



HIV s100 Prescribers' Information Sheet

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Prescriber renewals for 2008 – have you returned your renewal form?

Thank you to those that have submitted their renewal forms for 2008. For those who haven't, another copy has been sent with this information sheet. If you need advice, contact Hiba Jebeile 02 8204 0725 or hiba.jebeile@ashm.org.au. Here are a few suggestions for accumulating points ...

Mentoring / case conferencing – As well as claiming the time you have spent with your mentor in 2007, remember to claim any face-to-face, phone or email time you have spent consulting with other colleagues over particular cases. All this time is cumulative and **every 60 minutes earns 1 CME point for both parties**. You may submit an occurrence of mentorship online via the ASHM website at <http://www.ashm.org.au/mentoring-submission/>

If you'd like to be mentored or you'd like to mentor a new prescriber or existing low caseload prescriber, just email us at primarycare@ashm.org.au or register your interest online at <http://www.ashm.org.au/mentorship/>

Clinical placements – 2 CME points. Many prescribers in GP settings, particularly those from regional areas, find that a clinical placement with a specialist is an efficient way to update. ASHM can arrange a suitable placement and organise your travel and accommodation, plus cover the cost of a locum for rural, regional and remote prescribers. To register your interest email us at primarycare@ashm.org.au or via <http://www.ashm.org.au/clinical-placements/>

Upcoming HIV CME activities

NSW	29 February 2008 – AChSHM 2008 Scientific Meeting 'Leaps and Bounds'	2 CME points
	5 March 2008 – ASHM HIV Case Discussion Meeting, Sydney	2 CME points
	2 April 2008 – HIV GP Study Group Meeting, Sydney	1 CME point
	2 – 4 May 2008 – ASHM Short Course in HIV Medicine, Sydney	2 pts per module
VIC	February – August 2008 – Short Course in HIV Medicine by distance learning	2 pts per module
	18 – 20 April 2008 – Short Course in HIV Medicine, Melbourne	2 pts per module

To register or for further information on HIV CME activities in Victoria, please contact Michelle Wills as follows.
Email: m.wills@gpv.org.au; **Phone:** (03) 9341 5226; **Fax:** (03) 9341 5299.

Darunavir (Prezista)

Darunavir is now available to HIV-infected patients via the PBS who meet the following criteria. The product information leaflet PDF and an s100 declaration form was sent out with the last HIV info sheet in December. Treatment, in combination with other antiretroviral agents, and co-administered with 100mg ritonavir twice daily, of HIV infection in an antiretroviral experienced patient with:

- Evidence of HIV replication (viral load greater than 10,000 copies per mL); and/or
- CD4 cell counts of less than 500 per cubic millimetre.

A patient must have failed previous treatment with, or have resistance to, 3 different ART regimens that have included:

- At least 1 non-nucleoside reverse transcriptase inhibitor; and
- At least 1 nucleoside reverse transcriptase inhibitor; and
- At least 2 protease inhibitors

Maraviroc (Celsentri)

Maraviroc - the first CCR5 Inhibitor agent available in its class - is currently being made available in Australia through an early access clinical trial program by Pfizer Australia.

This has been a site limited investigator program, and has been designed to collect additional safety data outside of the existing Phase 2b and Phase 3 clinical trials.

For patients who are unable to satisfy the requirements for this EAP, a restricted SAS program is being offered under a compassionate access criterion. The eligibility criteria and details of this program can be discussed directly with the Pfizer Australia Associate Medical Director - Dr Alan Paul on 02 9850 3851 or Mobile 0409 392 688.

Efavirenz (Stocrin)

Commonwealth DOHA has advised that Efavirenz 200mg capsules will be deleted from the PBS s100 drug list from 1 April 2008. Thereafter, only 200mg tablets will be available.

Atazanavir (Reyataz)

The Reyataz (atazanavir) package insert was revised to include information regarding the administration of atazanavir and/or atazanavir/ritonavir with food, proton pump inhibitors, H₂ receptor antagonists, acetaminophen, and fluconazole. Additionally, dosing information in patients with renal impairment was included. For complete labelling changes, please refer to <http://www.fda.gov/cder/foi/label/2007/021567s014lbl.pdf> and these changes can be summarized as follows.

1. The dose recommendations for therapy-naïve patients receiving H₂-receptor antagonists or proton pump inhibitors are the following:
 - a) The H₂-receptor antagonist dose should not exceed a 40 mg dose equivalent of famotidine twice daily. Reyataz 300 mg and ritonavir 100 mg should be administered simultaneously with, and/or at least 10 hours after, the dose of the H₂-receptor antagonist.
 - b) The proton-pump inhibitor dose should not exceed a 20 mg dose equivalent of omeprazole and must be taken approximately 12 hours prior to the Reyataz 300 mg and ritonavir 100 mg dose.
2. The dose recommendations for therapy-experienced patients receiving H₂-receptor antagonists or proton pump inhibitors are the following:
 - a) Whenever an H₂-receptor antagonist is given to a patient receiving Reyataz with ritonavir, the H₂-receptor antagonist dose should not exceed a dose equivalent to famotidine 20 mg twice daily, and the Reyataz and ritonavir doses should be administered simultaneously with, and/or at least 10 hours after, the dose of the H₂-receptor antagonist.
 - b) Reyataz 300 mg (one 300-mg capsule or two 150-mg capsules) with ritonavir 100 mg once daily (all as a single dose with food) if taken with an H₂-receptor antagonist.
 - c) Reyataz 400 mg (two 200-mg capsules) with ritonavir 100 mg once daily (all as a single dose with food) if taken with both tenofovir and an H₂-receptor antagonist.
 - d) Proton-pump inhibitors should not be used in treatment-experienced patients receiving Reyataz.
3. In addition, the Dosage and Administration section was updated to provide dosing information in patients with renal impairment as follows:
 - a) For patients with renal impairment, including those with severe renal impairment who are not managed with hemodialysis, no dose adjustment is required for Reyataz.
 - b) Treatment-naïve patients with end stage renal disease managed with hemodialysis should receive Reyataz 300 mg with ritonavir 100 mg.
 - c) Reyataz should not be administered to HIV-treatment experienced patients with end stage renal disease managed with hemodialysis.

Fosamprenavir (Telzir) drug-drug interaction information from FDA

FDA has alerted HIV physicians to the fact that Fosamprenavir product information was recently updated to include new drug-drug interaction information regarding phenytoin (an anticonvulsant) and paroxetine (an antidepressant). Details of the newly added information are contained in the PDF file available at:

<http://www.fda.gov/cder/foi/label/2007/021548s014lbl.pdf>

Caution is advised if fosamprenavir is co-administered with phenytoin as the fosamprenavir may be less effective due to decreased amprenavir plasma concentrations. Caution is also advised if fosamprenavir is coadministered with paroxetine as fosamprenavir/ritonavir significantly decreases plasma levels of paroxetine. Any paroxetine dose adjustment should be guided by clinical effect (tolerability and efficacy).

FDA advice on Nelfinavir (Viracept) & Kaletra prescribing in HIV PEP

Since the CDC updated HIV PEP recommendations in 2005, two important changes to antiretroviral use have occurred that could affect the prescription of antiretroviral drugs for HIV PEP. Firstly Kaletra, a combination protease inhibitor, is no longer available in its original formulation: capsules containing 133 mg of lopinavir and 33 mg of ritonavir. Although the recommended daily prescribed amount of Kaletra ingredients is unchanged, the dosing regimen has changed as a result of the new Kaletra formulation. The previous dosing regimen for the capsule formulation was three capsules twice daily. Kaletra is now manufactured only in tablet form, with each tablet

containing 200 mg of lopinavir and 50 mg of ritonavir. To achieve the same recommended daily prescribed amount of the tablet formulation, two tablets of 200 mg of lopinavir and 50 mg of ritonavir should be taken twice daily. Secondly, on September 10 2007, Pfizer Inc. issued a letter warning to health-care providers about the use of Viracept (nelfinavir), because the nelfinavir manufactured in Europe contained high levels of ethyl methane mesylate (EMS). EMS is a byproduct of the manufacturing process and a known animal carcinogen, mutagen, and teratogen. The level at which EMS might become carcinogenic or teratogenic in humans is not known. The warning in the letter applies to pregnant women and states that information about the ability of EMS to cross the placenta or to enter breast milk is currently unknown. A review of data from the Antiretroviral Pregnancy Registry, which collects data on approximately 6,000 HIV-infected pregnant women, indicated that, during January 1989 to January 2007, no statistically significant difference was observed in the prevalence of birth defects among the infants of women who used nelfinavir compared with those whose mothers used other antiretroviral therapies. Nonetheless, the FDA recommends that pregnant women limit their exposure to EMS during pregnancy. Until further notice, pregnant women who need to begin antiretroviral therapy or HIV PEP should not be offered regimens containing nelfinavir.

23 valent pneumococcal vaccine prevents pneumonia in HIV-infected people

The 23-valent pneumococcal polysaccharide vaccine (PPV) was at one stage recommended for all HIV infected individuals, but over recent times and in the era of highly active antiretroviral therapy (HAART), the role of this vaccination has become less clear. Some studies have suggested that the widespread use of HAART has resulted in a decrease in the incidence of invasive pneumococcal disease (IPD). Feikin et al found that in developed countries, cohort studies showed that HAART had the most consistent effect on reducing pneumonia. Other groups have found that IPD incidence remained stable despite major advances in the potency of available antiretroviral therapy and was associated with several sociodemographic and clinical factors.

In Clinical Infectious Diseases there is a report about the influence of HAART on the efficacy of the pneumococcal vaccine in HIV-infected individuals. The report by Peñaranda et al is a retrospective Spanish case-control study. Multivariate analysis identified three factors that independently raised the risk of pneumococcal disease (cirrhosis, chronic obstructive pulmonary disease, alcoholism) and two factors that protected against pneumonia (antiretroviral therapy, Pneumococcal vaccine). The protective effect of 23-valent pneumococcal vaccine held true even in people with a CD4 count below 200 cells/ μ L. Although injecting drug use and cotrimoxazole prophylaxis were more frequent in people diagnosed with pneumococcal disease, neither factor reached a statistically significant level in multivariate analysis. Peñaranda et al (3) concluded that antiretroviral therapy and PPV have a significant, independent protective effect against pneumococcal disease, regardless of CD4 lymphocyte count. They suggest that all patients with HIV infection should be vaccinated with PPV to prevent pneumococcal disease, as these new results indicate that the vaccine does prevent pneumonia in HIV-infected people.

The research papers referred to in this article are listed on ASHM website at <http://www.ashm.org.au/news/216/11/>

New US DHHS ART guidelines released

The US Department of Health and Human Services (DHHS) has just released an updated version of the *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents*. The Australasian Antiretroviral Guidelines Panel has reviewed the revised document and is currently updating the Australian commentary.

The DHHS updated guidelines, including a "what's new in this document" page can be accessed at this link: <http://aidsinfo.nih.gov/Guidelines/GuidelineDetail.aspx?MenuItem=Guidelines&Search=Off&GuidelineID=7&ClassID=1>

The existing Australasian commentary can be accessed at this link: <http://www.ashm.org.au/uploads/File/aust-ARVG-2006-10.pdf>

Included with this Information Sheet:

Living longer with HIV – resource	Talkabout – Oct/Nov & Dec/Jan issues
Treat yourself right – Women and HIV resource	HIV Australia – Volume 6 No. 1
STIGMA Survey	HIV Case Discussion Meeting - flyer
Short Course in HIV Medicine - flyer	ASHM Conference 2008 - flyer

Plus ... your HIV s100 Prescribing renewal forms for 2008