

ZIDOVUDINE - zidovudine tablet, film coated
State of Florida DOH Central Pharmacy

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use zidovudine tablets safely and effectively. See full prescribing information for zidovudine tablets.

Zidovudine Tablets, USP
Initial U.S. Approval: 1987

WARNING: RISK OF HEMATOLOGICAL TOXICITY, MYOPATHY, LACTIC ACIDOSIS
See full prescribing information for complete boxed warning.

- Hematologic toxicity including neutropenia and severe anemia have been associated with the use of zidovudine. (5.1)
- Symptomatic myopathy associated with prolonged use of zidovudine. (5.2)
- Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside analogues including zidovudine. Suspend treatment if clinical or laboratory findings suggestive of lactic acidosis or pronounced hepatotoxicity occur. (5.3)

RECENT MAJOR CHANGES

Warnings and Precautions, Immune Reconstitution Syndrome (5.6) (11/2011)

INDICATIONS AND USAGE

Zidovudine is a nucleoside analogue reverse transcriptase inhibitor indicated for:

- Treatment of Human Immunodeficiency Virus (HIV-1) infection in combination with other antiretroviral agents. (1.1)
- Prevention of maternal-fetal HIV-1 transmission. (1.2)

DOSAGE AND ADMINISTRATION

- Treatment of HIV-1 infection: Adults: 600 mg/day in divided doses with other antiretroviral agents. Pediatric patients (aged 4 weeks to < 18 years): Dosage should be calculated based on body weight not to exceed adult dose. (2.1)
- Prevention of maternal-fetal HIV-1 transmission: Specific dosage instructions for mother and infant. (2.2)
- Patients with severe anemia and/or neutropenia: Dosage interruption may be necessary. (2.3)
- Renal impairment: Recommended dosage in hemodialysis or peritoneal dialysis patients is 100 mg every 6 to 8 hours. (2.4)

DOSAGE FORMS AND STRENGTHS

Tablets: 300 mg (3)

CONTRAINDICATIONS

Hypersensitivity to zidovudine (e.g., anaphylaxis, Stevens-Johnson Syndrome). (4)

WARNINGS AND PRECAUTIONS

- See boxed warning for information about the following: hematologic toxicity, myopathy and lactic acidosis and severe hepatomegaly (5.1, 5.2, 5.3)
- Exacerbation of anemia has been reported in HIV-1/HCV co-infected patients receiving ribavirin and zidovudine. Coadministration of ribavirin and zidovudine is not advised. (5.4)
- Hepatic decompensation, (some fatal), has occurred in HIV-1/HCV co-infected patients receiving combination antiretroviral therapy and interferon alfa with/without ribavirin. Discontinue zidovudine as medically appropriate and consider dose reduction or discontinuation of interferon alfa, ribavirin or both. (5.4)
- Zidovudine tablets should not be administered with other zidovudine-containing combination products. (5.5)
- Immune reconstitution syndrome (5.6) and redistribution/accumulation of body fat (5.7) have been reported in patients treated with combination antiretroviral therapy.

ADVERSE REACTIONS

- Most commonly reported adverse reactions (incidence \geq 15%) in adult HIV-1 clinical studies were headache, malaise, nausea, anorexia and vomiting. (6.1)
- Most commonly reported adverse reactions (incidence \geq 15%) in pediatric HIV-1 clinical studies were fever, cough and digestive disorders. (6.1)
- Most commonly reported adverse reactions in neonates (incidence \geq 15%) in the prevention of maternal-fetal transmission of HIV-1 clinical trial were anemia and neutropenia. (6.1)

To report SUSPECTED ADVERSE REACTIONS, contact Mylan Pharmaceuticals Inc. at 1-877-446-3769 (1-877-4-INFO-RX) or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

DRUG INTERACTIONS

- Stavudine: Concomitant use with zidovudine should be avoided. (7.1)
- Doxorubicin: Use with zidovudine should be avoided. (7.2)
- Bone marrow suppressive/cytotoxic agents: May increase the hematologic toxicity of zidovudine. (7.3)

USE IN SPECIFIC POPULATIONS

Pregnancy: Physicians are encouraged to register patients in the Antiretroviral Pregnancy Registry by calling 1-800-258-4263. (8.1)

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* Sections or subsections omitted from the full prescribing information are not listed.

FULL PRESCRIBING INFORMATION

WARNING: RISK OF HEMATOLOGICAL TOXICITY, MYOPATHY, LACTIC ACIDOSIS

Hematologic Toxicity: Zidovudine tablets have been associated with hematologic toxicity including neutropenia and severe anemia, particularly in patients with advanced HIV-1 disease [see Warnings and Precautions (5.1)].

Myopathy: Prolonged use of zidovudine has been associated with symptomatic myopathy [see Warnings and Precautions (5.2)].

Lactic Acidosis and Severe Hepatomegaly: Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside analogues alone or in combination, including zidovudine and other antiretrovirals. Suspend treatment if clinical or laboratory findings suggestive of lactic acidosis or pronounced hepatotoxicity occur [see Warnings and Precautions (5.3)].

1.1 Treatment of HIV-1

Zidovudine, a nucleoside reverse transcriptase inhibitor, is indicated in combination with other antiretroviral agents for the treatment of HIV-1 infection.

1.2 Prevention of Maternal-Fetal HIV-1 Transmission

Zidovudine tablets are indicated for the prevention of maternal-fetal HIV-1 transmission [see Dosage and Administration (2.2)]. The indication is based on a dosing regimen that included three components:

1. antepartum therapy of HIV-1 infected mothers
2. intrapartum therapy of HIV-1 infected mothers
3. post-partum therapy of HIV-1 exposed neonate.

Points to consider prior to initiating zidovudine tablets in pregnant women for the prevention of maternal-fetal HIV-1 transmission include:

- In most cases, zidovudine tablets for prevention of maternal-fetal HIV-1 transmission should be given in combination with other antiretroviral drugs.
- Prevention of HIV-1 transmission in women who have received zidovudine tablets for a prolonged period before pregnancy has not been evaluated.
- Because the fetus is most susceptible to the potential teratogenic effects of drugs during the first 10 weeks of gestation and the risks of therapy with zidovudine tablets during that period are not fully known, women in the first trimester of pregnancy who do not require immediate initiation of antiretroviral therapy for their own health may consider delaying use; this indication is based on use

after 14 weeks gestation.

2.1 Treatment of HIV-1 Infection

Adults

The recommended oral dose of zidovudine tablets is 600 mg/day in divided doses in combination with other antiretroviral agents.

Pediatric Patients (Aged 4 Weeks to <18 Years)

Healthcare professionals should pay special attention to accurate calculation of the dose of zidovudine tablets, transcription of the medication order, dispensing information and dosing instructions to minimize risk for medication dosing errors.

Prescribers should calculate the appropriate dose of zidovudine tablets for each child based on body weight (kg) and should not exceed the recommended adult dose.

Before prescribing zidovudine tablets, children should be assessed for the ability to swallow tablets. If a child is unable to reliably swallow a zidovudine tablet, the zidovudine syrup formulation should be prescribed.

The recommended dosage in pediatric patients 4 weeks of age and older and weighing ≥ 4 kg is provided in Table 1. Zidovudine syrup should be used to provide accurate dosage when whole tablets are not appropriate.

Table 1: Recommended Pediatric Dosage of Zidovudine Tablets

Body Weight (kg)	Total Daily Dose	Dosage Regimen and Dose	
		Twice Daily	Three Times Daily
4 to < 9	24 mg/kg/day	12 mg/kg	8 mg/kg
≥ 9 to < 30	18 mg/kg/day	9 mg/kg	6 mg/kg
≥ 30	600 mg/day	300 mg	200 mg

Alternatively, dosing for zidovudine tablets can be based on body surface area (BSA) for each child. The recommended oral dose of zidovudine tablets is 480 mg/m²/day in divided doses (240 mg/m² twice daily or 160 mg/m² three times daily). In some cases the dose calculated by mg/kg will not be the same as that calculated by BSA.

2.2 Prevention of Maternal-Fetal HIV-1 Transmission

The recommended dosage regimen for administration to pregnant women (> 14 weeks of pregnancy) and their neonates is:

Maternal Dosing

100 mg orally 5 times per day until the start of labor [see *Clinical Studies (14.3)*]. During labor and delivery, intravenous zidovudine should be administered at 2 mg/kg (total body weight) over 1 hour followed by a continuous intravenous infusion of 1 mg/kg/hour (total body weight) until clamping of the umbilical cord.

Neonatal Dosing

2 mg/kg orally every 6 hours starting within 12 hours after birth and continuing through 6 weeks of age. Neonates unable to receive oral dosing may be administered zidovudine intravenously at 1.5 mg/kg, infused over 30 minutes, every 6 hours.

2.3 Patients with Severe Anemia and/or Neutropenia

Significant anemia (hemoglobin < 7.5 g/dL or reduction > 25% of baseline) and/or significant neutropenia (granulocyte count < 750 cells/mm³ or reduction > 50% from baseline) may require a dose interruption until evidence of marrow recovery is observed [see *Warnings and Precautions (5.1)*]. In patients who develop significant anemia, dose interruption does not necessarily eliminate the need for transfusion. If marrow recovery occurs following dose interruption, resumption in dose may be appropriate using adjunctive measures such as epoetin alfa at recommended doses, depending on hematologic indices such as serum erythropoetin level and patient tolerance.

2.4 Patients with Renal Impairment

End-Stage Renal Disease

In patients maintained on hemodialysis or peritoneal dialysis, the recommended dosage is 100 mg every 6 to 8 hours [see *Clinical Pharmacology* (12.3)].

2.5 Patients with Hepatic Impairment

There are insufficient data to recommend dose adjustment of zidovudine tablets in patients with mild to moderate impaired hepatic function or liver cirrhosis.

3 DOSAGE FORMS AND STRENGTHS

Zidovudine tablets

The 300 mg tablets are white to off-white film-coated, round tablets debossed with **M 106** on one side of the tablet and blank on the other side.

4 CONTRAINDICATIONS

Zidovudine tablets are contraindicated in patients who have had potentially life threatening allergic reactions (e.g., anaphylaxis, Stevens-Johnson Syndrome) to any of the components of the formulations.

5.1 Hematologic Toxicity/Bone Marrow Suppression

Zidovudine should be used with caution in patients who have bone marrow compromise evidenced by granulocyte count < 1,000 cells/mm³ or hemoglobin < 9.5 g/dL. Hematologic toxicities appear to be related to pretreatment bone marrow reserve and to dose and duration of therapy. In patients with advanced symptomatic HIV-1 disease, anemia and neutropenia were the most significant adverse events observed. In patients who experience hematologic toxicity, a reduction in hemoglobin may occur as early as 2 to 4 weeks, and neutropenia usually occurs after 6 to 8 weeks. There have been reports of pancytopenia associated with the use of zidovudine, which was reversible in most instances after discontinuance of the drug. However, significant anemia, in many cases requiring dose adjustment, discontinuation of zidovudine, and/or blood transfusions, has occurred during treatment with zidovudine alone or in combination with other antiretrovirals.

Frequent blood counts are strongly recommended to detect severe anemia or neutropenia in patients with poor bone marrow reserve, particularly in patients with advanced HIV-1 disease who are treated with zidovudine. For HIV-1-infected individuals and patients with asymptomatic or early HIV-1 disease, periodic blood counts are recommended. If anemia or neutropenia develops, dosage interruption may be needed [see *Dosage and Administration* (2.3)].

5.2 Myopathy

Myopathy and myositis with pathological changes, similar to that produced by HIV-1 disease, have been associated with prolonged use of zidovudine.

5.3 Lactic Acidosis/Severe Hepatomegaly with Steatosis

Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside analogues alone or in combination, including zidovudine and other antiretrovirals. A majority of these cases have been in women. Obesity and prolonged exposure to antiretroviral nucleoside analogues may be risk factors. Particular caution should be exercised when administering zidovudine to any patient with known risk factors for liver disease; however, cases have also been reported in patients with no known risk factors. Treatment with zidovudine should be suspended in any patient who develops clinical or laboratory findings suggestive of lactic acidosis or pronounced hepatotoxicity (which may include hepatomegaly and steatosis even in the absence of marked transaminase elevations).

5.4 Use with Interferon- and Ribavirin-based Regimens in HIV-1/HCV Co-infected Patients

In vitro studies have shown ribavirin can reduce the phosphorylation of pyrimidine nucleoside analogues such as zidovudine. Although no evidence of a pharmacokinetic or pharmacodynamic interaction (e.g., loss of HIV-1/HCV virologic suppression) was seen when ribavirin was coadministered with zidovudine in HIV-1/HCV co-infected patients [see *Clinical Pharmacology* (12.3)], exacerbation of anemia due to ribavirin has been reported when zidovudine is part of the HIV regimen. Coadministration of ribavirin and zidovudine is not advised. Consideration should be given to replacing zidovudine in established combination HIV-1/HCV therapy, especially in patients with a known history of zidovudine-induced anemia.

Hepatic decompensation (some fatal) has occurred in HIV-1/HCV co-infected patients receiving combination antiretroviral therapy for HIV-1 and interferon alfa with or without ribavirin. Patients receiving interferon alfa with or without ribavirin and zidovudine should be closely monitored for

treatment-associated toxicities, especially hepatic decompensation, neutropenia and anemia.

Discontinuation of zidovudine should be considered as medically appropriate. Dose reduction or discontinuation of interferon alfa, ribavirin, or both should also be considered if worsening clinical toxicities are observed, including hepatic decompensation (e.g., Child-Pugh > 6) (see the complete prescribing information for interferon and ribavirin).

5.5 Use with Other Zidovudine-containing Products

Zidovudine tablets should not be administered with combination products that contain zidovudine as one of their components (e.g., COMBIVIR®* [lamivudine and zidovudine] Tablets or TRIZIVIR®* [abacavir sulfate, lamivudine, and zidovudine] Tablets).

5.6 Immune Reconstitution Syndrome

Immune reconstitution syndrome has been reported in patients treated with combination antiretroviral therapy, including zidovudine. During the initial phase of combination antiretroviral treatment, patients whose immune systems respond may develop an inflammatory response to indolent or residual opportunistic infections (such as *Mycobacterium avium* infection, cytomegalovirus, *Pneumocystis jirovecii* pneumonia [PCP], or tuberculosis), which may necessitate further evaluation and treatment.

Autoimmune disorders (such as Graves’ disease, polymyositis and Guillain-Barré syndrome) have also been reported to occur in the setting of immune reconstitution, however, the time to onset is more variable and can occur many months after initiation of treatment.

5.7 Fat Redistribution

Redistribution/accumulation of body fat, including central obesity, dorsocervical fat enlargement (buffalo hump), peripheral wasting, facial wasting, breast enlargement and “cushingoid appearance”, have been observed in patients receiving antiretroviral therapy. The mechanism and long-term consequences of these events are currently unknown. A causal relationship has not been established.

6 ADVERSE REACTIONS

The following adverse reactions are discussed in greater detail in other sections of the labeling:

- Hematologic toxicity, including neutropenia and anemia [see Boxed Warning, Warnings and Precautions (5.1)].
- Symptomatic myopathy [see Boxed Warning, Warnings and Precautions (5.2)].
- Lactic acidosis and severe hepatomegaly with steatosis [see Boxed Warning, Warnings and Precautions (5.3)].
- Hepatic decompensation in patients co-infected with HIV-1 and hepatitis C [see Warnings and Precautions (5.4)].

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

Adults

The frequency and severity of adverse reactions associated with the use of zidovudine are greater in patients with more advanced infection at the time of initiation of therapy.

Table 2 summarizes events reported at a statistically significant greater incidence for patients receiving zidovudine in a monotherapy study.

Table 2. Percentage (%) of Patients with Adverse Reactions* in Asymptomatic HIV-1 Infection (ACTG 019)

Adverse Reaction	Zidovudine 500 mg/day (n = 453)	Placebo (n = 428)
Body as a whole		
Asthenia	9%†	6%
Headache	63%	53%
Malaise	53%	45%
Gastrointestinal		
Anorexia	20%	11%
Constipation	6%†	4%
Nausea	51%	30%
Vomiting	17%	10%

* Reported in ≥ 5% of study population.

† Not statistically significant vs. placebo.

In addition to the adverse reactions listed in Table 2, adverse reactions observed at an incidence of ≥ 5% in any treatment arm in clinical studies (NUCA3001, NUCA3002, NUCB3001 and NUCB3002) were abdominal cramps, abdominal pain, arthralgia, chills, dyspepsia, fatigue, insomnia, musculoskeletal pain, myalgia and neuropathy. Additionally, in these studies hyperbilirubinemia was reported at an incidence of ≤ 0.8%.

Selected laboratory abnormalities observed during a clinical study of monotherapy with zidovudine are shown in Table 3.

Table 3. Frequencies of Selected (Grade 3/4) Laboratory Abnormalities in Patients with Asymptomatic HIV-1 Infection (ACTG 019)

Test (Abnormal Level)	Zidovudine 500 mg/day (n = 453)	Placebo (n = 428)
Anemia (Hgb < 8 g/dL)	1%	< 1%
Granulocytopenia (< 750 cells/mm ³)	2%	2%
Thrombocytopenia (platelets < 50,000/mm ³)	0%	< 1%
ALT (> 5 x ULN)	3%	3%
AST (> 5 x ULN)	1%	2%

ULN = Upper limit of normal.

Pediatrics

The clinical adverse reactions reported among adult recipients of zidovudine may also occur in pediatric patients.

Study ACTG 300

Selected clinical adverse reactions and physical findings with a ≥ 5% frequency during therapy with EPIVIR®* (lamivudine) Oral Suspension 4 mg/kg twice daily plus zidovudine 160 mg/m² three times daily compared with didanosine in therapy-naïve (≤ 56 days of antiretroviral therapy) pediatric patients are listed in Table 4.

Table 4. Selected Clinical Adverse Reactions and Physical Findings (≥ 5% Frequency) in Pediatric Patients in Study ACTG 300

Adverse Reaction	EPIVIR®* plus Zidovudine (n = 236)	Didanosine (n = 235)
Body as a whole		
Fever	25%	32%
Digestive		
Hepatomegaly	11%	11%
Nausea & vomiting	8%	7%
Diarrhea	8%	6%
Stomatitis	6%	12%
Splenomegaly	5%	8%
Respiratory		
Cough	15%	18%
Abnormal breath sounds/wheezing	7%	9%
Ear, Nose and Throat		
Signs or symptoms of ears*	7%	6%
Nasal discharge or congestion	8%	11%
Other		
Skin rashes	12%	14%
Lymphadenopathy	9%	11%

* Includes pain, discharge, erythema or swelling of an ear.

Selected laboratory abnormalities experienced by therapy-naïve (≤ 56 days of antiretroviral therapy) pediatric patients are listed in Table 5.

Table 5. Frequencies of Selected (Grade 3/4) Laboratory Abnormalities in Pediatric Patients in Study ACTG 300

Test (Abnormal Level)	EPIVIR®* plus Zidovudine	Didanosine
Neutropenia (ANC < 400 cells/mm ³)	8%	3%
Anemia (Hgb < 7 g/dL)	4%	2%
Thrombocytopenia (platelets < 50,000/mm ³)	1%	3%
ALT (> 10 x ULN)	1%	3%
AST (> 10 x ULN)	2%	4%
Lipase (> 2.5 x ULN)	3%	3%
Total amylase (> 2.5 x ULN)	3%	3%

ULN = Upper limit of normal.

ANC = Absolute neutrophil count.

Macrocytosis was reported in the majority of pediatric patients receiving zidovudine 180 mg/m² every 6 hours in open-label studies. Additionally, adverse reactions reported at an incidence of < 6% in these studies were congestive heart failure, decreased reflexes, ECG abnormality, edema, hematuria, left ventricular dilation, nervousness/irritability and weight loss.

Use for the Prevention of Maternal-Fetal Transmission of HIV-1

In a randomized, double-blind, placebo-controlled trial in HIV-1-infected women and their neonates conducted to determine the utility of zidovudine for the prevention of maternal-fetal HIV-1 transmission, zidovudine syrup at 2 mg/kg was administered every 6 hours for 6 weeks to neonates beginning within 12 hours following birth. The most commonly reported adverse reactions were anemia (hemoglobin < 9 g/dL) and neutropenia (< 1,000 cells/mm³). Anemia occurred in 22% of the neonates who received zidovudine and in 12% of the neonates who received placebo. The mean difference in hemoglobin values was less than 1 g/dL for neonates receiving zidovudine compared with neonates receiving placebo. No neonates with anemia required transfusion and all hemoglobin values spontaneously returned to normal within 6 weeks after completion of therapy with zidovudine. Neutropenia in neonates was reported with similar frequency in the group that received zidovudine (21%) and in the group that received placebo (27%). The long-term consequences of *in utero* and infant exposure to zidovudine are unknown.

6.2 Post-marketing Experience

In addition to adverse reactions reported from clinical trials, the following reactions have been identified during post-marketing use of zidovudine. Because they are reported voluntarily from a population of unknown size, estimates of frequency cannot be made. These reactions have been chosen for inclusion due to a combination of their seriousness, frequency of reporting, or potential causal connection to zidovudine.

Body as a Whole: Back pain, chest pain, flu-like syndrome, generalized pain, redistribution/accumulation of body fat [see Warnings and Precautions (5.7)].

Cardiovascular: Cardiomyopathy, syncope.

Endocrine: Gynecomastia.

Eye: Macular edema.

Gastrointestinal: Dysphagia, flatulence, oral mucosa pigmentation, mouth ulcer.

General: Sensitization reactions including anaphylaxis and angioedema, vasculitis.

Hemic and Lymphatic: Aplastic anemia, hemolytic anemia, leukopenia, lymphadenopathy, pancytopenia with marrow hypoplasia, pure red cell aplasia.

Hepatobiliary Tract and Pancreas: Hepatitis, hepatomegaly with steatosis, jaundice, lactic acidosis, pancreatitis.

Musculoskeletal: Increased CPK, increased LDH, muscle spasm, myopathy and myositis with pathological changes (similar to that produced by HIV-1 disease), rhabdomyolysis, tremor.

Nervous: Anxiety, confusion, depression, dizziness, loss of mental acuity, mania, paresthesia, seizures, somnolence, vertigo.

Respiratory: Dyspnea, rhinitis, sinusitis.

Skin: Changes in skin and nail pigmentation, pruritus, Stevens-Johnson Syndrome, toxic epidermal necrolysis, sweat, urticaria.

Special Senses: Amblyopia, hearing loss, photophobia, taste perversion.

Urogenital: Urinary frequency, urinary hesitancy.

7.1 Antiretroviral Agents

Stavudine

Concomitant use of zidovudine with stavudine should be avoided since an antagonistic relationship has been demonstrated *in vitro*.

Nucleoside Analogues Affecting DNA Replication

Some nucleoside analogues affecting DNA replication, such as ribavirin, antagonize the *in vitro* antiviral activity of zidovudine against HIV-1; concomitant use of such drugs should be avoided.

7.2 Doxorubicin

Concomitant use of zidovudine with doxorubicin should be avoided since an antagonistic relationship has been demonstrated *in vitro*.

7.3 Hematologic/Bone Marrow Suppressive/Cytotoxic Agents

Coadministration of ganciclovir, interferon alfa, ribavirin and other bone marrow suppressive or cytotoxic agents may increase the hematologic toxicity of zidovudine.

8.1 Pregnancy

Teratogenic Effects. Pregnancy Category C:

In humans, treatment with zidovudine during pregnancy reduced the rate of maternal-fetal HIV-1 transmission from 24.9% for infants born to placebo-treated mothers to 7.8% for infants born to mothers treated with zidovudine [see *Clinical Studies (14.3)*]. There were no differences in pregnancy-related adverse events between the treatment groups. Animal reproduction studies in rats and rabbits showed evidence of embryotoxicity and increased fetal malformations.

A randomized, double-blind, placebo-controlled trial was conducted in HIV-1-infected pregnant women to determine the utility of zidovudine for the prevention of maternal-fetal HIV-1-transmission [see *Clinical Studies (14.3)*]. Congenital abnormalities occurred with similar frequency between neonates born to mothers who received zidovudine and neonates born to mothers who received placebo. The observed abnormalities included problems in embryogenesis (prior to 14 weeks) or were recognized on ultrasound before or immediately after initiation of study drug.

Increased fetal resorptions occurred in pregnant rats and rabbits treated with doses of zidovudine that produced drug plasma concentrations 66 to 226 times (rats) and 12 to 87 times (rabbits) the mean steady-state peak human plasma concentration following a single 100 mg dose of zidovudine. There were no other reported developmental anomalies. In another developmental toxicity study, pregnant rats received zidovudine up to near-lethal doses that produced peak plasma concentrations 350 times peak human plasma concentrations (300 times the daily exposure [AUC] in humans given 600 mg/day zidovudine). This dose was associated with marked maternal toxicity and an increased incidence of fetal malformations. However, there were no signs of teratogenicity at doses up to one-fifth the lethal dose [see *Nonclinical Toxicology (13.2)*].

Antiretroviral Pregnancy Registry

To monitor maternal-fetal outcomes of pregnant women exposed to zidovudine, an Antiretroviral Pregnancy Registry has been established. Physicians are encouraged to register patients by calling 1-800-258-4263.

8.3 Nursing Mothers

Zidovudine is excreted in human milk [see *Clinical Pharmacology (12.3)*]. The Centers for Disease Control and Prevention recommend that HIV-1-infected mothers in the United States not breast-feed their infants to avoid risking postnatal transmission of HIV-1 infection. Because of both the potential for HIV-1 transmission and the potential for serious adverse reactions in nursing infants, mothers should be instructed not to breast-feed if they are receiving zidovudine.

8.4 Pediatric Use

Zidovudine has been studied in HIV-1-infected pediatric patients ≥ 6 weeks of age who had HIV-1-related symptoms or who were asymptomatic with abnormal laboratory values indicating significant HIV-1-related immunosuppression. Zidovudine has also been studied in neonates perinatally exposed to HIV-1 [see *Dosage and Administration (2.1)*, *Adverse Reactions (6.1)*, *Clinical Pharmacology (12.3)*,

Clinical Studies (14.2), (14.3)].

8.5 Geriatric Use

Clinical studies of zidovudine did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, reflecting the greater frequency of decreased hepatic, renal or cardiac function, and of concomitant disease or other drug therapy.

8.6 Renal Impairment

In patients with severely impaired renal function ($\text{CrCl} < 15 \text{ mL/min}$), dosage reduction is recommended [see Dosage and Administration (2.4), Clinical Pharmacology (12.3)].

8.7 Hepatic Impairment

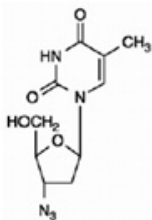
Zidovudine is eliminated from the body primarily by renal excretion following metabolism in the liver (glucuronidation). Although the data are limited, zidovudine concentrations appear to be increased in patients with severely impaired hepatic function, which may increase the risk of hematologic toxicity [see Dosage and Administration (2.5), Clinical Pharmacology (12.3)].

10 OVERDOSAGE

Acute overdoses of zidovudine have been reported in pediatric patients and adults. These involved exposures up to 50 grams. No specific symptoms or signs have been identified following acute overdosage with zidovudine apart from those listed as adverse events such as fatigue, headache, vomiting and occasional reports of hematological disturbances. All patients recovered without permanent sequelae. Hemodialysis and peritoneal dialysis appear to have a negligible effect on the removal of zidovudine while elimination of its primary metabolite, 3'-azido-3'-deoxy-5'-O- β -D-glucopyranuronosylthymidine (GZDV), is enhanced.

11 DESCRIPTION

Zidovudine (formerly called azidothymidine [AZT]), is a pyrimidine nucleoside analogue active against HIV-1. The chemical name of zidovudine is 3'-azido-3'-deoxythymidine; it has the following structural formula:



Zidovudine, USP is a white to beige, odorless, crystalline solid with a molecular weight of 267.24 and a solubility of 20.1 mg/mL in water at 25°C. The molecular formula is $\text{C}_{10}\text{H}_{13}\text{N}_5\text{O}_4$.

Zidovudine tablets, USP are for oral administration. Each film-coated tablet contains 300 mg of zidovudine, USP and the inactive ingredients hypromellose, magnesium stearate, microcrystalline cellulose, polyethylene glycol, sodium starch glycolate and titanium dioxide.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

Zidovudine is an antiviral agent [see Clinical Pharmacology (12.4)].

12.3 Pharmacokinetics

Absorption and Bioavailability

In adults, following oral administration, zidovudine is rapidly absorbed and extensively distributed, with peak serum concentrations occurring within 0.5 to 1.5 hours. The AUC was equivalent when zidovudine was administered as zidovudine tablets or syrup compared with zidovudine capsules. The pharmacokinetic properties of zidovudine in fasting adult patients are summarized in Table 6.

Table 6. Zidovudine Pharmacokinetic Parameters in Fasting Adult Patients

Parameter	Mean ± SD (except where noted)
Oral bioavailability (%)	64 ± 10 (n = 5)
Apparent volume of distribution (L/kg)	1.6 ± 0.6 (n = 8)
Plasma protein binding (%)	< 38
CSF:plasma ratio*	0.6 [0.04 to 2.62] (n = 39)
Systemic clearance (L/hr/kg)	1.6 ± 0.6 (n = 6)
Renal clearance (L/hr/kg)	0.34 ± 0.05 (n = 9)
Elimination half-life (hr) [†]	0.5 to 3 (n = 19)

* Median [range].

† Approximate range.

Distribution

The apparent volume of distribution of zidovudine, following oral administration, is 1.6 ± 0.6 L/kg; and binding to plasma protein is low, < 38% (Table 6).

Metabolism and Elimination

Zidovudine is primarily eliminated by hepatic metabolism. The major metabolite of zidovudine is GZDV. GZDV AUC is about 3-fold greater than the zidovudine AUC. Urinary recovery of zidovudine and GZDV accounts for 14% and 74%, respectively, of the dose following oral administration. A second metabolite, 3'-amino-3'-deoxythymidine (AMT), has been identified in the plasma following single-dose intravenous (IV) administration of zidovudine. The AMT AUC was one-fifth of the zidovudine AUC. Pharmacokinetics of zidovudine were dose independent at oral dosing regimens ranging from 2 mg/kg every 8 hours to 10 mg/kg every 4 hours.

Effect of Food on Absorption

Zidovudine may be administered with or without food. The zidovudine AUC was similar when a single dose of zidovudine was administered with food.

Special Populations

Renal Impairment

Zidovudine clearance was decreased resulting in increased zidovudine and GZDV half-life and AUC in patients with impaired renal function (n = 14) following a single 200 mg oral dose (Table 7). Plasma concentrations of AMT were not determined. A dose adjustment should not be necessary for patients with creatinine clearance (CrCl) ≥ 15 mL/min.

Table 7. Zidovudine Pharmacokinetic Parameters in Patients with Severe Renal Impairment*

Parameter	Control Subjects (Normal Renal Function) (n = 6)	Patients With Renal Impairment (n = 14)
CrCl (mL/min)	120 ± 8	18 ± 2
Zidovudine AUC (ng•hr/mL)	1,400 ± 200	3,100 ± 300
Zidovudine half-life (hr)	1 ± 2	1.4 ± 0.1

* Data are expressed as mean ± standard deviation.

Hemodialysis and Peritoneal Dialysis

The pharmacokinetics and tolerance of zidovudine were evaluated in a multiple-dose study in patients undergoing hemodialysis (n = 5) or peritoneal dialysis (n = 6) receiving escalating doses up to 200 mg five times daily for 8 weeks. Daily doses of 500 mg or less were well tolerated despite significantly elevated GZDV plasma concentrations. Apparent zidovudine oral clearance was approximately 50% of that reported in patients with normal renal function. Hemodialysis and peritoneal dialysis appeared to have a negligible effect on the removal of zidovudine, whereas GZDV elimination was enhanced. A dosage adjustment is recommended for patients undergoing hemodialysis or peritoneal dialysis [see *Dosage and Administration* (2.4)].

Hepatic Impairment

Data describing the effect of hepatic impairment on the pharmacokinetics of zidovudine are limited. However, because zidovudine is eliminated primarily by hepatic metabolism, it is expected that zidovudine clearance would be decreased and plasma concentrations would be increased following administration of the recommended adult doses to patients with hepatic impairment [see *Dosage and Administration (2.5)*].

Pediatric Patients

Zidovudine pharmacokinetics have been evaluated in HIV-1-infected pediatric patients (Table 8).

Patients Aged 3 Months to 12 Years

Overall, zidovudine pharmacokinetics in pediatric patients greater than 3 months of age are similar to those in adult patients. Proportional increases in plasma zidovudine concentrations were observed following administration of oral solution from 90 to 240 mg/m² every 6 hours. Oral bioavailability, terminal half-life and oral clearance were comparable to adult values. As in adult patients, the major route of elimination was by metabolism to GZDV. After intravenous dosing, about 29% of the dose was excreted in the urine unchanged and about 45% of the dose was excreted as GZDV [see *Dosage and Administration (2.1)*].

Patients Aged Less Than 3 Months

Zidovudine pharmacokinetics have been evaluated in pediatric patients from birth to 3 months of life. Zidovudine elimination was determined immediately following birth in eight neonates who were exposed to zidovudine *in utero*. The half-life was 13 ± 5.8 hours. In neonates ≤ 14 days old, bioavailability was greater, total body clearance was slower and half-life was longer than in pediatric patients > 14 days old. For dose recommendations for neonates [see *Dosage and Administration (2.2)*].

Table 8. Zidovudine Pharmacokinetic Parameters in Pediatric Patients *

Parameter	Birth to 14 Days	Aged 14 Days to 3 Months	Aged 3 Months to 12 Years
Oral bioavailability (%)	89 ± 19 (n = 15)	61 ± 19 (n = 17)	65 ± 24 (n = 18)
CSF:plasma ratio	no data	no data	0.68 [0.03 to 3.25] † (n = 38)
CL (L/hr/kg)	0.65 ± 0.29 (n = 18)	1.14 ± 0.24 (n = 16)	1.85 ± 0.47 (n = 20)
Elimination half-life (hr)	3.1 ± 1.2 (n = 21)	1.9 ± 0.7 (n = 18)	1.5 ± 0.7 (n = 21)

* Data presented as mean ± standard deviation except where noted.

† Median [range].

Pregnancy

Zidovudine pharmacokinetics have been studied in a Phase I study of eight women during the last trimester of pregnancy. Zidovudine pharmacokinetics were similar to those of nonpregnant adults. Consistent with passive transmission of the drug across the placenta, zidovudine concentrations in neonatal plasma at birth were essentially equal to those in maternal plasma at delivery [see *Use in Specific Populations (8.1)*].

Although data are limited, methadone maintenance therapy in five pregnant women did not appear to alter zidovudine pharmacokinetics.

Nursing Mothers

The Centers for Disease Control and Prevention recommend that HIV-1-infected mothers not breast-feed their infants to avoid risking postnatal transmission of HIV-1. After administration of a single dose of 200 mg zidovudine to 13 HIV-1-infected women, the mean concentration of zidovudine was similar in human milk and serum [see *Use in Specific Populations (8.3)*].

Geriatric Patients

Zidovudine pharmacokinetics have not been studied in patients over 65 years of age.

Gender

A pharmacokinetic study in healthy male (n = 12) and female (n = 12) subjects showed no differences in zidovudine AUC when a single dose of zidovudine was administered as the 300 mg zidovudine tablet.

Drug Interactions

[See Drug Interactions (7)].

Table 9. Effect of Coadministered Drugs on Zidovudine AUC*

Note: ROUTINE DOSE MODIFICATION OF ZIDOVUDINE IS NOT WARRANTED WITH COADMINISTRATION OF THE FOLLOWING DRUGS.

Coadministered Drug and Dose	Zidovudine Dose	n	Zidovudine Concentrations		Concentration of Coadministered Drug
			AUC	Variability	
Atovaquone 750 mg q 12 hr with food	200 mg q 8 hr	14	↑AUC 31%	Range 23% to 78% [†]	↔
Clarithromycin 500 mg twice daily	100 mg q 4 hr x 7 days	4	↓AUC 12%	Range ↓34% to ↑14%	Not Reported
Fluconazole 400 mg daily	200 mg q 8 hr	12	↑AUC 74%	95% CI: 54% to 98%	Not Reported
Lamivudine 300 mg q 12 hr	single 200 mg	12	↑AUC 13%	90% CI: 2% to 27%	↔
Methadone 30 mg to 90 mg daily	200 mg q 4 hr	9	↑AUC 43%	Range 16% to 64% [†]	↔
Nelfinavir 750 mg q 8 hr x 7 to 10 days	single 200 mg	11	↓AUC 35%	Range 28% to 41%	↔
Probenecid 500 mg q 6 hr x 2 days	2 mg/kg q 8 hr x 3 days	3	↑AUC 106%	Range 100% to 170% [†]	Not Assessed
Rifampin 600 mg daily x 14 days	200 mg q 8 hr x 14 days	8	↓AUC 47%	90% CI: 41% to 53%	Not Assessed
Ritonavir 300 mg q 6 hr x 4 days	200 mg q 8 hr x 4 days	9	↓AUC 25%	95% CI: 15% to 34%	↔
Valproic acid 250 mg or 500 mg q 8 hr x 4 days	100 mg q 8 hr x 4 days	6	↑AUC 80%	Range 64% to 130% [†]	Not Assessed

↑ = Increase; ↓ = Decrease; ↔ = no significant change; AUC = area under the concentration vs. time curve; CI = confidence interval.

* This table is not all inclusive.

[†] Estimated range of percent difference.

Phenytoin

Phenytoin plasma levels have been reported to be low in some patients receiving zidovudine, while in one case a high level was documented. However, in a pharmacokinetic interaction study in which 12 HIV-1-positive volunteers received a single 300 mg phenytoin dose alone and during steady-state zidovudine conditions (200 mg every 4 hours), no change in phenytoin kinetics was observed. Although not designed to optimally assess the effect of phenytoin on zidovudine kinetics, a 30% decrease in oral zidovudine clearance was observed with phenytoin.

Ribavirin

In vitro data indicate ribavirin reduces phosphorylation of lamivudine, stavudine and zidovudine. However, no pharmacokinetic (e.g., plasma concentrations or intracellular triphosphorylated active metabolite concentrations) or pharmacodynamic (e.g., loss of HIV-1/HCV virologic suppression) interaction was observed when ribavirin and lamivudine (n = 18), stavudine (n = 10), or zidovudine (n = 6) were coadministered as part of a multidrug regimen to HIV-1/HCV co-infected patients [see *Warnings and Precautions (5.4)*].

12.4 Microbiology

Mechanism of Action

Zidovudine is a synthetic nucleoside analogue. Intracellularly, zidovudine is phosphorylated to its

active 5'-triphosphate metabolite, zidovudine triphosphate (ZDV-TP). The principal mode of action of ZDV-TP is inhibition of reverse transcriptase (RT) via DNA chain termination after incorporation of the nucleotide analogue. ZDV-TP is a weak inhibitor of the cellular DNA polymerases α and γ and has been reported to be incorporated into the DNA of cells in culture.

Antiviral Activity

The antiviral activity of zidovudine against HIV-1 was assessed in a number of cell lines (including monocytes and fresh human peripheral blood lymphocytes). The EC_{50} and EC_{90} values for zidovudine were 0.01 to 0.49 μ M (1 μ M = 0.27 mcg/mL) and 0.1 to 9 μ M, respectively. HIV-1 from therapy-naive subjects with no mutations associated with resistance gave median EC_{50} values of 0.011 μ M (range: 0.005 to 0.110 μ M) from Virco (n = 92 baseline samples from COL40263) and 0.0017 μ M (0.006 to 0.0340 μ M) from Monogram Biosciences (n = 135 baseline samples from ESS30009). The EC_{50} values of zidovudine against different HIV-1 clades (A-G) ranged from 0.00018 to 0.02 μ M, and against HIV-2 isolates from 0.00049 to 0.004 μ M. In cell culture drug combination studies, zidovudine demonstrates synergistic activity with the nucleoside reverse transcriptase inhibitors abacavir, didanosine and lamivudine; the non-nucleoside reverse transcriptase inhibitors delavirdine and nevirapine; and the protease inhibitors indinavir, nelfinavir, ritonavir, and saquinavir; and additive activity with interferon alfa. Ribavirin has been found to inhibit the phosphorylation of zidovudine in cell culture.

Resistance

Genotypic analyses of the isolates selected in cell culture and recovered from zidovudine-treated patients showed mutations in the HIV-1 RT gene resulting in six amino acid substitutions (M41L, D67N, K70R, L210W, T215Y or F, and K219Q) that confer zidovudine resistance. In general, higher levels of resistance were associated with greater number of amino acid substitutions. In some patients harboring zidovudine-resistant virus at baseline, phenotypic sensitivity to zidovudine was restored by 12 weeks of treatment with lamivudine and zidovudine. Combination therapy with lamivudine plus zidovudine delayed the emergence of substitutions conferring resistance to zidovudine.

Cross-resistance

In a study of 167 HIV-1-infected patients, isolates (n = 2) with multidrug resistance to didanosine, lamivudine, stavudine, zalcitabine and zidovudine were recovered from patients treated for \geq 1 year with zidovudine plus didanosine or zidovudine plus zalcitabine. The pattern of resistance-associated amino acid substitutions with such combination therapies was different (A62V, V75I, F77L, F116Y, Q151M) from the pattern with zidovudine monotherapy, with the Q151M substitution being most commonly associated with multidrug resistance. The substitution at codon 151 in combination with substitutions at 62, 75, 77 and 116 results in a virus with reduced susceptibility to didanosine, lamivudine, stavudine, zalcitabine and zidovudine. Thymidine analogue mutations (TAMs) are selected by zidovudine and confer cross-resistance to abacavir, didanosine, stavudine, tenofovir and zalcitabine.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility

Zidovudine was administered orally at three dosage levels to separate groups of mice and rats (60 females and 60 males in each group). Initial single daily doses were 30, 60 and 120 mg/kg/day in mice and 80, 220 and 600 mg/kg/day in rats. The doses in mice were reduced to 20, 30 and 40 mg/kg/day after day 90 because of treatment-related anemia, whereas in rats only the high dose was reduced to 450 mg/kg/day on day 91 and then to 300 mg/kg/day on day 279.

In mice, seven late-appearing (after 19 months) vaginal neoplasms (five nonmetastasizing squamous cell carcinomas, one squamous cell papilloma and one squamous polyp) occurred in animals given the highest dose. One late-appearing squamous cell papilloma occurred in the vagina of a middle-dose animal. No vaginal tumors were found at the lowest dose.

In rats, two late-appearing (after 20 months), nonmetastasizing vaginal squamous cell carcinomas occurred in animals given the highest dose. No vaginal tumors occurred at the low or middle dose in rats. No other drug-related tumors were observed in either sex of either species.

At doses that produced tumors in mice and rats, the estimated drug exposure (as measured by AUC) was approximately 3 times (mouse) and 24 times (rat) the estimated human exposure at the recommended therapeutic dose of 100 mg every 4 hours.

It is not known how predictive the results of rodent carcinogenicity studies may be for humans.

Zidovudine was mutagenic in a 5178Y/TK[±] mouse lymphoma assay, positive in an *in vitro* cell transformation assay, clastogenic in a cytogenetic assay using cultured human lymphocytes, and positive in mouse and rat micronucleus tests after repeated doses. It was negative in a cytogenetic study in rats

given a single dose.

Zidovudine, administered to male and female rats at doses up to 7 times the usual adult dose based on body surface area, had no effect on fertility judged by conception rates.

Two transplacental carcinogenicity studies were conducted in mice. One study administered zidovudine at doses of 20 mg/kg/day or 40 mg/kg/day from gestation day 10 through parturition and lactation with dosing continuing in offspring for 24 months postnatally. The doses of zidovudine administered in this study produced zidovudine exposures approximately 3 times the estimated human exposure at recommended doses. After 24 months, an increase in incidence of vaginal tumors was noted with no increase in tumors in the liver or lung or any other organ in either gender. These findings are consistent with results of the standard oral carcinogenicity study in mice, as described earlier. A second study administered zidovudine at maximum tolerated doses of 12.5 mg/day or 25 mg/day (~1000 mg/kg nonpregnant body weight or ~450 mg/kg of term body weight) to pregnant mice from days 12 through 18 of gestation. There was an increase in the number of tumors in the lung, liver and female reproductive tracts in the offspring of mice receiving the higher dose level of zidovudine.

13.2 Reproductive and Developmental Toxicology Studies

Oral teratology studies in the rat and in the rabbit at doses up to 500 mg/kg/day revealed no evidence of teratogenicity with zidovudine. Zidovudine treatment resulted in embryo/fetal toxicity as evidenced by an increase in the incidence of fetal resorptions in rats given 150 or 450 mg/kg/day and rabbits given 500 mg/kg/day. The doses used in the teratology studies resulted in peak zidovudine plasma concentrations (after one-half of the daily dose) in rats 66 to 226 times, and in rabbits 12 to 87 times, mean steady-state peak human plasma concentrations (after one-sixth of the daily dose) achieved with the recommended daily dose (100 mg every 4 hours). In an *in vitro* experiment with fertilized mouse oocytes, zidovudine exposure resulted in a dose dependent reduction in blastocyst formation. In an additional teratology study in rats, a dose of 3000 mg/kg/day (very near the oral median lethal dose in rats of 3683 mg/kg) caused marked maternal toxicity and an increase in the incidence of fetal malformations. This dose resulted in peak zidovudine plasma concentrations 350 times peak human plasma concentrations. (Estimated AUC in rats at this dose level was 300 times the daily AUC in humans given 600 mg/day.) No evidence of teratogenicity was seen in this experiment at doses of 600 mg/kg/day or less.

14 CLINICAL STUDIES

Therapy with zidovudine has been shown to prolong survival and decrease the incidence of opportunistic infections in patients with advanced HIV-1 disease and to delay disease progression in asymptomatic HIV-1-infected patients.

14.1 Adults

Combination Therapy

Zidovudine in combination with other antiretroviral agents has been shown to be superior to monotherapy for one or more of the following endpoints: delaying death, delaying development of AIDS, increasing CD4+ cell counts, and decreasing plasma HIV-1 RNA.

The clinical efficacy of a combination regimen that includes zidovudine was demonstrated in study ACTG 320. This study was a multi-center, randomized, double-blind, placebo-controlled trial that compared zidovudine 600 mg/day plus EPIVIR[®]* 300 mg/day to zidovudine plus EPIVIR[®]* plus indinavir 800 mg three times daily. The incidence of AIDS-defining events or death was lower in the triple-drug-containing arm compared with the 2-drug-containing arm (6.1% vs. 10.9%, respectively).

Monotherapy

In controlled studies of treatment-naive patients conducted between 1986 and 1989, monotherapy with zidovudine, as compared with placebo, reduced the risk of HIV-1 disease progression, as assessed using endpoints that included the occurrence of HIV-1-related illnesses, AIDS-defining events, or death. These studies enrolled patients with advanced disease (BW 002), and asymptomatic or mildly symptomatic disease in patients with CD4+ cell counts between 200 and 500 cells/mm³ (ACTG 016 and ACTG 019). A survival benefit for monotherapy with zidovudine was not demonstrated in the latter two studies. Subsequent studies showed that the clinical benefit of monotherapy with zidovudine was time limited.

14.2 Pediatric Patients

ACTG 300 was a multi-center, randomized, double-blind study that provided for comparison of EPIVIR[®]* plus zidovudine to didanosine monotherapy. A total of 471 symptomatic, HIV-1-infected therapy-naive pediatric patients were enrolled in these two treatment arms. The median age was 2.7

years (range: 6 weeks to 14 years), the mean baseline CD4+ cell count was 868 cells/mm³, and the mean baseline plasma HIV-1 RNA was 5.0 log₁₀ copies/mL. The median duration that patients remained on study was approximately 10 months. Results are summarized in Table 10.

Table 10. Number of Patients (%) Reaching a Primary Clinical Endpoint (Disease Progression or Death)

Endpoint	EPIVIR®* plus zidovudine (n = 236)	Didanosine (n = 235)
HIV disease progression or death (total)	15 (6.4%)	37 (15.7%)
Physical growth failure	7 (3%)	6 (2.6%)
Central nervous system deterioration	4 (1.7%)	12 (5.1%)
CDC Clinical Category C	2 (0.8%)	8 (3.4%)
Death	2 (0.8%)	11 (4.7%)

14.3 Prevention of Maternal-Fetal HIV-1 Transmission

The utility of zidovudine for the prevention of maternal-fetal HIV-1 transmission was demonstrated in a randomized, double-blind, placebo-controlled trial (ACTG 076) conducted in HIV-1-infected pregnant women with CD4+ cell counts of 200 to 1,818 cells/mm³ (median in the treated group: 560 cells/mm³) who had little or no previous exposure to zidovudine. Oral zidovudine was initiated between 14 and 34 weeks of gestation (median 11 weeks of therapy) followed by IV administration of zidovudine during labor and delivery. Following birth, neonates received oral zidovudine syrup for 6 weeks. The study showed a statistically significant difference in the incidence of HIV-1 infection in the neonates (based on viral culture from peripheral blood) between the group receiving zidovudine and the group receiving placebo. Of 363 neonates evaluated in the study, the estimated risk of HIV-1 infection was 7.8% in the group receiving zidovudine and 24.9% in the placebo group, a relative reduction in transmission risk of 68.7%. Zidovudine was well tolerated by mothers and infants. There was no difference in pregnancy-related adverse events between the treatment groups.

16 HOW SUPPLIED/STORAGE AND HANDLING

Zidovudine Tablets, USP are available containing 300 mg of zidovudine, USP.

The 300 mg tablets are white to off-white film-coated, round tablets debossed with **M 106** on one side of the tablet and blank on the other side.

They are supplied by **State of Florida DOH Central Pharmacy** as follows:

NDC	Strength	Quantity/Form	Color	Source Prod. Code
53808-0878-2	300 mg	60 Tablets in a Blister Pack	white to off-white	0378-6106

Store at 20° to 25°C (68° to 77°F). [See USP Controlled Room Temperature.]

Protect from moisture.

17 PATIENT COUNSELING INFORMATION

17.1 Advice for the Patient

Neutropenia and Anemia

Patients should be informed that the major toxicities of zidovudine are neutropenia and/or anemia. The frequency and severity of these toxicities are greater in patients with more advanced disease and in those who initiate therapy later in the course of their infection. Patients should be informed that if toxicity develops, they may require transfusions or drug discontinuation. Patients should be informed of the extreme importance of having their blood counts followed closely while on therapy, especially for patients with advanced symptomatic HIV-1 disease [see *Boxed Warning, Warnings and Precautions (5.1)*].

Myopathy

Patients should be informed that myopathy and myositis with pathological changes, similar to that produced by HIV-1 disease, have been associated with prolonged use of zidovudine [see *Boxed Warning, Warnings and Precautions (5.2)*].

Lactic Acidosis/Hepatomegaly

Patients should be informed that some HIV medicines, including zidovudine, can cause a rare, but serious condition called lactic acidosis with liver enlargement (hepatomegaly) [see *Boxed Warning, Warnings and Precautions (5.3)*].

HIV-1/HCV Co-infection

Patients with HIV-1/HCV co-infection should be informed that hepatic decompensation (some fatal) has occurred in HIV-1/HCV co-infected patients receiving combination antiretroviral therapy for HIV-1 and interferon alfa with or without ribavirin [see *Warnings and Precautions (5.4)*].

Use with Other Zidovudine-containing Products

Zidovudine tablets should not be administered with combination products that contain zidovudine as one of their components (e.g., COMBIVIR®* [lamivudine and zidovudine] Tablets or TRIZIVIR®* [abacavir sulfate, lamivudine and zidovudine] Tablets) [see *Warnings and Precautions (5.5)*].

Redistribution/Accumulation of Body Fat

Patients should be informed that redistribution or accumulation of body fat may occur in patients receiving antiretroviral therapy and that the cause and long-term health effects of these conditions are not known at this time [see *Warnings and Precautions (5.7)*].

Common Adverse Reactions

Patients should be informed that the most commonly reported adverse reactions in adult patients being treated with zidovudine were headache, malaise, nausea, anorexia and vomiting. The most commonly reported adverse reactions in pediatric patients receiving zidovudine were fever, cough and digestive disorders. Patients also should be encouraged to contact their physician if they experience muscle weakness, shortness of breath, symptoms of hepatitis or pancreatitis, or any other unexpected adverse events while being treated with zidovudine [see *Adverse Reactions (6)*].

Drug Interactions

Patients should be cautioned about the use of other medications, including ganciclovir, interferon alfa and ribavirin, which may exacerbate the toxicity of zidovudine [see *Drug Interactions (7)*].

Pregnancy

Pregnant women considering the use of zidovudine during pregnancy for prevention of HIV-1 transmission to their infants should be informed that transmission may still occur in some cases despite therapy. The long-term consequences of *in utero* and infant exposure to zidovudine are unknown, including the possible risk of cancer [see *Use in Specific Populations (8.1)*].

HIV-1-infected pregnant women should be informed not to breast-feed to avoid postnatal transmission of HIV to a child who may not yet be infected [see *Use in Specific Populations (8.3)*].

Information About HIV-1 Infection

Zidovudine is not a cure for HIV-1 infection and patients may continue to experience illnesses associated with HIV-1 infection, including opportunistic infections. Patients should remain under the care of a physician when using zidovudine tablets. Patients should be advised to avoid doing things that can spread HIV-1 infection to others.

- **Do not share needles or other injection equipment.**
- **Do not share personal items that can have blood or body fluids on them, like toothbrushes and razor blades.**
- **Do not have any kind of sex without protection.** Always practice safe sex by using a latex or polyurethane condom or other barrier method to lower the chance of sexual contact with semen, vaginal secretions or blood.
- **Do not breast-feed.** Zidovudine is excreted in human breast milk. Mothers with HIV-1 should not breast-feed because HIV-1 can be passed to the baby in the breast milk.

Patients should be informed to take all HIV medications exactly as prescribed.

*The brand names mentioned are registered trademarks of their respective manufacturers.

Manufactured in India by:

Mylan Laboratories Limited

Hyderabad — 500 034, India

Code No.: MH/DRUGS/25/NKD/89

Manufactured for:

Mylan Pharmaceuticals Inc.

Morgantown, WV 26505 U.S.A.

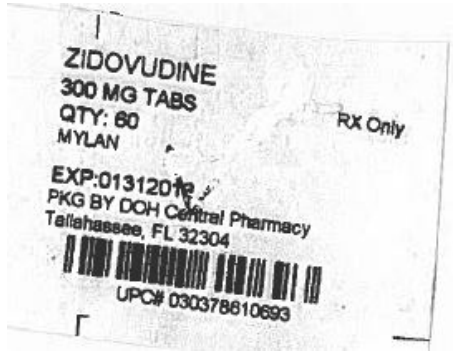
This Product was Repackaged By:

State of Florida DOH Central Pharmacy

104-2 Hamilton Park Drive
Tallahassee, FL 32304
United States

PACKAGE LABEL

Label Image for **53808-0878**
300mg



ZIDOVUDINE				
zidovudine tablet, film coated				
Product Information				
Product Type	HUMAN PRESCRIPTION DRUG	Item Code (Source)	NDC:53808-0878(NDC:0378-6106)	
Route of Administration	ORAL			
Active Ingredient/Active Moiety				
	Ingredient Name	Basis of Strength	Strength	
	ZIDO VUDINE (UNII: 4B9XT59T7S) (ZIDO VUDINE - UNII:4B9XT59T7S)	ZIDO VUDINE	300 mg	
Inactive Ingredients				
	Ingredient Name		Strength	
	HYPROMELLOSES (UNII: 3NXW29V3WO)			
	MAGNESIUM STEARATE (UNII: 70097M6B30)			
	CELLULOSE, MICROCRYSTALLINE (UNII: OP1R32D61U)			
	POLYETHYLENE GLYCOLS (UNII: 3WJQ0SDW1A)			
	SODIUM STARCH GLYCOLATE TYPE A POTATO (UNII: 5856J3G2A2)			
	TITANIUM DIOXIDE (UNII: 15FIX9V2JP)			
Product Characteristics				
Color	WHITE (white to off-white)	Score	no score	
Shape	ROUND	Size	10mm	
Flavor		Imprint Code	M;106	
Contains				
Packaging				
#	Item Code	Package Description	Marketing Start Date	Marketing End Date
1	NDC:53808-0878-2	60 in 1 BLISTER PACK		

Marketing Information

Marketing Category	Application Number or Monograph Citation	Marketing Start Date	Marketing End Date
ANDA	ANDA078922	01/01/2013	

Labeler - State of Florida DOH Central Pharmacy (829348114)

Establishment

Name	Address	ID/FEI	Business Operations
State of Florida DOH Central Pharmacy		829348114	repack(53808-0878)

Revised: 10/2013

State of Florida DOH Central Pharmacy