

Drug Interactions with Antiretroviral Medications

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Module 3: [Antiretroviral Therapy](#)

Lesson 3: [Drug Interactions with Antiretroviral Medications](#)

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<https://www.hiv.uw.edu/go/antiretroviral-therapy/drug-drug-interactions/core-concept/all>.

Overview

Successful antiretroviral therapy depends on attaining a therapeutic drug concentration that maximizes efficacy and minimizes toxicity.[1] Therefore, understanding drug interactions is an important component of providing effective and safe antiretroviral therapy. Drug interactions can be classified into two general categories: those that alter pharmacodynamics (what medications do to the body) or those that alter pharmacokinetics (what the body does to medications).

- **Pharmacodynamics:** Pharmacodynamics describes the relationship of a drug and its effect on the body’s receptors, which can be affected by the number and affinity of receptors, drug concentration, and genetics. In addition, genetic polymorphisms can influence the expression and availability of both receptor number and receptor affinity for a particular drug.
- **Pharmacokinetics:** Pharmacokinetics refers to the absorption, distribution, metabolism, and excretion of drugs in the body, which is often influenced by various biological, physiological, and chemical factors.[1] Pharmacokinetic studies define the steady-state concentration of a particular drug, accounting for dose, bioavailability, and clearance, as well as drug interactions that can alter the systemic concentration of coadministered medications.[1] Pharmacokinetic interactions can occur between concomitant use of antiretroviral and other medications during the absorption, metabolism, or elimination phases.

Table 1. Common Types of Pharmacokinetic Drug Interactions

Pharmacokinetic Drug Interactions	Interaction	Comment
	Absorption	Concurrent therapy or food ingestion results in increase or decrease in drug absorption, thereby increasing or decreasing bioavailability.
	Distribution	Concurrent therapy leads to protein binding displacement, altering the activity of either drug.
	Metabolism	Therapy induces or inhibits CYP450 enzymes, thereby increasing or decreasing drug concentration.
	Excretion	Concurrent therapy results in enhanced or decreased renal excretion of drug.

Types of Pharmacokinetic Interactions

This Topic Review will primarily focus on pharmacokinetic interactions that involve antiretroviral medications.

Pharmacokinetic interactions can occur between concomitant use of antiretroviral and other medications during the absorption, metabolism, or elimination phases. Most clinically significant interactions are mediated by the cytochrome P450 system, a superfamily of microsomal, catalytic enzymes responsible for metabolizing more than half of all drugs.[1,2,3] There are many cytochrome P450 proteins, but the most important for drug metabolism belong to the CYP1, CYP2, or CYP3 families.[3] Overall, the CYP3A enzyme has the greatest impact on the metabolism of antiretroviral medications; this enzyme is abundant in both enterocytes of the small intestinal epithelium and hepatocytes (Figure 1).[3] Other enzymes in the cytochrome P450 family, such as CYP1A2, 2C19, and 2D6, also play a key role. The uridine diphosphate (UDP)-glucuronosyltransferase (UGT) 1A1 enzyme is an important mediator of pharmacokinetic interactions related to the metabolism of integrase strand transfer inhibitors (INSTIs) and other antiretrovirals. Certain antiretroviral agents, such as tenofovir alafenamide, rely on enzymes like P-glycoprotein (P-gp) for absorption in the gut and thus may be affected by other medications that affect P-gp activity. Drug therapy may affect enzyme activity in one of three major ways: (1) by inhibiting the activity of the enzyme, (2) by inducing the activity of the enzyme, or (3) by acting as a substrate for the enzyme. Some medications act as both an inhibitor and inducer of a particular enzyme, which can further complicate drug interactions.

Pharmacokinetic Inhibition

Drugs that inhibit enzymes (inhibitors) reduce the metabolism of other drugs that depend on the same enzyme, leading to increased drug levels and potential drug toxicity (Figure 2). In the case of the cytochrome P450 enzyme system, inhibition of drug metabolism is usually rapid (based on the drug's half-life), with maximal effect occurring when the inhibiting drug reaches its peak concentration. Once the inhibitor is stopped, its effect typically dissipates after 3 to 5 half-lives.

Pharmacokinetic Induction

Drugs that induce enzymes (inducers) cause an increase in the clearance of drugs metabolized by the same enzyme, leading to decreased concentrations of the other drug(s) (Figure 3). The time to onset of induction is longer than the time to onset of inhibition and is based on the half-life of the inducing drug and the time required for new enzyme synthesis. As a general rule, the maximal effect of enzyme induction is apparent in 7 to 10 days, although for drugs with a relatively long half-life, the full effect of induction may take even longer. Upon discontinuation of the inducer, the effects of induction will last at least 3 to 5 half-lives plus the time for the induced enzyme to return to preinduction levels; this varies but is likely to be approximately 7 to 10 additional days.

Drug Interactions in HIV Clinical Care

The most commonly encountered drug interactions in the context of HIV clinical care occur between antiretroviral therapies and medications used to manage common comorbidities. Drug interactions range from mild to severe (and even potentially fatal). Medical providers who care for persons with HIV should always conduct a thorough medication history at each visit, including prescription, over-the-counter, herbal, and recreational drugs, and consider potential interactions before prescribing any new medication. The highly potent INSTI anchor antiretroviral medications bictegravir and dolutegravir have relatively few drug interactions.[4,5] In contrast, the pharmacologic boosters cobicistat and ritonavir frequently cause significant drug interactions, since they inhibit CYP3A and other transporters involved with the metabolism of many commonly used medications for general medical care. Medical providers should also be cautious when discontinuing boosters and changing HIV therapy to non-boosted regimens, as dose adjustments of concurrent medications may be needed following the regimen switch. Long-acting injectable antiretrovirals, such as intramuscular cabotegravir and rilpivirine, and subcutaneous lenacapavir, have drug interactions that require special consideration, given the long half-lives of these drugs. Clinicians should note that there exists potential for ongoing interactions for months after a long-acting injectable drug is discontinued. Interactions between antiretroviral medications and oral contraceptives can be found in the lesson [HIV in Women](#).

Resources for Drug Interactions Involving Antiretroviral Medications

For clinicians, it is impossible to know or memorize all the potential drug interactions that can occur in people with HIV who are taking antiretroviral medications. Therefore, we strongly recommend utilizing drug interaction resources whenever a new medication is started in a person receiving antiretroviral therapy, as well as when starting antiretroviral therapy in a person who is already taking other medications. It is beyond the scope of this lesson to address all drug interactions that can occur with antiretroviral medications. For this reason, this lesson will highlight select clinically significant drug interactions to enhance a clinician's awareness of such interactions. The following list highlights excellent resources that address a broad array of drug interactions that can occur with HIV antiretroviral medications.

- [University of Liverpool: HIV Drug Interaction Checker](#)
- [Adult and Adolescent ARV Guidelines Drug-Drug Interactions \(Overview Page\)](#)
- [Northeast Caribbean AIDS Education and Training Center Drug Interaction Mobile Apps](#)

Acid Suppressive Therapy and Supplements

Medications used to treat dyspepsia, heartburn, and gastroesophageal reflux disease (GERD), including histamine-2 receptor antagonists (H2 blockers) and proton pump inhibitors (PPIs), alter gastric pH and may affect the absorption of certain antiretroviral medications.[6] Among the antiretroviral agents, atazanavir and rilpivirine are the most vulnerable to pharmacokinetic interactions with acid-suppressing medications, since both of these agents require an acidic gastric pH for dissolution and absorption.[7,8,9] Unlike rilpivirine, the newer non-nucleoside reverse transcriptase inhibitor (NNRTI) doravirine is not impacted by gastric pH or by acid-suppressive therapy. In addition, other medications used to treat gastrointestinal symptoms, such as antacids and sucralfate, may contain polyvalent cations that can bind to and chelate certain antiretrovirals, most notably integrase strand transfer inhibitors (INSTIs). Further, many multivitamins and other supplements contain polyvalent cations. Specifically, if an INSTI is coadministered with a polyvalent cation, including a divalent or trivalent metal cation, the INSTI and the polyvalent cation may chelate, which lowers the solubility of the INSTI and significantly reduces absorption of the INSTI.[10,11] Medical providers should review potential drug interactions when coadministering antiretroviral medications with antacids, acid-suppressive medications, and supplements that contain divalent cations.[2] The following summarizes key interactions and recommendations for coadministration of antiretroviral medications with agents that lower gastrointestinal pH and with polyvalent cations. This discussion is not comprehensive, and does not include atazanavir, since it is now infrequently used in clinical practice.

Agents that Alter Gastrointestinal PH

Antacids

- **Rilpivirine:** Caution should be given with the concomitant use of oral rilpivirine and antacids. If used together, the oral rilpivirine should be given at least 4 hours before or 2 hours after the antacid. There are no interactions with long-acting injectable rilpivirine and antacids.
- **INSTIs:** Coadministration of antacids or buffered medication can impact INSTIs if the medication has a polyvalent cation (see section below on Polyvalent Cations). Note that many antacids and sucralfate have polyvalent cations.

H2 blockers (H2 Receptor antagonists)

- **INSTIs:** H2 blockers do not affect INSTI drug concentrations, and no dose adjustment is necessary.
- **Rilpivirine:** Caution is recommended if using oral rilpivirine and an H2 blocker. If used together, the H2 blocker should be given at least 12 hours before or at least 4 hours after the dose of oral rilpivirine. There are no interactions with long-acting injectable rilpivirine and H2 blockers.

Proton Pump Inhibitors

- **Darunavir:** For patients taking ritonavir-boosted darunavir, the omeprazole dose (or omeprazole equivalent dose) should not exceed 40 mg daily. There are no restrictions on the use of darunavir-cobicistat and proton pump inhibitors.
- **INSTIs:** Proton pump inhibitors do not affect INSTI drug concentrations and no dose adjustment is necessary.
- **Rilpivirine:** Proton pump inhibitors taken with oral rilpivirine lower plasma rilpivirine levels to unacceptably low levels; omeprazole 20 mg has been shown to decrease rilpivirine levels by as much as 40%. Accordingly, coadministration of a proton pump inhibitor is contraindicated with oral rilpivirine (or any combination antiretroviral regimen that contains oral rilpivirine). There are no interactions with long-acting injectable rilpivirine and proton pump inhibitors.

Polyvalent Cations and Interaction with INSTIs

- **Bictegravir:** In general, if bictegravir (as a component of bictegravir-tenofovir alafenamide-emtricitabine) is used concomitantly with any polyvalent cation, bictegravir should be administered at least 2 hours before or 6 hours after the polyvalent cation. The one exception is that bictegravir can be taken with calcium and/or iron if taken together with food.
- **Cabotegravir:** This medication is available as an oral medication and as a long-acting injectable formulation; oral cabotegravir is sometimes used for an oral lead-in period before transitioning to the injectable formulation. Polyvalent cations should be taken 2 hours before or 4 hours after oral cabotegravir. Injectable cabotegravir is not affected by oral polyvalent cations.
- **Dolutegravir:** In general, dolutegravir should be administered at least 2 hours before or 6 hours after any polyvalent cation. Dolutegravir can be taken with calcium or iron if taken together with food, based on a study in healthy volunteers. With dolutegravir-lamivudine, the recommendation is the same as dolutegravir alone. If dolutegravir-rilpivirine is used, it should be taken at least 4 hours before or 6 hours after the polyvalent cation.
- **Elvitegravir:** Elvitegravir is administered with boosted cobicistat, and it should be at least 2 hours before or 6 hours after any polyvalent cation.
- **Raltegravir:** Management interactions between raltegravir and polyvalent cations often depend on the formulation of raltegravir (400 mg twice daily versus 1200 mg once daily of the high-dose [HD] formulation) and the specific supplement. Raltegravir (400 mg twice daily or 1200 mg once daily) should not be coadministered with aluminum- or magnesium-containing antacids. Raltegravir 400 mg twice daily can be given with calcium and no dosing separation is required. The HD formulation of raltegravir (1200 mg once-daily) is not recommended with calcium or magnesium.

Antimycobacterials

There are significant and well-recognized interactions between antiretroviral therapy and medications used to treat mycobacterial infections, including *Mycobacterium tuberculosis* (active and latent infection) and *Mycobacterium avium* complex [MAC]. The following summarizes some key interactions between antimycobacterial medications and antiretroviral medications.

- **Azithromycin:** The macrolide azithromycin can be used with all antiretroviral medications without requiring drug dosing adjustments.
- **Clarithromycin:** An alternative to clarithromycin should be considered if used concomitantly with an NNRTI or a PI boosted with ritonavir or cobicistat.[12,13] Clarithromycin can be used with the INSTIs bictegravir, dolutegravir, and raltegravir without requiring dose adjustments; clarithromycin can also be used at a standard dose with cobicistat-boosted elvitegravir if renal function is not impaired.[14]
- **Ethambutol:** There are no significant drug interactions involving ethambutol and antiretroviral medications.
- **Isoniazid:** There are no significant drug interactions involving isoniazid and any of the antiretroviral medications.
- **Pyrazinamide:** There are no significant drug interactions involving pyrazinamide and antiretroviral medications.
- **Rifabutin:** This medication is a moderate inducer of CYP3A activity.
 - Tenofovir alafenamide can be coadministered with caution with rifabutin, but close monitoring of HIV RNA levels is recommended to monitor antiretroviral efficacy.[15]
 - Dolutegravir and raltegravir can be coadministration with rifabutin, and no dosage adjustment is needed. Coadministration of bictegravir-tenofovir alafenamide-emtricitabine or cobicistat-boosted elvitegravir with rifabutin is not recommended.[14,16]
 - Doravirine can be used with rifabutin, but the doravirine dose should be increased from 100 mg once daily to 100 mg twice daily. Similarly, if oral rilpivirine is used with rifabutin, the rilpivirine dose should be increased from 25 mg once daily to 50 mg once daily.[13] The use of efavirenz with rifabutin requires a higher dose of rifabutin (from 450 to 600 mg per day).[13,17] No dose adjustments are needed if rifabutin is used with etravirine.
 - Rifabutin should not be used with injectable cabotegravir and rilpivirine (due to decreased rilpivirine levels).
 - If doravirine-islatravir is coadministered with rifabutin, the recommended dose adjustment is to add an extra 100 mg doravirine tablet approximately 12 hours after taking the standard doravirine-islatravir daily dose (100 mg - 0.25 mg).
 - Rifabutin dose should be reduced to 150 mg daily when used with a ritonavir-boosted PI.[12] In addition, rifabutin should not be used concurrently with any cobicistat-boosted protease inhibitor.
 - Injectable lenacapavir is not recommended for use with rifabutin.[12,18]
- **Rifampin:** This medication is a strong inducer of CYP3A activity and poses challenges with concomitant antiretroviral therapy.[16]
 - Most NRTIs can be given in combination with rifampin, but tenofovir alafenamide should be used with caution and with monitoring for antiretroviral efficacy with HIV RNA levels.[15,16,19]
 - Dolutegravir and raltegravir can be coadministered with rifampin, but dose increases are required (dolutegravir increased to 50 mg twice daily and raltegravir increased to 800 mg twice daily). Dolutegravir should not be used in patients with integrase resistance who are receiving 50 mg twice daily. Coadministration of rifampin is not recommended with bictegravir-tenofovir alafenamide-emtricitabine, cabotegravir (oral or injectable), or cobicistat-boosted elvitegravir with rifampin.
 - Efavirenz, at the standard 600 mg dose, can be used, but with close monitoring to ensure adequate virologic response.[16,20] Rilpivirine, doravirine, and etravirine are not recommended for use with rifampin.[14,16]
 - Protease inhibitors are contraindicated for use with rifampin.

- The two-drug regimens (oral dolutegravir-rilpivirine, oral doravirine-islatravir, and injectable cabotegravir-rilpivirine) are not recommended for use with rifampin. Oral dolutegravir-lamivudine can be used with rifampin but an extra 50 mg dolutegravir tablet should be taken approximately 12 hours after the standard daily dolutegravir-lamivudine dose.
- Maraviroc can be used with rifampin, but the dose of maraviroc requires adjusting.[21] The attachment inhibitor fostemsavir should not be used with rifampin.
- Lenacapavir, a capsid inhibitor, should not be used with rifampin.[18,22]
- **Rifapentine:** The medication is a moderate CYP3A inducer when administered once weekly. When administered daily, it is a moderate-to-strong inducer.
 - Most NRTIs can be given in combination with rifampin, but tenofovir alafenamide should be used with caution and with monitoring of antiretroviral efficacy with HIV RNA levels.[23,24] Islatravir is not recommended for use with rifapentine.
 - Dolutegravir or raltegravir can be taken with once-weekly rifapentine without dose adjustment if the person has virologic suppression.[14,16] Dolutegravir can also be used (with a dose adjustment) with daily rifapentine, but the dolutegravir dose should be increased to 50 mg twice daily while taking daily rifapentine and for 2 weeks after stopping rifapentine. Rifapentine (weekly or daily) should not be used in persons taking twice-daily dolutegravir (e.g., individuals with integrase resistance mutations).[14,16] Bictegravir-tenofovir alafenamide-emtricitabine is not recommended for use with rifapentine.
 - Efavirenz (without a dose adjustment) can be used with weekly or daily rifapentine. Doravirine, rilpivirine, and etravirine should not be used with rifapentine.
 - Protease inhibitors are contraindicated for use with rifapentine.
 - Rifapentine is contraindicated for use with lenacapavir.
 - Rifapentine is not recommended for use with maraviroc, fostemsavir, or ibalizumab.

Cardiovascular Medications

Hypertension affects approximately 25 to 35% of persons with HIV.[[25,26,27,28,29](#)] Although data are conflicting regarding the association between HIV, antiretroviral therapy, and hypertension,[[28,30,31,32](#)] it is clear that important pharmacokinetic interactions exist between antiretroviral therapy and a number of cardiac medications used for control of blood pressure, rhythm, and rate.

Calcium Channel Blockers

Inhibition of the CYP4A, CYP2D6, and/or P-glycoprotein enzyme pathways by protease inhibitors and pharmacologic boosters (ritonavir and cobicistat) increases drug concentrations of calcium channel blockers.[[33](#)] These cardiac medications can generally be used with caution, starting at low doses, adjusting the dose for appropriate clinical response, and monitoring with electrocardiograms. There are no major interactions between calcium channel blockers and INSTIs. Interactions between calcium channel blockers and older NNRTIs are possible, but there are no significant interactions with the newer NNRTIs rilpivirine or doravirine.

Beta-Blockers

As with calcium channel blockers, CYP enzyme inhibition by protease inhibitors and pharmacologic boosters (ritonavir and cobicistat) can be expected to increase beta-blocker levels. It may be prudent to select a beta-blocker that is not metabolized through a CYP pathway (atenolol, labetalol, nadolol, or sotalol) to avoid these drug interactions for a person who requires a regimen with a pharmacologic booster. The NNRTIs have no significant impact on beta-blocker levels since beta-blockers are primarily metabolized by CYP2D6, whereas NNRTIs are CYP3A4 inducers.[[34](#)] There are no significant interactions between beta-blockers and INSTIs.

Diuretics, ACE Inhibitors, and Angiotensin II Receptor Blockers

Diuretics, angiotensin-converting enzyme (ACE) inhibitors, and angiotensin II receptor blockers (ARBs) are not involved in significant CYP450-mediated interactions and thus have a low potential for pharmacokinetic interactions with antiretroviral medications.[[34](#)]

Antiarrhythmics

Drug levels of antiarrhythmic medications, such as amiodarone, dofetilide, and flecainide, can increase with concomitant antiretroviral therapy that contains a PI or pharmacologic booster (ritonavir or cobicistat). The NNRTIs do not appear to impact antiarrhythmic therapy to a clinically significant degree. There are generally no significant class-wide interactions between INSTIs and these cardiac medications, with the following exception: bictegravir and dolutegravir increase the serum concentration of dofetilide by inhibiting the renal cation transporter OCT2, which is primarily responsible for the elimination of dofetilide.[[35](#)] Bictegravir and dolutegravir should not be coadministered with dofetilide.

Digoxin

Drug-induced inhibition of the efflux pump, P-glycoprotein, by ritonavir and other protease inhibitors can increase digoxin to toxic levels; cobicistat is also an inhibitor of P-glycoprotein, but no interaction with digoxin has been reported.[[36,37](#)] Nevertheless, therapeutic drug monitoring of digoxin levels is recommended when these antiretroviral therapies are coadministered. Lenacapavir, a moderate CYP3A inhibitor, can increase digoxin levels; monitoring therapeutic concentrations of digoxin is recommended when these medications are used concomitantly.[[18](#)] No special monitoring is needed for concomitant use of an INSTI or NNRTI if given with digoxin, as they have minimal effect on P-glycoprotein.

Corticosteroids

Significant potential pharmacokinetic drug interactions exist between antiretroviral therapy and corticosteroid treatment, including corticosteroid non-oral formulations. For example, serious complications, including adrenal suppression and Cushing's syndrome, have been reported in patients receiving the pharmacokinetic booster ritonavir who were given inhaled or nasal preparations of fluticasone.[[38](#),[39](#),[40](#),[41](#),[42](#)] This complication results from ritonavir-mediated inhibition of CYP3A4 enzymes, which increases the levels of certain corticosteroids also metabolized via CYP3A enzymes. Most cases involved intranasal or inhaled fluticasone, which is the most potent of the inhaled corticosteroids and also the most reliant on CYP3A4 metabolism, but complications have also been reported with coadministration of ritonavir with inhaled budesonide and mometasone.[[43](#)] Although most of the reports of serious drug interactions with corticosteroids have involved oral or inhaled corticosteroids, several reports have also described this complication with corticosteroids delivered through topical and injectable ocular preparations, as well as following intrabursal, intraarticular, and epidural injections.[[44](#),[45](#),[46](#),[47](#),[48](#)] A similar drug interaction between cobicistat, also a potent inhibitor of CYP3A4, and fluticasone has been documented, and it is expected that cobicistat will have similar effects as ritonavir on the metabolism of other steroids.[[49](#)] Lenacapavir is a moderate inhibitor of CYP3A and can increase levels of any corticosteroid metabolized via CYP3A.[[18](#)]

Use of Corticosteroids Not Metabolized by CYP3A

To mitigate these drug interactions in patients taking ritonavir, cobicistat, or lenacapavir, clinicians should consider using a corticosteroid other than fluticasone or budesonide, such as inhaled or nasal beclomethasone (which is not metabolized by the CYP3A4 enzyme and does not produce the same interaction).[[12](#),[50](#)] Until further pharmacokinetic research is completed with other inhaled steroids, caution is recommended when any inhaled or intranasal corticosteroid, other than beclomethasone, is used concomitantly with ritonavir or cobicistat. Injectable forms of methylprednisolone, prednisolone, and triamcinolone should also be avoided in patients taking antiretroviral regimens containing PIs or boosting agents (ritonavir or cobicistat). As a consequence of reciprocal corticosteroid induction of the CYP3A4 enzyme pathway, dexamethasone may decrease levels of all NNRTIs and compromise virologic efficacy; rilpivirine is most affected by this interaction, so more than a single dose of dexamethasone is contraindicated in patients taking rilpivirine.[[51](#)] Systemic dexamethasone may also decrease levels of bictegravir, cobicistat-boosted elvitegravir, and lenacapavir.[[14](#)] Further, lenacapavir levels may decrease if a person is taking dexamethasone at a dose greater than 16 mg per day.[[18](#)]

Hepatitis C Treatments

When considering the treatment of hepatitis C virus (HCV) in persons with HIV coinfection, most individuals are taking antiretroviral therapy, which may pose a problem with drug interactions with HCV direct-acting antiviral medications.[\[52,53,54\]](#) It is important to note that antiretroviral medications are not a contraindication for HCV treatment. Three major classes of direct-acting antiviral medications are used to treat hepatitis C: NS3/4A protease inhibitors, NS5A inhibitors, and NS5B polymerase inhibitors.[\[55,56\]](#) In current clinical practice, treatment of HCV usually involves the use of a pangenotypic regimen, either glecaprevir-pibrentasvir, sofosbuvir-velpatasvir, or sofosbuvir-velpatasvir, voxilaprevir. The following provides key summary points for drug interactions between the pangenotypic HCV direct-acting antiviral medication regimens and HIV antiretroviral therapy. In general, INSTI-based antiretroviral therapy without a pharmacokinetic booster is a safe option in combination with HCV therapeutics.

- Glecaprevir-Pibrentasvir:** The medications glecaprevir (NS3/4A protease inhibitor) and pibrentasvir (NS5A inhibitors) both have the potential to inhibit P-glycoprotein (P-gp), breast cancer resistance protein (BCRP), and organic anion transporting polypeptide (OATP) 1B1/3. In addition, glecaprevir and pibrentasvir are weak inhibitors of CYP3A4, CYP1A2, and uridine glucuronosyltransferase (UGT) 1A1. Coadministration of glecaprevir-pibrentasvir with darunavir-cobicistat, darunavir boosted with ritonavir, or lopinavir-ritonavir should be avoided because of the potential major increases in glecaprevir and pibrentasvir levels. Coadministration of glecaprevir-pibrentasvir with efavirenz or etravirine is not recommended because of substantial reductions in the levels of glecaprevir and pibrentasvir. Antiretroviral agents known to be safe and free of significant interactions with glecaprevir-pibrentasvir include the NRTIs, non-cobicistat-boosted INSTIs, doravirine, rilpivirine, fostemsavir, and maraviroc. Experience combining glecaprevir-pibrentasvir with lenacapavir or islatravir is limited.
- Sofosbuvir-Velpatasvir:** The NS5A inhibitor velpatasvir is metabolized predominantly by CYP2B6, CYP2C8, and CYP3A4 enzymes. The NNRTI medications efavirenz and etravirine should not be administered concurrently with velpatasvir. In persons receiving tenofovir DF, the sofosbuvir component may increase tenofovir levels.[\[57,58\]](#) As with ledipasvir-sofosbuvir, coadministration of sofosbuvir-velpatasvir with tenofovir DF can increase tenofovir levels. If sofosbuvir-velpatasvir must be used in conjunction with tenofovir DF and the individual has a baseline creatinine clearance below 60 mL/min or is also taking a boosted protease inhibitor, monthly laboratory monitoring should be implemented during HCV treatment to assess for renal side effects. Alternatively, most experts would favor switching from tenofovir DF to tenofovir alafenamide, which carries a lower risk, and/or switching the boosted protease inhibitor to another option (such as dolutegravir or bictegravir) prior to initiating sofosbuvir-velpatasvir. No significant issues are expected when combining velpatasvir-sofosbuvir with tenofovir alafenamide, abacavir, INSTIs, rilpivirine, doravirine, boosted atazanavir, or boosted darunavir (unless the boosted PI is in a regimen with tenofovir DF).
- Sofosbuvir-Velpatasvir-Voxilaprevir:** All drug interactions that are of concern with sofosbuvir-velpatasvir are also of concern with sofosbuvir-velpatasvir-voxilaprevir. The combination of sofosbuvir-velpatasvir-voxilaprevir with either efavirenz or etravirine should be avoided. Use of sofosbuvir-velpatasvir-voxilaprevir with tenofovir DF will likely cause increases in tenofovir levels. The coadministration of sofosbuvir-velpatasvir-voxilaprevir with either atazanavir or lopinavir would likely increase voxilaprevir levels and thus is not recommended. Fostemsavir may increase voxilaprevir levels, though the clinical significance has not been determined.

HMG-CoA Reductase Inhibitors (Statins)

The HMG-CoA reductase inhibitors, more commonly referred to as statins, are frequently used to treat lipid disorders in persons with HIV who are taking antiretroviral therapy. Statins have been associated with elevations of hepatic aminotransferase levels, as well as adverse effects on skeletal muscle (ranging from mild muscle pain to fatal rhabdomyolysis), and these adverse effects are directly linked to statin concentration.[59] The key pharmacokinetic interactions between antiretroviral medications and statins occur with the statins that are metabolized through the CYP3A4 pathway (simvastatin, lovastatin, and atorvastatin) when taken concomitantly with the potent CYP3A inhibitors ritonavir or cobicistat.[59,60] Clinically important interactions also occur through induction of the CYP3A4 pathway by certain NNRTI medications, which do not cause adverse effects but can decrease statin efficacy.[61] The attachment inhibitor fostemsavir may possibly raise levels of all statins, so the lowest possible statin dose should be used, with clinical monitoring for statin side effects.[22] The capsid inhibitor lenacapavir also causes increased levels of simvastatin and lovastatin, so coadministration of these statins with lenacapavir should be avoided.[18]

Atorvastatin

Levels of atorvastatin can be increased by ritonavir-boosted PIs and cobicistat-containing regimens, though the increases in drug levels are not as substantial as seen with simvastatin and lovastatin.[59] If atorvastatin is to be used in conjunction with a ritonavir-boosted PI or cobicistat-containing regimen, a low dose (20 mg or less of atorvastatin) should be used as initial therapy, since this dose is likely to provide the lipid-lowering effect equivalent to a dose 3 to 5 times higher than if administered without a ritonavir-boosted PI or cobicistat-containing regimen.[12,59] The same is likely true if combining atorvastatin with fostemsavir.[22] Since atorvastatin is considered a more potent statin, a low dose, with titration upward if needed, may be preferred over pravastatin, especially in patients with known cardiovascular disease. Medical providers should be cautious not to exceed the recommended dosing of atorvastatin since there are case reports of rhabdomyolysis and acute renal failure associated with protease inhibitors and atorvastatin.[62,63] Some NNRTIs (efavirenz and etravirine) may decrease atorvastatin levels, necessitating higher dosing of atorvastatin, but not exceeding the recommended maximum dose.[13,61,64]

Lovastatin and Simvastatin

The use of simvastatin or lovastatin is contraindicated in patients receiving PI-containing or cobicistat-containing regimens due to significant increases in serum statin levels.[12] For example, when twice-daily saquinavir (400 mg) boosted with ritonavir (400 mg) was combined with simvastatin, the area under the curve (AUC) of simvastatin increased 32-fold (Figure 4).[60] As might be expected, the combination of various PIs with simvastatin has been associated with rhabdomyolysis and acute renal failure, and a similar response is expected with lovastatin.[65,66,67,68] The use of simvastatin with efavirenz is also not recommended, though for the opposite reason that coadministration of efavirenz with simvastatin results in induction of statin metabolism and decreased lipid-reducing effect.[61]

Pitavastatin

Recent studies indicate that no significant pharmacokinetic interactions occur between pitavastatin and efavirenz or ritonavir-boosted darunavir; thus, pitavastatin may be safely coadministered with PIs and NNRTIs without dose adjustment.[12,69,70] Furthermore, the efficacy of pitavastatin 4 mg daily was found to be superior to that of pravastatin 40 mg in reducing low-density lipoprotein (LDL) and other atherogenic lipid parameters.[71] Pitavastatin was used in the REPRIEVE trial, a study that compared pitavastatin 4 mg daily versus placebo in persons with HIV who had low-to-moderate risk of cardiovascular disease, and found a reduced risk of developing major cardiovascular events among those who took pitavastatin.[72] There are insufficient data on interactions between pitavastatin and the pharmacologic booster cobicistat, but, based on data with ritonavir-boosted PIs, it is unlikely to interact and should be considered safe to use in this setting. Fostemsavir can raise pitavastatin levels; the combination is not contraindicated, but if coadministered, the

lowest starting dose of pitavastatin should be used with slow titration up if needed, with monitoring for side effects.[22]

Pravastatin

Because pravastatin is not metabolized by CYP3A4, it is considered one of the safest statins for use in combination with antiretroviral medications, with the exception that pravastatin levels increase by about 80% when used concomitantly with darunavir.[12,73] Therefore, when combining pravastatin and darunavir, pravastatin should be initiated at the lowest appropriate dose. It should be noted, though, that pravastatin is one of the least potent statins, so many clinicians prefer to use a low dose of a more potent agent, such as rosuvastatin or atorvastatin, rather than a standard dose of pravastatin.

Rosuvastatin

Rosuvastatin is not a CYP3A4 substrate, but clinically relevant interactions with antiretroviral medications primarily occur via other transporters, specifically with OATP1B1 or BCRP.[74] When coadministering rosuvastatin with PIs (boosted with cobicistat or ritonavir), cobicistat-boosted elvitegravir, or fostemsavir, rosuvastatin should be initiated at the lowest possible dose, with close observation for evidence of statin toxicity.[12,14,22,75] No significant effect on rosuvastatin levels is expected with NNRTI therapy; lipid levels should be monitored, and the rosuvastatin dose adjusted as needed.[13]

Mental Health Medications

Persons with HIV have a high prevalence of coexisting mental health conditions.[76] In the process of managing these coexisting conditions, clinicians caring for persons with HIV often need to consider complex drug interactions between antiretroviral medications and medications used to treat depression, anxiety, or other mood disorders.[77,78] Several of the key interactions are discussed below.

Antipsychotics

Many antipsychotic medications are metabolized by CYP450, particularly CYP3A4, and antipsychotic medication levels may increase when used concurrently with cobicistat- or ritonavir-containing regimens. Thus, drug interactions and recommendations should be closely checked when initiating an antipsychotic medication, especially with medications that can prolong the QTc. Similarly, drug interactions should be closely examined in a person on an antipsychotic who is starting a new antiretroviral regimen. For example, in a patient already taking any boosted PI, the lowest possible dose of quetiapine should be used. If a patient is already taking quetiapine and is starting antiretroviral therapy with a regimen that includes PIs, ritonavir, or cobicistat, the quetiapine dose should be reduced to approximately one-sixth of the current dose to avoid toxicity (or preferably choose a different antiretroviral regimen that does not interact with quetiapine).[12,79,80] Drug interactions may occur when cobicistat- or ritonavir-containing antiretroviral regimens are combined with older antipsychotics, such as perphenazine and thioridazine, as well as with some of the newer agents, such as risperidone and lurasidone. Recent label updates to cobicistat and protease inhibitors highlight concern with the concomitant use of these agents with lurasidone. Thus, medical providers should exert caution and carefully evaluate potential drug interactions when using antipsychotics and antiretroviral regimens that contain a PI, ritonavir, or cobicistat, especially when making changes to either regimen. Since most medications in the NNRTI class decrease antipsychotic drug concentrations, primarily due to induction of CYP3A4 and CYP2D6 enzymes, caution is advised with coadministration of these agents; the use of rilpivirine or doravirine is less likely to lead to significant interactions with antipsychotic medications.

Selective Serotonin Reuptake Inhibitors (SSRIs)

Similar to the interactions noted between antiretroviral medications and antipsychotics, selective serotonin reuptake inhibitors (SSRIs) may also interact with pharmacologic boosters (cobicistat and ritonavir), PIs, and NNRTIs. In general, most SSRIs are safe with concurrent antiretroviral therapy; nonetheless, the effects of coadministration are variable, and treatment should be titrated to response. For example, lopinavir-ritonavir raises paroxetine levels, darunavir given with ritonavir lowers paroxetine levels, and efavirenz does not significantly impact paroxetine levels.[12,81] Bictegravir, dolutegravir, and raltegravir do not appear to impact SSRI levels.[82] Doravirine and rilpivirine are also considered safe in combination with SSRIs, as are the non-boosted INSTIs and NRTIs.

Tricyclic Antidepressants (TCAs)

Protease inhibitors, ritonavir, and cobicistat have been shown to increase levels of tricyclic antidepressants and trazodone. When using TCAs or trazodone concurrently with protease inhibitors or cobicistat, the lowest possible starting dose of the TCA or trazodone should be used and then titrated for clinical effect.[12]

Benzodiazepines

Benzodiazepines are commonly used for acute anxiety and are extensively used in anesthesia as sedative-hypnotics. The use of benzodiazepines in the setting of antiretroviral therapy is complicated because benzodiazepines are metabolized via several different pathways, and thus, drug interactions are not always predictable. In patients taking a PI, ritonavir, or cobicistat, the safest benzodiazepines to use are those not metabolized via CYP450; these include lorazepam, oxazepam, and temazepam.[2,12] Drug concentrations of

other benzodiazepines, such as alprazolam, clonazepam, and diazepam, are likely to be increased by PIs and boosting agents (ritonavir and cobicistat), so these benzodiazepines and antiretroviral medications are not recommended for concurrent use. In patients taking a PI, ritonavir, or cobicistat, the use of triazolam or midazolam is contraindicated, except that midazolam can be used with caution when administered parenterally as a single dose, pre-procedural medication in a monitored setting.[\[2,12\]](#)

Opioid Agonist Therapy

A substantial proportion of persons with HIV have a concomitant opioid use disorder. Thus, health care providers should become familiar with the pharmacologic interactions between antiretroviral medications and opioid agonist medications used for treating opioid use disorder.[83] Key interactions between antiretroviral therapies, methadone, buprenorphine, and buprenorphine-naloxone will be addressed here.

Methadone

- **Integrase Strand Transfer Inhibitors (INSTIs):** There are no significant pharmacokinetic interactions between methadone and the INSTIs dolutegravir, elvitegravir (boosted with cobicistat), raltegravir, or cabotegravir.[14,84,85,86] Although bicitegravir coadministration with methadone has not yet been studied, no significant interaction is expected.[14] No dosage adjustments are recommended when using any of the INSTIs with methadone.[14]
- **Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs):** As a result of potent CYP3A4 induction by the NNRTI efavirenz, an increased methadone dose is often necessary for persons on methadone who are concomitantly taking efavirenz.[13,87] The likelihood of decreased methadone levels when coadministered with rilpivirine (oral or long-acting injectable) is lower than with efavirenz, but clinicians should monitor clinically for signs of decreased methadone levels if rilpivirine is used concomitantly.[13] No methadone dose adjustment is required for concurrent therapy with doravirine or etravirine.[13,84,88]
- **Protease Inhibitors:** Although PIs generally inhibit CYP enzymes and increase plasma concentrations of drugs metabolized through CYP pathways, all ritonavir-boosted protease inhibitors have the potential to reduce methadone exposure, possibly through induction of CYP2B6 or through other mechanisms; therefore, methadone dose adjustment may be necessary to avoid precipitating opiate withdrawal.[12,89,90]

Buprenorphine and Buprenorphine-Naloxone

- **Integrase Strand Transfer Inhibitors (INSTIs):** Raltegravir does not appear to have any clinically significant interaction with buprenorphine or buprenorphine-naloxone.[14,83,84] Although cobicistat-boosted elvitegravir raises buprenorphine levels, no dose adjustment is necessary.[14,83] No significant interaction is expected if dolutegravir, bicitegravir, or cabotegravir is coadministered with buprenorphine.[14]
- **Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs):** No dose adjustments are necessary when buprenorphine or buprenorphine-naloxone is used concurrently with NNRTIs, but efavirenz has been demonstrated to lower buprenorphine levels, so monitoring for withdrawal is recommended.[13,84]
- **Protease Inhibitors (PIs):** Buprenorphine and buprenorphine-naloxone are metabolized by CYP3A4 and also undergo glucuronidation by the liver enzyme uridine diphosphate glucuronosyltransferase 1A1 (UGT1A1). The drug interactions with PIs are variable. No buprenorphine or buprenorphine-naloxone dosage adjustment is necessary for patients taking darunavir boosted with ritonavir or cobicistat.
- **Capsid Inhibitor:** The capsid inhibitor lenacapavir, which inhibits the CYP3A4 enzyme, may increase levels of buprenorphine.[18] If coadministering these agents, it is recommended to use the lowest feasible initial dose of buprenorphine and titrate to the desired effect.[18]

Oral Anticoagulants and Antiplatelet Therapy

Direct-Acting Oral Anticoagulant Medications

The commonly used direct-acting oral anticoagulant medications (DOACs)—apixaban, dabigatran, edoxaban, and rivaroxaban—are eliminated either via CYP450 enzymes, P-glycoprotein, or both.[91]

Interactions with INSTIs

Drug interactions with DOACs and the non-boosted INSTIs bicittegravir, cabotegravir, dolutegravir, and raltegravir are not significant, and no dose adjustments are required.[14] The use of DOACs with regimens that contain elvitegravir-cobicistat can cause significant increases in the levels of apixaban, betrixaban, and dabigatran.[14]

Interactions with NNRTIs

Cytochrome P450 enzyme induction by certain NNRTIs may lower the levels of some DOACs, potentially leading to failure of the anticoagulant to prevent or treat thrombosis.[13,91] The most likely interactions to cause clinically significant lowering of the DOAC involve efavirenz, etravirine, or nevirapine combined with either apixaban or rivaroxaban.[13]

Interactions with Boosting Agents

Potent cytochrome P450 enzyme inhibition by PIs or pharmacologic boosters (ritonavir or cobicistat) may lead to higher plasma drug concentrations of the DOACs and potentially increase the risk of bleeding.[12,91] Thus, the concomitant use of most DOACs with ritonavir- or cobicistat-boosted PIs (and with elvitegravir-cobicistat) should be avoided due to potential increases in the DOAC concentrations and potential risk of bleeding.[12,14] In general, the use of apixaban, betrixaban, edoxaban, and rivaroxaban should be avoided in this setting.[12] Dabigatran has the most data to guide us when it is necessary to coadminister DOACs with boosted-PI therapy. Rivaroxaban should be avoided given the lack of data and potential risk for increased bleeding.

Interactions with Capsid Inhibitors

Lenacapavir, which inhibits cytochrome P450 enzymes and, to a lesser degree, P-glycoprotein, may possibly raise levels of apixaban, dabigatran, edoxaban, and rivaroxaban.[18] No dose adjustment is recommended with apixaban, dabigatran, and edoxaban, but monitoring for adverse events, such as increased bleeding, is recommended.[18] Caution is urged with the use of lenacapavir and rivaroxaban, and the rivaroxaban dose may need to be adjusted.[18]

Warfarin

Warfarin is metabolized via CYP2C9, and its use is complicated by a narrow therapeutic window, significant inter-patient variability, and major drug-drug and drug-food interactions.[7] Pharmacokinetic interactions between warfarin and antiretroviral medications are variable and often difficult to predict. Coadministration of warfarin with an antiretroviral regimen that contains a PI, NNRTI, or cobicistat is likely to alter warfarin levels. Therefore, close monitoring of the international normalized ratio (INR) is recommended whenever warfarin is combined with any of these antiretroviral medications. In addition, upon changing antiretroviral therapy in patients on a stable warfarin regimen, close INR monitoring is warranted. If reversal of warfarin anticoagulation is required, phytonadione (Vitamin K1) may be used. Bicittegravir, cabotegravir, dolutegravir, and raltegravir are not extensively metabolized via CYP450 and thus are unlikely to cause significant drug interactions with warfarin. In addition, the use of modern NRTIs is unlikely to impact warfarin levels. Lenacapavir may increase warfarin levels, and INR should be closely monitored.[18]

Platelet Aggregate Inhibitors

Platelet aggregate inhibitors, such as clopidogrel, prasugrel, ticagrelor, and vorapaxar, can interact with PI or NNRTI antiretroviral medications due to overlapping metabolism via CYP3A4 and CYP2C19 enzymes.[91] These interactions are complex, and the net effect can be difficult to predict and manage, especially in persons receiving both PI- and NNRTI-based therapies. An assay that measures platelet activation is available that may help measure the extent to which platelets are inhibited. Expert consultation is recommended.

- **Interactions with PIs:** The inhibition of CYP3A4 via PIs may decrease the metabolism of ticagrelor or vorapaxar, thereby significantly increasing ticagrelor and vorapaxar drug levels. Use of any PI with ticagrelor or vorapaxar is contraindicated. Use of any boosted PI with clopidogrel is not recommended due to the lowering of the clopidogrel active metabolite by 69%.[12] Although levels of the active prasugrel metabolite are also decreased when used with a boosted PI, this effect is less than with clopidogrel, and no dose adjustment is needed.
- **Interactions with NNRTIs:** The inhibition of CYP2C19, particularly by efavirenz or etravirine, blocks the conversion of clopidogrel to its active metabolite, resulting in a decreased antiplatelet drug effect. Clopidogrel should be avoided in individuals taking efavirenz or etravirine, but is considered acceptable in combination with doravirine or rilpivirine.[91] The inhibition of CYP2C19 by NNRTIs does not appear to result in clinically relevant interactions with either prasugrel or ticagrelor, so these agents could be used in patients taking NNRTI medications.[91]

Phosphodiesterase Type 5 (PDE5) Inhibitors

Phosphodiesterase type 5 (PDE5) inhibitors are frequently prescribed in men with HIV for symptoms of erectile dysfunction, sometimes for benign prostatic hypertrophy, and rarely for pulmonary artery hypertension. Pharmacokinetic interactions between antiretroviral therapies and the PDE5 inhibitors—avanafil, sildenafil, tadalafil, and vardenafil—are well recognized.[\[92,93\]](#) The major drug interactions with antiretroviral therapy medications and PDE5 inhibitors involve pharmacologic boosters, PIs, and cobicistat-boosted elvitegravir. In general, significant drug interactions with PDE5 inhibitors do not occur with NRTIs, NNRTIs, or unboosted INSTIs.

- **Use of PDE5 for Erectile Dysfunction:** The use of PDE5 inhibitors with PIs and/or pharmacologic boosters (ritonavir or cobicistat) typically causes an increase in the level of the PDE5 inhibitor medications, which can potentially result in priapism, hypotension, and other adverse effects; in these situations, it is recommended to use lower doses of the PDE5 inhibitor, monitoring for adverse effects, and to not exceed a threshold dose over a specific duration (the threshold dose and duration vary depending on the recommended dose and half-life of the PDE5 inhibitor). Similarly, the capsid inhibitor lenacapavir, which inhibits CYP3A4, may increase PDE5 inhibitor levels, requiring lower doses and enhanced monitoring. In contrast, etravirine and efavirenz lower PDE5 inhibitor levels and may necessitate dose increases for the PDE5 inhibitors sildenafil, tadalafil, and vardenafil; rilpivirine has been studied with sildenafil and tadalafil, and no dose adjustment appears to be necessary with either combination.[\[8,92,93,94\]](#) For persons taking lenacapavir, the levels of PDE5 inhibitors are increased, and dose adjustment may be needed with avanafil, sildenafil, and vardenafil.[\[18\]](#)
- **Use of PDE5 Inhibitors for Benign Prostatic Hypertrophy:** The PDE5 inhibitor tadalafil is the only PDE5 inhibitor recommended for treating benign prostatic hypertrophy. When using tadalafil with a protease inhibitor, the maximum daily dose of tadalafil is 2.5 mg per day.[\[12\]](#)
- **Use of PDE5 Inhibitors for Pulmonary Arterial Hypertension (PAH):** Use of high doses of the PDE5 inhibitors, such as doses used to treat pulmonary arterial hypertension (PAH), is contraindicated with most HIV medications that inhibit CYP3A4 because the PDE5 inhibitors may reach dangerous levels.[\[12\]](#) Sildenafil for PAH is contraindicated with all PIs and pharmacologic boosters (ritonavir or cobicistat). In a person receiving a PI or cobicistat-boosted elvitegravir, tadalafil can be initiated at 20 mg once daily and increased to 40 mg once daily based on tolerability.[\[12,14\]](#)

Miscellaneous Interactions

Alpha Adrenergic Blockers

Tamsulosin and other alpha adrenergic receptor antagonists (prazosin, alfuzosin, doxazosin, and terazosin), which may be used for benign prostatic hypertrophy (BPH) or hypertension, are metabolized by CYP3A4 and, to a lesser degree, by CYP2D6. Therefore, antiretroviral medications that affect these pathways can alter drug levels, including boosted PIs, cobicistat-boosted elvitegravir, and lenacapavir. Increased levels of the alpha adrenergic blockers can lead to orthostatic hypotension and other adverse effects, so starting with the lowest feasible dose and monitoring for side effects is recommended when coadministering these agents.

Anticonvulsant Medications

Significant pharmacokinetic drug interactions occur with concomitant use of anticonvulsants and antiretroviral medications. Several anticonvulsant medications significantly lower antiretroviral drug levels, potentially leading to virologic failure. This is particularly a concern with older anticonvulsants, such as phenobarbital, phenytoin, carbamazepine, and oxcarbazepine, since these medications act as potent inducers of CYP enzymes; these older anticonvulsants can lower levels of PIs, NNRTIs, INSTIs, tenofovir alafenamide, the attachment inhibitor fostemsavir, long-acting injectable cabotegravir and rilpivirine, and long-acting injectable lenacapavir. Due to these potentially significant drug interactions, many antiretroviral-anticonvulsant combinations are contraindicated. Accordingly, prior to initiating concomitant therapy with an older anticonvulsant and antiretroviral medications, careful review of interactions and recommendations should be performed.^[2] For persons on antiretroviral therapy who require an anticonvulsant, levetiracetam is considered the antiepileptic of choice due to its broad spectrum of activity, minimal drug interactions (it is not metabolized via any CYP450 pathway), and low side-effect profile.^[95] For patients who are not candidates for levetiracetam therapy and require a different anticonvulsant, expert consultation is recommended.

Metformin

The use of metformin with concurrent dolutegravir therapy results in a roughly 2-fold increase in metformin levels, likely due to the inhibition of organic cation transporter 2 (OCT2) by dolutegravir.^[96,97] Medical providers should use caution with this combination and limit the metformin dose to no more than 1 gram per day.^[14] Less pronounced effects on metformin concentrations were observed with bictegravir coadministration, so the recommendation is to monitor for adverse events from metformin, generally without reducing the metformin dose.^[14] None of the other INSTIs, or other classes of antiretrovirals, have demonstrated a significant drug interaction with metformin.^[14]

St. John's Wort

The herbal medication St. John's Wort is contraindicated with a number of antiretroviral medications. Because of induction effects on CYP3A4 and P-gp, it should not be coadministered with protease inhibitors, NNRTIs, INSTIs, maraviroc, or fostemsavir. The low-hyperforin formulations of St. John's Wort may be safer and less likely to interact, but have not been studied in combination with antiretroviral medications.

Interactions Between Antiretroviral Medications

Although clinically significant drug interactions between antiretroviral medications of different classes are uncommon, clinicians should be aware that some exist, particularly when designing a multi-drug salvage antiretroviral regimen that combines NNRTIs with a boosted PI. For example, etravirine should not be coadministered with a cobicistat-boosted PI or with certain older PIs because of a bidirectional effect on CYP3A4 that reduces drug levels of both the etravirine and the PI. Combining etravirine with boosted darunavir is acceptable, and combining etravirine with dolutegravir is acceptable as long as ritonavir-boosted darunavir is in the regimen. Etravirine should not be combined with bictegravir because it induces CYP3A4 and reduces

bictegravir levels significantly. Further, etravirine should not be combined with cobicistat-boosted elvitegravir because etravirine and cobicistat have opposing effects on CYP3A4, and the resulting drug levels are difficult to predict. Efavirenz also has some problematic interactions, such as with lenacapavir. Islatravir, an NRTI, should not be coadministered with lamivudine or emtricitabine, since these medications all compete for intracellular phosphorylation by the same enzyme, deoxycytidine kinase. The concomitant use of islatravir with either lamivudine or emtricitabine results in reduced activation (phosphorylation) of islatravir and diminished efficacy.

Summary Points

- Effective antiretroviral therapy depends on attaining a therapeutic serum drug concentration that maximizes efficacy and minimizes toxicity.
- Excellent online resources are available to help clinicians manage drug interactions.
- The most common mechanisms involve absorption issues or interactions mediated by the CYP and UGT1A1 enzymes, which can increase or decrease serum drug levels.
- Regimens containing integrase inhibitors (without cobicistat) generally have low potential for causing problematic drug interactions.
- Regimens containing boosted protease inhibitors generally confer the greatest risk of drug interactions. In addition, regimens containing most of the non-nucleoside reverse transcriptase inhibitors also have significant potential to cause drug interactions.
- Ritonavir and cobicistat are both pharmacologic enhancers (boosters) that are potent inhibitors of CYP3A4; however, they may have different effects on other CYP and UGT enzymes or other transporters and should not be considered interchangeable.
- The capsid inhibitor lenacapavir has significant inhibition of CYP3A and may cause significant drug interactions, even for months after the last injection, due to the very long half-life of lenacapavir.
- Any changes to a drug regimen require careful consideration of potential drug interactions.

Citations

1. Valdes R Jr, Yin DT. Fundamentals of Pharmacogenetics in Personalized, Precision Medicine. Clin Lab Med. 2016;36:447-59.
[\[PubMed Abstract\]](#) -
2. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in adults and adolescents with HIV. Department of Health and Human Services. Drug-drug Interactions: overview. May 26, 2023.
[\[HIV.gov\]](#) -
3. Wilkinson GR. Drug metabolism and variability among patients in drug response. N Engl J Med. 2005;352:2211-21.
[\[PubMed Abstract\]](#) -
4. Patel N, Abdelsayed S, Veve M, Miller CD. Predictors of clinically significant drug-drug interactions among patients treated with nonnucleoside reverse transcriptase inhibitor-, protease inhibitor-, and raltegravir-based antiretroviral regimens. Ann Pharmacother. 2011;45:317-24.
[\[PubMed Abstract\]](#) -
5. Podany AT, Scarsi KK, Fletcher CV. Comparative Clinical Pharmacokinetics and Pharmacodynamics of HIV-1 Integrase Strand Transfer Inhibitors. Clin Pharmacokinet. 2017;56:25-40.
[\[PubMed Abstract\]](#) -
6. Wang X, Boffito M, Zhang J, et al. Effects of the H₂-receptor antagonist famotidine on the pharmacokinetics of atazanavir-ritonavir with or without tenofovir in HIV-infected patients. AIDS Patient Care STDS. 2011;25:509-15.
[\[PubMed Abstract\]](#) -
7. Bélique L, Giguère P, la Porte C, Angel J. Interactions between protease inhibitors and acid-reducing agents: a systematic review. HIV Med. 2007;8:335-45.
[\[PubMed Abstract\]](#) -
8. Crauwels H, van Heeswijk RP, Stevens M, et al. Clinical perspective on drug-drug interactions with the non-nucleoside reverse transcriptase inhibitor rilpivirine. AIDS Rev. 2013;15:87-101.
[\[PubMed Abstract\]](#) -
9. Luber AD. Use of acid-reducing agents in protease inhibitor-based HAART and the potential for negative treatment outcomes. AIDS Read. 2005;15:692-5, 698-700.
[\[PubMed Abstract\]](#) -
10. Kiser JJ, Bumpass JB, Meditz AL, et al. Effect of antacids on the pharmacokinetics of raltegravir in human immunodeficiency virus-seronegative volunteers. Antimicrob Agents Chemother. 2010;54:4999-5003.
[\[PubMed Abstract\]](#) -
11. Song I, Borland J, Arya N, Wynne B, Piscitelli S. Pharmacokinetics of dolutegravir when administered with mineral supplements in healthy adult subjects. J Clin Pharmacol. 2015;55:490-6.
[\[PubMed Abstract\]](#) -
12. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in adults and adolescents with HIV. Department of Health and Human Services. Drug-drug interactions. Drug-drug interactions. Table 24a. Drug interactions between protease inhibitors and

other drugs. September 12, 2024.

[\[HIV.gov\]](#) -

13. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in adults and adolescents with HIV. Department of Health and Human Services. Drug-drug interactions. Table 24b. Drug interactions between non-nucleoside reverse transcriptase inhibitors and other drugs. September 12, 2024.

[\[HIV.gov\]](#) -

14. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in adults and adolescents with HIV. Department of Health and Human Services. Drug-drug interactions. Table 24d. Drug interactions between integrase strand transfer inhibitors and other drugs. September 12, 2024.

[\[HIV.gov\]](#) -

15. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in adults and adolescents with HIV. Department of Health and Human Services. Drug-drug interactions. Table 24c. Drug interactions between nucleoside reverse transcriptase inhibitors and other drugs (including antiretroviral agents). September 12, 2024.

[\[HIV.gov\]](#) -

16. Panel on Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV. National Institutes of Health, HIV Medicine Association, and Infectious Diseases Society of America. *Mycobacterium tuberculosis* infection and disease. Last updated May 2, 2024.

[\[HIV.gov\]](#) -

17. Jiang HY, Zhang MN, Chen HJ, Yang Y, Deng M, Ruan B. Nevirapine versus efavirenz for patients co-infected with HIV and tuberculosis: a systematic review and meta-analysis. *Int J Infect Dis*. 2014;25:130-5.

[\[PubMed Abstract\]](#) -

18. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in adults and adolescents with HIV. Department of Health and Human Services. Drug-drug interactions. Table 24g. Drug interactions between the capsid inhibitor lenacapavir and other drugs. March 23, 2023

[\[HIV.gov\]](#) -

19. Cerrone M, Alfarisi O, Neary M, et al. Rifampicin effect on intracellular and plasma pharmacokinetics of tenofovir alafenamide. *J Antimicrob Chemother*. 2019;74:1670-8.

[\[PubMed Abstract\]](#) -

20. Taburet AM, Sauvageon H, Grinsztejn B, et al. Pharmacokinetics of Raltegravir in HIV-Infected Patients on Rifampicin-Based Antitubercular Therapy. *Clin Infect Dis*. 2015;61:1328-35.

[\[PubMed Abstract\]](#) -

21. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in adults and adolescents with HIV. Department of Health and Human Services. Drug-drug interactions. Table 24e. Drug interactions between the CCR5 antagonist maraviroc and other drugs (including antiretroviral agents). September 12, 2024.

[\[HIV.gov\]](#) -

22. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral

agents in adults and adolescents with HIV. Department of Health and Human Services. Drug-drug interactions. Table 24f. Drug interactions between the HIV-1 gp120-directed attachment inhibitors and other drugs (including antiretroviral agents). May 26, 2023
[\[HIV.gov\]](#) -

23. Podany AT, Bao Y, Swindells S, et al. Efavirenz Pharmacokinetics and Pharmacodynamics in HIV-Infected Persons Receiving Rifapentine and Isoniazid for Tuberculosis Prevention. *Clin Infect Dis*. 2015;61:1322-7.
[\[PubMed Abstract\]](#) -
24. Weiner M, Egelund EF, Engle M, et al. Pharmacokinetic interaction of rifapentine and raltegravir in healthy volunteers. *J Antimicrob Chemother*. 2014;69:1079-85.
[\[PubMed Abstract\]](#) -
25. Armah KA, Chang CC, Baker JV, et al. Prehypertension, hypertension, and the risk of acute myocardial infarction in HIV-infected and -uninfected veterans. *Clin Infect Dis*. 2013;58:121-9.
[\[PubMed Abstract\]](#) -
26. Khalsa A, Karim R, Mack WJ, et al. Correlates of prevalent hypertension in a large cohort of HIV-infected women: Women's Interagency HIV Study. *AIDS*. 2007;21:2539-41.
[\[PubMed Abstract\]](#) -
27. Krauskopf K, Van Natta ML, Danis RP, et al. Correlates of hypertension in patients with AIDS in the era of highly active antiretroviral therapy. *J Int Assoc Provid AIDS Care*. 2013;12:325-33.
[\[PubMed Abstract\]](#) -
28. Medina-Torne S, Ganesan A, Barahona I, Crum-Cianflone NF. Hypertension is common among HIV-infected persons, but not associated with HAART. *J Int Assoc Physicians AIDS Care (Chic)*. 2011;11:20-5.
[\[PubMed Abstract\]](#) -
29. Nüesch R, Wang Q, Elzi L, et al. Risk of cardiovascular events and blood pressure control in hypertensive HIV-infected patients: Swiss HIV Cohort Study (SHCS). *J Acquir Immune Defic Syndr*. 2013;62:396-404.
[\[PubMed Abstract\]](#) -
30. Cattelan AM, Trevenzoli M, Sasset L, Rinaldi L, Balasso V, Cadrobbi P. Indinavir and systemic hypertension. *AIDS*. 2001;15:805-7.
[\[PubMed Abstract\]](#) -
31. Chow DC, Souza SA, Chen R, Richmond-Crum SM, Grandinetti A, Shikuma C. Elevated blood pressure in HIV-infected individuals receiving highly active antiretroviral therapy. *HIV Clin Trials*. 2003;4:411-6.
[\[PubMed Abstract\]](#) -
32. Thiébaud R, El-Sadr WM, Friis-Møller N, et al. Predictors of hypertension and changes of blood pressure in HIV-infected patients. *Antivir Ther*. 2005;10:811-23.
[\[PubMed Abstract\]](#) -
33. Glesby MJ, Aberg JA, Kendall MA, et al. Pharmacokinetic interactions between indinavir plus ritonavir and calcium channel blockers. *Clin Pharmacol Ther*. 2005;78:143-53.
[\[PubMed Abstract\]](#) -
34. Peyriere H, Eiden C, Macia JC, Reynes J. Antihypertensive drugs in patients treated with antiretrovirals. *Ann Pharmacother*. 2012;46:703-9.

[\[PubMed Abstract\]](#) -

35. Gillette MA, Shah BM, Schafer JJ, DeSimone JA Jr. Dolutegravir: a new integrase strand transfer inhibitor for the treatment of HIV - an alternative viewpoint. *Pharmacotherapy*. 2014;34:e173-4.
[\[PubMed Abstract\]](#) -
36. Phillips EJ, Rachlis AR, Ito S. Digoxin toxicity and ritonavir: a drug interaction mediated through p-glycoprotein? *AIDS*. 2003;17:1577-8.
[\[PubMed Abstract\]](#) -
37. Yoganathan K, Roberts B, Heatley MK. Life-threatening digoxin toxicity due to drug-drug interactions in an HIV-positive man. *Int J STD AIDS*. 2017;28:297-301.
[\[PubMed Abstract\]](#) -
38. Clevenbergh P, Corcostegui M, Gérard D, et al. Iatrogenic Cushing's syndrome in an HIV-infected patient treated with inhaled corticosteroids (fluticasone propionate) and low dose ritonavir enhanced PI containing regimen. *J Infect*. 2002;44:194-5.
[\[PubMed Abstract\]](#) -
39. Foisy MM, Yakiwchuk EM, Chiu I, Singh AE. Adrenal suppression and Cushing's syndrome secondary to an interaction between ritonavir and fluticasone: a review of the literature. *HIV Med*. 2008;9:389-96
[\[PubMed Abstract\]](#) -
40. Gupta SK, Dubé MP. Exogenous cushing syndrome mimicking human immunodeficiency virus lipodystrophy. *Clin Infect Dis*. 2002;35:E69-71.
[\[PubMed Abstract\]](#) -
41. Samaras K, Pett S, Gowers A, McMurchie M, Cooper DA. Iatrogenic Cushing's syndrome with osteoporosis and secondary adrenal failure in human immunodeficiency virus-infected patients receiving inhaled corticosteroids and ritonavir-boosted protease inhibitors: six cases. *J Clin Endocrinol Metab*. 2005;90:4394-8.
[\[PubMed Abstract\]](#) -
42. St Germain RM, Yigit S, Wells L, Giroto JE, Salazar JC. Cushing syndrome and severe adrenal suppression caused by fluticasone and protease inhibitor combination in an HIV-infected adolescent. *AIDS Patient Care STDS*. 2007;21:373-7.
[\[PubMed Abstract\]](#) -
43. Kedem E, Shahar E, Hassoun G, Pollack S. Iatrogenic Cushing's syndrome due to coadministration of ritonavir and inhaled budesonide in an asthmatic human immunodeficiency virus infected patient. *J Asthma*. 2010;47:830-1.
[\[PubMed Abstract\]](#) -
44. Hall JJ, Hughes CA, Foisy MM, Houston S, Shafran S. Iatrogenic Cushing syndrome after intra-articular triamcinolone in a patient receiving ritonavir-boosted darunavir. *Int J STD AIDS*. 2013;24:748-52.
[\[PubMed Abstract\]](#) -
45. Jakeman B, Conklin J, Bouchonville M, Thornton K. Iatrogenic Cushing's syndrome after triamcinolone plus ritonavir-boosted atazanavir. *J Am Pharm Assoc (2003)*. 2015;55:193-7.
[\[PubMed Abstract\]](#) -
46. Molloy A, Matheson NJ, Meyer PA, Chatterjee K, Gkrania-Klotsas E. Cushing's syndrome and adrenal axis suppression in a patient treated with ritonavir and corticosteroid eye drops. *AIDS*. 2011;25:1337-9.

[\[PubMed Abstract\]](#) -

47. Song Y, Schroeder JR, Bush LM. Iatrogenic Cushing syndrome and secondary adrenal insufficiency related to concomitant triamcinolone and ritonavir administration: a case report and review. *J Int Assoc Provid AIDS Care*. 2014;13:511-4.
[\[PubMed Abstract\]](#) -
48. Albert NE, Kazi S, Santoro J, Dougherty R. Ritonavir and epidural triamcinolone as a cause of iatrogenic Cushing's syndrome. *Am J Med Sci*. 2012;344:72-4.
[\[PubMed Abstract\]](#) -
49. Lewis J, Turtle L, Khoo S, Nsutebu EN. A case of iatrogenic adrenal suppression after co-administration of cobicistat and fluticasone nasal drops. *AIDS*. 2014;28:2636-7.
[\[PubMed Abstract\]](#) -
50. Boyd SD, Hadigan C, McManus M, et al. Influence of low-dose ritonavir with and without darunavir on the pharmacokinetics and pharmacodynamics of inhaled beclomethasone. *J Acquir Immune Defic Syndr*. 2013;63:355-61.
[\[PubMed Abstract\]](#) -
51. Sharma M, Saravolatz LD. Rilpivirine: a new non-nucleoside reverse transcriptase inhibitor. *J Antimicrob Chemother*. 2013;68:250-6.
[\[PubMed Abstract\]](#) -
52. King JR, Menon RM. Ombitasvir/Paritaprevir/Ritonavir and Dasabuvir: Drug Interactions With Antiretroviral Agents and Drugs for Substance Abuse. *Clin Pharmacol Drug Dev*. 2017;6:201-205.
[\[PubMed Abstract\]](#) -
53. Wyles DL. Regimens for Patients Coinfected with Human Immunodeficiency Virus. *Clin Liver Dis*. 2015;19:689-706, vi-vii.
[\[PubMed Abstract\]](#) -
54. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in adults and adolescents with HIV. Department of Health and Human Services. Considerations for antiretroviral use in patients with coinfections. hepatitis C virus/HIV coinfection. March 23, 2023.
[\[HIV.gov\]](#) -
55. Falade-Nwulia O, Suarez-Cuervo C, Nelson DR, Fried MW, Segal JB, Sulkowski MS. Oral Direct-Acting Agent Therapy for Hepatitis C Virus Infection: A Systematic Review. *Ann Intern Med*. 2017;166:637-648.
[\[PubMed Abstract\]](#) -
56. Weisberg IS, Jacobson IM. Primer on Hepatitis C Virus Resistance to Direct-Acting Antiviral Treatment: A Practical Approach for the Treating Physician. *Clin Liver Dis*. 2017;21:659-672.
[\[PubMed Abstract\]](#) -
57. Brooks KM, Castillo-Mancilla JR, Blum J, et al. Increased tenofovir monoester concentrations in patients receiving tenofovir disoproxil fumarate with ledipasvir/sofosbuvir. *J Antimicrob Chemother*. 2019;74:2360-4.
[\[PubMed Abstract\]](#) -
58. MacBrayne CE, Marks KM, Fierer DS, et al. Effects of sofosbuvir-based hepatitis C treatment on the pharmacokinetics of tenofovir in HIV/HCV-coinfected individuals receiving tenofovir disoproxil fumarate. *J Antimicrob Chemother*. 2018;73:2112-19.

[\[PubMed Abstract\]](#) -

59. Chauvin B, Drouot S, Barrail-Tran A, Taburet AM. Drug-drug interactions between HMG-CoA reductase inhibitors (statins) and antiviral protease inhibitors. *Clin Pharmacokinet*. 2013;52:815-31.
[\[PubMed Abstract\]](#) -
60. Fichtenbaum CJ, Gerber JG, Rosenkranz SL, et al. Pharmacokinetic interactions between protease inhibitors and statins in HIV seronegative volunteers: ACTG Study A5047. *AIDS*. 2002;16:569-77.
[\[PubMed Abstract\]](#) -
61. Gerber JG, Rosenkranz SL, Fichtenbaum CJ, et al. Effect of efavirenz on the pharmacokinetics of simvastatin, atorvastatin, and pravastatin: results of AIDS Clinical Trials Group 5108 Study. *J Acquir Immune Defic Syndr*. 2005;39:307-12.
[\[PubMed Abstract\]](#) -
62. Castro JG, Gutierrez L. Rhabdomyolysis with acute renal failure probably related to the interaction of atorvastatin and delavirdine. *Am J Med*. 2002;112:505.
[\[PubMed Abstract\]](#) -
63. Mah Ming JB, Gill MJ. Drug-induced rhabdomyolysis after concomitant use of clarithromycin, atorvastatin, and lopinavir/ritonavir in a patient with HIV. *AIDS Patient Care STDS*. 2003;17:207-10.
[\[PubMed Abstract\]](#) -
64. Kakuda TN, Schöller-Gyüre M, Hoetelmans RM. Pharmacokinetic interactions between etravirine and non-antiretroviral drugs. *Clin Pharmacokinet*. 2011;50:25-39.
[\[PubMed Abstract\]](#) -
65. Aboulafia DM, Johnston R. Simvastatin-induced rhabdomyolysis in an HIV-infected patient with coronary artery disease. *AIDS Patient Care STDS*. 2000;14:13-8.
[\[PubMed Abstract\]](#) -
66. Cheng CH, Miller C, Lowe C, Pearson VE. Rhabdomyolysis due to probable interaction between simvastatin and ritonavir. *Am J Health Syst Pharm*. 2002;59:728-30.
[\[PubMed Abstract\]](#) -
67. Hare CB, Vu MP, Grunfeld C, Lampiris HW. Simvastatin-nelfinavir interaction implicated in rhabdomyolysis and death. *Clin Infect Dis*. 2002;35:e111-2.
[\[PubMed Abstract\]](#) -
68. Schmidt GA, Hoehns JD, Purcell JL, Friedman RL, Elhawi Y. Severe rhabdomyolysis and acute renal failure secondary to concomitant use of simvastatin, amiodarone, and atazanavir. *J Am Board Fam Med*. 2007;20:411-6.
[\[PubMed Abstract\]](#) -
69. Malvestutto CD, Ma Q, Morse GD, Underberg JA, Aberg JA. Lack of pharmacokinetic interactions between pitavastatin and efavirenz or darunavir/ritonavir. *J Acquir Immune Defic Syndr*. 2014;67:390-6.
[\[PubMed Abstract\]](#) -
70. Yu CY, Campbell SE, Sponseller CA, Small DS, Medlock MM, Morgan RE. Steady-state pharmacokinetics of darunavir/ritonavir and pitavastatin when co-administered to healthy adult volunteers. *Clin Drug Investig*. 2014;34:475-82.
[\[PubMed Abstract\]](#) -

71. Miller PE, Martin SS, Joshi PH, et al. Pitavastatin 4 mg Provides Significantly Greater Reduction in Remnant Lipoprotein Cholesterol Compared With Pravastatin 40 mg: Results from the Short-term Phase IV PREVAIL US Trial in Patients With Primary Hyperlipidemia or Mixed Dyslipidemia. *Clin Ther.* 2016;38:603-9.
[\[PubMed Abstract\]](#) -
72. Grinspoon SK, Fitch KV, Zanni MV, et al. Pitavastatin to Prevent Cardiovascular Disease in HIV Infection. *N Engl J Med.* 2023;389:687-99.
[\[PubMed Abstract\]](#) -
73. Aquilante CL, Kiser JJ, Anderson PL, et al. Influence of SLCO1B1 polymorphisms on the drug-drug interaction between darunavir/ritonavir and pravastatin. *J Clin Pharmacol.* 2012;52:1725-38.
[\[PubMed Abstract\]](#) -
74. Pham PA, la Porte CJ, Lee LS, et al. Differential effects of tipranavir plus ritonavir on atorvastatin or rosuvastatin pharmacokinetics in healthy volunteers. *Antimicrob Agents Chemother.* 2009;53:4385-92.
[\[PubMed Abstract\]](#) -
75. van der Lee M, Sankatsing R, Schippers E, et al. Pharmacokinetics and pharmacodynamics of combined use of lopinavir/ritonavir and rosuvastatin in HIV-infected patients. *Antivir Ther.* 2007;12:1127-32.
[\[PubMed Abstract\]](#) -
76. Bing EG, Burnam MA, Longshore D, et al. Psychiatric disorders and drug use among human immunodeficiency virus-infected adults in the United States. *Arch Gen Psychiatry.* 2001;58:721-8.
[\[PubMed Abstract\]](#) -
77. Watkins CC, Pieper AA, Treisman GJ. Safety considerations in drug treatment of depression in HIV-positive patients: an updated review. *Drug Saf.* 2011;34:623-39.
[\[PubMed Abstract\]](#) -
78. Treisman G, Angelino A. Interrelation between psychiatric disorders and the prevention and treatment of HIV infection. *Clin Infect Dis.* 2007;45 Suppl 4:S313-7.
[\[PubMed Abstract\]](#) -
79. Geraci MJ, McCoy SL, Crum PM, Patel RA. Antipsychotic-induced priapism in an HIV patient: a cytochrome P450-mediated drug interaction. *Int J Emerg Med.* 2010;3:81-4.
[\[PubMed Abstract\]](#) -
80. Pollack TM, McCoy C, Stead W. Clinically significant adverse events from a drug interaction between quetiapine and atazanavir-ritonavir in two patients. *Pharmacotherapy.* 2009;29:1386-91.
[\[PubMed Abstract\]](#) -
81. Pieper AA, Treisman GJ. Drug treatment of depression in HIV-positive patients : safety considerations. *Drug Saf.* 2005;28:753-62.
[\[PubMed Abstract\]](#) -
82. Blonk MI, Langemeijer CC, Colbers AP, et al. Pharmacokinetic drug-drug interaction study between raltegravir and citalopram. *Antivir Ther.* 2016;21:143-52.
[\[PubMed Abstract\]](#) -
83. Bruce RD, Moody DE, Altice FL, Gourevitch MN, Friedland GH. A review of pharmacological interactions between HIV or hepatitis C virus medications and opioid agonist therapy: implications and

management for clinical practice. Expert Rev Clin Pharmacol. 2013;6:249-69.

[\[PubMed Abstract\]](#) -

84. Meemken L, Hanhoff N, Tseng A, Christensen S, Gillissen A. Drug-Drug Interactions With Antiviral Agents in People Who Inject Drugs Requiring Substitution Therapy. Ann Pharmacother. 2015;49:796-807.
[\[PubMed Abstract\]](#) -
85. Anderson MS, Mabalot Luk JA, Hanley WD, et al. Effect of raltegravir on the pharmacokinetics of methadone. J Clin Pharmacol. 2010;50:1461-6.
[\[PubMed Abstract\]](#) -
86. Song I, Mark S, Chen S, et al. Dolutegravir does not affect methadone pharmacokinetics in opioid-dependent, HIV-seronegative subjects. Drug Alcohol Depend. 2013;133:781-4.
[\[PubMed Abstract\]](#) -
87. Clarke SM, Mulcahy FM, Tjia J, Reynolds HE, Gibbons SE, Barry MG, Back DJ. The pharmacokinetics of methadone in HIV-positive patients receiving the non-nucleoside reverse transcriptase inhibitor efavirenz. Br J Clin Pharmacol. 2001; 51:213-7.
[\[PubMed Abstract\]](#) -
88. Clarke SM, Mulcahy FM, Tjia J, Reynolds HE, Gibbons SE, Barry MG, Back DJ. Pharmacokinetic interactions of nevirapine and methadone and guidelines for use of nevirapine to treat injection drug users. Clin Infect Dis. 2001;33:1595-7.
[\[PubMed Abstract\]](#) -
89. McCance-Katz EF, Rainey PM, Friedland G, Jatlow P. The protease inhibitor lopinavir-ritonavir may produce opiate withdrawal in methadone-maintained patients. Clin Infect Dis. 2003;37:476-82.
[\[PubMed Abstract\]](#) -
90. Sekar V, Tomaka F, Lefebvre E, De Pauw M, Vangeneugden T, van den Brink W, Hoetelmans R. Pharmacokinetic interactions between darunavir/ritonavir and opioid maintenance therapy using methadone or buprenorphine/naloxone. J Clin Pharmacol. 2011;51:271-8.
[\[PubMed Abstract\]](#) -
91. Egan G, Hughes CA, Ackman ML. Drug interactions between antiplatelet or novel oral anticoagulant medications and antiretroviral medications. Ann Pharmacother. 2014;48:734-40.
[\[PubMed Abstract\]](#) -
92. Crum NF, Furtek KJ, Olson PE, Amling CL, Wallace MR. A review of hypogonadism and erectile dysfunction among HIV-infected men during the pre- and post-HAART eras: diagnosis, pathogenesis, and management. AIDS Patient Care STDS. 2005;19:655-71.
[\[PubMed Abstract\]](#) -
93. Roberson DW, Kosko DA. Men living with HIV and experiencing sexual dysfunction: an analysis of treatment options. J Assoc Nurses AIDS Care. 2013;24:S135-45.
[\[PubMed Abstract\]](#) -
94. Hohmann N, Reinhard R, Schnaidt S, et al. Treatment with rilpivirine does not alter plasma concentrations of the CYP3A substrates tadalafil and midazolam in humans. J Antimicrob Chemother. 2016;71:2241-7.
[\[PubMed Abstract\]](#) -
95. Siddiqi O, Birbeck GL. Safe Treatment of Seizures in the Setting of HIV/AIDS. Curr Treat Options

Neurol. 2013;15:529-43.

[\[PubMed Abstract\]](#) -

96. Song IH, Zong J, Borland J, et al. The Effect of Dolutegravir on the Pharmacokinetics of Metformin in Healthy Subjects. *J Acquir Immune Defic Syndr*. 2016;72:400-7.

[\[PubMed Abstract\]](#) -

97. Zong J, Borland J, Jerva F, Wynne B, Choukour M, Song I. The effect of dolutegravir on the pharmacokinetics of metformin in healthy subjects. *J Int AIDS Soc*. 2014;17:19584.

[\[PubMed Abstract\]](#) -

References

- Aberg JA, Zackin RA, Brobst SW, et al. A randomized trial of the efficacy and safety of fenofibrate versus pravastatin in HIV-infected subjects with lipid abnormalities: AIDS Clinical Trials Group Study 5087. *AIDS Res Hum Retroviruses*. 2005;21:757-67.
[\[PubMed Abstract\]](#) -
- Aberg JA. Lipid management in patients who have HIV and are receiving HIV therapy. *Endocrinol Metab Clin North Am*. 2009;38:207-22.
[\[PubMed Abstract\]](#) -
- Arrington-Sanders R, Hutton N, Siberry GK. Ritonavir-fluticasone interaction causing Cushing syndrome in HIV-infected children and adolescents. *Pediatr Infect Dis J*. 2006;25:1044-8.
[\[PubMed Abstract\]](#) -
- Bhasin S, Brito JP, Cunningham GR, et al. Testosterone Therapy in Men With Hypogonadism: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*. 2018;103:1715-1744.
[\[PubMed Abstract\]](#) -
- Bhatia R, Murphy AB, Raper JL, et al. Testosterone replacement therapy among HIV-infected men in the CFAR Network of Integrated Clinical Systems. *AIDS*. 2015;29:77-81.
[\[PubMed Abstract\]](#) -
- Bhumbra NA, Sahloff EG, Oehrtman SJ, Horner JM. Exogenous Cushing syndrome with inhaled fluticasone in a child receiving lopinavir/ritonavir. *Ann Pharmacother*. 2007;41:1306-9.
[\[PubMed Abstract\]](#) -
- Calza L, Colangeli V, Manfredi R, Bon I, Re MC, Viale P. Clinical management of dyslipidaemia associated with combination antiretroviral therapy in HIV-infected patients. *J Antimicrob Chemother*. 2016;71:1451-65.
[\[PubMed Abstract\]](#) -
- Corallo CE, Grannell L, Tran H. Postoperative Bleeding After Administration of a Single Dose of Rivaroxaban to a Patient Receiving Antiretroviral Therapy. *Drug Saf Case Rep*. 2015;2:11.
[\[PubMed Abstract\]](#) -
- Dooley KE, Kaplan R, Mwelase N, et al. Dolutegravir-based Antiretroviral Therapy for Patients Coinfected With Tuberculosis and Human Immunodeficiency Virus: A Multicenter, Noncomparative, Open-label, Randomized Trial. *Clin Infect Dis*. 2020;70:549-56.
[\[PubMed Abstract\]](#) -
- Douglas Bruce R, Moody DE, Chodkowski D, et al. Pharmacokinetic interactions between

buprenorphine/naloxone and raltegravir in subjects receiving chronic buprenorphine/naloxone treatment. *Am J Drug Alcohol Abuse*. 2013;39:80-5.

[\[PubMed Abstract\]](#) -

- Dunne M, Fessel J, Kumar P, et al. A randomized, double-blind trial comparing azithromycin and clarithromycin in the treatment of disseminated *Mycobacterium avium* infection in patients with human immunodeficiency virus. *Clin Infect Dis*. 2000;31:1245-52.
[\[PubMed Abstract\]](#) -
- Gruber VA, Rainey PM, Moody DE, et al. Interactions between buprenorphine and the protease inhibitors darunavir-ritonavir and fosamprenavir-ritonavir. *Clin Infect Dis*. 2012;54:414-23.
[\[PubMed Abstract\]](#) -
- Havlir DV, Dube MP, Sattler FR, et al. Prophylaxis against disseminated *Mycobacterium avium* complex with weekly azithromycin, daily rifabutin, or both. California Collaborative Treatment Group. *N Engl J Med*. 1996;335:392-8.
[\[PubMed Abstract\]](#) -
- Johnson SR, Marion AA, Vrchticky T, Emmanuel PJ, Lujan-Zilbermann J. Cushing syndrome with secondary adrenal insufficiency from concomitant therapy with ritonavir and fluticasone. *J Pediatr*. 2006;148:386-8.
[\[PubMed Abstract\]](#) -
- Lakatos B, Stoeckle M, Elzi L, Battegay M, Marzolini C. Gastrointestinal bleeding associated with rivaroxaban administration in a treated patient infected with human immunodeficiency virus. *Swiss Med Wkly*. 2014;144:w13906.
[\[PubMed Abstract\]](#) -
- Nisly SA, Stevens BN. Ritonavir- or cobicistat-boosted antiretroviral therapy and direct oral anticoagulants: A case for apixaban. *Int J STD AIDS*. 2019;30:718-22.
[\[PubMed Abstract\]](#) -
- Pessanha TM, Campos JM, Barros AC, Pone MV, Garrido JR, Pone SM. Iatrogenic Cushing's syndrome in an adolescent with AIDS on ritonavir and inhaled fluticasone. Case report and literature review. *AIDS*. 2007;21:529-32.
[\[PubMed Abstract\]](#) -
- Pham HT, Mesplède T. Bictegravir in a fixed-dose tablet with emtricitabine and tenofovir alafenamide for the treatment of HIV infection: pharmacology and clinical implications. *Expert Opin Pharmacother*. 2019;20:385-397.
[\[PubMed Abstract\]](#) -
- Soldatos G, Sztal-Mazer S, Woolley I, Stockigt J. Exogenous glucocorticoid excess as a result of ritonavir-fluticasone interaction. *Intern Med J*. 2005;35:67-8.
[\[PubMed Abstract\]](#) -
- Valin N, De Castro N, Garrait V, Bergeron A, Bouche C, Molina JM. Iatrogenic Cushing's syndrome in HIV-infected patients receiving ritonavir and inhaled fluticasone: description of 4 new cases and review of the literature. *J Int Assoc Physicians AIDS Care (Chic)*. 2009;8:113-21.
[\[PubMed Abstract\]](#) -

Figures

Figure 1 First-Pass Metabolism after Oral Administration of a Drug and Its Interaction with Grapefruit Juice

Figure legend from article: CYP3A enzymes (e.g., CYP3A4) present in enterocytes of the intestinal epithelium extensively metabolize felodipine during its absorption, and, on average, only 30% of the administered dose enters the portal vein (solid line). Subsequently, CYP3A enzymes in the liver further metabolize the drug so that only 15% of the dose is bioavailable and finally reaches the systemic circulation and is able to exert its effects. Grapefruit juice selectively inhibits CYP3A in the enterocyte, with the net result being an increase in the oral bioavailability of felodipine by a factor of three, denoted by the asterisks and the dashed lines.

Source: Wilkinson GR. Drug metabolism and variability among patients in drug response. *N Engl J Med.* 2005;352:2211-21.

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Figure 2 CYP 450 Inhibition

Source: Illustration by John J. Faragon, PharmD

CYP 450 Inhibition



Figure 3 CYP 450 Induction

Source: Illustration by John J. Faragon, PharmD

CYP 450 Induction



Figure 4 Ritonavir-Boosted Saquinavir Interactions with Statins

Source: Fichtenbaum CJ, Gerber JG, Rosenkranz SL, et al. Pharmacokinetic interactions between protease inhibitors and statins in HIV seronegative volunteers: ACTG Study A5047. AIDS. 2002;16:569-77. Reproduced with permission from Lippincott Williams & Wilkins



Table 1. Common Types of Pharmacokinetic Drug Interactions

Pharmacokinetic Drug Interactions	Interaction	Comment
	Absorption	Concurrent therapy or food ingestion results in increase or decrease in drug absorption, thereby increasing or decreasing bioavailability.
	Distribution	Concurrent therapy leads to protein binding displacement, altering the activity of either drug.
	Metabolism	Therapy induces or inhibits CYP450 enzymes, thereby increasing or decreasing drug concentration.
	Excretion	Concurrent therapy results in enhanced or decreased renal excretion of drug.

