Anti-tuberculosis Treatment Selector

Charts revised October 2018. Full information available at www.hiv-druginteractions.org

		ATV/r	DRV/r	LPV/r	EFV	ETV	NVP	RPV	MVC	DTG	RAL	ABC	FTC	3TC	TDF	ZDV	E/C/F/TAF	E/C/F/TDF
First Line and Second Line Drugs	Amikacin	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔[a]	↔	↔[b]	↔	↔[a]	↔[b]
	Capreomycin	↔	↔	↔	↔	↔	↔	↔	↔	↑?[a]	↔	↔	↑?[a]	↑?[a]	↑?[b]	↔	↔[a]	↑?[b]
	Clofazimine	↔[c]	↔	↔[c]	↔	↔	↔	↔[c]	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	Cycloserine	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	Delamanid	d	d	d	↔[e]	↔	↔	↔[c]	↔	↔	↔	↔	↔	↔	↔	↔	d	d
	Ethambutol	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	Ethionamide	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	Isoniazid	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	Kanamycin	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔[b]	↔	↔	↔[b]
	Moxifloxacin	↑[c]	↔	↔[c]	↓	↓	↔	↔[f]	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	Para-aminosalicylic acid	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↑?	↑?	↑?	↔	↑?[a]	↑?
	Pyrazinamide	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
	Rifabutin	↑	↑ ⇑50%	↑	↓38%	⇓ 37%	↑17%	⇓[g]	h	↔	↔	↔	↔	↔	↔	↔	↑ ⇓	↑ ⇓
	Rifampicin	⇓ 72%	⇓	⇓	⇓ 26%	⇓	⇓ 58%	⇓ 80%	⇓[i]	⇓ 54%[j]	⇓ 40%	⇓	↔	↔	↔	⇓ 47%	⇓	⇓
	Rifapentine	⇓	⇓	⇓	⇓	⇓	⇓	⇓	⇓[i]	⇓[k]	⇓	↔	↔	↔	↔	↔	⇓	⇓
	Streptomycin	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔[b]	↔	↔	↔[b]

Colour Legend

- No clinically significant interaction expected.
- These drugs should not be coadministered.
- Potential interaction which may require a dosage adjustment or close monitoring.
- Potential interaction predicted to be of weak intensity. No *a priori* dosage adjustment is recommended.

Text Legend

↑ Potential increased exposure of the anti-tuberculosis drug
↓ Potential decreased exposure of the anti-tuberculosis drug
↔ No significant effect
⇑ Potential increased exposure of HIV drug
⇓ Potential decreased exposure of HIV drug

Numbers refer to increased or decreased AUC of the HIV drug or anti-tuberculosis drug as observed in drug-drug interaction studies.

a Aminoglycosides are nephrotoxic (risk is dose and treatment duration related). Renal function should be monitored as clinically appropriate and the dosage of the antiretroviral adjusted accordingly.

b Coadministration should be avoided due to the risk of additive tubular toxicity, but if such use is unavoidable, closely monitor renal function.

c Both drugs can potentially prolong the QT interval, ECG monitoring recommended.

d Coadministration is expected to increase concentrations of DM-6705, a delamanid metabolite which is associated with QT prolongation. Frequent ECG monitoring is recommended.

e A higher rate of neuropsychiatric adverse effects (e.g., euphoric mood and abnormal dreams) was observed with delamanid plus efavirenz compared to either drug alone.

f Rilpivirine's manufacturer recommends caution when coadministering with another drug susceptible to prolong QT interval as supratherapeutic dose of rilpivirine (75 and 300 mg once daily) were shown to prolong QT interval.

g Coadministration is contraindicated in rilpivirine's US Prescribing Information, however, its European SPC recommends the rilpivirine dose should be increased to 50 mg once daily during coadministration (and decreased to 25 mg once daily when rifabutin is stopped). The charts reflect the more caution option.

h No dose adjustment for MCV in absence of PI. With PI (except TPV/r, FPV/r), give MVC 150 mg twice daily.

i Give MVC 600 mg twice daily

j A dose adjustment of dolutegravir to 50 mg twice daily is recommended in treatment-naïve or INSTI-naïve patients. Alternatives to rifampicin should be used where possible for INSTI-experienced patients with certain INSTI-associated resistance substitutions or clinically suspected INSTI resistance.

k Based on dolutegravir interactions studies with rifabutin and rifampicin, consider administering dolutegravir at 50 mg twice daily in the presence of rifapentine.

Abbreviations ATV atazanavir ABC abacavir DRV darunavir FTC emtricitabine LPV lopinavir 3TC lamivudine /r ritonavir TDF tenofovir disoproxil fumarate EFV efavirenz ZDV zidovudine ETV etravirine E/C/F/ Elvitegravir/Cobicistat/FTC NVP nevirapine TAF tenofovir alafenamide RPV rilpivirine MVC maraviroc DTG dolutegravir RAL raltegravir