

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use RETROVIR safely and effectively. See full prescribing information for RETROVIR.

RETROVIR® (zidovudine) Tablets, Capsules, and Syrup

Initial U.S. Approval: 1987

WARNING: RISK OF HEMATOLOGICAL TOXICITY, MYOPATHY, LACTIC ACIDOSIS.

See full prescribing information for complete boxed warning.

- Hematologic toxicity including neutropenia and severe anemia have been associated with the use of zidovudine. (5.1)
- Symptomatic myopathy associated with prolonged use of zidovudine. (5.2)
- Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside analogues including RETROVIR. Suspend treatment if clinical or laboratory findings suggestive of lactic acidosis or pronounced hepatotoxicity occur. (5.3)

RECENT MAJOR CHANGES

Dosage and Administration, Pediatric Patients (2.1) September 2008

INDICATIONS AND USAGE

RETROVIR is a nucleoside analogue reverse transcriptase inhibitor indicated for:

- Treatment of Human Immunodeficiency Virus (HIV-1) infection in combination with other antiretroviral agents. (1.1)
- Prevention of maternal-fetal HIV-1 transmission. (1.2)

DOSAGE AND ADMINISTRATION

- Treatment of HIV-1 infection:
Adults: 600 mg/day in divided doses with other antiretroviral agents.
Pediatric patients (6 weeks to <18 years of age): Dosage should be calculated based on body weight not to exceed adult dose. (2.1)
- Prevention of maternal-fetal HIV-1 transmission:
Specific dosage instructions for mother and infant. (2.2)
- Patients with severe anemia and/or neutropenia:
Dosage interruption may be necessary. (2.3)
- Renal Impairment – Recommended dosage in hemodialysis or peritoneal dialysis patients is 100 mg every 6 to 8 hours. (2.4)

DOSAGE FORMS AND STRENGTHS

Tablets: 300 mg (3)
Capsules: 100 mg (3)
Syrup: 50 mg/5 mL (3)

CONTRAINDICATIONS

Hypersensitivity to zidovudine (e.g., anaphylaxis, Stevens-Johnson syndrome). (4)

WARNINGS AND PRECAUTIONS

- Hematologic toxicity/bone marrow suppression including neutropenia and severe anemia have been associated with the use of zidovudine. (5.1)
- Symptomatic myopathy associated with prolonged use of zidovudine. (5.2)
- Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside analogues including RETROVIR. Suspend treatment if clinical or laboratory findings suggestive of lactic acidosis or pronounced hepatotoxicity occur. (5.3)
- Exacerbation of anemia has been reported in HIV-1/HCV co-infected patients receiving ribavirin and zidovudine. Coadministration of ribavirin and zidovudine is not advised. (5.4)
- Hepatic decompensation, (some fatal), has occurred in HIV-1/HCV co-infected patients receiving combination antiretroviral therapy and interferon alfa with/without ribavirin. Discontinue zidovudine as medically appropriate and consider dose reduction or discontinuation of interferon alfa, ribavirin, or both. (5.4)
- RETROVIR should not be administered with other zidovudine-containing combination products. (5.5)
- Immune reconstitution syndrome (5.6) and redistribution/accumulation of body fat (5.7) have been reported in patients treated with combination antiretroviral therapy.

ADVERSE REACTIONS

- The most commonly reported adverse reactions (incidence $\geq 15\%$) in adult HIV-1 clinical studies were headache, malaise, nausea, anorexia, and vomiting. (6.1)
- The most commonly reported adverse reactions (incidence $\geq 15\%$) in pediatric HIV-1 clinical studies were fever, cough, and digestive disorders. (6.1)
- The most commonly reported adverse reactions in neonates (incidence $\geq 15\%$) in the prevention of maternal-fetal transmission of HIV-1 clinical trial were anemia and neutropenia. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact GlaxoSmithKline at 1-888-825-5249 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DRUG INTERACTIONS

- Stavudine: Concomitant use with zidovudine should be avoided. (7.1)
- Doxorubicin: Use with zidovudine should be avoided. (7.2)
- Bone marrow suppressive/cytotoxic agents: May increase the hematologic toxicity of zidovudine. (7.3)

USE IN SPECIFIC POPULATIONS

Pregnancy: Physicians are encouraged to register patients in the Antiretroviral Pregnancy Registry by calling 1-800-258-4263. (8.1)

See 17 for PATIENT COUNSELING INFORMATION.

Revised: September 2008
Version No.

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1

2 **FULL PRESCRIBING INFORMATION**

3 **WARNING: RISK OF HEMATOLOGICAL TOXICITY, MYOPATHY, LACTIC**
4 **ACIDOSIS**

5 **RETROVIR (zidovudine) has been associated with hematologic toxicity including**
6 **neutropenia and severe anemia, particularly in patients with advanced HIV-1 disease [see**
7 **Warnings and Precautions (5.1)].**

8 **Prolonged use of RETROVIR has been associated with symptomatic myopathy [see**
9 **Warnings and Precautions (5.2)].**

10 **Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have**
11 **been reported with the use of nucleoside analogues alone or in combination, including**
12 **RETROVIR and other antiretrovirals. Suspend treatment if clinical or laboratory findings**
13 **suggestive of lactic acidosis or pronounced hepatotoxicity occur [see Warnings and**
14 **Precautions (5.3)].**

15 **1 INDICATIONS AND USAGE**

16 **1.1 Treatment of HIV-1**

17 RETROVIR, a nucleoside reverse transcriptase inhibitor, is indicated in combination with
18 other antiretroviral agents for the treatment of HIV-1 infection.

19 **1.2 Prevention of Maternal-Fetal HIV-1 Transmission**

20 RETROVIR is indicated for the prevention of maternal-fetal HIV-1 transmission [see
21 *Dosage and Administration (2.2)*]. The indication is based on a dosing regimen that included
22 3 components:

- 23 1. antepartum therapy of HIV-1 infected mothers
- 24 2. intrapartum therapy of HIV-1 infected mothers
- 25 3. post-partum therapy of HIV-1 exposed neonate.

26 Points to consider prior to initiating RETROVIR in pregnant women for the prevention of
27 maternal-fetal HIV-1 transmission include:

- 28 • In most cases, RETROVIR for prevention of maternal-fetal HIV-1 transmission should be
29 given in combination with other antiretroviral drugs.
- 30 • Prevention of HIV-1 transmission in women who have received RETROVIR for a
31 prolonged period before pregnancy has not been evaluated.
- 32 • Because the fetus is most susceptible to the potential teratogenic effects of drugs during the
33 first 10 weeks of gestation and the risks of therapy with RETROVIR during that period are
34 not fully known, women in the first trimester of pregnancy who do not require immediate
35 initiation of antiretroviral therapy for their own health may consider delaying use; this
36 indication is based on use after 14 weeks gestation.

37 **2 DOSAGE AND ADMINISTRATION**

38 **2.1 Treatment of HIV-1 Infection**

39 Adults: The recommended oral dose of RETROVIR is 600 mg/day in divided doses in
40 combination with other antiretroviral agents.

41 Pediatric Patients (6 weeks to <18 years of age): Healthcare professionals should
42 pay special attention to accurate calculation of the dose of RETROVIR, transcription of the
43 medication order, dispensing information, and dosing instructions to minimize risk for
44 medication dosing errors.

45 Prescribers should calculate the appropriate dose of RETROVIR for each child based on
46 body weight (kg) and should not exceed the recommended adult dose.

47 Before prescribing RETROVIR capsules or tablets, children should be assessed for the
48 ability to swallow capsules or tablets. If a child is unable to reliably swallow a RETROVIR
49 capsule or tablet, the RETROVIR syrup formulation should be prescribed.

50 The recommended dosage in pediatric patients 6 weeks of age and older and weighing
51 ≥ 4 kg is provided in Table 1. RETROVIR Syrup should be used to provide accurate dosage
52 when whole tablets or capsules are not appropriate.

53

54 **Table 1: Recommended Pediatric Dosage of RETROVIR**

Body Weight (kg)	Total Daily Dose	Dosage Regimen and Dose	
		b.i.d.	t.i.d.
4 to <9	24 mg/kg/day	12 mg/kg	8 mg/kg
≥ 9 to <30	18 mg/kg/day	9 mg/kg	6 mg/kg
≥ 30	600 mg/day	300 mg	200 mg

55

56 Alternatively, dosing for RETROVIR can be based on body surface area (BSA) for each
57 child. The recommended oral dose of RETROVIR is 480 mg/m²/day in divided doses
58 (240 mg/m² twice daily or 160 mg/m² three times daily). In some cases the dose calculated by
59 mg/kg will not be the same as that calculated by BSA.

60 **2.2 Prevention of Maternal-Fetal HIV-1 Transmission**

61 The recommended dosage regimen for administration to pregnant women (>14 weeks of
62 pregnancy) and their neonates is:

63 Maternal Dosing: 100 mg orally 5 times per day until the start of labor [*see Clinical*
64 *Studies (14.3)*]. During labor and delivery, intravenous RETROVIR should be administered at
65 2 mg/kg (total body weight) over 1 hour followed by a continuous intravenous infusion of
66 1 mg/kg/hour (total body weight) until clamping of the umbilical cord.

67 Neonatal Dosing: 2 mg/kg orally every 6 hours starting within 12 hours after birth and
68 continuing through 6 weeks of age. Neonates unable to receive oral dosing may be administered
69 RETROVIR intravenously at 1.5 mg/kg, infused over 30 minutes, every 6 hours.

70 **2.3 Patients With Severe Anemia and/or Neutropenia**

71 Significant anemia (hemoglobin <7.5 g/dL or reduction >25% of baseline) and/or
72 significant neutropenia (granulocyte count <750 cells/mm³ or reduction >50% from baseline)
73 may require a dose interruption until evidence of marrow recovery is observed [*see Warnings*
74 *and Precautions (5.1)*]. In patients who develop significant anemia, dose interruption does not
75 necessarily eliminate the need for transfusion. If marrow recovery occurs following dose
76 interruption, resumption in dose may be appropriate using adjunctive measures such as epoetin
77 alfa at recommended doses, depending on hematologic indices such as serum erythropoetin level
78 and patient tolerance.

79 **2.4 Patients With Renal Impairment:**

80 End-Stage Renal Disease: In patients maintained on hemodialysis or peritoneal
81 dialysis, the recommended dosage is 100 mg every 6 to 8 hours [*see Clinical Pharmacology*
82 *(12.3)*].

83 **2.5 Patients With Hepatic Impairment:**

84 There are insufficient data to recommend dose adjustment of RETROVIR in patients with
85 mild to moderate impaired hepatic function or liver cirrhosis.

86 **3 DOSAGE FORMS AND STRENGTHS**

87 **RETROVIR Tablets** 300 mg (biconvex, white, round, film-coated) containing 300 mg
88 zidovudine, one side engraved “GX CW3” and “300” on the other side.

89 **RETROVIR Capsules** 100 mg (white, opaque cap and body) containing 100 mg
90 zidovudine and printed with “Wellcome” and unicorn logo on cap and “Y9C” and “100” on
91 body.

92 **RETROVIR Syrup** (colorless to pale yellow, strawberry-flavored) containing 50 mg
93 zidovudine in each teaspoonful (5 mL).

94 **4 CONTRAINDICATIONS**

95 RETROVIR Tablets, Capsules, and Syrup are contraindicated in patients who have had
96 potentially life-threatening allergic reactions (e.g., anaphylaxis, Stevens-Johnson syndrome) to
97 any of the components of the formulations.

98 **5 WARNINGS AND PRECAUTIONS**

99 **5.1 Hematologic Toxicity/Bone Marrow Suppression**

100 RETROVIR should be used with caution in patients who have bone marrow compromise
101 evidenced by granulocyte count <1,000 cells/mm³ or hemoglobin <9.5 g/dL. Hematologic
102 toxicities appear to be related to pretreatment bone marrow reserve and to dose and duration of
103 therapy. In patients with advanced symptomatic HIV-1 disease, anemia and neutropenia were the
104 most significant adverse events observed. In patients who experience hematologic toxicity, a
105 reduction in hemoglobin may occur as early as 2 to 4 weeks, and neutropenia usually occurs after
106 6 to 8 weeks. There have been reports of pancytopenia associated with the use of RETROVIR,
107 which was reversible in most instances after discontinuance of the drug. However, significant
108 anemia, in many cases requiring dose adjustment, discontinuation of RETROVIR, and/or blood

109 transfusions, has occurred during treatment with RETROVIR alone or in combination with other
110 antiretrovirals.

111 Frequent blood counts are strongly recommended to detect severe anemia or neutropenia
112 in patients with poor bone marrow reserve, particularly in patients with advanced HIV-1 disease
113 who are treated with RETROVIR. For HIV-1-infected individuals and patients with
114 asymptomatic or early HIV-1 disease, periodic blood counts are recommended. If anemia or
115 neutropenia develops, dosage interruption may be needed [*see Dosage and Administration*
116 (2.3)].

117 **5.2 Myopathy**

118 Myopathy and myositis with pathological changes, similar to that produced by HIV-1
119 disease, have been associated with prolonged use of RETROVIR.

120 **5.3 Lactic Acidosis/Severe Hepatomegaly With Steatosis**

121 Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been
122 reported with the use of nucleoside analogues alone or in combination, including zidovudine and
123 other antiretrovirals. A majority of these cases have been in women. Obesity and prolonged
124 exposure to antiretroviral nucleoside analogues may be risk factors. Particular caution should be
125 exercised when administering RETROVIR to any patient with known risk factors for liver
126 disease; however, cases have also been reported in patients with no known risk factors.
127 Treatment with RETROVIR should be suspended in any patient who develops clinical or
128 laboratory findings suggestive of lactic acidosis or pronounced hepatotoxicity (which may
129 include hepatomegaly and steatosis even in the absence of marked transaminase elevations).

130 **5.4 Use With Interferon- and Ribavirin-Based Regimens in HIV-1/HCV** 131 **Co-Infected Patients**

132 In vitro studies have shown ribavirin can reduce the phosphorylation of pyrimidine
133 nucleoside analogues such as zidovudine. Although no evidence of a pharmacokinetic or
134 pharmacodynamic interaction (e.g., loss of HIV-1/HCV virologic suppression) was seen when
135 ribavirin was coadministered with zidovudine in HIV-1/HCV co-infected patients [*see Clinical*
136 *Pharmacology (12.3)*], exacerbation of anemia due to ribavirin has been reported when
137 zidovudine is part of the HIV regimen. Coadministration of ribavirin and zidovudine is not
138 advised. Consideration should be given to replacing zidovudine in established combination
139 HIV-1/HCV therapy, especially in patients with a known history of zidovudine-induced anemia.

140 Hepatic decompensation (some fatal) has occurred in HIV-1/HCV co-infected patients
141 receiving combination antiretroviral therapy for HIV-1 and interferon alfa with or without
142 ribavirin. Patients receiving interferon alfa with or without ribavirin and zidovudine should be
143 closely monitored for treatment-associated toxicities, especially hepatic decompensation,
144 neutropenia, and anemia.

145 Discontinuation of zidovudine should be considered as medically appropriate. Dose
146 reduction or discontinuation of interferon alfa, ribavirin, or both should also be considered if
147 worsening clinical toxicities are observed, including hepatic decompensation (e.g., Childs Pugh
148 >6) (see the complete prescribing information for interferon and ribavirin).

149 **5.5 Use With Other Zidovudine-Containing Products**

150 RETROVIR should not be administered with combination products that contain
151 zidovudine as one of their components (e.g., COMBIVIR[®] or TRIZIVIR[®]).

152 **5.6 Immune Reconstitution Syndrome**

153 Immune reconstitution syndrome has been reported in patients treated with combination
154 antiretroviral therapy, including RETROVIR. During the initial phase of combination
155 antiretroviral treatment, patients whose immune systems respond may develop an inflammatory
156 response to indolent or residual opportunistic infections (such as *Mycobacterium avium*
157 infection, cytomegalovirus, *Pneumocystis jirovecii* pneumonia [PCP], or tuberculosis), which
158 may necessitate further evaluation and treatment.

159 **5.7 Fat Redistribution**

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

165 **6 ADVERSE REACTIONS**

166 **6.1 Clinical Trials Experience**

167 The following adverse reactions are discussed in greater detail in other sections of the
168 labeling:

- 169 • Hematologic toxicity, including neutropenia and anemia [*see Boxed Warning, Warnings and*
170 *Precautions (5.1)*].
- 171 • Symptomatic myopathy [*see Boxed Warning, Warnings and Precautions (5.2)*].
- 172 • Lactic acidosis and severe hepatomegaly with steatosis [*see Boxed Warning, Warnings and*
173 *Precautions (5.3)*].
- 174 • Hepatic decompensation in patients co-infected with HIV-1 and hepatitis C [*see Warnings*
175 *and Precautions (5.4)*].

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

179 **Adults:** The frequency and severity of adverse reactions associated with the use of
180 RETROVIR are greater in patients with more advanced infection at the time of initiation of
181 therapy.

182 Table 2 summarizes events reported at a statistically significant greater incidence for
183 patients receiving RETROVIR in a monotherapy study.

184

185 **Table 2. Percentage (%) of Patients With Adverse Reactions* in Asymptomatic HIV-1**
 186 **Infection (ACTG 019)**

Adverse Reaction	RETROVIR 500 mg/day (n = 453)	Placebo (n = 428)
Body as a whole		
Asthenia	9% [†]	6%
Headache	63%	53%
Malaise	53%	45%
Gastrointestinal		
Anorexia	20%	11%
Constipation	6% [†]	4%
Nausea	51%	30%
Vomiting	17%	10%

187 *Reported in ≥5% of study population.

188 [†]Not statistically significant versus placebo.

189
 190 In addition to the adverse reactions listed in Table 2, adverse reactions observed at an
 191 incidence of ≥5% in any treatment arm in clinical studies (NUCA3001, NUCA3002,
 192 NUCB3001, and NUCB3002) were abdominal cramps, abdominal pain, arthralgia, chills,
 193 dyspepsia, fatigue, insomnia, musculoskeletal pain, myalgia, and neuropathy. Additionally, in
 194 these studies hyperbilirubinemia was reported at an incidence of ≤0.8%.

195 Selected laboratory abnormalities observed during a clinical study of monotherapy with
 196 RETROVIR are shown in Table 3.

197
 198 **Table 3. Frequencies of Selected (Grade 3/4) Laboratory Abnormalities in Patients With**
 199 **Asymptomatic HIV-1 Infection (ACTG 019)**

Test (Abnormal Level)	RETROVIR 500 mg/day (n = 453)	Placebo (n = 428)
Anemia (Hgb<8 g/dL)	1%	<1%
Granulocytopenia (<750 cells/mm ³)	2%	2%
Thrombocytopenia (platelets<50,000/mm ³)	0%	<1%
ALT (>5 x ULN)	3%	3%
AST (>5 x ULN)	1%	2%

200 ULN = Upper limit of normal.

201
 202 **Pediatrics:** The clinical adverse reactions reported among adult recipients of
 203 RETROVIR may also occur in pediatric patients.

204 *Study ACTG300:* Selected clinical adverse reactions and physical findings with a
 205 ≥5% frequency during therapy with EPIVIR 4 mg/kg twice daily plus RETROVIR 160 mg/m²

206 3 times daily compared with didanosine in therapy-naive (≤ 56 days of antiretroviral therapy)
 207 pediatric patients are listed in Table 4.

208

209 **Table 4. Selected Clinical Adverse Reactions and Physical Findings ($\geq 5\%$ Frequency) in**
 210 **Pediatric Patients in Study ACTG300**

Adverse Reaction	EPIVIR plus RETROVIR (n = 236)	Didanosine (n = 235)
Body as a whole		
Fever	25%	32%
Digestive		
Hepatomegaly	11%	11%
Nausea & vomiting	8%	7%
Diarrhea	8%	6%
Stomatitis	6%	12%
Splenomegaly	5%	8%
Respiratory		
Cough	15%	18%
Abnormal breath sounds/wheezing	7%	9%
Ear, Nose, and Throat		
Signs or symptoms of ears*	7%	6%
Nasal discharge or congestion	8%	11%
Other		
Skin rashes	12%	14%
Lymphadenopathy	9%	11%

211 *Includes pain, discharge, erythema, or swelling of an ear.

212

213 Selected laboratory abnormalities experienced by therapy-naive (≤ 56 days of
 214 antiretroviral therapy) pediatric patients are listed in Table 5.

215

216 **Table 5. Frequencies of Selected (Grade 3/4) Laboratory Abnormalities in Pediatric**
 217 **Patients in Study ACTG300**

Test (Abnormal Level)	EPIVIR plus RETROVIR	Didanosine
Neutropenia (ANC<400 cells/mm ³)	8%	3%
Anemia (Hgb<7.0 g/dL)	4%	2%
Thrombocytopenia (platelets<50,000/mm ³)	1%	3%
ALT (>10 x ULN)	1%	3%
AST (>10 x ULN)	2%	4%
Lipase (>2.5 x ULN)	3%	3%
Total amylase (>2.5 x ULN)	3%	3%

218 ULN = Upper limit of normal.

219 ANC = Absolute neutrophil count.

220
 221 **Macrocytosis was reported in the majority of pediatric patients receiving RETROVIR**
 222 **180 mg/m² every 6 hours in open-label studies.** Additionally, adverse reactions reported **at an**
 223 **incidence of <6%** in these studies were congestive heart failure, decreased reflexes, ECG
 224 abnormality, edema, hematuria, left ventricular dilation, nervousness/irritability, and weight loss.

225 Use for the Prevention of Maternal-Fetal Transmission of HIV-1: In a randomized,
 226 double-blind, placebo-controlled trial in HIV-1-infected women and their neonates conducted to
 227 determine the utility of RETROVIR for the prevention of maternal-fetal HIV-1 transmission,
 228 RETROVIR Syrup at 2 mg/kg was administered every 6 hours for 6 weeks to neonates
 229 beginning within 12 hours following birth. The most commonly reported adverse reactions were
 230 anemia (hemoglobin <9.0 g/dL) and neutropenia (<1,000 cells/mm³). Anemia occurred in 22%
 231 of the neonates who received RETROVIR and in 12% of the neonates who received placebo.
 232 The mean difference in hemoglobin values was less than 1.0 g/dL for neonates receiving
 233 RETROVIR compared with neonates receiving placebo. No neonates with anemia required
 234 transfusion and all hemoglobin values spontaneously returned to normal within 6 weeks after
 235 completion of therapy with RETROVIR. Neutropenia in neonates was reported with similar
 236 frequency in the group that received RETROVIR (21%) and in the group that received placebo
 237 (27%). The long-term consequences of in utero and infant exposure to RETROVIR are
 238 unknown.

239 **6.2 Postmarketing Experience**

240 In addition to adverse reactions reported from clinical trials, the following reactions have
 241 been identified during postmarketing use of RETROVIR. Because they are reported voluntarily
 242 from a population of unknown size, estimates of frequency cannot be made. These reactions have
 243 been chosen for inclusion due to a combination of their seriousness, frequency of reporting, or
 244 potential causal connection to RETROVIR.

245 Body as a Whole: Back pain, chest pain, flu-like syndrome, generalized pain,
 246 redistribution/accumulation of body fat [*see Warnings and Precautions (5.6)*].

247 Cardiovascular: Cardiomyopathy, syncope.
248 Endocrine: Gynecomastia.
249 Eye: Macular edema.
250 Gastrointestinal: Dysphagia, flatulence, oral mucosa pigmentation, mouth ulcer.
251 General: Sensitization reactions including anaphylaxis and angioedema, vasculitis.
252 Hemic and Lymphatic: Aplastic anemia, hemolytic anemia, leukopenia,
253 lymphadenopathy, pancytopenia with marrow hypoplasia, pure red cell aplasia.
254 Hepatobiliary Tract and Pancreas: Hepatitis, hepatomegaly with steatosis, jaundice,
255 lactic acidosis, pancreatitis.
256 Musculoskeletal: Increased CPK, increased LDH, muscle spasm, myopathy and
257 myositis with pathological changes (similar to that produced by HIV-1 disease), rhabdomyolysis,
258 tremor.
259 Nervous: Anxiety, confusion, depression, dizziness, loss of mental acuity, mania,
260 paresthesia, seizures, somnolence, vertigo.
261 Respiratory: Dyspnea, rhinitis, sinusitis.
262 Skin: Changes in skin and nail pigmentation, pruritus, Stevens-Johnson syndrome, toxic
263 epidermal necrolysis, sweat, urticaria.
264 Special Senses: Amblyopia, hearing loss, photophobia, taste perversion.
265 Urogenital: Urinary frequency, urinary hesitancy.

266 **7 DRUG INTERACTIONS**

267 **7.1 Antiretroviral Agents**

268 Stavudine: Concomitant use of zidovudine with stavudine should be avoided since an
269 antagonistic relationship has been demonstrated in vitro.

270 Nucleoside Analogues Affecting DNA Replication: Some nucleoside analogues
271 affecting DNA replication, such as ribavirin, antagonize the in vitro antiviral activity of
272 RETROVIR against HIV-1; concomitant use of such drugs should be avoided.

273 **7.2 Doxorubicin**

274 Concomitant use of zidovudine with doxorubicin should be avoided since an antagonistic
275 relationship has been demonstrated in vitro.

276 **7.3 Hematologic/Bone Marrow Suppressive/Cytotoxic Agents**

277 Coadministration of ganciclovir, interferon alfa, ribavirin, and other bone marrow
278 suppressive or cytotoxic agents may increase the hematologic toxicity of zidovudine.

279 **8 USE IN SPECIFIC POPULATIONS**

280 **8.1 Pregnancy**

281 Pregnancy Category C.

282 In humans, treatment with RETROVIR during pregnancy reduced the rate of
283 maternal-fetal HIV-1 transmission from 24.9% for infants born to placebo-treated mothers to
284 7.8% for infants born to mothers treated with RETROVIR [*see Clinical Studies (14.3)*]. There
285 were no differences in pregnancy-related adverse events between the treatment groups. Animal

286 reproduction studies in rats and rabbits showed evidence of embryotoxicity and increased fetal
287 malformations.

288 A randomized, double-blind, placebo-controlled trial was conducted in HIV-1-infected
289 pregnant women to determine the utility of RETROVIR for the prevention of maternal-fetal
290 HIV-1-transmission [see *Clinical Studies (14.3)*]. Congenital abnormalities occurred with similar
291 frequency between neonates born to mothers who received RETROVIR and neonates born to
292 mothers who received placebo. The observed abnormalities included problems in embryogenesis
293 (prior to 14 weeks) or were recognized on ultrasound before or immediately after initiation of
294 study drug.

295 Increased fetal resorptions occurred in pregnant rats and rabbits treated with doses of
296 zidovudine that produced drug plasma concentrations 66 to 226 times (rats) and 12 to 87 times
297 (rabbits) the mean steady-state peak human plasma concentration following a single 100-mg
298 dose of zidovudine. There were no other reported developmental anomalies. In another
299 developmental toxicity study, pregnant rats received zidovudine up to near-lethal doses that
300 produced peak plasma concentrations 350 times peak human plasma concentrations (300 times
301 the daily AUC in humans given 600 mg/day zidovudine). This dose was associated with marked
302 maternal toxicity and an increased incidence of fetal malformations. However, there were no
303 signs of teratogenicity at doses up to one fifth the lethal dose [see *Nonclinical Toxicology*
304 *(13.2)*].

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

308 **8.3 Nursing Mothers**

309 Zidovudine is excreted in human milk [see *Clinical Pharmacology (12.3)*].

310 The Centers for Disease Control and Prevention recommend that HIV-1-infected mothers
311 in the United States not breastfeed their infants to avoid risking postnatal transmission of HIV-1
312 infection. Because of both the potential for HIV-1 transmission and the potential for serious
313 adverse reactions in nursing infants, mothers should be instructed not to breastfeed if they are
314 receiving RETROVIR.

315 **8.4 Pediatric Use**

316 RETROVIR has been studied in HIV-1-infected pediatric patients ≥ 6 weeks of age who
317 had HIV-1-related symptoms or who were asymptomatic with abnormal laboratory values
318 indicating significant HIV-1-related immunosuppression. RETROVIR has also been studied in
319 neonates perinatally exposed to HIV-1 [see *Dosage and Administration (2.1)*, *Adverse Reactions*
320 *(6.1)*, *Clinical Pharmacology (12.3)*, *Clinical Studies (14.2)*, *(14.3)*].

321 **8.5 Geriatric Use**

322 Clinical studies of RETROVIR did not include sufficient numbers of subjects aged 65
323 and over to determine whether they respond differently from younger subjects. Other reported
324 clinical experience has not identified differences in responses between the elderly and younger
325 patients. In general, dose selection for an elderly patient should be cautious, reflecting the greater

326 frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other
327 drug therapy.

328 **8.6 Renal Impairment**

329 In patients with severely impaired renal function ($\text{CrCl} < 15 \text{ mL/min}$), dosage reduction is
330 recommended [see *Dosage and Administration (2.4)*, *Clinical Pharmacology (12.3)*].

331 **8.7 Hepatic Impairment**

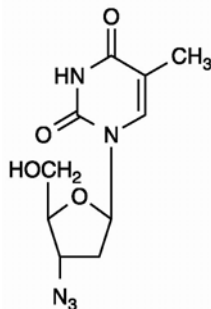
332 Zidovudine is eliminated from the body primarily by renal excretion following
333 metabolism in the liver (glucuronidation). Although the data are limited, zidovudine
334 concentrations appear to be increased in patients with severely impaired hepatic function which
335 may increase the risk of hematologic toxicity [see *Dosage and Administration (2.5)*, *Clinical*
336 *Pharmacology (12.3)*].

337 **10 OVERDOSAGE**

338 Acute overdoses of zidovudine have been reported in pediatric patients and adults. These
339 involved exposures up to 50 grams. No specific symptoms or signs have been identified
340 following acute overdosage with zidovudine apart from those listed as adverse events such as
341 fatigue, headache, vomiting, and occasional reports of hematological disturbances. All patients
342 recovered without permanent sequelae. Hemodialysis and peritoneal dialysis appear to have a
343 negligible effect on the removal of zidovudine while elimination of its primary metabolite, 3'-
344 azido-3'-deoxy-5'-O- β -D-glucopyranuronosylthymidine (GZDV), is enhanced.

345 **11 DESCRIPTION**

346 RETROVIR is the brand name for zidovudine (formerly called azidothymidine [AZT]), a
347 pyrimidine nucleoside analogue active against HIV-1. The chemical name of zidovudine is 3'-
348 azido-3'-deoxythymidine; it has the following structural formula:



349 Zidovudine is a white to beige, odorless, crystalline solid with a molecular weight of
350 267.24 and a solubility of 20.1 mg/mL in water at 25°C. The molecular formula is $\text{C}_{10}\text{H}_{13}\text{N}_5\text{O}_4$.

351 RETROVIR Tablets are for oral administration. Each film-coated tablet contains 300 mg
352 of zidovudine and the inactive ingredients hypromellose, magnesium stearate, microcrystalline
353 cellulose, polyethylene glycol, sodium starch glycolate, and titanium dioxide.

354 RETROVIR Capsules are for oral administration. Each capsule contains 100 mg of
355 zidovudine and the inactive ingredients corn starch, magnesium stearate, microcrystalline
356 cellulose, and sodium starch glycolate. The 100-mg empty hard gelatin capsule, printed with
357

358 edible black ink, consists of black iron oxide, dimethylpolysiloxane, gelatin, pharmaceutical
359 shellac, soya lecithin, and titanium dioxide.

360 RETROVIR Syrup is for oral administration. Each teaspoonful (5 mL) of RETROVIR
361 Syrup contains 50 mg of zidovudine and the inactive ingredients sodium benzoate 0.2% (added
362 as a preservative), citric acid, flavors, glycerin, and liquid sucrose. Sodium hydroxide may be
363 added to adjust pH.

364 **12 CLINICAL PHARMACOLOGY**

365 **12.1 Mechanism of Action**

366 Zidovudine is an antiviral agent [*see Clinical Pharmacology (12.4)*].

367 **12.3 Pharmacokinetics**

368 Absorption and Bioavailability: In adults, following oral administration, zidovudine is
369 rapidly absorbed and extensively distributed, with peak serum concentrations occurring within
370 0.5 to 1.5 hours. The extent of absorption (AUC) was equivalent when zidovudine was
371 administered as RETROVIR Tablets or Syrup compared with RETROVIR Capsules. The
372 pharmacokinetic properties of zidovudine in fasting adult patients are summarized in Table 6.
373

374 **Table 6. Zidovudine Pharmacokinetic Parameters in Fasting Adult Patients**

Parameter	Mean ± SD (except where noted)
Oral bioavailability (%)	64 ± 10 (n = 5)
Apparent volume of distribution (L/kg)	1.6 ± 0.6 (n = 8)
Plasma protein binding (%)	<38
CSF:plasma ratio*	0.6 [0.04 to 2.62] (n = 39)
Systemic clearance (L/hr/kg)	1.6 ± 0.6 (n = 6)
Renal clearance (L/hr/kg)	0.34 ± 0.05 (n = 9)
Elimination half-life (hr) [†]	0.5 to 3 (n = 19)

375 *Median [range].

376 [†]Approximate range.

377

378 Distribution: The apparent volume of distribution of zidovudine, following oral
379 administration, is 1.6 ± 0.6 L/kg; and binding to plasma protein is low, <38% (Table 6).

380 **Metabolism and Elimination:** Zidovudine is primarily eliminated by hepatic
 381 metabolism. The major metabolite of zidovudine is GZDV. GZDV AUC is about 3-fold greater
 382 than the zidovudine AUC. Urinary recovery of zidovudine and GZDV accounts for 14% and
 383 74%, respectively, of the dose following oral administration. A second metabolite, 3'-amino-3'-
 384 deoxythymidine (AMT), has been identified in the plasma following single-dose intravenous
 385 (IV) administration of zidovudine. The AMT AUC was one fifth of the zidovudine AUC.
 386 Pharmacokinetics of zidovudine were dose independent at oral dosing regimens ranging from
 387 2 mg/kg every 8 hours to 10 mg/kg every 4 hours.

388 **Effect of Food on Absorption:** RETROVIR may be administered with or without food.
 389 The extent of zidovudine absorption (AUC) was similar when a single dose of zidovudine was
 390 administered with food.

391 **Special Populations: Renal Impairment:** Zidovudine clearance was decreased
 392 resulting in increased zidovudine and GZDV half-life and AUC in patients with impaired renal
 393 function (n = 14) following a single 200-mg oral dose (Table 7). Plasma concentrations of AMT
 394 were not determined. A dose adjustment should not be necessary for patients with creatinine
 395 clearance (CrCl) ≥ 15 mL/min.

396
 397 **Table 7. Zidovudine Pharmacokinetic Parameters in Patients With Severe Renal**
 398 **Impairment***

Parameter	Control Subjects (Normal Renal Function) (n = 6)	Patients With Renal Impairment (n = 14)
CrCl (mL/min)	120 \pm 8	18 \pm 2
Zidovudine AUC (ng•hr/mL)	1,400 \pm 200	3,100 \pm 300
Zidovudine half-life (hr)	1.0 \pm 0.2	1.4 \pm 0.1

399 *Data are expressed as mean \pm standard deviation.

400
 401 **Hemodialysis and Peritoneal Dialysis:** The pharmacokinetics and tolerance of
 402 zidovudine were evaluated in a multiple-dose study in patients undergoing hemodialysis (n = 5)
 403 or peritoneal dialysis (n = 6) receiving escalating doses up to 200 mg 5 times daily for 8 weeks.
 404 Daily doses of 500 mg or less were well tolerated despite significantly elevated GZDV plasma
 405 concentrations. Apparent zidovudine oral clearance was approximately 50% of that reported in
 406 patients with normal renal function. Hemodialysis and peritoneal dialysis appeared to have a
 407 negligible effect on the removal of zidovudine, whereas GZDV elimination was enhanced. A
 408 dosage adjustment is recommended for patients undergoing hemodialysis or peritoneal dialysis
 409 [see Dosage and Administration (2.4)].

410 **Hepatic Impairment:** Data describing the effect of hepatic impairment on the
 411 pharmacokinetics of zidovudine are limited. However, because zidovudine is eliminated
 412 primarily by hepatic metabolism, it is expected that zidovudine clearance would be decreased

413 and plasma concentrations would be increased following administration of the recommended
414 adult doses to patients with hepatic impairment [see Dosage and Administration (2.5)].

415 **Pediatric Patients:** Zidovudine pharmacokinetics have been evaluated in
416 HIV-1-infected pediatric patients (Table 8).

417 **Patients 3 Months to 12 Years of Age:** Overall, zidovudine pharmacokinetics in
418 pediatric patients greater than 3 months of age are similar to those in adult patients. Proportional
419 increases in plasma zidovudine concentrations were observed following administration of oral
420 solution from 90 to 240 mg/m² every 6 hours. Oral bioavailability, terminal half-life, and oral
421 clearance were comparable to adult values. As in adult patients, the major route of elimination
422 was by metabolism to GZDV. After intravenous dosing, about 29% of the dose was excreted in
423 the urine unchanged, and about 45% of the dose was excreted as GZDV [see Dosage and
424 Administration (2.1)].

425 **Patients <3 Months of Age:** Zidovudine pharmacokinetics have been evaluated in
426 pediatric patients from birth to 3 months of life. Zidovudine elimination was determined
427 immediately following birth in 8 neonates who were exposed to zidovudine in utero. The
428 half-life was 13.0 ± 5.8 hours. In neonates ≤14 days old, bioavailability was greater, total body
429 clearance was slower, and half-life was longer than in pediatric patients >14 days old. For dose
430 recommendations for neonates [see Dosage and Administration (2.2)].

431

432 **Table 8. Zidovudine Pharmacokinetic Parameters in Pediatric Patients***

Parameter	Birth to 14 Days of Age	14 Days to 3 Months of Age	3 Months to 12 Years of Age
Oral bioavailability (%)	89 ± 19 (n = 15)	61 ± 19 (n = 17)	65 ± 24 (n = 18)
CSF:plasma ratio	no data	no data	0.68 [0.03 to 3.25] [†] (n = 38)
CL (L/hr/kg)	0.65 ± 0.29 (n = 18)	1.14 ± 0.24 (n = 16)	1.85 ± 0.47 (n = 20)
Elimination half-life (hr)	3.1 ± 1.2 (n = 21)	1.9 ± 0.7 (n = 18)	1.5 ± 0.7 (n = 21)

433 *Data presented as mean ± standard deviation except where noted.

434 [†]Median [range].

435

436 **Pregnancy:** Zidovudine pharmacokinetics have been studied in a Phase I study of
437 8 women during the last trimester of pregnancy. Zidovudine pharmacokinetics were similar to
438 those of nonpregnant adults. Consistent with passive transmission of the drug across the
439 placenta, zidovudine concentrations in neonatal plasma at birth were essentially equal to those in
440 maternal plasma at delivery [see Use in Specific Populations (8.1)].

441 Although data are limited, methadone maintenance therapy in 5 pregnant women did not
442 appear to alter zidovudine pharmacokinetics.

443 *Nursing Mothers:* The Centers for Disease Control and Prevention recommend that
444 HIV-1-infected mothers not breastfeed their infants to avoid risking postnatal transmission of
445 HIV-1. After administration of a single dose of 200 mg zidovudine to 13 HIV-1-infected women,
446 the mean concentration of zidovudine was similar in human milk and serum [*see Use In Specific*
447 *Populations (8.3)*].

448 *Geriatric Patients:* Zidovudine pharmacokinetics have not been studied in patients
449 over 65 years of age.

450 *Gender:* A pharmacokinetic study in healthy male (n = 12) and female (n = 12)
451 subjects showed no differences in zidovudine exposure (AUC) when a single dose of zidovudine
452 was administered as the 300-mg RETROVIR Tablet.

453 Drug Interactions: [*See Drug Interactions (7)*].

454

455 **Table 9. Effect of Coadministered Drugs on Zidovudine AUC***

Note: ROUTINE DOSE MODIFICATION OF ZIDOVUDINE IS NOT WARRANTED WITH COADMINISTRATION OF THE FOLLOWING DRUGS.					
Coadministered Drug and Dose	Zidovudine Dose	n	Zidovudine Concentrations		Concentration of Coadministered Drug
			AUC	Variability	
Atovaquone 750 mg q 12 hr with food	200 mg q 8 hr	14	↑AUC 31%	Range 23% to 78% [†]	↔
Fluconazole 400 mg daily	200 mg q 8 hr	12	↑AUC 74%	95% CI: 54% to 98%	Not Reported
Lamivudine 300 mg q 12 hr	single 200 mg	12	↑AUC 13%	90% CI: 2% to 27%	↔
Methadone 30 to 90 mg daily	200 mg q 4 hr	9	↑AUC 43%	Range 16% to 64% [†]	↔
Nelfinavir 750 mg q 8 hr x 7 to 10 days	single 200 mg	11	↓AUC 35%	Range 28% to 41%	↔
Probenecid 500 mg q 6 hr x 2 days	2 mg/kg q 8 hr x 3 days	3	↑AUC 106%	Range 100% to 170% [†]	Not Assessed
Rifampin 600 mg daily x 14 days	200 mg q 8 hr x 14 days	8	↓AUC 47%	90% CI: 41% to 53%	Not Assessed
Ritonavir 300 mg q 6 hr x 4 days	200 mg q 8 hr x 4 days	9	↓AUC 25%	95% CI: 15% to 34%	↔
Valproic acid 250 mg or 500 mg q 8 hr x 4 days	100 mg q 8 hr x 4 days	6	↑AUC 80%	Range 64% to 130% [†]	Not Assessed

456 ↑ = Increase; ↓ = Decrease; ↔ = no significant change; AUC = area under the concentration
457 versus time curve; CI = confidence interval.

458 *This table is not all inclusive.

459 [†]Estimated range of percent difference.

460

461 *Phenytoin:* Phenytoin plasma levels have been reported to be low in some patients
462 receiving RETROVIR, while in one case a high level was documented. However, in a
463 pharmacokinetic interaction study in which 12 HIV-1-positive volunteers received a single
464 300-mg phenytoin dose alone and during steady-state zidovudine conditions (200 mg every

465 4 hours), no change in phenytoin kinetics was observed. Although not designed to optimally
466 assess the effect of phenytoin on zidovudine kinetics, a 30% decrease in oral zidovudine
467 clearance was observed with phenytoin.

468 **Ribavirin:** In vitro data indicate ribavirin reduces phosphorylation of lamivudine,
469 stavudine, and zidovudine. However, no pharmacokinetic (e.g., plasma concentrations or
470 intracellular triphosphorylated active metabolite concentrations) or pharmacodynamic (e.g., loss
471 of HIV-1/HCV virologic suppression) interaction was observed when ribavirin and lamivudine
472 (n = 18), stavudine (n = 10), or zidovudine (n = 6) were coadministered as part of a multi-drug
473 regimen to HIV-1/HCV co-infected patients [see *Warnings and Precautions (5.4)*].

474 **12.4 Microbiology**

475 **Mechanism of Action:** Zidovudine is a synthetic nucleoside analogue. Intracellularly,
476 zidovudine is phosphorylated to its active 5'-triphosphate metabolite, zidovudine triphosphate
477 (ZDV-TP). The principal mode of action of ZDV-TP is inhibition of reverse transcriptase (RT)
478 via DNA chain termination after incorporation of the nucleotide analogue. ZDV-TP is a weak
479 inhibitor of the cellular DNA polymerases α and γ and has been reported to be incorporated into
480 the DNA of cells in culture.

481 **Antiviral Activity:** The antiviral activity of zidovudine against HIV-1 was assessed in a
482 number of cell lines (including monocytes and fresh human peripheral blood lymphocytes). The
483 EC_{50} and EC_{90} values for zidovudine were 0.01 to 0.49 μ M (1 μ M = 0.27 mcg/mL) and 0.1 to
484 9 μ M, respectively. HIV-1 from therapy-naive subjects with no mutations associated with
485 resistance gave median EC_{50} values of 0.011 μ M (range: 0.005 to 0.110 μ M) from Virco (n = 92
486 baseline samples from COLA40263) and 0.0017 μ M (0.006 to 0.0340 μ M) from Monogram
487 Biosciences (n = 135 baseline samples from ESS30009). The EC_{50} values of zidovudine against
488 different HIV-1 clades (A-G) ranged from 0.00018 to 0.02 μ M, and against HIV-2 isolates from
489 0.00049 to 0.004 μ M. In cell culture drug combination studies, zidovudine demonstrates
490 synergistic activity with the nucleoside reverse transcriptase inhibitors abacavir, didanosine, and
491 lamivudine; the non-nucleoside reverse transcriptase inhibitors delavirdine and nevirapine; and
492 the protease inhibitors indinavir, nelfinavir, ritonavir, and saquinavir; and additive activity with
493 interferon alfa. Ribavirin has been found to inhibit the phosphorylation of zidovudine in cell
494 culture.

495 **Resistance:** Genotypic analyses of the isolates selected in cell culture and recovered
496 from zidovudine-treated patients showed mutations in the HIV-1 RT gene resulting in 6 amino
497 acid substitutions (M41L, D67N, K70R, L210W, T215Y or F, and K219Q) that confer
498 zidovudine resistance. In general, higher levels of resistance were associated with greater number
499 of amino acid substitutions. In some patients harboring zidovudine-resistant virus at baseline,
500 phenotypic sensitivity to zidovudine was restored by 12 weeks of treatment with lamivudine and
501 zidovudine. Combination therapy with lamivudine plus zidovudine delayed the emergence of
502 substitutions conferring resistance to zidovudine.

503 **Cross-Resistance:** In a study of 167 HIV-1-infected patients, isolates (n = 2) with
504 multi-drug resistance to didanosine, lamivudine, stavudine, zalcitabine, and zidovudine were

505 recovered from patients treated for ≥ 1 year with zidovudine plus didanosine or zidovudine plus
506 zalcitabine. The pattern of resistance-associated amino acid substitutions with such combination
507 therapies was different (A62V, V75I, F77L, F116Y, Q151M) from the pattern with zidovudine
508 monotherapy, with the Q151M substitution being most commonly associated with multi-drug
509 resistance. The substitution at codon 151 in combination with substitutions at 62, 75, 77, and 116
510 results in a virus with reduced susceptibility to didanosine, lamivudine, stavudine, zalcitabine,
511 and zidovudine. Thymidine analogue mutations (TAMs) are selected by zidovudine and confer
512 cross-resistance to abacavir, didanosine, stavudine, tenofovir, and zalcitabine.

513 **13 NONCLINICAL TOXICOLOGY**

514 **13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility**

515 Zidovudine was administered orally at 3 dosage levels to separate groups of mice and rats
516 (60 females and 60 males in each group). Initial single daily doses were 30, 60, and
517 120 mg/kg/day in mice and 80, 220, and 600 mg/kg/day in rats. The doses in mice were reduced
518 to 20, 30, and 40 mg/kg/day after day 90 because of treatment-related anemia, whereas in rats
519 only the high dose was reduced to 450 mg/kg/day on day 91 and then to 300 mg/kg/day on
520 day 279.

521 In mice, 7 late-appearing (after 19 months) vaginal neoplasms (5 nonmetastasizing
522 squamous cell carcinomas, 1 squamous cell papilloma, and 1 squamous polyp) occurred in
523 animals given the highest dose. One late-appearing squamous cell papilloma occurred in the
524 vagina of a middle-dose animal. No vaginal tumors were found at the lowest dose.

525 In rats, 2 late-appearing (after 20 months), nonmetastasizing vaginal squamous cell
526 carcinomas occurred in animals given the highest dose. No vaginal tumors occurred at the low or
527 middle dose in rats. No other drug-related tumors were observed in either sex of either species.

528 At doses that produced tumors in mice and rats, the estimated drug exposure (as
529 measured by AUC) was approximately 3 times (mouse) and 24 times (rat) the estimated human
530 exposure at the recommended therapeutic dose of 100 mg every 4 hours.

531 It is not known how predictive the results of rodent carcinogenicity studies may be for
532 humans.

533 Zidovudine was mutagenic in a 5178Y/TK^{+/-} mouse lymphoma assay, positive in an in
534 vitro cell transformation assay, clastogenic in a cytogenetic assay using cultured human
535 lymphocytes, and positive in mouse and rat micronucleus tests after repeated doses. It was
536 negative in a cytogenetic study in rats given a single dose.

537 Zidovudine, administered to male and female rats at doses up to 7 times the usual adult
538 dose based on body surface area, had no effect on fertility judged by conception rates.

539 Two transplacental carcinogenicity studies were conducted in mice. One study
540 administered zidovudine at doses of 20 mg/kg/day or 40 mg/kg/day from gestation day 10
541 through parturition and lactation with dosing continuing in offspring for 24 months postnatally.
542 The doses of zidovudine administered in this study produced zidovudine exposures
543 approximately 3 times the estimated human exposure at recommended doses. After 24 months,

544 an increase in incidence of vaginal tumors was noted with no increase in tumors in the liver or
545 lung or any other organ in either gender. These findings are consistent with results of the
546 standard oral carcinogenicity study in mice, as described earlier. A second study administered
547 zidovudine at maximum tolerated doses of 12.5 mg/day or 25 mg/day (~1,000 mg/kg
548 nonpregnant body weight or ~450 mg/kg of term body weight) to pregnant mice from days 12
549 through 18 of gestation. There was an increase in the number of tumors in the lung, liver, and
550 female reproductive tracts in the offspring of mice receiving the higher dose level of zidovudine.

551 **13.2 Reproductive and Developmental Toxicology Studies**

552 Oral teratology studies in the rat and in the rabbit at doses up to 500 mg/kg/day revealed
553 no evidence of teratogenicity with zidovudine. Zidovudine treatment resulted in embryo/fetal
554 toxicity as evidenced by an increase in the incidence of fetal resorptions in rats given 150 or
555 450 mg/kg/day and rabbits given 500 mg/kg/day. The doses used in the teratology studies
556 resulted in peak zidovudine plasma concentrations (after one half of the daily dose) in rats 66 to
557 226 times, and in rabbits 12 to 87 times, mean steady-state peak human plasma concentrations
558 (after one sixth of the daily dose) achieved with the recommended daily dose (100 mg every
559 4 hours). In an in vitro experiment with fertilized mouse oocytes, zidovudine exposure resulted
560 in a dose-dependent reduction in blastocyst formation. In an additional teratology study in rats, a
561 dose of 3,000 mg/kg/day (very near the oral median lethal dose in rats of 3,683 mg/kg) caused
562 marked maternal toxicity and an increase in the incidence of fetal malformations. This dose
563 resulted in peak zidovudine plasma concentrations 350 times peak human plasma concentrations.
564 (Estimated area under the curve [AUC] in rats at this dose level was 300 times the daily AUC in
565 humans given 600 mg/day.) No evidence of teratogenicity was seen in this experiment at doses
566 of 600 mg/kg/day or less.

567 **14 CLINICAL STUDIES**

568 Therapy with RETROVIR has been shown to prolong survival and decrease the incidence
569 of opportunistic infections in patients with advanced HIV-1 disease and to delay disease
570 progression in asymptomatic HIV-1-infected patients.

571 **14.1 Adults**

572 Combination Therapy: RETROVIR in combination with other antiretroviral agents has
573 been shown to be superior to monotherapy for one or more of the following endpoints: delaying
574 death, delaying development of AIDS, increasing CD4+ cell counts, and decreasing plasma
575 HIV-1 RNA.

576 The clinical efficacy of a combination regimen that includes RETROVIR was
577 demonstrated in study ACTG320. This study was a multi-center, randomized, double-blind,
578 placebo-controlled trial that compared RETROVIR 600 mg/day plus EPIVIR[®] 300 mg/day to
579 RETROVIR plus EPIVIR plus indinavir 800 mg t.i.d. The incidence of AIDS-defining events or
580 death was lower in the triple-drug-containing arm compared with the 2-drug-containing arm
581 (6.1% versus 10.9%, respectively).

582 **Monotherapy:** In controlled studies of treatment-naive patients conducted between 1986
 583 and 1989, monotherapy with RETROVIR, as compared with placebo, reduced the risk of HIV-1
 584 disease progression, as assessed using endpoints that included the occurrence of HIV-1-related
 585 illnesses, AIDS-defining events, or death. These studies enrolled patients with advanced disease
 586 (BW002), and asymptomatic or mildly symptomatic disease in patients with CD4+ cell counts
 587 between 200 and 500 cells/mm³ (ACTG016 and ACTG019). A survival benefit for monotherapy
 588 with RETROVIR was not demonstrated in the latter 2 studies. Subsequent studies showed that
 589 the clinical benefit of monotherapy with RETROVIR was time limited.

590 **14.2 Pediatric Patients**

591 ACTG300 was a multi-center, randomized, double-blind study that provided for
 592 comparison of EPIVIR plus RETROVIR to didanosine monotherapy. A total of
 593 471 symptomatic, HIV-1-infected therapy-naive pediatric patients were enrolled in these
 594 2 treatment arms. The median age was 2.7 years (range 6 weeks to 14 years), the mean baseline
 595 CD4+ cell count was 868 cells/mm³, and the mean baseline plasma HIV-1 RNA was
 596 5.0 log₁₀ copies/mL. The median duration that patients remained on study was approximately
 597 10 months. Results are summarized in Table 10.

598
 599 **Table 10. Number of Patients (%) Reaching a Primary Clinical Endpoint (Disease**
 600 **Progression or Death)**

Endpoint	EPIVIR plus RETROVIR (n = 236)	Didanosine (n = 235)
HIV disease progression or death (total)	15 (6.4%)	37 (15.7%)
Physical growth failure	7 (3.0%)	6 (2.6%)
Central nervous system deterioration	4 (1.7%)	12 (5.1%)
CDC Clinical Category C	2 (0.8%)	8 (3.4%)
Death	2 (0.8%)	11 (4.7%)

601
 602 **14.3 Prevention of Maternal-Fetal HIV-1 Transmission**

603 The utility of RETROVIR for the prevention of maternal-fetal HIV-1 transmission was
 604 demonstrated in a randomized, double-blind, placebo-controlled trial (ACTG076) conducted in
 605 HIV-1-infected pregnant women with CD4+ cell counts of 200 to 1,818 cells/mm³ (median in
 606 the treated group: 560 cells/mm³) who had little or no previous exposure to RETROVIR. Oral
 607 RETROVIR was initiated between 14 and 34 weeks of gestation (median 11 weeks of therapy)
 608 followed by IV administration of RETROVIR during labor and delivery. Following birth,
 609 neonates received oral RETROVIR Syrup for 6 weeks. The study showed a statistically
 610 significant difference in the incidence of HIV-1 infection in the neonates (based on viral culture
 611 from peripheral blood) between the group receiving RETROVIR and the group receiving
 612 placebo. Of 363 neonates evaluated in the study, the estimated risk of HIV-1 infection was 7.8%
 613 in the group receiving RETROVIR and 24.9% in the placebo group, a relative reduction in

614 transmission risk of 68.7%. RETROVIR was well tolerated by mothers and infants. There was
615 no difference in pregnancy-related adverse events between the treatment groups.

616 **16 HOW SUPPLIED/STORAGE AND HANDLING**

617 RETROVIR Tablets 300 mg (biconvex, white, round, film-coated) containing 300 mg
618 zidovudine, one side engraved “GX CW3” and “300” on the other side.

619 Bottle of 60 (NDC 0173-0501-00).

620 **Store at 15° to 25°C (59° to 77°F).**

621 RETROVIR Capsules 100 mg (white, opaque cap and body) containing 100 mg
622 zidovudine and printed with “Wellcome” and unicorn logo on cap and “Y9C” and “100” on
623 body.

624 Bottles of 100 (NDC 0173-0108-55).

625 Unit Dose Pack of 100 (NDC 0173-0108-56).

626 **Store at 15° to 25°C (59° to 77°F) and protect from moisture.**

627 RETROVIR Syrup (colorless to pale yellow, strawberry-flavored) containing 50 mg
628 zidovudine in each teaspoonful (5 mL).

629 Bottle of 240 mL (NDC 0173-0113-18) with child-resistant cap.

630 **Store at 15° to 25°C (59° to 77°F).**

631 **17 PATIENT COUNSELING INFORMATION**

632 **17.1 Information About Therapy With RETROVIR**

633 Neutropenia and Anemia: The major toxicities of RETROVIR are neutropenia and/or
634 anemia. The frequency and severity of these toxicities are greater in patients with more advanced
635 disease and in those who initiate therapy later in the course of their infection. They should be
636 told that if toxicity develops, they may require transfusions or drug discontinuation. They should
637 be told of the extreme importance of having their blood counts followed closely while on
638 therapy, especially for patients with advanced symptomatic HIV-1 disease [*see Boxed Warning,*
639 *Warnings and Precautions (5.1)*].

640 Common Adverse Reactions: Other adverse effects of RETROVIR include nausea and
641 vomiting. Patients should also be encouraged to contact their physician if they experience muscle
642 weakness, shortness of breath, symptoms of hepatitis or pancreatitis, or any other unexpected
643 adverse events while being treated with RETROVIR [*see Adverse Reactions (6)*].

644 Drug Interactions: Patients should be cautioned about the use of other medications,
645 including ganciclovir, interferon alfa, and ribavirin, which may exacerbate the toxicity of
646 RETROVIR.

647 Redistribution/Accumulation of Body Fat: Redistribution or accumulation of body fat
648 may occur in patients receiving antiretroviral therapy and that the cause and long-term health
649 effects of these conditions are not known at this time [*see Warnings and Precautions (5.6)*].

650 Pregnancy: Pregnant women considering the use of RETROVIR during pregnancy for
651 prevention of HIV-1 transmission to their infants should be advised that transmission may still

652 occur in some cases despite therapy. The long-term consequences of in utero and infant exposure
653 to RETROVIR are unknown, including the possible risk of cancer.

654 HIV-1-infected pregnant women should be advised not to breastfeed to avoid postnatal
655 transmission of HIV to a child who may not yet be infected.

656 Information About Therapy With RETROVIR: RETROVIR is not a cure for HIV-1
657 infection, and patients may continue to acquire illnesses associated with HIV-1 infection,
658 including opportunistic infections. Therefore, patients should be advised to seek medical care for
659 any significant change in their health status.

660 Patients should be told of the importance of taking RETROVIR exactly as prescribed.
661 They should be told not to share medication and not to exceed the recommended dose. Patients
662 should be told that the long-term effects of RETROVIR are unknown at this time.

663 Therapy with RETROVIR has not been shown to reduce the risk of transmission of
664 HIV-1 to others through sexual contact or blood contamination.

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671 GlaxoSmithKline
672 Research Triangle Park, NC 27709

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