

## PRODUCT MONOGRAPH

### **PrPAT-darunavir**

darunavir tablets 75 mg, 150 mg, 400 mg, 600 mg, 800 mg

(as darunavir ethanolate)

Human Immunodeficiency Virus (HIV) Protease Inhibitor

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## PrPAT-darunavir

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Human Immunodeficiency Virus (HIV) Protease Inhibitor

### PART I: HEALTH PROFESSIONAL INFORMATION

#### SUMMARY PRODUCT INFORMATION

Route of Administration	Pharmaceutical Form/Strength	Clinically Relevant Nonmedicinal Ingredients*
Oral	tablet, 75 mg	None
Oral	tablet, 150 mg	None
Oral	tablet, 400 mg	None
Oral	tablet, 600 mg	None
Oral	tablet, 800 mg	None

\*For a complete listing see DOSAGE FORMS, COMPOSITION AND PACKAGING section

#### INDICATIONS AND CLINICAL USE

PAT-darunavir (darunavir), co-administered with 100 mg ritonavir, and with other antiretroviral agents, is indicated for the treatment of HIV infection.

For a description of the clinical data in support of this indication, refer to *Product Monograph, Part II: CLINICAL TRIALS*.

#### **Pediatrics (from 6 to < 18 years of age)**

PAT-darunavir co-administered with low-dose ritonavir, and with other antiretroviral agents, is indicated for the treatment of HIV infection in treatment-experienced pediatric patients 6 years of age and above (see **WARNINGS AND PRECAUTIONS** and **DOSAGE AND ADMINISTRATION**). This indication is based on 24-week analyses of plasma HIV RNA levels and CD4+ cell counts from an ongoing open-label Phase 2 trial in antiretroviral treatment-experienced pediatric patients 6 to < 18 of age.

#### **Geriatrics (> 65 years of age)**

Clinical studies of darunavir did not include sufficient numbers of patients aged 65 and over to determine whether they respond differently from younger patients. In general, caution should be exercised in the administration and monitoring of PAT-darunavir in elderly patients, reflecting the greater frequency of decreased hepatic, renal or cardiac function and of concomitant disease or other drug therapy (see **WARNINGS AND PRECAUTIONS, DOSAGE AND ADMINISTRATION, and ACTION AND CLINICAL PHARMACOLOGY**).

## CONTRAINDICATIONS

PAT-darunavir is contraindicated in patients who are hypersensitive to this drug or to any ingredient in the formulation or component of the container. For a complete listing, see the **DOSAGE FORMS, COMPOSITION AND PACKAGING** section of the Product Monograph.

PAT-darunavir is contraindicated in patients with severe (Child-Pugh Class C) hepatic insufficiency.

Co-administration of PAT-darunavir/rtv is contraindicated with drugs that are highly dependent on CYP3A4 for clearance and for which elevated plasma concentrations are associated with serious and/or life-threatening events (narrow therapeutic index). These drugs are listed in Table 1 (also see **DRUG INTERACTIONS, Drug-Drug Interactions**, Table 8).

<b>Drug Class</b>	<b>Drugs within Class that are Contraindicated with PAT-darunavir/rtv</b>
Alpha 1-Adrenoreceptor Antagonist	alfuzosin
Antiarrhythmics	amiodarone, bepridil <sup>1</sup> , lidocaine (systemic), quinidine
Antihistamines	astemizole <sup>1</sup> , terfenadine <sup>1</sup>
Antimycobacterial	rifampin
Ergot Derivatives	dihydroergotamine, ergonovine, ergotamine, methylergonovine
GI Motility Agents	cisapride <sup>1</sup>
Herbal Products	St. John's wort ( <i>Hypericum perforatum</i> )
HMG-CoA Reductase Inhibitors	lovastatin, simvastatin
Neuroleptics	pimozide
PDE-5 Inhibitor	sildenafil (for treatment of pulmonary arterial hypertension)
Sedatives/Hypnotics	midazolam, triazolam

<sup>1</sup> Bepridil, astemizole, terfenadine and cisapride are no longer marketed in Canada.

## WARNINGS AND PRECAUTIONS

### **General**

PAT-darunavir (darunavir) must be administered with low-dose ritonavir to ensure its therapeutic effect (see **DETAILED PHARMACOLOGY, Pharmacokinetics, Drug-Drug Interactions**, Table 26; **DOSAGE AND ADMINISTRATION**; and **ACTION AND CLINICAL PHARMACOLOGY, Pharmacokinetics**). Failure to correctly co-administer PAT-darunavir with ritonavir will result in reduced plasma levels of darunavir that may be insufficient to achieve the desired antiviral effect. Patients should be instructed accordingly. Please refer to the ritonavir Product Monograph for additional information on precautionary measures.

PAT-darunavir is not a cure for HIV-1 infection or AIDS. Patients receiving darunavir or any other antiretroviral therapy may continue to develop opportunistic infections and other complications of HIV-1 infection.

PAT-darunavir therapy has not been shown to reduce the risk of transmission of HIV-1 to others.

### **Carcinogenesis and Mutagenesis**

Darunavir was evaluated for carcinogenic potential by oral gavage administration to mice and rats up to 104 weeks. A dose-related increase in the incidence of hepatocellular adenomas and carcinomas were observed in males and females of both species as well as an increase in thyroid follicular cell adenomas in male rats. These findings are considered to be of limited relevance to humans. Based on AUC measurements, exposure to darunavir at the dose levels studied was below or approximately equivalent to exposure in humans at the recommended therapeutic dose (see *Product Monograph Part II: TOXICOLOGY, Carcinogenesis and Mutagenesis*).

Darunavir was not mutagenic or genotoxic in a battery of *in vitro* and *in vivo* assays including bacterial reverse mutation (Ames), chromosomal aberration in human lymphocytes and *in vivo* micronucleus test in mice (see *Product Monograph Part II: TOXICOLOGY, Carcinogenesis and Mutagenesis*).

### **Endocrine and Metabolism**

#### **Diabetes Mellitus/Hyperglycemia**

New onset diabetes mellitus, exacerbation of pre-existing diabetes mellitus, and hyperglycemia have been reported during postmarketing surveillance in HIV-infected patients receiving protease inhibitor (PI) therapy. Some patients required either initiation or dose adjustments of insulin or oral hypoglycemic agents for treatment of these events. In some cases, diabetic ketoacidosis has occurred. In those patients who discontinued PI therapy, hyperglycemia persisted in some cases. Because these events have been reported voluntarily during clinical practice, estimates of frequency cannot be made and causal relationships between PI therapy and these events have not been established.

#### **Fat Distribution**

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

### **Hematologic**

There have been reports of increased bleeding, including spontaneous skin hematomas and hemarthrosis, in patients with hemophilia type A and B treated with protease inhibitors. In some patients, additional factor VIII was given. In more than half of the reported cases, treatment with protease inhibitors was continued or reintroduced. A causal relationship between protease inhibitor therapy and these events has not been established; however, the frequency of bleeding episodes should be closely monitored in patients on PAT-darunavir/rtv.

## **Hepatic/Biliary/Pancreatic**

### **Hepatic Impairment**

PAT-darunavir is contraindicated in patients with severe hepatic insufficiency (Child-Pugh Class C) (see **CONTRAINDICATIONS**). Patients with mild or moderate hepatic impairment (Child-Pugh Class A or B, respectively) should be closely monitored.

Patients with chronic hepatitis B or C and treated with combination antiretroviral therapy are at an increased risk for severe and potentially fatal hepatic adverse events. Limited data are currently available for the use of darunavir co-administered with low dose ritonavir, in patients co-infected with hepatitis B or C.

### **Hepatotoxicity**

Drug-induced hepatitis (e.g., acute hepatitis, cytolytic hepatitis) has been reported with darunavir/rtv. During the clinical development program (n=3,063), hepatitis has been reported in 0.5% of patients receiving combination therapy with darunavir/rtv.

Post-marketing cases of clinical hepatitis and hepatic decompensation, including some fatalities have been reported. These have generally occurred in patients with advanced HIV disease taking multiple concomitant medications, having co-morbidities including hepatitis B or C co-infection, and/or developing immune reconstitution syndrome. A causal relationship with darunavir/rtv therapy has not been established.

Patients with pre-existing liver dysfunction including chronic hepatitis B or C have an increased frequency of liver function abnormalities during combination antiretroviral therapy. Appropriate monitoring should be conducted prior to initiating therapy with PAT-darunavir/rtv and increased monitoring should be considered in patients with elevated baseline transaminase levels, active hepatitis B or C and in patients with underlying liver disease, especially during the first several months of PAT-darunavir/rtv treatment. Evidence of new or worsening liver dysfunction (including clinically significant elevation of liver enzymes and/or symptoms such as fatigue, anorexia, nausea, jaundice, dark urine, liver tenderness and hepatomegaly) in patients on PAT-darunavir/rtv, should prompt consideration to interrupt or discontinue treatment.

For information on the multi-dose pharmacokinetics of darunavir in hepatically impaired patients, see **ACTION AND CLINICAL PHARMACOLOGY**.

### **Pancreatic**

Pancreatitis has been observed in patients receiving darunavir/rtv therapy, including those who developed marked triglyceride elevations. Although a causal relationship to darunavir has not been established, marked triglyceride elevation is a risk factor for development of pancreatitis (see **WARNINGS AND PRECAUTIONS, Lipid Elevations**). Patients with advanced HIV disease may be at risk of elevated triglycerides and pancreatitis, and patients with a history of pancreatitis may be at increased risk for recurrence during PAT-darunavir/rtv therapy.

## **Immune**

### **Immune Reconstitution Syndrome**

During the initial phase of treatment, patients responding to antiretroviral therapy may develop an inflammatory response to indolent or residual opportunistic infections (such as MAC, CMV, PCP, and TB), which may necessitate further evaluation and treatment.

## **Lipid Elevations**

Treatment with darunavir has resulted in increases in the concentration of total cholesterol and triglycerides. Triglyceride and cholesterol testing should be performed prior to initiating PAT-darunavir therapy and at periodic intervals during therapy. Lipid disorders should be managed as clinically appropriate. See Table 8 and Table 9 for additional information on potential drug interactions with PAT-darunavir and HMG-CoA reductase inhibitors.

## **Renal**

### **Renal Impairment**

Population pharmacokinetic analysis showed that the pharmacokinetics of darunavir were not significantly affected in HIV-infected patients with moderate renal impairment (CrCL between 30–60 mL/min, n=20). There are no pharmacokinetic data available in HIV-1 infected patients with severe renal impairment or end stage renal disease. However, since the renal clearance of darunavir is limited, a decrease in total body clearance is not expected in patients with renal impairment. As darunavir and ritonavir are highly bound to plasma proteins, it is unlikely that they will be significantly removed by hemodialysis or peritoneal dialysis (see **DOSAGE AND ADMINISTRATION** and **ACTION AND CLINICAL PHARMACOLOGY**, **Special Populations and Conditions**, **Renal Insufficiency**).

## **Sensitivity**

Darunavir contains a sulfonamide moiety. PAT-darunavir should be used with caution in patients with a known sulfonamide allergy. The potential for cross-sensitivity between drugs in the sulfonamide class and darunavir is unknown. In clinical studies with darunavir/ritonavir, the incidence and severity of rash was similar in patients with or without a history of sulphonamide allergy.

## **Severe Skin Reactions**

During the clinical development program (n=3,063), severe skin reactions, which may be accompanied by fever and/or elevations of transaminases, have been reported in 0.4% of patients. Stevens-Johnson Syndrome was rarely (< 0.1%) reported; and during post-marketing experience toxic epidermal necrolysis and acute generalized exanthematous pustulosis have been reported very rarely (< 0.01%). Discontinue PAT-darunavir immediately if signs or symptoms of severe skin reactions develop. These can include but are not limited to severe rash or rash accompanied with fever, general malaise, fatigue, muscle or joint aches, blisters, oral lesions, conjunctivitis, hepatitis and/or eosinophilia.

Rash (all grades, regardless of causality) occurred in 10.3% of patients treated with darunavir (see **ADVERSE REACTIONS**). Rash was mostly mild-to-moderate, often occurring within the first four weeks of treatment and resolving with continued dosing. The discontinuation rate due to rash in patients using darunavir/rtv was 0.5%.

Darunavir contains a sulfonamide moiety. PAT-darunavir should be used with caution in patients with a known sulfonamide allergy. In clinical studies with darunavir/rtv, the incidence and severity of rash was similar in patients with or without a history of sulfonamide allergy.

Rash occurred more commonly in treatment-experienced patients receiving regimens containing darunavir/rtv + raltegravir compared to subjects receiving darunavir/rtv without raltegravir or raltegravir without darunavir/rtv. However, rash that was considered drug related occurred at similar rates for all three groups. These rashes were mild to moderate in severity and did not limit therapy; there were no discontinuations due to rash.

### **Special Populations**

#### **Pregnant Women**

There are no adequate and well-controlled studies with darunavir in pregnant women. Studies in animals have not shown evidence of developmental toxicity or effect on reproductive function and fertility. However, due to limited bioavailability and/or dosing limitations, animal exposures (based on AUC) were only 50% (mice and rats) and 5% (rabbit) of those obtained in humans at the recommended clinical dose boosted with ritonavir (see *Product Monograph Part II: TOXICOLOGY, Reproductive and Developmental Toxicity*).

PAT-darunavir should be used during pregnancy only if the potential benefit justifies the potential risk.

**Antiretroviral Pregnancy Registry:** *To monitor maternal-fetal outcomes of pregnant women exposed to PAT-darunavir, an Antiretroviral Pregnancy Registry has been established. Physicians are encouraged to register patients by calling 1-800-258-4263.*

#### **Nursing Women**

**HIV-infected mothers should not breast-feed their infants to avoid risking postnatal transmission of HIV.** It is not known whether darunavir is excreted in human milk. Studies in rats have demonstrated that darunavir is excreted into the milk of lactating rats and at high levels (1,000 mg/kg/day) resulted in toxicity. Because of both the potential for HIV transmission and the potential for serious adverse events in nursing infants, mothers should be instructed not to breast-feed if they are receiving PAT-darunavir (see *Product Monograph Part II: TOXICOLOGY, Reproductive and Developmental Toxicity*).

#### **Pediatrics (< 6 years of age)**

The pharmacokinetics, safety, tolerability and efficacy of PAT-darunavir in antiretroviral treatment-experienced pediatric patients 3 to < 6 years of age have not been established.



PAT-darunavir should not be used in pediatric patients below 3 years of age in view of toxicity and mortality observed in juvenile rats dosed with darunavir (from 20 mg/kg to 1,000 mg/kg) up to days 23 to 26 of age ( see **ACTION AND CLINICAL PHARMACOLOGY, Special Populations and Conditions, Pediatrics and TOXICOLOGY, Reproductive and Developmental Toxicity**).

#### Treatment-Naïve Pediatric Patients

The pharmacokinetics, safety, tolerability and efficacy of PAT-darunavir in antiretroviral treatment-naïve pediatric patients have not been established.

#### **Geriatrics (> 65 years of age)**

Clinical studies of darunavir did not include sufficient numbers of patients aged 65 and over to determine whether they respond differently from younger patients. In general, caution should be exercised in the administration and monitoring of PAT-darunavir in elderly patients, reflecting the greater frequency of decreased hepatic, renal or cardiac function and of concomitant disease or other drug therapy.

## **ADVERSE REACTIONS**

### **Adverse Drug Reaction Overview**

During the clinical development program (n=3,063), 65.9% of patients experienced at least one ADR. The total mean exposure for patients was 57.5 weeks. The most common ADRs were diarrhea (23.7%), nausea (14.9%), headache (13.8%), and rash (10.3%). The majority of ADRs were mild or moderate in severity. The overall incidence of any Grade 3 or 4 ADR was 15.1%. The most common Grade 3 or 4 ADRs were diarrhea (1.3%) and those related to laboratory abnormalities, i.e., hepatic enzyme increased (3.4%), hypertriglyceridemia (2.9%), pancreatic enzyme increased (2.7%), and hypercholesterolemia (1.4%). Treatment discontinuation due to ADRs was infrequent (2.5%). The most common ADRs leading to treatment discontinuation were rash (0.5%), hepatic enzyme increased (0.6%), diarrhea (0.3%), and nausea (0.3%).

### **Clinical Trial Adverse Drug Reactions**

*Because clinical trials are conducted under very specific conditions the adverse reaction rates observed in the clinical trials may not reflect the rates observed in practice and should not be compared to the rates in the clinical trials of another drug. Adverse drug reaction information from clinical trials is useful for identifying drug-related adverse events and for approximating rates.*

#### **Antiretroviral Treatment-Naïve Adult Patients**

The safety assessment is based on all safety data from the randomized, controlled, open-label Phase 3 trial TMC114-C211 comparing darunavir/rtv 800/100 mg q.d. versus lopinavir/ritonavir 800/200 mg per day in antiretroviral treatment-naïve HIV-1-infected adult patients. The total mean exposure in weeks for patients in the darunavir/rtv 800/100 mg q.d. arm and the lopinavir/ritonavir 800/200 mg per day arm was 162.5 and 153.5, respectively.

Discontinuation due to adverse events/HIV-related events occurred in 4.7% of patients in the darunavir/rtv group and in 12.7% of patients in the LPV/rtv group.

The majority of the ADRs reported during treatment with darunavir/rtv 800/100 mg q.d. were mild in severity. The most common ADRs to darunavir/rtv 800/100 mg q.d. ( $\geq 5\%$ ) of at least moderate intensity ( $\geq$  Grade 2) were diarrhea, headache and abdominal pain.

ADRs to darunavir/rtv 800/100 mg q.d. of at least moderate intensity ( $\geq$  Grade 2) in antiretroviral treatment-naïve HIV-1-infected adult patients are presented in Table 2.

<b>Table 2: Adverse Drug Reactions* of At Least Moderate Intensity (<math>\geq</math>Grade 2) Reported in <math>\geq 1\%</math> of Antiretroviral Treatment-Naïve HIV-1-Infected Adult Patients Who Received darunavir/rtv 800/100 mg q.d.</b>		
<b>System Organ Class, Preferred Term</b>	<b>Randomized Study TMC114-C211 (through 192 weeks)</b>	
	<b>darunavir/rtv 800/100 mg q.d. + TDF/FTC N=343</b>	<b>lopinavir/ritonavir 800/200 mg per day + TDF/FTC N=346</b>
<b>Gastrointestinal Disorders</b>		
Abdominal pain	5.8%	6.1%
Diarrhea	8.7%	15.9%
Nausea	4.1%	3.8%
Vomiting	2.0%	3.5%
<b>Metabolism and Nutrition Disorders</b>		
Anorexia	1.5%	0.9%
<b>Nervous System Disorders</b>		
Headache	6.7%	5.5%
<b>Skin and Subcutaneous Tissue Disorders</b>		
Pruritus	1.2%	0.9%
Rash	6.1%	6.6%
Urticaria <sup>†</sup>	1.2%	0.6%

N = total number of patients per treatment group      TDF = tenofovir disoproxil fumarate      FTC = emtricitabine  
\* Excluding laboratory abnormalities reported as ADRs      <sup>†</sup> Adverse drug reaction also identified from post-marketing experience

### **Less Common Clinical Trial Adverse Drug Reactions (<1%)**

Adverse drug reactions occurring in less than 1% of patients receiving darunavir/rtv considered at least possibly related to treatment and of at least moderate intensity are listed below by body system:

**Gastrointestinal Disorders:** acute pancreatitis, dyspepsia, flatulence

**General Disorders and Administration Site Conditions:** asthenia, fatigue

**Hepatobiliary Disorders:** acute hepatitis

**Immune System Disorders:** (drug) hypersensitivity<sup>†</sup>, immune reconstitution syndrome

**Metabolism and Nutrition Disorders:** diabetes mellitus

**Musculoskeletal and Connective Tissue Disorders:** myalgia, osteonecrosis

**Psychiatric Disorders:** abnormal dreams

**Skin and Subcutaneous Tissue Disorders:** angioedema<sup>†</sup>, lipodystrophy (lipohypertrophy, lipodystrophy and lipoatrophy), pruritus, Stevens-Johnson Syndrome, urticaria<sup>†</sup>

<sup>†</sup>Adverse drug reaction also identified from post-marketing experience

### Abnormal Hematologic and Clinical Chemistry Findings

The percentages of antiretroviral treatment-naïve HIV-1-infected adult patients treated with darunavir/rtv 800/100 mg q.d. with Grade 2 to 4 laboratory abnormalities, considered ADRs, are presented in Table 3.

<b>Table 3: Grade 2 to 4 Laboratory Abnormalities Observed in Antiretroviral Treatment-Naïve HIV-1-Infected Adult Patients</b>		<b>Randomized Study TMC114-C211 (through 192 weeks)</b>	
<b>Laboratory Parameter Preferred Term</b>	<b>Limit</b>	<b>darunavir/rtv 800/100 mg q.d. + TDF/FTC N=343</b>	<b>lopinavir/ritonavir 800/200 mg per day + TDF/FTC N=346</b>
<b>Biochemistry</b>			
Alanine Aminotransferase			
Grade 2	> 2.5 to ≤ 5.0 X ULN	8.8%	9.4%
Grade 3	> 5.0 to ≤ 10.0 X ULN	2.9%	3.5%
Grade 4	> 10.0 X ULN	0.9%	2.9%
Aspartate Aminotransferase			
Grade 2	> 2.5 to ≤ 5.0 X ULN	7.3%	9.9%
Grade 3	> 5.0 to ≤ 10.0 X ULN	4.4%	2.3%
Grade 4	> 10.0 X ULN	1.2%	2.6%
Alkaline Phosphatase			
Grade 2	> 2.5 to ≤ 5.0 X ULN	1.5%	1.5%
Grade 3	> 5.0 to ≤ 10.0 X ULN	0%	0.6%
Grade 4	> 10.0 X ULN	0%	0%
Hyperbilirubinemia			
Grade 2	>1.5 to ≤ 2.5 X ULN	0.9%	4.4%
Grade 3	> 2.5 to ≤ 5.0 X ULN	0.3%	0.6%
Grade 4	> 5.0 X ULN	0%	0%
Triglycerides			
Grade 2	5.65–8.48 mmol/L 500–750 mg/dL	2.6%	9.9%
Grade 3	8.49–13.56 mmol/L 751–1200 mg/dL	1.8%	5.0%
Grade 4	> 13.56 mmol/L > 1200 mg/dL	1.5%	1.2%
Total Cholesterol*			
Grade 2	6.20–7.77 mmol/L 240–300 mg/dL	22.9%	27.1%
Grade 3	> 7.77 mmol/L > 300 mg/dL	1.5%	5.5%
Low-Density Lipoprotein*			

<b>Table 3: Grade 2 to 4 Laboratory Abnormalities Observed in Antiretroviral Treatment-Naïve HIV-1-Infected Adult Patients</b>			
		<b>Randomized Study TMC114-C211 (through 192 weeks)</b>	
<b>Laboratory Parameter Preferred Term</b>	<b>Limit</b>	<b>darunavir/rtv 800/100 mg q.d. + TDF/FTC N=343</b>	<b>lopinavir/ritonavir 800/200 mg per day + TDF/FTC N=346</b>
Cholesterol			
Grade 2	4.13–4.90 mmol/L 160–190 mg/dL	14.1%	12.3%
Grade 3	≥ 4.91 mmol/L ≥ 191 mg/dL	8.8%	6.1%
Elevated Glucose Levels			
Grade 2	6.95–13.88 mmol/L 126–250 mg/dL	10.8%	9.6%
Grade 3	13.89–27.75 mmol/L 251–500 mg/dL	1.2%	0.3%
Grade 4	> 27.75 mmol/L > 500 mg/dL	0%	0%
Pancreatic Lipase			
Grade 2	> 1.5 to ≤ 3.0 X ULN	2.6%	1.7%
Grade 3	> 3.0 to ≤ 5.0 X ULN	0.6%	1.2%
Grade 4	> 5.0 X ULN	0%	0.9%
Pancreatic Amylase			
Grade 2	> 1.5 to ≤ 2.0 X ULN	4.7%	2.3%
Grade 3	> 2.0 to ≤ 5.0 X ULN	4.7%	4.1%
Grade 4	> 5.0 X ULN	0%	0.9%
N = total number of patients per treatment group TDF = tenofovir disoproxil fumarate FTC = emtricitabine * Grade 4 data not applicable in Division of AIDS grading scale.			

### **Antiretroviral Treatment-Experienced Adult Patients**

The safety assessment is based on all safety data from the randomized, controlled, open-label Phase 3 trial TMC114-C214 comparing darunavir/rtv 600/100 mg b.i.d. versus lopinavir/ritonavir 400/100 mg b.i.d. in antiretroviral treatment-experienced HIV-1-infected adult patients. The total mean exposure in weeks for patients in the darunavir/rtv 600/100 mg b.i.d. arm and the lopinavir/ritonavir 400/100 mg b.i.d. arm was 80.7 and 76.4, respectively.

Discontinuation due to adverse events/HIV-related events occurred in 7.7% of patients in the darunavir/rtv group and in 8.1% of patients in the LPV/rtv group.

The majority of the ADRs reported during treatment with darunavir/rtv 600/100 mg b.i.d. were mild in severity. The most common ADRs to darunavir/rtv 600/100 mg b.i.d. (≥5%) of at least moderate intensity (≥ Grade 2) were diarrhea, hypertriglyceridemia, hypercholesterolemia, nausea, abdominal pain, vomiting, lipodystrophy, hepatic enzymes increased and rash.

ADRs of at least moderate intensity ( $\geq$  Grade 2) and reported in  $\geq 1\%$  of patients treated with darunavir/rtv 600/100 mg b.i.d. in antiretroviral treatment-experienced HIV-1 infected adult patients are presented in Table 4.

<b>Table 4: Adverse Drug Reactions* of At Least Moderate Intensity (<math>\geq</math> Grade 2) Reported in <math>\geq 1\%</math> of Antiretroviral Treatment-Experienced HIV-1-Infected Adult Patients Who Received darunavir/rtv 600/100 mg b.i.d.</b>		
<b>System Organ Class, Preferred Term</b>	<b>Randomized Study TMC114-C214 (through 96 weeks)</b>	
	<b>darunavir/rtv 600/100 mg b.i.d. + OBR N=298</b>	<b>lopinavir/rtv 400/100 mg b.i.d. + OBR N=297</b>
<b>Gastrointestinal Disorders</b>		
Abdominal distension	2.0%	0.3%
Abdominal pain	5.7%	2.7%
Diarrhea	14.4%	19.9%
Dyspepsia	2.0%	1.0%
Nausea	7.0%	6.4%
Vomiting	5.4%	2.7%
<b>General Disorders and Administration Site Conditions</b>		
Asthenia	3.0%	1.0%
Fatigue	1.3%	1.3%
<b>Metabolism and Nutrition Disorders</b>		
Anorexia	1.7%	2.0%
Diabetes mellitus	1.7%	0.3%
<b>Musculoskeletal and Connective Tissue Disorders</b>		
Myalgia	1.0%	0.7%
<b>Nervous System Disorders</b>		
Headache	2.7%	3.0%
<b>Skin and Subcutaneous Tissue Disorders</b>		
Lipodystrophy (lipohypertrophy, lipodystrophy and lipoatrophy)	5.4%	4.4%
Pruritus	1.0%	1.0%
Rash	7.0%	3.0%

N = total number of patients per treatment group  
 OBR = optimized background regimen  
 \* Excluding laboratory abnormalities reported as ADRs

### **Less Common Clinical Trial Adverse Drug Reactions (<1%)**

Adverse drug reactions occurring in less than 1% of patients receiving darunavir/rtv, considered at least possibly related to treatment and of at least moderate intensity are listed below by body system:

**Gastrointestinal Disorders:** acute pancreatitis, flatulence

**Immune System Disorders:** immune reconstitution syndrome

**Psychiatric Disorders:** abnormal dreams

**Reproductive and Breast Disorders:** gynecomastia

**Skin and Subcutaneous Tissue Disorders:** urticaria<sup>†</sup>

<sup>†</sup>Adverse drug reaction also identified from post-marketing experience

Additional safety data was obtained from the randomized, controlled, open-label trial TMC114-C229 comparing darunavir/rtv 800/100 mg q.d. to darunavir/rtv 600/100 mg b.i.d. in treatment-experienced HIV-1 infected patients with screening genotype resistance test showing no darunavir resistance associated mutations. ADRs of at least moderate intensity ( $\geq$  Grade 2) and reported in  $\geq 1\%$  of patients treated with darunavir are presented in Table 5.

<b>Table 5: Adverse Drug Reactions* of At Least Moderate Intensity (<math>\geq</math> Grade 2) Reported in <math>\geq 1\%</math> of Antiretroviral Treatment-Experienced HIV-1 Infected Adult Patients with No DRV-RAMs Who Received darunavir/rtv 800/100 mg Once Daily and darunavir/rtv 600/100 b.i.d.</b>		
<b>System Organ Class, Preferred Term</b>	<b>Randomized Study TMC114-C229 Week 48</b>	
	<b>darunavir/rtv 800/100 mg once daily + OBR<sup>#</sup> N=294</b>	<b>darunavir/rtv 600/100 mg b.i.d. + OBR<sup>#</sup> N=296</b>
<b>Gastrointestinal Disorders</b>		
Abdominal pain	3.1%	2.4%
Diarrhea	5.8%	5.4%
Dyspepsia	0.3%	1.4%
Nausea	4.8%	5.1%
Vomiting	3.4%	5.4%
<b>Metabolism and Nutrition Disorders</b>		
Anorexia	0.3%	1.4%
Diabetes mellitus	0.3%	1.0%
<b>Musculoskeletal and Connective Tissue Disorders</b>		
Myalgia	0.7%	1.4%
<b>Nervous System Disorders</b>		
Headache	3.4%	4.4%
<b>Skin and Subcutaneous Tissue Disorders</b>		
Rash	2.0%	0.3%

N = total number of patients per treatment group  
<sup>#</sup>OBR = optimized background regimen  
\* Excluding laboratory abnormalities reported as ADRs

### **Less Common Clinical Trial Adverse Drug Reactions (<1%)**

Adverse drug reactions occurring in less than 1% of patients receiving darunavir/rtv considered at least possibly related to treatment and of at least moderate intensity are listed below by body system:

**Gastrointestinal Disorders:** abdominal distention, flatulence

**General Disorders and Administration Site Conditions:** asthenia, fatigue

**Hepatobiliary Disorders:** hepatitis acute

**Skin and Subcutaneous Tissue Disorders:** angioedema, lipodystrophy, pruritus, urticaria<sup>†</sup>

<sup>†</sup>Adverse drug reaction also identified from post-marketing experience

## Abnormal Hematologic and Clinical Chemistry Findings

The percentages of antiretroviral treatment-experienced HIV-1-infected adult patients treated with darunavir/rtv 600/100 mg b.i.d. with Grade 2 to 4 laboratory abnormalities, considered ADRs, are presented in Table 6.

<b>Table 6: Grade 2 to 4 Laboratory Abnormalities Observed in Antiretroviral Treatment-Experienced HIV-1-Infected Adult Patients</b>			
<b>Laboratory Parameter Preferred Term</b>	<b>Limit</b>	<b>Randomized Study TMC114-C214 (through 96 weeks)</b>	
		<b>darunavir/rtv 600/100 mg b.i.d. + OBR N = 298</b>	<b>lopinavir/rtv 400/100 mg b.i.d. + OBR N = 297</b>
<b>Biochemistry</b>			
Alanine Aminotransferase			
Grade 2	> 2.5 to ≤ 5.0 X ULN	6.9%	4.8%
Grade 3	> 5.0 to ≤ 10.0 X ULN	2.4%	2.4%
Grade 4	> 10.0 X ULN	1.0%	1.7%
Aspartate Aminotransferase			
Grade 2	> 2.5 to ≤ 5.0 X ULN	5.5%	6.2%
Grade 3	> 5.0 to ≤ 10.0 X ULN	2.4%	1.7%
Grade 4	> 10.0 X ULN	0.7%	1.7%
Alkaline Phosphatase			
Grade 2	> 2.5 to ≤ 5.0 X ULN	0.3%	0%
Grade 3	> 5.0 to ≤ 10.0 X ULN	0.3%	0.3%
Grade 4	> 10.0 X ULN	0%	0%
Hyperbilirubinemia			
Grade 2	>1.5 to ≤ 2.5 X ULN	0.3%	1.7%
Grade 3	> 2.5 to ≤ 5.0 X ULN	0.3%	0.3%
Grade 4	> 5.0 X ULN	0.3%	0%
Triglycerides			
Grade 2	5.65–8.48 mmol/L 500–750 mg/dL	10.4%	11.4%
Grade 3	8.49–13.56 mmol/L 751–1200 mg/dL	6.9%	9.7%
Grade 4	> 13.56 mmol/L > 1200 mg/dL	3.1%	6.2%
Total Cholesterol*			
Grade 2	6.20–7.77 mmol/L 240–300 mg/dL	24.9%	23.2%
Grade 3	> 7.77 mmol/L > 300 mg/dL	9.7%	13.5%
Low-Density Lipoprotein* Cholesterol			
Grade 2	4.13–4.90 mmol/L 160–190 mg/dL	14.4%	13.5%
Grade 3	≥ 4.91 mmol/L ≥ 191 mg/dL	7.7%	9.3%

<b>Table 6: Grade 2 to 4 Laboratory Abnormalities Observed in Antiretroviral Treatment-Experienced HIV-1-Infected Adult Patients</b>			
<b>Laboratory Parameter Preferred Term</b>	<b>Limit</b>	<b>Randomized Study TMC114-C214 (through 96 weeks)</b>	
		<b>darunavir/rtv 600/100 mg b.i.d. + OBR N = 298</b>	<b>lopinavir/rtv 400/100 mg b.i.d. + OBR N = 297</b>
Elevated Glucose Levels			
Grade 2	6.95–13.88 mmol/L 126–250 mg/dL	10.0%	11.4%
Grade 3	13.89–27.75 mmol/L 251–500 mg/dL	1.4%	0.3%
Grade 4	> 27.75 mmol/L > 500 mg/dL	0.3%	0%
Pancreatic Lipase			
Grade 2	> 1.5 to ≤ 3.0 X ULN	2.8%	3.5%
Grade 3	> 3.0 to ≤ 5.0 X ULN	2.1%	0.3%
Grade 4	> 5.0 X ULN	0.3%	0%
Pancreatic Amylase			
Grade 2	> 1.5 to ≤ 2.0 X ULN	6.2%	7.3%
Grade 3	> 2.0 to ≤ 5.0 X ULN	6.6%	2.8%
Grade 4	> 5.0 X ULN	0%	0%
N = total number of patients per treatment group OBR = optimized background regimen * Grade 4 data not applicable in Division of AIDS grading scale.			

Except for a lower incidence of diarrhea and Grade 3 or 4 increases in triglycerides, and a higher incidence of rash-related AEs with DRV/rtv than with LPV/rtv, there were no clinically relevant differences in the overall safety profile for DRV/rtv 600/100 mg b.i.d. and LPV/rtv 400/100 mg b.i.d. in the TMC114-C214 study.

The percentages of antiretroviral treatment-experienced HIV-1-infected adult patients with no darunavir resistance-associated mutations treated with darunavir/rtv 800/100 mg once daily and darunavir/rtv 600/100 b.i.d. with Grade 2 to 4 laboratory abnormalities, considered ADRs, are presented in Table 7.



<b>Table 7: Grade 2 to 4 Laboratory Abnormalities Observed in Antiretroviral Treatment-Experienced HIV-1-Infected Adult Patients with No RAMS</b>			
<b>Laboratory Parameter Preferred Term</b>	<b>Limit</b>	<b>Randomized Study TMC114-C229 (48 weeks)</b>	
		<b>darunavir/rtv 800/100 mg once daily + OBR<sup>#</sup> N = 294</b>	<b>darunavir/rtv 600/100 mg b.i.d. + OBR<sup>#</sup> N = 296</b>
<b>Biochemistry</b>			
Alanine Transaminase			
Grade 2	> 2.5 to ≤ 5.0 X ULN	1.7%	2.5%
Grade 3	> 5.0 to ≤ 10.0 X ULN	0%	0.7%
Grade 4	> 10.0 X ULN	0%	0.4%
Aspartate Aminotransferase			
Grade 2	> 2.5 to ≤ 5.0 X ULN	1.4%	2.5%
Grade 3	> 5.0 to ≤ 10.0 X ULN	0.7%	0.7%
Grade 4	> 10.0 X ULN	0%	0.4%
Alkaline Phosphatase			
Grade 2	> 2.5 to ≤ 5.0 X ULN	0.7%	0.4%
Grade 3	> 5.0 to ≤ 10.0 X ULN	0%	0%
Grade 4	> 10.0 X ULN	0%	0%
Alanine Transaminase			
Grade 2	> 2.5 to ≤ 5.0 X ULN	1.7%	2.5%
Grade 3	> 5.0 to ≤ 10.0 X ULN	0%	0.7%
Grade 4	> 10.0 X ULN	0%	0.4%
Triglycerides			
Grade 2	5.65–8.48 mmol/L 500–750 mg/dL	3.5%	7.1%
Grade 3	8.49–13.56 mmol/L 751–1200 mg/dL	1.4%	2.8%
Grade 4	> 13.56 mmol/L > 1200 mg/dL	0.3%	1.1%
Total Cholesterol*			
Grade 2	6.20–7.77 mmol/L 240–300 mg/dL	7.7%	14.9%
Grade 3	> 7.77 mmol/L > 300 mg/dL	2.4%	5.7%
Low-Density Lipoprotein* Cholesterol			
Grade 2	4.13–4.90 mmol/L 160–190 mg/dL	7.0%	12.8%
Grade 3	≥ 4.91 mmol/L ≥ 191 mg/dL	2.8%	3.9%
Elevated Glucose Levels			
Grade 2	6.95–13.88 mmol/L 126–250 mg/dL	6.6%	5.3%
Grade 3	13.89–27.75 mmol/L 251–500 mg/dL	0.7%	0.7%
Grade 4	> 27.75 mmol/L > 500 mg/dL	0%	0.4%
Pancreatic Lipase			
Grade 2	> 1.5 to ≤ 3.0 X ULN	1.0%	1.8%

<b>Table 7: Grade 2 to 4 Laboratory Abnormalities Observed in Antiretroviral Treatment-Experienced HIV-1-Infected Adult Patients with No RAMS</b>			
		<b>Randomized Study TMC114-C229 (48 weeks)</b>	
<b>Laboratory Parameter Preferred Term</b>	<b>Limit</b>	<b>darunavir/rtv 800/100 mg once daily + OBR<sup>#</sup> N = 294</b>	<b>darunavir/rtv 600/100 mg b.i.d. + OBR<sup>#</sup> N = 296</b>
Grade 3	> 3.0 to ≤ 5.0 X ULN	0.3%	0%
Grade 4	> 5.0 X ULN	0%	0%
<b>Pancreatic Amylase</b>			
Grade 2	> 1.5 to ≤ 2.0 X ULN	3.1%	2.5%
Grade 3	> 2.0 to ≤ 5.0 X ULN	2.4%	1.1%
Grade 4	> 5.0 X ULN	0.3%	0.4%
N=total number of patients per treatment group #OBR = optimized background regimen * Grade 4 data not applicable in Division of AIDS grading scale.			

### **Additional ADRs to darunavir/rtv Identified in Adult Patients in Other Clinical Trials**

The additional ADRs of interest identified from other clinical trials were osteonecrosis (0.4%).

### **Serious ADRs**

The following serious ADRs of at least moderate ( $\geq$  Grade 2) occurred in the Phase 2b studies and Phase 3 studies with darunavir/rtv: abdominal pain, acute hepatitis, acute pancreatitis, anorexia, asthenia, diabetes mellitus, diarrhea, fatigue, headache, hepatic enzyme increased, hypercholesterolemia, hyperglycemia, hypertriglyceridemia, immune reconstitution syndrome, low density lipoprotein increased, nausea, pancreatic enzyme increased, rash, Stevens-Johnson Syndrome and vomiting.

### **Patients Co-infected with Hepatitis B and/or Hepatitis C Virus**

The incidence of adverse events or clinical chemistry abnormalities, except for increased hepatic enzymes, was comparable in patients co-infected with hepatitis B or C virus and patients who were not co-infected. Patients co-infected with hepatitis B or C virus receiving darunavir/rtv were more likely to have baseline and treatment-emergent hepatic transaminase elevations than those without chronic viral hepatitis. Patients with chronic hepatitis B and/or C co-infection should be monitored appropriately.

### **Clinical Trial Experience in Pediatric Patients**

#### **Study TMC114-C212**

The safety assessment in children and adolescents is based on the safety data from the Phase 2 DELPHI trial (TMC114-C212) in which 80 antiretroviral treatment-experienced HIV-1-infected pediatric patients 6 to < 18 years of age and weighing at least 44 lbs (20 kg) received darunavir/rtv in combination with other antiretroviral agents (see **ACTION AND CLINICAL PHARMACOLOGY, Special Populations and Conditions, Pediatrics and Product Monograph Part II: CLINICAL TRIALS**).

The mean duration of patient exposure to DRV/rtv at the time of the data cut-off for the Week 24 analysis was 39.5 ( $\pm$ 11.02) weeks. Total patient years of exposure was 60.8 years. Frequency, type and severity of adverse drug reactions in pediatric patients were comparable to those observed in adults. The overall incidence of ADRs was 40%. The most common ADRs (all Grades,  $\geq$  3%) were vomiting (12.5%), diarrhea (11.3%), abdominal pain (10%), headache (9%), rash (5%), nausea (4%), and fatigue (3%).

Grade 3 or 4 laboratory abnormalities were ALT increased (Grade 3: 3%; Grade 4: 1%), AST increased (Grade 3: 1%), pancreatic amylase increased (Grade 3: 4%; Grade 4: 1%), pancreatic lipase increased (Grade 3: 1%), total cholesterol increased (Grade 3: 1%), and LDL increased (Grade 3: 3%). The majority of ADRs were mild or moderate in severity.

There were no ADRs leading to treatment discontinuation in the Week 24 analysis of the TMC114-C212 trial.

### **Post-Market Adverse Drug Reactions**

In addition to adverse events identified in clinical trials, the following post-marketing events have been included due to their seriousness, frequency of reporting, potential causal association with darunavir/rtv, or a combination of these factors. Because they are reported spontaneously from a population of unknown size, estimates of incidence cannot be made.

**Blood and Lymphatic System Disorders:** anemia, pancytopenia, thrombocytopenia and neutropenia

**Cardiac Disorders:** bradycardia, myocarditis

**Eye Disorders:** eye swelling, uveitis, maculopathy, blurred vision

**Gastrointestinal Disorders:** pancreatitis, pancreatitis relapsing, rectal hemorrhage, gastritis

**Hepatobiliary Disorders:** bile duct obstruction, hepatic cirrhosis, hepatic failure, hepatitis, hepatotoxicity, jaundice

**Infections and Infestations:** clostridial infection, cryptosporidiosis infection, cytomegalovirus encephalitis, hepatitis B, esophageal candidiasis, progressive multifocal leukoencephalopathy, sepsis

**Investigations:** blood alkaline phosphatase increased, blood bilirubin increased, abnormal liver function test

**Immune System Disorder:** drug hypersensitivity, immune reconstitution syndrome

**Injury, Poisoning and Procedural Complications:** drug toxicity

**Metabolism and Nutrition Disorders:** dehydration, hyperkalemia, metabolic acidosis

**Musculoskeletal and Connective Tissue Disorders:** myositis, osteonecrosis, rhabdomyolysis, sensation of heaviness, arthritis, bone pain, pain in extremities, arthropathy

**Neoplasms Benign, Malignant and Unspecified:** diffuse large B-cell neoplasm, malignant hepatic neoplasm, lymphoma

**Nervous System Disorders:** altered state of consciousness, cerebrovascular accident, dizziness, facial palsy, grand mal convulsion, ischemic cerebral infarction, nervous system disorder, neuromyopathy, petit mal epilepsy

**Psychiatric Disorders:** completed suicide, anxiety, depression

**Renal and Urinary Disorders:** acute renal failure, hematuria, renal tubular necrosis, creatinine renal decreased, GFR decreased, renal failure, proteinuria

**Respiratory, Thoracic and Mediastinal Disorders:** acute respiratory distress syndrome, pharyngeal lesion, pneumothorax, respiratory failure, pulmonary edema, epistaxis

**Skin and Subcutaneous Tissue Disorders:** angioedema, rash, swelling face, Stevens-Johnson syndrome, toxic epidermal necrolysis, urticaria, acute generalized exanthematous pustulosis

## DRUG INTERACTIONS

### Serious Drug Interactions

- Darunavir and ritonavir are both inhibitors of the cytochrome P450 3A4 (CYP3A4) isoform. PAT-darunavir/rtv should not be co-administered with medicinal products that are highly dependent on CYP3A4 for clearance, and for which increased plasma concentrations are associated with serious and/or life-threatening events (narrow therapeutic index). These medicinal products include alfuzosin, amiodarone, astemizole, bepridil, cisapride, lidocaine (systemic), lovastatin, midazolam, pimozide, quinidine, rifampin, sildenafil (when used for the treatment of pulmonary arterial hypertension), simvastatin, terfenadine, the ergot alkaloids (e.g., ergotamine, dihydroergotamine, ergonovine, and methylergonovine), St John's wort (*Hypericum perforatum*), and triazolam (see **CONTRAINDICATIONS**).

### Overview

Darunavir and ritonavir are both inhibitors of the cytochrome P450 isoform CYP3A4. Co-administration of darunavir and ritonavir with drugs primarily metabolized by CYP3A4 may result in increased plasma concentrations of such drugs, which could increase or prolong their therapeutic effect and adverse events (see **CONTRAINDICATIONS** and **Drug-Drug Interactions**, Tables 8 and 9).

## **Drug-Drug Interactions**

Drugs that are contraindicated and not recommended for co-administration with PAT-darunavir/rtv are included in Table 8. These recommendations are based on either drug interaction studies or predicted interactions due to the expected magnitude of interaction and potential for serious events or loss of efficacy.

<b>Table 8: Drugs that Should Not Be Co-administered with PAT-darunavir/rtv</b>	
<b>Drug Class: Drug Name</b>	<b>Clinical Comment</b>
<b>Alpha 1–Adrenoreceptor Antagonists:</b> alfuzosin	CONTRAINDICATED due to potential for serious and/or life-threatening reactions such as hypotension.
<b>Antiarrhythmics:</b> bepridil <sup>1</sup> lidocaine (systemic) quinidine amiodarone	CONTRAINDICATED: Concentrations of bepridil, lidocaine, quinidine and amiodarone may be increased when co-administered with PAT-darunavir/rtv.
<b>Anticonvulsants:</b> phenobarbital phenytoin	Phenobarbital and phenytoin are inducers of CYP450 enzymes. PAT-darunavir/rtv should not be used in combination with phenobarbital, or phenytoin as co-administration may cause significant decreases in darunavir plasma concentrations. This may result in loss of therapeutic effect of PAT-darunavir.
<b>Antihistamines:</b> astemizole <sup>1</sup> terfenadine <sup>1</sup>	CONTRAINDICATED due to potential for serious and/or life-threatening reactions such as cardiac arrhythmias.
<b>Antimycobacterials:</b> rifampin	CONTRAINDICATED: Rifampin is a potent inducer of CYP450 metabolism. PAT-darunavir/rtv should not be used in combination with rifampin, as this may cause significant decreases in darunavir plasma concentrations. This may result in loss of therapeutic effect of PAT-darunavir.
<b>Ergot Derivatives:</b> dihydroergotamine ergonovine ergotamine methylergonovine	CONTRAINDICATED due to potential for serious and/or life-threatening reactions such as acute ergot toxicity characterized by peripheral vasospasm and ischemia of the extremities and other tissues.
<b>Gastrointestinal Motility Agents:</b> cisapride <sup>1</sup>	CONTRAINDICATED due to potential for serious and/or life-threatening reactions such as cardiac arrhythmias.
<b>Herbal Products:</b> St. John's wort ( <i>Hypericum perforatum</i> )	CONTRAINDICATED: PAT-darunavir/rtv should not be used concomitantly with products containing St. John's wort ( <i>Hypericum perforatum</i> ) because co-administration may cause significant decreases in darunavir plasma concentrations. This may result in loss of therapeutic effect of PAT-darunavir.
<b>HIV-Protease Inhibitor:</b> lopinavir/ritonavir	Results of interaction trials with darunavir with or without ritonavir and lopinavir/ritonavir (1200 mg darunavir b.i.d. with or without 100 mg ritonavir b.i.d. and lopinavir/ritonavir 400/100 mg b.i.d. or 533/133.3 mg b.i.d.) demonstrated a decrease in the exposure (AUC) of darunavir by 40%. The appropriate doses of the combination have not been established. Hence, it is not recommended to co-administer PAT-darunavir/rtv with lopinavir/ritonavir.

**Table 8: Drugs that Should Not Be Co-administered with PAT-darunavir/rtv**

<b>Drug Class: Drug Name</b>	<b>Clinical Comment</b>
<b>HIV-Protease Inhibitor:</b> saquinavir	An interaction trial between darunavir (400 mg b.i.d.), saquinavir (1000 mg b.i.d.), and low-dose ritonavir (100 mg b.i.d.) demonstrated that darunavir exposure was decreased by 26% when co-administered with saquinavir and ritonavir; saquinavir exposure was not affected when administered concomitantly with darunavir/ritonavir. It is not recommended to co-administer saquinavir and PAT-darunavir, with or without low-dose ritonavir.
<b>HMG-CoA Reductase Inhibitors:</b> lovastatin simvastatin	CONTRAINDICATED: HMG-CoA reductase inhibitors, such as lovastatin and simvastatin, which are highly dependent on CYP3A4 metabolism, are expected to have markedly increased plasma concentrations when co-administered with darunavir/ritonavir. Increased concentrations of HMG-CoA reductase inhibitors may cause myopathy, including rhabdomyolysis. Concomitant use of PAT-darunavir/rtv with lovastatin or simvastatin is not recommended.  For information regarding atorvastatin and pravastatin see Table 9.
<b>Inhaled Beta Agonist:</b> salmeterol	Concurrent administration of salmeterol and PAT-darunavir/rtv is not recommended. The combination may result in increased risk of cardiovascular adverse events associated with salmeterol, including QT prolongation, palpitations and sinus tachycardia.
<b>Neuroleptics:</b> pimozide	CONTRAINDICATED due to the potential for serious and/or life-threatening reactions such as cardiac arrhythmias.
<b>PDE-5 Inhibitors:</b> sildenafil (for treatment of pulmonary arterial hypertension)	CONTRAINDICATED: A safe and effective dose of the PDE-5 inhibitors for the treatment of pulmonary arterial hypertension has not been established when co-administered with PAT-darunavir/rtv. There is an increased potential for sildenafil-associated adverse events (which include visual disturbances, hypotension, prolonged erection, and syncope).
<b>Sedatives/Hypnotics:</b> midazolam triazolam	CONTRAINDICATED due to the potential for serious and/or life-threatening reactions such as prolonged or increased sedation or respiratory depression.
<b>NS3-4A protease inhibitors</b> [Hepatitis C Virus (HCV) direct-acting antivirals]: boceprevir telaprevir	In an interaction trial between darunavir/rtv (600/100 mg b.i.d.) and boceprevir (800 mg three times daily), darunavir exposure was reduced by 44% and boceprevir exposure was reduced by 32%. It is not recommended to co-administer PAT-darunavir/rtv with boceprevir.  In a drug interaction study in healthy volunteers where telaprevir was co-administered with darunavir/ritonavir, the steady-state exposure to telaprevir and darunavir was reduced. Coadministration of darunavir/ritonavir and telaprevir is not recommended.

<sup>1</sup> Bepridil, astemizole, terfenadine and cisapride are no longer marketed in Canada.

Established and other potentially significant drug interactions with PAT-darunavir/rtv are included in Table 9. These recommendations are based on either drug interaction studies or predicted interactions due to the expected magnitude of interaction and potential for serious events or loss of efficacy.

**Table 9: Established and Other Potentially Significant Drug Interactions: Alterations in Dose or Regimen May Be Recommended Based on Drug Interaction Studies or Predicted Interaction (See Tables 26 and 27)**

<b>Concomitant Drug Class: Drug Name</b>	<b>Effect on Concentration of Darunavir or Concomitant Drug</b>	<b>Clinical Comment</b>
<b>HIV-Antiviral Agents: Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)</b>		
efavirenz	↓ darunavir ↑ efavirenz	An interaction trial between darunavir (300 mg twice daily [b.i.d.]), low-dose ritonavir (100 mg b.i.d.), and efavirenz (600 mg once daily [q.d.]) has been performed. In the presence of efavirenz, a decrease of 13% for darunavir exposure was observed. Exposure to efavirenz increased by 21% when administered in combination with darunavir and ritonavir. Since this difference is not considered to be clinically relevant, the combination of PAT-darunavir/rtv and efavirenz can be used without dose adjustments.
etravirine	↔ darunavir ↓ etravirine	In an interaction trial between darunavir/rtv (600/100 mg b.i.d.) and etravirine (100 mg b.i.d.), there was a 37% decrease in etravirine exposure in the presence of darunavir/rtv and no relevant change in exposure to darunavir. Therefore, PAT-darunavir/rtv can be co-administered with etravirine at the recommended therapeutic dose of 200 mg b.i.d. without dose adjustments.
nevirapine	↔ darunavir ↑ nevirapine	The results of an interaction trial with darunavir (400 mg b.i.d.), low-dose ritonavir (100 mg b.i.d.), and nevirapine (200 mg b.i.d.) demonstrated that darunavir exposure was not affected when administered concomitantly with nevirapine. Exposure to nevirapine increased by 27% (compared to historical controls) when administered in combination with darunavir and ritonavir. No dose adjustment is currently recommended for the combination of PAT-darunavir/rtv and nevirapine. However, the literature indicates that changes in plasma exposure of nevirapine can lead to significant safety concerns, specifically hepatotoxicity. For further information, please refer to the nevirapine Product Monograph.
rilpivirine	↔ darunavir ↑ rilpivirine	Concomitant use of rilpivirine with darunavir/ritonavir may cause an increase in the plasma concentrations of rilpivirine (inhibition of CYP3A enzymes). An interaction trial between rilpivirine (150 mg q.d.) and darunavir/ritonavir (800 mg/100 mg q.d.) demonstrated that darunavir/ritonavir increased the mean exposure of rilpivirine by 2.3-fold and from 2.7-fold to 3.8-fold in a subset (31%) of subjects. Caution should be exercised when these drugs are co-administered.
<b>HIV-Antiviral Agents: Nucleoside Reverse Transcriptase Inhibitors (NRTIs)</b>		

**Table 9: Established and Other Potentially Significant Drug Interactions: Alterations in Dose or Regimen May Be Recommended Based on Drug Interaction Studies or Predicted Interaction (See Tables 26 and 27)**

Concomitant Drug Class: Drug Name	Effect on Concentration of Darunavir or Concomitant Drug	Clinical Comment
didanosine	↔ darunavir ↔ didanosine	Darunavir/rtv (600/100 mg b.i.d.) did not significantly affect didanosine exposure. The combination of PAT-darunavir co-administered with 100 mg ritonavir and didanosine can be used without dose adjustments. Dosing of enteric-coated didanosine and darunavir, co-administered with low-dose ritonavir, should be separated by at least 2 hours to avoid formulation incompatibility (see <b>Drug-Food Interactions</b> and <b>DOSAGE AND ADMINISTRATION, Dosing Considerations</b> ).
tenofovir disoproxil fumarate	↔ darunavir ↑ tenofovir	The results of an interaction trial between darunavir (300 mg b.i.d.), low-dose ritonavir (100 mg b.i.d.), and tenofovir disoproxil fumarate (300 mg q.d.) demonstrated that darunavir exposure was not significantly affected when administered concomitantly with tenofovir disoproxil fumarate. Exposure to tenofovir disoproxil fumarate increased by 22% when administered in combination with darunavir and ritonavir. This finding is not considered to be clinically relevant. There was no change in the urinary excretion of tenofovir disoproxil fumarate or darunavir during co-administration. The combination of PAT-darunavir/rtv and tenofovir disoproxil fumarate can be used without dose adjustments.
<b>HIV-Antiviral Agents: HIV-Protease Inhibitors (PIs)</b>		
ritonavir	↑ darunavir	The overall pharmacokinetic enhancement effect by ritonavir was an approximate 14-fold increase in the systemic exposure of darunavir when a single dose of 600 mg darunavir was given orally in combination with ritonavir at 100 mg b.i.d. Therefore, PAT-darunavir should only be used in combination with 100 mg of ritonavir as a pharmacokinetic enhancer (see <b>WARNINGS AND PRECAUTIONS, General</b> and <b>ACTION AND CLINICAL PHARMACOLOGY, Pharmacokinetics, Absorption</b> ).
atazanavir	↔ darunavir ↔ atazanavir	An interaction trial between darunavir (400 mg b.i.d.), low-dose ritonavir (100 mg b.i.d.), and atazanavir (300 mg q.d.) demonstrated that exposure to darunavir and atazanavir was not significantly affected when co-administered. Atazanavir can be co-administered with PAT-darunavir/rtv.



**Table 9: Established and Other Potentially Significant Drug Interactions: Alterations in Dose or Regimen May Be Recommended Based on Drug Interaction Studies or Predicted Interaction (See Tables 26 and 27)**

<b>Concomitant Drug Class: Drug Name</b>	<b>Effect on Concentration of Darunavir or Concomitant Drug</b>	<b>Clinical Comment</b>
indinavir	↑ darunavir ↑ indinavir	An interaction trial between darunavir (400 mg b.i.d.), low-dose ritonavir (100 mg b.i.d.), and indinavir (800 mg b.i.d.) demonstrated that darunavir exposure was increased by 24% when co-administered with indinavir and ritonavir; indinavir exposure was increased by 23% when administered concomitantly with darunavir/ritonavir. When used in combination with PAT-darunavir/rtv, dose adjustment of indinavir may be warranted in case of intolerance.
<b>HIV-Antiviral Agents: CCR5 Antagonist</b>		
maraviroc	↔ darunavir ↑ maraviroc	An interaction trial between darunavir (600 mg b.i.d.), low dose ritonavir (100 mg b.i.d.), and maraviroc (150 mg b.i.d.) demonstrated that in the presence of darunavir/rtv the exposure of maraviroc was increased by 305%. There was no apparent effect of maraviroc on darunavir/ritonavir exposure. When used in combination with PAT-darunavir/rtv, the dose of maraviroc should be 150 mg twice daily.
<b>Other Agents</b>		
<b>Antiarrhythmics</b> digoxin	↑ digoxin	An interaction trial with darunavir/rtv (600/100 mg b.i.d.) and a single dose of digoxin (0.4 mg) showed an increase of digoxin AUC <sub>last</sub> of 77% (ratio of Least Square Means was 1.77 with a 90% CI of 0.90 to 3.50). It is recommended that the lowest dose of digoxin should initially be prescribed and digoxin dose should be titrated to obtain the desired clinical effect when co-administered with PAT-darunavir/rtv. Serum digoxin concentrations should be monitored to assist in the titration.
<b>Anticoagulants:</b> warfarin	↓ warfarin ↔ darunavir	Warfarin concentrations may be affected when co-administered with PAT-darunavir/rtv. It is recommended that the international normalized ratio (INR) be monitored when warfarin is combined with PAT-darunavir/rtv.
<b>Anticonvulsant:</b> carbamazepine	↔ darunavir ↑ carbamazepine	An interaction trial between darunavir/rtv (600/100 mg b.i.d.) and carbamazepine (200 mg b.i.d.) showed that the exposure to darunavir, co-administered with ritonavir, was unaffected by carbamazepine. Ritonavir exposure (AUC <sub>12h</sub> ) was decreased by 49%. For carbamazepine, AUC <sub>12h</sub> was increased by 45%. No dose adjustment for PAT-darunavir/rtv is recommended. If there is a need to combine PAT-darunavir/rtv and carbamazepine, patients should be monitored for potential carbamazepine-related adverse events. Carbamazepine concentrations should be monitored and its dose should be titrated for adequate response. Based upon the findings, the dose of carbamazepine may need to be reduced by 25% to 50% in the presence of PAT-darunavir/rtv.

**Table 9: Established and Other Potentially Significant Drug Interactions: Alterations in Dose or Regimen May Be Recommended Based on Drug Interaction Studies or Predicted Interaction (See Tables 26 and 27)**

<b>Concomitant Drug Class: Drug Name</b>	<b>Effect on Concentration of Darunavir or Concomitant Drug</b>	<b>Clinical Comment</b>
<b>Anti-infectives:</b> clarithromycin	↔ darunavir ↑ clarithromycin	An interaction trial between darunavir (400 mg b.i.d.), low-dose ritonavir (100 mg b.i.d.), and clarithromycin (500 mg b.i.d.) demonstrated an increase in exposure to clarithromycin by 57%, while exposure to darunavir was not affected. For patients with renal impairment, the following dose adjustments should be considered: <ul style="list-style-type: none"> <li>• For patients with CLcr of 30-60 mL/min, the dose of clarithromycin should be reduced by 50%.</li> <li>• For patients with CLcr of &lt; 30 mL/min, the dose of clarithromycin should be reduced by 75%.</li> </ul>
<b>Antifungals:</b> ketoconazole itraconazole (not studied)  voriconazole (not studied)	↑ ketoconazole ↑ darunavir itraconazole (not studied) voriconazole (not studied)	Ketoconazole and itraconazole are potent inhibitors as well as substrates of CYP3A4. Concomitant systemic use of ketoconazole or itraconazole, and darunavir and ritonavir may increase plasma concentrations of both darunavir and ketoconazole, or itraconazole.  In an interaction trial, concomitant administration of ketoconazole (200 mg b.i.d.) with darunavir (400 mg b.i.d.) and ritonavir (100 mg b.i.d.) increased exposure of ketoconazole and darunavir by 212% and 42%, respectively. When co-administration is required, the daily dose of ketoconazole or itraconazole should not exceed 200 mg.  Co-administration of voriconazole with PAT-darunavir/rtv has not been studied. Administration of voriconazole with ritonavir (100 mg twice daily) decreased the AUC of voriconazole by an average of 39%. Voriconazole should not be administered to patients receiving darunavir/ritonavir unless an assessment of the benefit/risk ratio justifies the use of voriconazole.

**Table 9: Established and Other Potentially Significant Drug Interactions: Alterations in Dose or Regimen May Be Recommended Based on Drug Interaction Studies or Predicted Interaction (See Tables 26 and 27)**

Concomitant Drug Class: Drug Name	Effect on Concentration of Darunavir or Concomitant Drug	Clinical Comment
<b>Anti-gout:</b> colchicine	↑ colchicine	<p>Exposure of colchicines, a CYP34A substrate, may be increased when co-administered with darunavir/rtv.</p> <p><u>Treatment of gout-flares – co-administration of colchicine in patients on PAT-darunavir/rtv:</u> 0.6 mg (1 tablet) x 1 dose, followed by 0.3 mg (half tablet) 1 hour later. Treatment course to be repeated no earlier than 3 days.</p> <p><u>Prophylaxis of gout-flares – co-administration of colchicine in patients on PAT-darunavir/rtv:</u> If the original regimen was 0.6 mg twice a day, the regimen should be adjusted to 0.3 mg (half tablet) once a day. If the original regimen was 0.6 mg once a day, the regimen should be adjusted to 0.3 mg (half tablet) once every other day.</p> <p><u>Treatment of familial Mediterranean fever – co-administration of colchicine in patients on PAT-darunavir/ritonavir:</u> Maximum daily dose of 0.6 mg (may be given as 0.3 mg twice a day).</p> <p><b>Patients with renal or hepatic impairment should not be given colchicine with PAT-darunavir/ritonavir.</b></p>
<b>Antimycobacterials:</b> rifabutin	↑ darunavir ↑ rifabutin ↑ 25- <i>O</i> -desacetyl-rifabutin	<p>Rifabutin is a substrate of CYP450 enzymes. In an interaction trial, an increase of systemic exposure to darunavir by 57% was observed when darunavir/rtv (600/100 mg b.i.d.) was administered with rifabutin (150 mg once every other day (q.o.d.)). Based on the safety profile of PAT-darunavir/rtv, the increase in darunavir exposure in the presence of rifabutin does not warrant a dose adjustment for PAT-darunavir/rtv. The interaction trial showed a comparable systemic exposure for rifabutin between treatment at 300 mg q.d. alone and at 150 mg q.o.d. in combination with darunavir/rtv (600/100 mg b.i.d.) with an increase in exposure to the active metabolite 25-<i>O</i>-desacetyl-rifabutin. A dosage reduction of rifabutin by 75% of the usual dose of 300 mg/day (i.e., rifabutin 150 mg every other day) is warranted if rifabutin is co-administered with PAT-darunavir/rtv. Increased monitoring for rifabutin-related adverse events is warranted in patients receiving the combination.</p>
<b>Calcium Channel Blockers:</b> felodipine nifedipine nicardipine	↑ calcium channel blockers	<p>Plasma concentrations of calcium channel blockers (e.g. felodipine, nifedipine, nicardipine) may increase when PAT-darunavir/rtv are co-administered. Caution is warranted and clinical monitoring of patients is recommended.</p>

**Table 9: Established and Other Potentially Significant Drug Interactions: Alterations in Dose or Regimen May Be Recommended Based on Drug Interaction Studies or Predicted Interaction (See Tables 26 and 27)**

Concomitant Drug Class: Drug Name	Effect on Concentration of Darunavir or Concomitant Drug	Clinical Comment
<b>Corticosteroids:</b> <u>Systemic</u> dexamethasone  <u>Inhaled/Nasal</u> fluticasone	↓ darunavir  ↑ fluticasone	Use with caution. Systemic dexamethasone induces CYP3A4 and can thereby decrease darunavir plasma concentrations. This may result in loss of therapeutic effect to PAT-darunavir.  Concomitant use of inhaled fluticasone and PAT-darunavir/rtv may increase plasma concentrations of fluticasone. Alternatives should be considered, particularly for long-term use.
<b>Endothelin Receptor Antagonists:</b> bosentan	↑ bosentan	<u>Co-administration of bosentan in patients on PAT-darunavir/rtv:</u> In patients who have been receiving PAT-darunavir/rtv for at least 10 days, start bosentan at 62.5 mg once daily or every other day based upon individual tolerability.  <u>Co-administration of PAT-darunavir/rtv in patients on bosentan:</u> Discontinue use of bosentan at least 36 hours prior to initiation of PAT-darunavir/rtv. After at least 10 days following the initiation of PAT-darunavir/rtv, resume bosentan at 62.5 mg once daily or every other day based upon individual tolerability.
<b>Estrogen-Based Contraceptives:</b> ethinyl estradiol norethindrone	↓ ethinyl estradiol ↓ norethindrone	The results of an interaction trial between darunavir/rtv (600/100 mg b.i.d.) and ethinyl estradiol and norethindrone demonstrated that at steady-state, systemic exposures to ethinyl estradiol and norethindrone are decreased by 44% and 14%, respectively. Therefore, alternative methods of non-hormonal contraception are recommended.

**Table 9: Established and Other Potentially Significant Drug Interactions: Alterations in Dose or Regimen May Be Recommended Based on Drug Interaction Studies or Predicted Interaction (See Tables 26 and 27)**

<b>Concomitant Drug Class: Drug Name</b>	<b>Effect on Concentration of Darunavir or Concomitant Drug</b>	<b>Clinical Comment</b>
<b>HMG-CoA Reductase Inhibitors:</b> atorvastatin  rosuvastatin  pravastatin	↑atorvastatin  ↑rosuvastatin  ↑pravastatin	<p>An interaction trial between darunavir (300 mg b.i.d.), low-dose ritonavir (100 mg b.i.d.), and atorvastatin (10 mg q.d.) demonstrated that exposure to atorvastatin was only 15% lower when co-administered with darunavir and ritonavir than when atorvastatin (40 mg q.d.) was administered alone. When administration of atorvastatin and PAT-darunavir/rtv is desired, it is recommended to start with an atorvastatin dose of 10 mg q.d. A gradual dose increase of atorvastatin may be tailored to the clinical response.</p> <p>An interaction study evaluating darunavir/rtv (600/100 mg b.i.d.) in combination with rosuvastatin (10 mg q.d.) resulted in a significant increase in rosuvastatin plasma exposures. It is recommended to start with the lowest possible dose of rosuvastatin and titrate up to the desired clinical effect while monitoring for safety.</p> <p>An interaction trial between darunavir (600 mg b.i.d.), low dose ritonavir (100 mg b.i.d.) and pravastatin (40 mg single dose) demonstrated that DRV/rtv did not increase exposure of pravastatin in most patients but increased pravastatin exposure up to 5-fold in a limited subset of patients. When administration of pravastatin and PAT-darunavir/rtv is required, it is recommended to start with the lowest possible dose of pravastatin and titrate up to the desired clinical effects while monitoring safety.</p>
<b>H2-Receptor Antagonists and Proton Pump Inhibitors:</b> omeprazole ranitidine	↔ darunavir	<p>Co-administration of omeprazole (20 mg q.d.) or ranitidine (150 mg b.i.d.) and darunavir (400 mg b.i.d.) in the presence of low-dose ritonavir (100 mg b.i.d.) did not affect the exposure to darunavir. Based on these results, PAT-darunavir/rtv can be co-administered with H2-receptor antagonists and proton pump inhibitors without dose adjustments. The effects of PAT-darunavir/rtv on omeprazole or ranitidine exposures were not evaluated.</p>
<b>Immunosuppressants:</b> cyclosporine tacrolimus sirolimus	↑ immunosuppressants	<p>Plasma concentrations of cyclosporine, tacrolimus or sirolimus may be increased when co-administered with PAT-darunavir/rtv. Therapeutic concentration monitoring of the immunosuppressive agent is recommended for immunosuppressant agents when co-administered with PAT-darunavir/rtv.</p>





### **Other Protease Inhibitors**

The co-administration of PAT-darunavir/rtv and PIs other than lopinavir/ritonavir, saquinavir, atazanavir, and indinavir has not been studied. Therefore, such co-administration is not recommended.

### **CCR5 Antagonist**

When used in combination with PAT-darunavir/rtv, the dose of maraviroc should be 150 mg twice daily.

An interaction trial between darunavir/rtv (600/100 mg b.i.d.) and maraviroc (150 mg b.i.d.) demonstrated that in the presence of darunavir/rtv the exposure of maraviroc was increased by 305%. There was no apparent effect of maraviroc on darunavir/ritonavir exposure.

### **Drug-Food Interactions**

Darunavir, when given as a tablet and co-administered with low-dose ritonavir as a pharmacokinetic enhancer, should be taken with food. The type of food does not affect the exposure to darunavir.

### **Drug-Herb Interactions**

Concomitant use of PAT-darunavir/rtv and St. John's wort (*Hypericum perforatum*) or products containing St. John's wort is contraindicated. Co-administration of protease inhibitors (PIs), including PAT-darunavir/rtv, with St. John's wort is expected to substantially decrease PI concentrations and may result in suboptimal concentrations of darunavir and lead to loss of virologic response and possible resistance to PAT-darunavir/rtv or to the class of PIs (see **Drug-Drug Interactions**, Table 8).

Interactions with other herbal products have not been established.

### **Drug-Laboratory Interactions**

Interactions with laboratory tests have not been established.

## **DOSAGE AND ADMINISTRATION**

### **Dosing Considerations**

PAT-darunavir must always be given with 100 mg ritonavir as a pharmacokinetic enhancer, and in combination with other antiretroviral medicinal products. The prescribing information of ritonavir must, therefore, be consulted prior to initiation of therapy with PAT-darunavir/rtv.

### **Recommended Dose and Dosage Adjustment**

#### **Adults**

There are two recommended oral dosing regimens for adult patients which are PAT-darunavir tablets 800 mg once daily (q.d.) taken with ritonavir, (100 mg), q.d. and with food, or 600 mg twice daily (b.i.d.) with ritonavir, (100 mg), b.i.d. and with food. The type of food does not



affect exposure to darunavir (see **DRUG INTERACTIONS, Drug-Food Interactions**). The dosing schedule for PAT-darunavir/rtv is presented in Table 10.

<b>Treatment-Naïve Adult Patients</b>	<b>Treatment-Experienced Adult Patients</b>	
	<b>With no darunavir resistance-associated mutations (DRV-RAMs)<sup>‡</sup></b>	<b>With at least one darunavir resistance-associated mutation (DRV-RAM)<sup>‡</sup></b>
800 mg (two 400 mg tablets or one 800 mg tablet) PAT-darunavir once daily with ritonavir 100 mg once daily and with food	800 mg (two 400 mg tablets or one 800 mg tablet) PAT-darunavir once daily with ritonavir 100 mg once daily and with food	600 mg (one 600 mg tablet) PAT-darunavir twice daily taken with 100 mg ritonavir and with food

<sup>‡</sup> DRV-RAMs: V11I, V32I, L33F, I47V, I50V, I54M, I54L, T74P, L76V, I84V and L89V

For antiretroviral treatment-experienced patients genotypic testing is recommended. However, when genotypic testing is not feasible, the PAT-darunavir/rtv once-daily dosing regimen is recommended in protease inhibitor-naïve patients and the twice daily dosing regimen is recommended in protease inhibitor-experienced patients.

The type of food does not affect exposure to darunavir. Ritonavir is used as a pharmacokinetic enhancer of PAT-darunavir (see **DRUG INTERACTIONS, Drug-Drug Interactions**, and **ACTION AND CLINICAL PHARMACOLOGY, Pharmacokinetics, Effects of Food on Oral Absorption**). A further increase in the dose of darunavir or ritonavir is not likely to result in any clinically relevant increase in antiviral activity.

### **Geriatric Patients**

In general, caution should be exercised in the administration and monitoring of PAT-darunavir in elderly patients, reflecting the greater frequency of decreased hepatic, renal or cardiac function, and of concomitant disease or other drug therapy (see **INDICATIONS AND CLINICAL USE, WARNINGS AND PRECAUTIONS** and **ACTION AND CLINICAL PHARMACOLOGY**).

### **Pediatric Patients**

#### Antiretroviral Treatment-Experienced Pediatric Patients 6 to < 18 years of age

The recommended dose of PAT-darunavir for pediatric patients (6 to < 18 years of age and weighing at least 44 lbs (20 kg)) is based on body weight (see Table 11) and should not exceed the recommended adult dose (PAT-darunavir/rtv 600/100 mg b.i.d.) (see **Product Monograph Part II: CLINICAL TRIALS**). PAT-darunavir tablets should be taken with ritonavir twice daily and with food. The type of food does not affect exposure to darunavir (see **ACTION AND CLINICAL PHARMACOLOGY, Pharmacokinetics, Effects of Food on Oral Absorption**).

<b>Table 11: Recommended Dose for Antiretroviral Treatment-Experienced Pediatric Patients (6 to &lt; 18 years of age) for PAT-darunavir Tablets with ritonavir</b>		
<b>Body Weight</b>		<b>Dose</b>
<b>(kg)</b>	<b>(lbs)</b>	
≥ 20 kg – < 30 kg	≥ 44 lbs – < 66 lbs	375 mg PAT-darunavir/50 mg ritonavir twice daily
≥ 30 kg – < 40 kg	≥ 66 lbs – < 88 lbs	450 mg PAT-darunavir/60 mg ritonavir twice daily
≥ 40 kg	≥ 88 lbs	600 mg PAT-darunavir/100 mg ritonavir twice daily

Antiretroviral Treatment-Experienced Pediatric Patients < 6 years of age and Antiretroviral Treatment-Naïve Pediatric Patients

The safety and efficacy of PAT-darunavir/rtv in antiretroviral treatment-experienced pediatric patients 3 to < 6 years of age and in antiretroviral treatment-naïve pediatric patients have not been established.

PAT-darunavir/rtv should not be used in pediatric patients below 3 years of age (see **WARNINGS AND PRECAUTIONS** and *Product Monograph Part II: TOXICOLOGY*).

**Hepatic Impairment**

The safety and efficacy of PAT-darunavir have not been established in patients with severe hepatic insufficiency (see **CONTRAINDICATIONS**). No dose adjustment is required in patients with mild or moderate hepatic impairment (see **ACTION AND CLINICAL PHARMACOLOGY, Pharmacokinetics**).

**Renal Impairment**

No dose adjustment is required in patients with renal impairment (see **WARNINGS AND PRECAUTIONS, Renal** and **ACTION AND CLINICAL PHARMACOLOGY, Pharmacokinetics**).

**Dosing with Didanosine**

Dosing of enteric-coated didanosine and darunavir, co-administered with low-dose ritonavir, should be separated by at least 2 hours to avoid formulation incompatibility.

**Missed Dose**

Patients Taking 600 mg of PAT-darunavir Twice Daily

The missed dose should be taken as soon as possible, if the dose was missed by less than 6 hours. The next dose of PAT-darunavir and ritonavir should be taken at the regularly scheduled time. If the dose of PAT-darunavir or ritonavir was missed by more than 6 hours, the next dose of PAT-darunavir and ritonavir should be taken at the regularly scheduled time. Doses should not be doubled.

Patients Taking 800 mg of PAT-darunavir Once Daily

The missed dose (two 400 mg tablets or one 800 mg tablet) should be taken as soon as possible, if the dose was missed by less than 12 hours. The next dose of PAT-darunavir (two 400 mg tablets or one 800 mg tablet) and ritonavir should be taken at the regularly scheduled time. If the dose of PAT-darunavir (two 400 mg tablets or one 800 mg tablet) or ritonavir was missed by

more than 12 hours, the next dose of PAT-darunavir (two 400 mg tablets or one 800 mg tablet) and ritonavir should be taken at the regularly scheduled time. Doses should not be doubled.

## **OVERDOSAGE**

For management of a suspected drug overdose, contact your regional Poison Control Centre.

Human experience of acute overdose with PAT-darunavir/rtv is limited. Single doses up to 3,200 mg of the oral solution of darunavir alone and up to 1,600 mg of the tablet formulation of darunavir co-administered with ritonavir have been administered to healthy volunteers without untoward symptomatic effects.

There is no specific antidote for overdose with PAT-darunavir. Treatment of overdose with PAT-darunavir consists of general supportive measures including monitoring of vital signs and observation of the clinical status of the patient. Administration of activated charcoal may be used to aid in removal of unabsorbed active substance. Since PAT-darunavir is highly protein bound, dialysis is unlikely to be beneficial in significant removal of the active substance.

## **ACTION AND CLINICAL PHARMACOLOGY**

### **Mechanism of Action**

Darunavir is an inhibitor of the dimerization and of the catalytic activity of the HIV-1 protease. It selectively inhibits the cleavage of HIV-encoded Gag-Pol polyproteins in virus-infected cells, thereby preventing the formation of mature infectious virus particles.

Darunavir tightly binds to the HIV-1 protease with a  $K_D$  of  $4.5 \times 10^{-12}$  M.

Darunavir is not an inhibitor of any of 13 tested human cellular proteases.

### **Pharmacodynamics**

#### **Electrocardiogram (Effect on QT Intervals)**

In an open-label, randomized, placebo- and active-controlled, four-way crossover trial, 40 healthy subjects were administered supratherapeutic doses of darunavir/ritonavir 1,600/100 mg once daily and 800/100 mg twice daily for seven days.

At the mean maximum darunavir concentration of 6,599 ng/mL observed in this study, the mean increase in QTcF was 2.2 ms with a 90% two-sided confidence interval (CI) of -2.0 to 6.3 ms. When evaluating the two-sided 90% CI on the time-matched mean changes in QTcF versus placebo control, the upper bounds of both darunavir/ritonavir groups never exceeded the 10 ms boundary. In the setting of this trial, darunavir/ritonavir did not appear to prolong the QTc interval.

## **Pharmacokinetics**

### **General**

Darunavir is primarily metabolized by CYP3A4. The overall pharmacokinetic enhancement effect by ritonavir was an approximate 14-fold increase in the systemic exposure of darunavir when a single dose of 600 mg darunavir was given orally co-administered with ritonavir at 100 mg b.i.d. Therefore, PAT-darunavir should only be co-administered with 100 mg of ritonavir as a pharmacokinetic enhancer.

<b>Pharmacokinetics of darunavir</b>	<b>Darunavir 600 mg Oral N=7 (mean ±SD, t<sub>max</sub>: median [range])</b>	<b>Darunavir 600 mg Oral + rtv 100 mg b.i.d. N=7 (mean ±SD, t<sub>max</sub>: median [range])</b>
t <sub>max</sub> , h	2.00 (1.00 – 4.00)	4.00 (2.00 – 5.00)
C <sub>max</sub> , ng/mL	2,204 ± 1071	5,627 ± 923.5
AUC <sub>last</sub> , ng.h/mL	7,748 ± 4867	91,390 ± 20050
AUC <sub>∞</sub> , ng.h/mL	10,990 ± 4061	92,340 ± 20020
Bioavailability (F) (%)	36.93	81.93

### **Absorption and Bioavailability**

Darunavir was rapidly absorbed following oral administration. Maximum plasma concentration of darunavir in the presence of low-dose ritonavir is generally achieved within 2.5-4.0 hours.

The absolute oral bioavailability of a single 600 mg dose of darunavir alone was approximately 37% and increased to approximately 82% in the presence of 100 mg b.i.d. ritonavir. Increasing the dose of ritonavir to above 100 mg b.i.d. did not significantly affect darunavir concentrations and is not recommended. *In vivo* data suggest that darunavir/ritonavir is an inhibitor of the p-glycoprotein (p-gp) transporter.

#### **Effects of Food on Oral Absorption**

When administered without food, the relative bioavailability of darunavir in the presence of low-dose ritonavir is 30% lower as compared to intake with food. Therefore, PAT-darunavir tablets should be taken with ritonavir and with food. The type of food does not affect exposure to darunavir.

### **Distribution**

Darunavir is approximately 95% bound to plasma proteins. Darunavir binds primarily to plasma alpha-1-acid glycoprotein (AAG).

### **Metabolism**

*In vitro* experiments with human liver microsomes (HLMs) indicate that darunavir primarily undergoes oxidative metabolism. Darunavir is extensively metabolized by the hepatic CYP system, and almost exclusively by isozyme CYP3A4. A <sup>14</sup>C-darunavir trial in healthy volunteers

showed that a majority of the radioactivity in plasma after a single 400/100 mg darunavir/ritonavir dose was due to the parent drug. At least three oxidative metabolites of darunavir have been identified in humans; all showed activity that was at least 10-fold less than the activity of darunavir against wild-type HIV.

### **Excretion**

After a 400/100 mg <sup>14</sup>C-darunavir/ritonavir dose, approximately 79.5% and 13.9% of the administered dose of <sup>14</sup>C-darunavir could be retrieved in feces and urine, respectively. Unchanged darunavir accounted for approximately 41.2% and 7.7% of the administered dose in feces and urine, respectively. The terminal elimination half-life of darunavir was approximately 15 hours when combined with ritonavir. The intravenous clearance of darunavir alone (150 mg) and in the presence of low-dose ritonavir was 32.8 L/h and 5.9 L/h, respectively.

### **Special Populations and Conditions**

#### **Pediatrics**

The pharmacokinetics of darunavir in combination with ritonavir in 74 antiretroviral treatment-experienced HIV-1-infected pediatric patients 6 to <18 years of age and weighing at least 44 lbs (20 kg) showed that the administered weight-based dosages resulted in darunavir exposure comparable to that in adults receiving darunavir/rtv 600/100 mg b.i.d. (see **DOSAGE AND ADMINISTRATION**).

<b>Table 13: Population Pharmacokinetic Estimates of darunavir (Study TMC114-C212, Primary 24-Week Analysis)</b>	
<b>Parameter Median (Range)</b>	<b>Darunavir/Ritonavir N=74</b>
AUC <sub>12h</sub> (ng·h/mL)	63,670 (33,527-115,360)
C <sub>0h</sub> (ng/mL)	3,888 (1,836-7,821)
N = number of patients with data.	

#### **Geriatrics**

Population pharmacokinetic analysis in HIV-infected patients showed that darunavir pharmacokinetics are not considerably different in the age range (18 to 75 years) evaluated in HIV-infected patients (n=12, age ≥ 65) (see **WARNINGS AND PRECAUTIONS, Special Populations, Geriatrics**).

#### **Gender**

Population pharmacokinetic analysis showed a slightly higher darunavir exposure (16.8%) in HIV-infected females (n=68) compared to males. This difference is not considered clinically relevant.

#### **Race**

Population pharmacokinetic analysis of darunavir in HIV-infected patients indicated that race had no apparent effect on the exposure to darunavir.

## **Hepatic Insufficiency**

### Hepatic Impairment

In a multiple dose study with darunavir co-administered with ritonavir (600/100 mg) twice daily, it was demonstrated that the steady-state pharmacokinetic parameters of darunavir in patients with mild (Child-Pugh Class A, n=8) and moderate (Child-Pugh Class B, n=8) hepatic impairment were comparable with those in healthy patients. The effect of severe hepatic impairment of on the pharmacokinetics of darunavir has not been studied (see **CONTRAINDICATIONS, WARNINGS AND PRECAUTIONS**, and **DOSAGE AND ADMINISTRATION**).

### Hepatitis B or Hepatitis C Virus Co-infection

The primary 48-week analysis of the data from Study TMC114-C211 and TMC114-C214 in HIV-1-infected patients indicated that hepatitis B and/or hepatitis C virus co-infection status had no apparent effect on the exposure to darunavir.

## **Renal Insufficiency**

Results from a mass balance study with <sup>14</sup>C-darunavir/ritonavir showed that approximately 7.7% of the administered dose of darunavir is excreted in the urine as unchanged drug. As darunavir and ritonavir are highly bound to plasma proteins, it is unlikely that they will be significantly removed by hemodialysis or peritoneal dialysis. Although darunavir has not been studied in patients with renal impairment, population pharmacokinetic analysis showed that the pharmacokinetics of darunavir were not significantly affected in HIV-infected patients with moderate renal impairment (CrCL between 30–60 mL/min, n=20) (see **WARNINGS AND PRECAUTIONS**, **Renal** and **DOSAGE AND ADMINISTRATION**, **Recommended Dose and Dosage Adjustment**, **Renal Impairment**).

## **STORAGE AND STABILITY**

Store PAT-darunavir tablets between 15 – 30°C.

## **DOSAGE FORMS, COMPOSITION AND PACKAGING**

### **PAT-darunavir 75 mg Tablets**

PAT-darunavir (darunavir) 75 mg tablets are available as white, caplet-shaped, film-coated tablets containing 75 mg of darunavir (corresponding to 81.31 mg of darunavir ethanolate). Each tablet is debossed with “75” on one side and “TMC” on the other side.

### **PAT-darunavir 150 mg Tablets**

PAT-darunavir (darunavir) 150 mg tablets are supplied as white, oval-shaped, film-coated tablets containing 150 mg of darunavir (corresponding to 162.62 mg of darunavir ethanolate). Each tablet is debossed with “150” on one side and “TMC” on the other side.

**PAT-darunavir 400 mg Tablets**

PAT-darunavir (darunavir) 400 mg tablets are supplied as light orange, oval-shaped, film-coated tablets containing darunavir ethanolate equivalent to 400 mg of darunavir per tablet. Each tablet is debossed with “400MG” on one side and “TMC” on the other side.

**PAT-darunavir 600 mg Tablets**

PAT-darunavir (darunavir) 600 mg tablets are supplied as orange, oval-shaped, film-coated tablets containing darunavir ethanolate equivalent to 600 mg of darunavir per tablet. Each tablet is debossed with “600MG” on one side and “TMC” on the other side.

**PAT-darunavir 800 mg Tablets**

PAT-darunavir (darunavir) 800 mg tablets are supplied as dark red, oval-shaped, film-coated tablets containing darunavir ethanolate equivalent to 800 mg of darunavir per tablet. Each tablet is debossed with “800” on one side and “T” on the other side.

Each tablet also contains the inactive ingredients microcrystalline cellulose, colloidal silicon dioxide, crospovidone, and magnesium stearate. The 800 mg tablet core also contains hypromellose. The tablet film coatings contain either OPADRY<sup>®</sup> II White (polyethylene glycol, polyvinyl alcohol - partially hydrolyzed, talc, titanium dioxide) for the 75 and 150 mg tablets or OPADRY<sup>®</sup> II Orange (polyethylene glycol, polyvinyl alcohol - partially hydrolyzed, titanium dioxide, talc, sunset yellow FCF aluminum lake) for the 400 and 600 mg tablets or OPADRY<sup>®</sup> II Dark Red (polyethylene glycol, polyvinyl alcohol - partially hydrolyzed, titanium dioxide, talc, iron oxide red) for the 800 mg tablets.

PAT-darunavir tablets are packaged in bottles in the following configuration:

75 mg tablets—bottles of 480 tablets  
150 mg tablets—bottles of 240 tablets  
400 mg tablets—bottles of 60 tablets  
600 mg tablets—bottles of 60 tablets  
800 mg tablets—bottles of 30 tablets

## PART II: SCIENTIFIC INFORMATION

### PHARMACEUTICAL INFORMATION

#### Drug Substance

Common name:

Darunavir ethanolate

Chemical name:

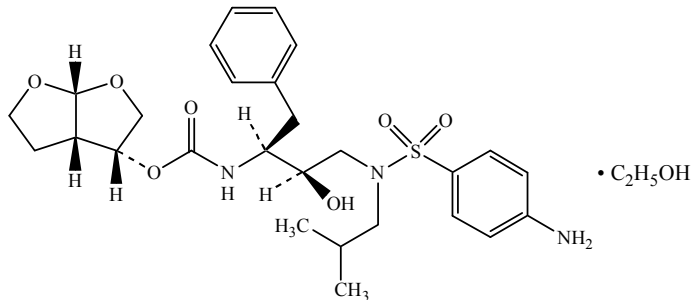
[(1*S*,2*R*)-3-[[[4-aminophenyl)sulfonyl](2-methylpropyl)amino]-2-hydroxy-1-(phenylmethyl)propyl]-carbamic acid (3*R*,3*aS*,6*aR*)-hexahydrofuro[2,3-*b*]furan-3-yl ester ethanolate

Molecular formula and molecular mass:

Molecular formula: C<sub>27</sub>H<sub>37</sub>N<sub>3</sub>O<sub>7</sub>S.C<sub>2</sub>H<sub>5</sub>OH

Molecular mass: 547.66 (593.73 as the ethanolate)

Structural formula:



Physicochemical properties:

Physical Description: Darunavir ethanolate is a white to off-white powder.

Solubility: The solubility of darunavir (or darunavir ethanolate) is approximately 0.015 mg/mL in water at 20°C.



## CLINICAL TRIALS

### **General**

The evidence of efficacy of darunavir/rtv is based on the analyses of 192-week data from a randomized, controlled open-label Phase 3 trial in treatment-naïve (TMC114-C211 [ARTEMIS]) HIV-1 infected adult subjects and 96-week data from a randomized, controlled, open-label Phase 3 trial in antiretroviral treatment-experienced (TMC114-C214 [TITAN]) HIV-1-infected adult patients, and the analysis of 48-week data from one randomized, open-label Phase 3 trial in early treatment experienced HIV-1-infected adult patients (TMC114-C229 [ODIN]).

In addition, 96-week data is included from 2 randomized, controlled Phase 2b trials, TMC114-C213 (POWER 1) and TMC114-C202 (POWER 2), in antiretroviral treatment-experienced HIV-1-infected adult patients, and 96-week data is included from the open label trial TMC114-C215 (POWER 3) in patients who initiated darunavir/rtv at the recommended dose.

### **Antiretroviral Treatment-Naïve Adult Patients** **TMC114-C211 (ARTEMIS)**

#### *Demographics and Trial Design*

The evidence of efficacy of darunavir/rtv 800/100 mg q.d. is based on the analyses of 192 week data from the randomised, controlled, open-label Phase 3 trial TMC114-C211 in antiretroviral treatment naïve HIV-1 infected patients comparing darunavir/rtv 800/100 mg q.d. with lopinavir/rtv 800/200 mg per day (given as a twice-daily or as a once-daily regimen). Both arms used a fixed background regimen consisting of tenofovir disoproxil fumarate 300 mg q.d. (TDF) and emtricitabine 200 mg q.d. (FTC).

HIV-1 infected patients who were eligible for this trial had plasma HIV-1 RNA > 5000 copies/mL. Randomization was stratified by screening plasma viral load and screening CD4+ cell count. Virologic response was defined as a confirmed plasma HIV-1 RNA viral load < 50 copies/mL. Analyses included 689 patients in Study TMC114-C211 who had completed 48 and 192 weeks of treatment or discontinued earlier.

Demographics and baseline characteristics were balanced between the darunavir/rtv arm and the lopinavir/rtv arm (see Table 14). Table 14 compares the demographic and baseline characteristics between patients in the darunavir/rtv 800/100 mg q.d. arm and patients in the lopinavir/ritonavir 800/200 mg per day arm in the ARTEMIS trial. The 343 patients on darunavir/rtv 800/100 mg q.d. had a median age of 34 years (range 18-70), 70% were male, 40% white, 23% black, 23% hispanic, and 13% asian. The mean baseline plasma HIV-1 RNA was 4.86 log<sub>10</sub> copies/mL and the median baseline CD4+ cell count was 228 x 10<sup>6</sup> cells/l (range 4 – 750 x 10<sup>6</sup> cells/l).

<b>Table 14: Demographic and Baseline Characteristics of Patients in TMC114-C211 Trial</b>		
	<b>Randomized TMC114-C211 Trial</b>	
	<b>darunavir/rtv 800/100 mg q.d. + TDF/FTC N = 343</b>	<b>lopinavir/ritonavir 800/200 mg per day + TDF/FTC N = 346</b>
<b>Demographic Characteristics</b>		
Median Age (years) (range, years)	34 (18-70)	33 (19-68)
Sex		
Male	70%	70%
Female	30%	30%
Race		
White	40%	45%
Black	23%	21%
Hispanic	23%	22%
Asian	13%	11%
<b>Baseline Characteristics</b>		
Mean Baseline Plasma HIV-1 RNA (log <sub>10</sub> copies/mL)	4.86	4.84
Median Baseline CD4+ Cell Count (cells/mm <sup>3</sup> ) (range, cells/mm <sup>3</sup> )	228 (4-750)	218 (2-714)
Percentage of Patients with Baseline Viral Load ≥ 100,000 copies/mL	34%	35%
Percentage of Patients with Baseline CD4+ Cell Count < 200 cells/mm <sup>3</sup>	41%	43%

### *Study Results*

According to the statistical methods for analysis at Week 48 and Week 192 in the TMC114-C211 protocol, if at each time point, the lower limit of the 95% 2-sided CI of the difference between DRV/rtv and LPV/rtv exceeded -12% (for the On-Protocol (OP) population), noninferiority of DRV/rtv versus LPV/rtv could be concluded for that time point. Noninferiority in virologic response (HIV-1 RNA < 50 copies/mL) with darunavir/rtv 800/100 mg q.d. compared to treatment with lopinavir/ritonavir 800/200 mg per day was demonstrated through 48 weeks of treatment (83.7% in the darunavir/rtv 800/100 mg q.d arm versus 78.3% in the lopinavir/ritonavir 800/200 mg per day arm) (p< 0.001). The difference (95% CI) in response at Week 48 between DRV and LPV is 5.5% (-0.4 - 11.4) for <50 copies/mL and 2.7% (-2.4 - 7.8) for 400 copies/mL.

Analyses of the data at 192 weeks of treatment in the ARTEMIS trial demonstrated sustained antiretroviral efficacy and immunological benefit of the darunavir/rtv arm. In the 192 weeks analysis, virologic response (HIV-1 RNA<50 copies/mL) in the ITT population was 68.8% and 57.2% for the darunavir/rtv and lopinavir/rtv arm, respectively. Non-inferiority in virologic response was demonstrated (p<0.001) for both ITT and OP population. Furthermore, statistical superiority of the darunavir/rtv arm over the lopinavir/rtv arm was demonstrated (p=0.002) for both ITT and OP population.

Week 48 and 192 week outcomes for patients in the On-Protocol population on darunavir/rtv 800/100 mg q.d. from the ARTEMIS trial are shown in Table 15.

<b>Table 15: Outcomes of Randomized Treatment Through Week 48 and 192 of the TMC114-C211 Trial for the On-Protocol Population</b>				
	<b>Randomized Study TMC114-C211</b>			
	<b>Week 48</b>		<b>Week 192</b>	
	<b>darunavir/ rtv 800/100 mg q.d. + TDF/FTC N = 340</b>	<b>lopinavir/ritonavir 800/200 mg per day + TDF/FTC N = 346</b>	<b>darunavir/rtv 800/100 mg q.d. + TDF/FTC N = 340</b>	<b>lopinavir/ritonavir 800/200 mg per day + TDF/FTC N = 346</b>
Virologic Responders HIV-1 RNA < 50 copies/mL	83.8%	78.3%	69.1%	57.1%
(HIV-1 RNA < 400 copies/mL)	(87.9%)	(85.3%)	(75.2%)	(65.0%)
Virologic failures	5.8%	10.1%	8.2%	12.5%
Rebounder*	1.5%	2.6%	7.0%	11.0%
Never suppressed†	4.4%	7.5%	1.2%	1.4%
Discontinuation due to adverse events	2.9%	5.5%	4.1%	11.3%
Death	0.3%	0.6%	0.3%	1.4%
Discontinuation due to other reasons	7.1%	5.5%	18.2%	17.7%
N = total number of patients in the On-Protocol population with data				
*Patients with a confirmed viral load < 50 copies/mL before Week 48 or 192, but without a confirmed viral load < 50 copies/mL at Week 48 and 192				
† Patients who never reached a confirmed viral load < 50 copies/mL before Week 48 or 192				

The mean changes in plasma HIV-1 RNA from baseline in the ITT population were  $-2.77 \log_{10}$  copies/mL at 48 weeks ( $-2.35 \log_{10}$  copies/mL at 192 weeks) in the arm receiving darunavir/rtv 800/100 mg q.d. and  $-2.65 \log_{10}$  copies/mL at 48 weeks ( $-2.03 \log_{10}$  copies/mL at 192 weeks) for the arm receiving lopinavir/ritonavir 800/200 mg per day. The median increase from baseline in CD4+ cell counts was comparable for both treatment groups (148 cells/mm<sup>3</sup> and 148 cells/mm<sup>3</sup> at 48 weeks (266 cells/mm<sup>3</sup> and 269 cells/mm<sup>3</sup> at 192 weeks) in the darunavir/rtv 800/100 mg q.d. arm and the lopinavir/ritonavir 800/200 mg per day arm, respectively).

The virological response (< 50 copies/mL) by baseline viral load for all ITT patients is presented in Table 16. For patients with baseline VL < 100,000 copies/mL, responses were similar for darunavir/rtv and lopinavir/ritonavir; patients with baseline VL  $\geq$ 100,000 copies/mL receiving darunavir/ritonavir had a statistically superior virological response (< 50 copies/mL) than lopinavir/rtv (67.5 % vs. 51.7%; p= 0.012).

<b>Table 16: Virological Response (&lt; 50 copies/mL) at 192 Weeks by Baseline Viral Load and Baseline CD4+ Cell Count</b>					
	<b>darunavir/rtv 800/100 mg q.d. n=343</b>		<b>lopinavir/ritonavir 800/200 mg per day n=346</b>		<b>treatment difference</b>
	<b>N</b>	<b>number of responders at week 192 n (%)</b>	<b>N</b>	<b>number of responders at week 192 n (%)</b>	<b>Difference in % response (95% CI of difference in % response)</b>
<b>Baseline plasma viral load (copies/mL)</b>					
< 100,000	226	157 (69.5)	226	136 (60.2)	9.3 (0.5; 18.1)
≥ 100,000	117	79 (67.5)	120	62 (51.7)	15.9 (3.5; 28.3)
<b>Baseline CD4+ cell count (x 10<sup>6</sup>/L)</b>					
< 200	141	92 (65.2)	148	80 (54.1)	11.2 (-0.1; 22.5)
≥ 200	202	144 (71.3)	198	118 (59.6)	11.7 (2.4; 21.0)

### **Antiretroviral Treatment-Experienced Adult Patients**

The evidence of comparable efficacy of darunavir/rtv 800/100 mg q.d. and darunavir/rtv 600/100 mg b.i.d. in treatment-experienced patients with no darunavir resistance associated mutations is based on the 48 week analysis of the Phase 3 trial TMC114-C229 (ODIN).

The evidence of efficacy of darunavir/rtv 600/100 mg b.i.d. in treatment experienced patients is based on the 96 week analysis of the Phase 3 trial TMC114-C214 (TITAN) in treatment experienced, lopinavir/rtv naïve patients and on the analyses of 96 week data from the Phase 2b trials POWER 1, 2 and 3, in patients with high level of PI resistance.

### TMC114-C229 (ODIN)

#### *Demographics and Trial Design*

Study TMC114-C229 is a randomized, open-label trial comparing darunavir/rtv 800/100 mg q.d. to darunavir/rtv 600/100 mg b.i.d. in treatment-experienced HIV-1 infected patients with screening genotype resistance test showing no darunavir resistance associated mutations (i.e. V11I, V32I, L33F, I47V, I50V, I54M, I54L, T47P, L76V, I84V, L89V) and a screening viral load of >1,000 HIV-1 RNA copies/mL. Both arms used an optimized background regimen consisting of ≥2 NRTIs selected by the investigator.

HIV-1-infected patients who were eligible for this trial were on a stable highly active antiretroviral therapy regimen (HAART) for at least 12 weeks. Virologic response was defined as a confirmed plasma HIV-1 RNA viral load <50 copies/mL. Analyses included 590 patients who had completed 48 weeks of treatment or discontinued earlier (ITT population). Table 17 compares the demographic and baseline characteristics between patients in the darunavir/rtv 800/100 mg q.d. and patients in the darunavir/rtv 600/100 mg b.i.d. arm in study TMC114-C229. No imbalances between the two arms were noted. The majority of the patient population (>87%) was not co-infected with hepatitis B and/or hepatitis C virus.

<b>Table 17: Demographic and Baseline Characteristics of Patients in Study TMC114-C229 (ITT Population<sup>§</sup>)</b>		
	<b>Randomized Study TMC114-C229</b>	
	<b>darunavir/ritonavir 800/100 mg once daily + OBR N = 294</b>	<b>darunavir/ritonavir 600/100 mg twice daily + OBR N = 296</b>
<b>Demographic Characteristics</b>		
Median Age (years) (range, years)	40 (18-70)	40 (18-77)
Sex		
Male	61%	67%
Female	39%	33%
Race		
White	35%	37%
Black	28%	24%
Hispanic	16%	20%
Asian	16%	14%
<b>Baseline Characteristics</b>		
Mean Baseline Plasma HIV-1 RNA (log <sub>10</sub> copies/mL)	4.19	4.13
Median Baseline CD4+ Cell Count (cells/mm <sup>3</sup> ) (range, cells/mm <sup>3</sup> )	219 (24-1306)	236 (44-864)
Percentage of Patients with Baseline Viral Load ≥ 100,000 copies/mL	13%	11%
Percentage of Patients with Baseline CD4+ Cell Count < 200 cells/mm <sup>3</sup>	43%	39%
Median Darunavir Fold Change (range) <sup>‡</sup>	0.50 (0.1-1.8)	0.50 (0.1-1.9)
Median Number of Resistance-Associated*: PI mutations NNRTI mutations NRTI mutations	3 2 1	4 1 1
Percentage of Patients with Number of Baseline Primary Protease Inhibitor Mutations		
0	84%	84%
1	8%	9%
2	5%	4%
≥ 3	3%	2%
Median Number of ARVs Previously Used <sup>†</sup> : NRTIs NNRTIs PIs (excluding low-dose ritonavir)	3 1 1	3 1 1
* Johnson VA, Brun-Vézinet F, Clotet B, et al. Update of the drug resistance mutations in HIV-1: December 2008. Top HIV Med 2008; 16(5): 138-145		
§ Intent-to-treat (ITT) population was defined as the set of patients who were randomized and who had taken ≥1 dose of trial medication, regardless of their compliance with the protocol.		
† Only counting ARVs, excluding low-dose ritonavir		
‡ Based on phenotype [FC] (Antivirogram <sup>®</sup> ) FC = EC <sub>50</sub> of the patient virus/EC <sub>50</sub> of reference wild type virus		

### Study Results

In the 48 week primary analysis, the virologic response defined as a confirmed plasma HIV-1 RNA viral load <50 copies/mL (ITT, TLOVR), was 72.1% for the darunavir/rtv q.d. arm and 70.9% for the darunavir/rtv b.i.d. arm (difference = 1.2%, 95% CI = [-6.1; 8.5]). Statistical comparisons between the treatment arms at week 48 based on a normal approximation of the difference in virologic response, confirmed non-inferiority of darunavir/rtv q.d. versus darunavir/rtv b.i.d. for both the ITT and OP populations (p-value<0.001). A summary of all Week 48 outcomes for patients on darunavir/rtv 800/100 mg q.d. from study TMC114-C229 are shown in Table 18.

<b>Table 18: Outcomes of Randomized Treatment Through Week 48 of Study TMC114-C229</b>				
	<b>Randomized Study TMC114-C229</b>			
	<b>darunavir/rtv 800/100 mg q.d. + OBR N =294</b>	<b>darunavir/rtv 600/100 mg b.i.d. + OBR N =296</b>	<b>Difference in virologic response [95% CI]</b>	<b>P-value for non-inferiority</b>
Virologic Responders (HIV-1 RNA < 50 copies/mL)	71.4% <sup>Ω</sup>	70.3% <sup>Ω</sup>	1.2 [-6.2; 8.5]	< 0.001*
Virologic failures: <sup>†</sup> Lack of initial response <sup>#</sup>	10.5% <sup>Ω</sup>	8.1% <sup>Ω</sup>		
Rebounder <sup>£</sup>	2.4%	2.0%		
Never suppressed <sup>‡</sup>	4.8%	5.1%		
Discontinuation due to adverse events	2.4%	2.0%		
Death	0.6%	1.7%		
Discontinuation due to other reasons <sup>§</sup>	7.8%	10.8%		

N = total number of patients in the ITT population with data  
<sup>†</sup> Patients who discontinued prior to Week 48 for lack of efficacy; patients who are ≥50 copies in Week 48 and patients who had a switch in their background regimen that was not permitted by the protocol.  
<sup>#</sup> Patients are considered to show an initial lack of response if i) they have viral load data beyond the considered time point, and ii) confirmed virologic response (VL<400 copies/mL – TLOVR) at Week 24 equals 0.  
<sup>£</sup> Patients who have a confirmed response (<50 copies/mL – TLOVR) before the considered time point (any response = 1) but who have a confirmed rebound at the considered time point (i.e. TLOVR response = No at the considered time point)  
<sup>‡</sup> Patients who never reached a confirmed viral load < 50 copies/mL before Week 48  
<sup>§</sup> Includes: withdrew consent, loss to follow-up, moved etc.  
<sup>Ω</sup> Two patients in each arm with a confirmed virologic response at Week 48 demonstrated an initial lack of response at week 24, and were therefore not considered virologic responders in this outcome summary.  
\* Based on a normal approximation of the difference in response.

At week 48, the mean change in log<sub>10</sub> viral load from baseline in the ITT population was -1.84 and -1.80 log<sub>10</sub> copies/mL for the DRV/rtv q.d. and DRV/rtv b.i.d. groups, respectively. The difference in mean change and 95% confidence interval in log<sub>10</sub> viral load from baseline between

treatment groups at week 48 was -0.04 (-0.24, 0.16). Statistical comparison (ITT-ANCOVA) showed an estimated difference (difference between LS Means and the 95% CI) between the DRV/rtv q.d. and the b.i.d. treatment groups at 48 weeks of -0.003 (-0.188, 0.182) (p=0.977).

The mean increase from baseline in CD4+ cell counts was comparable for both treatment arms (108 cells/mm<sup>3</sup> and 112 cells/mm<sup>3</sup> in the darunavir/rtv 800/100 mg q.d. arm and the darunavir/rtv 600/100 mg b.i.d. arm, respectively).

### Study TMC114-C214 (TITAN)

#### *Demographics and Trial Design*

Study TMC114-C214 was an ongoing randomized, controlled, open label Phase 3 trial comparing darunavir/rtv 600/100 mg b.i.d. versus lopinavir/rtv 400/100 mg b.i.d. in antiretroviral treatment-experienced, lopinavir/rtv naïve HIV-1 infected adult patients. Both arms used an optimised background regimen (OBR) consisting of at least 2 antiretrovirals (NRTIs with or without NNRTIs).

HIV-1 infected patients who were eligible for this trial had plasma HIV-1 RNA > 1000 copies/mL and were on a highly active antiretroviral therapy regimen (HAART) for at least 12 weeks. Virologic response was defined as a confirmed plasma HIV 1 RNA viral load < 400 copies/mL. Analyses included 595 patients in the TITAN trial who had completed 96 weeks of treatment or discontinued earlier.

Demographics and baseline characteristics were balanced between the darunavir/rtv arm and the lopinavir/ritonavir arm (see Table 19). Table 19 compares the demographic and baseline characteristics between patients in the darunavir/rtv 600/100 mg b.i.d. arm and patients in the lopinavir/ritonavir 400/100 mg b.i.d. arm in study TMC114-C214.

<b>Table 19: Demographic and Baseline Characteristics of Patients in Study TMC114-C214</b>		
	<b>Randomized Study TMC114-C214</b>	
	<b>darunavir/rtv 600/100 mg b.i.d. + OBR N = 298</b>	<b>lopinavir/ritonavir 400/100 mg b.i.d. + OBR N = 297</b>
<b>Demographic Characteristics</b>		
Median Age (years) (range, years)	40 (18-68)	41 (22-76)
Sex		
Male	77%	81%
Female	23%	19%
Race		
White	54%	57%
Black	18%	17%
Hispanic	15%	15%
Asian	9%	9%
<b>Baseline Characteristics</b>		
Mean Baseline Plasma HIV-1 RNA (log <sub>10</sub> copies/mL)	4.33	4.28
Median Baseline CD4+ Cell Count (cells/mm <sup>3</sup> ) (range, cells/mm <sup>3</sup> )	235 (3-831)	230 (2-1096)
Percentage of Patients with Baseline Viral Load ≥ 100,000 copies/mL	19%	17%
Percentage of Patients with Baseline CD4+ Cell Count < 200 cells/mm <sup>3</sup>	40%	40%
Median Darunavir FC	0.60 (0.1 - 37.4)	0.60 (0.1 - 43.8)
Median Lopinavir FC	0.70 (0.4 - 74.4)	0.80 (0.3 - 74.5)
Median Number of Resistance-Associated*: PI mutations	4	4
NNRTI mutations	1	1
NRTI mutations	2	2
Percentage of Patients with Number of Baseline Primary Protease Inhibitor Mutations*: ≤ 1		
2	78%	80%
≥ 3	8%	9%
	13%	11%
Median Number of ARVs Previously Used <sup>‡</sup> : NRTIs	4	4
NNRTIs	1	1
PIs (excluding low-dose ritonavir)	1	1
Percentage of Patients Resistant <sup>‡</sup> to All Available <sup>§</sup> PIs at Baseline, excluding Darunavir	2%	3%
* Johnson VA, Brun-Vezinet F, Clotet B, et al. Update of the drug resistance mutations in HIV-1: Fall 2006. Top HIV Med 2006; 14(3): 125-130		
† Only counting ARVs, excluding low-dose ritonavir		
‡ Based on phenotype (Antivirogram™)		
§ Commercially available PIs at the time of study enrollment		



### Study Results

According to the statistical methods in the TMC114-C214 protocol, if the lower limit of the 95% 2-sided CI of the difference between DRV/rtv and LPV/rtv exceeded -12% (for the On-protocol (OP) population), noninferiority of DRV/rtv versus LPV/rtv was concluded. Week 48 and 96 outcomes for patients on darunavir/rtv 600/100 mg b.i.d. from study TMC114-C214 are shown in Table 20.

<b>Table 20: Outcomes of Randomized Treatment Through Week 48 and 96 of Study TMC114-C214</b>				
	<b>Randomized Study TMC114-C214</b>			
	<b>48 Weeks</b>		<b>96 Weeks</b>	
	<b>darunavir/rtv 600/100 mg b.i.d. + OBR N = 274 N</b>	<b>lopinavir/ritonavir 400/100 mg b.i.d. + OBR N = 280 N</b>	<b>darunavir/rtv 600/100 mg b.i.d. + OBR N = 280 N</b>	<b>lopinavir/ritonavir 400/100 mg b.i.d. + OBR N = 294 N</b>
<b>Virologic Responders HIV-1 RNA &lt; 400 copies/mL (HIV-1 RNA &lt; 50 copies/mL)</b>	211 (77.0%) [196 (71.5%)]	189 (67.5%) [169 (60.4%)]	189 (67.5%) [172 (61.4%)]	175 (59.5%) [164 (55.8%)]
<b>Virologic failures</b>	28 (10.2%)	51 (18.2%)	31 (11.1%)	61 (20.7%)
<b>Lack of initial response<sup>§</sup></b>	19 (6.9%)	29 (10.4%)	19 (6.8%)	35 (11.9%)
<b>Rebounder<sup>†</sup></b>	9 (3.3%)	21 (7.5%)	12 (4.3%)	25 (8.5%)
<b>Discontinued due to virologic failure: never suppressed<sup>‡</sup></b>	0 (0%)	1 (0.4%)	0 (0%)	1 (0.3%)
<b>Discontinuation due to adverse events</b>	14 (5.1%)	13 (4.6%)	22 (7.9%)	23 (7.8%)
<b>Death</b>	2 (0.7%)	2 (0.7%)	20 (7.1%)	17 (5.8%)
<b>Discontinuation due to other reasons</b>	19 (6.9%)	25 (8.9%)	2 (0.7%)	3 (1.0%)
N = total number of patients with data				
<sup>§</sup> Patients with viral load ≥ 400 copies/mL at Week 16 and without a confirmed viral load <400 copies/mL at Week 48 and 96				
<sup>†</sup> Patients with a confirmed viral load < 400 copies/mL before Week 48 and 96, but without a confirmed viral load < 400 copies/mL at Week 48 and 96				
<sup>‡</sup> Patients who never reached a confirmed viral load < 400 copies/mL before Week 48 and 96				

Through 96 weeks of treatment, there was a significantly greater proportion of patients with HIV-1 RNA < 400 copies/mL and with HIV-1 RNA < 50 copies/mL in the arm receiving darunavir/rtv 600/100 mg b.i.d. (67.5% and 61.4%, respectively) compared to the arm receiving lopinavir/ritonavir 400/100 mg b.i.d. (59.5% and 55.8%, respectively). The difference (95% CI) in response at Week 96 between DRV and LPV is 8.0% (0.1 - 15.8) for <400 copies/mL and 5.6% (2.4 - 13.7) for <50 copies/mL.

Noninferiority in virologic response (HIV-1 RNA < 400 copies/mL) with darunavir/rtv 600/100 mg b.i.d. compared to treatment with lopinavir/ritonavir 400/100 mg b.i.d. was demonstrated ( $p < 0.001$ ), furthermore superiority of darunavir/rtv over the lopinavir/rtv arm was demonstrated ( $p = 0.033$ ).

The proportion of patients with at least 1 log<sub>10</sub> HIV-1 RNA below baseline was 77.7% in the arm receiving darunavir/rtv 600/100 mg b.i.d. compared to 69.3% in the arm receiving lopinavir/ritonavir 400/100 mg b.i.d. At week 96, the mean changes in plasma HIV-1 RNA from baseline were -1.72 log<sub>10</sub> copies/mL in the arm receiving darunavir/rtv 600/100 mg b.i.d. and -1.54 log<sub>10</sub> copies/mL for the arm receiving lopinavir/ritonavir 400/100 mg b.i.d. The median increase from baseline in CD4+ cell counts was comparable for both treatment groups (81 cells/mm<sup>3</sup> and 96 cells/mm<sup>3</sup> in the darunavir/rtv 600/100 mg b.i.d. arm and lopinavir/ritonavir 400/100 mg b.i.d. arm, respectively).

### TMC114-C213 (POWER 1) and TMC114-C202 (POWER 2)

#### *Demographics and Trial Design*

Studies TMC 114-C213 (Power 1) and TMC114-C202 (Power 2) are randomized, controlled Phase 2b trials in patients with a high level of PI resistance, consisting of 2 parts: an initial partially blinded, dose finding part and a second long term part in which all patients randomized to darunavir/rtv received the recommended dose of 600/100 mg b.i.d.

HIV-1 infected patients who were eligible for these trials had plasma HIV-1 RNA > 1000 copies/mL, had prior treatment with PI(s), NNRTI(s) and NRTI(s), had at least one primary PI mutation (D30N, M46I/L, G48V, I50L/V, V82A/F/S/T, I84A/C/V, L90M) at screening, and were on a stable PI-containing regimen at screening for at least 8 weeks. Randomization was stratified by the number of PI mutations, screening viral load, and the use of enfuvirtide.

The virologic response rate was evaluated in patients receiving darunavir/rtv plus an optimized background regimen (OBR) versus a control group receiving an investigator-selected PI(s) regimen plus an OBR. The OBR consisted of at least 2 NRTIs with or without enfuvirtide. Based on resistance testing and prior medical history, selected PIs in the control arm included: lopinavir/ritonavir in 36%, (fos)amprenavir in 34%, saquinavir in 35% and atazanavir in 17%; 23% of the control patients used dual-boosted PIs. Approximately 47% of all patients used enfuvirtide (ENF), and 35% of the use was in patients who were ENF-naïve. Virologic response was defined as a decrease in plasma HIV-1 RNA viral load of at least 1.0 log<sub>10</sub> versus baseline.

In the pooled analysis for TMC114-C213 and TMC114-C202, demographics and baseline characteristics were balanced between the darunavir/rtv arm and the comparator PI arm. Table 21 compares the demographic and baseline characteristics between patients in the darunavir/rtv 600/100 mg b.i.d. arm and patients in the comparator PI arm in the pooled analysis of studies TMC114-C213 and TMC114-C202.

<b>Table 21: Demographic and Baseline Characteristics of Patients in Studies TMC114-C213 and TMC114-C202 (Pooled Analysis)</b>		
	<b>Randomized Studies TMC114-C213 and TMC114-202</b>	
	<b>darunavir/rtv 600/100 mg b.i.d. + OBR N = 131</b>	<b>Comparator PI(s) + OBR N = 124</b>
<b>Demographic Characteristics</b>		
Median Age (years) (range, years)	43 (27-73)	44 (25-65)
Sex		
Male	89%	88%
Female	11%	12%
Race		
White	81%	73%
Black	10%	15%
Hispanic	7%	8%
<b>Baseline Characteristics</b>		
Mean Baseline Plasma HIV-1 RNA (log <sub>10</sub> copies/mL)	4.61	4.49
Median Baseline CD4+ Cell Count (cells/mm <sup>3</sup> ) (range, cells/mm <sup>3</sup> )	153 (3-776)	163 (3-1274)
Percentage of Patients with Baseline Viral Load > 100,000 copies/mL	24%	29%
Percentage of Patients with Baseline CD4+ Cell Count < 200 cells/mm <sup>3</sup>	67%	58%
Median Darunavir FC	4.3	3.3
Median Number of Resistance-Associated*: PI mutations	12	12
NNRTI mutations	1	1
NRTI mutations	6	5
Percentage of Patients with Number of Baseline Primary Protease Inhibitor Mutations*: ≤ 1	8%	9%
2	22%	21%
≥ 3	70%	70%
Median Number of ARVs Previously Used†: NRTIs	6	6
NNRTIs	1	1
PIs (excluding low-dose ritonavir)	4	4
Percentage of Patients Resistant† to All Available‡ PIs at Baseline, excluding Tipranavir and Darunavir	66%	61%
Percentage of Patients with Prior Use of Enfuvirtide	20%	17%
* Johnson VA, Brun-Vezinet F, Clotet B, et al. Update of the drug resistance mutations in HIV-1: Fall 2006. Top HIV Med 2006; 14(3): 125-130		
† Based on phenotype (Antivirogram™)		
‡ Commercially available PIs at the time of study enrollment		

### Study Results

Week 48 outcomes for patients on the recommended dose darunavir/rtv 600/100 mg b.i.d. from the pooled studies TMC114-C213 and TMC114-C202 are shown in Table 22.

	Randomized Studies TMC114-C213 and TMC114-C202	
	darunavir/rtv 600 mg b.i.d. + OBR N=131	Comparator PI + OBR N=124
Virologic Responders confirmed at least 1 log <sub>10</sub> HIV-1 RNA below baseline through Week 48 ( $< 50$ copies/mL at Week 48)	61.1% <sup>§</sup> (45.0%) <sup>§</sup>	16.1% (11.3%) <sup>§</sup>
Virologic failures	29.0%	75.0%
Lack of initial response*	8.4%	53.2%
Rebounder <sup>†</sup>	16.0%	13.7%
Never Suppressed <sup>‡</sup>	4.6%	8.1%
Discontinuation due to adverse events	4.6%	2.4%
Deaths	2.3%	0.8%
Discontinuation due to other reasons	3.1%	5.6%
* Patients who did not achieve at least a confirmed 0.5 log <sub>10</sub> HIV-1 RNA drop from baseline at Week 12		
† Patients with an initial response (confirmed 1 log <sub>10</sub> drop in viral load), but without a confirmed 1 log <sub>10</sub> drop in viral load at Week 48		
‡ Patients who never reached a confirmed 1 log <sub>10</sub> drop in viral load before Week 48		
§ p<0.001, based on logistic regression model; p-values [darunavir/rtv 600/100 mg b.i.d vs. comparator PI + OB]		

In the pooled TMC114-C213 and TMC114-C202 analysis through 48 weeks of treatment, the proportion of patients with HIV-1 RNA  $< 400$  copies/mL in the arm receiving darunavir/rtv 600/100 mg b.i.d. compared to the comparator PI arm was 55.0% and 14.5%, respectively ( $p<0.001$ ). In addition, the mean changes in plasma HIV-1 RNA from baseline were  $-1.69$  log<sub>10</sub> copies/mL in the arm receiving darunavir/rtv 600/100 mg b.i.d. and  $-0.37$  log<sub>10</sub> copies/mL for the comparator PI arm ( $p<0.001$ ). The mean increase from baseline in CD4<sup>+</sup> cell counts was higher in the arm receiving darunavir/rtv 600/100 mg b.i.d. (103 cells/mm<sup>3</sup>) than in the comparator PI arm (17 cells/mm<sup>3</sup>) ( $p<0.001$ ).

Analyses of the data through 96 weeks of treatment in the pooled TMC114-C213 and TMC114-C202 trials demonstrated sustained antiretroviral efficacy and immunological benefit. Treatment with darunavir/rtv 600/100 mg b.i.d. resulted in 56.5% of patients with a decrease of at least 1 log<sub>10</sub> HIV-1 RNA versus baseline and 38.9% of patients reaching less than 50 HIV-1 RNA copies/mL. At Week 96, 49.6% of patients reached less than 400 HIV-1 RNA copies/mL, and the mean change in plasma HIV-1 RNA from baseline was  $-1.58$  log<sub>10</sub> copies/mL. The mean increase in CD4<sup>+</sup> cell count versus baseline was 133 cells/mm<sup>3</sup> at Week 96.

## TMC114-C215 (POWER 3)

### *Demographics and Trial Design*

Additional data on the efficacy of darunavir/rtv 600/100 mg b.i.d. have been obtained in treatment-experienced patients participating in the non-randomized trial TMC114-C215. The 318 patients included in the 96-week efficacy analysis initiated therapy with darunavir/rtv with the recommended dose of 600/100 mg b.i.d. The OBR consisted of at least two NRTIs with or without enfuvirtide. Entry criteria for Study TMC114-C215 were the same as those for TMC114-C213 (POWER 1) and TMC114-C202 (POWER 2) trials.

Baseline characteristics of the patients included in TMC114-C215 trial were comparable to those patients in TMC114-C213 and TMC114-C202 trials.

### *Study Results*

The TMC114-C215 48-week efficacy analysis supported the viral load reduction and CD4+ cell count increases observed in the TMC114-C213 and TMC114-C202 trials. Of the 334 patients at Week 48, 58.7% had a virologic response defined as a decrease of at least 1.0 log<sub>10</sub> HIV-1 RNA versus baseline and 46.4% of the patients reached less than 50 HIV-1 RNA copies/mL. At Week 48, 54.8% of the patients reached less than 400 HIV-1 RNA copies/mL, and the mean changes in plasma HIV-1 RNA from baseline were -1.62 log<sub>10</sub> copies/mL. The mean increase in CD4+ cell count versus baseline was 105 cells/mm<sup>3</sup> at Week 48.

Analyses of the data through 96 weeks of treatment in the non-randomized trial TMC114-C215 demonstrated sustained antiretroviral efficacy and immunological benefit. Of the 318 patients at Week 96, 52.2% had a virologic response defined as a decrease of at least 1.0 log<sub>10</sub> HIV-1 RNA versus baseline and 42.1% of the patients reached less than 50 HIV-1 RNA copies/mL. At Week 96, 50.0% of the patients reached less than 400 HIV-1 RNA copies/mL, and the mean change in plasma HIV-1 RNA from baseline was -1.43 log<sub>10</sub> copies/mL. The mean increase in CD4+ cell count versus baseline was 103 cells/mm<sup>3</sup> at Week 96.

### TMC114-C213, TMC114-C202 and TMC114-C215 Trials

Out of the 206 patients who responded with complete viral suppression (< 50 HIV-1 RNA copies/mL) at Week 48, 86% of patients remained responders at Week 96.

## **Pediatric Patients**

### Treatment-Experienced Pediatric Patients

#### *Demographics and Trial Design*

Study TMC114-C212 is an on-going open-label, Phase 2 trial of 48 week duration evaluating the pharmacokinetics, safety, tolerability, and efficacy of darunavir/rtv in 80 antiretroviral treatment-experienced HIV-1-infected pediatric patients 6 to < 18 years of age and weighing at least 44 lbs (20 kg).

At Week 24, the virologic response rate was evaluated in pediatric patients receiving darunavir/rtv in combination with other antiretroviral agents (see **DOSAGE AND**

**ADMINISTRATION** for dosage recommendations per body weight). Virologic response was defined as a decrease in plasma HIV-1 RNA viral load of at least 1 log<sub>10</sub> versus baseline. The mean baseline plasma HIV-1 RNA was 4.64 log<sub>10</sub> copies/mL, and the median baseline CD4+ cell count was 330 cells/mm<sup>3</sup> (range: 6 to 1505 cells/mm<sup>3</sup>).

In the study, pediatric patients who were at risk of discontinuing therapy due to intolerance of ritonavir oral solution (e.g., taste aversion) were allowed to switch to the capsule formulation. Of the 44 pediatric patients taking ritonavir oral solution, 23 patients switched to the 100 mg capsule formulation and exceeded the weight-based ritonavir dose without changes in observed safety.

#### *Study Results*

At Week 24, 73.8% of pediatric patients had at least 1 log<sub>10</sub> HIV-1 RNA decrease from baseline. The proportion of pediatric patients reaching undetectable viral load (< 50 HIV-1 RNA copies/mL) was 50.0%, and the proportion of pediatric patients with < 400 HIV-1 RNA copies/mL was 63.8%. The mean change in plasma HIV-1 RNA from baseline was -1.98 log<sub>10</sub> copies/mL. The mean CD4+ cell count increase from baseline was 117 cells/mm<sup>3</sup> and the median CD4+ cell count increase was 96 cells/mm<sup>3</sup> (range: -232 to 465 cells/mm<sup>3</sup>).

### **Pivotal Comparative Bioavailability Study**

#### **TMC114-TiDP3-C162**

In a Phase 1, open-label, randomized 2-panel, 2-way crossover bioavailability trial the rate and extent of absorption of darunavir following administration of two tablet strengths (in the presence of low-dose ritonavir) under fed and fasted conditions was assessed in 96 healthy subjects.

In Panel 1, 47 subjects randomly received under fasted conditions a single oral 600 mg dose of darunavir formulated as the 300 mg tablet (2 x 300 mg; Treatment A) in one session, followed by a single oral 600 mg dose formulated as the 600 mg tablet (1 x 600 mg; Treatment B) in the second session. The results indicate that the bioavailability of a 1x 600 mg dose of darunavir is comparable to the bioavailability of a 2 x 300 mg dose of darunavir.

In Panel 2, 46 subjects randomly received under fed conditions a single oral 600 mg dose of darunavir formulated as the 300 mg tablet (2 x 300 mg; Treatment C) in one session and a single oral 600 mg dose of darunavir formulated as the 600 mg tablet (1 x 600 mg; Treatment D) in the second session. The results indicate that the bioavailability of a 1x 600 mg dose of darunavir is comparable to the bioavailability of a 2 x 300 mg dose of darunavir.

The summary of results is presented in Table 23.

<b>Table 23: Summary Table of the Comparative Bioavailability Data Under Fed and Fasting Conditions</b>						
<b>Darunavir (TMC114)</b> <b>1 x 600 mg tablet and 2 x 300 mg tablet</b> <b>From measured data</b>						
<b>Geometric Mean<sup>Ω</sup></b> <b>Arithmetic Mean (CV%)</b>						
Fed Conditions				Fasted Conditions		
Parameter	Reference <sup>†</sup>	Test*	% Ratio of Geometric Means <sup>Ω</sup> (90% Confidence Interval)	Reference <sup>†</sup>	Test*	% Ratio of Geometric Means <sup>Ω</sup> (90% Confidence Interval)
AUC <sub>last</sub> (ng.h/mL)	103900 111800 (44.3)	99650 103900 (32.4)	95.87 (89.67 - 102.5)	81250 85470 (31.5)	78140 82500 (34.0)	96.17 (89.75 - 103.0)
AUC <sub>∞</sub> (ng.h/mL)	108600 117300 (45.7)	105000 110600 (36.5)	96.66 (90.35 - 103.4)	87870 93700 (36.5)	85000 92440 (43.6)	96.73 (89.35 - 104.7)
C <sub>max</sub> (ng/mL)	5843 6024 (26.6)	5706 5803 (18.6)	97.66 (92.84 - 102.7)	4056 4134 (19.7)	4076 4213 (28.0)	100.5 (94.31 - 107.1)
T <sub>max</sub> <sup>§</sup> (h)	4.0 (1.0 - 5.0)	4.0 (1.0 - 6.0)		2.0 (1.0 - 5.0)	2.0 (1.0 - 5.0)	
T <sub>1/2</sub> <sup>ε</sup> (h)	15.81 (33.4)	15.94 (42.9)		19.09 (38.0)	18.97 (58.5)	

<sup>†</sup>TMC114 300 mg tablet (F016)

\* TMC114 600 mg tablet (F032)

<sup>§</sup> Expressed arithmetic median (range) only

<sup>ε</sup> Expressed as the arithmetic mean (CV%) only

<sup>Ω</sup> Based on least square mean estimates

### TMC114-TiDP3-C176

In a Phase 1, open-label, randomized 2-panel, 2-way crossover bioavailability trial the rate and extent of absorption of darunavir following administration of two tablet strengths (in the presence of low-dose ritonavir) under fed and fasted conditions was assessed in 124 healthy subjects.

In Panel 1, 78 subjects randomly received under fasted conditions a single oral 800 mg dose of darunavir formulated as the 400 mg tablet (2 x 400 mg; Treatment A) in one session, followed by a single oral 800 mg dose formulated as the 800 mg tablet (1 x 800 mg; Treatment B) in the second session. The results indicate that the bioavailability of a 1x 800 mg dose of darunavir is comparable to the bioavailability of a 2 x 400 mg dose of darunavir.

In Panel 2, 40 subjects randomly received under fed conditions a single oral 800 mg dose of darunavir formulated as the 400 mg tablet (2 x 400 mg; Treatment C) in one session, followed by a single oral 800 mg dose formulated as the 800 mg tablet (1 x 800 mg; Treatment D) in the

second session. The results indicate that the bioavailability of a 1x 800 mg dose of darunavir is comparable to the bioavailability of a 2 x 400 mg dose of darunavir.

The summary of results is presented in Table 24.

<b>Table 24: Summary Table of the Comparative Bioavailability Data Under Fed and Fasting Conditions</b>						
<b>Darunavir (TMC114)</b>						
<b>1 x 800 mg tablet and 2 x 400 mg tablet</b>						
<b>From measured data</b>						
<b>Geometric Mean</b>						
<b>Arithmetic Mean (CV%)</b>						
Fed Conditions				Fasted Conditions		
Parameter	Reference <sup>†</sup>	Test*	% Ratio of Geometric Means <sup>Ω</sup> (90% Confidence Interval)	Reference <sup>†</sup>	Test*	% Ratio of Geometric Means <sup>Ω</sup> (90% Confidence Interval)
AUC <sub>last</sub> (ng.h/mL)	101800 105900 (30.72)	99350 105100 (36.04)	97.59 (93.82 – 101.51)	86000 96120 (57.04)	85300 91140 (44.16)	99.18 (94.35 - 104.27)
AUC <sub>∞</sub> (ng.h/mL)	105100 109700 (32.32)	103100 109600 (37.91)	98.12 (94.11– 101.31)	92420 105000 (62.36)	92720 99540 (49.60)	100.33 (94.80 - 106.19)
C <sub>max</sub> (ng/mL)	6890 7031 (23.74)	6580 6773 (24.63)	95.50 (92.15 – 98.97)	4658 4866 (29.62)	4750 4914 (27.10)	101.97 (98.03 - 106.07)
T <sub>max</sub> <sup>§</sup> (h)	2.98 (1.00 – 5.97)	2.98 (0.97 – 5.00)		2.02 (0.97 - 23.93)	2.00 (1.00 - 4.98)	
T <sub>1/2</sub> <sup>€</sup> (h)	13.45 (35.47)	14.03 (32.94)		16.09 (52.05)	16.96 (101.30)	

\* Darunavir 800 mg tablet (G002)

† Darunavir 400 mg tablet (F030)

§ Expressed as the median (range) only

€ Expressed as the mean (CV%) only

Ω Based on least square mean estimates

## DETAILED PHARMACOLOGY

### Pharmacodynamics

#### Electrocardiogram

See *Product Monograph Part I: ACTION AND CLINICAL PHARMACOLOGY*;

#### Pharmacodynamics.



## **Pharmacokinetics**

### **Absorption**

Maximum plasma concentration of darunavir in the presence of low-dose ritonavir is generally achieved within 2.5-4.0 hours. The absolute oral bioavailability of a single 600 mg dose of darunavir alone was approximately 37% and increased to approximately 82% in the presence of 100 mg b.i.d. ritonavir. Increasing the dose of ritonavir to above 100 mg b.i.d. did not significantly affect darunavir concentrations and is not recommended.

The pharmacokinetic properties of darunavir, co-administered with ritonavir, have been evaluated in healthy adult volunteers and in HIV-1 infected patients. Exposure to darunavir was higher in HIV-1 infected patients than in healthy patients. Darunavir is primarily metabolized by CYP3A. Ritonavir inhibits CYP3A, thereby increasing the plasma concentrations of darunavir considerably.

Table 25 displays the mean plasma concentrations of darunavir at steady-state for the darunavir/ritonavir 800/100 mg q.d. dose.

<b>Scheduled Time</b>	<b>Darunavir</b>		<b>Ritonavir</b>	
	<b>Mean ± SD (ng/mL)</b>	<b>CV (%)</b>	<b>Mean ± SD (ng/mL)</b>	<b>CV (%)</b>
<b>0 h</b>	1826 ± 1003	54.92	141.2 ± 156.0	110.5
<b>1 h</b>	3964 ± 1805	45.52	154.4 ± 122.6	79.36
<b>2 h</b>	4692 ± 1135	24.19	264.5 ± 247.2	93.46
<b>3 h</b>	4949 ± 1344	27.15	386.8 ± 357.6	92.45
<b>4 h</b>	4426 ± 1300	29.38	465.9 ± 256.5	55.06
<b>6 h</b>	3532 ± 1065	30.16	463.1 ± 205.3	44.33
<b>9 h</b>	2664 ± 1002	37.59	282.7 ± 137.5	48.64
<b>12 h</b>	2353 ± 919.6	39.08	229.4 ± 159.8	69.67
<b>24 h</b>	1440 ± 513.9	35.68	97.10 ± 99.08	102.0

Table 26 displays the mean plasma concentrations of darunavir and ritonavir at steady-state for the darunavir/ritonavir 600/100 mg b.i.d. dose.

**Table 26: Mean Steady-State Plasma Concentration-Time Profiles of Darunavir and Ritonavir at 600/100 mg b.i.d. at Week 4 (Integrated Data from POWER 1 and POWER 2, Primary 24-Week Analysis)**

Scheduled Time	Darunavir		Ritonavir	
	Mean ± SD (ng/mL)	CV (%)	Mean ± SD (ng/mL)	CV (%)
0 h	4010 ± 1635	40.78	495.6 ± 258.6	52.18
1 h	5386 ± 1538	28.55	634.0 ± 462.2	72.90
2 h	6125 ± 1750	28.57	658.1 ± 439.7	66.81
3 h	6471 ± 2066	31.92	713.8 ± 371.5	52.04
4 h	5307 ± 1796	33.84	719.5 ± 274.7	38.18
6 h	4856 ± 2007	41.33	701.9 ± 318.3	45.36
9 h	3618 ± 1893	52.33	516.9 ± 224.4	43.42
12 h	2813 ± 1612	57.30	321.9 ± 180.1	55.97

### Effect of food on oral absorption

When administered without food, the relative bioavailability of darunavir in the presence of low-dose ritonavir is 30% lower as compared to intake with food. Therefore, to achieve optimal exposure, PAT-darunavir tablets should be taken with ritonavir and with food. The type of food does not affect exposure to darunavir. (See **DOSAGE AND ADMINISTRATION** and **DRUG INTERACTIONS; Drug-Food Interactions**).

### Distribution

Darunavir is approximately 95% bound to plasma proteins. Darunavir binds primarily to plasma alpha-1-acid glycoprotein (AAG).

### Metabolism

*In vitro* experiments with human liver microsomes indicate that darunavir primarily undergoes oxidative metabolism. Darunavir is extensively metabolized by the hepatic CYP system, and almost exclusively by isozyme CYP3A4. At least 3 oxidative metabolites of darunavir have been identified in humans; all showed activity that was at least 10-fold less than the activity of darunavir against wild-type HIV.

### Elimination

The terminal elimination half-life of darunavir was approximately 15 hours when combined with ritonavir. After administration of <sup>14</sup>C-darunavir with low-dose ritonavir, approximately 79.5% and 13.9% of the administered dose of <sup>14</sup>C -darunavir could be retrieved in feces and urine, respectively.

### Drug-Drug Interactions

See also **CONTRAINDICATIONS, WARNINGS AND PRECAUTIONS** and **DRUG INTERACTIONS**.

Darunavir co-administered with ritonavir is an inhibitor of CYP3A and CYP2D6. Co-administration of darunavir and ritonavir with drugs primarily metabolized by CYP3A and

CYP2D6 may result in increased plasma concentrations of such drugs, which could increase or prolong the therapeutic effect and adverse events.

Darunavir and ritonavir are metabolized by CYP3A. Drugs that induce CYP3A activity would be expected to increase the clearance of darunavir and ritonavir, resulting in lowered plasma concentrations of darunavir and ritonavir. Co-administration of darunavir and ritonavir and other drugs that inhibit CYP3A may decrease the clearance of darunavir and ritonavir and may result in increased plasma concentrations of darunavir and ritonavir.

Drug interaction studies were performed with darunavir and other drugs likely to be co-administered and some drugs commonly used as probes for pharmacokinetic interactions. The effects of co-administration of darunavir on the AUC,  $C_{\max}$  and  $C_{\min}$  values are summarized in Table 27 (effect of other drugs on darunavir) and Table 28 (effect of darunavir on other drugs). For information regarding clinical recommendations, see **DRUG INTERACTIONS**.

<b>Table 27: Drug Interactions: Pharmacokinetic Parameters for <u>Darunavir</u> in the Presence of Co-administered Drugs</b>							
Co-Administered Drug	Dose/Schedule		N	PK	LS Mean Ratio (90% CI) of <u>Darunavir</u> Pharmacokinetic Parameters With/Without Co-administered Drug No Effect =1.00		
	Co-Administered Drug	Darunavir/ritonavir			C <sub>max</sub>	AUC	C <sub>min</sub>
<b>Co-Administration With Other Protease Inhibitors</b>							
Atazanavir	300 mg q.d.*	400/100 mg b.i.d.†	13	↔	1.02 (0.96-1.09)	1.03 (0.94-1.12)	1.01 (0.88-1.16)
Indinavir	800 mg b.i.d.	400/100 mg b.i.d.	9	↑	1.11 (0.98-1.26)	1.24 (1.09-1.42)	1.44 (1.13-1.82)
Lopinavir/ Ritonavir	400/100 mg b.i.d.	1200/100 mg b.i.d.‡	14	↓	0.79 (0.67-0.92)	0.62 (0.53-0.73)	0.49 (0.39-0.63)
	533/133.3 mg b.i.d.	1200 mg b.i.d.‡	15	↓	0.79 (0.64-0.97)	0.59 (0.50-0.70)	0.45 (0.38-0.52)
Ritonavir	Titrated: 300 to 600 mg b.i.d. over 6 days	Darunavir 800 mg single dose	9	↑	1.97 (1.40-2.77)	9.23 (6.62-12.88)	-
Saquinavir hard gel capsule	1000 mg b.i.d.	400/100 mg b.i.d.	14	↓	0.83 (0.75-0.92)	0.74 (0.63-0.86)	0.58 (0.47-0.72)
<b>Co-Administration With Other Antiretrovirals</b>							
Didanosine	400 mg q.d.	600/100 mg b.i.d.	17	↔	0.93 (0.86-1.00)	1.01 (0.95-1.07)	1.07 (0.95-1.21)
Efavirenz	600 mg q.d.	300/100 mg b.i.d.	12	↓	0.85 (0.72-1.00)	0.87 (0.75-1.01)	0.69 (0.54-0.87)
Etravirine	200 mg b.i.d.	600/100 mg b.i.d.	15	↔	1.11 (1.01-1.22)	1.15 (1.05-1.26)	1.02 (0.90-1.17)
Nevirapine	200 mg b.i.d.	400/100 mg b.i.d.	8	↑	1.40 <sup>§</sup> (1.14-1.73)	1.24 <sup>§</sup> (0.97-1.57)	1.02 <sup>§</sup> (0.79-1.32)
Rilpivirine	150 mg q.d. <sup>¥</sup>	800/100 mg q.d.	15	↔	0.90 (0.81-1.00)	0.89 (0.81-0.99)	0.89 (0.68-1.16)
Tenofovir Disoproxil Fumarate	300 mg q.d.	300/100 mg b.i.d.	12	↑	1.16 (0.94-1.42)	1.21 (0.95-1.54)	1.24 (0.90-1.69)
<b>Co-Administration With Other Drugs</b>							
Carbamazepine	200 mg b.i.d.	600/100 mg b.i.d.	16	↔	1.04 (0.93-1.16)	0.99 (0.90-1.08)	0.85 (0.73-1.00)
Clarithromycin	500 mg b.i.d.	400/100 mg b.i.d.	17	↔	0.83 (0.72-0.96)	0.87 (0.75-1.01)	1.01 (0.81-1.26)
Ketoconazole	200 mg b.i.d.	400/100 mg b.i.d.	14	↑	1.21 (1.04-1.40)	1.42 (1.23-1.65)	1.73 (1.39-2.14)
Omeprazole	20 mg q.d.	400/100 mg b.i.d.	16	↔	1.02 (0.95-1.09)	1.04 (0.96-1.13)	1.08 (0.93-1.25)
Paroxetine	20 mg q.d.	400/100 mg b.i.d.	16	↔	0.97 (0.92-1.02)	1.02 (0.95-1.10)	1.07 (0.96-1.19)

<b>Table 27: Drug Interactions: Pharmacokinetic Parameters for <u>Darunavir</u> in the Presence of Co-administered Drugs</b>							
<b>Co-Administered Drug</b>	<b>Dose/Schedule</b>		<b>N</b>	<b>PK</b>	<b>LS Mean Ratio (90% CI) of <u>Darunavir</u> Pharmacokinetic Parameters With/Without Co-administered Drug No Effect =1.00</b>		
	<b>Co-Administered Drug</b>	<b>Darunavir/ritonavir</b>			<b>C<sub>max</sub></b>	<b>AUC</b>	<b>C<sub>min</sub></b>
Ranitidine	150 mg b.i.d.	400/100 mg b.i.d.	16	↔	0.96 (0.89-1.05)	0.95 (0.90-1.01)	0.94 (0.90-0.99)
Rifabutin	150 mg q.o.d. <sup>¶</sup>	600/100 mg b.i.d.	11	↑	1.42 (1.21-1.67)	1.57 (1.28-1.93)	1.75 (1.28-2.37)
Sertraline	50 mg q.d.	400/100 mg b.i.d.	13	↔	1.01 (0.89-1.14)	0.98 (0.84-1.14)	0.94 (0.76-1.16)
Telaprevir	750 mg q8h for 10 days	600/100 mg b.i.d. for 20 days	11 <sup>ε</sup>	↓	0.60 (0.56- 0.64)	0.60 (0.57- 0.63)	0.58 (0.52-0.64)
	1125 mg q12h for 4 days	600/100 mg b.i.d. for 24 days	15	↓	0.53 (0.47- 0.59)	0.49 (0.43-0.55)	0.42 (0.35- 0.51)

N = number of patients with data; - = no information available.  
\* q.d. = once daily  
† b.i.d. = twice daily  
‡ The pharmacokinetic parameters of darunavir in this study were compared with the pharmacokinetic parameters following administration of darunavir/ritonavir 600/100 mg b.i.d.  
§ Ratio based on between-study comparison.  
¶ q.o.d. = every other day  
<sup>v</sup> This interaction study has been performed with a dose higher than the recommended dose for rilpivirine (25 mg once daily) assessing the maximal effect on the co-administered drug.  
<sup>ε</sup> N=14 for C<sub>max</sub>

<b>Table 28: Drug Interactions: Pharmacokinetic Parameters for Co-administered Drugs in the Presence of Darunavir/Ritonavir</b>							
Co-Administered Drug	Dose/Schedule		N	PK	LS Mean Ratio (90% CI) of Co-Administered Drug Pharmacokinetic Parameters With/Without Darunavir No effect =1.00		
	Co-Administered Drug	Darunavir/ritonavir			C <sub>max</sub>	AUC	C <sub>min</sub>
<b>Co-Administration With Other Protease Inhibitors</b>							
Atazanavir	300 mg q.d.* /100 mg ritonavir q.d. when administered alone  300 mg q.d. when administered with darunavir/ritonavir	400/100 mg b.i.d.†	13	↔	0.89 (0.78-1.01)	1.08 (0.94-1.24)	1.52 (0.99-2.34)
Indinavir	800 mg b.i.d. /100 mg ritonavir b.i.d. when administered alone  800 mg b.i.d. when administered with darunavir/ritonavir	400/100 mg b.i.d.	9	↑	1.08 (0.95-1.22)	1.23 (1.06-1.42)	2.25 (1.63-3.10)
Lopinavir/ Ritonavir	400/100 mg b.i.d.‡  533/133.3 mg b.i.d.‡	1200/100 mg b.i.d.  1200 mg b.i.d.	14  15	↔  ↔	0.98 (0.78-1.22)  1.11 (0.96-1.30)	1.09 (0.86-1.37)  1.09 (0.96-1.24)	1.23 (0.90-1.69)  1.13 (0.90-1.42)
Saquinavir hard gel capsule	1000 mg b.i.d. /100 mg ritonavir b.i.d. when administered alone  1000 mg b.i.d. when administered with darunavir/ritonavir	400/100 mg b.i.d.	12	↔	0.94 (0.78-1.13)	0.94 (0.76-1.17)	0.82 (0.52-1.30)
<b>Co-Administration With Other Antiretrovirals</b>							
Didanosine	400 mg q.d.	600/100 mg b.i.d.	17	↔	0.84 (0.59-1.20)	0.91 (0.75-1.10)	-
Efavirenz	600 mg q.d.	300/100 mg b.i.d.	12	↑	1.15 (0.97-1.35)	1.21 (1.08-1.36)	1.17 (1.01-1.36)
Etravirine	100 mg b.i.d.	600/100 mg b.i.d.	14	↓	0.68 (0.57-0.82)	0.63 (0.54-0.73)	0.51 (0.44-0.61)

<b>Table 28: Drug Interactions: Pharmacokinetic Parameters for Co-administered Drugs in the Presence of Darunavir/Ritonavir</b>							
<b>Co-Administered Drug</b>	<b>Dose/Schedule</b>		<b>N</b>	<b>PK</b>	<b>LS Mean Ratio (90% CI) of Co-Administered Drug Pharmacokinetic Parameters With/Without Darunavir No effect =1.00</b>		
	<b>Co-Administered Drug</b>	<b>Darunavir/ritonavir</b>			<b>C<sub>max</sub></b>	<b>AUC</b>	<b>C<sub>min</sub></b>
Rilpivirine	150 mg q.d. <sup>‡</sup>	800/100 mg q.d.	14	↑	1.79 (1.56-2.06)	2.30 (1.98-2.67)	2.78 (2.39-3.24)
Nevirapine	200 mg b.i.d.	400/100 mg b.i.d.	8	↑	1.18 (1.02-1.37)	1.27 (1.12-1.44)	1.47 (1.20-1.82)
Tenofovir Disoproxil Fumarate	300 mg q.d.	300/100 mg b.i.d.	12	↑	1.24 (1.08-1.42)	1.22 (1.10-1.35)	1.37 (1.19-1.57)
Maraviroc	150 mg b.i.d.	600/100 mg b.i.d.	12	↑	2.29 (1.46-3.59)	4.05 (2.94-5.59)	8.00 (6.35-10.1)
<b>Co-Administration With Other Drugs</b>							
Atorvastatin	40 mg q.d. when administered alone  10 mg q.d. when administered with darunavir/ Ritonavir	300/100 mg b.i.d.	15	↑	0.56 (0.48-0.67)	0.85 (0.76-0.97)	1.81 (1.37-2.40)
Buprenorphine/ Naloxone	8/2 mg to 16/4 mg q.d.	600/100 mg b.i.d.	17	↔	0.92 <sup>§</sup> (0.79-1.08)	0.89 <sup>§</sup> (0.78-1.02)	0.98 <sup>§</sup> (0.82-1.16)
Norbuprenorphine			17	↑	1.36 (1.06-1.74)	1.46 (1.15-1.85)	1.71 (1.29-2.27)
Carbamazepine	200 mg b.i.d.	600/100 mg b.i.d.	16	↑	1.43 (1.34-1.53)	1.45 (1.35-1.57)	1.54 (1.41-1.68)
Carbamazepine epoxide			16	↓	0.46 (0.43-0.49)	0.46 (0.44-0.49)	0.48 (0.45-0.51)
Clarithromycin	500 mg b.i.d.	400/100 mg b.i.d.	17	↑	1.26 (1.03-1.54)	1.57 (1.35-1.84)	2.74 (2.30-3.26)
Digoxin	0.4 mg	600/100 mg b.i.d.	8	↑	1.15 (0.89-1.48)	1.36 (0.81-2.27)	-
Ethinyl Estradiol (EE)	Ortho-Novum 1/35 (35 µg EE / 1 mg NE)	600/100 mg b.i.d.	11	↓	0.68 (0.61-0.74)	0.56 (0.50-0.63)	0.38 (0.27-0.54)
Norethindrone (NE)			11	↓	0.90 (0.83-0.97)	0.86 (0.75-0.98)	0.70 (0.51-0.97)
Ketoconazole	200 mg b.i.d.	400/100 mg b.i.d.	15	↑	2.11 (1.81-2.44)	3.12 (2.65-3.68)	9.68 (6.44-14.55)

<b>Table 28: Drug Interactions: Pharmacokinetic Parameters for Co-administered Drugs in the Presence of Darunavir/Ritonavir</b>							
Co-Administered Drug	Dose/Schedule		N	PK	LS Mean Ratio (90% CI) of Co-Administered Drug Pharmacokinetic Parameters With/Without Darunavir No effect =1.00		
	Co-Administered Drug	Darunavir/ritonavir			C <sub>max</sub>	AUC	C <sub>min</sub>
	R-Methadone	55-150 mg q.d.			600/100 mg b.i.d.	16	↓
Paroxetine	20 mg q.d.	400/100 mg b.i.d.	16	↓	0.64 (0.59-0.71)	0.61 (0.56-0.66)	0.63 (0.55-0.73)
Pravastatin	40 mg single dose	600/100 mg b.i.d.	14	↑	1.63 (0.95-2.82)	1.81 (1.23-2.66)	-
Rifabutin	150 mg q.o.d. <sup>¶</sup> when administered with darunavir/ritonavir	600/100 mg b.i.d. <sup>#</sup>	11	↑	0.72 (0.55-0.93)	0.93 (0.80-1.09)	1.64 (1.48-1.81)
25- <i>O</i> -desacetyl-rifabutin	300 mg q.d. when administered alone		11	↑	4.77 (4.04-5.63)	9.81 (8.09-11.9)	27.1 (22.2-33.2)
Sertraline	50 mg q.d.	400/100 mg b.i.d.	13	↓	0.56 (0.49-0.63)	0.51 (0.46-0.58)	0.51 (0.45-0.57)
Sildenafil	100 mg (single dose) administered alone  25 mg (single dose) when administered with darunavir/ritonavir	400/100 mg b.i.d.	16	↑	0.62 (0.55-0.70)	0.97 (0.86-1.09)	-
Telaprevir	750 mg q8h for 10 days	600/100 mg b.i.d. for 20 days	11 <sup>€</sup>	↓	0.64 (0.61-0.67)	0.65 (0.61-0.69)	0.68 (0.63-0.74)

N = number of patients with data; - = no information available.  
\* q.d. = once daily  
† b.i.d. = twice daily  
‡ The pharmacokinetic parameters of lopinavir in this study were compared with the pharmacokinetic parameters following administration of lopinavir/ritonavir 400/100 mg b.i.d.  
§ ratio is for buprenorphine; mean C<sub>max</sub> and AUC<sub>24</sub> for naloxone were comparable when buprenorphine/naloxone was administered with or without darunavir/rtv  
¶ q.o.d. = every other day  
# In comparison to rifabutin 300 mg q.d.  
€ N=14 for C<sub>max</sub>

### Population Pharmacokinetics

Population pharmacokinetic analysis in HIV-infected patients showed that darunavir pharmacokinetics is not considerably different in the age range (18 to 75 years) evaluated in HIV-infected patients. The pharmacokinetics of darunavir in children and adolescents are under investigation. Population pharmacokinetic analysis showed a slightly higher darunavir exposure in HIV-infected females compared to males. This difference is not considered clinically relevant.

Population pharmacokinetic analysis of darunavir in HIV-infected patients indicated that race had no apparent effect on the exposure to darunavir. The steady-state pharmacokinetic



parameters of darunavir in patients with mild and moderate hepatic impairment were comparable with those in healthy patients, therefore, no dose adjustment is required in patients with mild or moderate hepatic impairment. Darunavir has not been studied in patients with severe hepatic impairment.

Population pharmacokinetic analysis showed that the pharmacokinetics of darunavir were not significantly affected in HIV infected patients with moderate renal impairment. There are no pharmacokinetic data available in HIV-1 infected patients with severe renal impairment or end stage renal disease. However, since the renal clearance of darunavir is limited, a decrease in total body clearance is not expected in patients with renal impairment.

The population pharmacokinetics derived geometric mean (SD)  $C_{0h}$  and  $AUC_{12h}$  for darunavir in 119 HIV-1-infected patients (TMC114-C213 and TMC114-C202, Primary 24-Week Analysis) receiving [600/100 mg b.i.d. darunavir/ritonavir] is 3578 ( $\pm$ 1151) ng/mL and 62349 ( $\pm$ 16143) ng.h/mL, respectively.

The pharmacokinetics of darunavir, co-administered with low dose ritonavir (100 mg), has been evaluated in healthy adult volunteers and in HIV-1-infected patients. Table 29 displays the population pharmacokinetic estimates of darunavir after oral administration of darunavir/rtv 600/100 mg twice daily [based on sparse sampling in 285 patients in study TMC114-C214 and 119 patients (integrated data) from Studies TMC114-C202 and TMC114-C213] and darunavir/rtv 800/100 mg once daily [based on sparse sampling in 335 patients in Study TMC114-C211 and 280 patients in Study TMC114-C229] to HIV-1-infected patients.

<b>Table 29: Population Pharmacokinetic Estimates of darunavir at darunavir/rtv 800/100 mg once daily (Study TMC114-C211, 48 Week Analysis and Study TMC114-C229, 48 Week Analysis) and darunavir/rtv 600/100 mg twice daily (Study TMC114-C214, 48 Week Analysis and Integrated data from Studies TMC114-C213 and TMC114-C202, Primary 24-Week Analysis)</b>					
<b>Parameter</b>	<b>Study TMC114-C211 darunavir/ rtv 800/100 mg once daily N = 335</b>	<b>Study TMC114-C229 darunavir/ rtv 800/100 mg once daily N = 280</b>	<b>Study TMC114-C214 darunavir/ rtv 600/100 mg twice daily N = 285</b>	<b>Study TMC114-C229 darunavir/ rtv 600/100 mg twice daily N = 278</b>	<b>Studies TMC114-C213 and TMC114-C202 (integrated data) darunavir/ rtv 600/100 mg twice daily N =119</b>
<b><math>AUC_{24h}</math> (ng·h/mL)*</b>					
Mean $\pm$ Standard Deviation	93026 $\pm$ 27050	93334 $\pm$ 28626	116796 $\pm$ 33594	114302 $\pm$ 32681	124698 $\pm$ 32286
Median (Range)	87854 (45000-219240)	87788 (45456-236920)	111632 (64874-355360)	109401 (48934-323820)	123336 (67714-212980)
<b><math>C_{0h}</math> (ng/mL)</b>					
Mean $\pm$ Standard Deviation	2282 $\pm$ 1168	2160 $\pm$ 1201	3490 $\pm$ 1401	3386 $\pm$ 1372	3578 $\pm$ 1151
Median (Range)	2041 (368-7242)	1896 (184-7881)	3307 (1517-13198)	3197 (250-11865)	3539 (1255-7368)

N = number of patients with data.\* $AUC_{24h}$  is calculated as  $AUC_{12h} \times 2$

## MICROBIOLOGY

### Antiviral Activity *In Vitro*

Darunavir exhibits activity against laboratory strains and clinical isolates of HIV-1 and laboratory strains of HIV-2 in acutely infected T-cell lines, human peripheral blood mononuclear cells and human monocytes/macrophages with median EC<sub>50</sub> values ranging from 1.2 to 8.5 nM (0.7 to 5.0 ng/mL). Darunavir demonstrates antiviral activity *in vitro* against a broad panel of HIV-1 group M (A, B, C, D, E, F, G) and group O primary isolates with EC<sub>50</sub> values ranging from < 0.1 to 4.3 nM.

These EC<sub>50</sub> values are well below the 50% cellular toxicity concentration range of 87 µM to > 100 µM. The EC<sub>50</sub> value of darunavir increases by a median factor of 5.4 in the presence of human serum.

Darunavir showed synergistic antiviral activity when studied in combination with the PIs ritonavir, nelfinavir, or amprenavir, and additive antiviral activity when studied in combination with the PIs indinavir, saquinavir, lopinavir, atazanavir, or tipranavir, the nucleoside (nucleotide) reverse transcriptase inhibitors (N(t)RTIs) zidovudine, lamivudine, zalcitabine, didanosine, stavudine, abacavir, emtricitabine, or tenofovir, the non-nucleoside reverse transcriptase inhibitors (NNRTIs) nevirapine, delavirdine, etravirine, or efavirenz, and the fusion inhibitor enfuvirtide. No antagonism was observed between darunavir and any of these antiretrovirals *in vitro*.

### Resistance *In Vitro*

*In vitro* selection of darunavir-resistant virus from wild-type HIV-1 was lengthy (more than 2 years). The selected viruses were unable to grow in the presence of darunavir concentrations above 220 nM. Viruses selected in these conditions and showing decreased susceptibility to darunavir (range: 23- to 50fold) harboured 2 to 4 amino acid substitutions in the protease gene. Identification of determinants of decreased susceptibility to darunavir in those viruses is under investigation.

*In vitro* selection of darunavir resistant HIV-1 (range: 53- to 641-fold change in EC<sub>50</sub> values) from 9 HIV-1 strains harbouring multiple PI resistance-associated mutations (RAMs) resulted in the overall emergence of 22 mutations in the protease, of which L10F, V32I, L33F, S37N, M46I, I47V, I50V, L63P, A71V, and I84V were present in more than 50% of the 9 darunavir-resistant isolates. A minimum of 8 of these darunavir *in vitro* selected mutations, from which at least 2 were already present in the protease prior to selection, were required in the HIV-1 protease to render a virus resistant (fold change (FC) > 10) to darunavir.

In 1113 clinical isolates resistant to amprenavir, atazanavir, indinavir, lopinavir, nelfinavir, ritonavir, saquinavir and/or tipranavir, and in 886 baseline isolates from the patients enrolled in the TMC114-C213 (POWER 1) and TMC114-C202 (POWER 2) trials and in the TMC114-C215 (POWER 3) analysis, only the subgroups with > 10 PI resistance-associated mutations showed a median FC for darunavir > 10.

### **Cross-Resistance *In Vitro***

Cross-resistance has been observed among PIs. Darunavir has a < 10-fold decreased susceptibility against 90% of 3309 clinical isolates resistant to amprenavir, atazanavir, indinavir, lopinavir, nelfinavir, ritonavir, saquinavir and/or tipranavir showing that viruses resistant to most PIs remain susceptible to darunavir.

Seven of the 9 darunavir-resistant viruses selected from PI-resistant viruses had phenotypic data for tipranavir. Six of those showed a FC in EC<sub>50</sub> value < 3 for tipranavir, indicative of limited cross-resistance between these 2 PIs.

Cross-resistance between darunavir and the nucleoside/nucleotide reverse transcriptase inhibitors, the non-nucleoside reverse transcriptase inhibitors the entry inhibitors, or the integrase inhibitor is unlikely because the viral targets for those inhibitors are different.

### ***In Vivo* Selection of Viral Resistance During darunavir/ritonavir Therapy**

In the 192-week analysis of the TMC114-C211 (ARTEMIS) trial, the number of virologic failures was lower in the group of patients receiving darunavir/rtv 800/100 mg q.d. than in patients receiving lopinavir/ritonavir 800/200 mg per day (16.0% vs. 20.5%, respectively). In the virologic failures of the darunavir/rtv arm with paired baseline/endpoint genotype data, four patients with developing PI RAMs were identified. In the virologic failures of the lopinavir/ritonavir arm with paired baseline/endpoint genotype data, nine patients with developing PI RAMs at endpoint were identified. This was not associated with a loss in susceptibility to lopinavir. None of the developing mutations in the darunavir/rtv group or in the lopinavir/rtv group were primary (i.e. major) PI mutations. In four virologic failures in the darunavir/rtv arm and seven virologic failures in the lopinavir/ritonavir arm, a maximum of two developing NRTI RAMs were identified. The development of the NRTI RAM at position 184 (n= 9) was identified, which was associated with a decreased susceptibility to emtricitabine (FTC) included in the fixed background regimen.

In the 48-week analysis of the TMC114-C229 (ODIN) trial, the number of virologic failures was comparable in the darunavir/rtv 800/100 mg q.d. group and the darunavir/rtv 600/100 mg b.i.d. group (22.1% vs. 18.2%, respectively). Of the virologic failures, the darunavir/rtv 800/100 mg q.d. group reported 7 (12%) patients with developing PI RAMs compared to 4 (10%) patients in the darunavir/rtv 600/100 mg b.i.d group. Only 1 subject, in the DRV/rtv q.d. group, developed primary (major) PI mutations (V32I, M46I, L76V and I84V), which included 3 DRV RAMs (V32I, L76V and I84V). The emergence of these DRV RAMs was associated with loss of DRV susceptibility.

All virologic failures from the darunavir/rtv 600/100 mg b.i.d. group retained susceptibility to darunavir. Four (6.7%) and 3 (7.1%) virologic failures developed 1 or 2 NRTI RAMs in the darunavir/rtv 800/100 mg q.d. and the darunavir/rtv 600/100 mg b.i.d. groups, respectively. In 3 and 2 of these virologic failures in the darunavir/rtv 800/100 mg q.d. and the darunavir/rtv 600/100 mg b.i.d. groups, respectively, the development of these NRTI RAMs (V75I+M184V;

M184V; T215Y in the q.d. group and M184V; M41L+T215Y in the b.i.d. group) was associated with a decreased susceptibility to a NRTI included in the background regimen.

In the 96-week analysis of the TMC114-C214 (TITAN) trial, the number of virologic failures was lower in the group of patients receiving darunavir/rtv 600/100 mg b.i.d. than in patients receiving lopinavir/ritonavir 400/100 mg b.i.d. (41/298, 13.8% versus 76/297, 25.6%, respectively). Examination of patients who failed on darunavir/rtv 600/100 mg twice daily and had post-baseline genotypes and phenotypes showed that 6 patients (6/39; 15%) developed PI substitutions on darunavir/ritonavir treatment resulting in decreased susceptibility to darunavir. Five of the 6 had baseline PI resistance-associated substitutions and baseline darunavir phenotypes  $> 7$ . The most common emerging PI substitutions in the virologic failures were V32I, I47V, T74P, and L76V.

For the lopinavir/ritonavir arm, baseline and endpoint genotype was available for 72 of 76 virologic failures. Comparing patients with available baseline and endpoint genotypes, fewer virologic failures treated with darunavir/rtv 600/100 mg b.i.d. than with lopinavir/ritonavir 400/100 mg b.i.d. developed primary (i.e. major) PI mutations (7 vs. 25, respectively) or NRTI RAMS (4 vs. 20, respectively) or lost susceptibility to the PI (3 vs. 17, respectively) or NRTI(s) (4 vs. 20, respectively) used in the treatment regimen.

In a pooled analysis of the POWER and DUET trials, the percentage of rebounders (patients who lost a viral load  $\geq 1.0 \log_{10}$  below baseline) was 17.6% (188 out of 1071 patients). Baseline and endpoint genotype was available for 185 out of 188 rebounders. The most common protease mutations that developed in  $\geq 20\%$  of the isolates from patients who experienced virological failure by rebound were V32I, I54L, and L89V. Amino acid substitutions that developed in 10 to 20% of the isolates were V11I, I13V, L33F, I50V, and F53L. The percentage of never suppressed patients (patients that never achieved a viral load  $\geq 1.0 \log_{10}$  below baseline at 2 consecutive visits) was 19.7% (211 out of 1071 patients). Baseline and endpoint genotype was available for 197 out of the 211 never suppressed patients. The most common protease mutations that developed in  $\geq 20\%$  of the analyzed never suppressed patients were V32I and I54L. Mutations that developed in 10 to 20% of these never suppressed patients were V11I, I15V, L33F, I47V and L89V.

### **In Vivo Cross-Resistance with Other Protease Inhibitors**

In the virologic failures of the ARTEMIS trial, no cross-resistance with other PIs was observed.

Of the viruses isolated from patients receiving darunavir/rtv 800/100 mg q.d. experiencing virologic failure in the ODIN trial, 98% remained susceptible to darunavir after treatment. In the same group of patients, 96% to 100% that were susceptible at baseline to amprenavir, atazanavir, indinavir, lopinavir, saquinavir or tipranavir remained susceptible to these protease inhibitors after treatment. In the virologic failures receiving darunavir/rtv 600/100 mg b.i.d. no cross-resistance with other PIs was observed.

In the TITAN trial, the number of virologic failures was lower in the DRV/rtv group than in the LPV/rtv group and fewer virologic failures treated with DRV/rtv than with LPV/rtv lost susceptibility to PIs. Of the viruses isolated from patients receiving darunavir/rtv 600/100 mg b.i.d. experiencing virologic failures in the TITAN trial, 8% of those susceptible to darunavir at baseline developed decreased susceptibility to darunavir during treatment. In the same group of patients, 97% to 100% that were susceptible at baseline to amprenavir, atazanavir, indinavir, lopinavir, saquinavir or tipranavir remained susceptible after darunavir/rtv treatment.

Of the viruses isolated from patients experiencing virologic failure by rebound from the darunavir/rtv 600/100 mg b.i.d. group, of the POWER and DUET trials, 85% that were susceptible to darunavir at baseline developed decreased susceptibility to darunavir during treatment. In the same group of patients, 71% of viruses that were susceptible to tipranavir at baseline remained susceptible after treatment. In the POWER trials, patients with resistance to tipranavir (FC > 3) at baseline showed a mean change in viral load at Week 24 of -1.38 log<sub>10</sub>. Cross resistance with the other PIs could not be studied in the POWER and DUET trials, since most of the baseline viruses were already resistant to these PIs. Patients with no susceptible PI at baseline (excluding tipranavir) showed a mean change in viral load at Week 24 of -1.57 log<sub>10</sub>.

### **Baseline Genotype or Phenotype and Virologic Outcome**

In a pooled analysis of the 600/100 mg b.i.d. groups of the POWER and DUET trials, the presence at baseline of three or more of the darunavir- specific mutations (V11I, V32I, L33F, I47V, I50V, I54L or M, T74P, L76V, I84V or L89V) was associated with a decreased virologic response to darunavir/rtv. In early treatment-experienced patients (TITAN) three or more of these mutations were only found in 4% of the patients at baseline.

<b>Table 30: Response (HIV 1 RNA &lt; 50 copies/mL at week 24) to darunavir/rtv 600/100 mg b.i.d. by baseline genotype* and by use of enfuvirtide: As-treated analysis of the POWER and DUET trials</b>			
<b>Number of mutations at baseline*</b>	<b>All % n/N</b>	<b>No/non-naïve use of ENF % n/N</b>	<b>Naïve use of ENF % n/N</b>
All Ranges	45% 455/1014	39% 290/741	60% 165/273
0 – 2	54% 359/660	50% 238/477	66% 121/183
3	39% 67/172	29% 35/120	62% 32/52
≥4	12% 20/171	7% 10/135	28% 10/36
* Number of mutations from the list of mutations associated with a diminished response to darunavir/rtv (V11I, V32I, L33F, I47V, I50V, I54L or M, T74P, L76V, I84V or L89V)			

Baseline darunavir phenotype (shift in susceptibility relative to reference) was shown to be the most predictive factor of virologic outcome. Response rates assessed by baseline darunavir phenotype are shown in Table 31. The data are provided to give clinicians information on the likelihood of virologic success based on pre-treatment susceptibility to darunavir.

<b>Table 31: Response (HIV 1 RNA &lt; 50 copies/mL at week 24) to darunavir/rtv 600/100 mg b.i.d. by baseline darunavir phenotype and by use of enfuvirtide: As-treated analysis of the POWER and DUET trials</b>			
<b>Baseline darunavir phenotype</b>	<b>All % n/N</b>	<b>No/non naïve use of ENF % n/N</b>	<b>Naïve use of ENF % n/N</b>
All ranges	45% 455/1014	39% 290/741	60% 165/273
≤ 10	55% 364/659	51% 244/477	66% 120/182
10-40	29% 59/203	17% 25/147	61% 34/56
>40	8% 9/118	5% 5/94	17% 4/24

In deciding on a new regimen for patients who have failed an antiretroviral regimen, careful consideration should be given to the treatment history and to resistance testing results where available.

## **TOXICOLOGY**

Animal toxicology studies have been conducted with darunavir alone, in mice, rats and dogs and in combination with ritonavir in rats and dogs.

In chronic toxicology studies in rats and dogs, there were only limited effects of treatment with darunavir. In the rat the key target organs identified were the hematopoietic system, the blood coagulation system, liver and thyroid, observed at 100 mg/kg/day and above and at exposures below clinical levels. A variable but limited decrease in red blood cell-related parameters was observed, together with increases in activated PTT. The observed liver and thyroid changes were considered to reflect an adaptive response to enzyme induction in the rat rather than an adverse effect. In combination toxicity studies with ritonavir, no additional target organs of toxicity were reported in rats. In the dog, no major toxicity findings or key target organs were identified at doses up to 120 mg/kg/day and exposures equivalent to clinical exposure at the recommended dose.

### **Carcinogenesis and Mutagenesis**

Darunavir was evaluated for carcinogenic potential by oral gavage administration to mice and rats up to 104 weeks. Daily doses of 150, 450 and 1000 mg/kg were administered to mice and doses of 50, 150 and 500 mg/kg were administered to rats. A dose related increase in the

incidences of hepatocellular adenomas and carcinomas were observed in males and females of both species. Thyroid follicular cell adenomas were noted in male rats. Administration of darunavir did not cause a statistically significant increase in the incidence of any other benign or malignant neoplasm in mice or rats. The observed hepatocellular findings in rodents are considered to be of limited relevance to humans. Repeated administration of darunavir to rats caused hepatic microsomal enzyme induction and increased thyroid hormone elimination, which predispose rats, but not humans, to thyroid neoplasms. At the highest tested doses, the systemic exposures (based on AUC) to darunavir were between 0.4 and 0.7 fold (mice) and 0.7 and 1 fold (rats), relative to those observed in humans at the recommended therapeutic doses (600/100 mg twice daily or 800/100 mg once daily). Darunavir was not mutagenic or genotoxic in a battery of in vitro and in vivo assays including bacterial reverse mutation (Ames), chromosomal aberration in human lymphocytes and in vivo micronucleus test in mice.

### **Reproductive and Developmental Toxicity**

Investigation of fertility and early embryonic development was performed in rats, teratogenicity studies were conducted in mice, rats and rabbits, and the pre- and post-natal development study was conducted in rats.

In the fertility and early embryonic development study, a significant decrease in body weight gain with subsequent related reduction in the number of ovulations resulting in a reduction in the number of live fetuses was observed in female rats treated with 1000 mg/kg. Otherwise, there were no effects on mating or fertility with darunavir treatment up to 1000 mg/kg/day and exposure levels below (AUC 0.5 fold) that in humans at the clinically recommended dose. Up to the same dose levels, there was no teratogenicity with darunavir in rats and rabbits when treated alone nor in mice when treated in combination with ritonavir. The exposure levels were lower than those observed with the recommended clinical dose in humans. In a pre- and post-natal development assessment in rats, darunavir with and without ritonavir caused a transient reduction in body weight gain of the offspring during lactation. This was attributed to drug exposure via the milk. No post-weaning functions were affected with darunavir alone or in combination with ritonavir.

In juvenile rats directly dosed with darunavir (from 20 mg/kg to 1000 mg/kg) up to days 23 to 26 of age, mortality was observed and, in some of the animals, convulsions. Within this age range exposures in plasma, liver and brain were dose and age dependent and were considerably greater than those observed in adult rats. These findings were attributed to the ontogeny of the CYP450 liver enzymes involved in the metabolism of darunavir and the immaturity of the blood-brain barrier. No treatment related mortalities were noted in juvenile rats dosed at 1000 mg/kg darunavir (single dose) on day 26 of age or at 500 mg/kg (repeated dose) from day 23 to 50 of age, and the exposures and toxicity profile were comparable to those observed in adult rats. In humans, the activity of drug-metabolizing enzymes approaches adult values by 3 years of age.

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## PART III: CONSUMER INFORMATION

### <sup>Pr</sup>PAT-darunavir darunavir Tablets

This leaflet is Part III of a three-part "Product Monograph" published when PAT-darunavir was approved for sale in Canada and is designed specifically for Consumers. This leaflet is a summary and will not tell you everything about PAT-darunavir. Contact your doctor or pharmacist if you have any questions about the drug.

### ABOUT THIS MEDICATION

#### What the medication is used for:

PAT-darunavir is an oral tablet used for the treatment of HIV (Human Immunodeficiency Virus) infection in adults and in children 6 years of age and older who have taken anti-HIV medicines in the past, when co-administered with ritonavir and other antiretroviral medications. HIV is the virus that causes AIDS (Acquired Immune Deficiency Syndrome). PAT-darunavir is a type of anti-HIV medicine called a protease (PRO-tee-ase) inhibitor.

PAT-darunavir does not reduce the risk of passing HIV to others through sexual contact, sharing needles, or being exposed to your blood. For your health and the health of others, it is important to always practice safer sex by using a latex or polyurethane condom or other barrier method to lower the chance of sexual contact with any body fluids such as semen, vaginal secretions, or blood. Never use or share dirty needles.

Ask your doctor if you have any questions on how to prevent passing HIV to other people.

#### What it does:

PAT-darunavir blocks HIV protease, an enzyme which is needed for HIV to multiply. When used with other anti-HIV medicines, PAT-darunavir can help to reduce the amount of HIV in your blood (called "viral load") and increase your CD4+ (T) cell count. HIV infection destroys CD4+ (T) cells, which are important to the immune system. The immune system helps fight infection. Reducing the amount of HIV and increasing the CD4+ (T) cell count may improve your immune system.

PAT-darunavir is always taken with and at the same time as 100 mg of ritonavir (NORVIR<sup>®</sup>), in combination with other anti-HIV medicines. PAT-darunavir should also be taken with food.

PAT-darunavir does not cure HIV infection or AIDS. At present, there is no cure for HIV infection. People taking PAT-darunavir may still develop infections or other conditions associated with HIV infection. Because of this, it is very important for you to remain under the care of a doctor.

#### When it should not be used:

Together with your doctor, you need to decide whether taking PAT-darunavir is right for you.

#### **Do not take PAT-darunavir:**

- if you are allergic to darunavir or any of the other ingredients in PAT-darunavir (see **What the nonmedicinal ingredients are**)
- if you are allergic to ritonavir (NORVIR<sup>®</sup>)
- if you have severe liver disease
- if you take any of the following types of medicines because you could experience serious side effects:

#### **Type of Drug**

#### **Examples of Generic Names (Brand Names)**

**Alpha-Adrenoreceptor Antagonists**  
(to treat enlarged prostate)

alfuzosin

**Antiarrhythmics**  
(to treat abnormal heart rhythms)

bepidil<sup>1</sup>  
lidocaine  
quinidine  
amiodarone (Cordarone<sup>®</sup>)  
astemizole<sup>1</sup>  
terfenadine<sup>1</sup>

**Antihistamines**  
(to treat allergy symptoms)

**Antimycobacterials**  
(to treat tuberculosis)

**Ergot Derivatives**  
(to treat migraine and headaches)

rifampin (Rifadin<sup>®</sup>, Rifater<sup>®</sup>)  
dihydroergotamine (Migranal<sup>®</sup>)  
ergonovine  
ergotamine (Cafergot<sup>®</sup>)  
methylergonovine  
cisapride<sup>1</sup>

**Gastrointestinal Motility Agents**  
(to treat some digestive conditions)

**Herbal products**  
(to improve mood)

St. John's Wort

**HMG-CoA Reductase Inhibitors**  
also known as statins  
(to lower cholesterol)

lovastatin (Mevacor<sup>®</sup>)  
simvastatin (Zocor<sup>®</sup>)

**Neuroleptics**  
(to treat psychiatric conditions)

pimozide (Orap<sup>®</sup>)

<u>Type of Drug</u>	<u>Examples of Generic Names (Brand Names)</u>
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<p><b>PDE-5 Inhibitor</b> (to treat pulmonary arterial hypertension)</p> <p><b>Sedatives/Hypnotics</b> (to treat trouble with sleeping and/or anxiety)</p>	<p>sildenafil (Revatio<sup>®</sup>)</p> <p>midazolam</p> <p>triazolam (Halcion<sup>®</sup>)</p>
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<sup>1</sup> Bepiridil, astemizole, terfenadine and cisapride are no longer marketed in Canada.

**What the medicinal ingredient is:**

The active substance is darunavir.

Each 75 mg tablet contains 81.31 mg of darunavir ethanolate corresponding to 75 mg of darunavir.

Each 150 mg tablet contains 162.62 mg of darunavir ethanolate corresponding to 150 mg of darunavir.

Each 400 mg tablet contains 433.64 mg of darunavir ethanolate, corresponding to 400 mg of darunavir.

Each 600 mg tablet contains 650.46 mg of darunavir ethanolate, corresponding to 600 mg of darunavir.

Each 800 mg tablet contains 867.28 mg of darunavir ethanolate, corresponding to 800 mg of darunavir.

**What the nonmedicinal ingredients are:**

The other ingredients are colloidal anhydrous silica, crospovidone, magnesium stearate, and microcrystalline cellulose. The 800 mg tablet core also contains hypromellose. The tablet film coatings contain either OPADRY<sup>®</sup> II White (polyethylene glycol, polyvinyl alcohol - partially hydrolyzed, talc, titanium dioxide) for the 75 and 150 mg tablets or OPADRY<sup>®</sup> II Orange (polyethylene glycol, polyvinyl alcohol - partially hydrolyzed, titanium dioxide, talc, sunset yellow FCF aluminum lake) for the 400 and 600 mg tablets or OPADRY<sup>®</sup> II Dark Red (polyethylene glycol, polyvinyl alcohol - partially hydrolyzed, titanium dioxide, talc, iron oxide red) for the 800 mg tablets.

**What dosage forms it comes in:**

75 mg tablets  
150 mg tablets  
400 mg tablets  
600 mg tablets  
800 mg tablets

**WARNINGS AND PRECAUTIONS**

BEFORE you use PAT-darunavir talk to your doctor or pharmacist if you:

- have diabetes. In general, anti-HIV medicines, such as PAT-darunavir, might increase sugar levels in the blood.
- have liver problems, including hepatitis B and/or C.
- have hemophilia. Anti-HIV medicines, such as PAT-darunavir, might increase the risk of bleeding.
- are pregnant or planning to become pregnant. It is not known if PAT-darunavir can harm your unborn baby. You and your doctor will need to decide if taking PAT-darunavir is right for you. If you take PAT-darunavir while you are pregnant, talk to your doctor about how you can be included in the Antiretroviral Pregnancy Registry.
- are breast-feeding. Do not breast-feed if you are taking PAT-darunavir. You should not breast-feed if you have HIV because of the chance of passing HIV to your baby. Talk with your doctor about the best way to feed your baby.
- are allergic to sulpha medications.

**INTERACTIONS WITH THIS MEDICATION**

Tell your doctor about all the medicines you take including prescription and nonprescription medicines, vitamins, and herbal supplements, including St. John's wort (*Hypericum perforatum*). PAT-darunavir and many other medicines can interact. Sometimes serious side effects will happen if PAT-darunavir is taken with certain other medicines (see "**When it should not be used**").

PAT-darunavir should not be combined with phenobarbital, phenytoin, rifampin or St. John's wort because the combination may significantly lower the amount of PAT-darunavir in your blood and reduce the effects of PAT-darunavir.

PAT-darunavir should not be combined with vardenafil, because you may be at increased risk of side effects of vardenafil such as low blood pressure, visual changes and penile erection lasting more than 4 hours.

Tell your doctor if you are taking estrogen-based contraceptives. PAT-darunavir might reduce the effectiveness of estrogen-based contraceptives (birth control). Therefore, alternative methods of non-hormonal contraception, such as a condom, are recommended.

Tell your doctor if you take other anti-HIV medicines (e.g. rilpivirine). PAT-darunavir can be combined with some other anti-HIV medicines while other combinations are not recommended.

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

<b><u>Type of Drug</u></b>	<b><u>Examples of Generic Names (Brand Names)</u></b>
<b>Anticoagulants</b> (to prevent the clotting of red blood cells)	warfarin (Coumadin <sup>®</sup> )
<b>Anticonvulsants</b> (to treat epilepsy and prevent seizures)	carbamazepine (Tegretol <sup>®</sup> ) phenobarbital phenytoin (Dilantin <sup>®</sup> )
<b>Antigout</b> (to treat gout and familial Mediterranean fever)	colchicine
<b>Anti-infectives</b> (to treat bacterial infections)	clarithromycin (Biaxin <sup>®</sup> )
<b>Antifungals</b> (to treat fungal infections)	ketoconazole (Nizoral <sup>®</sup> ) itraconazole (Sporanox <sup>®</sup> ) voriconazole (Vfend <sup>®</sup> )
<b>Antimycobacterials</b> (to treat bacterial infections)	rifabutin (Mycobutin <sup>®</sup> ) rifampin (Rifadin <sup>®</sup> , Rifater <sup>®</sup> )
<b>Calcium Channel Blockers</b> (to treat heart disease)	felodipine nifedipine (Adalat <sup>®</sup> ) nicardipine
<b>Corticosteroids</b> (to treat inflammation or asthma)	dexamethasone fluticasone propionate (Advair Diskus <sup>®</sup> , Cutivate <sup>®</sup> , Flonase <sup>®</sup> , Flovent Diskus <sup>®</sup> )
<b>Endothelial receptor Antagonist</b> (to treat pulmonary arterial hypertension)	bosentan (Tracleer <sup>®</sup> )
<b>HMG-CoA Reductase Inhibitors</b> (to lower cholesterol levels)	atorvastatin (Lipitor <sup>®</sup> ) lovastatin (Mevacor <sup>®</sup> ) pravastatin (Pravachol <sup>®</sup> ) simvastatin (Zocor <sup>®</sup> ) rosuvastatin (Crestor <sup>®</sup> )
<b>Immunosuppressants</b> (to prevent organ transplant rejection)	cyclosporine (Sandimmune <sup>®</sup> , Neoral <sup>®</sup> ) tacrolimus (Prograf <sup>®</sup> ) sirolimus (Rapamune <sup>®</sup> )
<b>Inhaled beta agonist</b>	salmeterol (Advair <sup>®</sup> )

<b><u>Type of Drug</u></b>	<b><u>Examples of Generic Names (Brand Names)</u></b>
<b>Narcotic Analgesics</b>	methadone buprenorphine/naloxone (Suboxone <sup>™</sup> )
<b>NS3-4A Protease Inhibitors:</b> (to treat Hepatitis C Virus [HCV])	boceprevir (Victrelis <sup>™</sup> ) telaprevir (Incivek <sup>™</sup> )
<b>PDE-5 Inhibitors</b> (to treat erectile dysfunction)	sildenafil (Viagra <sup>®</sup> ) vardenafil (Levitra <sup>®</sup> ) tadalafil (Cialis <sup>®</sup> )
<b>Selective Serotonin Reuptake Inhibitors (SSRIs)</b> (to treat depression, anxiety, or panic disorder)	paroxetine (Paxil <sup>®</sup> ) sertraline (Zoloft <sup>®</sup> )

Tell your doctor if you are taking any medicines that you obtained without a prescription.

This is **not** a complete list of medicines that you should tell your doctor that you are taking. Know and keep track of all the medicines you take and have a list of them with you. Show this list to all of your doctors and pharmacists any time you get a new medicine. Both your doctor and your pharmacist can tell you if you can take these other medicines with PAT-darunavir. Do not start any new medicines while you are taking PAT-darunavir without first talking with your doctor or pharmacist. You can ask your doctor or pharmacist for a list of medicines that can interact with PAT-darunavir.

**PROPER USE OF THIS MEDICATION**

Always use PAT-darunavir exactly as your doctor has told you. You must check with your doctor if you are not sure.

**Usual dose:**

**Take PAT-darunavir tablets every day exactly as prescribed by your doctor. You must take ritonavir (NORVIR<sup>®</sup>) at the same time as PAT-darunavir.**

**Adults:**

- For adults who have never taken anti-HIV medicines the usual dose is 800 mg (two 400 mg tablets or one 800 mg tablet) of PAT-darunavir, together with 100 mg (one 100 mg capsule) of ritonavir (NORVIR<sup>®</sup>), once daily every day.
- For adults who have taken anti-HIV medicines in the past, the dose is either 800 mg (two 400 mg tablets or one 800 mg tablet) of PAT-darunavir

together with 100 mg (one 100 mg capsule) of ritonavir (NORVIR<sup>®</sup>), once daily *every day* **OR** 600 mg (one 600 mg tablet) of PAT-darunavir together with 100 mg (one 100 mg capsule) ritonavir (NORVIR<sup>®</sup>), twice daily *every day*. Please discuss with your doctor which dose is right for you.

**Children:**

- For children at least 6 years of age weighing at least 44 lbs (20 kg) who have taken anti-HIV medicines in the past, your child’s doctor will decide the right dose based on your child’s weight. Your child’s doctor will inform you exactly on how many PAT-darunavir tablets and how much ritonavir (NORVIR<sup>®</sup>) (capsules or solution) your child should take. In case your child does not tolerate ritonavir oral solution, ask your child’s doctor for advice.

If you have questions about when to take PAT-darunavir and ritonavir (NORVIR<sup>®</sup>), your doctor can help you decide which schedule works for you.

**You should always take PAT-darunavir and ritonavir (NORVIR<sup>®</sup>) together with food.** The type of food is not important.

Continue taking PAT-darunavir and ritonavir (NORVIR<sup>®</sup>) unless your doctor tells you to stop. Take the exact amount of PAT-darunavir and ritonavir (NORVIR<sup>®</sup>) that your doctor tells you to take, right from the very start. To help make sure you will benefit from PAT-darunavir and ritonavir (NORVIR<sup>®</sup>), you must not skip doses or interrupt therapy. If you don’t take PAT-darunavir and ritonavir (NORVIR<sup>®</sup>) as prescribed, the beneficial effects of PAT-darunavir and ritonavir (NORVIR<sup>®</sup>) may be reduced or even lost.

If you have also been prescribed enteric-coated didanosine as well as PAT-darunavir and ritonavir, take didanosine 2 hours before or after the PAT-darunavir/ritonavir combination.

**Overdose:**

In case of drug overdose, contact a health care practitioner, hospital emergency department or regional Poison Control Centre immediately, even if there are no symptoms.

**Missed dose:**

**Patients taking 800 mg of PAT-darunavir once daily: If you miss a dose of PAT-darunavir (two 400 mg tablets or one 800 mg tablet) or ritonavir (NORVIR<sup>®</sup>) by more than 12 hours, wait and then take the next dose of PAT-darunavir (two 400 mg tablets or one 800 mg tablet) and ritonavir**

**(NORVIR<sup>®</sup>) at the regularly scheduled time.** If you miss a dose of PAT-darunavir (two 400 mg tablets or one 800 mg tablet) or ritonavir (NORVIR<sup>®</sup>) by less than 12 hours, take your missed dose of PAT-darunavir (two 400 mg tablets or one 800 mg tablet) and ritonavir (NORVIR<sup>®</sup>) immediately. Then take your next dose of PAT-darunavir (two 400 mg tablets or one 800 mg tablet) and ritonavir (NORVIR<sup>®</sup>) at the regularly scheduled time.

**Patients taking 600 mg of PAT-darunavir twice daily:**

**If you miss a dose of PAT-darunavir or ritonavir (NORVIR<sup>®</sup>) by more than 6 hours, wait and then take the next dose of PAT-darunavir and ritonavir (NORVIR<sup>®</sup>) at the regularly scheduled time.** If you miss a dose of PAT-darunavir or ritonavir (NORVIR<sup>®</sup>) by less than 6 hours, take your missed dose of PAT-darunavir and ritonavir (NORVIR<sup>®</sup>) immediately. Then take your next dose of PAT-darunavir and ritonavir (NORVIR<sup>®</sup>) at the regularly scheduled time.

If a dose of PAT-darunavir or ritonavir (NORVIR<sup>®</sup>) is skipped, do not double the next dose. Do not take more or less than your prescribed dose of PAT-darunavir or ritonavir (NORVIR<sup>®</sup>) at any one time.

**Do not stop using PAT-darunavir without talking to your doctor first.**

**SIDE EFFECTS AND WHAT TO DO ABOUT THEM**

Like all prescription drugs, PAT-darunavir can cause side effects. The following is **not** a complete list of side effects reported with PAT-darunavir when taken either alone or with other anti-HIV medicines. Do not rely on this leaflet alone for information about side effects. Your doctor can discuss with you a more complete list of side effects.

Liver problems that may occasionally be severe have been reported. Your doctor should do blood tests prior to initiating PAT-darunavir. If you have chronic hepatitis B or C infection, your doctor should check your blood tests more often because you have an increased chance of developing liver problems. Talk to your doctor about the signs and symptoms of liver problems. These may include yellowing of your skin or whites of your eyes, dark (tea coloured) urine, pale coloured stools (bowel movements), nausea, vomiting, loss of appetite, or pain, aching, or sensitivity on your right side below your ribs.

Rash has been reported in 10.3% of patients receiving PAT-darunavir. In patients taking PAT-darunavir and raltegravir, rashes (generally mild or moderate) may

occur more frequently than in patients taking either drug separately. Contact your doctor immediately if you develop a rash. Your doctor will advise you whether your symptoms can be managed on therapy or whether PAT-darunavir should be stopped.

In some patients, PAT-darunavir has been reported to cause a severe or life-threatening rash. **If you develop a severe rash (e.g. blisters, peeling skin) which may be accompanied with symptoms such as fever, fatigue, muscle aches and pain, and liver problems, immediately discontinue PAT-darunavir and contact your doctor.**

Other relevant severe side effects reported at an uncommon or rare frequency were inflammation of the liver or pancreas, increased blood fat levels, diabetes, and changes in body fat.

The most common side effects include diarrhea, nausea, headache, abdominal pain and vomiting.

Some side effects are typical for anti-HIV medicines in the same family as PAT-darunavir. These are:

- high blood sugar (hyperglycemia) and diabetes. This can happen in patients taking PAT-darunavir or other protease inhibitor medicines. Some patients have diabetes before starting treatment with PAT-darunavir, which gets worse. Some patients get diabetes during treatment with PAT-darunavir. Some patients will need changes in their diabetes medicine. Some patients may need new diabetes medicine.
- increased bleeding in patients with hemophilia. This may happen in patients taking PAT-darunavir as it has been reported with other protease inhibitor medicines.
- changes in body fat. These changes can happen in patients taking anti-HIV medicines. The changes may include an increased amount of fat in the upper back and neck, breast, and around the back, chest, and stomach area. Loss of fat from the legs, arms, and face may also happen. The exact cause and long-term health effects of these conditions are not known.
- increases in triglycerides and cholesterol (forms of fat that are found in your blood). Your doctor may order blood testing for you.
- development of pancreatitis (inflammation of the pancreas) with symptoms such as abdominal pain, nausea and vomiting. If you suffer these symptoms while taking PAT-darunavir, contact your doctor.
- immune reconstitution syndrome. In some patients with advanced HIV infection (AIDS) and a history of opportunistic infection, 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.

Tell your doctor promptly about these or any other unusual symptoms. If the condition persists or worsens, seek medical attention.

SERIOUS SIDE EFFECTS, HOW OFTEN THEY HAPPEN AND WHAT TO DO ABOUT THEM				
Symptom / effect		Talk with your doctor or pharmacist		Stop taking drug and call your doctor or pharmacist
		Only if severe	In all cases	
Uncommon	<u>Severe and sometimes life-threatening rash</u> (blisters, peeling skin) which may be accompanied by fever, fatigue, muscle aches and pain, and liver problems.			✓
	<u>Liver problems</u> with symptoms such as yellowing of the skin or whites of the eyes, dark (tea coloured) urine, pale coloured stools (bowel movements), nausea, vomiting, loss of appetite, or pain, aching, or sensitivity on right side below ribs.		✓	
	<u>Diabetes</u> with symptoms such as excessive thirst, excessive urination, excessive eating, unexplained weight loss, poor wound healing, infections.		✓	
	<u>Inflammation of the pancreas</u> with symptoms such as abdominal pain, nausea and vomiting.		✓	

**HOW TO STORE IT**

Keep out of the reach and sight of children.

Store PAT-darunavir tablets at room temperature between 15-30°C. Ask your doctor or pharmacist if you have any questions about storing your tablets.

**This medication is prescribed for your particular condition. Do not use it for any other condition or give it to anybody else. Keep PAT-darunavir and all of your medicines out of the reach of children. If you suspect that more than the prescribed dose of this medicine has been taken, contact your local poison control centre or emergency room immediately.**

This leaflet provides a summary of information about PAT-darunavir. If you have any questions or concerns about either PAT-darunavir or HIV, talk to your doctor.

**REPORTING SUSPECTED SIDE EFFECTS**

You can report any suspected adverse reactions associated with the use of health products to the Canada Vigilance Program by one of the following 3 ways:

- Report online at [www.healthcanada.gc.ca/medeffect](http://www.healthcanada.gc.ca/medeffect)
- Call toll-free at 1-866-234-2345
- Complete a Canada Vigilance Reporting Form and:
  - Fax toll-free to 1-866-678-6789, or
  - Mail to: Canada Vigilance Program  
Health Canada  
Postal Locator 0701E  
Ottawa, ON K1A 0K9

Postage paid labels, Canada Vigilance Reporting Form and the adverse reaction reporting guidelines are available on [www.healthcanada.gc.ca/medeffect](http://www.healthcanada.gc.ca/medeffect).

***NOTE: Should you require information related to the management of side effects, contact your health professional. The Canada Vigilance Program does not provide medical advice.***

**MORE INFORMATION**

This document plus the full product monograph, prepared for health professionals can be found at: <http://www.patriot-canada.ca> or by contacting the sponsor, Janssen Inc., at: 1-800-567-3331 or 1-800-387-8781

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