

Antiepileptic Treatment Selector

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	DCV	ELB/GZR	G/P	LED/SOF	OBV/PTV/r	OBV/PTV/r +DSV	SMV	SOF	SOF/VEL	SOF/VEL/VOX
Carbamazepine	↓ ^a	↓	↓ ^{b, c}	↓ ^b	↓ ^d	↓ ^d	↓	↓ ^{b, e}	↓ ^b	↓
Clobazam	↔	↔	↔	↔	↑ ^f	↑ ^f	↑ ^f	↔	↔	↔
Clonazepam	↔	↔	↔	↔	↑	↑	↑	↔	↔	↔
Eslicarbazepine	↓ ^g	↓	↓ ^b	↔	↓	↓	↓	↔	↓ ^b	↓
Diazepam	↔	↔	↔	↔	↑ ^h	↑ ^h	↑ ⁱ	↔	↔	↔
Ethosuximide	↔	↔	↔	↔	↑	↑	↑	↔	↔	↔
Gabapentin	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Lacosamide	↔	↔	↔	↔	↑	↑	↑	↔	↔	↔
Lamotrigine	↔	↔	↔	↔	↓	↓	↔	↔	↔	↔
Levetiracetam	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Lorazepam	↔	↔	↔	↔	↑	↑	↔	↔	↔	↔
Midazolam (oral)	↔	↑	↔	↔	↑	↑	↑45%	↔	↔	↔
Midazolam (parental)	↔	↑	↔	↔	↑ ^j	↑ ^j	↑10%	↔	↔	↔
Oxcarbazepine	↓ ^g	↓	↓ ^b	↓ ^b	↓	↓	↓	↓ ^b	↓ ^b	↓
Perampanel	↔	↔	↔	↔	↑	↑	↑	↔	↔	↔
Phenobarbital	↓ ^a	↓	↓ ^b	↓ ^b	↓ ^l	↓ ^l	↓	↓ ^b	↓ ^b	↓
Phenytoin	↓ ^a	↓	↓ ^b	↓ ^b	↓ ^l	↓ ^l	↓	↓ ^b	↓ ^b	↓
Pregabalin	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Primidone	↓ ^a	↓	↓ ^b	↓ ^b	↓ ^l	↓ ^l	↓	↓ ^b	↓ ^b	↓
Retigabine	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Rufinamide	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓
Sultiame	↔	↔	↔	↔	↑ ^f	↑ ^f	↑↑ ^k	↔	↔	↔
Tiagabine	↔	↔	↔	↔	↑ ^f	↑ ^f	↑ ^f	↔	↔	↔
Topiramate	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Valproate	↔	↔	↔	↔	↓ ^l	↓ ^l	↔	↔	↔	↔
Vigabatrin	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔
Zonisamide	↔	↔	↔	↔	↔	↔	↔	↔	↔	↔

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.

Text Legend

↑	Potential increased exposure of the anticonvulsant	↑	Potential increased exposure of HCV DAA
↓	Potential decreased exposure of the anticonvulsant	↓	Potential decreased exposure of HCV DAA
↔	No significant effect		

Numbers refer to increased or decreased AUC as observed in drug-drug interaction studies.

- a Coadministration is contraindicated. However, a published case series demonstrates that clinical cure (guided by TDM) may be achieved in patients where coadministration cannot be avoided.
- b Coadministration is not recommended. However, reports indicate that patients who remained on anti-epileptics during HCV DAA therapy achieved SVR. TDM should be considered.
- c Glecaprevir AUC decreased by 66%; pibrentasvir AUC decreased by 51%.
- d Coadministration with ombitasvir/paritaprevir/ritonavir + dasabuvir decreased the AUCs of ombitasvir, paritaprevir and dasabuvir by 31%, 70% and 70%, respectively.
- e Coadministration decreased sofosbuvir C_{max} and AUC by 48%. C_{max} of GS-331007 increased by 4%; AUC decreased by 1%.
- f Close monitoring is recommended for signs and symptoms of increased antiepileptic concentration.
- g If coadministration is necessary, the dose of daclatasvir should be increased to 90 mg once daily.
- h Coadministration with ombitasvir/paritaprevir/ritonavir + dasabuvir increased diazepam C_{max} by 18%, but decreased AUC by 22%; nordiazepam C_{max} increased by 10%, but AUC decreased by 40%. Monitor closely and adjust dose if indicated.
- i Use with caution and at the lowest possible dose.
- j Coadministration should take place under close clinical monitoring with medical management in case of respiratory depression. Dose reduction should be considered.
- k Monitor the usual clinical parameters closely for increased side effects and concentrations.
- l The clinical significance of this is unclear. No a priori dose adjustment is required. Perform therapeutic drug monitoring and adjust dose if indicated.

Abbreviations: DCV Daclatasvir ELB/GZR Elbasvir/Grazoprevir G/P Glecaprevir/Pibrentasvir LED Ledipasvir OBV/PTV/r +DSV Ombitasvir/Paritaprevir/Ritonavir +Dasabuvir
SMV Simeprevir SOF Sofosbuvir VEL Velpatasvir VOX Voxilaprevir

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