Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection

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### Dosing Recommendations

**Pediatric Dose (Aged >6 Months to 18 Years):**

- **Unboosted fosamprenavir (without ritonavir)** is Food and Drug Administration (FDA)-approved for antiretroviral (ARV)-naive children aged 2 to 5 years, but not recommended by the Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV (the Panel) because of low exposures (see text below).

- **Boosted fosamprenavir (with ritonavir)** is FDA-approved for ARV-naive infants ≥4 weeks and for treatment-experienced infants ≥6 months; however, the Panel does not recommend use in infants aged <6 months because of similarly low exposures (see text below). If used in infants as young as 4 weeks, it should only be administered to infants born at 38 weeks’ gestation or greater.

**Note:** Once-daily dosing is not recommended for any pediatric patient.

**Pediatric Dose (Aged ≥6 Months to 18 Years):**

**Twice-Daily Dose Regimens by Weight for Pediatric Patients ≥6 Months Using Fosamprenavir Oral Suspension with Ritonavir**

<table>
<thead>
<tr>
<th>Weight</th>
<th>Dose (Both Drugs Twice Daily with Food)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;11 kg</td>
<td>Fosamprenavir 45 mg/kg/dose plus ritonavir 7 mg/kg/dose</td>
</tr>
<tr>
<td>11 kg to &lt;15 kg</td>
<td>Fosamprenavir 30 mg/kg/dose plus ritonavir 3 mg/kg/dose</td>
</tr>
<tr>
<td>15 kg to &lt;20 kg</td>
<td>Fosamprenavir 23 mg/kg/dose plus ritonavir 3 mg/kg/dose</td>
</tr>
<tr>
<td>≥20 kg</td>
<td>Fosamprenavir 18 mg/kg/dose plus ritonavir 3 mg/kg/dose</td>
</tr>
</tbody>
</table>

* Not to exceed the adult dose of fosamprenavir 700 mg plus ritonavir 100 mg twice daily.

**Selected Adverse Events**

- Diarrhea, nausea, vomiting
- Skin rash (fosamprenavir has a sulfonamide moiety. Stevens-Johnson syndrome and erythema multiforme have been reported.)
- Headache
- Hyperlipidemia, hyperglycemia
- Nephrolithiasis
- Transaminase elevation
- Fat maldistribution
- Possible increased bleeding episodes in patients with hemophilia

**Special Instructions**

- Fosamprenavir tablets with ritonavir should be taken with food. Children should take the suspension with food.
- Patients taking antacids should take fosamprenavir at least 1 hour before or after antacid use.
- Fosamprenavir contains a sulfonamide moiety. The potential for cross sensitivity between fosamprenavir and other drugs in the sulfonamide class is unknown. Fosamprenavir should be used with caution in patients with sulfonamide allergy.
- Shake oral suspension well before use. Refrigeration is not required.

**Metabolism/Elimination**

- The prodrug fosamprenavir is rapidly and almost completely hydrolyzed to amprenavir by cellular phosphatases in the gut as it is absorbed.
- Amprenavir is a cytochrome P (CYP) 450 3A4 inhibitor, inducer, and substrate.
**Drug Interactions** (see also the Adult and Adolescent Guidelines and HIV Drug Interaction Checker)

- Fosamprenavir may interact with a number of other drugs, and using ritonavir as a boosting agent increases the potential for drug interactions. Before administration, a patient’s medication profile should be carefully reviewed for potential drug interactions with fosamprenavir.

**Major Toxicities**

- More common: Vomiting, nausea, diarrhea, perioral paresthesia, headache, rash, and lipid abnormalities.

- Less common (more severe): Life-threatening rash, including Stevens-Johnson syndrome, in <1% of patients. Fat maldistribution, neutropenia, and elevated serum creatinine kinase levels.

- Rare: New-onset diabetes mellitus, hyperglycemia, ketoacidosis, exacerbation of preexisting diabetes mellitus, spontaneous bleeding in hemophiliacs, hemolytic anemia, elevation in serum transaminases, angioedema, and nephrolithiasis.

- Pediatric-specific: Vomiting was more frequent in children than in adults during clinical trials of fosamprenavir with ritonavir (20% to 36% vs. 10%, respectively) and in trials of fosamprenavir without ritonavir (60% vs. 16%, respectively). Neutropenia was also more common in children across all the trials (15% vs. 3%, respectively).¹

**Resistance**

The International Antiviral Society-USA (IAS-USA) maintains a [list of updated resistance mutations](https://aidsinfo.nih.gov/guidelines) and the [Stanford University HIV Drug Resistance Database](https://aidsinfo.nih.gov/guidelines) offers a discussion of each mutation.

**Pediatric Use**

**Approval**

Fosamprenavir is Food and Drug Administration (FDA)-approved for use in children as young as age 4 weeks, but the Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV (the Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection M-175

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Panel) recommends use only in children aged ≥6 months. While unboosted fosamprenavir has been approved by the FDA for antiretroviral-naive children aged 2 to 5 years, the Panel does not recommend unboosted fosamprenavir for this—or any other—age group because of low exposures and also because unboosted fosamprenavir may select for mutations associated with resistance to darunavir.2

Efficacy and Pharmacokinetics

Dosing recommendations for fosamprenavir are based on three pediatric studies that enrolled more than 200 children aged 4 weeks to 18 years. In two, open-label trials in both treatment-experienced and treatment-naive children aged 2 to 18 years,3,4 fosamprenavir was well-tolerated and effective in suppressing viral load and increasing CD4 T lymphocyte count. However, data were insufficient to support a once-daily dosing regimen of fosamprenavir/ritonavir in children; therefore, once-daily dosing is not recommended for pediatric patients.

Pharmacokinetics in Infants

In a study of infants, higher doses of both fosamprenavir and ritonavir were used in treatment-naive infants as young as age 4 weeks and in treatment-experienced infants as young as age 6 months.1,5 Exposures in those aged <6 months were much lower than those achieved in older children and adults and comparable to those seen with unboosted fosamprenavir (see table below). Given these low exposures, limited data, large dosing volumes, unpleasant taste, and the availability of alternatives for infants and young children, the Panel does not recommend fosamprenavir use in infants aged <6 months.

Table A. Fosamprenavir Dose and Amprenavir Exposure by Age Group

<table>
<thead>
<tr>
<th>Population</th>
<th>Dose</th>
<th>AUC0-24h (mcg*hr/mL)</th>
<th>Cmin (mcg/mL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants Aged &lt;6 Months</td>
<td>FPV 45 mg/kg plus RTV 10 mg/kg twice daily</td>
<td>26.6a</td>
<td>0.86</td>
</tr>
<tr>
<td>Children Aged 2 Years to &lt;6 Years</td>
<td>FPV 30 mg/kg twice daily (no RTV)</td>
<td>22.3a</td>
<td>0.513</td>
</tr>
<tr>
<td>Children Weighing &lt;11 kg</td>
<td>FPV 45 mg/kg plus RTV 7 mg/kg twice daily</td>
<td>57.3</td>
<td>1.65</td>
</tr>
<tr>
<td>Children Weighing 15 kg to &lt;20 kg</td>
<td>FPV 23 mg/kg FPV plus RTV 3 mg/kg twice daily</td>
<td>121.0</td>
<td>3.56</td>
</tr>
<tr>
<td>Children Weighing ≥20 kg</td>
<td>FPV 18 mg/kg plus RTV 3 mg/kg twice daily (maximum 700/100 mg)</td>
<td>72.3–97.9</td>
<td>1.98–2.54</td>
</tr>
<tr>
<td>Adults</td>
<td>FPV 1400 mg twice daily (no RTV)</td>
<td>33</td>
<td>0.35</td>
</tr>
<tr>
<td>Adults</td>
<td>FPV 1400 mg plus RTV 100–200 mg RTV once daily</td>
<td>66.4–69.4</td>
<td>0.86–1.45</td>
</tr>
<tr>
<td>Adults</td>
<td>FPV 700 mg plus RTV 100 mg twice daily</td>
<td>79.2</td>
<td>2.12</td>
</tr>
</tbody>
</table>

a AUC0-12 (mcg*hr/mL)

Key to Acronyms: AUC0-24h = area under the curve for 24 hours post-dose; Cmin = minimum plasma concentration; FPV = fosamprenavir; RTV = ritonavir

Note: Dose for those weighing 11 kg to <15 kg is based on population pharmacokinetic studies; therefore, AUC and Cmin are not available.

References

3. Chadwick E, Borkowsky W, Fortuny C, et al. Safety and antiviral activity of fosamprenavir/ritonavir once daily regimens in HIV-infected pediatric subjects ages 2 to 18 years (48-week interim data, study apv20003). Presented at: