

Antiepileptic Treatment Selector

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

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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.
- 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 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 44%. Monitor closely and adjust dose if indicated.
- h If coadministration is necessary, the dose of daclatasvir should be increased to 90 mg once daily.
- i Coadministration should take place under close clinical monitoring with medical management in case of respiratory depression. Dose reduction should be considered.
- j The clinical significance of decrease in valproate semisodium 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
RDV Ravidasvir SOF Sofosbuvir VEL Velpatasvir VOX Voxilaprevir

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