Renal Dose Adjustments[1]

NRTIs	
didanosine	≥ 60 kg: CrCl 30-59: (buffered) 100 mg bid or 200 mg qd, (EC) 200 mg qd; CrCl 10-29: (buffered) 150 mg qd, (EC) 125 mg qd; CrCl < 10, HD[2] or CAPD: (buffered) 100 mg qd, (EC) 125 mg qd < 60 kg: CrCl 30-59: (buffered) 75 mg bid or 150 mg qd, (EC) 125 mg qd; CrCl 10-29: (buffered) 100 mg qd, (EC) 125 mg qd; CrCl < 10, HD[2] or CAPD: (buffered) 75 mg qd
emtricitabine	CrCl 30-49: 200 mg cap q48h or 120 mg soln. q24h; CrCl 15-29: 200 mg cap q72h or 80 mg soln. q24h; CrCl < 15 or HD[2]: 200 mg cap q96h or 60 mg soln. q24h
lamivudine	CrCl 30-49: 150 mg qd; CrCl 15-29: 150 mg x 1 then 100 mg qd; CrCl 5-14: 150 mg x 1 then 50 mg qd; CrCl < 5 or HD[2]: 50 mg x 1 then 25 mg qd
stavudine	≥ 60 kg: CrCl 26-50: 20 mg q12h, CrCl ≤ 25 or HD[2]: 20 mg q24h; < 60 kg: CrCl 26-50: 15 mg q12h, CrCl ≤ 25 or HD[2]: 15 mg q24h
tenofovir	CrCl 30-49: 300 mg q48h; CrCl 10-29: 300 mg twice weekly; CrCl < 10 or HD[2]: 300 mg qweek
tenofovir + emtricitabine (Truvada®)	CrCl 30-49 one tab q48h; CrCl < 30 combo product cannot be used; see dosing for individual agents
zidovudine	CrCl < 15 or HD[2]: 100 mg TID

1. There are no renal dose adjustment recommendations for ABC, PIs, NNRTIs, and T-20
2. Dose after HD on HD days

Creatinine Clearance Calculation:

$$\text{CrCl} = \frac{(140\text{-age}) \times (\text{IBW in kg})}{\text{Serum Cr} \times 72} \times (0.85 \text{ if female})$$

Estimate Ideal Body Weight (IBW) in kg:

IBW = (50 kg ♂ or 45.5 kg ♀) + 2.3 kg for each in. > 5 ft.

Note: If Actual Body Wt. (ABW) is < IBW, use ABW for calculation

Dual NRTI, Boosted PI, Dual PI, PI/NRTI, PI/NNRTI Combination Dose Adjustments

Combination	Adjustment
didanosine + tenofovir [1]	≥ 60 kg: ↓ ddI dose to 250 mg qd < 60 kg: ↓ ddI dose to 200 mg qd
atazanavir + ritonavir	ATV 300 mg qd + RTV 100 mg qd (PI-exp or naïve)
atazanavir + tenofovir	ATV 300 mg qd + RTV 100 mg qd + TDF 300 mg qd
atazanavir + efavirenz	ATV 300 mg qd + RTV 100 mg qd + EFV 600 mg qd
fosamprenavir + efavirenz	f-APV 700 mg bid + RTV 100 mg bid + EFV 600 mg qd
fosamprenavir + ritonavir	fos-APV 1400 mg qd + RTV 200 mg qd (PI-naïve) [2] fos-APV 700 mg bid + RTV 100 mg bid (PI-naïve or exp)
indinavir + ritonavir	IDV 800 mg bid + RTV 100 - 200 mg bid
indinavir + efavirenz or nevirapine	IDV 1000 mg q8h (or IDV 800 mg bid + RTV 100-200 mg bid) with EFV or NVP standard dose
lopinavir/ritonavir + efavirenz or nevirapine	↑ KAL dose to 3 tabs bid with EFV or NVP standard dose
saquinavir + ritonavir [3]	SQV 1000 mg bid + RTV 100 mg bid
saquinavir + lopinavir/ritonavir [3]	SQV 1000 mg bid + KAL 2 tabs bid

1. CAUTION: early failure seen with combination of TDF + ddI when used with NVP or EFV
2. fosamprenavir + ritonavir qd regimen should not be used in PI-exp patients
3. Invirase® should only be used in combination with ritonavir or Kaletra®

Hepatic Dose Adjustments[1]

NRTIs	
abacavir [2]	Mild (Child-Pugh 5-6): 200 mg bid; Moderate/Severe: Contraindicated
zidovudine	No dose adjustment recommended, monitor for toxicity
NNRTIs	
delavirdine or efavirenz	Use with caution-no recommendation
nevirapine	Avoid use with moderate to severe hepatic impairment
PIs	
amprenavir	Child-Pugh 5-8: 450 mg bid; Child-Pugh 9-12: 300 mg bid
atazanavir	Child-Pugh Class B: 300 mg qd; Class C: not recommended
fosamprenavir	Child-Pugh 5-8: 700 mg bid; Child-Pugh 9-12: Not recommended. Ritonavir boosting not advised with hepatic disease
indinavir	Mild to moderate insufficiency with cirrhosis: 600 mg q8h; no data in severe hepatic impairment
lopinavir/ritonavir	Use with caution; no dosing information available
nelfinavir	Use with caution; no dosing information available
ritonavir	No adjustment for mild impairment; no data for moderate/severe impairment-use with caution
saquinavir	Use with caution; no dosing information available
tipranavir	Use with caution. Contraindicated with moderate/severe impairment (Child-Pugh Class B & C)

1. There are no hepatic dose adjustment recommendations for other NRTIs and T-20
2. http://us.gsk.com/products/assets/us_ziagen_tablets.pdf

Child-Pugh Score (add scores for each category to determine class)

Score	1	2	3
Encephalopathy*	None	Grade 1-2	Grade 3-4
Ascites	None	Mild or controlled by diuretics	Moderate or refractory to diuretics
Albumin	> 3.5 g/dL	2.8-3.5 g/dL	< 2.8 g/dL
Total Bilirubin or	< 2 mg/dL	2-3 mg/dL	> 3 mg/dL
Modified Total Bilirubin**	< 4 mg/dL	4-7 mg/dL	> 7 mg/dL
Prothrombin time or INR	< 4 < 1.7	4-6 1.7-2.3	> 6 > 2.3

*Grade 1: mild confusion, anxiety, restlessness, fine tremor, slowed coordination; Grade 2: drowsiness, disorientation, asterixis; Grade 3: somnolent but rousable, marked confusion, incomprehensible speech, incontinent, hyperventilation; Grade 4: coma, decerebrate posturing, flaccidity

**Modified Total Bilirubin used to score patients with Gilbert's Syndrome or taking IDV or ATV

Class A: Score 5-6; Class B: Score 7-9; Class C: Score > 9

ARV Components Not Recommended as Part of *Initial* Therapy

Agent(s)	Comments
ddC + AZT	Inferior efficacy; higher rates of adverse effects
TDF + ddI + NNRTI	High rate of early virologic failure and rapid development of resistance
delavirdine	Inferior efficacy; inconvenient dosing
amprenavir (boosted or unboosted)	High pill burden
indinavir (unboosted)	Inconvenient dosing; meal restrictions
ritonavir as sole PI	High pill burden; GI intolerance
tipranavir/ritonavir	Lack of data in treatment-naïve patients
enfuvirtide (T-20)	Lack of data in treatment-naïve patients; requires bid injections

Please visit our website at

www.FAETC.org

Antiretroviral Regimens or Components Not Recommended at Any Time

Regimens	Comments
Monotherapy	Zidovudine monotherapy may be considered for use in pregnant women to prevent perinatal transmission if pre-treatment VL < 1000 copies/mL; combination therapy preferred
Two-agent drug combinations	Rapid development of resistance. Inferior to 3 or more drugs. If virologic goals are achieved, some clinicians may choose to continue
ABC + TDF + 3TC (or FTC)	High rate of early virologic non-response seen in ARV-naïve patients
TDF + ddI + 3TC (or FTC)	High rate of early virologic non-response seen in ARV-naïve patients
d4T + AZT	Both thymidine analogs; antagonistic
ddC + d4T	Additive peripheral neuropathy
ddC + ddI	Additive peripheral neuropathy
ddC + 3TC	In vitro antagonism
d4T + ddI	Increased risk of toxicities such as lactic acidosis and pancreatitis; May be considered when no other options available and potential benefits outweigh the risks. Reports of fatalities when used in pregnancy
FTC + 3TC	Similar resistance profile; no potential benefit
amprenavir oral solution	Contains large amounts of propylene glycol; contraindicated in pregnancy, children < 4 years old, renal or hepatic failure, and those taking metronidazole, disulfiram, or ritonavir oral solution
amprenavir oral solution + ritonavir oral solution	Should not be combined due to propylene glycol content of amprenavir solution/alcohol content of ritonavir solution
amprenavir + fosamprenavir	Amprenavir is active component of both drugs; no benefit in combination
atazanavir + indinavir	Potential for additive hyperbilirubinemia
saquinavir hard gel capsule or tablet (Invirase®) as single PI	Must be combined with other PIs such as ritonavir or lopinavir/ritonavir due to poor bioavailability
efavirenz in 1st trimester of pregnancy or in women with pregnancy potential	Teratogenic - consider use only when no other options available and potential benefits outweigh risks
nevirapine initiation in women with CD4 > 250 or in men with CD4 > 400	Higher incidence of symptomatic hepatic events; use only if potential benefits outweigh risks

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Antiretroviral Therapy in Adults and Adolescents

February 2006

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Antiretroviral Regimens Recommended for Treatment of HIV-1 in Antiretroviral Naïve Patients

NNRTI - Based Regimens	
Preferred	efavirenz[1] + (3TC[2] or FTC[3]) + (AZT[2] or TDF[3])
Alternative	efavirenz[1] + (3TC[4] or FTC) + (ddI or ABC[4] or d4T[5]) nevirapine[6] + (3TC[2,4] or FTC[3]) + (AZT[2] or d4T[5] or ddI or ABC[4] or TDF[3])
PI - Based Regimens	
Preferred	lopinavir/ritonavir + (3TC[2] or FTC) + AZT[2]
Alternative	atazanavir[7] + (3TC[2,4] or FTC[3]) + (AZT[2] or d4T[5] or ABC[4] or ddI or TDF[3,7]) fosamprenavir ± ritonavir[8] + (3TC[2,4] or FTC[3]) + (AZT[2] or d4T[5] or ABC[4] or ddI or TDF[3]) indinavir + ritonavir[8] + (3TC[2,4] or FTC[3]) + (AZT[2] or d4T[5] or ABC[4] or ddI or TDF[3]) lopinavir/ritonavir + (3TC[4] or FTC[3]) + (d4T[5] or ABC[4] or ddI or TDF[3]) nelfinavir + (3TC[2,4] or FTC[3]) + (AZT[2] or d4T[5] or ABC[4] or ddI or TDF[3]) saquinavir (HGC or tablets) + ritonavir[8] + (3TC[2,4] or FTC[3]) + (AZT[2] or d4T[5] or ABC[4] or ddI or TDF[3])

Triple NRTI Regimen - Only when an NNRTI- or PI-based regimen cannot or should not be used as first line therapy	
Alternative	ABC + 3TC + AZT[9]

1. Except for women in first trimester of pregnancy or women with high pregnancy potential due to teratogenic possibility
2. Lamivudine (3TC) + Zidovudine (AZT) available in combination as Combivir®
3. Emtricitabine (FTC) + Tenofovir (TDF) available in combination as Truvada®
4. Abacavir (ABC) + Lamivudine (3TC) available in combination as Epzicom®
5. Higher incidence of lipoatrophy, hyperlipidemia, and mitochondrial toxicities with stavudine (d4T)
6. Note: Higher incidence of hepatotoxicity in women with pre-nevirapine CD4+ cell counts > 250 cells/mm^3 and in men with pre-nevirapine CD4+ cell counts > 400 cells/mm^3
7. Boosted atazanavir regimen (300 mg qd + ritonavir 100 mg qd) recommended with tenofovir (TDF) or in PI-experienced patients
8. See Combination Table for dose recommendations
9. Abacavir (ABC) + Lamivudine (3TC) + Zidovudine (AZT) available in combination as Trizivir®

Warmline:

National HIV Telephone Consultation Services

1-800-933-3413

PEPline:

National Clinicians' Post-Exposure Prophylaxis Hotline

1-888-HIV-4911 (448-4911)

Perinatal Hotline

1-888-448-8765

NUCLEOSIDE/NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTIs)

Class adverse effects: *Lactic acidosis with hepatic steatosis*

Abacavir (Ziagen®, ABC)

Dosage form: 300 mg tab, 20 mg/mL solution
Adult dose: 300 mg po bid or 600 mg po qd

Patient Counseling Points:
- Alcohol ↑ ABC levels 41%; potential for adverse effects
- AEs: Hypersensitivity reaction occurs in 2-9% of patients, characterized by a sign or symptom from 2 or more of the following groups: G1: fever; G2: rash; G3: nausea, vomiting, diarrhea, or abdominal pain; G4: malaise, fatigue, or achiness; G5: dyspnea, cough, or pharyngitis. Onset is usually in 1st 4-6 weeks
  Discontinue drug promptly and **DO NOT RECHALLENGE!**

Didanosine (Videx®, Videx EC®, ddI)

Dosage form: 25, 50, 100, 150, 200 mg Videx® buffered tab (no longer available in U.S.)
Pediatric powder for oral solution 10 mg/mL (2g or 4g bottle)
125, 200, 250, 400 mg cap (Videx EC®, generic available)
Adult dose: ≥ 60 kg: 200 mg po bid or 400 mg po qd
< 60 kg: 125 mg po bid or 250 mg po qd
Dose with tenofovir: ≥ 60 kg: ↓ ddI dose to 250 mg qd
< 60 kg: ↓ ddI dose to 200 mg qd

Patient Counseling Points:
- Must chew tabs or dissolve in non-acidic liquid (Videx® only)
- Take on empty stomach, 30 min ac or 2 hr pc (Videx® and Videx EC®) - except when given with tenofovir-can be with or without food
- Drug interactions with non-enteric coated formulation due to buffer
- Swallow Videx EC® capsules whole; do not crush, chew or break open
- AEs: peripheral neuropathy, pancreatitis, diarrhea (less with Videx EC®), nausea

Emtricitabine (Emtriva®, FTC)

Dosage form: 200 mg cap, 10mg/mL oral solution
Adult dose: 200 mg cap or 240 mg (24mL) solution po qd

Patient Counseling Points:
- AEs: Generally well-tolerated, hyperpigmentation of palms/soles seen in up to 6% of patients (more common in Black and Hispanic patients)
- Solution should be refrigerated or used within 3 mos. if stored at room temperature

Lamivudine (Epivir®, 3TC)

Dosage form: 150 mg tab, 300 mg tab, 10 mg/mL solution
Adult dose: 150 mg po bid or 300 mg po qd

Patient Counseling Points:
- AEs: Generally well-tolerated

Stavudine (Zerit®, d4T)

Dosage form: 15, 20, 30, 40 mg caps, 1 mg/mL solution
Adult dose: ≥ 60 kg: 40 mg po bid
< 60 kg: 30 mg po bid

Patient Counseling Points:
- AEs: peripheral neuropathy, pancreatitis (especially with didanosine), lipoatrophy, hyperlipidemia, rapidly progressing ascending neuromuscular weakness
- Refrigerate solution and shake well

Tenofovir (Viread®, TDF)

A nucleotide reverse transcriptase inhibitor

Dosage form: 300 mg tab
Adult dose: 300 mg po qd

Patient Counseling Points:
- Interacts with ddI and ATV (see combo table for dosing)
- AEs: nausea, vomiting, diarrhea, flatulence, renal insufficiency, Fanconi Syndrome, hypophosphatemia, asthenia, headache

NRTIs (Continued)

Zidovudine (Retrovir®, AZT, ZDV)

Dosage form: 300 mg tab, 100 mg cap, 10 mg/mL syrup, 10mg/mL IV soln.
Adult dose: 300 mg po bid, 200 mg po tid
Intrapartum dose: 2 mg/kg IV over 1 hour followed by 1 mg/kg/hr IV until cord clamping

Patient Counseling Points:
- AEs: headache, nausea, hyperpigmentation of the skin and nails, anemia, neutropenia, myopathy

Combination Products:

Combivir®

Each tablet contains: 300 mg AZT + 150 mg 3TC
Adult dose: 1 tablet po bid

Epzicom®

Each tablet contains: 300 mg 3TC + 600 mg ABC
Adult dose: 1 tablet po qd

Trizivir®

Each tablet contains: 300 mg AZT + 150 mg 3TC + 300 mg ABC
Adult dose: 1 tablet po bid

* See individual components on Renal Dose Adjustment Table
These combo products should not be used if CrCl is < 50 mL/min.

Truvada®

Each tablet contains: 200 mg FTC + 300 mg TDF
Adult dose: 1 tablet po qd

PROTEASE INHIBITORS (PIs)

Class adverse effects: Hyperglycemia, hyperlipidemia (except atazanavir), lipodystrophy, increased transaminases, increased bleeding episodes in hemophiliacs. **All undergo hepatic metabolism mostly by CYP3A4 - Many drug interactions!**

Atazanavir (Reyataz®, ATV)

Dosage form: 100 mg, 150 mg, 200 mg cap
Adult dose: 400 mg po qd (PI-naïve only), often boosted with ritonavir, see combo table for dosing

Patient Counseling Points:
- Interacts with antacids (separate by 2 hrs), H-2 blockers (separate by 12 hours), and proton pump inhibitors (do not use together)
- [1] Use OC with lower estrogen dose; RTV boosted ↓ OC, use alternate/additional form of contraception
- Must be boosted when used with TDF
- AEs: Increases unconjugated bilirubin levels (common), jaundice or scleral icterus (less common), does not adversely affect lipid profile (even with low-dose ritonavir), prolonged PR interval, asymptomatic 1st degree AV block can occur

Fosamprenavir (Lexiva®, fos-APV-prodrug of amprenavir)

Dosage form: 700 mg tab
Adult dose: 1400 mg bid (PI-naïve), often boosted with ritonavir, see combo table for dosing

Patient Counseling Points:
- OCs ↓ Fos-APV levels; do not coadminister
- AEs: Skin rash (19%), nausea, vomiting, diarrhea, **caution with sulfa allergy**

Indinavir (Crixivan®, IDV)

Dosage form: 100, 200, 333, 400 mg cap
Adult dose: 800 mg po q8h, rarely used unboosted, see combo table for dosing with ritonavir

Patient Counseling Points:
- Take on empty stomach; 1 hr ac or 2 hr pc. Can be taken with **low fat/protein** snack
- IDV + RTV can be taken with meals
- Drink 48 ounces (6 eight oz glasses) of fluid each day (water preferred)
- Separate at least 1 hour from doses of ddI (Videx® only, OK with Videx EC®)
- AEs: nephrolithiasis, hyperbilirubinemia
- Store in original container with desiccant

PIs (Continued)

Lopinavir/Ritonavir (Kaletra®, KAL)

Dosage form: 200/50 mg tab
133.3/33/3 mg cap
400/100 mg per 5 mL solution
Adult dose: 400/100 mg 2 tabs, 3 caps or 5 mL po bid
800/200 mg 4 tabs, 6 caps or 10 mL po qd (PI-naïve)
Once daily dosing should not be used with nevirapine, efavirenz, amprenavir, fosamprenavir, or nelfinavir
In treatment experienced patients where decreased susceptibility to lopinavir is clinically suspected, 3 tabs po bid may be considered

Patient Counseling Points:
- Tablets must be swallowed whole and cannot be chewed, broken, or crushed
- Tablets can be taken without food, solution and caps should be taken with food
- Oral solution contains 42% alcohol
- Take ddI 1.5 hr apart from LPV
- AEs: GI intolerance (nausea, vomiting, diarrhea), asthenia
- Refrigerate solution or store at room temp (up to 77°) for up to 60 days
- Tablets do not require refrigeration; caps OK at room temp up to 60 days
- Store in original container; exposure to high humidity for > 2 weeks is not recommended

Nelfinavir (Viracept®, NFV)

Dosage form: 250 mg tab, 625 mg tab, 50 mg/scoop powder
Adult dose: 750 mg po tid, 1250 mg po bid

Patient Counseling Points:
- AEs: diarrhea (can use OTC loperamide to treat diarrhea; calcium carbonate 1-2 tabs with each dose may lessen diarrhea)

Ritonavir (Norvir®, RTV)

Dosage form: 100 mg cap, 600 mg / 7.5 mL solution
Adult dose: Rarely used as sole PI-mainly used in mini-doses to boost other PIs

Patient Counseling Points:
- Take with food (may not be required with all PI/RTV combinations)
- Take ddI 2 hr apart from RTV
- Oral solution contains 43% alcohol
- AEs: GI intolerance (nausea, vomiting, diarrhea), asthenia, taste disturbances, paresthesias, pancreatitis-adverse effects less common/severe when used in low doses with other PIs (i.e. boosting)
- Refrigerate caps, may be stored at room temp. (up to 77°) for up to 30 days

Saquinavir (Invirase®-HGC or tab, SQV)

Dosage form: 200 mg cap or 500 mg tab (Invirase®)
Adult dose: Unboosted SQV not recommended;
SQV 1,000 mg + RTV 100 mg bid

Patient Counseling Points:
- Grapefruit juice ↑ SQV level, Garlic supplements ↓ SQV level (potential interaction with all PIs/NNRTIs)
- AEs: GI intolerance (nausea, diarrhea, abdominal pain, dyspepsia)

Tipranavir (Aptivus®, TPV)

Dosage Form: 250 mg capsule
Adult Dose: 500 mg po bid with ritonavir 200 mg po bid

Patient Counseling Points:
- **High fat** meal preferred
- Antacids may decrease TPV/RTV absorption (25-29%), consider separating dosing
- AEs: Hepatotoxicity-monitor LFTs closely; See Hepatic Dose Adjustment table; Rash-8-14% of patients (may be more common in women taking estrogen-containing medications), diarrhea, nausea, vomiting, caution with sulfa allergy
- Keep in refrigerator or store at room temperature for up to 60 days

NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTIs)

Delavirdine (Rescriptor®, DLV)

Dosage form: 100, 200 mg tab
Adult dose: 400 mg po tid or 600 mg po bid
(DLV bid dose not FDA-approved)

Patient Counseling Points:
- Separate antacids and bufferred ddI (Videx®) by approx 1 hour
- Potential for ↑ in ethinyl estradiol levels; clinical significance unknown
- AEs: rash - mild to severe, usually within 1st six weeks. D/C drug if severe rash (with blistering, desquamation, muscle involvement or fever), ↑ transaminases, headaches

Efavirenz (Sustiva®, EFV)

Dosage form: 50, 100, 200 mg cap, 600 mg tab
Adult dose: 600 mg po qd at bedtime

Patient counseling points:
- Capsules: empty stomach advised, avoid **high fat** meal
- Take at bedtime and without food to lessen CNS side effects
- Teratogenic-use with caution in women of child-bearing potential
- Interacts with OCs-OC levels increased but since EFV is terotegenic, an alternate/additional form of contraception is recommended.
- AEs: CNS - drowsinesss, dizziness, insomnia, abnormal dreaming, agitation, hallucinations. Begins 1st or 2nd day and generally resolves in 2-4 weeks; Rash - usually mild to moderate, onset usually 1-2 weeks. D/C if severe rash (with blistering, desquamation, muscle involvement or fever), ↑ transaminases, false positive cannabinoid test

Nevirapine (Viramune®, NVP)

Dosage form: 200 mg tab, 10 mg/mL suspension
Adult dose: 200 mg po qd x 14d, then (200 mg po bid OR 400 mg po qd) NVP qd dose not FDA-approved

Patient Counseling Points:
- AEs: rash - mild to severe, usually within 1st six weeks. D/C drug if severe rash (with blistering, desquamation, muscle involvement or fever), ↑ transaminases, hepatitis (Monitor LFTs at baseline, 2 wks, then q4wks for first 3 months, then q3months). Hepatotoxicity is often rash-associated. Check LFTs in any patient presenting with rash on nevirapine. Women with CD4+ cell counts > 250, men with CD4+ cell counts > 400, and pts with Hep B or C co-infection are at greater risk for hepatic events with nevirapine

FUSION INHIBITOR

Enfuvirtide (Fuzeon®, T-20)

Dosage form: Powder for SC injection, mix with 1.1 mL of sterile water for injection for final concentration of 90 mg/mL
Adult dose: 90 mg SC bid

Patient Counseling Points:
- Must instruct patient on reconstitution and administration techniques
- Administer SC in upper arm, upper leg, or stomach (do not inject into naval area, scar tissue, bruise, mole, or area with injection site reaction)
- Rotate injection sites
- AEs: injection site reactions (usually mild to moderate, can be severe)-itching, swelling, redness, pain or tenderness, induration, nodules and cysts; bacterial pneumonia occurred more frequently in T-20 treated patients; injection site infections (must be instructed on aseptic technique!); Hypersensitivity reactions (< 1%) - sxs. may include rash, fever, nausea, vomiting, chills, rigors, hypotension, or elevated transaminases; rechallenging is not recommended
- Reconstituted soln. should be refrigerated and used within 24 hours

= Take with food
= Take without food
= Take with or without food
R = Renal Adjustment (See table other side)
H = Hepatic Adjustment (See table other side)
C = Combination, Dual, or Boosted Adjustment (See table other side)
↑OC = ↑ Combination Oral Contraceptive Level
↓OC = ↓ Combination Oral Contraceptive Level; Use alternate/additional form of birth control
OC = Do not coadminister with Combination Oral Contraceptive

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