenz. The mechanism and long-term consequences of these events are currently unknown. A causal relationship has not been established.

6 ADVERSE REACTIONS

Efavirenz, Emtricitabine and Tenofovir DF: The following adverse reactions are discussed in other sections of the labeling:

- Severe Acute Exacerbations of Hepatitis B [See Boxed Warning, Warnings and Precautions (5.1)].
- Lactic Acidosis/Severe Hepatomegaly with Steatosis [See Warnings and Precautions (5.3)].
- QTc Prolongation [See Warnings and Precautions (5.5)].
- Psychiatric Symptoms [See Warnings and Precautions (5.6)].
- Nervous System Symptoms [See Warnings and Precautions (5.7)].
- New Onset or Worsening Renal Impairment [See Warnings and Precautions (5.8)].
- Rash [See Warnings and Precautions (5.10)].
- Hepatotoxicity [See Warnings and Precautions (5.11)].
- Bone Effects of Tenofovir DF [See Warnings and Precautions (5.12)].
- Immune Reconstitution Syndrome [See Warnings and Precautions (5.14)].
- Fat Redistribution [See Warnings and Precautions (5.15)].
- Drug Interactions [See Contraindications (4.2), Warnings and Precautions (5.2) and Drug Interactions (7)].

For additional safety information about SUSTIVA (efavirenz), EMTRIVA (emtricitabine), or VIREAD (tenofovir DF) in combination with other antiretroviral agents, consult the prescribing information for these products.

6.1 Adverse Reactions from Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

Clinical Trials in Adult Subjects

Study 934

Study 934 was an open-label active-controlled trial in which 511 antiretroviral-naïve subjects received efavirenz + tenofovir DF administered in combination with efavirenz (N=257) or zidovudine/lamivudine administered in combination with efavirenz (N=254).

The most common adverse reactions (incidence greater than or equal to 10%, any severity) occurring in Study 934 include diarrhea, nausea, fatigue, headache, dizziness, depression, insomnia, abnormal dreams, and rash. Adverse reactions observed in Study 934 were generally consistent with those seen in previous trials of the individual components (Table 1).

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Selected Treatment-Emergent Adverse Reactions (Grades 2–4) Reported in ≥5% in Either Treatment Group in Study 934 (0–144 Weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FTC+TDF+EFV</td>
</tr>
<tr>
<td></td>
<td>N=257</td>
</tr>
<tr>
<td>Gastrointestinal Disorder</td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td>9%</td>
</tr>
<tr>
<td>Nausea</td>
<td>9%</td>
</tr>
<tr>
<td>Vomiting</td>
<td>2%</td>
</tr>
<tr>
<td>General Disorders and Administration Site Condition</td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td>9%</td>
</tr>
</tbody>
</table>

Study 073

In Study 073, subjects with stable, virologic suppression on antiretroviral therapy and no history of virologic failure were randomized to receive ATRIPLA or to stay on their baseline regimen. The adverse reactions observed in Study 073 were generally consistent with those seen in Study 934 and those seen with the individual components of ATRIPLA when each was administered in combination with other antiretroviral agents.

Efavirenz, Emtricitabine, or Tenofovir DF

In addition to the adverse reactions in Study 934 and Study 073, the following adverse reactions were observed in clinical trials of efavirenz, emtricitabine, or tenofovir DF in combination with other antiretroviral agents.

Efavirenz: The most significant adverse reactions observed in subjects treated with efavirenz were nervous system symptoms [See Warnings and Precautions (5.7)], psychiatric symptoms [See Warnings and Precautions (5.6)], and rash [See Warnings and Precautions (5.10)].

Selected adverse reactions of moderate-to-severe intensity observed in greater than or equal to 2% of efavirenz-treated subjects in two controlled clinical trials included pain, impaired concentration, abnormal dreams, somnolence, anorexia, dyspepsia, abdominal pain, nervousness, and pruritus.

Pancreatitis has also been reported, although a causal relationship with efavirenz has not been established. Asymptomatic increases in serum amylase levels were observed in a significantly higher number of subjects treated with efavirenz 600 mg than in control subjects.

Emtricitabine and Tenofovir DF: Adverse reactions that occurred in at least 5% of treatment-experienced or treatment-naïve subjects receiving emtricitabine or tenofovir DF with other antiretroviral agents in clinical trials included arthralgia, increased cough, dyspepsia, fever, myalgia, pain, abdominal pain, back pain, paresthesia, peripheral neuropathy (including peripheral neuritis and neuropathy), pneumonia, rashes, and rash event (including rash, pruritus, maculopapular rash, urticaria, vesiculobullous rash, purpuric rash, and allergic reaction).

Skin discoloration has been reported with higher frequency among emtricitabine-treated subjects; it was manifested by hyperpigmentation on the palms and/or soles and was generally mild and asymptomatic. The mechanism and clinical significance are unknown.

Clinical Trials in Pediatric Subjects

Efavirenz: Assessment of adverse reactions is based on three pediatric clinical trials in 182 HIV-1 infected pediatric subjects 3 months to 21 years of age who received efavirenz in combination with other antiretroviral agents for a median of 123 weeks. The type and frequency of adverse reactions in the three trials were generally similar to that of adult subjects with the exception of a higher incidence of rash, which was reported in 32% (69/182) of pediatric subjects compared to 26% of adults, and a higher frequency of Grade 3 or 4 rash reported in 3% (6/182) of pediatric subjects compared to 0.9% of adults [See Warnings and Precautions (5.10)]. For additional information, please consult the SUSTIVA prescribing information.
**ATRIPLA® (efavirenz/emtricitabine/tenofovir disoproxil fumarate)**

*Efavirenz:* In addition to the adverse reactions reported in adults, anemia and hyperpigmentation were observed in 7% and 32%, respectively, of pediatric subjects (3 months to less than 18 years of age) who received treatment with emtricitabine in the larger of two open-label, uncontrolled pediatric trials (N=116). For additional information, please consult the EMTRIVA prescribing information.

*Tenoforv DF:* In a pediatric clinical trial conducted in subjects 12 to less than 18 years of age, the adverse reactions observed in pediatric subjects who received treatment with tenofovir DF were consistent with those observed in clinical trials of tenofovir DF in adults [See Warnings and Precautions (5.17)].

### 6.2 Laboratory Abnormalities

**Efavirenz, Emtricitabine and Tenofovir DF:** Laboratory abnormalities observed in Study 934 were generally consistent with those seen in previous trials (Table 2).

#### Table 2  Significant Laboratory Abnormalities Reported in ≥1% of Subjects in Either Treatment Group in Study 934 (0–144 Weeks)

<table>
<thead>
<tr>
<th></th>
<th>FTC+TDF+EFV&lt;sup&gt;a&lt;/sup&gt;</th>
<th>AZT/3TC+EFV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any ≥ Grade 3 Laboratory Abnormality</td>
<td>30%</td>
<td>26%</td>
</tr>
<tr>
<td>Fasting Cholesterol (&gt;240 mg/dL)</td>
<td>22%</td>
<td>24%</td>
</tr>
<tr>
<td>Creatine Kinase (M: &gt;990 U/L; F: &gt;845 U/L)</td>
<td>9%</td>
<td>7%</td>
</tr>
<tr>
<td>Serum Amylase (&gt;175 U/L)</td>
<td>8%</td>
<td>4%</td>
</tr>
<tr>
<td>Alkaline Phosphatase (&gt;550 U/L)</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>AST (M: &gt;180 U/L; F: &gt;170 U/L)</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>ALT (M: &gt;215 U/L; F: &gt;170 U/L)</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>Hemoglobin (&lt;8.0 mg/dL)</td>
<td>0%</td>
<td>4%</td>
</tr>
<tr>
<td>Hyperglycemia (&gt;250 mg/dL)</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Hematuria (&gt;75 RBC/HPF)</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Glycosuria (&gt;3+)</td>
<td>&lt;1%</td>
<td>1%</td>
</tr>
<tr>
<td>Neutrophils (&lt;750/mm&lt;sup&gt;3&lt;/sup&gt;)</td>
<td>3%</td>
<td>5%</td>
</tr>
<tr>
<td>Fasting Triglycerides (&gt;750 mg/dL)</td>
<td>4%</td>
<td>2%</td>
</tr>
</tbody>
</table>

<sup>a</sup> From Weeks 96 to 144 of the trial, subjects received emtricitabine/tenofovir DF administered in combination with efavirenz in place of emtricitabine + tenofovir DF with efavirenz.

Laboratory abnormalities observed in Study 073 were generally consistent with those in Study 934.

In addition to laboratory abnormalities described for Study 934 (Table 2), Grade 3/4 laboratory abnormalities of increased bilirubin (greater than 2.0 x upper limit of normal (ULN)), increased pancreatic amylase (greater than 2.0 x ULN), increased or decreased serum glucose (less than 40 or greater than 250 mg/dL), and increased serum lipase (greater than 2.0 x ULN) occurred in up to 3% of subjects treated with emtricitabine or tenofovir DF with other antiretroviral agents in clinical trials.

**Hepatic Events:** In Study 934, 19 subjects treated with efavirenz, emtricitabine, and tenofovir DF and 20 subjects treated with efavirenz and fixed-dose zidovudine/lamivudine were hepatitis B surface antigen or hepatitis C antibody positive. Among these coinfected subjects, one subject (1/19) in the efavirenz, emtricitabine, and tenofovir DF arm had elevations in transaminases to greater than five times ULN through 144 weeks. In the fixed-dose zidovudine/lamivudine arm, two subjects (2/20) had elevations in transaminases to greater than five times ULN through 144 weeks. No HBV and/or HCV coinfected subject discontinued from the trial due to hepatobiliary disorders [See Warnings and Precautions (5.11)].

### 6.3 Postmarketing Experience

The following adverse reactions have been identified during postapproval use of efavirenz, emtricitabine, or tenofovir DF. Because postmarketing reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

**Efavirenz:**

- **Cardiac Disorders**
  - Palpitations
- **Ear and Labyrinth Disorders**
  - Tinitus, vertigo
- **Endocrine Disorders**
  - Gynecomastia

**Emtricitabine:**

- **Ear and Labyrinth Disorders**
  - Tinnitus, vertigo
- **Endocrine Disorders**
  - Gynecomastia
- **Hepatobiliary Disorders**
  - Hepatic enzyme increase, hepatic failure, hepatitis. A few of the postmarketing reports of hepatic failure, including cases in patients with no pre-existing hepatic disease or other identifiable risk factors, were characterized by a fulminant course, progressing in some cases to transplantation or death.

**Tenofovir DF:**

- **Eye Disorders**
  - Abnormal vision
- **Gastrointestinal Disorders**
  - Constipation, malabsorption
- **General Disorders and Administration Site Conditions**
  - Asthenia
- **Psychiatric Disorders**
  - Aggressive reactions, agitation, delusions, emotional lability, mania, neurosis, paranoia, psychosis, suicide, catatonia
- **Respiratory, Thoracic and Mediastinal Disorders**
  - Dyspnea
  - Skin and Subcutaneous Tissue Disorders
    - Flushing, erythema multiforme, photoallergic dermatitis, Stevens-Johnson syndrome

**Emtricitabine:**

- **Eye Disorders**
  - Allergic reactions
- **Gastrointestinal Disorders**
  - Abnormal coordination, ataxia, cerebellar coordination and balance disturbances, convulsions, hypoaesthesia, paresis, neuropathy, tremor
- **Musculoskeletal and Connective Tissue Disorders**
  - Asthenia
  - Pancreatitis, increased amylase, abdominal pain
- **Nervous System Disorders**
  - Abnormal coordination, ataxia, cerebellar coordination and balance disturbances, convulsions, hypoaesthesia, paresis, neuropathy, tremor
- **Psychiatric Disorders**
  - Aggressive reactions, agitation, delusions, emotional lability, mania, neurosis, paranoia, psychosis, suicide, catatonia
- **Respiratory, Thoracic and Mediastinal Disorders**
  - Dyspnea
- **Skin and Subcutaneous Tissue Disorders**
  - Flushing, erythema multiforme, photoallergic dermatitis, Stevens-Johnson syndrome
- **Skin and Subcutaneous Tissue Disorders**
  - Flushing, erythema multiforme, photoallergic dermatitis, Stevens-Johnson syndrome

**Tenofovir DF:**

- **Immune System Disorders**
  - Allergic reaction, including angioedema
- **Metabolism and Nutrition Disorders**
  - Lactic acidosis, hypokalemia, hypophosphatemia
- **Respiratory, Thoracic and Mediastinal Disorders**
  - Dyspnea
- **Gastrointestinal Disorders**
  - Pancreatitis, increased amylase, abdominal pain
- **Hepatobiliary Disorders**
  - Hepatic steatosis, hepatitis, increased liver enzymes (most commonly AST, ALT, gamma GT)
- **Skin and Subcutaneous Tissue Disorders**
  - Rash

**Mucoskeletal and Connective Tissue Disorders**

- **Drug Interactions**

### 7 DRUG INTERACTIONS

This section describes clinically relevant drug interactions with ATRIPLA. Drug interaction trials are described elsewhere in the labeling [See Clinical Pharmacology (12.3)].
## 7.2 Efavirenz, Emtricitabine and Tenofovir DF

Since emtricitabine and tenofovir are primarily eliminated by the kidneys, coadministration of ATRIPLA with drugs that reduce renal function or compete for active tubular secretion may increase serum concentrations of emtricitabine, tenofovir, and/or other renally eliminated drugs. Some examples include, but are not limited to, acyclovir, adeefovir dipivoxil, cidofovir, ganciclovir, valacyclovir, valganciclovir, aminoglycosides (e.g., gentamicin), and high-dose or multiple NSAIDs (See Warnings and Precautions (5.8)).

Coadministration of tenofovir DF and didanosine should be undertaken with caution, and patients receiving this combination should be monitored closely for didanosine-associated adverse reactions. Didanosine should be discontinued in patients who develop didanosine-associated adverse reactions (for didanosine dosing adjustment recommendations, see Table 3). Suppression of CD4+ cell counts has been observed in patients receiving tenofovir DF with didanosine 400 mg daily.

Darunavir with ritonavir and lopinavir/ritonavir have been shown to increase tenofovir concentrations. Tenofovir DF is a substrate of P-glycoprotein (P-gp) and breast cancer resistance protein (BCRP) transporters. When tenofovir DF is coadministered with an inhibitor of these transporters, an increase in absorption may be observed. Patients receiving darunavir with ritonavir and ATRIPLA, or lopinavir/ritonavir with ATRIPLA, should be monitored for tenofovir-associated adverse reactions. ATRIPLA should be discontinued in patients who develop tenofovir-associated adverse reactions (Table 3). Coadministration of atazanavir with ATRIPLA is not recommended, as coadministration of atazanavir with either efavirenz or tenofovir DF has been shown to decrease plasma concentrations of atazanavir. Also, atazanavir has been shown to increase tenofovir concentrations. There are insufficient data to support dosing recommendations for atazanavir or atazanavir/ritonavir in combination with ATRIPLA (Table 3).

### Other important drug interaction information for ATRIPLA

The drug interactions described are based on trials conducted with either ATRIPLA, the components of ATRIPLA (efavirenz, emtricitabine, or tenofovir DF) as individual agents, or are potential drug interactions for pharmacokinetic data see Clinical Pharmacology (12.3), Tables 4–7. The tables include potentially significant interactions, but are not all inclusive.

#### Table 3 Established and Other Potentially Significant Drug Interactions: Alteration in Dose or Regimen May Be Recommended Based on Drug Interaction Triads or Predicted Interaction

<table>
<thead>
<tr>
<th>Concomitant Drug Class: Drug Name</th>
<th>Effect</th>
<th>Clinical Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV antiviral agents</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protease inhibitor: atazanavir</td>
<td>↓ atazanavir ↑ tenofovir</td>
<td>Coadministration of atazanavir with ATRIPLA is not recommended. Coadministration of atazanavir with either efavirenz or tenofovir DF decreases plasma concentrations of atazanavir. The combined effect of efavirenz plus tenofovir DF on atazanavir plasma concentrations is not known. Also, atazanavir has been shown to increase tenofovir concentrations. There are insufficient data to support dosing recommendations for atazanavir or atazanavir/ritonavir in combination with ATRIPLA.</td>
</tr>
<tr>
<td>Protease inhibitor: fosamprenavir calcium</td>
<td>↓ amprenavir</td>
<td>Fosamprenavir (unboosted): Appropriate doses of fosamprenavir and ATRIPLA with respect to safety and efficacy have not been established. Fosamprenavir/ritonavir: An additional 100 mg/day (300 mg total) of ritonavir is recommended when ATRIPLA is administered with fosamprenavir/ritonavir once daily. No change in the ritonavir dose is required when ATRIPLA is administered with fosamprenavir plus ritonavir twice daily.</td>
</tr>
<tr>
<td>Protease inhibitor: indinavir</td>
<td>↓ indinavir</td>
<td>The optimal dose of indinavir, when given in combination with efavirenz, is not known. Increasing the indinavir dose to 1000 mg every 8 hours does not compensate for the increased indinavir metabolism due to efavirenz.</td>
</tr>
<tr>
<td>Protease inhibitor: lopinavir/ritonavir</td>
<td>↓ lopinavir ↑ tenofovir</td>
<td>Do not use once daily administration of lopinavir/ritonavir. Dose increase of lopinavir/ritonavir is recommended for all patients who coadministered with efavirenz. Refer to the full prescribing information for lopinavir/ritonavir for guidance on coadministration with efavirenz- or tenofovir-containing regimens, such as ATRIPLA. Patients should be monitored for tenofovir-associated adverse reactions.</td>
</tr>
</tbody>
</table>

### NNRTI:

<table>
<thead>
<tr>
<th>Other NNRTIs</th>
<th>↑ or ↓ efavirenz and/or NNRTI</th>
<th>Combining two NNRTIs has not been shown to be beneficial. ATRIPLA contains efavirenz and should not be coadministered with other NNRTIs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrase strand transfer inhibitor: raltegravir</td>
<td>↓ raltegravir</td>
<td>Efavirenz reduces plasma concentrations of raltegravir. The clinical significance of this interaction has not been directly assessed.</td>
</tr>
<tr>
<td>Protease inhibitor: boceprevir</td>
<td>↓ boceprevir</td>
<td>Plasma trough concentrations of boceprevir were decreased when boceprevir was coadministered with efavirenz, which may result in loss of therapeutic effect. The combination should be avoided.</td>
</tr>
<tr>
<td>Protease inhibitor: simprevir</td>
<td>↓ simprevir ↑ efavirenz</td>
<td>Concomitant administration of simprevir with efavirenz is not recommended because it may result in loss of therapeutic effect of simprevir.</td>
</tr>
<tr>
<td>NRTIs: didanosine</td>
<td>↑ didanosine</td>
<td>Coadministration of ATRIPLA and didanosine should be undertaken with caution, and patients receiving this combination should be monitored closely for didanosine-associated adverse reactions including pancreatitis, lactic acidosis, and neuropathy. A dose reduction of didanosine is recommended when coadministered with tenofovir DF. For additional information on coadministration with tenofovir DF-containing products, please refer to the didanosine prescribing information.</td>
</tr>
<tr>
<td>Other agents</td>
<td></td>
<td>Plasma concentrations and effects potentially increased or decreased by efavirenz.</td>
</tr>
<tr>
<td>Anticoagulant: warfarin</td>
<td>↑ or ↓ warfarin</td>
<td>Plasma concentrations and effects potentially increased or decreased by efavirenz.</td>
</tr>
<tr>
<td>Anticonvulsants: carbamazepine</td>
<td>↓ carbamazepine ↑ efavirenz</td>
<td>There are insufficient data to make a dose recommendation for ATRIPLA. Alternative anticonvulsant treatment should be used.</td>
</tr>
<tr>
<td>Antidepressants: bupropion</td>
<td>↓ bupropion</td>
<td>The effect of efavirenz on bupropion exposure is thought to be due to the induction of bupropion metabolism. Increases in bupropion dosage should be guided by clinical response, but the maximum recommended dose of bupropion should not be exceeded.</td>
</tr>
</tbody>
</table>
### Table 3 (Continued) Established and Other Potentially Significant® Drug Interactions: Alteration in Dose or Regimen May Be Recommended Based on Drug Interaction Trials or Predicted Interaction

<table>
<thead>
<tr>
<th>Concomitant Drug Class: Drug Name</th>
<th>Effect</th>
<th>Clinical Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Other agents (Continued)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>sertraline</td>
<td>↓ sertraline</td>
<td>Increases in sertraline dose should be guided by clinical response.</td>
</tr>
<tr>
<td>Antifungals: itraconazole</td>
<td>↓ itraconazole ↓ hydroxy-itraconazole</td>
<td>Since no dose recommendation for itraconazole can be made, alternative antifungal treatment should be considered.</td>
</tr>
<tr>
<td>ketoconazole</td>
<td>↓ ketoconazole</td>
<td>Drug interaction trials with ATRIPLA and ketoconazole have not been conducted. Efavirenz has the potential to decrease plasma concentrations of ketoconazole.</td>
</tr>
<tr>
<td>posaconazole</td>
<td>↓ posaconazole</td>
<td>Avoid concomitant use unless the benefit outweighs the risks.</td>
</tr>
<tr>
<td>Anti-infective: clarithromycin</td>
<td>↑ clarithromycin 14-OH metabolite</td>
<td>Consider alternatives to macrolide antibiotics because of the risk of QT interval prolongation.</td>
</tr>
<tr>
<td>Antimycobacterial: rifampin</td>
<td>↓ rifampin</td>
<td>Increase daily dose of rifampin by 50%. Consider doubling the rifabutin dose in regimes where rifabutin is given 2 or 3 times a week.</td>
</tr>
<tr>
<td>Antimalarials: artesunate/ lumefantrine</td>
<td>↓ artemether ↓ dihydroartesminin ↓ lumefantrine</td>
<td>Consider alternatives to artemether/ lumefantrine because of the risk of QT interval prolongation.</td>
</tr>
<tr>
<td>atovaquone/ proguanil</td>
<td>↓ atovaquone ↓ proguanil</td>
<td>Concomitant administration of atovaquone/proguanil with ATRIPLA is not recommended.</td>
</tr>
<tr>
<td>Calcium channel blockers: diltiazem</td>
<td>↓ diltiazem desacetyl diltiazem N-monodes-methyl diltiazem</td>
<td>Diltiazem dose adjustments should be guided by clinical response (refer to the full prescribing information for diltiazem). No dose adjustment of ATRIPLA is necessary when administered with diltiazem.</td>
</tr>
<tr>
<td>Others (e.g., feldopidine, nicardipine, nifedipine, verapamil)</td>
<td>↓ calcium channel blocker</td>
<td>No data are available on the potential interactions of efavirenz with other calcium channel blockers that are substrates of CYP3A. The potential exists for reduction in plasma concentrations of the calcium channel blocker. Dose adjustments should be guided by clinical response (refer to the full prescribing information for the calcium channel blocker).</td>
</tr>
<tr>
<td>HMG-CoA reductase inhibitors: atorvastatin pravastatin simvastatin</td>
<td>↓ atorvastatin ↓ pravastatin ↓ simvastatin</td>
<td>Plasma concentrations of atorvastatin, pravastatin, and simvastatin decreased with efavirenz. Consult the full prescribing information for the HMG-CoA reductase inhibitor for guidance on individualizing the dose.</td>
</tr>
<tr>
<td>Hormonal contraceptives: Oral: ethinyl estradiol/ norgestimate</td>
<td>↓ active metabolites of norgestimate</td>
<td>A reliable method of barrier contraception must be used in addition to hormonal contraceptives. Efavirenz had no effect on ethinyl estradiol concentrations, but progestin levels (norelgestromin and levonorgestrel) were markedly decreased. No effect of ethinyl estradiol/norgestimate on efavirenz plasma concentrations was observed. A reliable method of barrier contraception must be used in addition to hormonal contraceptives. The interaction between etonogestrel and efavirenz has not been studied. Decreased exposure of etonogestrel may be expected. There have been postmarketing reports of contraceptive failure with etonogestrel in efavirenz-exposed patients.</td>
</tr>
<tr>
<td>Implant: etonogestrel</td>
<td>↓ etonogestrel</td>
<td></td>
</tr>
</tbody>
</table>

### Table 3 (Continued) Established and Other Potentially Significant® Drug Interactions: Alteration in Dose or Regimen May Be Recommended Based on Drug Interaction Trials or Predicted Interaction

<table>
<thead>
<tr>
<th>Concomitant Drug Class: Drug Name</th>
<th>Effect</th>
<th>Clinical Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immuno-suppressants: cyclosporine, tacrolimus, sirolimus, and others metabolized by CYP3A</td>
<td>↓ immuno-suppressant</td>
<td>Decreased exposure of the immuno-suppressant may be expected due to CYP3A induction by efavirenz. These immuno-suppressants are not anticipated to affect exposure of efavirenz. Dose adjustments of the immuno-suppressant may be required. Close monitoring of immuno-suppressant concentrations for at least 2 weeks (until stable concentrations are reached) is recommended when starting or stopping treatment with ATRIPLA.</td>
</tr>
<tr>
<td>Narcotic analgesics: methadone</td>
<td>↓ methadone</td>
<td>Close monitoring of efavirenz in HIV-1 infected patients with a history of injection drug use resulted in decreased plasma levels of methadone and signs of opiate withdrawal. Methadone dose was increased by a mean of 22% to alleviate withdrawal symptoms. Patients should be monitored for signs of withdrawal and their methadone dose increased as required to alleviate withdrawal symptoms.</td>
</tr>
</tbody>
</table>

a. This table is not all inclusive. **

### 7.4 Efavirenz Assay Interference

Cannabinoid Test Interaction: Efavirenz does not bind to cannabinoid receptors. False-positive urine cannabinoid test results have been reported with cannabinoid screening tests in uninfected and HIV-infected subjects receiving efavirenz. Confirmation of positive screening tests for cannabinoids by a more specific method is recommended.

### 8 USE IN SPECIFIC POPULATIONS

#### 8.1 Pregnancy

*Antiretroviral Pregnancy Registry:* To monitor fetal outcomes of pregnant women, an Antiretroviral Pregnancy Registry has been established. Physicians are encouraged to register patients who become pregnant by calling (800) 258-4263.

*Efavirenz:* As of July 2010, the Antiretroviral Pregnancy Registry has received prospective reports of 792 pregnancies exposed to efavirenz-containing regimens, nearly all of which were first-trimester exposures (718 pregnancies). Birth defects occurred in 17 of 604 live births (first-trimester exposure) and 2 of 69 live births (second/third-trimester exposure). One of these prospectively reported defects with first-trimester exposure was a neural tube defect. A single case of anophthalmia with first-trimester exposure to efavirenz has also been prospectively reported; however, this case included severe oblique facial clefts and amniotic banding, a known association with anophthalmia. There have been six retrospective reports of findings consistent with neural tube defects, including meningocele. All mothers were exposed to efavirenz-containing regimens in the first trimester. Although a causal relationship of these events to the use of efavirenz has not been established, similar defects have been observed in preclinical studies of efavirenz.

*Animal Data* Effects of efavirenz on embryo-fetal development have been studied in three nonclinical species (cynomolgus monkeys, rats, and rabbits). In monkeys, efavirenz 60 mg/kg/day was administered to pregnant females throughout pregnancy (gestation Days 20 through 150). The maternal systemic drug exposures (AUC) were 1.3 times the exposure in humans at the recommended clinical dose (600 mg/day), with fetal umbilical venous drug concentrations approximately 0.7 times the maternal values. Three fetuses of 20 fetuses/infants had one or more malformations; there were no malformed fetuses or infants from placebo-treated mothers. The malformations that occurred in these three monkey fetuses included anencephaly and unilateral anophthalmia in one fetus, microphthalmia in a second, and cleft palate in the third. There was no NOEL (no observable adverse effect level) established for this study because only one dosage was evaluated. In rats, efavirenz was administered either during organogenesis (gestation Days 7 to 18) or from gestation Day 7 through lactation Day 21 at 50, 100, or 200 mg/kg/day. Administration of 200 mg/kg/day in rats was associated with an increase in the incidence of early resorptions, and doses 100 mg/kg/day and greater were associated with early neonatal mortality. The AUC at the NOEL (50 mg/kg/day) in this rat study was 0.1 times that in humans at the recommended clinical dose. Drug concentrations in the milk on lactation Day 10 were approximately 8 times higher than those in maternal plasma. In pregnant rabbits, efavirenz was neither embryo lethal nor teratogenic when administered at doses of 25, 50, and 75 mg/kg/day over the period of organogenesis (gestation Days 6 through 18). The AUC at the NOEL (75 mg/kg/day) in rabbits was 0.4 times that in humans at the recommended clinical dose.
8.3 Nursing Mothers

The Centers for Disease Control and Prevention recommend that HIV-1-infected mothers not breastfeed their infants to avoid risking postnatal transmission of HIV-1. Studies in humans have shown that efavirenz, tenofovir, and emtricitabine are excreted in human milk. Because of the risks of low-level exposure to efavirenz, emtricitabine, and tenofovir to infants are unknown, and because of the potential for HIV-1 transmission, mothers should be instructed not to breastfeed if they are receiving ATRIPLA.

Emtricitabine

Samples of breast milk obtained from five HIV-1-infected mothers show that emtricitabine is secreted in human milk. Breastfeeding infants whose mothers are being treated with emtricitabine may be at risk for developing viral resistance to emtricitabine. Other emtricitabine-associated risks in breastfed infants by mothers being treated with emtricitabine are unknown.

Tenofovir DF

Samples of breast milk obtained from five HIV-1-infected mothers show that tenofovir is secreted in human milk. Tenofovir-associated risks in breastfed infants by mothers being treated with tenofovir disoproxil fumarate are unknown.

8.4 Pediatric Use

ATRIPLA should only be administered to pediatric patients 12 years of age and older with a body weight greater than or equal to 40 kg (greater than or equal to 88 lbs) because ATRIPLA is a fixed-dose combination tablet, the dose adjustments recommended for pediatric patients younger than 12 years of age for each individual component cannot be made with ATRIPLA [See Warnings and Precautions (5.10, 5.12), Adverse Reactions (6.1), and Clinical Pharmacology (12.3)].

8.5 Geriatric Use

Clinical trials of efavirenz, emtricitabine, or tenofovir DF did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. In general, dose selection for elderly patients should be cautious, keeping in mind the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

8.6 Hepatic Impairment

ATRIPLA is not recommended for patients with moderate or severe hepatic impairment because there are insufficient data to determine an appropriate dose. Patients with mild hepatic impairment may be treated with ATRIPLA at the approved dose. Because of the extensive cytochrome P450-mediated metabolism of efavirenz and limited clinical experience in patients with hepatic impairment, caution should be exercised in administering ATRIPLA to these patients [See Warnings and Precautions (5.11) and Clinical Pharmacology (12.3)].

8.7 Renal Impairment

Because ATRIPLA is a fixed-dose combination, it should not be prescribed for patients requiring dosage adjustment such as those with moderate or severe renal impairment (estimated creatinine clearance below 50 mL/min) [See Warnings and Precautions (5.8)].

10 OVERDOSAGE

If overdose occurs, the patient should be monitored for evidence of toxicity, including monitoring of vital signs and observation of the patient’s clinical status; standard supportive treatment should then be applied as necessary. Administration of activated charcoal may be used to aid removal of unabsorbed efavirenz. Hemodialysis can remove both emtricitabine and tenofovir DF (refer to detailed information below), but is unlikely to significantly remove efavirenz from the blood.

Efavirenz: Some patients accidentally taking 600 mg twice daily have reported increased nervous system symptoms. One patient experienced involuntary muscle contractions. Emtricitabine: Limited clinical experience is available at doses higher than the therapeutic dose of emtricitabine. In one clinical pharmacology trial single doses of emtricitabine 1200 mg were administered to 11 subjects. No severe adverse reactions were reported. Hemodialysis treatment removes approximately 30% of the emtricitabine dose over a 3-hour dialysis period starting within 1.5 hours of emtricitabine dosing (blood flow rate of 400 mL/min and a dialysate flow rate of 600 mL/min). It is not known whether emtricitabine can be removed by peritoneal dialysis. Tenofovir DF: Limited clinical experience at doses higher than the therapeutic dose of tenofovir DF 300 mg is available. In one trial, 600 mg tenofovir DF was administered to 8 subjects orally for 28 days, and no severe adverse reactions were reported. The effects of higher doses are not known.

Tenofovir is efficiently removed by hemodialysis with an extraction coefficient of approximately 54%. Following a single 300 mg dose of tenofovir DF, a 4-hour hemodialysis session removed approximately 10% of the administered tenofovir dose.

11 DESCRIPTION

ATRIPLA is a fixed-dose combination tablet containing efavirenz, emtricitabine, and tenofovir DF. SUSTIVA is the brand name for efavirenz, a non-nucleoside reverse transcriptase inhibitor (NNRTI). EMTRIVA is the brand name for emtricitabine, a synthetic nucleoside analog of cytidine. VIREAD is the brand name for tenofovir DF, which is converted in vivo to tenofovir, an acyclic nucleoside phosphonate (nucleotide) analog of adenosine 5’-monophosphate. VIREAD and EMTRIVA are the components of TRUVADA.

ATRIPLA tablets are for oral administration. Each tablet contains 600 mg of efavirenz, 200 mg of emtricitabine, and 300 mg of tenofovir DF (which is equivalent to 245 mg of tenofovir disoproxil) as active ingredients. The tablets include the following inactive ingredients: croscarmellose sodium, hydroxypropyl cellulose, magnesium stearate, microcrystalline cellulose, and sodium lauryl sulfate. The tablets are film coated with a coating material containing black iron oxide, polyethylene glycol, polyvinyl alcohol, red iron oxide, t alc, and titanium dioxide.

Efavirenz: Efavirenz is chemically described as (S)-6-chloro-4-(cyclopropylmethy 1)-1,4-dihydro-4-[(trifluoromethyl)-2H-3,1-benzoxazin-2-1. Its molecular formula is C20H18F3N2O2 and its structural formula is:

```
H2N
\ C\ H\ N\ O\ S
```

Emtricitabine is a white to slightly pink crystalline powder with a molecular mass of 315.68. It is practically insoluble in water (less than 10 µg/mL). Emtricitabine: The chemical name of emtricitabine is 5-fluoro-1-(2R,5S)-2-(hydroxymethyl)-1,3-oxathiolan-5-yl)cystine. Emtricitabine is the (-) enantiomer of a thio analog of cytidine, which differs from other cytidine analogs in that it has a fluorine in the 5-position.

It has a molecular formula of C8H10FN3O3S and a molecular weight of 247.24. It has the following structural formula:

```
H2N
\ C\ H\ N\ O\ S
```

Emtricitabine is a white to off-white crystalline powder with a solubility of approximately 112 mg/mL in water at 25°C.

Tenofovir DF: Tenofovir DF is a fumaric acid salt of the bis-isopropoxycarbonylomethyl ester derivative of tenofovir. The chemical name of tenofovir DF is 9-{[(R)-2-[bis(isopropoxy carbonyloxy)methoxy]phosphonylmethoxy}propyl]adenine fumarate (1:1). It has a molecular formula of C9H12N6O6P • C4H4O4 and a molecular weight of 635.52. It has the following structural formula:

```
C\ H\ N\ O\ P
```

Tenoforv DF is a white to off-white crystalline powder with a solubility of 13.4 mg/mL in water at 25°C.

12 CLINICAL PHARMACOLOGY

For additional information on Mechanism of Action, Antiviral Activity, Resistance and Cross Resistance, please consult the SUSTIVA, EMTRIVA, and VIREAD prescribing information.

12.1 Mechanism of Action

ATRIPLA is a fixed-dose combination of antiviral drugs efavirenz, emtricitabine, and tenofovir DF [See Microbiology (12.4)].

12.2 Pharmacodynamics

Cardiac Electrophysiology

Efavirenz: The effect of efavirenz on the QTc interval was evaluated in an open-label, positive and placebo-controlled, fixed single sequence 3-period, 3-treatment crossover QT study in 58 healthy subjects enriched for CYP2B6 polymorphisms. The mean Cmax of efavirenz in subjects with CYP2B6*6/*6 genotype following the administration of 600 mg daily dose for 14 days was 2.25-fold the mean Cmax observed in subjects with CYP2B6*1/*1 genotype. A positive relationship between efavirenz concentration and QTc prolongation was observed. Based on the concentration-QTC relationship, the mean QTc prolongation and its upper bound 90% confidence interval are 8.7 msec and 11.3 msec in subjects with CYP2B6*6/*6 genotype following the administration of 600 mg daily dose for 14 days [See Warnings and Precautions (5.5)].

12.3 Pharmacokinetics

Cardiac Electrophysiology

Efavirenz: The effect of efavirenz on the QTc interval was evaluated in an open-label, positive and placebo-controlled, fixed single sequence 3-period, 3-treatment crossover QT study in 58 healthy subjects enriched for CYP2B6 polymorphisms. The mean Cmax of efavirenz in subjects with CYP2B6*6/*6 genotype following the administration of 600 mg daily dose for 14 days was 2.25-fold the mean Cmax observed in subjects with CYP2B6*1/*1 genotype. A positive relationship between efavirenz concentration and QTc prolongation was observed. Based on the concentration-QTC relationship, the mean QTc prolongation and its upper bound 90% confidence interval are 8.7 msec and 11.3 msec in subjects with CYP2B6*6/*6 genotype following the administration of 600 mg daily dose for 14 days [See Warnings and Precautions (5.5)].

12.3 Pharmacokinetics

ATRIPLA: One ATRIPLA tablet is bioequivalent to one SUSTIVA tablet (600 mg) plus one EMTRIVA capsule (200 mg) plus one VIREAD tablet (300 mg) following single-dose
ATRIPLA® (efavirenz/emtricitabine/tenofovir disoproxil fumarate)

administration to fasting healthy subjects (N=45).

Efavirenz: In HIV-1 infected subjects time-to-peak plasma concentrations were approximately 3–5 hours and steady-state plasma concentrations were reached in 6–10 days. In 35 HIV-1 infected subjects receiving efavirenz 600 mg once daily, steady-state Cmax was 12.9 ± 3.7 μg/mL (mean ± SD), Cmin was 5.6 ± 3.2 μg/mL, and AUC was 184 ± 73 μg•hr/mL. Efavirenz is highly bound (approximately 99.5–99.75%) to human plasma proteins, predominantly albumin. Following administration of 14C-labeled efavirenz, 14–34% of the dose was recovered in the urine (mostly as metabolites). The CYP3A and CYP2B6 enzymes are responsible for efavirenz metabolism. Efavirenz has been shown to induce CYP enzymes, resulting in induction of its own metabolism. Efavirenz has a terminal half-life of 52–76 hours after single doses and 40–55 hours after multiple doses.

Emtricitabine: Following oral administration, emtricitabine is rapidly absorbed, with peak plasma concentrations occurring at 1–2 hours postdose. Following multiple dose oral administration of emtricitabine to 20 HIV-1 infected subjects, the steady-state plasma emtricitabine Cmax was 1.8 ± 0.7 μg/mL (mean ± SD) and the AUC over a 24-hour dosing interval was 10.0 ± 3.1 μg•hr/mL. The mean steady-state plasma trough concentration at 24 hours postdose was 0.03 μg/mL. The mean absolute bioavailability of emtricitabine was 93%. Less than 4% of emtricitabine binds to human plasma proteins in vitro, and the binding is independent of concentration over the range of 0.02–200 μM. Following administration of radiolabelled emtricitabine, approximately 86% is recovered in the urine and 13% is recovered as metabolites. The metabolites of emtricitabine include 3'-sulfone diastereomers and their glucuronide acid conjugate. Emtricitabine is eliminated by a combination of glomerular filtration and active tubular secretion with a renal clearance in adults with normal renal function of 213 ± 89 mL/min (mean ± SD). Following a single oral dose, the plasma emtricitabine half-life is approximately 10 hours.

Tenofovir DF: Following oral administration of a single 300 mg dose of tenofovir DF to HIV-1 infected subjects in the fasted state, maximum serum concentrations (Cmax) were achieved in 1.0 ± 0.4 hrs (mean ± SD) and Cmax and AUC values were 396 ± 90 ng/mL and 2287 ± 685 ng•hr/mL, respectively. The oral bioavailability of tenofovir from tenofovir DF tablets is approximately 25%. Less than 0.7% of tenofovir binds to human plasma proteins in vitro, and the binding is independent of concentration over the range of 0.01–25 μg/mL. Approximately 70–80% of the intravenous dose of tenofovir is recovered as unchanged drug in the urine. Tenofovir is eliminated by a combination of glomerular filtration and active tubular secretion, with a renal clearance in adults with normal renal function of 243 ± 33 mL/min (mean ± SD). Following a single oral dose, the terminal elimination half-life of tenofovir is approximately 17 hours.

Effects of Food on Oral Absorption

ATRIPLA has not been evaluated in the presence of food. Administration of efavirenz tablets with a high-fat meal increased the mean AUC and C max of tenofovir by 18%–61% in healthy volunteers with parent drug), in vitro studies suggest CYP3A and CYP2B6 are the major isozymes responsible for efavirenz metabolism. Efavirenz has been shown to induce CYP enzymes, resulting in induction of its own metabolism. Efavirenz has a terminal half-life of 52–76 hours after single doses and 40–55 hours after multiple doses.

Specific Populations

Race

Efavirenz: The pharmacokinetics of efavirenz in HIV-1 infected subjects appear to be similar among the racial groups studied.

Emtricitabine: No pharmacokinetic differences due to race have been identified following the administration of emtricitabine.

Tenofovir DF: There were insufficient numbers from racial and ethnic groups other than Caucasian to adequately determine potential pharmacokinetic differences among these populations following the administration of tenofovir DF.

Gender

Efavirenz, Emtricitabine, and Tenofovir DF: Efavirenz, emtricitabine, and tenofovir pharmacokinetics are similar in male and female subjects.

Pediatric Patients

ATRIPLA should only be administered to pediatric patients 12 years of age and weighing greater than or equal to 40 kg (greater than or equal to 88 lb).

Efavirenz: In an open-label trial in NRTI-experienced pediatric subjects (mean age 8 years, range 3–16), the pharmacokinetics of efavirenz in pediatric subjects were similar to the pharmacokinetics in adults who received a 600 mg daily dose of efavirenz. Based on mean steady-state predicted population pharmacokinetic modeling in pediatric subjects weighing >40 kg receiving the 600 mg dose of efavirenz, Cmax was 6.57 μg/mL, Cmin was 2.82 μg/mL, and AUC0-24 was 254.78 μg•hr/mL.

Emtricitabine: The pharmacokinetics of emtricitabine at steady state were determined in 27 HIV-1 infected pediatric subjects 13 to 17 years of age receiving a daily dose of 6 mg/kg up to a maximum dose of 240 mg oral solution or a 200 mg capsule; 26 of 27 subjects in this age group received the 200 mg EMTRIVA capsule. Mean ± SD Cmax and AUC were 2.7 ± 0.9 μg/mL and 12.6 ± 5.4 μg•hr/mL, respectively. Emtricitabine exposure achieved in pediatric subjects 12 to less than 18 years of age were similar to those achieved in adults receiving a once daily dose of 200 mg.

ATRIPLA® (efavirenz/emtricitabine/tenofovir disoproxil fumarate)

Tenofovir DF: Steady-state pharmacokinetics of tenofovir were evaluated in 8 HIV-1 infected pediatric subjects (12 to less than 18 years). Mean ± SD Cmax and AUCave were 0.13 μg/mL and 3.93 ± 2.22 μg•hr/mL, respectively. Tenofovir exposure achieved in these pediatric subjects receiving oral daily doses of VIREAD 300 mg was similar to exposures achieved in adults receiving once-daily doses of VIREAD 300 mg.

Geriatric Patients

Pharmacokinetics of efavirenz, emtricitabine, and tenofovir have not been fully evaluated in the elderly (65 years of age and older) [See Use in Specific Populations (8.5)].

Patients with Impaired Renal Function

Efavirenz: The pharmacokinetics of efavirenz have not been studied in subjects with renal insufficiency; however, less than 1% of efavirenz is excreted unchanged in the urine, so the impact of renal impairment on efavirenz elimination should be minimal.

Emtricitabine and Tenofovir DF: The pharmacokinetics of emtricitabine and tenofovir DF are altered in subjects with renal impairment. In subjects with creatinine clearance below 50 mL/min, Cmax and AUC of emtricitabine and tenofovir were increased [See Warnings and Precautions (5.8)].

Patients with Hepatic Impairment

Efavirenz: A multiple-dose trial showed no significant effect on efavirenz pharmacokinetics in subjects with mild hepatic impairment (Child-Pugh Class A) compared with controls. There were insufficient data to determine whether moderate or severe hepatic impairment (Child-Pugh Class B or C) affects efavirenz pharmacokinetics [See Warnings and Precautions (5.1) and Use in Specific Populations (8.6)].

Emtricitabine: The pharmacokinetics of emtricitabine have not been studied in subjects with hepatic impairment; however, emtricitabine is not significantly metabolized by liver enzymes, so the impact of liver impairment should be limited.

Tenofovir DF: The pharmacokinetics of tenofovir following a 300 mg dose of tenofovir DF have been studied in non-HIV infected subjects with moderate to severe hepatic impairment. There were no substantial alterations in tenofovir pharmacokinetics in subjects with hepatic impairment compared with unimpaired subjects.

Assessment of Drug Interactions

The drug interaction trials described were conducted with either ATRIPLA or the components of ATRIPLA (efavirenz, emtricitabine, or tenofovir DF) as individual agents. Efavirenz: The steady-state pharmacokinetics of efavirenz and tenofovir were unaffected when efavirenz and tenofovir DF were administered together versus each agent dosed alone. Specific drug interaction trials have not been performed with efavirenz and NRTIs other than tenofovir, lamivudine, and zidovudine. Clinically significant interactions would not be expected based on NRTIs elimination pathways.

Efavirenz has been shown to cause hepatic enzyme induction, thus increasing the biotransformation of some drugs metabolized by CYP3A and CYP2B6. In vitro studies have shown that efavirenz inhibited CYP isozymes 2C9 and 2C19 with Ki values (8.5–17 μM) in the range of observed efavirenz plasma concentrations. In in vitro studies, efavirenz did not inhibit CYP2E1 and inhibited CYP2D6 and CYP1A2 (Ki values 82–160 μM) at concentrations well above those achieved clinically. Coadministration of efavirenz with drugs primarily metabolized by CYP3A, CYP2D19, CYP3A or CYP2B6 isozymes may result in altered plasma concentrations of the coadministered drug. Drugs which induce CYP3A and CYP2B6 activity would be expected to increase the clearance of efavirenz resulting in lowered plasma concentrations. Drug interaction trials were performed with efavirenz and other drugs likely to be coadministered or drugs commonly used as probes for pharmacokinetic interaction. There was no clinically significant interaction observed between efavirenz and zidovudine, lamivudine, azithromycin, fluconazole, lorazepam, cetirizine, or paroxetine. Single doses of famotidine or an aluminum and magnesium antacid with simethicone had no effects on efavirenz exposures. The effects of coadministration of efavirenz on Cmax, AUC, and Cmin are summarized in Table 4 (effect of other drugs on efavirenz) and Table 5 (effect of efavirenz on other drugs). [For information regarding clinical recommendations, see Drug Interactions (7)].
### ATRIPLA® (efavirenz/emtricitabine/tenofovir disoproxil fumarate)

#### Table 4: Drug Interactions: Changes in Pharmacokinetic Parameters for Efavirenz in the Presence of the Coadministered Drug

<table>
<thead>
<tr>
<th>Coadministered Drug</th>
<th>Dose of Coadministered Drug (mg)</th>
<th>Efavirenz Dose (mg)</th>
<th>N</th>
<th>C&lt;sub&gt;max&lt;/sub&gt;</th>
<th>AUC</th>
<th>C&lt;sub&gt;min&lt;/sub&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lopinavir/ritonavir</td>
<td>400/100 mg q12h × 9 days</td>
<td>600 mg qd × 9 days</td>
<td>11, 12&lt;sup&gt;b&lt;/sup&gt;</td>
<td>↓ 16 (↓ 38 to ↑ 15)</td>
<td>↓ 16 (↓ 42 to ↑ 20)</td>
<td></td>
</tr>
<tr>
<td>Nelfinavir</td>
<td>750 mg q8h × 7 days</td>
<td>600 mg qd × 7 days</td>
<td>10</td>
<td>↓ 12 (↑ 13)&lt;sup&gt;c&lt;/sup&gt;</td>
<td>↓ 12 (↑ 35 to ↑ 18)</td>
<td></td>
</tr>
<tr>
<td>Ritonavir</td>
<td>500 mg q12h × 10 days</td>
<td>600 mg qd × 10 days</td>
<td>9</td>
<td>↑ 14 (↑ 4 to ↑ 26)</td>
<td>↑ 21 (↑ 10 to ↑ 34)</td>
<td></td>
</tr>
<tr>
<td>Boceprevir</td>
<td>800 mg tid × 6 days</td>
<td>600 mg qd × 16 days</td>
<td>NA</td>
<td>↑ 11 (↑ 2 to ↑ 20)</td>
<td>↑ 20 (↑ 15 to ↑ 26)</td>
<td></td>
</tr>
<tr>
<td>Rifabutin</td>
<td>300 mg qd × 14 days</td>
<td>600 mg qd × 14 days</td>
<td>11</td>
<td>← ← ←</td>
<td>↓ 12 (↑ 24 to ↑ 1)</td>
<td></td>
</tr>
<tr>
<td>Ritonavir</td>
<td>600 mg × 7 days</td>
<td>600 mg qd × 7 days</td>
<td>12</td>
<td>↓ 20 (↓ 11 to ↓ 15)</td>
<td>↓ 26 (↑ 15 to ↓ 46)</td>
<td></td>
</tr>
<tr>
<td>Artemether/Lumefantrine</td>
<td>600 mg qd × 26 days</td>
<td>600 mg qd × 8 days</td>
<td>12</td>
<td>← ←</td>
<td>↓ 17 (↑ 1)</td>
<td></td>
</tr>
<tr>
<td>Simvastatin</td>
<td>40 mg qd × 4 days</td>
<td>600 mg qd × 16 days</td>
<td>14</td>
<td>↓ 12 (↓ 28 to ↑ 10)</td>
<td>← ← (↑ 25 to ↑ 3)</td>
<td></td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>200 mg qd × 3 days, then 400 mg qd × 15 days</td>
<td>600 mg qd × 35 days</td>
<td>14</td>
<td>↓ 21 (↓ 15 to ↓ 26)</td>
<td>↓ 36 (↑ 32 to ↓ 40)</td>
<td></td>
</tr>
<tr>
<td>Diltiazem</td>
<td>240 mg × 14 days</td>
<td>600 mg qd × 10 days</td>
<td>12</td>
<td>↑ 16 (↑ 6 to ↑ 26)</td>
<td>↑ 11 (↑ 5 to ↑ 18)</td>
<td></td>
</tr>
<tr>
<td>Voriconazole</td>
<td>400 mg po q12h × 27 days</td>
<td>400 mg qd × 28 days</td>
<td>12</td>
<td>↑ 12 (↑ 6 to ↑ 26)</td>
<td>↑ 13 (↑ 1 to ↑ 26)</td>
<td></td>
</tr>
<tr>
<td>Metabolite AG-1402</td>
<td>500 mg q12h × 28 days</td>
<td>600 mg qd × 10 days</td>
<td>11</td>
<td>↑ 16 (↑ 12 to ↑ 26)</td>
<td>↑ 18 (↑ 6 to ↑ 26)</td>
<td></td>
</tr>
</tbody>
</table>

#### Table 5: Drug Interactions: Changes in Pharmacokinetic Parameters for Efavirenz in the Presence of the Coadministered Drug

<table>
<thead>
<tr>
<th>Coadministered Drug</th>
<th>Dose of Coadministered Drug (mg)</th>
<th>Efavirenz Dose (mg)</th>
<th>N</th>
<th>C&lt;sub&gt;max&lt;/sub&gt;</th>
<th>AUC</th>
<th>C&lt;sub&gt;min&lt;/sub&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lopinavir/ritonavir</td>
<td>400/100 mg q12h × 9 days</td>
<td>600 mg qd × 9 days</td>
<td>11, 7&lt;sup&gt;d&lt;/sup&gt;</td>
<td>← ←</td>
<td>↓ 19 (↓ 36 to ↑ 3)</td>
<td></td>
</tr>
<tr>
<td>Nelfinavir</td>
<td>750 mg q8h × 7 days</td>
<td>600 mg qd × 7 days</td>
<td>10</td>
<td>↑ 21 (↑ 10 to ↑ 33)</td>
<td>↑ 20 (↑ 8 to ↑ 34)</td>
<td></td>
</tr>
<tr>
<td>Metabolite AG-1402</td>
<td>500 mg q12h × 8 days</td>
<td>600 mg qd × 10 days</td>
<td>11</td>
<td>↑ 24 (↑ 12 to ↑ 38)</td>
<td>↑ 18 (↑ 6 to ↑ 33)</td>
<td></td>
</tr>
<tr>
<td>Ritonavir</td>
<td>600 mg qd × 8 days</td>
<td>600 mg qd × 10 days</td>
<td>12</td>
<td>↓ 50 (↓ 28 to ↓ 66)</td>
<td>↓ 62 (↓ 45 to ↓ 74)</td>
<td></td>
</tr>
<tr>
<td>Maraviroc</td>
<td>100 mg bid</td>
<td>600 mg qd × 10 days</td>
<td>12</td>
<td>↓ 51 (↓ 37 to ↓ 62)</td>
<td>↓ 45 (↓ 38 to ↓ 51)</td>
<td></td>
</tr>
<tr>
<td>Raltegravir</td>
<td>400 mg single dose</td>
<td>600 mg qd × 9 days</td>
<td>36</td>
<td>↓ 36 (↓ 2 to ↓ 59)</td>
<td>↓ 36 (↓ 20 to ↓ 48)</td>
<td></td>
</tr>
</tbody>
</table>

NA = not available  
<sup>a</sup> Increase = ▲; Decrease = ↓; No Effect = ←; Parallel-group design; N for efavirenz + lopinavir/ritonavir; N for efavirenz alone.  
<sup>b</sup> 95% CI; d. 90% CI not available.  
<sup>c</sup> Relative to steady-state administration of efavirenz (600 mg once daily for 9 days).

No effect on the pharmacokinetic parameters of efavirenz was observed with the following coadministered drugs: indinavir, saquinavir soft gelatin capsule, simprevir, ledipasvir/sofosbuvir, sofosbuvir, clarithromycin, itraconazole, atorvastatin, pravastatin, or sertraline.
<table>
<thead>
<tr>
<th>Coadministered Drug</th>
<th>Dose of Coadministered Drug (mg)</th>
<th>Efavirenz Dose (mg)</th>
<th>N</th>
<th>C&lt;sub&gt;max&lt;/sub&gt;</th>
<th>AUC</th>
<th>C&lt;sub&gt;min&lt;/sub&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boceprevir</td>
<td>800 mg tid × 6 days</td>
<td>600 mg qd × 16 days</td>
<td>NA</td>
<td>↓ 8 (↓ 22 to ▼ 6)</td>
<td>▼ 19 (▼ 11 to ▼ 25)</td>
<td>▼ 44 (▼ 26 to ▼ 56)</td>
</tr>
<tr>
<td>Simeprevir</td>
<td>150 mg qd × 14 days</td>
<td>600 mg qd × 14 days</td>
<td>23</td>
<td>▼ 51 (▼ 46 to ▼ 56)</td>
<td>▼ 71 (▼ 67 to ▼ 74)</td>
<td>▼ 91 (▼ 88 to ▼ 92)</td>
</tr>
<tr>
<td>Ledipasvir/ Sofosbuvir&lt;sup&gt;h&lt;/sup&gt;</td>
<td>90/400 mg qd × 14 days</td>
<td>600 mg qd × 14 days</td>
<td>15</td>
<td>▼ 34 (▼ 25 to ▼ 41)</td>
<td>▼ 34 (▼ 24 to ▼ 43)</td>
<td>▼ 34 (▼ 24 to ▼ 43)</td>
</tr>
<tr>
<td>Sofosbuvir GS-331007&lt;sup&gt;i&lt;/sup&gt;</td>
<td>400 mg qd single dose</td>
<td>600 mg qd × 14 days</td>
<td>16</td>
<td>▼ 19 (▼ 10 to ▼ 10)</td>
<td>▼ 19 (▼ 10 to ▼ 10)</td>
<td>NA</td>
</tr>
<tr>
<td>Sofosbuvir GS-331007&lt;sup&gt;i&lt;/sup&gt;</td>
<td>400/100 mg qd × 14 days</td>
<td>600 mg qd × 14 days</td>
<td>14</td>
<td>▼ 38 (▼ 37 to ▼ 36)</td>
<td>▼ 53 (▼ 52 to ▼ 53)</td>
<td>NA</td>
</tr>
<tr>
<td>Clarithromycin</td>
<td>500 mg q12h × 7 days</td>
<td>400 mg qd × 7 days</td>
<td>11</td>
<td>▼ 26 (▼ 25 to ▼ 26)</td>
<td>▼ 39 (▼ 38 to ▼ 39)</td>
<td>▼ 53 (▼ 52 to ▼ 53)</td>
</tr>
<tr>
<td>14-OH metabolite</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Itraconazole</td>
<td>200 mg q12h × 28 days</td>
<td>600 mg qd × 14 days</td>
<td>18</td>
<td>▼ 37 (▼ 20 to ▼ 21)</td>
<td>▼ 39 (▼ 20 to ▼ 21)</td>
<td>▼ 44 (▼ 27 to ▼ 34)</td>
</tr>
<tr>
<td>Hydroxyitraconazole</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posaconazole</td>
<td>400 mg (oral suspension) bid × 10 and 20 days</td>
<td>400 mg qd × 10 and 20 days</td>
<td>11</td>
<td>▼ 45 (▼ 34 to ▼ 35)</td>
<td>▼ 50 (▼ 40 to ▼ 40)</td>
<td>NA</td>
</tr>
<tr>
<td>Ritabutin</td>
<td>300 mg qd × 14 days</td>
<td>600 mg qd × 14 days</td>
<td>9</td>
<td>▼ 32 (▼ 15 to ▼ 46)</td>
<td>▼ 38 (▼ 28 to ▼ 47)</td>
<td>▼ 45 (▼ 31 to ▼ 56)</td>
</tr>
</tbody>
</table>

(Continued)
Emtricitabine and Tenofovir DF: The steady-state pharmacokinetics of emtricitabine and tenofovir were unaffected when emtricitabine and tenofovir DF were administered together versus each agent dosed alone.

In vitro and clinical pharmacokinetic drug-drug interaction studies have shown that the potential for CYP mediated interactions involving emtricitabine and tenofovir with other medicinal products is low.

Emtricitabine and tenofovir are primarily excreted by the kidneys by a combination of glomerular filtration and active tubular secretion. No drug-drug interactions due to competition for renal excretion have been observed; however, coadministration of emtricitabine and tenofovir DF with drugs that are eliminated by active tubular secretion may increase concentrations of emtricitabine, tenofovir, and/or the coadministered drug. Drugs that decrease renal function may increase concentrations of emtricitabine and/or tenofovir.

Table 5  Drug Interactions: Changes in Pharmacokinetic Parameters for Coadministered Drug in the Presence of Tenofovir DF

<table>
<thead>
<tr>
<th>Coadministered Drug</th>
<th>Dose of Coadministered Drug (mg)</th>
<th>Efavirenz Dose (mg)</th>
<th>N</th>
<th>Cmax (90% CI)</th>
<th>AUC (90% CI)</th>
<th>Cmin (90% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bupropion</td>
<td>150 mg single dose (sustained-release)</td>
<td>600 mg qd × 14 days</td>
<td>13</td>
<td>↓ 34 (13 to 14)</td>
<td>↓ 55 (7 to 62)</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>↑ 50 (7 to 80)</td>
<td>↔</td>
<td>NA</td>
</tr>
<tr>
<td>Hydroxybupropion</td>
<td>50 mg qd × 14 days</td>
<td>600 mg qd × 14 days</td>
<td>13</td>
<td>↓ 29 (15 to 40)</td>
<td>↓ 39 (27 to 50)</td>
<td>↓ 46 (31 to 58)</td>
</tr>
<tr>
<td>Sertraline</td>
<td>400 mg po q12h × 1 day then 200 mg po q12h × 8 days</td>
<td>400 mg qd × 9 days</td>
<td>NA</td>
<td>↓ 61 (32 to 100)</td>
<td>↓ 77 (51 to 100)</td>
<td>NA</td>
</tr>
<tr>
<td>Voriconazole</td>
<td>300 mg po q12h days 2–7</td>
<td>300 mg qd × 7 days</td>
<td>NA</td>
<td>↓ 36 (21 to 49)</td>
<td>↓ 59 (45 to 62)</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>300 mg qd × 7 days</td>
<td>NA</td>
<td>↑ 23 (17 to 53)</td>
<td>↓ 71 (23 to 13)</td>
<td>NA</td>
</tr>
</tbody>
</table>

NA = not available. a. Increase = ↑; Decrease = ↓; No Effect = ↔. b. Compared with atazanavir 400 mg qd alone. c. Comparator dose of indinavir was 800 mg q8h × 10 days. d. Parallel-group design; N for efavirenz + lopinavir/ritonavir, N for lopinavir/ritonavir alone. e. Values are for lopinavir. The pharmacokinetics of lopinavir 100 mg q12h are unaffected by concurrent efavirenz. f. 95% CI. g. Soft Gelatin Capsule. h. Not available because of insufficient data. i. 90% CI not available. j. Relative to steady-state administration of voriconazole (400 mg for 1 day, then 200 mg po q12h for 2 days). k. Study conducted with ATRIPLA coadministered with HARVONI. l. The predominant circulating nucleoside metabolite of sofosbuvir. m. Study conducted with ATRIPLA coadministered with SOVALDI® (sofosbuvir). n. Study conducted with ATRIPLA coadministered with EPCLEUSA.

Table 6  Drug Interactions: Changes in Pharmacokinetic Parameters for Tenofovir in the Presence of the Coadministered Drug

<table>
<thead>
<tr>
<th>Coadministered Drug</th>
<th>Dose of Coadministered Drug (mg)</th>
<th>N</th>
<th>Mean % Change of Tenofovir Pharmacokinetic Parameters (90% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cmax</td>
</tr>
<tr>
<td>Atazanavird</td>
<td>400 once daily × 14 days</td>
<td>33</td>
<td>↑ 14 (10 to 16)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(&lt; 8 to 8)</td>
</tr>
<tr>
<td>Atazanavir/</td>
<td></td>
<td>12</td>
<td>↑ 34 (10 to 36)</td>
</tr>
<tr>
<td>ritonavirf</td>
<td>300/100 once daily</td>
<td></td>
<td>(&lt; 20 to 30)</td>
</tr>
<tr>
<td>Darunavir/</td>
<td></td>
<td>12</td>
<td>↑ 24 (6 to 32)</td>
</tr>
<tr>
<td>ritonavirf</td>
<td>300/100 twice daily</td>
<td></td>
<td>(&lt; 8 to 10)</td>
</tr>
<tr>
<td>Didanosineg</td>
<td>250 or 400 once daily × 7 days</td>
<td>14</td>
<td>↔ ↔ ↔</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(&lt; 8 to 9)</td>
</tr>
<tr>
<td>Sofosbuvir</td>
<td>90/400 once daily</td>
<td>15</td>
<td>↑ 79 (49 to 99)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(&lt; 56 to 104)</td>
</tr>
<tr>
<td>Lopinavir/ritonavir</td>
<td>400/100 twice daily × 14 days</td>
<td>24</td>
<td>↔ ↔ ↔</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(&lt; 25 to 38)</td>
</tr>
<tr>
<td>Sofosbuvir</td>
<td>400 once daily</td>
<td>16</td>
<td>↑ 25 (10 to 39)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(&lt; 8 to 49)</td>
</tr>
<tr>
<td>Sofosbuvir/</td>
<td>400/100 once daily</td>
<td>15</td>
<td>↑ 77 (35 to 107)</td>
</tr>
<tr>
<td>velpatasvir</td>
<td></td>
<td></td>
<td>(&lt; 53 to 104)</td>
</tr>
<tr>
<td>Tipranavir/</td>
<td>500/100 twice daily</td>
<td>22</td>
<td>↓ 23 (12 to 34)</td>
</tr>
<tr>
<td>ritonavirf</td>
<td></td>
<td></td>
<td>(&lt; 32 to 53)</td>
</tr>
<tr>
<td></td>
<td>750/200 twice daily (23 doses)</td>
<td>20</td>
<td>↓ 38 (15 to 53)</td>
</tr>
</tbody>
</table>

a. All interaction trials conducted in healthy volunteers. b. Subjects received tenofovir DF 300 mg once daily. c. Increase = ↑; Decrease = ↓; No Effect = ↔. d. Reyataz Prescribing Information. e. Prezista Prescribing Information. f. Subjects received didanosine buffered tablets. g. Atripla Prescribing Information.
Emtricitabine:

- Inhibits the activity of the HIV-1 RT by competing with the natural substrate deoxyadenosine 5'-triphosphate. Tenofovir diphosphate inhibits the activity of HIV-1 RT by competing with the natural substrate deoxycytidine 5'-triphosphate and by being incorporated into nascent viral DNA which results in chain termination. Emtricitabine 5'-triphosphate is a weak inhibitor of mammalian DNA polymerases α, β, ε, and mitochondrial DNA polymerase γ.

Tenofovir DF:

- Is an acyclic nucleoside phosphate diester analog of adenosine monophosphate. Tenofovir DF requires initial diester hydrolysis for conversion to tenofovir and subsequent phosphorylations by cellular enzymes to form tenofovir diphosphate.
- Tenofovir diphosphate inhibits the activity of HIV-1 RT by competing with the natural substrate deoxycytidine 5'-triphosphate after incorporation into DNA, by DNA chain termination. Tenofovir diphosphate is a weak inhibitor of mammalian DNA polymerases α, β, and mitochondrial DNA polymerase γ.

Ar特ivisal Activity

Efavirenz, Emtricitabine, and Tenofovir DF: In combination studies evaluating the antiviral activity in cell culture of emtricitabine and efavirenz together, efavirenz and tenofovir together, and emtricitabine and tenofovir together, additive to synergistic antiviral effects were observed.

Efavirenz: The concentration of efavirenz inhibiting replication of wild-type laboratory adapted strains and clinical isolates in cell culture by 90–95% (EC\textsubscript{90,95}) ranged from 1.7–25 nM in lymphoblastoid cell lines, peripheral blood mononuclear cells, and macrophage/monocyte cultures. Efavirenz demonstrated additive antiviral activity against HIV-1 in cell culture when combined with non-nucleoside reverse transcriptase inhibitors (NNRTIs) (delavirdine and nevirapine), nucleoside reverse transcriptase inhibitors (NRTIs) (abacavir, didanosine, lamivudine, stavudine, zalcitabine, and zidovudine), protease inhibitors (PIs) (ampranavir, indinavir, lopinavir, neflinavir, ritonavir, and saquinavir), and the fusion inhibitor enfuvirtide. Efavirenz demonstrated additive to antagonistic antiviral activity in cell culture with atazanavir. Efavirenz demonstrated antiviral activity against clade B and most non-clade B isolates (subtypes A, AE, AG, C, D, F, G, J, and N), but had reduced antiviral activity against group O viruses. Efavirenz is not active against HIV-2.

Emtricitabine: The antiviral activity in cell culture of emtricitabine against laboratory and clinical isolates of HIV-1 was assessed in lymphoblastoid cell lines, the MAGI-CCR5 cell line, and peripheral blood mononuclear cells. The EC\textsubscript{50} values for emtricitabine were in the range of 0.0013–0.64 μM (0.0003–0.158 μg/mL). In drug combination studies of emtricitabine with NRTIs (abacavir, lamivudine, stavudine, zalcitabine, and zidovudine), NNRTIs (delavirdine, efavirenz, and nevirapine), and PIs (ampranavir, neflinavir, ritonavir, and saquinavir), additive to synergistic effects were observed. Emtricitabine displayed antiviral activity in cell culture against HIV-1 clades A, B, C, D, E, F, and G (EC\textsubscript{50} values ranged from 0.007–0.075 μM) and showed strain-specific activity against HIV-2 (EC\textsubscript{50} values ranged from 0.007–1.5 μM).

Tenofovir DF: The antiviral activity in cell culture of tenofovir against laboratory and clinical isolates of HIV-1 was assessed in lymphoblastoid cell lines, primary monocyte/macrophage cells and peripheral blood lymphocytes. The EC\textsubscript{50} values for tenofovir were in the range of 0.044–5.3 μM. In drug combination studies of tenofovir with NRTIs (abacavir, didanosine, lamivudine, stavudine, zalcitabine, and zidovudine), NNRTIs (delavirdine, efavirenz, and nevirapine), and PIs (ampranavir, indinavir, neflinavir, ritonavir, and saquinavir), additive to synergistic effects were observed. Tenofovir displayed antiviral activity in cell culture against HIV-1 clades A, B, C, D, F, E, G, and 0 (EC\textsubscript{50} values ranged from 0.5–2.2 μM) and showed strain-specific activity against HIV-2 (EC\textsubscript{50} values ranged from 1.6–5.5 μM).

Resistance

Efavirenz, Emtricitabine, and Tenofovir DF: HIV-1 isolates with reduced susceptibility to the combination of emtricitabine and tenofovir have been selected in cell culture and in clinical trials. Genotypic analysis of these isolates identified the M184V/I and/or K65R amino acid substitutions in the viral RT. In addition, a K70E substitution in HIV-1 reverse transcriptase has been selected by tenofovir and results in reduced susceptibility to tenofovir.

In a clinical trial of treatment-naive subjects [Study 934, see Clinical Studies (14)] resistance analysis was performed on HIV-1 isolates from all confirmed virologic failure subjects with greater than 400 copies/mL of HIV-1 RNA at Week 144 or early discontinuations. Genotypic resistance to efavirenz, predominantly the K103N substitution, was the most common form of resistance that developed. Resistance to efavirenz occurred in 13/19 analyzed subjects in the emtricitabine + tenofovir DF group and in 21/29 analyzed subjects in the zidovudine/lamivudine fixed-dose combination group. The M184V amino acid substitution, associated with resistance to emtricitabine and tenofovir, was observed in 12/19 analyzed subjects in the emtricitabine + tenofovir DF group and in 10/29 analyzed subject isolates in the zidovudine/lamivudine group. Through 144 weeks of Study 934, no subjects developed a detectable K65R substitution in their HIV-1 as analyzed through standard genotypic analysis.

In a clinical trial of treatment-naive subjects, isolates from 8/47 (17%) analyzed subjects receiving tenofovir DF developed the K65R substitution through 144 weeks of therapy; 7 of these occurred in the first 48 weeks of treatment and one at Week 96. In dually experienced subjects, 14/324 (5%) of tenofovir DF treated subjects with virologic failure through Week 96 showed greater than 1.4-fold (median 2.7) reduced susceptibility to tenofovir. Genotypic analysis of the resistant isolates showed a substitution in the HIV-1 RT gene resulting in the K65R amino acid substitution.

Efavirenz: Clinical isolates with reduced susceptibility in cell culture to efavirenz have been obtained. The most frequently observed amino acid substitution in clinical trials with efavirenz is K103N (54%). One or more RT substitutions at amino acid positions 98, 100, 101, 103, 106, 108, 198, 203, 227, and 230 were observed in subjects failing treatment with efavirenz in combination with other antiretrovirals. Other resistance substitutions observed to emerge commonly included L100I (7%), K101E/D/R (14%), V108I (11%), G190S/T/A (7%), F225H (18%), and M230L/L (11%).

HIV-1 isolates with reduced susceptibility to efavirenz (greater than 380-fold increase in EC\textsubscript{90} value) emerged rapidly under selection in cell culture. Genotypic characterization of these viruses revealed substitutions resulting in single amino acids substitutions L100I or L101M to substitutions V109I or V109Q, and double substitutions L100V/M101I to V179D, and triple substitutions L100I/V179D/Y181C in RT.

Emtricitabine: Emtricitabine-resistant isolates of HIV-1 have been selected in cell culture and in clinical trials. Genotypic analysis of these isolates showed that the reduced susceptibility to emtricitabine was associated with a substitution in the HIV-1 RT gene at codon 184 which resulted in an amino acid substitution of methionine by valine or isoleucine (M184V/I).

Tenofovir DF: HIV-1 isolates with reduced susceptibility to tenofovir have been selected in cell culture. These viruses expressed a K65R substitution in RT and showed a 2- to 4-fold reduction in susceptibility to tenofovir.

Cross Resistance

Efavirenz, Emtricitabine, and Tenofovir DF: Cross resistance has been recognized among NRTIs. Cross resistance has also been recognized among certain NNRTIs. The M184V/I amino acid substitutions selected in cell culture by the combination of emtricitabine and tenofovir are also observed in some HIV-1 isolates from subjects failing treatment with tenofovir. Resistance to tenofovir in combination with other antiretrovirals, as well as tenofovir and emtricitabine, is also commonly observed. Therefore, cross resistance among these drugs may occur in patients whose viral harbors either or both of these amino acid substitutions.

Efavirenz: Clinical isolates previously characterized as efavirenz resistant were also phenotypically resistant in cell culture to delavirdine and nevirapine compared to baseline. Delavirdine- and/or nevirapine-resistant clinical viral isolates with NNRTI resistance-associated substitutions (A98G, L100I, K101E/P, K103N/S, V106A, Y181X, Y188C, G190A, P225H, F227L, or M230L) showed reduced susceptibility to efavirenz in cell culture. Greater than 90% of NNRTI-resistant isolates tested in cell culture retained susceptibility to emtricitabine and tenofovir.

Emtricitabine: Emtricitabine-resistant isolates (M184V/I) were cross resistant to lamivudine but retained susceptibility in cell culture to didanosine, stavudine, zidovudine, and NNRTIs (delavirdine, efavirenz, and nevirapine). HIV-1 isolates containing the K65R substitution, selected in vivo by abacavir, didanosine, and tenofovir, demonstrated reduced susceptibility to inhibition by emtricitabine. Viruses harboring
13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Efavirenz: Long-term carcinogenicity studies in mice and rats were carried out with efavirenz. Mice were dosed with 0, 25, 75, 150, or 300 mg/kg/day for 2 years. Incidences of hepatocellular adenomas and carcinomas and pulmonary alveolar/bronchial adenomas were increased above background in females. No increases in tumor incidence above background were observed in males. In studies in which rats were administered efavirenz at doses of 0, 25, 50, or 100 mg/kg/day for 2 years, no increases in tumor incidence above background were observed. The systemic exposure (based on AUCs) in mice was approximately 1.7-fold that in humans receiving the 600-mg/day dose. The exposure in rats was lower than that in humans. The mechanism of the carcinogenic potential is unknown. However, in genetic toxicity assays, efavirenz showed no evidence of mutagenic or clastogenic activity in a battery of in vitro and in vivo studies. These included bacterial mutation assays in S. typhimurium and E. coli, mammalian mutation assays in Chinese hamster ovary cells, chromosome aberration assays in human peripheral blood lymphocytes or Chinese hamster ovary cells, and an in vivo mouse bone marrow micronucleus assay. Given the lack of genotoxic activity of efavirenz, the relevance to humans of neoplasms in efavirenz-treated mice is not known.

Efavirenz did not impair mating or fertility of male or female rats, and did not affect sperm of treated male rats. The reproductive performance of offspring born to female rats given efavirenz was not affected. As a result of the rapid clearance of efavirenz in rats, systemic drug exposures achieved in these studies were equivalent to or below those achieved in humans given therapeutic doses of efavirenz.

Emtricitabine: In long-term carcinogenicity studies of emtricitabine, no drug-related increases in tumor incidence were found in mice at doses up to 750 mg/kg/day (26 times the human systemic exposure at the therapeutic dose) or in rats at doses up to 600 mg/day (31 times the human systemic exposure at the therapeutic dose).

Emtricitabine was not genotoxic in the reverse mutation bacterial test (Ames test), or the mouse lymphoma or mouse micronucleus assays.

Emtricitabine did not affect fertility in male rats at approximately 140-fold or in male and female mice at approximately 60-fold higher exposures (AUC) than in humans given the recommended 200 mg daily dose. Fertility was normal in the offspring of mice exposed daily from before birth (in utero) through sexual maturity at daily exposures (AUC) of approximately 60-fold higher than exposures at the recommended 200 mg daily dose.

Tenofovir DF: Long-term oral carcinogenicity studies of tenofovir DF in mice and rats were carried out at exposures up to approximately 16 times (mice) and 5 times (rats) those observed in humans at the therapeutic dose for HIV-1 infection. At the high dose in female mice, liver adenomas were increased at exposures 16 times that in humans. In rats, the study was negative for carcinogenic findings at exposures up to 5 times that observed in humans at the therapeutic dose.

Tenofovir DF was mutagenic in the in vitro mouse lymphoma assay and negative in an in vitro base-substitution mutagenesis (Ames test). In an in vivo mouse micronucleus assay, tenofovir DF was negative when administered to male mice.

There were no effects on fertility, mating performance, or early embryonic development when tenofovir DF was administered to male rats at a dose equivalent to 10 times the human dose based on body surface area comparisons for 28 days prior to mating and to female rats for 15 days prior to mating through Day 7 of gestation. There was, however, an alteration of the estrous cycle in female rats.

13.2 Animal Toxicology and/or Pharmacology

Efavirenz: Nonsustained convulsions were observed in 6 of 20 monkeys receiving efavirenz at doses yielding plasma AUC values 4- to 13-fold greater than those in humans given the recommended dose.

Tenofovir DF: Tenofovir and tenofovir DF administered in toxicology studies to rats, dogs, and monkeys at exposures (based on AUCs) greater than or equal to 6-fold those observed in humans caused bone toxicity. In monkeys the bone toxicity was diagnosed as osteomalacia. Osteomalacia observed in monkeys appeared to be reversible upon dose reduction or discontinuation of tenofovir. In rats and dogs, the bone toxicity manifested as reduced bone mineral density. The mechanism(s) underlying bone toxicity is unknown.

ATRIPLA® (efavirenz/emtricitabine/tenofovir disoproxil fumarate)

Evidence of renal toxicity was noted in 4 animal species administered tenofovir and tenofovir DF. Increases in serum creatinine, BUN, glycosuria, proteinuria, phosphaturia and/or calcium and decreases in serum phosphate were observed to varying degrees in these animals. These toxicities were noted at exposures (based on AUCs) 2- to 20-times higher than those observed in humans. The relationship of the renal abnormalities, particularly the phosphaturia, to the bone toxicity is not known.

14 CLINICAL STUDIES

Clinical Study 934 supports the use of ATRIPLA tablets in antiretroviral treatment-naïve HIV-1 infected patients. Additional data in support of the use of ATRIPLA in treatment-naïve patients can be found in the prescribing information for VIREAD.

Clinical Study 073 provides clinical experience in subjects with stable, virologic suppression and no history of virologic failure who switched from their current regimen to ATRIPLA.

In antiretroviral treatment-experienced patients, the use of ATRIPLA tablets may be considered for patients with HIV-1 strains that are expected to be susceptible to the components of ATRIPLA as assessed by treatment history or by genotypic or phenotypic testing [See Microbiology (12.4)].

Study 934: Data through 144 weeks are reported for Study 934, a randomized, open-label, active-controlled multicenter trial comparing emtricitabine + tenofovir DF administered in combination with efavirenz versus zidovudine/lamivudine fixed-dose combination administered in combination with efavirenz in 511 antiretroviral-naïve subjects. From Weeks 96 to 144 of the trial, subjects received emtricitabine/tenofovir DF fixed-dose combination with efavirenz in place of emtricitabine + tenofovir DF with efavirenz. Subjects had a mean age of 38 years (range 18–80); 86% were male, 59% were Caucasian, and 23% were Black. The mean baseline CD4+ cell count was 245 cells/mm3 (range 2–1191), and median baseline plasma HIV-1 RNA was 5.01 log10 copies/mL (range 3.56–6.54). Subjects were stratified by baseline CD4+ cell count (< or ≥200 cells/mm3), and 41% had CD4+ cell counts <200 cells/mm3. Fifty-one percent (51%) of subjects had baseline viral load >100,000 copies/mL. Treatment outcomes through 48 and 144 weeks for those subjects who did not have efavirenz resistance at baseline (N=487) are presented in Table 8.

<table>
<thead>
<tr>
<th>Table 8</th>
<th>Outcomes of Randomized Treatment at Weeks 48 and 144 (Study 934)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>At Week 48</td>
</tr>
<tr>
<td></td>
<td>FTC+TDF +EFV (N=224)</td>
</tr>
<tr>
<td>Responderb</td>
<td>84%</td>
</tr>
<tr>
<td>Virologic failurec</td>
<td>2%</td>
</tr>
<tr>
<td>Rebound</td>
<td>1%</td>
</tr>
<tr>
<td>Never suppressed</td>
<td>0%</td>
</tr>
<tr>
<td>Change in antiretroviral regimen</td>
<td>1%</td>
</tr>
<tr>
<td>Death</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Discontinued due to adverse event</td>
<td>4%</td>
</tr>
<tr>
<td>Discontinued for other reasonsd</td>
<td>10%</td>
</tr>
</tbody>
</table>

a. Subjects who were responders at Week 48 or Week 96 (HIV-1 RNA <400 copies/mL) but did not consent to continue trial after Week 48 or Week 96 were excluded from analysis.

b. Subjects achieved and maintained confirmed HIV-1 RNA <400 copies/mL through Weeks 48 and 144.

c. Includes confirmed viral rebound and failure to achieve confirmed HIV-1 RNA <400 copies/mL through Weeks 48 and 144.

d. Includes lost to follow-up, patient withdrawal, noncompliance, protocol violation and other reasons.

Through Week 48, 84% and 73% of subjects in the emtricitabine + tenofovir DF group and the zidovudine/lamivudine group, respectively, achieved and maintained HIV-1 RNA <400 copies/mL (71% and 58% through Week 144). The difference in the proportion of subjects who achieved and maintained HIV-1 RNA <400 copies/mL through 48 weeks largely results from the higher number of discontinuations due to adverse events and other reasons in the zidovudine/lamivudine group in this open-label trial. In addition, 80% and 70% of subjects in the emtricitabine + tenofovir DF group and the zidovudine/ lamivudine group, respectively, achieved and maintained HIV-1 RNA <50 copies/mL through Week 48 (64% and 56% through Week 144). The mean increase from baseline in CD4+ cell count was 190 cells/mm3 in the emtricitabine + tenofovir DF group and 158 cells/mm3 in the zidovudine/lamivudine group at Week 48 (312 and 271 cells/mm3 at Week 144).

Through 48 weeks, 7 subjects in the emtricitabine + tenofovir DF group and 5 subjects in the zidovudine/lamivudine group experienced a new CDC Class C event (10 and 25 events through 48 weeks).

Study 072: Study 073 was a 48-week open-label, randomized clinical trial in subjects with stable virologic suppression on combination antiretroviral therapy consisting of at least two NRTIs administered in combination with a protease inhibitor (with or without ritonavir) or a NNRTI.
To be enrolled, subjects were to have HIV-1 RNA <200 copies/mL for at least 12 weeks on their current regimen prior to trial entry with no known HIV-1 substitutions conferring resistance to the components of ATRIPLA and no history of virologic failure.

The trial compared the efficacy of switching to ATRIPLA or staying on the baseline antiretroviral regimen (SBR). Subjects were randomized in a 2:1 ratio to switch to ATRIPLA (N=203) or stay on SBR (N=97). Subjects had a mean age of 43 years (range 22–73 years); 88% were male, 68% were white, 29% were Black or African-American, and 3% were of other races. At baseline, median CD4+ cell count was 516 cells/mm³, and 96% had HIV-1 RNA <50 copies/mL. The median time since onset of antiretroviral therapy was 3 years, and 88% of subjects were receiving their first antiretroviral regimen at trial enrollment.

At Week 48, 89% and 87% of subjects who switched to ATRIPLA maintained HIV RNA <200 copies/mL and <50 copies/mL, respectively, compared to 88% and 85% who remained on SBR; this difference was not statistically significant. No changes in CD4+ cell counts from baseline to Week 48 were observed in either treatment arm.

16 HOW SUPPLIED/STORAGE AND HANDLING
ATRIPLA tablets are pink, capsule shaped, film coated, debossed with “123” on one side and plain faced on the other side. Each bottle contains 30 tablets (NDC 15584-0101-1) and silica gel desiccant, and is closed with a child-resistant closure.

Store at 25°C (77°F); excursions permitted to 15–30°C (59–86°F) [See USP Controlled Room Temperature].

• Keep container tightly closed.
• Dispense only in original container.
• Do not use if seal over bottle opening is broken or missing.

17 PATIENT COUNSELING INFORMATION
Advise the patient to read the FDA-approved patient labeling (Patient Information).

Drug Interactions
A statement to patients and healthcare providers is included on the product’s bottle labels: ALERT: Find out about medicines that should NOT be taken with ATRIPLA. ATRIPLA may interact with some drugs; therefore, advise patients to report to their doctor the use of any other prescription or nonprescription medication, vitamins, or herbal supplements.

General Information for Patients
Inform patients that ATRIPLA is not a cure for HIV-1 infection and patients may continue to experience illnesses associated with HIV-1 infection, including opportunistic infections. Patients should remain under the care of a physician when using ATRIPLA.

Advise patients to avoid doing things that can spread HIV-1 to others:

• Do not share needles or other injection equipment.
• Do not share personal items that can have blood or body fluids on them, like toothbrushes and razor blades.
• Do not have any kind of sex without protection. Always practice safe sex by using a latex or polyurethane condom to lower the chance of sexual contact with semen, vaginal secretions, or blood.
• Do not breastfeed. Some of the medicines in ATRIPLA can be passed to your baby in your breast milk. We do not know whether it could harm your baby. Also, mothers with HIV-1 should not breastfeed because HIV-1 can be passed to the baby in the breast milk.

Advise patients that:
• The long-term effects of ATRIPLA are unknown.
• Redistribution or accumulation of body fat may occur in patients receiving antiretroviral therapy and that the cause and long-term health effects of these conditions are not known [See Warnings and Precautions (5.15)].
• ATRIPLA should not be coadministered with COMPLERA, DESCovy, EMTRIVA, GENOVA, ODEFSEY, STRIBILD, TRUVADA, VEMULY, or VIREAD; or drugs containing lamivudine, including Combivir, Epivir, Epivir-HBV, Epzicom, or Trizivir. SUSTIVA should not be coadministered with ATRIPLA unless needed for dose adjustment [See Warnings and Precautions (5.4)].
• ATRIPLA should not be administered with HEPSERA [See Warnings and Precautions (5.1)].

18 PATIENTS INFECTED WITH HIV-1 AND HIV
Advise patients that severe acute exacerbations of hepatitis B have been reported in patients who are coinfected with HBV and HIV-1 and have discontinued EMTRIVA (emtricitabine) or VIREAD (tenofovir DF), which are components of ATRIPLA [See Warnings and Precautions (5.1)].

Lactic Acidosis and Severe Hepatomegaly
Inform patients that lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported. Treatment with ATRIPLA should be suspended in any patient who develops clinical symptoms suggestive of lactic acidosis or pronounced hepatotoxicity [See Warnings and Precautions (5.3)].
Patient Information

ATRIPLA® (uh TRIP luh) Tablets

ALERT: Find out about medicines that should NOT be taken with ATRIPLA.

Please also read the section "MEDICINES YOU SHOULD NOT TAKE WITH ATRIPLA."

Generic name: efavirenz, emtricitabine, and tenofovir disoproxil fumarate (eh FAH vih renz, em tri SIT uh bean and te NOE’ fo veer dye soe PROX il FYOU mar ate)

Read the Patient Information that comes with ATRIPLA before you start taking it and each time you get a refill since there may be new information. This information does not take the place of talking to your healthcare provider about your medical condition or treatment. You should stay under a healthcare provider’s care when taking ATRIPLA. Do not change or stop your medicine without first talking with your healthcare provider. Talk to your healthcare provider or pharmacist if you have any questions about ATRIPLA.

What is the most important information I should know about ATRIPLA?

If you also have hepatitis B virus (HBV) infection and you stop taking ATRIPLA, you may get a “flare-up” of your hepatitis. A “flare-up” is when the disease suddenly returns in a worse way than before. Patients with HBV who stop taking ATRIPLA need close medical follow-up for several months, including medical exams and blood tests to check for hepatitis that could be getting worse. ATRIPLA is not approved for the treatment of HBV, so you must discuss your HBV therapy with your healthcare provider.

What is ATRIPLA?

ATRIPLA contains 3 medicines, SUSTIVA® (efavirenz), EMTRIVA® (emtricitabine), and VIREAD® (tenofovir disoproxil fumarate also called tenofovir DF) combined in one pill. EMTRIVA and VIREAD are HIV-1 (human immunodeficiency virus) nucleoside analog reverse transcriptase inhibitors (NRTIs) and SUSTIVA is an HIV-1 non-nucleoside analog reverse transcriptase inhibitor (NNRTI). VIREAD and EMTRIVA are the components of TRUVADA®. ATRIPLA can be used alone as a complete regimen, or in combination with other anti-HIV-1 medicines to treat people with HIV-1 infection. ATRIPLA is for adults and children 12 years of age and older who weigh at least 40 kg (at least 88 lbs). ATRIPLA is not recommended for children younger than 12 years of age. ATRIPLA has not been studied in adults over 65 years of age.

HIV infection destroys CD4+ T cells, which are important to the immune system. The immune system helps fight infection. After a large number of T cells are destroyed, acquired immune deficiency syndrome (AIDS) develops.

ATRIPLA helps block HIV-1 reverse transcriptase, a viral chemical in your body (enzyme) that is needed for HIV-1 to multiply. ATRIPLA lowers the amount of HIV-1 in the blood (viral load). ATRIPLA may also help to increase the number of T cells (CD4+ cells), allowing your immune system to improve. Lowering the amount of HIV-1 in the blood lowers the chance of death or infections that happen when your immune system is weak (opportunistic infections).

Does ATRIPLA cure HIV-1 or AIDS?

ATRIPLA does not cure HIV-1 infection or AIDS and you may continue to experience illnesses associated with HIV-1 infection, including opportunistic infections. You should remain under the care of a doctor when using ATRIPLA.

Who should not take ATRIPLA?

Together with your healthcare provider, you need to decide whether ATRIPLA is right for you. Do not take ATRIPLA if you are allergic to ATRIPLA or any of its ingredients. The active ingredients of ATRIPLA are efavirenz, emtricitabine, and tenofovir DF. See the end of this leaflet for a complete list of ingredients.

What should I tell my healthcare provider before taking ATRIPLA?

Tell your healthcare provider if you:

- Are pregnant or planning to become pregnant (see “What should I avoid while taking ATRIPLA?”).
- Are breastfeeding (see “What should I avoid while taking ATRIPLA?”).
- Have kidney problems or are undergoing kidney dialysis treatment.
- Have bone problems.
- Have liver problems, including hepatitis B virus infection. Your healthcare provider may want to do tests to check your liver while you take ATRIPLA or may switch you to another medicine.
- Have ever had mental illness or are using drugs or alcohol.
- Have ever had seizures or are taking medicine for seizures.

What important information should I know about taking other medicines with ATRIPLA?

ATRIPLA may change the effect of other medicines, including the ones for HIV-1, and may cause serious side effects. Your healthcare provider may change your other medicines or change their doses. Other medicines, including herbal products, may affect ATRIPLA. For this reason, it is very important to let all your healthcare providers and pharmacists know what medications, herbal supplements, or vitamins you are taking.
MEDICINES YOU SHOULD NOT TAKE WITH ATRIPLA

- ATRIPLA also should not be used with Combivir (lamivudine/zidovudine), COMPLERA®, DESCOVY®, EMTRIVA, Epivir, Epivir-HBV (lamivudine), Epzicom (abacavir sulfate/lamivudine), GENVOYA®, ODEFSEY®, STRIBILD®, Trizivir (abacavir sulfate/lamivudine/zidovudine), TRUVADA, VEMLIDY®, or VIREAD. ATRIPLA also should not be used with SUSTIVA unless recommended by your healthcare provider.
- Vfend (voriconazole) should not be taken with ATRIPLA since it may lose its effect or may increase the chance of having side effects from ATRIPLA.
- ATRIPLA should not be used with HEPSERA® (adefovir dipivoxil).

It is also important to tell your healthcare provider if you are taking any of the following:
- Fortovase, Invirase (saquinavir), Biaxin (clarithromycin), Noxfil (posaconazole), Sporanox (itraconazole), Victrelis (boceprevir), Olysio (simeprevir), or EPCLUSA (sofosbuvir/velpatasvir); these medicines may need to be replaced with another medicine when taken with ATRIPLA.
- Calcium channel blockers such as Cardizem or Tiazac (diltiazem), Covera HS or Isoptin (verapamil) and others; Crixivan (indinavir), Selzentry (maraviroc); the immunosuppressant medicines cyclosporine (Gengraf, Neoral, Sandimmune, and others), Prograf (tacrolimus), or Rapamune (sirolimus); Methadone; Mycobutin (rifabutin); Rifampin; cholesterol-lowering medicines such as Lipitor (atorvastatin), Pravachol (pravastatin sodium), and Zocor (simvastatin); or the anti-depressant medications bupropion (Wellbutrin, Wellbutrin SR, Wellbutrin XL, and Zyban) or Zoloft (sertraline); dose changes may be needed when these drugs are taken with ATRIPLA.
- Videx, Videx EC (didanosine); tenofovir DF (a component of ATRIPLA) may increase the amount of didanosine in your blood, which could result in more side effects. You may need to be monitored more carefully if you are taking ATRIPLA and didanosine together. Also, the dose of didanosine may need to be changed.
- Reyataz (atazanavir sulfate), Prezista (darunavir) with Norvir (ritonavir), Kaletra (lopinavir/ritonavir), EPCLUSA (sofosbuvir/velpatasvir) or HARVONI® (ledipasvir/sofosbuvir); these medicines may increase the amount of tenofovir DF (a component of ATRIPLA) in your blood, which could result in more side effects. EPCLUSA and Reyataz are not recommended with ATRIPLA. You may need to be monitored more carefully if you are taking ATRIPLA, Prezista, and Norvir together, or if you are taking ATRIPLA and Kaletra together. The dose of Kaletra should be increased when taken with efavirenz.
- Medicine for seizures [for example, Dilantin (phenytoin), Tegretol (carbamazepine), or phenobarbital]; your healthcare provider may want to switch you to another medicine or check drug levels in your blood from time to time.

These are not all the medicines that may cause problems if you take ATRIPLA. Be sure to tell your healthcare provider about all medicines that you take.

Keep a complete list of all the prescription and nonprescription medicines as well as any herbal remedies that you are taking, how much you take, and how often you take them. Make a new list when medicines or herbal remedies are added or stopped, or if the dose changes. Give copies of this list to all of your healthcare providers and pharmacists every time you visit your healthcare provider or fill a prescription. This will give your healthcare provider a complete picture of the medicines you use. Then he or she can decide the best approach for your situation.

How should I take ATRIPLA?

- Take the exact amount of ATRIPLA your healthcare provider prescribes. Never change the dose on your own. Do not stop this medicine unless your healthcare provider tells you to stop.
- You should take ATRIPLA on an empty stomach.
- Swallow ATRIPLA with water.
- Taking ATRIPLA at bedtime may make some side effects less bothersome.
- Do not miss a dose of ATRIPLA. If you forget to take ATRIPLA, take the missed dose right away, unless it is almost time for your next dose. Do not double the next dose. Carry on with your regular dosing schedule. If you need help in planning the best times to take your medicine, ask your healthcare provider or pharmacist.
- If you believe you took more than the prescribed amount of ATRIPLA, contact your local poison control center or emergency room right away.
- Tell your healthcare provider if you start any new medicine or change how you take old ones. Your doses may need adjustment.
- When your ATRIPLA supply starts to run low, get more from your healthcare provider or pharmacy. This is very important because the amount of virus in your blood may increase if the medicine is stopped for even a short time. The virus may develop resistance to ATRIPLA and become harder to treat.
- Your healthcare provider may want to do blood tests to check for certain side effects while you take ATRIPLA.

What should I avoid while taking ATRIPLA?

- Women should not become pregnant while taking ATRIPLA and for 12 weeks after stopping it. Serious birth defects have been seen in the babies of animals and women treated with efavirenz (a component of ATRIPLA) during pregnancy. It is not known whether efavirenz caused these defects. Tell your healthcare provider right away if you are pregnant.
- Women should not rely only on hormone-based birth control, such as pills, injections, or implants, because ATRIPLA may make these contraceptives ineffective. Women must use a reliable form of barrier contraception, such as a condom or diaphragm, even if they also use other methods of birth control. Efavirenz, a component of ATRIPLA, may remain in your blood for a time after therapy is stopped. Therefore, you should continue to use contraceptive measures for 12 weeks after you stop taking ATRIPLA.
• Do not breastfeed if you are taking ATRIPLA. Some of the medicines in ATRIPLA can be passed to your baby in your breast milk. We do not know whether it could harm your baby. Also, mothers with HIV-1 should not breastfeed because HIV-1 can be passed to the baby in the breast milk. Talk with your healthcare provider if you are breastfeeding. You should stop breastfeeding or may need to use a different medicine.

• Taking ATRIPLA with alcohol or other medicines causing similar side effects as ATRIPLA, such as drowsiness, may increase those side effects.

• Do not take any other medicines, including prescription and nonprescription medicines and herbal products, without checking with your healthcare provider.

• Avoid doing things that can spread HIV-1 to others.
  - Do not share needles or other injection equipment.
  - Do not share personal items that can have blood or body fluids on them, like toothbrushes and razor blades.
  - Do not have any kind of sex without protection. Always practice safe sex by using a latex or polyurethane condom to lower the chance of sexual contact with semen, vaginal secretions, or blood.

What are the possible side effects of ATRIPLA?

ATRIPLA may cause the following serious side effects:

• “Flare-ups” of hepatitis B virus (HBV) infection, in which the disease suddenly returns in a worse way than before, can occur if you have HBV and you stop taking ATRIPLA. Your healthcare provider will monitor your condition for several months after stopping ATRIPLA if you have both HIV-1 and HBV infection and may recommend treatment for your HBV. ATRIPLA is not approved for the treatment of hepatitis B virus infection. If you have advanced liver disease and stop treatment with ATRIPLA, the “flare-up” of hepatitis B may cause your liver function to decline. (See “What is the most important information I should know about ATRIPLA?”)

• Too much lactic acid in your blood (lactic acidosis). Too much lactic acid is a serious but rare medical emergency that can lead to death. Tell your healthcare provider right away if you get these symptoms: weakness or being more tired than usual, unusual muscle pain, being short of breath or fast breathing, stomach pain with nausea and vomiting, cold or blue hands and feet, feel dizzy or lightheaded, or a fast or abnormal heartbeat.

• Severe liver problems. In rare cases, severe liver problems can happen that can lead to death. Tell your healthcare provider right away if you get these symptoms: skin or the white part of your eyes turns yellow, dark “tea-colored” urine, light-colored stools, loss of appetite for several days or longer, nausea, or stomach-area pain.

• Serious psychiatric problems. A small number of patients may experience severe depression, strange thoughts, or angry behavior while taking ATRIPLA. Some patients have thoughts of suicide and a few have actually committed suicide. These problems may occur more often in patients who have had mental illness. Contact your healthcare provider right away if you think you are having these psychiatric symptoms, so your healthcare provider can decide if you should continue to take ATRIPLA.

• Kidney problems (including decline or failure of kidney function). If you have had kidney problems in the past or take other medicines that can cause kidney problems, your healthcare provider should do regular blood tests to check your kidneys. Symptoms that may be related to kidney problems include a high volume of urine, thirst, muscle pain, and muscle weakness.

• Serious liver problems. Some patients have experienced serious liver problems including liver failure resulting in transplantation or death. Most of these serious side effects occurred in patients with a chronic liver disease such as hepatitis infection, but there have also been a few reports in patients without any existing liver disease.

• Changes in bone mineral density (thinning bones). Laboratory tests show changes in the bones of patients treated with tenofovir DF, a component of ATRIPLA. Some HIV patients treated with tenofovir DF developed thinning of the bones (osteopenia) which could lead to fractures. If you have had bone problems in the past, your healthcare provider may need to do tests to check your bone mineral density or may prescribe medicines to help your bone mineral density. Additionally, bone pain and softening of the bone (which may contribute to fractures) may occur as a consequence of kidney problems.

Common side effects:

Patients may have dizziness, headache, trouble sleeping, drowsiness, trouble concentrating, and/or unusual dreams during treatment with ATRIPLA. These side effects may be reduced if you take ATRIPLA at bedtime on an empty stomach. They also tend to go away after you have taken the medicine for a few weeks. If you have these common side effects, such as dizziness, it does not mean that you will also have serious psychiatric problems, such as severe depression, strange thoughts, or angry behavior. Tell your healthcare provider right away if any of these side effects continue or if they bother you. It is possible that these symptoms may be more severe if ATRIPLA is used with alcohol or mood altering (street) drugs.

If you are dizzy, have trouble concentrating, or are drowsy, avoid activities that may be dangerous, such as driving or operating machinery.

Rash may be common. Rashes usually go away without any change in treatment. In a small number of patients, rash may be serious. If you develop a rash, call your healthcare provider right away. Rash may be a serious problem in some children. Tell your child’s healthcare provider right away if you notice rash or any other side effects while your child is taking ATRIPLA. Other common side effects include tiredness, upset stomach, vomiting, gas, and diarrhea.

Other possible side effects with ATRIPLA:

• Changes in body fat. Changes in body fat develop in some patients taking anti HIV-1 medicine. These changes may include an increased amount of fat in the upper back and neck ("buffalo hump"), in the breasts, and around the trunk. Loss of fat from the legs, arms, and face may also happen. The cause and long-term health effects of these fat changes are not known.

• Skin discoloration (small spots or freckles) may also happen with ATRIPLA.
In some patients with advanced HIV infection (AIDS), signs and symptoms of inflammation from previous infections may occur soon after anti-HIV treatment is started. It is believed that these symptoms are due to an improvement in the body's immune response, enabling the body to fight infections that may have been present with no obvious symptoms. If you notice any symptoms of infection, please inform your doctor immediately.

Tell your healthcare provider or pharmacist if you notice any side effects while taking ATRIPLA. Contact your healthcare provider before stopping ATRIPLA because of side effects or for any other reason. This is not a complete list of side effects possible with ATRIPLA. Ask your healthcare provider or pharmacist for a more complete list of side effects of ATRIPLA and all the medicines you will take.

How do I store ATRIPLA?
- Keep ATRIPLA and all other medicines out of reach of children.
- Store ATRIPLA at room temperature 77°F (25°C).
- Keep ATRIPLA in its original container and keep the container tightly closed.
- Do not keep medicine that is out of date or that you no longer need. If you throw any medicines away make sure that children will not find them.

General information about ATRIPLA:
Medicines are sometimes prescribed for conditions that are not mentioned in patient information leaflets. Do not use ATRIPLA for a condition for which it was not prescribed. Do not give ATRIPLA to other people, even if they have the same symptoms you have. It may harm them.

This leaflet summarizes the most important information about ATRIPLA. If you would like more information, talk with your healthcare provider. You can ask your healthcare provider or pharmacist for information about ATRIPLA that is written for health professionals.

Do not use ATRIPLA if the seal over bottle opening is broken or missing.

What are the ingredients of ATRIPLA?
- **Active Ingredients:** efavirenz, emtricitabine, and tenofovir disoproxil fumarate
- **Inactive Ingredients:** croscarmellose sodium, hydroxypropyl cellulose, microcrystalline cellulose, magnesium stearate, and sodium lauryl sulfate. The film coating contains black iron oxide, polyethylene glycol, polyvinyl alcohol, red iron oxide, talc, and titanium dioxide.

Revised: April 2017

Manufactured and distributed by:
Gilead Sciences, Inc.
Foster City, CA 94404

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