

BIKTARVY[®]
(Bictegravir/emtricitabine/tenofovir alafenamide fumarate)
Film-coated tablets

1. NAME OF THE MEDICINAL PRODUCT

Biktarvy[®]

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

Each film-coated tablet contains bictegravir sodium equivalent to 50 mg of bictegravir, 200 mg of emtricitabine, and tenofovir alafenamide fumarate equivalent to 25 mg of tenofovir alafenamide.

For the full list of excipients, see section 6.1.

3. PHARMACEUTICAL FORM

Film-coated tablet (tablet).

Purplish-brown, capsule-shaped, film-coated tablet debossed with “GSI” on one side and “9883” on the other side of the tablet. Each tablet is approximately 15 mm × 8 mm.

4. CLINICAL PARTICULARS

4.1 Therapeutic indications

Biktarvy is indicated for the treatment of adults infected with human immunodeficiency virus-1 (HIV-1) without present or past evidence of viral resistance to the integrase inhibitor class, emtricitabine or tenofovir (see section 5.1).

4.2 Posology and method of administration

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

Posology

One tablet to be taken once daily.

Missed doses

If the patient misses a dose of Biktarvy within 18 hours of the time it is usually taken, the patient should take Biktarvy as soon as possible and resume the normal dosing schedule. If a patient misses a dose of Biktarvy by more than 18 hours, the patient should not take the missed dose and simply resume the usual dosing schedule.

If the patient vomits within 1 hour of taking Biktarvy another tablet should be taken. If a patient vomits more than 1 hour after taking Biktarvy they do not need to take another dose of Biktarvy until the next regularly scheduled dose.

Elderly

There are limited data on the use of Biktarvy in patients aged 65 years and over. No dose adjustment of Biktarvy is required in elderly patients (see section 5.2).

Renal impairment

No dose adjustment of Biktarvy is required in patients with estimated creatinine clearance (CrCl) ≥ 30 mL/min.

Initiation of Biktarvy is not recommended in patients with estimated CrCl below 30 mL/min, as there are insufficient data available regarding the use of Biktarvy in this population (see section 5.2).

Hepatic impairment

No dose adjustment of Biktarvy is required in patients with mild (Child-Pugh Class A) or moderate (Child-Pugh Class B) hepatic impairment. Biktarvy has not been studied in patients with severe hepatic impairment (Child-Pugh Class C), therefore Biktarvy is not recommended for use in patients with severe hepatic impairment (see sections 4.4 and 5.2).

Paediatric population

The safety and efficacy of Biktarvy in children under the age of 18 years have not yet been established. No data are available.

Method of administration

Oral use.

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

It is not recommended to chew, crush or split the tablet as it has a very bitter taste. No information available regarding tablet effectiveness after splitting, chewing or crushing it.

4.3 Contraindications

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

Co-administration with rifampicin and St. John's wort (*Hypericum perforatum*) (see section 4.5).

4.4 Special warnings and precautions for use

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

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

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

There are limited safety and efficacy data for Biktarvy in patients co-infected with HIV-1 and hepatitis C virus (HCV).

Biktarvy contains tenofovir alafenamide, which is active against hepatitis B virus (HBV).

Discontinuation of Biktarvy therapy in patients co-infected with HIV and HBV may be associated with severe acute exacerbations of hepatitis. Patients co-infected with HIV and HBV who discontinue Biktarvy should be closely monitored with both clinical and laboratory follow-up for at least several months after stopping treatment.

Liver disease

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

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

Weight and metabolic parameters

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

Mitochondrial dysfunction following exposure *in utero*

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

Immune Reactivation Syndrome

In HIV infected patients with severe immune deficiency at the time of institution of CART, an inflammatory reaction to asymptomatic or residual opportunistic pathogens may arise and cause serious clinical conditions, or aggravation of symptoms. Typically, such reactions have been observed within the first few weeks or months of initiation of CART. Relevant examples include cytomegalovirus retinitis, generalised and/or focal mycobacterial infections, and *Pneumocystis jirovecii* pneumonia. Any inflammatory symptoms should be evaluated and treatment instituted when necessary.

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

Opportunistic infections

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

Osteonecrosis

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

Nephrotoxicity

A potential risk of nephrotoxicity resulting from chronic exposure to low levels of tenofovir due to dosing with tenofovir alafenamide cannot be excluded (see section 5.3).

It is recommended that renal function is assessed in all patients prior to, or when initiating, therapy with Biktarvy and that it is also monitored during therapy in all patients as clinically appropriate. In patients who develop clinically significant decreases in renal function, or evidence of proximal renal tubulopathy, discontinuation of Biktarvy should be considered.

Co-administration of other medicinal products

Biktarvy should not be co-administered simultaneously with magnesium/aluminium-containing antacids or iron supplements under fasted conditions. Biktarvy should be administered at least 2 hours before, or with food 2 hours after antacids containing magnesium and/or aluminium. Biktarvy should be administered at least 2 hours before iron supplements, or taken together with food (see section 4.5).

Some medicinal products are not recommended for co-administration with Biktarvy: atazanavir, carbamazepine, ciclosporin (IV or oral use), oxcarbazepine, phenobarbital, phenytoin, rifabutin, rifapentine, or sucralfate.

Biktarvy should not be co-administered with other antiretroviral medicinal products.

Excipients

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

4.5 Interaction with other medicinal products and other forms of interaction

Interaction studies have only been performed in adults.

Biktarvy should not be administered concomitantly with medicinal products containing tenofovir alafenamide, tenofovir disoproxil, lamivudine or adefovir dipivoxil used for the treatment of HBV infection.

Bictegravir

Bictegravir is a substrate of CYP3A and UGT1A1. Co-administration of bictegravir and medicinal products that potentially induce both CYP3A and UGT1A1, such as rifampicin or St. John's wort, may significantly decrease plasma concentrations of bictegravir, which may result in a loss of therapeutic effect of Biktarvy and development of resistance, therefore co-administration is contraindicated (see section 4.3). Co-administration of bictegravir with medicinal products that potentially inhibit both CYP3A and UGT1A1, such as atazanavir, may significantly increase plasma concentrations of bictegravir, therefore co-administration is not recommended.

Bictegravir is both a P-gp and a BCRP substrate. The clinical relevance of this feature is not established. Therefore, caution is recommended when bictegravir is combined with medicinal products known to inhibit P-gp and/or BCRP (e.g. macrolides, ciclosporin, verapamil, dronedarone, glecaprevir/pibrentasvir) (see also table below).

Bictegravir inhibits organic cation transporter 2 (OCT2) and multidrug and toxin extrusion transporter 1 (MATE1) *in vitro*. Co-administration of Biktarvy with the OCT2 and MATE1 substrate metformin did not result in a clinically significant increase in metformin exposure. Biktarvy may be co-administered with substrates of OCT2 and MATE1.

Bictegravir is not an inhibitor or inducer of CYP *in vivo*.

Emtricitabine

In vitro and clinical pharmacokinetic drug-drug interaction studies have shown that the potential for CYP-mediated interactions involving emtricitabine with other medicinal products is low. Co-administration of emtricitabine with medicinal products that are eliminated by active tubular secretion may increase concentrations of emtricitabine, and/or the co-administered medicinal product. Medicinal products that decrease renal function may increase concentrations of emtricitabine.

Tenofovir alafenamide

Tenofovir alafenamide is transported by P-glycoprotein (P-gp) and breast cancer resistance protein (BCRP). Co-administration of Biktarvy with medicinal products that strongly affect P-gp and BCRP activity may lead to changes in tenofovir alafenamide absorption. Medicinal products that induce P-gp activity (e.g. rifabutin, carbamazepine, phenobarbital) are expected to decrease the absorption of tenofovir alafenamide, resulting in decreased plasma concentration of tenofovir alafenamide, which may lead to loss of therapeutic effect of Biktarvy and development of resistance. Co-administration of Biktarvy with other medicinal products that inhibit P-gp and BCRP may increase the absorption and plasma concentration of tenofovir alafenamide.

Tenofovir alafenamide is not an inhibitor or inducer of CYP3A *in vivo*.

Other interactions

Interactions between Biktarvy or its individual component(s) and co-administered medicinal products are listed in Table 1 below (increase is indicated as “↑”, decrease as “↓” and no change as “↔”; all No Effect Boundaries are 70%-143%).

Table 1: Interactions between Biktarvy or its individual component(s) and other medicinal products

Medicinal product by therapeutic areas/possible mechanism of interaction	Effects on medicinal product levels. Mean percent change in AUC, C _{max} , C _{min}	Recommendation concerning co-administration with Biktarvy
<i>HERBAL PRODUCTS</i>		
St. John’s wort (<i>Hypericum perforatum</i>) (Induction of CYP3A, UGT1A1, and P-gp)	Interaction not studied with any of the components of Biktarvy. Co-administration may decrease bictegravir and tenofovir alafenamide plasma concentrations.	Co-administration with St. John’s wort is contraindicated, due to the effect of St. John’s wort on the bictegravir component of Biktarvy.
<i>ANTI-INFECTIVES</i>		
<i>Antimycobacterials</i>		
Rifampicin (600 mg once daily), Bictegravir ¹ (Induction of CYP3A, UGT1A1, and P-gp)	Bictegravir: AUC: ↓ 75% C _{max} : ↓ 28% Interaction not studied with tenofovir alafenamide. Co-administration of rifampicin may decrease tenofovir alafenamide plasma concentrations.	Co-administration is contraindicated due to the effect of rifampicin on the bictegravir component of Biktarvy.

Medicinal product by therapeutic areas/possible mechanism of interaction	Effects on medicinal product levels. Mean percent change in AUC, C _{max} , C _{min}	Recommendation concerning co-administration with Biktarvy
Rifabutin (300 mg once daily), Bictegravir ¹ (Induction of CYP3A and P-gp)	Bictegravir: AUC: ↓ 38% C _{min} : ↓ 56% C _{max} : ↓ 20% Interaction not studied with tenofovir alafenamide. Co-administration of rifabutin may decrease tenofovir alafenamide plasma concentrations.	Co-administration is not recommended due to the expected decrease of tenofovir alafenamide.
Rifapentine (Induction of CYP3A and P-gp)	Interaction not studied with any of the components of Biktarvy. Co-administration of rifapentine may decrease bictegravir and tenofovir alafenamide plasma concentrations.	Co-administration is not recommended.
HIV-1 antiviral agents		
Atazanavir (300 mg once daily), Cobicistat (150 mg once daily), Bictegravir ¹ (Inhibition of CYP3A, UGT1A1, and P-gp/BCRP)	Bictegravir: AUC: ↑ 306% C _{max} : ↔	Co-administration is not recommended.
Atazanavir (400 mg once daily), Bictegravir ¹ (Inhibition of CYP3A and UGT1A1)	Bictegravir: AUC: ↑ 315% C _{max} : ↔	
Hepatitis C virus antiviral agents		
Ledipasvir/Sofosbuvir (90 mg/400 mg once daily), Bictegravir/Emtricitabine/Tenofovir alafenamide ²	Bictegravir: AUC: ↔ C _{min} : ↔ C _{max} : ↔ Emtricitabine: AUC: ↔ C _{min} : ↔ C _{max} : ↔ Tenofovir alafenamide: AUC: ↔ C _{max} : ↔ Ledipasvir: AUC: ↔ C _{min} : ↔ C _{max} : ↔ Sofosbuvir: AUC: ↔ C _{max} : ↔ Sofosbuvir metabolite GS-331007: AUC: ↔ C _{min} : ↔ C _{max} : ↔	No dose adjustment is required upon co-administration.

Medicinal product by therapeutic areas/possible mechanism of interaction	Effects on medicinal product levels. Mean percent change in AUC, C _{max} , C _{min}	Recommendation concerning co-administration with Biktarvy
Sofosbuvir/Velpatasvir/Voxilaprevir (400/100/100 + 100 mg ³ once daily), Bicitegravir/Emtricitabine/Tenofovir alafenamide (Inhibition of P-gp/BCRP)	Bicitegravir: AUC: ↔ C _{min} : ↔ C _{max} : ↔ Emtricitabine: AUC: ↔ C _{min} : ↔ C _{max} : ↔ Tenofovir alafenamide: AUC: ↑ 57% C _{max} : ↑ 28% Sofosbuvir: AUC: ↔ C _{max} : ↔ Sofosbuvir metabolite GS-331007: AUC: ↔ C _{min} : ↔ C _{max} : ↔ Velpatasvir: AUC: ↔ C _{min} : ↔ C _{max} : ↔ Voxilaprevir: AUC: ↔ C _{min} : ↔ C _{max} : ↔	No dose adjustment is required upon co-administration.
Antifungals		
Voriconazole (300 mg twice daily), Bicitegravir ¹ (Inhibition of CYP3A)	Bicitegravir: AUC: ↑ 61% C _{max} : ↔	No dose adjustment is required upon co-administration.
Itraconazole Posaconazole (Inhibition of P-gp/BCRP)	Interaction not studied with any of the components of Biktarvy. Co-administration of itraconazole or posaconazole may increase bicitegravir plasma concentrations.	
Macrolides		
Azithromycin Clarithromycin (Inhibition of P-gp)	Interaction not studied. Co-administration of azithromycin or clarithromycin may increase bicitegravir plasma concentrations.	Caution is recommended due to the potential effect of these agents on the bicitegravir component of Biktarvy.
ANTICONVULSANTS		
Carbamazepine (titrated from 100 mg to 300 mg twice a day), Emtricitabine/Tenofovir alafenamide ⁴ (Induction of CYP3A, UGT1A1, and P-gp)	Tenofovir alafenamide: AUC: ↓ 54% C _{max} : ↓ 57% Interaction not studied with bicitegravir. Co-administration of carbamazepine may decrease bicitegravir plasma concentrations.	Co-administration is not recommended.

Medicinal product by therapeutic areas/possible mechanism of interaction	Effects on medicinal product levels. Mean percent change in AUC, C _{max} , C _{min}	Recommendation concerning co-administration with Biktarvy
Oxcarbazepine Phenobarbital Phenytoin (Induction of CYP3A, UGT1A1, and P-gp)	Interaction not studied with any of the components of Biktarvy. Co-administration of oxcarbazepine, phenobarbital, or phenytoin may decrease bicittegravir and tenofovir alafenamide plasma concentrations.	Co-administration is not recommended.
ANTACIDS, SUPPLEMENTS AND BUFFERED MEDICINES		
Magnesium/aluminium-containing antacid suspension (20 mL single dose ⁵), Bicittegravir (Chelation with polyvalent cations)	Bicittegravir (antacid suspension 2 hours prior, fasted): AUC: ↓ 52% C _{max} : ↓ 58% Bicittegravir (antacid suspension after 2 hours, fasted): AUC: ↔ C _{max} : ↔ Bicittegravir (simultaneous administration, fasted): AUC: ↓ 79% C _{max} : ↓ 80% Bicittegravir (simultaneous administration with food): AUC: ↓ 47% C _{max} : ↓ 49%	Biktarvy should not be taken simultaneously with supplements containing magnesium and/or aluminium due to the expected substantial decrease of bicittegravir exposure (see section 4.4). Biktarvy should be administered at least 2 hours before, or with food 2 hours after antacids containing magnesium and/or aluminium.
Ferrous fumarate (324 mg single dose), Bicittegravir (Chelation with polyvalent cations)	Bicittegravir (simultaneous administration, fasted): AUC: ↓ 63% C _{max} : ↓ 71% Bicittegravir (simultaneous administration with food): AUC: ↔ C _{max} : ↓ 25%	Biktarvy should be administered at least 2 hours before iron supplements, or taken together with food.
Calcium carbonate (1,200 mg single dose), Bicittegravir (Chelation with polyvalent cations)	Bicittegravir (simultaneous administration, fasted): AUC: ↓ 33% C _{max} : ↓ 42% Bicittegravir (simultaneous administration with food): AUC: ↔ C _{max} : ↔	Biktarvy and calcium-containing supplements can be taken together, without regard to food.
Sucralfate (Chelation with polyvalent cations)	Interaction not studied with any of the components of Biktarvy. Co-administration may decrease bicittegravir plasma concentrations.	Co-administration not recommended.

Medicinal product by therapeutic areas/possible mechanism of interaction	Effects on medicinal product levels. Mean percent change in AUC, C _{max} , C _{min}	Recommendation concerning co-administration with Biktarvy
ANTIDEPRESSANTS		
Sertraline (50 mg single dose), Tenofovir alafenamide ⁶	Tenofovir alafenamide: AUC: ↔ C _{max} : ↔ Sertraline: AUC: ↔ C _{max} : ↔ No interaction is expected with bicitegravir and emtricitabine.	No dose adjustment is required upon co-administration.
IMMUNOSUPPRESSANTS		
Ciclosporin (IV or oral use) (P-gp inhibition)	Interaction not studied with any of the components of Biktarvy. Co-administration of ciclosporin (IV or oral use) is expected to increase plasma concentrations of both bicitegravir and tenofovir alafenamide.	Co-administration of ciclosporin (IV or oral use) is not recommended. If the combination is needed, clinical and biological monitoring, notably renal function, is recommended.
ORAL ANTI-DIABETICS		
Metformin (500 mg twice daily), Bicitegravir/Emtricitabine/ Tenofovir alafenamide (Inhibition of OCT2/MATE1)	Metformin: AUC: ↑ 39% C _{min} : ↑ 36% C _{max} : ↔	No dose adjustment is required upon co-administration in patients with normal renal function. In patients with moderate renal impairment, close monitoring should be considered when starting co-administration of bicitegravir with metformin, due to the increased risk for lactic acidosis in these patients. A dose adjustment of metformin should be considered if required.
ORAL CONTRACEPTIVES		
Norgestimate (0.180/0.215/0.250 mg once daily)/ Ethinylestradiol (0.025 mg once daily), Bicitegravir ¹ ----- Norgestimate (0.180/0.215/0.250 mg once daily), Ethinylestradiol (0.025 mg once daily), Emtricitabine/Tenofovir alafenamide ⁴	Norelgestromin: AUC: ↔ C _{min} : ↔ C _{max} : ↔ Norgestrel: AUC: ↔ C _{min} : ↔ C _{max} : ↔ Ethinylestradiol: AUC: ↔ C _{min} : ↔ C _{max} : ↔	No dose adjustment is required upon co-administration.
SEDATIVES/HYPNOTICS		
Midazolam (2 mg, oral syrup, single dose), Bicitegravir/Emtricitabine/ Tenofovir alafenamide	Midazolam: AUC: ↔ C _{max} : ↔	No dose adjustment is required upon co-administration.

- 1 This study was conducted using bicitegravir 75 mg single dose.
- 2 This study was conducted using bicitegravir/emtricitabine/tenofovir alafenamide 75/200/25 mg once daily.
- 3 Study conducted with additional voxilaprevir 100 mg to achieve voxilaprevir exposures expected in HCV-infected patients.
- 4 This study was conducted using emtricitabine/tenofovir alafenamide 200/25 mg once daily.
- 5 Maximum strength antacid contained 80 mg aluminium hydroxide, 80 mg magnesium hydroxide, and 8 mg simethicone per mL.
- 6 This study was conducted using elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide 150/150/200/10 mg once daily.

Based on drug interaction studies conducted with Biktarvy or the components of Biktarvy, no clinically significant drug interactions are expected with: amlodipine, atorvastatin, buprenorphine, drospirenone, famciclovir, famotidine, fluticasone, methadone, naloxone, norbuprenorphine, omeprazole or rosuvastatin.

4.6 Fertility, pregnancy and lactation

Pregnancy

There are no or limited data (less than 300 pregnancy outcomes) from the use of bicitegravir or tenofovir alafenamide in pregnant women. A large amount of data on pregnant women (more than 1,000 exposed outcomes) indicate no malformative nor foetal/neonatal toxicity associated with emtricitabine.

Animal studies do not indicate direct or indirect harmful effects of emtricitabine with respect to fertility parameters, pregnancy, foetal development, parturition or postnatal development. Studies of bicitegravir and tenofovir alafenamide, administered separately, in animals have shown no evidence of harmful effects on fertility parameters, pregnancy, or foetal development (see section 5.3).

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

Breast-feeding

It is not known whether bicitegravir or tenofovir alafenamide is excreted in human milk. Emtricitabine is excreted in human milk. In animal studies, bicitegravir was detected in the plasma of nursing rat pups likely due to the presence of bicitegravir in milk, without effects on nursing pups. In animal studies it has been shown that tenofovir is excreted in milk.

There is insufficient information on the effects of all the components of Biktarvy in newborns/infants, therefore Biktarvy should not be used during breast-feeding.

In order to avoid transmission of HIV to the infant it is recommended that HIV-infected women do not breast-feed their infants under any circumstances.

Fertility

No human data on the effect of Biktarvy on fertility are available. Animal studies indicate no effects of bicitegravir, emtricitabine or tenofovir alafenamide on mating or fertility (see section 5.3).

4.7 Effects on ability to drive and use machines

Patients should be informed that dizziness has been reported during treatment with the components of Biktarvy (see section 4.8).

4.8 Undesirable effects

Summary of the safety profile

The assessment of adverse reactions is based on safety data from across all Phase 2 and 3 studies with Biktarvy and from post-marketing experience. In clinical studies of treatment-naïve patients receiving Biktarvy, the most frequently reported adverse reactions in the double-blind phase (Week 144) were headache (5%), diarrhoea (5%) and nausea (4%).

Tabulated summary of adverse reactions

The adverse reactions in Table 2 are listed by system organ class and frequency. Frequencies are defined as follows: common ($\geq 1/100$ to $< 1/10$) uncommon ($\geq 1/1,000$ to $< 1/100$) and rare ($\geq 1/10,000$ to $< 1/1,000$).

Table 2: Tabulated list of adverse reactions¹

Frequency	Adverse reaction
<i>Blood and lymphatic system disorders</i>	
Uncommon:	anaemia ²
<i>Psychiatric disorders</i>	
Common:	depression, abnormal dreams
Uncommon:	suicidal ideation, suicide attempt (particularly in patients with a pre-existing history of depression or psychiatric illness), anxiety, sleep disorders
<i>Nervous system disorders</i>	
Common:	headache, dizziness
<i>Gastrointestinal disorders</i>	
Common:	diarrhoea, nausea
Uncommon:	vomiting, abdominal pain, dyspepsia, flatulence
<i>Hepatobiliary disorders</i>	
Uncommon:	hyperbilirubinaemia
<i>Skin and subcutaneous tissue disorders</i>	
Uncommon:	angioedema ^{3,4} , rash, pruritus, urticaria ⁴
Rare:	Stevens-Johnson syndrome ⁵
<i>Musculoskeletal and connective tissue disorders</i>	
Uncommon:	arthralgia
<i>General disorders and administration site conditions</i>	
Common:	fatigue

¹ With the exception of angioedema, anaemia, urticaria and Stevens-Johnson syndrome (see footnotes 2-5), all adverse reactions were identified from Biktarvy clinical studies. The frequencies were derived from the double-blind phase (Week 144) of Phase 3 Biktarvy clinical studies in treatment-naïve patients (GS-US-380-1489 and GS-US-380-1490).

² This adverse reaction was not observed in the clinical studies of emtricitabine + tenofovir alafenamide-containing products but identified from clinical studies or post-marketing experience for emtricitabine when used with other antiretrovirals.

³ This adverse reaction was identified through post-marketing surveillance for emtricitabine-containing products.

⁴ This adverse reaction was identified through post-marketing surveillance for tenofovir alafenamide-containing products.

⁵ This adverse reaction was identified through post-marketing surveillance for Biktarvy. The frequency has been calculated using $3/X$, where X represent the cumulative number of subjects exposed to Biktarvy in clinical trials (N=3963).

Description of selected adverse reactions

Metabolic parameters

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

Immune Reactivation Syndrome

In HIV infected patients with severe immune deficiency at the time of initiation of CART, an inflammatory reaction to asymptomatic or residual opportunistic infections may arise. Autoimmune disorders (such as Graves' disease and autoimmune hepatitis) have also been reported; however, the

reported time to onset is more variable and these events can occur many months after initiation of treatment (see section 4.4).

Osteonecrosis

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

Changes in serum creatinine

Bictegravir has been shown to increase serum creatinine due to inhibition of tubular secretion of creatinine, however these changes are not considered to be clinically relevant since they do not reflect a change in glomerular filtration rate. Increases in serum creatinine occurred by Week 4 of treatment and remained stable through Week 144. In Studies GS-US-380-1489 and GS-US-380-1490, median (Q1, Q3) serum creatinine increased by 0.11 (0.03, 0.19) mg/dL (9.7 [2.7, 16.8] $\mu\text{mol/L}$), 0.11 (0.04, 0.19)mg/dL (9.7 [3.5, 16.8] $\mu\text{mol/L}$), and 0.12 (0.06, 0.21) mg/dL (10.6 [5.3, 18.6] $\mu\text{mol/L}$) from baseline to Week 144 in the Biktarvy, abacavir/dolutegravir/lamivudine, and dolutegravir + emtricitabine/tenofovir alafenamide groups, respectively. There were no discontinuations due to renal adverse events through Week 144 in patients administered Biktarvy in clinical studies.

Changes in bilirubin

In Studies GS-US-380-1489 and GS-US-380-1490, total bilirubin increases were observed in 17% of treatment-naïve patients administered Biktarvy through Week 144. Increases were primarily Grade 1 (12%) and Grade 2 (4%) (≥ 1.0 to $2.5 \times$ Upper Limit of Normal [ULN]), and were not associated with hepatic adverse reactions or other liver related laboratory abnormalities. Five patients administered Biktarvy (1%) had grade 3 bilirubin increases that were not considered related to study drug. There were no discontinuations due to hepatic adverse events through Week 144 in Biktarvy clinical studies.

Other special populations

Patients co-infected with hepatitis B

In 16 HIV/HBV co-infected adults administered Biktarvy (8 HIV/HBV treatment-naïve adults in Study GS-US-380-1490; 8 HIV/HBV suppressed adults in Study GS-US-380-1878), the safety profile of Biktarvy was similar to that in patients with HIV-1 mono-infection (see section 5.1).

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product.

You can report any side effects to the Ministry of Health by clicking on the link "Report side effects due to medical treatment" that is located on the Ministry of Health homepage (www.health.gov.il) which redirects to the online form for reporting side effects or by clicking on the link: <https://sideeffects.health.gov.il>.

Additionally, adverse events can be reported to the registration holder by email (DrugSafety.Israel@gilead.com).

4.9 Overdose

If overdose occurs the patient must be monitored for evidence of toxicity (see section 4.8). Treatment of overdose with Biktarvy consists of general supportive measures including monitoring of vital signs as well as observation of the clinical status of the patient.

There is no specific antidote for overdose with Biktarvy. As bictegravir is highly bound to plasma proteins, it is unlikely that it will be significantly removed by haemodialysis or peritoneal dialysis. Emtricitabine can be removed by haemodialysis, which removes approximately 30% of the

emtricitabine dose over a 3-hour dialysis period starting within 1.5 hours of emtricitabine dosing. Tenofovir is efficiently removed by haemodialysis with an extraction coefficient of approximately 54%. It is not known whether emtricitabine or tenofovir can be removed by peritoneal dialysis.

5. PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: Antiviral for systemic use; antivirals for treatment of HIV infections, combinations, ATC code: J05AR20

Mechanism of action and pharmacodynamic effects

Bictegravir is an integrase strand transfer inhibitor (INSTI) that binds to the integrase active site and blocks the strand transfer step of retroviral deoxyribonucleic acid (DNA) integration which is essential for the HIV replication cycle. Bictegravir has activity against HIV-1 and HIV-2.

Emtricitabine is a nucleoside reverse transcriptase inhibitor (NRTI) and analogue of 2'-deoxycytidine. Emtricitabine is phosphorylated by cellular enzymes to form emtricitabine triphosphate. Emtricitabine triphosphate inhibits HIV replication through incorporation into viral DNA by the HIV reverse transcriptase (RT), which results in DNA chain-termination. Emtricitabine has activity against HIV-1, HIV-2 and HBV.

Tenofovir alafenamide is a nucleotide reverse transcriptase inhibitor (NtRTI) and phosphoramidate prodrug of tenofovir (2'-deoxyadenosine monophosphate analogue). Tenofovir alafenamide is permeable into cells and due to increased plasma stability and intracellular activation through hydrolysis by cathepsin A, tenofovir alafenamide is more efficient than tenofovir disoproxil in loading tenofovir into peripheral blood mononuclear cells (PBMCs) (including lymphocytes and other HIV target cells) and macrophages. Intracellular tenofovir is subsequently phosphorylated to the pharmacologically active metabolite tenofovir diphosphate. Tenofovir diphosphate inhibits HIV replication through incorporation into viral DNA by the HIV RT, which results in DNA chain-termination. Tenofovir has activity against HIV-1, HIV-2 and HBV.

Antiviral activity *in vitro*

The antiviral activity of bictegravir against laboratory and clinical isolates of HIV-1 was assessed in lymphoblastoid cell lines, PBMCs, primary monocyte/macrophage cells, and CD4+ T-lymphocytes. The 50% effective concentration (EC₅₀) values for bictegravir were in the range of < 0.05 to 6.6 nM. The protein-adjusted EC₉₅ of bictegravir was 361 nM (0.162 µg/mL) for wild type HIV-1 virus. Bictegravir displayed antiviral activity in cell culture against HIV-1 group (M, N, O), including subtypes A, B, C, D, E, F, and G (EC₅₀ values ranged from < 0.05 to 1.71 nM), and activity against HIV-2 (EC₅₀ = 1.1 nM).

The antiviral activity of emtricitabine against laboratory and clinical isolates of HIV-1 was assessed in lymphoblastoid cell lines, the MAGI CCR5 cell line, and PBMCs. The EC₅₀ values for emtricitabine were in the range of 0.0013 to 0.64 µM. Emtricitabine displayed antiviral activity in cell culture against HIV-1 clades A, B, C, D, E, F, and G (EC₅₀ values ranged from 0.007 to 0.075 µM) and showed activity against HIV-2 (EC₅₀ values ranged from 0.007 to 1.5 µM).

The antiviral activity of tenofovir alafenamide against laboratory and clinical isolates of HIV-1 subtype B was assessed in lymphoblastoid cell lines, PBMCs, primary monocyte/macrophage cells, and CD4+ T-lymphocytes. The EC₅₀ values for tenofovir alafenamide were in the range of 2.0 to 14.7 nM. Tenofovir alafenamide displayed antiviral activity in cell culture against all HIV-1 groups (M, N, O), including subtypes A, B, C, D, E, F, and G (EC₅₀ values ranged from 0.10 to 12.0 nM) and activity against HIV-2 (EC₅₀ values ranged from 0.91 to 2.63 nM).

Resistance

In vitro

HIV-1 isolates with reduced susceptibility to bictegravir have been selected in cell culture. In one selection, amino acid substitutions M50I and R263K emerged and phenotypic susceptibility to bictegravir was reduced 1.3-, 2.2-, and 2.9-fold for M50I, R263K, and M50I + R263K, respectively. In a second selection, amino acid substitutions T66I and S153F emerged and phenotypic susceptibility to bictegravir was shifted 0.4-, 1.9-, and 0.5-fold for T66I, S153F, and T66I + S153F, respectively.

HIV-1 isolates with reduced susceptibility to emtricitabine have been selected in cell culture and had M184V/I mutations in HIV-1 RT.

HIV-1 isolates with reduced susceptibility to tenofovir alafenamide have been selected in cell culture and had the K65R mutation in HIV-1 RT; in addition, a K70E mutation in HIV-1 RT has been transiently observed. HIV-1 isolates with the K65R mutation have low level reduced susceptibility to abacavir, emtricitabine, tenofovir, and lamivudine. *In vitro* drug resistance selection studies with tenofovir alafenamide have shown no development of high-level resistance after extended culture.

In vivo

In treatment-naïve patients (Studies GS-US-380-1489 and GS-US-380-1490), through Week 144 of the double-blind phase or 96 weeks of the open-label extension phase, no patient receiving Biktarvy, with HIV-1 RNA \geq 200 copies/mL at the time of confirmed virologic failure or early study drug discontinuation, had HIV-1 with treatment-emergent genotypic or phenotypic resistance to bictegravir, emtricitabine, or tenofovir alafenamide in the final resistance analysis population (n = 11 with data). At the time of study entry, one treatment-naïve patient had pre-existing INSTI resistance-associated mutations Q148H + G140S and had HIV-1 RNA < 50 copies/mL at Week 4 through Week 144. In addition, 6 patients had the pre-existing INSTI resistance-associated mutation T97A; all had HIV-1 RNA < 50 copies/mL at Week 144 or the last visit.

In virologically-suppressed patients (Studies GS-US-380-1844 and GS-US-380-1878), no patients receiving Biktarvy, with HIV-1 RNA \geq 200 copies/mL at the time of confirmed virologic failure, Week 48, or early study drug discontinuation, had HIV-1 with treatment-emergent genotypic or phenotypic resistance to bictegravir, emtricitabine, or tenofovir alafenamide in the final resistance analysis population (n = 2).

Cross-resistance

The susceptibility of bictegravir was tested against 64 INSTI-resistant clinical isolates (20 with single substitutions and 44 with 2 or more substitutions). Of these, all single and double mutant isolates lacking Q148H/K/R and 10 of 24 isolates with Q148H/K/R with additional INSTI resistance associated substitutions had \leq 2.5-fold reduced susceptibility to bictegravir; > 2.5-fold reduced susceptibility to bictegravir was found for 14 of the 24 isolates that contained G140A/C/S and Q148H/R/K substitutions in integrase. Of those, 9 of the 14 isolates had additional mutations at L74M, T97A, or E138A/K. In a separate study, site-directed mutants with G118R and T97A+G118R had 3.4- and 2.8-fold reduced susceptibility to bictegravir, respectively. The relevance of these *in vitro* cross-resistance data remains to be established in clinical practice.

Bictegravir demonstrated equivalent antiviral activity against 5 nonnucleoside reverse transcriptase inhibitor (NNRTI)-resistant, 3 NRTI-resistant, and 4 protease inhibitor (PI)-resistant HIV-1 mutant clones compared with the wild-type strain.

Emtricitabine-resistant viruses with the M184V/I substitution were cross-resistant to lamivudine, but retained sensitivity to didanosine, stavudine, tenofovir, and zidovudine.

The K65R and K70E mutations result in reduced susceptibility to abacavir, didanosine, lamivudine, emtricitabine, and tenofovir, but retain sensitivity to zidovudine. Multinucleoside resistant HIV-1 with a T69S double insertion mutation or with a Q151M mutation complex including K65R showed reduced susceptibility to tenofovir alafenamide.

Clinical data

The efficacy and safety of Biktarvy in HIV-1 infected, treatment-naïve adults are based on 48-week and 144-week data from two randomised, double-blind, active-controlled studies, GS-US-380-1489 (n = 629) and GS-US-380-1490 (n = 645). Furthermore, additional efficacy and safety data are available from adults who received open-label Biktarvy for an additional 96 weeks after Week 144 in an optional extension phase of these studies (n = 1025).

The efficacy and safety of Biktarvy in virologically-suppressed HIV-1 infected adults are based on 48-week data from a randomised, double-blind, active-controlled study, GS-US-380-1844 (n = 563); and a randomised, open label, active-controlled study, GS-US-380-1878 (n = 577).

HIV-1 infected, treatment-naïve patients

In Study GS-US-380-1489, patients were randomised in a 1:1 ratio to receive either bicitgravir/emtricitabine/tenofovir alafenamide (B/F/TAF) (n = 314) or abacavir/dolutegravir/lamivudine (600/50/300 mg) (n = 315) once daily. In Study GS-US-380-1490, patients were randomised in a 1:1 ratio to receive either B/F/TAF (n = 320) or dolutegravir + emtricitabine/tenofovir alafenamide (50+200/25 mg) (n = 325) once daily.

In Studies GS-US-380-1489 and GS-US-380-1490, the mean age was 35 years (range 18-77), 89% were male, 58% were White, 33% were Black, and 3% were Asian. Twenty-four percent of patients identified as Hispanic/Latino. The prevalence of different subtypes was comparable across all three treatment groups, with subtype B predominant in both groups; 11% were non-B subtypes. The mean baseline plasma HIV-1 RNA was 4.4 log₁₀ copies/mL (range 1.3-6.6). The mean baseline CD4+ cell count was 460 cells/mm³ (range 0-1,636) and 11% had CD4+ cell counts less than 200 cells/mm³. Eighteen percent of patients had baseline viral loads greater than 100,000 copies/mL. In both studies, patients were stratified by baseline HIV-1 RNA (less than or equal to 100,000 copies/mL, greater than 100,000 copies/mL to less than or equal to 400,000 copies/mL, or greater than 400,000 copies/mL), by CD4+ cell count (less than 50 cells/μL, 50-199 cells/μL, or greater than or equal to 200 cells/μL), and by region (US or ex-US).

Treatment outcomes of Studies GS-US-380-1489 and GS-US-380-1490 through Weeks 48 and 144 are presented in Table 3.

Table 3: Pooled virologic outcomes of Studies GS-US-380-1489 and GS-US-380-1490 at Weeks 48^a and 144^b

	Week 48			Week 144		
	B/F/TAF (n = 634) ^c	ABC/DTG/ 3TC (n = 315) ^d	DTG + F/TAF (n = 325) ^e	B/F/TAF (n = 634) ^c	ABC/DTG /3TC (n = 315) ^d	DTG + F/TAF (n = 325) ^e
HIV-1 RNA < 50 copies/mL	91%	93%	93%	82%	84%	84%
Treatment difference (95% CI) B/F/TAF vs Comparator	-	-2.1% (-5.9% to 1.6%)	-1.9% (-5.6% to 1.8%)	-	-2.7% (-7.8% to 2.4%)	-1.9% (-7.0% to 3.1%)
HIV-1 RNA ≥ 50 copies/mL^f	3%	3%	1%	3%	3%	3%
No virologic data at week 48 or 144 window	6%	4%	6%	16%	13%	13%
Discontinued study drug due to AE or death ^g	<1%	1%	1%	2%	2%	3%

	Week 48			Week 144		
	B/F/TAF (n = 634) ^c	ABC/DTG/ 3TC (n = 315) ^d	DTG + F/TAF (n = 325) ^e	B/F/TAF (n = 634) ^c	ABC/DTG /3TC (n = 315) ^d	DTG + F/TAF (n = 325) ^e
Discontinued study drug due to other reasons and last available HIV-1 RNA < 50 copies/mL ^h	4%	3%	4%	13%	11%	9%
Missing data during window but on study drug	2%	<1%	1%	1%	≤1%	1%
Proportion (%) of patients with HIV-1 RNA < 50 copies/mL by subgroup						
By baseline viral load						
≤ 100,000 copies/mL	92%	94%	93%	82%	86%	84%
> 100,000 copies/mL	87%	90%	94%	79%	74%	83%
By baseline CD4+ cell count						
< 200 cells/mm ³	90%	81%	100%	80%	69%	91%
≥ 200 cells/mm ³	91%	94%	92%	82%	86%	83%
HIV-1 RNA < 20 copies/mL	85%	87%	87%	78%	82%	79%

ABC = abacavir DTG = dolutegravir 3TC = lamivudine F/TAF = emtricitabine/tenofovir alafenamide

a Week 48 window was between Day 295 and 378 (inclusive).

b Week 144 window was between Day 967 and 1050 (inclusive).

c Pooled from Study GS-US-380-1489 (n=314) and Study GS-US-380-1490 (n = 320).

d Study GS-US-380-1489.

e Study GS-US-380-1490.

f Includes patients who had ≥ 50 copies/mL in the Week 48 or 144 window; patients who discontinued early due to lack or loss of efficacy (n = 0); patients who discontinued for reasons other than an adverse event (AE), death or lack or loss of efficacy (B/F/TAF n = 12 and 15; ABC/DTG/3TC n = 2 and 7; DTG+F/TAF n = 3 and 6, at Weeks 48 and 144, respectively) and at the time of discontinuation had a viral value of ≥ 50 copies/mL.

g Includes patients who discontinued due to AE or death at any time point from Day 1 through the time window if this resulted in no virologic data on treatment during the specified window.

h Includes patients who discontinued for reasons other than an AE, death or lack or loss of efficacy, e.g. withdrew consent, loss to follow-up, etc.

B/F/TAF was non-inferior in achieving HIV-1 RNA < 50 copies/mL at both Weeks 48 and 144 when compared to abacavir/dolutegravir/lamivudine and to dolutegravir + emtricitabine/tenofovir alafenamide, respectively. Treatment outcomes between treatment groups were similar across subgroups by age, sex, race, baseline viral load, baseline CD4+ cell count, and region.

In Studies GS-US-380-1489 and GS-US-380-1490, the mean increase from baseline in CD4+ cell count at Week 144 was 288, 317, and 289 cells/mm³ in the pooled B/F/TAF, abacavir/dolutegravir/lamivudine, and dolutegravir + emtricitabine/tenofovir alafenamide groups, respectively.

In the optional 96 week open-label extension phase of Studies GS-US-380-1489 and GS-US-380-1490, high rates of virologic suppression were achieved and maintained.

HIV-1 infected, virologically-suppressed patients

In Study GS-US-380-1844, the efficacy and safety of switching from a regimen of dolutegravir + abacavir/lamivudine or abacavir/dolutegravir/lamivudine to B/F/TAF were evaluated in a randomised, double-blind study of virologically-suppressed (HIV-1 RNA < 50 copies/mL) HIV-1 infected adults (n=563). Patients must have been stably suppressed (HIV-1 RNA < 50 copies/mL) on their baseline regimen for at least 3 months prior to study entry. Patients were randomised in a 1:1 ratio to either switch to B/F/TAF at baseline (n = 282), or stay on their baseline antiretroviral regimen (n=281).

Patients had a mean age of 45 years (range 20-71), 89% were male, 73% were White, and 22% were Black. Seventeen percent of patients identified as Hispanic/Latino. The prevalence of different HIV-1 subtypes was comparable between treatment groups, with subtype B predominant in both groups; 5% were non-B subtypes. The mean baseline CD4+ cell count was 723 cells/mm³ (range 124-2,444).

In Study GS-US-380-1878, the efficacy and safety of switching from either abacavir/lamivudine or emtricitabine/tenofovir disoproxil fumarate (200/300 mg) plus atazanavir or darunavir (boosted by either cobicistat or ritonavir) to B/F/TAF were evaluated in a randomised, open-label study of virologically-suppressed HIV-1 infected adults (n = 577). Patients must have been stably suppressed on their baseline regimen for at least 6 months and must not have been previously treated with any INSTI. Patients were randomised in a 1:1 ratio to either switch to B/F/TAF (n = 290), or stay on their baseline antiretroviral regimen (n = 287). Patients had a mean age of 46 years (range 20-79), 83% were male, 66% were White, and 26% were Black. Nineteen percent of patients identified as Hispanic/Latino. The mean baseline CD4+ cell count was 663 cells/mm³ (range 62-2,582). The prevalence of different subtypes was comparable across treatment groups, with subtype B predominant in both groups; 11% were non-B subtypes. Patients were stratified by prior treatment regimen. At screening, 15% of patients were receiving abacavir/lamivudine plus atazanavir or darunavir (boosted by either cobicistat or ritonavir) and 85% of patients were receiving emtricitabine/tenofovir disoproxil fumarate plus atazanavir or darunavir (boosted by either cobicistat or ritonavir).

Treatment outcomes of Studies GS-US-380-1844 and GS-US-380-1878 through Week 48 are presented in Table 4.

Table 4: Virologic outcomes of Studies GS-US-380-1844 and GS-US-380-1878 at Week 48^a

	Study GS-US-380-1844		Study GS-US-380-1878	
	B/F/TAF(n = 282)	ABC/DTG/3TC (n = 281)	B/F/TAF (n = 290)	Baseline ATV- or DRV-based regimen (n = 287)
HIV-1 RNA < 50 copies/mL	94%	95%	92%	89%
Treatment difference (95% CI)	-1.4% (-5.5% to 2.6%)		3.2% (-1.6% to 8.2%)	
HIV-1 RNA ≥ 50 copies/mL^b	1%	<1%	2%	2%
Treatment difference (95% CI)	0.7% (-1.0% to 2.8%)		0.0% (-2.5% to 2.5%)	
No virologic data at Week 48 window	5%	5%	6%	9%
Discontinued study drug due to AE or death and last available HIV-1 RNA < 50 copies/mL	2%	1%	1%	1%
Discontinued study drug due to other reasons and last available HIV-1 RNA < 50 copies/mL ^c	2%	3%	3%	7%
Missing data during window but on study drug	2%	1%	2%	2%

ABC = abacavir ATV = atazanavir DRV = darunavir DTG = dolutegravir 3TC = lamivudine

a Week 48 window was between Day 295 and 378 (inclusive).

b Includes patients who had ≥ 50 copies/mL in the Week 48 window; patients who discontinued early due to lack or loss of efficacy; patients who discontinued for reasons other than lack or loss of efficacy and at the time of discontinuation had a viral value of ≥ 50 copies/mL.

c Includes patients who discontinued for reasons other than an AE, death or lack or loss of efficacy, e.g. withdrew consent, loss to follow-up, etc.

B/F/TAF was non-inferior to the control regimen in both studies. Treatment outcomes between treatment groups were similar across subgroups by age, sex, race, and region.

In GS-US-380-1844, the mean change from baseline in CD4+ cell count at Week 48 was -31 cells/mm³ in patients who switched to B/F/TAF and 4 cells/mm³ in patients who stayed on abacavir/dolutegravir/lamivudine. In GS-US-380-1878, the mean change from baseline in CD4+ cell count at Week 48 was 25 cells/mm³ in patients who switched to B/F/TAF and 0 cells/mm³ in patients who stayed on their baseline regimen.

Patients co-infected with HIV and HBV

The number of patients co-infected with HIV and HBV treated with B/F/TAF is limited. In Study GS-US-380-1490, 8 patients with HIV/HBV co-infection at baseline were randomised to receive B/F/TAF. At Week 48, 7 patients were HBV suppressed (HBV DNA < 29 IU/mL) and had HIV-1 RNA < 50 copies/mL. One patient had missing HBV DNA data at Week 48. At Week 144, 5 patients were HBV suppressed and had HIV-1 RNA < 50 copies/mL. Three patients had missing HBV DNA data at Week 144 (1 lost to follow-up from Week 48, 1 lost to follow-up after Week 72, and 1 lost to follow-up after Week 120).

In Study GS-US-380-1878, at Week 48, 100% (8/8) of the patients co-infected with HIV/HBV at baseline in the B/F/TAF arm maintained HBV DNA < 29 IU/mL (missing = excluded analysis) and HIV RNA < 50 copies/mL.

5.2 Pharmacokinetic properties

Absorption

Bictegravir is absorbed following oral administration with peak plasma concentrations occurring at 2.0-4.0 hours after administration of B/F/TAF. Relative to fasting conditions, the administration of B/F/TAF with either a moderate fat (~600 kcal, 27% fat) or high fat meal (~800 kcal, 50% fat) resulted in an increase in bictegravir AUC (24%). This modest change is not considered clinically meaningful and B/F/TAF can be administered with or without food.

Following oral administration of B/F/TAF with or without food in HIV-1 infected adults, the multiple dose mean (CV%) pharmacokinetic parameters of bictegravir were $C_{\max} = 6.15 \mu\text{g/mL}$ (22.9%), $\text{AUC}_{\text{tau}} = 102 \mu\text{g}\cdot\text{h/mL}$ (26.9%), and $C_{\text{trough}} = 2.61 \mu\text{g/mL}$ (35.2%).

Emtricitabine is rapidly and extensively absorbed following oral administration with peak plasma concentrations occurring at 1.5-2.0 hours after administration of B/F/TAF. The mean absolute bioavailability of emtricitabine from 200 mg hard capsules was 93%. Emtricitabine systemic exposure was unaffected when emtricitabine was administered with food and B/F/TAF can be administered with or without food.

Following oral administration of B/F/TAF with or without food in HIV-1 infected adults, the multiple dose mean (CV%) pharmacokinetic parameters of emtricitabine were $C_{\max} = 2.13 \mu\text{g/mL}$ (34.7%), $\text{AUC}_{\text{tau}} = 12.3 \mu\text{g}\cdot\text{h/mL}$ (29.2%), and $C_{\text{trough}} = 0.096 \mu\text{g/mL}$ (37.4%).

Tenofovir alafenamide is rapidly absorbed following oral administration with peak plasma concentrations occurring at 0.5-2.0 hours after administration of B/F/TAF. Relative to fasting conditions, the administration of tenofovir alafenamide with a moderate fat meal (~600 kcal, 27% fat) and a high fat meal (~800 kcal, 50% fat) resulted in an increase in AUC_{last} by 48% and 63%, respectively. These modest changes are not considered clinically meaningful and B/F/TAF can be administered with or without food.

Following oral administration of B/F/TAF with or without food in HIV-1 infected adults, the multiple dose mean (CV%) pharmacokinetic parameters of tenofovir alafenamide were $C_{\max} = 0.121 \mu\text{g/mL}$ (15.4%), and $\text{AUC}_{\text{tau}} = 0.142 \mu\text{g}\cdot\text{h/mL}$ (17.3%).

Distribution

In vitro binding of bicitegravir to human plasma proteins was > 99% (free fraction ~0.25%). The *in vitro* human blood to plasma bicitegravir concentration ratio was 0.64.

In vitro binding of emtricitabine to human plasma proteins was < 4% and independent of concentration over the range of 0.02 to 200 µg/mL. At peak plasma concentration, the mean plasma to blood drug concentration ratio was ~1.0 and the mean semen to plasma drug concentration ratio was ~4.0.

In vitro binding of tenofovir to human plasma proteins is ≤ 0.7% and is independent of concentration over the range of 0.01-25 µg/mL. *Ex-vivo* binding of tenofovir alafenamide to human plasma proteins in samples collected during clinical studies was approximately 80%.

Biotransformation

Metabolism is the major clearance pathway for bicitegravir in humans. *In vitro* phenotyping studies showed that bicitegravir is primarily metabolised by CYP3A and UGT1A1. Following a single dose oral administration of [¹⁴C]-bicitegravir, ~60% of the dose from faeces included unchanged parent, desfluoro-hydroxy-BIC-cysteine-conjugate, and other minor oxidative metabolites. Thirty-five percent of the dose was recovered from urine and consisted primarily of the glucuronide of bicitegravir and other minor oxidative metabolites and their phase II conjugates. Renal clearance of the unchanged parent was minimal.

Following administration of [¹⁴C]-emtricitabine, complete recovery of the emtricitabine dose was achieved in urine (~86%) and faeces (~14%). Thirteen percent of the dose was recovered in the urine as three putative metabolites. The biotransformation of emtricitabine includes oxidation of the thiol moiety to form the 3'-sulfoxide diastereomers (~9% of dose) and conjugation with glucuronic acid to form 2'-O-glucuronide (~4% of dose). No other metabolites were identifiable.

Metabolism is a major elimination pathway for tenofovir alafenamide in humans, accounting for > 80% of an oral dose. *In vitro* studies have shown that tenofovir alafenamide is metabolised to tenofovir (major metabolite) by cathepsin A in PBMCs (including lymphocytes and other HIV target cells) and macrophages; and by carboxylesterase-1 in hepatocytes. *In vivo*, tenofovir alafenamide is hydrolysed within cells to form tenofovir (major metabolite), which is phosphorylated to the active metabolite, tenofovir diphosphate. In human clinical studies, a 25 mg oral dose of tenofovir alafenamide resulted in tenofovir diphosphate concentrations > 4-fold higher in PBMCs and > 90% lower concentrations of tenofovir in plasma as compared to a 245 mg oral dose of tenofovir disoproxil.

Elimination

Bicitegravir is primarily eliminated by hepatic metabolism. Renal excretion of intact bicitegravir is a minor pathway (~1% of dose). The plasma bicitegravir half-life was 17.3 hours.

Emtricitabine is primarily excreted by the kidneys by both glomerular filtration and active tubular secretion. The plasma emtricitabine half-life was approximately 10 hours.

Tenofovir alafenamide is eliminated following metabolism to tenofovir. Tenofovir alafenamide and tenofovir have a median plasma half-life of 0.51 and 32.37 hours, respectively. Tenofovir is eliminated by the kidneys by both glomerular filtration and active tubular secretion. Renal excretion of intact tenofovir alafenamide is a minor pathway with less than 1% of the dose eliminated in urine.

Linearity

The multiple dose pharmacokinetics of bicitegravir are dose proportional over the dose range of 25 to 100 mg. The multiple dose pharmacokinetics of emtricitabine are dose proportional over the dose

range of 25 to 200 mg. Tenofovir alafenamide exposures are dose proportional over the dose range of 8 mg to 125 mg.

Other special populations

Renal impairment

No clinically relevant differences in bicitegravir, tenofovir alafenamide, or tenofovir pharmacokinetics were observed between healthy subjects and subjects with severe renal impairment (estimated CrCl < 30 mL/min). There are no pharmacokinetic data on bicitegravir or tenofovir alafenamide in patients with creatinine clearance less than 15 mL/min. Mean systemic emtricitabine exposure was higher in patients with severe renal impairment (CrCl < 30 mL/min) (33.7 µg•h/mL) than in subjects with normal renal function (11.8 µg•h/mL).

Hepatic impairment

Clinically relevant changes in the pharmacokinetics of bicitegravir were not observed in subjects with moderate hepatic impairment. The pharmacokinetics of emtricitabine have not been studied in subjects with hepatic impairment; however, emtricitabine is not significantly metabolised by liver enzymes, so the impact of liver impairment should be limited. Clinically relevant changes in the pharmacokinetics of tenofovir alafenamide or its metabolite tenofovir were not observed in patients with mild, moderate, or severe hepatic impairment.

Age, gender and race

Pharmacokinetics of bicitegravir, emtricitabine, and tenofovir have not been fully evaluated in the elderly (≥ 65 years of age). Population analyses using pooled pharmacokinetic data from adult studies did not identify any clinically relevant differences due to age, gender or race on the exposures of bicitegravir, emtricitabine, or tenofovir alafenamide.

5.3 Preclinical safety data

Bicitegravir was not mutagenic or clastogenic in conventional genotoxicity assays.

Bicitegravir was not carcinogenic in a 6-month rasH2 transgenic mouse study (at doses of up to 100 mg/kg/day in males and 300 mg/kg/day in females, which resulted in exposures of approximately 15 and 23 times, in males and females, respectively, the exposure in humans at the recommended human dose) nor in a 2-year rat study (at doses of up to 300 mg/kg/day, which resulted in exposures of approximately 31 times the exposure in humans).

Studies of bicitegravir in monkeys revealed the liver as the primary target organ of toxicity. Hepatobiliary toxicity was described in a 39-week study at a dosage of 1,000 mg/kg/day, which resulted in exposures of approximately 16 times the exposure in humans at the recommended human dose, and was partially reversible after a 4-week recovery period.

Studies in animals with bicitegravir have shown no evidence of teratogenicity or an effect on reproductive function. In offspring from rat and rabbit dams treated with bicitegravir during pregnancy, there were no toxicologically significant effects on developmental endpoints.

Non-clinical data on emtricitabine reveal no special hazard for humans based on conventional studies of safety pharmacology, repeated dose toxicity, genotoxicity, carcinogenic potential, toxicity to reproduction and development. Emtricitabine has demonstrated low carcinogenic potential in mice and rats.

Non-clinical studies of tenofovir alafenamide in rats and dogs revealed bone and kidney as the primary target organs of toxicity. Bone toxicity was observed as reduced bone mineral density in rats and dogs at tenofovir exposures at least 43 times greater than those expected after administration of B/F/TAF. A minimal infiltration of histiocytes was present in the eye in dogs at tenofovir alafenamide and tenofovir exposures of approximately 14 and 43 times greater, respectively, than those expected after administration of B/F/TAF.

Tenofovir alafenamide was not mutagenic or clastogenic in conventional genotoxicity assays.

Because there is a lower tenofovir exposure in rats and mice after the administration of tenofovir alafenamide compared to tenofovir disoproxil, carcinogenicity studies and a rat peri-postnatal study were conducted only with tenofovir disoproxil. No special hazard for humans was revealed in conventional studies of carcinogenic potential and toxicity to reproduction and development. Reproductive toxicity studies in rats and rabbits showed no effects on mating, fertility, pregnancy or foetal parameters. However, tenofovir disoproxil reduced the viability index and weight of pups in a peri-postnatal toxicity study at maternally toxic doses.

6. PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Tablet core

Microcrystalline cellulose
Croscarmellose sodium
Magnesium stearate

Film-coating

Polyvinyl alcohol
Titanium dioxide (E171)
Polyethylene glycol
Talc
Iron oxide red (E172)
Iron oxide black (E172)

6.2 Incompatibilities

Not applicable.

6.3 Shelf life

The expiry date of the product is indicated on the packaging materials.

6.4 Special precautions for storage

No special storage conditions are required. Storage at room temperature is recommended.

Bottle

Store in the original package in order to protect from moisture. Keep the bottle tightly closed. Do not use if seal over bottle opening is broken or missing.

Blister

Store in the original package in order to protect from moisture. Do not use if foil over blister is broken or pierced.

6.5 Nature and contents of container

The following pack configurations are available:

White, high density polyethylene (HDPE) bottle with a polypropylene continuous-thread, child-resistant cap, lined with an induction activated aluminium foil liner containing 30 film-coated tablets. Each bottle contains silica gel desiccant and polyester coil.

Outer carton containing 1 bottle of 30 film-coated tablets.

Blister packs consisting of polyvinyl chloride/polyethylene/polychlorotrifluoroethylene (PVC/PE/PCTFE) film, sealed to aluminium foil lidding material fitted with a molecular sieve desiccant within each blister cavity.

- Outer carton containing 30 film-coated tablets (4 x blister strips containing 7 film-coated tablets and 1 x blister strip containing 2 film-coated tablets).
- Outer carton containing 90 (3 blister packs of 30) film-coated tablets.

Not all pack sizes may be marketed.

6.6 Special precautions for disposal

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

7. MANUFACTURER

Gilead Sciences Ireland UC
IDA Business & Technology Park
Carrigtohill
County Cork
Ireland

8. REGISTRATION HOLDER

Gilead Sciences Israel Ltd.
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