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Anti-tuberculosis Treatment Selector

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	ATV/c	ATV/r	DRV/c	DRV/r	LPV/r	DOR	EFV	ETV	NVP	RPV	MVC	BIC/ F/TAF	DTG	EVG/c/ F/TAF	EVG/c/ F/TDF	RAL	ABC	FTC or 3TC	F/TAF	TDF	ZDV
First line and Second line Drugs																					
Amikacin	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔ [a]	↔	↔	↔	↔	↔ [a]	↔
Bedaquiline	↑♥	↑♥	↑	↑	↑62%♥	↔	↓18%	↓	↑3%	↔♥	↔	↔	↔	↑	↑	↔	↔	↔	↔	↔	↔
Capreomycin	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↑⇑ [b]	↑ [c]	↑⇑ [b]	↑⇑ [a,d]	↔	↔	↑⇑ [e]	↑⇑ [b]	↑⇑ [a]	↔
Clofazimine	↔♥	↔♥	↔	↔	↔♥	⇑	↔	↔	↔	⇑♥	⇑	⇑ [f]	↔	↔	↔	↔	↔	↔	↔	↔	↔
Cycloserine	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Delamanid	g	g	g	g	g	↔	↔ [h]	↔	↔	↔♥	↔	↔	↔	g	g	↔	↔	↔	↔	↔	↔
Ethambutol	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Ethionamide	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Isoniazid	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Kanamycin	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔ [a]	↔	↔	↔	↔	↔ [a]	↔
Moxifloxacin	↑♥	↓♥	↔	↓	↓♥	↔	↓	↓	↔	↔♥	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Para-aminosalicylic acid	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↑⇑ [i]	↑	↑⇑ [i]	↑⇑ [j]	↔	⇓	↑⇑ [k]	↑⇑ [i]	↑⇑	↔
Pyrazinamide	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Rifabutin	↑⇓	↑	↑⇓	↑⇑50%	↑	⇓50% [l]	↓38%	⇓37%	↑17%	⇓42% [m]	n	⇓38% [o]	↔	↑⇓	↑⇓	⇑19%	↔	↔	⇓ [p]	↔	↔
Rifampicin	⇓	⇓72%	⇓	⇓57%	⇓75%	⇓82%	⇓26%	⇓	⇓58%	⇓80%	⇓ [q]	⇓75% [o]	⇓54% [r]	⇓	⇓	⇓40%	↔	↔	⇓ [p]	⇓12%	⇓47%
Rifapentine	⇓	⇓	⇓	⇓	⇓	⇓	⇓	⇓	⇓	⇓	⇓ [q]	⇓	⇓ [s]	⇓	⇓	⇓	↔	↔	⇓ [p]	↔	↔
Streptomycin	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔ [a]	↔	↔	↔	↔	↔ [a]	↔

Colour Legend

- No clinically significant interaction expected.
- These drugs should not be coadministered.
- Potential interaction which may require a dose 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

♥ One or both drugs may cause QT and/or PR prolongation. ECG monitoring is advised if coadministered with atazanavir or lopinavir; caution is advised with rilpivirine as supratherapeutic doses of rilpivirine (75 and 300 mg once daily) were shown to prolong the QT interval.

Numbers refer to increase or decrease in AUC as observed in drug-drug interaction studies.

Notes

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

b Coadministration may increase concentrations of capreomycin and emtricitabine. Renal function should be monitored as clinically appropriate.

c 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.

d Coadministration may increase concentrations of capreomycin, emtricitabine and tenofovir. Renal function should be monitored as clinically appropriate.

e Coadministration may increase concentrations of capreomycin and emtricitabine or lamivudine. Renal function should be monitored as clinically appropriate.

f Coadministration may increase bictegravir concentrations, but this is unlikely to be clinically significant.

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

h 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.

i Coadministration may increase concentrations of para-aminosalicylic acid and emtricitabine.

j Coadministration may increase concentrations of para-aminosalicylic acid, emtricitabine and tenofovir.

k Coadministration may increase concentrations of para-aminosalicylic acid and emtricitabine or lamivudine.

l The product label for doravirine recommends to increase doravirine dosage to 100 mg twice daily when co-administered with rifabutin. Doravirine should be kept at 100 mg twice daily for at least another 2 weeks following cessation of rifabutin due to the persisting inducing effect upon discontinuation of a moderate/strong inducer.

m The rilpivirine dose should be increased to 50 mg once daily during coadministration (and decreased to 25 mg once daily when rifabutin is stopped). Note, it is recommended to maintain rilpivirine 50 mg once daily for at least another 2 weeks following cessation of rifabutin due to the persisting inducing effect upon discontinuation of a moderate/strong inducer.

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

o Numbers refer to decrease in bictegravir AUC; decreases in the absorption of tenofovir alafenamide and thereby its plasma concentrations are also expected.

p Coadministration is expected to decrease the exposure of tenofovir alafenamide; no effect on emtricitabine is expected.

q Give MVC 600 mg twice daily

r 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.

s 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 DRV darunavir LPV lopinavir /c cobicistat /r ritonavir DOR doravirine EFV efavirenz ETV etravirine NVP nevirapine RPV rilpivirine MVC maraviroc
BIC bictegravir DTG dolutegravir EVG elvitegravir RAL raltegravir ABC Abacavir F or FTC emtricitabine 3TC lamivudine TAF tenofovir alafenamide TDF tenofovir-DF ZDV zidovudine