To be sold by retail on prescription of Hepatologist only

SOFOCRUZ LP
(Ledipasvir & Sofosbuvir Tablets 90 mg + 400 mg)

COMPOSITION
Each film-coated tablet contains:
Ledipasvir …….90 mg
Sofosbuvir ……400 mg
Colours: Ferric Oxide USP-NF Red, Ferric Oxide USP-NF Yellow & Titanium Dioxide I.P.

DOSAGE FORM
Film coated tablet

THERAPEUTIC INDICATIONS
For the treatment of chronic hepatitis C (CHC) genotype 1 infection in adults.

POSOLOGY AND METHOD OF ADMINISTRATION
Sofocruz LP treatment should be initiated and monitored by a physician experienced in the management of patients with CHC.

The recommended dose of Sofocruz LP is one tablet once daily with or without food

Table 1: Recommended treatment duration for Sofocruz LP and the recommended use of co-administered ribavirin for certain subgroups

Patient population*	**Treatment and duration**
Patients with genotype 1 or genotype 4 CHC	
Patients without cirrhosis	Sofocruz LP for 12 weeks. - Sofocruz LP for 8 weeks may be considered in previously untreated genotype 1-infected patients (ION-3 study). - Sofocruz LP + ribavirin for 12 weeks or Sofocruz LP (without ribavirin) for 24 weeks should be considered for previously treated patients with uncertain subsequent retreatment options
Patients with compensated cirrhosis	Sofocruz LP + ribavirin for 12 weeks or Sofocruz LP (without ribavirin) for 24 weeks. - Sofocruz LP (without ribavirin) for 12 weeks may be considered for patients deemed at low risk for clinical disease progression and who have subsequent retreatment options.
Patients who are post-liver transplant without cirrhosis or with compensated cirrhosis	Sofocruz LP + ribavirin for 12 weeks - Sofocruz LP (without ribavirin) for 12 weeks (in patients without cirrhosis) or 24 weeks (in patients with cirrhosis) may be considered for patients who are ineligible for or intolerant to ribavirin.

Patients with decompensated cirrhosis, irrespective of transplant status	Sofocruz LP + ribavirin for 12 weeks - Sofocruz LP (without ribavirin) for 24 weeks may be considered in patients who are ineligible for or intolerant to ribavirin.
Patients with genotype 3 CHC	
Patients with cirrhosis and/or prior treatment failure	Sofocruz LP + ribavirin for 24 weeks.

* Includes patients co-infected with human immunodeficiency virus (HIV).
When used in combination with ribavirin, refer also to the Summary of Product Characteristics of ribavirin.

In patients without decompensated cirrhosis requiring the addition of ribavirin to their treatment regimen (see Table 1), the daily dose of ribavirin is weight based (< 75 kg = 1,000 mg and ≥ 75 kg = 1,200 mg) and administered orally in two divided doses with food.

In patients with decompensated cirrhosis, ribavirin should be administered at a starting dose of 600 mg given in a divided daily dose. If the starting dose is well-tolerated, the dose can be titrated up to a maximum of 1,000-1,200 mg daily (1,000 mg for patients weighing < 75 kg and 1,200 mg for patients weighing ≥ 75 kg). If the starting dose is not well-tolerated, the dose should be reduced as clinically indicated based on haemoglobin levels.

Dose modification of ribavirin in patients taking 1,000-1,200 mg daily
If Sofocruz LP is used in combination with ribavirin and a patient has a serious adverse reaction potentially related to ribavirin, the ribavirin dose should be modified or discontinued, if appropriate, until the adverse reaction abates or decreases in severity. Table 2 provides guidelines for dose modifications and discontinuation based on the patient's haemoglobin concentration and cardiac status.

Table 2: Ribavirin dose modification guideline for co-administration with Sofocruz LP

Laboratory values	**Reduce ribavirin dose to 600 mg/day if:**	**Discontinue ribavirin if:**
Haemoglobin in patients with no cardiac disease	< 10 g/dL	< 8.5 g/dL
Haemoglobin in patients with history of stable cardiac disease	≥ 2 g/dL decrease in haemoglobin during any 4-week treatment period	< 12 g/dL despite 4 weeks at reduced dose

Once ribavirin has been withheld due to either a laboratory abnormality or clinical manifestation, an attempt may be made to restart ribavirin at 600 mg daily and further increase the dose to 800 mg daily. However, it is not recommended that ribavirin be increased to the originally assigned dose (1,000 mg to 1,200 mg daily).

Patients should be instructed that if vomiting occurs within 5 hours of dosing an additional tablet should be taken. If vomiting occurs more than 5 hours after dosing, no further dose is needed.

If a dose is missed and it is within 18 hours of the normal time, patients should be instructed to take the tablet as soon as possible and then patients should take the next dose at the usual time. If it is after 18 hours then patients should be instructed to wait and take the next dose at the usual time. Patients should be instructed not to take a double dose.

Elderly
No dose adjustment is warranted for elderly patients.

Renal impairment
No dose adjustment of Sofocruz LP is required for patients with mild or moderate renal impairment. The safety of ledipasvir/sofosbuvir has not been assessed in patients with severe renal impairment (estimated glomerular filtration rate [eGFR] < 30 mL/min/1.73 m^2) or end stage renal disease (ESRD) requiring haemodialysis.

Hepatic impairment
No dose adjustment of Sofocruz LP is required for patients with mild, moderate or severe hepatic impairment (Child-Pugh-Turcotte [CPT] class A, B or C). Safety and efficacy of ledipasvir/sofosbuvir have been established in patients with decompensated cirrhosis.

Paediatric population
The safety and efficacy of Sofocruz LP in children and adolescents aged less than 18 years have not yet been established. No data are available.

Method of administration
For oral use.
Patients should be instructed to swallow the tablet whole with or without food. Due to the bitter taste, it is recommended that the film-coated tablet is not chewed or crushed.

CONTRAINDICATIONS
Hypersensitivity to the active substances or to any of the excipients

Use with potent P-gp inducers

Medicinal products that are potent P-glycoprotein (P-gp) inducers in the intestine (rifampicin, rifabutin, St. John's wort [Hypericum perforatum], carbamazepine, phenobarbital and phenytoin). Co-administration will significantly decrease ledipasvir and sofosbuvir plasma concentrations and could result in loss of efficacy of Sofocruz LP.

SPECIAL WARNINGS AND PRECAUTIONS FOR USE

Sofocruz LP should not be administered concomitantly with other medicinal products containing sofosbuvir.

Genotype-specific activity

Concerning recommended regimens with different HCV genotypes. Concerning genotype-specific virological and clinical activity.

The clinical data to support the use of Sofocruz LP in patients infected with HCV genotype 3 are limited. The relative efficacy of a 12-week regimen consisting of ledipasvir/sofosbuvir + ribavirin, compared to a 24-week regimen of sofosbuvir + ribavirin has not been investigated. A conservative 24 weeks of therapy is advised in all

treatment-experienced genotype 3 patients and those treatment-naïve genotype 3 patients with cirrhosis. In genotype 3-infection, the use of Sofocruz LP (always in combination with ribavirin) should only be considered for patients who are deemed at high risk for clinical disease progression and who do not have alternative treatment options.

The clinical data to support the use of Sofocruz LP in patients infected with HCV genotype 2 and 6 are limited.

Severe bradycardia and heart block

Cases of severe bradycardia and heart block have been observed when Sofocruz LP is used with concomitant amiodarone with or without other drugs that lower heart rate. The mechanism is not established.

The concomitant use of amiodarone was limited through the clinical development of sofosbuvir plus direct-acting antivirals (DAAs). Cases are potentially life threatening, therefore amiodarone should only be used in patients on Sofocruz LP when other alternative anti-arrhythmic treatments are not tolerated or are contraindicated.

Should concomitant use of amiodarone be considered necessary it is recommended that patients are closely monitored when initiating Sofocruz LP. Patients who are identified as being high risk of bradyarrhythmia should be continuously monitored for 48 hours in an appropriate clinical setting.

Due to the long half-life of amiodarone, appropriate monitoring should also be carried out for patients who have discontinued amiodarone within the past few months and are to be initiated on Sofocruz LP.

All patients receiving Sofocruz LP in combination with amiodarone with or without other drugs that lower heart rate should also be warned of the symptoms of bradycardia and heart block and should be advised to seek medical advice urgently should they experience them.

Treatment of patients with prior exposure to HCV direct-acting antivirals

In patients who fail treatment with ledipasvir/sofosbuvir, selection of NS5A resistance mutations that substantially reduce the susceptibility to ledipasvir is seen in the majority of cases. Limited data indicate that such NS5A mutations do not revert on long-term follow-up. There are presently no data to support the effectiveness of retreatment of patients who have failed ledipasvir/sofosbuvir with a subsequent regimen that contains an NS5A inhibitor. Similarly, there are presently no data to support the effectiveness of NS3/4A protease inhibitors in patients who previously failed prior therapy that included an NS3/4A protease inhibitor. Such patients may therefore be dependent on other drug classes for clearance of HCV infection. Consequently, consideration should be given to longer treatment for patients with uncertain subsequent retreatment options.

Renal impairment

No dose adjustment of Sofocruz LP is required for patients with mild or moderate renal impairment. The safety of Sofocruz LP has not been assessed in patients with severe renal impairment (estimated glomerular filtration rate [eGFR] < 30 mL/min/1.73 m2) or end stage renal disease (ESRD) requiring haemodialysis. When Sofocruz LP is used in

combination with ribavirin refer also to the Summary of Product Characteristics for ribavirin for patients with creatinine clearance (CrCl) < 50 mL/min.

Patients with decompensated cirrhosis and/or who are awaiting liver transplant or post-liver transplant

The efficacy of ledipasvir/sofosbuvir in genotype 5 and genotype 6 HCV-infected patients with decompensated cirrhosis and/or who are awaiting liver transplant or post-liver transplant has not been investigated. Treatment with Sofocruz LP should be guided by an assessment of the potential benefits and risks for the individual patient.

Use with moderate P-gp inducers

Medicinal products that are moderate P-gp inducers in the intestine (e.g. oxcarbazepine) may decrease ledipasvir and sofosbuvir plasma concentrations leading to reduced therapeutic effect of Sofocruz LP. Co-administration of such medicinal products is not recommended with Sofocruz LP.

Use with certain HIV antiretroviral regimens

Sofocruz LP has been shown to increase tenofovir exposure, especially when used together with an HIV regimen containing tenofovir disoproxil fumarate and a pharmacokinetic enhancer (ritonavir or cobicistat). The safety of tenofovir disoproxil fumarate in the setting of Sofocruz LP and a pharmacokinetic enhancer has not been established. The potential risks and benefits associated with co-administration of Sofocruz LP with the fixed-dose combination tablet containing elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate or tenofovir disoproxil fumarate given in conjunction with a boosted HIV protease inhibitor (e.g. atazanavir or darunavir) should be considered, particularly in patients at increased risk of renal dysfunction. Patients receiving Sofocruz LP concomitantly with elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate or with tenofovir disoproxil fumarate and a boosted HIV protease inhibitor should be monitored for tenofovir-associated adverse reactions. Refer to tenofovir disoproxil fumarate, emtricitabine/tenofovir disoproxil fumarate, or elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate Summary of Product Characteristics for recommendations on renal monitoring.

Use with HMG-CoA reductase inhibitors

Co-administration of Sofocruz LP and HMG-CoA reductase inhibitors (statins) can significantly increase the concentration of the statin, which increases the risk of myopathy and rhabdomyolysis.

HCV/HBV (hepatitis B virus) co-infection

Cases of hepatitis B virus (HBV) reactivation, some of them fatal, have been reported during or after treatment with direct-acting antiviral agents. HBV screening should be performed in all patients before initiation of treatment. HBV/HCV co-infected patients are at risk of HBV reactivation, and should therefore be monitored and managed according to current clinical guidelines.

Paediatric population

Sofocruz LP is not recommended for use in children and adolescents under 18 years of age because the safety and efficacy have not been established in this population.

Excipients

Sofocruz LP contains the azo colouring agent sunset yellow FCF aluminium lake (E110), which may cause allergic reactions. It also contains lactose. Consequently, patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency, or glucose-galactose malabsorption should not take this medicinal product.

DRUG INTERACTION

As Sofocruz LP contains ledipasvir and sofosbuvir, any interactions that have been identified with these active substances individually may occur with Sofocruz LP.

Potential for Sofocruz LP to affect other medicinal products

Ledipasvir is an in vitro inhibitor of drug transporter P-gp and breast cancer resistance protein (BCRP) and may increase intestinal absorption of co-administered substrates for these transporters. In vitro data indicate that ledipasvir may be a weak inducer of metabolising enzymes such as CYP3A4, CYP2C and UGT1A1. Compounds that are substrates of these enzymes may have decreased plasma concentrations when co-administered with ledipasvir/sofosbuvir. In vitro ledipasvir inhibits intestinal CYP3A4 and UGT1A1. Medicinal products that have a narrow therapeutic range and which are metabolised by these isoenzymes should be used with caution and carefully monitored.

Potential for other medicinal products to affect Sofocruz LP

Ledipasvir and sofosbuvir are substrates of drug transporter P-gp and BCRP while GS-331007 is not.

Medicinal products that are potent P-gp inducers (rifampicin, rifabutin, St. John's wort, carbamazepine, phenobarbital and phenytoin) may significantly decrease ledipasvir and sofosbuvir plasma concentrations leading to reduced therapeutic effect of ledipasvir/sofosbuvir and thus are contraindicated with Sofocruz LP. Medicinal products that are moderate P-gp inducers in the intestine (e.g. oxcarbazepine) may decrease ledipasvir and sofosbuvir plasma concentrations leading to reduced therapeutic effect of Sofocruz LP. Co-administration with such medicinal products is not recommended with Sofocruz LP. Co-administration with medicinal products that inhibit P-gp and/or BCRP may increase ledipasvir and sofosbuvir plasma concentrations without increasing GS-331007 plasma concentration; Sofocruz LP may be co-administered with P-gp and/or BCRP inhibitors. Clinically significant medicinal product interactions with ledipasvir/sofosbuvir mediated by CYP450s or UGT1A1 enzymes are not expected.

Patients treated with vitamin K antagonists

As liver function may change during treatment with Sofocruz LP, a close monitoring of International Normalised Ratio (INR) values is recommended.

Interactions between Sofocruz LP and other medicinal products

Table 4 provides a listing of established or potentially clinically significant medicinal product interactions (where 90% confidence interval [CI] of the geometric least-squares mean [GLSM] ratio were within "↔", extended above "↑", or extended below "↓" the predetermined equivalence boundaries). The medicinal product interactions described are based on studies conducted with either ledipasvir/sofosbuvir or ledipasvir and sofosbuvir as individual agents, or are predicted medicinal product interactions that may occur with ledipasvir/sofosbuvir. The table is not all-inclusive.

Table 4: Interactions between Sofocruz LP and other medicinal products

Medicinal product by therapeutic areas	Effects on medicinal product levels. Mean ratio (90% confidence interval) for AUC, Cmax, Cmina, b	Recommendation concerning co-administration with Sofocruz LP
ACID REDUCING AGENTS		
		Ledipasvir solubility decreases as pH increases. Medicinal products that increase gastric pH are expected to decrease concentration of ledipasvir.
Antacids		
e.g. Aluminium or magnesium hydroxide; calcium carbonate	Interaction not studied. Expected: ↓ Ledipasvir ↔ Sofosbuvir ↔ GS-331007 (Increase in gastric pH)	It is recommended to separate antacid and Sofocruz LP administration by 4 hours.
H2-receptor antagonists		
Famotidine (40 mg single dose)/ ledipasvir (90 mg single dose)c/ sofosbuvir (400 mg single dose)c, d Famotidine dosed simultaneously with Sofocruz LPd	Ledipasvir ↓ Cmax 0.80 (0.69, 0.93) ↔ AUC 0.89 (0.76, 1.06) Sofosbuvir	H2-receptor antagonists may be administered simultaneously with or staggered from Sofocruz LP at a dose that does not exceed doses comparable to famotidine 40 mg twice daily.

Cimetidinee Nizatidinee Ranitidinee	↑ Cmax 1.15 (0.88, 1.50) ↔ AUC 1.11 (1.00, 1.24) GS-331007 ↔ Cmax 1.06 (0.97, 1.14) ↔ AUC 1.06 (1.02, 1.11) (Increase in gastric pH)	
Famotidine (40 mg single dose)/ ledipasvir (90 mg single dose)c/ sofosbuvir (400 mg single dose)c, d Famotidine dosed 12 hours prior to Sofocruz LPd	Ledipasvir ↓ Cmax 0.83 (0.69, 1.00) ↔ AUC 0.98 (0.80, 1.20) Sofosbuvir ↔ Cmax 1.00 (0.76, 1.32) ↔ AUC 0.95 (0.82, 1.10) GS-331007 ↔ Cmax 1.13 (1.07, 1.20) ↔ AUC 1.06 (1.01, 1.12) (Increase in gastric pH)	
Proton pump inhibitors		
Omeprazole (20 mg once daily)/ ledipasvir (90 mg single dose)c/ sofosbuvir (400 mg single dose)c Omeprazole dosed simultaneously with Sofocruz LP	Ledipasvir ↓ Cmax 0.89 (0.61, 1.30) ↓ AUC 0.96 (0.66, 1.39) Sofosbuvir	Proton pump inhibitor doses comparable to omeprazole 20 mg can be administered simultaneously with Sofocruz LP. Proton pump inhibitors should not be taken before Sofocruz LP.

Lansoprazolee Rabeprazolee Pantoprazolee Esomeprazolee	↔ Cmax 1.12 (0.88, 1.42) ↔ AUC 1.00 (0.80, 1.25) GS-331007 ↔ Cmax 1.14 (1.01, 1.29) ↔ AUC 1.03 (0.96, 1.12) (Increase in gastric pH)	
ANTIARRHYTHMICS		
Amiodarone	Interaction not studied.	Use only if no other alternative is available. Close monitoring is recommended if this medicinal product is administered with Sofocruz LP
Digoxin	Interaction not studied. Expected: ↑ Digoxin ↔ Ledipasvir ↔ Sofosbuvir ↔ GS-331007 (Inhibition of P-gp)	Co-administration of Sofocruz LP with digoxin may increase the concentration of digoxin. Caution is warranted and therapeutic concentration monitoring of digoxin is recommended when co-administered with Sofocruz LP.
ANTICOAGULANTS		
Dabigatran etexilate	Interaction not studied. Expected: ↑ Dabigatran ↔ Ledipasvir ↔ Sofosbuvir ↔ GS-331007 (Inhibition of P-gp)	Clinical monitoring, looking for signs of bleeding and anaemia, is recommended when dabigatran etexilate is co-administered with Sofocruz LP. A coagulation test helps to identify patients with an increased bleeding risk due to increased dabigatran exposure.
Vitamin K antagonists	Interaction not studied	Close monitoring of INR is recommended with all vitamin K antagonists. This is due

		to liver function changes during treatment with Sofocruz LP.
ANTICONVULSANTS		
Carbamazepine Phenobarbital Phenytoin	Interaction not studied. Expected: ↓ Ledipasvir ↓ Sofosbuvir ↔ GS-331007 (Induction of P-gp)	Sofocruz LP is contraindicated with carbamazepine, phenobarbital and phenytoin, potent intestinal P-gp inducers.
Oxcarbazepine	Interaction not studied. Expected: ↓ Ledipasvir ↓ Sofosbuvir ↔ GS-331007 (Induction of P-gp)	Co-administration of Sofocruz LP with oxcarbazepine is expected to decrease the concentration of ledipasvir and sofosbuvir leading to reduced therapeutic effect of Sofocruz LP. Such co-administration is not recommended.
ANTIMYCOBACTERIALS		
Rifampicin (600 mg once daily)/ ledipasvir (90 mg single dose)d	Interaction not studied. Expected: Rifampicin ↔ Cmax ↔ AUC ↔ Cmin Observed: Ledipasvir ↓ Cmax 0.65 (0.56, 0.76) ↓ AUC 0.41 (0.36, 0.48) (Induction of P-gp)	Sofocruz LP is contraindicated with rifampicin, a potent intestinal P-gp inducer.

Rifampicin (600 mg once daily)/ sofosbuvir (400 mg single dose)d	Interaction not studied. Expected: Rifampicin ↔ Cmax ↔ AUC ↔ Cmin Observed: Sofosbuvir ↓ Cmax 0.23 (0.19, 0.29) ↓ AUC 0.28 (0.24, 0.32) GS-331007 ↔ Cmax 1.23 (1.14, 1.34) ↔ AUC 0.95 (0.88, 1.03) (Induction of P-gp)	
Rifabutin Rifapentine	Interaction not studied. Expected: ↓ Ledipasvir ↓ Sofosbuvir ↔ GS-331007 (Induction of P-gp)	Sofocruz LP is contraindicated with rifabutin, a potent intestinal P-gp inducer. Co-administration of Sofocruz LP with rifapentine is expected to decrease the concentration of ledipasvir and sofosbuvir, leading to reduced therapeutic effect of Sofocruz LP. Such co-administration is not recommended.
HCV PRODUCTS		
Simeprevir (150 mg once daily)/ ledipasvir (30 mg once daily)	Simeprevir ↑ Cmax 2.61 (2.39, 2.86) ↑ AUC 2.69 (2.44, 2.96) Ledipasvir	Concentrations of ledipasvir, sofosbuvir and simeprevir are increased when simeprevir is co-administered with Sofocruz LP. Co-administration is not recommended.

	↑ Cmax 1.81 (1.69, 2.94) ↑ AUC 1.92 (1.77, 2.07)	
Simeprevirh	Simeprevir ↔ Cmax 0.96 (0.71, 1.30) ↔ AUC 0.94 (0.67, 1.33) Sofosbuvir ↑ Cmax 1.91 (1.26, 2.90) ↑ AUC 3.16 (2.25, 4.44) GS-331007 ↓ Cmax 0.69 (0.52, 0.93) ↔ AUC 1.09 (0.87, 1.37)	
HIV ANTIVIRAL AGENTS: REVERSE TRANSCRIPTASE INHIBITORS		
Efavirenz/ emtricitabine/ tenofovir disoproxil fumarate (600 mg/ 200 mg/ 300 mg/ once daily)/ ledipasvir (90 mg once daily)c/ sofosbuvir (400 mg once daily)c, d	Efavirenz ↔ Cmax 0.87 (0.79, 0.97) ↔ AUC 0.90 (0.84, 0.96) ↔ Cmin 0.91 (0.83, 0.99) Emtricitabine ↔ Cmax 1.08 (0.97, 1.21) ↔ AUC 1.05 (0.98, 1.11) ↔ Cmin 1.04 (0.98, 1.11)	No dose adjustment of Sofocruz LP or efavirenz/ emtricitabine/ tenofovir disoproxil fumarate is required.

	Tenofovir ↑ Cmax 1.79 (1.56, 2.04) ↑ AUC 1.98 (1.77, 2.23) ↑ Cmin 2.63 (2.32, 2.97) Ledipasvir ↓ Cmax 0.66 (0.59, 0.75) ↓ AUC 0.66 (0.59, 0.75) ↓ Cmin 0.66 (0.57, 0.76) Sofosbuvir ↔ Cmax 1.03 (0.87, 1.23) ↔ AUC 0.94 (0.81, 1.10) GS-331007 ↔ Cmax 0.86 (0.76, 0.96) ↔ AUC 0.90 (0.83, 0.97) ↔ Cmin 1.07 (1.02, 1.13)	
Emtricitabine/ rilpivirine/ tenofovir disoproxil fumarate (200 mg/ 25 mg/ 300 mg once daily)/ ledipasvir (90 mg once daily)c/ sofosbuvir (400 mg once daily)c, d	Emtricitabine ↔ Cmax 1.02 (0.98, 1.06) ↔ AUC 1.05 (1.02, 1.08) ↔ Cmin 1.06 (0.97, 1.15) Rilpivirine	No dose adjustment of Sofocruz LP or emtricitabine/ rilpivirine/ tenofovir disoproxil fumarate is required.

	↔ Cmax 0.97 (0.88, 1.07) ↔ AUC 1.02 (0.94, 1.11) ↔ Cmin 1.12 (1.03, 1.21) Tenofovir ↔ Cmax 1.32 (1.25, 1.39) ↑ AUC 1.40 (1.31, 1.50) ↑ Cmin 1.91 (1.74, 2.10) Ledipasvir ↔ Cmax 1.01 (0.95, 1.07) ↔ AUC 1.08 (1.02, 1.15) ↔ Cmin 1.16 (1.08, 1.25) Sofosbuvir ↔ Cmax 1.05 (0.93, 1.20) ↔ AUC 1.10 (1.01, 1.21) GS-331007 ↔ Cmax 1.06 (1.01, 1.11) ↔ AUC 1.15 (1.11, 1.19) ↔ Cmin 1.18 (1.13, 1.24)	
Abacavir/ lamivudine (600 mg/ 300 mg once daily)/ ledipasvir (90 mg once daily)c/	Abacavir ↔ Cmax 0.92 (0.87, 0.97)	No dose adjustment of Sofocruz LP or abacavir/ lamivudine is required.

sofosbuvir (400 mg once daily)c, d	↔ AUC 0.90 (0.85, 0.94) Lamivudine ↔ Cmax 0.93 (0.87, 1.00) ↔ AUC 0.94 (0.90, 0.98) ↔ Cmin 1.12 (1.05, 1.20) Ledipasvir ↔ Cmax 1.10 (1.01, 1.19) ↔ AUC 1.18 (1.10, 1.28) ↔ Cmin 1.26 (1.17, 1.36) Sofosbuvir ↔ Cmax 1.08 (0.85, 1.35) ↔ AUC 1.21 (1.09, 1.35) GS-331007 ↔ Cmax 1.00 (0.94, 1.07) ↔ AUC 1.05 (1.01, 1.09) ↔ Cmin 1.08 (1.01, 1.14)	
HIV ANTIVIRAL AGENTS: HIV PROTEASE INHIBITORS		
Atazanavir boosted with ritonavir (300 mg/ 100 mg once daily)/ ledipasvir (90 mg once daily)c/	Atazanavir ↔ Cmax 1.07 (1.00, 1.15) ↔ AUC 1.33 (1.25, 1.42)	No dose adjustment of Sofocruz LP or atazanavir (ritonavir boosted) is required. For the combination of tenofovir/emtricitabine + atazanavir/ritonavir, please see below.

sofosbuvir (400 mg once daily)c, d	↑ Cmin 1.75 (1.58, 1.93) Ledipasvir ↑ Cmax 1.98 (1.78, 2.20) ↑ AUC 2.13 (1.89, 2.40) ↑ Cmin 2.36 (2.08, 2.67) Sofosbuvir ↔ Cmax 0.96 (0.88, 1.05) ↔ AUC 1.08 (1.02, 1.15) GS-331007 ↔ Cmax 1.13 (1.08, 1.19) ↔ AUC 1.23 (1.18, 1.29) ↔ Cmin 1.28 (1.21, 1.36)	
Atazanavir boosted with ritonavir (300 mg/ 100 mg once daily) + emtricitabine/ tenofovir disoproxil fumarate (200 mg/ 300 mg once daily)/ ledipasvir (90 mg once daily)c/ sofosbuvir (400 mg once daily)c, d Dosed simultaneouslyf	Atazanavir ↔ Cmax 1.07 (0.99, 1.14) ↔ AUC 1.27 (1.18, 1.37) ↑ Cmin 1.63 (1.45, 1.84) Ritonavir ↔ Cmax 0.86 (0.79, 0.93) ↔ AUC 0.97 (0.89, 1.05) ↑ Cmin 1.45 (1.27, 1.64)	When given with tenofovir disoproxil fumarate used in conjunction with atazanavir/ritonavir, Sofocruz LP increased the concentration of tenofovir. The safety of tenofovir disoproxil fumarate in the setting of Sofocruz LP and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established. The combination should be used with caution with frequent renal monitoring, if other alternatives are not available. Atazanavir concentrations are also increased, with a risk for an increase in bilirubin levels/icterus. That risk is even higher if ribavirin is used as part of the HCV treatment.

	Emtricitabine ↔ Cmax 0.98 (0.94, 1.02) ↔ AUC 1.00 (0.97, 1.04) ↔ Cmin 1.04 (0.96, 1.12) Tenofovir ↑ Cmax 1.47 (1.37, 1.58) ↔ AUC 1.35 (1.29, 1.42) ↑ Cmin 1.47 (1.38, 1.57) Ledipasvir ↑ Cmax 1.68 (1.54, 1.84) ↑ AUC 1.96 (1.74, 2.21) ↑ Cmin 2.18 (1.91, 2.50) Sofosbuvir ↔ Cmax 1.01 (0.88, 1.15) ↔ AUC 1.11 (1.02, 1.21) GS-331007 ↔ Cmax 1.17 (1.12, 1.23) ↔ AUC 1.31 (1.25, 1.36) ↑ Cmin 1.42 (1.34, 1.49)	
Darunavir boosted with ritonavir	Darunavir	No dose adjustment of Sofocruz LP or darunavir (ritonavir boosted) is required.

(800 mg/ 100 mg once daily)/ ledipasvir (90 mg once daily)d	↔ Cmax 1.02 (0.88, 1.19) ↔ AUC 0.96 (0.84, 1.11) ↔ Cmin 0.97 (0.86, 1.10) Ledipasvir ↑ Cmax 1.45 (1.34, 1.56) ↑ AUC 1.39 (1.28, 1.49) ↑ Cmin 1.39 (1.29, 1.51)	For the combination of tenofovir/emtricitabine + darunavir/ritonavir, please see below.
Darunavir boosted with ritonavir (800 mg/ 100 mg once daily)/ sofosbuvir (400 mg once daily)	Darunavir ↔ Cmax 0.97 (0.94, 1.01) ↔ AUC 0.97 (0.94, 1.00) ↔ Cmin 0.86 (0.78, 0.96) Sofosbuvir ↑ Cmax 1.45 (1.10, 1.92) ↑ AUC 1.34 (1.12, 1.59) GS-331007 ↔ Cmax 0.97 (0.90, 1.05) ↔ AUC 1.24 (1.18, 1.30)	
Darunavir boosted with ritonavir (800 mg/ 100 mg once daily) + emtricitabine/ tenofovir disoproxil fumarate (200 mg/ 300 mg once	Darunavir ↔ Cmax 1.01 (0.96, 1.06) ↔ AUC 1.04 (0.99, 1.08)	When given with darunavir/ritonavir used in conjunction with tenofovir disoproxil fumarate, Sofocruz LP increased the concentration of tenofovir. The safety of tenofovir disoproxil fumarate in the setting of Sofocruz LP and a

daily)/ ledipasvir (90 mg once daily)c/ sofosbuvir (400 mg once daily)c, d Dosed simultaneouslyf	↔ Cmin 1.08 (0.98, 1.20) Ritonavir ↔ Cmax 1.17 (1.01, 1.35) ↔ AUC 1.25 (1.15, 1.36) ↑ Cmin 1.48 (1.34, 1.63) Emtricitabine ↔ Cmax 1.02 (0.96, 1.08) ↔ AUC 1.04 (1.00, 1.08) ↔ Cmin 1.03 (0.97, 1.10) Tenofovir ↑ Cmax 1.64 (1.54, 1.74) ↑ AUC 1.50 (1.42, 1.59) ↑ Cmin 1.59 (1.49, 1.70) Ledipasvir ↔ Cmax 1.11 (0.99, 1.24) ↔ AUC 1.12 (1.00, 1.25) ↔ Cmin 1.17 (1.04, 1.31) Sofosbuvir ↓ Cmax 0.63 (0.52, 0.75) ↓ AUC 0.73 (0.65, 0.82)	pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established. The combination should be used with caution with frequent renal monitoring, if other alternatives are not available.

	GS-331007 ↔ Cmax 1.10 (1.04, 1.16) ↔ AUC 1.20 (1.16, 1.24) ↔ Cmin 1.26 (1.20, 1.32)	
Lopinavir boosted with ritonavir + emtricitabine/ tenofovir disoproxil fumarate	Interaction not studied. Expected: ↑ Lopinavir ↑ Ritonavir ↔ Emtricitabine ↑ Tenofovir ↑ Ledipasvir ↔ Sofosbuvir ↔ GS-331007	When given with lopinavir/ritonavir used in conjunction with tenofovir disoproxil fumarate, Sofocruz LP is expected to increase the concentration of tenofovir. The safety of tenofovir disoproxil fumarate in the setting of Sofocruz LP and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established. The combination should be used with caution with frequent renal monitoring, if other alternatives are not available.
Tipranavir boosted with ritonavir	Interaction not studied. Expected: ↓ Ledipasvir ↓ Sofosbuvir ↔ GS-331007 (Induction of P-gp)	Co-administration of Sofocruz LP with tipranavir (ritonavir boosted) is expected to decrease the concentration of ledipasvir, leading to reduced therapeutic effect of Sofocruz LP. Co-administration is not recommended.
HIV ANTIVIRAL AGENTS: INTEGRASE INHIBITORS		
Raltegravir (400 mg twice daily)/ ledipasvir (90 mg once daily)d	Raltegravir ↓ Cmax 0.82 (0.66, 1.02) ↔ AUC 0.85 (0.70, 1.02) ↑ Cmin 1.15 (0.90, 1.46) Ledipasvir	No dose adjustment of Sofocruz LP or raltegravir is required.

	↔ Cmax 0.92 (0.85, 1.00) ↔ AUC 0.91 (0.84, 1.00) ↔ Cmin 0.89 (0.81, 0.98)	
Raltegravir (400 mg twice daily)/ sofosbuvir (400 mg once daily)d	Raltegravir ↓ Cmax 0.57 (0.44, 0.75) ↓ AUC 0.73 (0.59, 0.91) ↔ Cmin 0.95 (0.81, 1.12) Sofosbuvir ↔ Cmax 0.87 (0.71, 1.08) ↔ AUC 0.95 (0.82, 1.09) GS-331007 ↔ Cmax 1.09 (0.99, 1.19) ↔ AUC 1.02 (0.97, 1.08)	
Elvitegravir/ cobicistat/ emtricitabine/ tenofovir disoproxil fumarate (150 mg/ 150 mg/ 200 mg/ 300 mg once daily)/ ledipasvir (90 mg once daily)c/ sofosbuvir (400 mg once daily)c	Interaction not studied. Expected: ↔ Emtricitabine ↑ Tenofovir Observed: Elvitegravir ↔ Cmax 0.88 (0.82, 0.95) ↔ AUC 1.02 (0.95, 1.09)	When given with elvitegravir/ cobicistat/ emtricitabine/ tenofovir disoproxil fumarate, Sofocruz LP is expected to increase the concentration of tenofovir. The safety of tenofovir disoproxil fumarate in the setting of Sofocruz LP and a pharmacokinetic enhancer (e.g. ritonavir or cobicistat) has not been established. The combination should be used with caution with frequent renal monitoring, if other alternatives are not available.

	↑ Cmin 1.36 (1.23, 1.49) Cobicistat ↔ Cmax 1.25 (1.18, 1.32) ↑ AUC 1.59 (1.49, 1.70) ↑ Cmin 4.25 (3.47, 5.22) Ledipasvir ↑ Cmax 1.63 (1.51, 1.75) ↑ AUC 1.78 (1.64, 1.94) ↑ Cmin 1.91 (1.76, 2.08) Sofosbuvir ↑ Cmax 1.33 (1.14, 1.56) ↑ AUC 1.36 (1.21, 1.52) GS-331007 ↑ Cmax 1.33 (1.22, 1.44) ↑ AUC 1.44 (1.41, 1.48) ↑ Cmin 1.53 (1.47, 1.59)	
Dolutegravir	Interaction not studied. Expected: ↔ Dolutegravir ↔ Ledipasvir ↔ Sofosbuvir ↔ GS-331007	No dose adjustment required.

HERBAL SUPPLEMENTS		
St. John's wort	Interaction not studied. Expected: ↓ Ledipasvir ↓ Sofosbuvir ↔ GS-331007 (Induction of P-gp)	Sofocruz LP is contraindicated with St. John's wort, a potent intestinal P-gp inducer.
HMG-CoA REDUCTASE INHIBITORS		
Rosuvastating	↑ Rosuvastatin (Inhibition of drug transporters OATP and BCRP)	Co-administration of Sofocruz LP with rosuvastatin may significantly increase the concentration of rosuvastatin (several fold-increase in AUC) which is associated with increased risk of myopathy, including rhabdomyolysis. Co-administration of Sofocruz LP with rosuvastatin is contraindicated.
Pravastating	↑ Pravastatin	Co-administration of Sofocruz LP with pravastatin may significantly increase the concentration of pravastatin which is associated with increased risk of myopathy. Clinical and biochemical control is recommended in these patients and a dose adjustment may be needed.
Other statins	Expected: ↑ Statins	Interactions cannot be excluded with other HMG-CoA reductase inhibitors. When co-administered with Sofocruz LP, a reduced dose of statins should be considered and careful monitoring for statin adverse reactions should be undertaken.
NARCOTIC ANALGESICS		
Methadone	Interaction not studied. Expected: ↔ Ledipasvir	No dose adjustment of Sofocruz LP or methadone is required.
Methadone	R-methadone	

(Methadone maintenance therapy [30 to 130 mg/daily])/ sofosbuvir (400 mg once daily)d	↔ Cmax 0.99 (0.85, 1.16) ↔ AUC 1.01 (0.85, 1.21) ↔ Cmin 0.94 (0.77, 1.14) S-methadone ↔ Cmax 0.95 (0.79, 1.13) ↔ AUC 0.95 (0.77, 1.17) ↔ Cmin 0.95 (0.74, 1.22) Sofosbuvir ↓ Cmax 0.95 (0.68, 1.33) ↑ AUC 1.30 (1.00, 1.69) GS-331007 ↓ Cmax 0.73 (0.65, 0.83) ↔ AUC 1.04 (0.89, 1.22)	
IMMUNOSUPPRESSANTS		
Ciclosporing	Interaction not studied. Expected: ↑ Ledipasvir ↔ Ciclosporin	No dose adjustment of Sofocruz LP or ciclosporin is required.
Ciclosporin (600 mg single dose)/ sofosbuvir (400 mg single dose)h	Ciclosporin ↔ Cmax 1.06 (0.94, 1.18) ↔ AUC 0.98 (0.85, 1.14)	

	Sofosbuvir ↑ Cmax 2.54 (1.87, 3.45) ↑ AUC 4.53 (3.26, 6.30) GS-331007 ↓ Cmax 0.60 (0.53, 0.69) ↔ AUC 1.04 (0.90, 1.20)	
Tacrolimus	Interaction not studied. Expected: ↔ Ledipasvir	No dose adjustment of Sofocruz LP or tacrolimus is required.
Tacrolimus (5 mg single dose)/ sofosbuvir (400 mg single dose)h	Tacrolimus ↓ Cmax 0.73 (0.59, 0.90) ↑ AUC 1.09 (0.84, 1.40) Sofosbuvir ↓ Cmax 0.97 (0.65, 1.43) ↑ AUC 1.13 (0.81, 1.57) GS-331007 ↔ Cmax 0.97 (0.83, 1.14) ↔ AUC 1.00 (0.87, 1.13)	
ORAL CONTRACEPTIVES		
Norgestimate/ ethinyl estradiol (norgestimate 0.180 mg/ 0.215 mg/ 0.25 mg/ ethinyl estradiol 0.025 mg)/	Norelgestromin ↔ Cmax 1.02 (0.89, 1.16)	No dose adjustment of oral contraceptives is required.

ledipasvir (90 mg once daily)d	↔ AUC 1.03 (0.90, 1.18) ↔ Cmin 1.09 (0.91, 1.31) Norgestrel ↔ Cmax 1.03 (0.87, 1.23) ↔ AUC 0.99 (0.82, 1.20) ↔ Cmin 1.00 (0.81, 1.23) Ethinyl estradiol ↑ Cmax 1.40 (1.18, 1.66) ↔ AUC 1.20 (1.04, 1.39) ↔ Cmin 0.98 (0.79, 1.22)	
Norgestimate/ ethinyl estradiol (norgestimate 0.180 mg/ 0.215 mg/ 0.25 mg/ ethinyl estradiol 0.025 mg)/ sofosbuvir (400 mg once daily)d	Norelgestromin ↔ Cmax 1.07 (0.94, 1.22) ↔ AUC 1.06 (0.92, 1.21) ↔ Cmin 1.07 (0.89, 1.28) Norgestrel ↔ Cmax 1.18 (0.99, 1.41) ↑ AUC 1.19 (0.98, 1.45) ↑ Cmin 1.23 (1.00, 1.51) Ethinyl estradiol ↔ Cmax 1.15 (0.97, 1.36)	

	↔ AUC 1.09 (0.94, 1.26) ↔ Cmin 0.99 (0.80, 1.23)	

a. Mean ratio (90% CI) of co-administered drug pharmacokinetics of study medicinal products alone or in combination. No effect = 1.00.

b. All interaction studies conducted in healthy volunteers.

c. Administered as Sofocruz LP.

d. Lack of pharmacokinetics interaction bounds 70-143%.

e. These are drugs within class where similar interactions could be predicted.

f. Staggered administration (12 hours apart) of atazanavir/ritonavir + emtricitabine/tenofovir disoproxil fumarate or darunavir/ritonavir + emtricitabine/tenofovir disoproxil fumarate and Sofocruz LP provided similar results.

g. This study was conducted in the presence of another two direct-acting antiviral agents.

h. Bioequivalence/Equivalence boundary 80-125%.

FERTILITY, PREGNANCY AND LACTATION

Women of childbearing potential / contraception in males and females

When Sofocruz LP is used in combination with ribavirin, extreme care must be taken to avoid pregnancy in female patients and in female partners of male patients. Significant teratogenic and/or embryocidal effects have been demonstrated in all animal species exposed to ribavirin. Women of childbearing potential or their male partners must use an effective form of contraception during treatment and for a period of time after the treatment has concluded as recommended in the Summary of Product Characteristics for ribavirin. Refer to the Summary of Product Characteristics for ribavirin for additional information.

Pregnancy

There are no or limited amount of data (less than 300 pregnancy outcomes) from the use of ledipasvir, sofosbuvir or Sofocruz LP in pregnant women.

Animal studies do not indicate direct harmful effects with respect to reproductive toxicity. No significant effects on foetal development have been observed with ledipasvir or sofosbuvir in rats and rabbits. However, it has not been possible to fully estimate exposure margins achieved for sofosbuvir in the rat relative to the exposure in humans at the recommended clinical dose.

As a precautionary measure, it is preferable to avoid the use of Sofocruz LP during pregnancy.

Breast-feeding

It is unknown whether ledipasvir or sofosbuvir and its metabolites are excreted in human milk.

Available pharmacokinetic data in animals has shown excretion of ledipasvir and metabolites of sofosbuvir in milk.

A risk to the newborns/infants cannot be excluded. Therefore, Sofocruz LP should not be used during breast-feeding.

Fertility

No human data on the effect of Sofocruz LP on fertility are available. Animal studies do not indicate harmful effects of ledipasvir or sofosbuvir on fertility.

If ribavirin is co-administered with Sofocruz LP, the contraindications regarding use of ribavirin during pregnancy and breast-feeding apply (see also the Summary of Product Characteristics for ribavirin).

EFFECTS ON ABILITY TO DRIVE AND USE MACHINES

Sofocruz LP (administered alone or in combination with ribavirin) has no or negligible influence on the ability to drive and use machines. However, patients should be advised that fatigue was more common in patients treated with ledipasvir/sofosbuvir compared to placebo.

UNDESIRABLE EFFECTS

Summary of the safety profile

The safety assessment of ledipasvir/sofosbuvir is based on pooled data from three Phase 3 clinical studies (ION-3, ION-1 and ION-2) including 215, 539 and 326 patients who received ledipasvir/sofosbuvir for 8, 12 and 24 weeks, respectively; and 216, 328 and 328 patients who received ledipasvir/sofosbuvir + ribavirin combination therapy for 8, 12 and 24 weeks, respectively. These studies did not include any control group not receiving ledipasvir/sofosbuvir. Further data include a double-blind comparison of the safety of ledipasvir/sofosbuvir (12 weeks) and placebo in 155 cirrhotic patients.

The proportion of patients who permanently discontinued treatment due to adverse events was 0%, < 1% and 1% for patients receiving ledipasvir/sofosbuvir for 8, 12 and 24 weeks, respectively; and < 1%, 0%, and 2% for patients receiving ledipasvir/sofosbuvir + ribavirin combination therapy for 8, 12 and 24 weeks, respectively.

In clinical studies, fatigue and headache were more common in patients treated with ledipasvir/sofosbuvir compared to placebo. When ledipasvir/sofosbuvir was studied with ribavirin, the most frequent adverse drug reactions to ledipasvir/sofosbuvir + ribavirin combination therapy were consistent with the known safety profile of ribavirin, without increasing the frequency or severity of the expected adverse drug reactions.

The following adverse drug reactions have been identified with Sofocruz LP (Table 5). The adverse reactions are listed below by body system organ class and frequency. Frequencies are defined as follows : very common (≥ 1/10), common (≥ 1/100 to < 1/10),

uncommon (≥ 1/1,000 to < 1/100), rare (≥ 1/10,000 to < 1/1,000) or very rare (< 1/10,000).

Table 5: Adverse drug reactions identified with Sofocruz LP

Frequency	Adverse drug reaction
Nervous system disorders:	
Very common	headache
Skin and subcutaneous tissue disorders:	
Common	rash
Unknown frequency	angioedema
General disorders:	
Very common	fatigue

Patients with decompensated cirrhosis and/or who are awaiting liver transplant or post-liver transplant

The safety profile of ledipasvir/sofosbuvir with ribavirin for 12 or 24 weeks in patients with decompensated liver disease and/or those post-liver transplant was assessed in two open-label studies (SOLAR-1 and SOLAR-2). No new adverse drug reactions were detected among patients with decompensated cirrhosis and/or who were post-liver transplant and who received ledipasvir/sofosbuvir with ribavirin. Although adverse events, including serious adverse events, occurred more frequently in this study compared to studies that excluded decompensated patients and/or patients who were post-liver transplantation, the adverse events observed were those expected as clinical sequelae of advanced liver disease and/or transplantation or were consistent with the known safety profile of ribavirin.

Decreases in haemoglobin to < 10 g/dL and < 8.5 g/dL during treatment were experienced by 39% and 13% of patients treated with ledipasvir/sofosbuvir with ribavirin, respectively. Ribavirin was discontinued in 15% of the patients.

7% of liver transplant recipients had a modification of their immunosuppressive agents.

Paediatric population

The safety and efficacy of Sofocruz LP in children and adolescents aged less than 18 years have not yet been established. No data are available.

Description of selected adverse reactions

Cardiac arrhythmias

Cases of severe bradycardia and heart block have been observed when Sofocruz LP is used with concomitant amiodarone and/or other drugs that lower heart rate.

OVERDOSE

The highest documented doses of ledipasvir and sofosbuvir were 120 mg twice daily for 10 days and a single dose of 1,200 mg, respectively. In these healthy volunteer studies, there were no untoward effects observed at these dose levels, and adverse reactions were similar in frequency and severity to those reported in the placebo groups. The effects of higher doses are not known.

No specific antidote is available for overdose with Sofocruz LP. If overdose occurs the patient must be monitored for evidence of toxicity. Treatment of overdose with Sofocruz LP consists of general supportive measures including monitoring of vital signs as well as observation of the clinical status of the patient. Haemodialysis is unlikely to result in significant removal of ledipasvir as ledipasvir is highly bound to plasma protein. Haemodialysis can efficiently remove the predominant circulating metabolite of sofosbuvir, GS-331007, with an extraction ratio of 53%.

PHARMACOLOGICAL PROPERTIES

- **Pharmacodynamic properties**

Pharmacotherapeutic group: Direct-acting antiviral, ATC code: J05AX65

Mechanism of action

Ledipasvir is a HCV inhibitor targeting the HCV NS5A protein, which is essential for both RNA replication and the assembly of HCV virions. Biochemical confirmation of NS5A inhibition by ledipasvir is not currently possible as NS5A has no enzymatic function. In vitro resistance selection and cross-resistance studies indicate ledipasvir targets NS5A as its mode of action.

Sofosbuvir is a pan-genotypic inhibitor of the HCV NS5B RNA-dependent RNA polymerase, which is essential for viral replication. Sofosbuvir is a nucleotide prodrug that undergoes intracellular metabolism to form the pharmacologically active uridine analogue triphosphate (GS-461203), which can be incorporated into HCV RNA by the NS5B polymerase and acts as a chain terminator. GS-461203 (the active metabolite of sofosbuvir) is neither an inhibitor of human DNA and RNA polymerases nor an inhibitor of mitochondrial RNA polymerase.

Antiviral activity

The EC50 values of ledipasvir and sofosbuvir against full-length or chimeric replicons encoding NS5A and NS5B sequences from clinical isolates are detailed in Table 6. The presence of 40% human serum had no effect on the anti-HCV activity of sofosbuvir but reduced the anti-HCV activity of ledipasvir by 12-fold against genotype 1a HCV replicons.

Table 6: Activity of ledipasvir and sofosbuvir against chimeric replicons

Genotype replicons	Ledipasvir activity (EC50, nM)		Sofosbuvir activity (EC50, nM)	
	Stable replicons	NS5A transient replicons Median (range)a	Stable replicons	NS5B transient replicons Median (range)a
Genotype 1a	0.031	0.018 (0.009-0.085)	40	62 (29-128)
Genotype 1b	0.004	0.006 (0.004-0.007)	110	102 (45-170)
Genotype 2a	21-249	-	50	29 (14-81)
Genotype 2b	16-530b	-	15b	-
Genotype 3a	168	-	50	81 (24-181)
Genotype 4a	0.39	-	40	-
Genotype 4d	0.60	-	-	-
Genotype 5a	0.15b	-	15b	-
Genotype 6a	1.1b	-	14b	-
Genotype 6e	264b	-	-	-

a. Transient replicons carrying NS5A or NS5B from patient isolates.

b. The chimeric replicons carrying NS5A genes from genotype 2b, 5a, 6a and 6e were used for testing ledipasvir while the chimeric replicons carrying NS5B genes from genotype 2b, 5a or 6a were used for testing sofosbuvir.

Resistance

In cell culture

HCV replicons with reduced susceptibility to ledipasvir have been selected in cell culture for genotype 1a and 1b. Reduced susceptibility to ledipasvir was associated with the primary NS5A substitution Y93H in both genotype 1a and 1b. Additionally a Q30E substitution developed in genotype 1a replicons. Site-directed mutagenesis of NS5A RAVs showed that substitutions conferring a fold-change > 100 and ≤ 1,000 in ledipasvir susceptibility are Q30H/R, L31I/M/V, P32L and Y93T in genotype 1a and P58D and Y93S in genotype 1b; and substitutions conferring a fold-change > 1,000 are M28A/G, Q30E/G/K, H58D, Y93C/H/N/S in genotype 1a and A92K and Y93H in genotype 1b.

HCV replicons with reduced susceptibility to sofosbuvir have been selected in cell culture for multiple genotypes including 1b, 2a, 2b, 3a, 4a, 5a and 6a. Reduced susceptibility to sofosbuvir was associated with the primary NS5B substitution S282T in all replicon genotypes examined. Site-directed mutagenesis of the S282T substitution in replicons of 8 genotypes conferred 2- to 18-fold reduced susceptibility to sofosbuvir and reduced the viral replication capacity by 89% to 99% compared to the corresponding wild-type.

In clinical studies – Genotype 1

In a pooled analysis of patients who received ledipasvir/sofosbuvir in Phase 3 studies (ION-3, ION-1 and ION-2), 37 patients (29 with genotype 1a and 8 with genotype 1b) qualified for resistance analysis due to virologic failure or early study drug discontinuation and having HCV RNA > 1,000 IU/mL. Post-baseline NS5A and NS5B deep sequencing data (assay cut off of 1%) were available for 37/37 and 36/37 patients, respectively.

NS5A resistance-associated variants (RAVs) were observed in post-baseline isolates from 29/37 patients (22/29 genotype 1a and 7/8 genotype 1b) not achieving sustained virologic response (SVR). Of the 29 genotype 1a patients who qualified for resistance testing, 22/29 (76%) patients harboured one or more NS5A RAVs at positions K24, M28, Q30, L31, S38 and Y93 at failure, while the remaining 7/29 patients had no NS5A RAVs detected at failure. The most common variants were Q30R, Y93H and L31M. Of the 8 genotype 1b patients who qualified for resistance testing, 7/8 (88%) harboured one or more NS5A RAVs at positions L31 and Y93 at failure, while 1/8 patients had no NS5A RAVs at failure. The most common variant was Y93H. Among the 8 patients who had no NS5A RAVs at failure, 7 patients received 8 weeks of treatment (n = 3 with ledipasvir/sofosbuvir; n = 4 with ledipasvir/sofosbuvir + ribavirin) and 1 patient received ledipasvir/sofosbuvir for 12 weeks. In phenotypic analyses, post-baseline isolates from patients who harboured NS5A RAVs at failure showed 20- to at least a 243-fold (the highest dose tested) reduced susceptibility to ledipasvir. Site-directed mutagenesis of the Y93H substitution in both genotype 1a and 1b as well as the Q30R and L31M substitution in genotype 1a conferred high levels of reduced susceptibility to ledipasvir (fold-change in EC50 ranging from 544-fold to 1,677-fold).

Among post-transplant subjects with compensated liver disease or subjects with decompensated liver disease either pre- or post-transplant (SOLAR-1 and SOLAR-2 studies), relapse was associated with the detection of one or more of the following NS5A RAVs: K24R, M28T, Q30R/H/K, L31V, H58D and Y93H/C in 12/14 genotype 1a subjects, and L31M, Y93H/N in 6/6 genotype 1b subjects.

A NS5B substitution E237G was detected in 3 subjects (1 genotype 1b and 2 genotype 1a) in the Phase 3 studies (ION-3, ION-1 and ION-2) and 3 subjects with genotype 1a infection in the SOLAR-1 and SOLAR-2 studies at the time of relapse. The E237G substitution showed a 1.3-fold reduction in susceptibility to sofosbuvir in the genotype 1a replicon assay. The clinical significance of this substitution is currently unknown.

The sofosbuvir resistance-associated substitution S282T in NS5B was not detected in any virologic failure isolate from the Phase 3 studies. However, the NS5B S282T substitution in combination with NS5A substitutions L31M, Y93H and Q30L were detected in one

patient at failure following 8 weeks of treatment with ledipasvir/sofosbuvir from a Phase 2 study (LONESTAR). This patient was subsequently retreated with ledipasvir/sofosbuvir + ribavirin for 24 weeks and achieved SVR following retreatment.

In the SIRIUS study (see "Clinical efficacy and safety", below) 5 patients with genotype 1 infection relapsed after treatment with ledipasvir/sofosbuvir with or without ribavirin. NS5A RAVs were seen at relapse in 5/5 patients (for genotype 1a: Q30R/H + L31M/V [n = 1] and Q30R [n = 1]; for genotype 1b: Y93H [n = 3]).

In clinical studies – Genotype 2, 3, 4, 5 and 6

NS5A RAVs: No genotype 2 infected patients experienced relapse in the clinical study and therefore there are no data regarding NS5A RAVs at the time of failure.

In genotype 3 infected patients experiencing virologic failure, development of NS5A RAVs (including enrichment of RAVs present at baseline) was typically not detected at the time of failure (n = 17).

In genotype 4, 5 and 6 infection, only small numbers of patients have been evaluated (total of 5 patients with failure). The NS5A substitution Y93C emerged in the HCV of 1 patient (genotype 4), while NS5A RAVs present at baseline were observed at the time of failure in all patients. In the SOLAR-2 study, one subject with genotype 4d developed NS5B substitution E237G at the time of relapse. The clinical significance of this substitution is currently unknown.

NS5B RAVs: The NS5B substitution S282T emerged in the HCV of 1/17 genotype 3-failures, and in the HCV of 1/3, 1/1 and 1/1 of genotype 4-, 5- and 6-failures, respectively.

Effect of baseline HCV resistance-associated variants on treatment outcome

Genotype 1

Analyses were conducted to explore the association between pre-existing baseline NS5A RAVs and treatment outcome. In the pooled analysis of the Phase 3 studies, 16% of patients had baseline NS5A RAVs identified by population or deep sequencing irrespective of subtype. Baseline NS5A RAVs were overrepresented in patients who experienced relapse in the Phase 3 studies (see "Clinical efficacy and safety").

Following 12 weeks of treatment with ledipasvir/sofosbuvir (without ribavirin) in treatment-experienced patients (arm 1 of ION-2 study) 4/4 patients with baseline NS5A RAVs conferring a ledipasvir fold-change of ≤ 100 achieved SVR. For the same treatment arm, patients with baseline NS5A RAVs conferring a fold-change of > 100, relapse occurred in 4/13 (31%), as compared to 3/95 (3%) in those without any baseline RAVs or RAVs conferring a fold-change of ≤ 100.

Following 12 weeks of treatment with ledipasvir/sofosbuvir with ribavirin in treatment-experienced patients with compensated cirrhosis (SIRIUS, n = 77), 8/8 patients with baseline NS5A RAVs conferring > 100-fold reduced susceptibility to ledipasvir achieved SVR12.

Among post-transplant subjects with compensated liver disease (SOLAR-1 and SOLAR-2 studies), no relapse occurred in subjects with baseline NS5A RAVs (n = 23) following 12 weeks of treatment with ledipasvir/sofosbuvir + ribavirin. Among subjects with decompensated liver disease (pre- and post-transplant), 4/16 (25%) subjects with NS5A RAVs conferring > 100-fold resistance relapsed after 12 weeks treatment with ledipasvir/sofosbuvir + ribavirin compared to 7/120 (6%) in those without any baseline NS5A RAVs or RAVs conferring a fold-change of ≤ 100.

The group of NS5A RAVs that conferred > 100-fold shift and was observed in patients were the following substitutions in genotype 1a (M28A, Q30H/R/E, L31M/V/I, H58D, Y93H/N/C) or in genotype 1b (Y93H). The proportion of such baseline NS5A RAVs seen with deep sequencing varied from very low (cut off for assay = 1%) to high (main part of the plasma population).

The sofosbuvir resistance-associated substitution S282T was not detected in the baseline NS5B sequence of any patient in Phase 3 studies by population or deep sequencing. SVR was achieved in all 24 patients (n = 20 with L159F+C316N; n = 1 with L159F; and n = 3 with N142T) who had baseline variants associated with resistance to NS5B nucleoside inhibitors.

Genotype 2, 3, 4, 5 and 6

Due to the limited size of studies, the impact of baseline NS5A RAVs on treatment outcome for patients with genotype 2, 3, 4, 5 or 6 CHC has not been fully evaluated. No major differences in outcomes were observed by the presence or absence of baseline NS5A RAVs.

Cross-resistance

Ledipasvir was fully active against the sofosbuvir resistance-associated substitution S282T in NS5B while all ledipasvir resistance-associated substitutions in NS5A were fully susceptible to sofosbuvir. Both sofosbuvir and ledipasvir were fully active against substitutions associated with resistance to other classes of direct-acting antivirals with different mechanisms of actions, such as NS5B non-nucleoside inhibitors and NS3 protease inhibitors. NS5A substitutions conferring resistance to ledipasvir may reduce the antiviral activity of other NS5A inhibitors.

Clinical efficacy and safety

The efficacy of Sofocruz LP (ledipasvir [LDV]/sofosbuvir [SOF]) was evaluated in three open-label Phase 3 studies with data available for a total of 1,950 patients with genotype 1 CHC. The three Phase 3 studies included one study conducted in non-cirrhotic treatment-naïve patients (ION-3); one study in cirrhotic and non-cirrhotic treatment-naïve patients (ION-1); and one study in cirrhotic and non-cirrhotic patients who failed prior therapy with an interferon-based regimen, including regimens containing an HCV protease inhibitor (ION-2). Patients in these studies had compensated liver disease. All three Phase 3 studies evaluated the efficacy of ledipasvir/sofosbuvir with or without ribavirin.

Treatment duration was fixed in each study. Serum HCV RNA values were measured during the clinical studies using the COBAS TaqMan HCV test (version 2.0), for use with

the High Pure System. The assay had a lower limit of quantification (LLOQ) of 25 IU/mL. SVR was the primary endpoint to determine the HCV cure rate which was defined as HCV RNA less than LLOQ at 12 weeks after the cessation of treatment.

Treatment-naïve adults without cirrhosis – ION-3 (study 0108) – Genotype 1

ION-3 evaluated 8 weeks of treatment with ledipasvir/sofosbuvir with or without ribavirin and 12 weeks of treatment with ledipasvir/sofosbuvir in treatment-naïve non-cirrhotic patients with genotype 1 CHC. Patients were randomised in a 1:1:1 ratio to one of the three treatment groups and stratified by HCV genotype (1a versus 1b).

Table 7: Demographics and baseline characteristics in study ION-3

Patient disposition	LDV/SOF 8 weeks (n = 215)	LDV/SOF+RBV 8 weeks (n = 216)	LDV/SOF 12 weeks (n = 216)	TOTAL (n = 647)
Age (years): median (range)	53 (22-75)	51 (21-71)	53 (20-71)	52 (20-75)
Male gender	60% (130)	54% (117)	59% (128)	58% (375)
Race: Black/ African American	21% (45)	17% (36)	19% (42)	19% (123)
White	76% (164)	81% (176)	77% (167)	78% (507)
Genotype 1a	80% (171)	80% (172)	80% (172)	80% (515)a
IL28CC genotype	26% (56)	28% (60)	26% (56)	27% (172)
FibroTest-Determined Metavir scoreb				
F0-F1	33% (72)	38% (81)	33% (72)	35% (225)
F2	30% (65)	28% (61)	30% (65)	30% (191)
F3-F4	36% (77)	33% (71)	37% (79)	35% (227)
Not interpretable	< 1% (1)	1% (3)	0% (0)	< 1% (4)

a. One patient in the LDV/SOF 8-week treatment arm did not have a confirmed genotype 1 subtype.

b. Non-missing FibroTest results are mapped to Metavir scores according to: 0-0.31 = F0-F1; 0.32-0.58 = F2; 0.59-1.00 = F3-F4.

Table 8: Response rates in study ION-3

	LDV/SOF 8 weeks (n = 215)	LDV/SOF+RBV 8 weeks (n = 216)	LDV/SOF 12 weeks (n = 216)
SVR	94% (202/215)	93% (201/216)	96% (208/216)
Outcome for patients without SVR			
On-treatment virologic failure	0/215	0/216	0/216
Relapsea	5% (11/215)	4% (9/214)	1% (3/216)
Otherb	< 1% (2/215)	3% (6/216)	2% (5/216)
Genotype			
Genotype 1a	93% (159/171)	92% (159/172)	96% (165/172)
Genotype 1b	98% (42/43)	95% (42/44)	98% (43/44)

a. The denominator for relapse is the number of patients with HCV RNA < LLOQ at their last on-treatment assessment.

b. Other includes patients who did not achieve SVR and did not meet virologic failure criteria (e.g. lost to follow-up).

The 8-week treatment of ledipasvir/sofosbuvir without ribavirin was non-inferior to the 8-week treatment of ledipasvir/sofosbuvir with ribavirin (treatment difference 0.9%; 95% confidence interval: -3.9% to 5.7%) and the 12-week treatment of ledipasvir/sofosbuvir (treatment difference -2.3%; 97.5% confidence interval: -7.2% to 3.6%). Among patients with a baseline HCV RNA < 6 million IU/mL, the SVR was 97% (119/123) with 8-week treatment of ledipasvir/sofosbuvir and 96% (126/131) with 12-week treatment of ledipasvir/sofosbuvir.

Table 9: Relapse rates by baseline characteristics in the ION-3 study, virological failure population*

	LDV/SOF 8 weeks (n = 213)	LDV/SOF+RBV 8 weeks (n = 210)	LDV/SOF 12 weeks (n = 211)
Gender			
Male	8% (10/129)	7% (8/114)	2% (3/127)

Female	1% (1/84)	1% (1/96)	0% (0/84)
IL28 genotype			
CC	4% (2/56)	0% (0/57)	0% (0/54)
Non-CC	6% (9/157)	6% (9/153)	2% (3/157)
Baseline HCV RNAa			
HCV RNA < 6 million IU/mL	2% (2/121)	2% (3/136)	2% (2/128)
HCV RNA ≥ 6 million IU/mL	10% (9/92)	8% (6/74)	1% (1/83)

* Patients lost to follow-up or who withdrew consent excluded.

a. HCV RNA values were determined using the Roche TaqMan Assay; a patient's HCV RNA may vary from visit to visit.

Treatment-naïve adults with or without cirrhosis – ION-1 (study 0102) – Genotype 1

ION-1 was a randomised, open-label study that evaluated 12 and 24 weeks of treatment with ledipasvir/sofosbuvir with or without ribavirin in 865 treatment-naïve patients with genotype 1 CHC including those with cirrhosis (randomised 1:1:1:1). Randomisation was stratified by the presence or absence of cirrhosis and HCV genotype (1a versus 1b).

Table 10: Demographics and baseline characteristics in study ION-1

Patient disposition	LDV/SOF 12 weeks (n = 214)	LDV/SOF+ RBV 12 weeks (n = 217)	LDV/SOF 24 weeks (n = 217)	LDV/SOF+ RBV 24 weeks (n = 217)	TOTAL (n = 865)
Age (years): median (range)	52 (18-75)	52 (18-78)	53 (22-80)	53 (24-77)	52 (18-80)
Male gender	59% (127)	59% (128)	64% (139)	55% (119)	59% (513)
Race: Black/ African American	11% (24)	12% (26)	15% (32)	12% (26)	12% (108)
White	87% (187)	87% (188)	82% (177)	84% (183)	85% (735)
Genotype 1aa	68% (145)	68% (148)	67% (146)	66% (143)	67% (582)
IL28CC genotype	26% (55)	35% (76)	24% (52)	34% (73)	30% (256)
FibroTest-Determined Metavir scoreb					

F0-F1	27% (57)	26% (56)	29% (62)	30% (66)	28% (241)
F2	26% (56)	25% (55)	22% (47)	28% (60)	25% (218)
F3-F4	47% (100)	48% (104)	49% (107)	42% (91)	46% (402)
Not interpretable	< 1% (1)	1% (2)	< 1% (1)	0% (0)	< 1% (4)

a. Two patients in the LDV/SOF 12-week treatment arm, one patient in the LDV/SOF+RBV 12-week treatment arm, two patients in the LDV/SOF 24-week treatment arm, and two patients in the LDV/SOF+RBV 24-week treatment arm did not have a confirmed genotype 1 subtype.

b. Non-missing FibroTest results are mapped to Metavir scores according to: 0-0.31 = F0-F1; 0.32-0.58 = F2; 0.59-1.00 = F3-F4.

Table 11: Response rates in study ION-1

	LDV/SOF 12 weeks (n = 214)	LDV/SOF+RBV 12 weeks (n = 217)	LDV/SOF 24 weeks (n = 217)	LDV/SOF+RBV 24 weeks (n = 217)
SVR	99% (210/213)	97% (211/217)	98% (213/217)	99% (215/217)
Outcome for patients without SVR				
On-treatment virologic failure	0/213a	0/217	< 1% (1/217)	0/216
Relapseb	< 1% (1/212)	0/217	< 1% (1/215)	0/216
Otherc	< 1% (2/213)	3% (6/217)	< 1% (2/217)	< 1% (2/217)
SVR rates for selected subgroups				
Genotype				
Genotype 1a	98% (142/145)	97% (143/148)	99% (144/146)	99% (141/143)
Genotype 1b	100% (67/67)	99% (67/68)	97% (67/69)	100% (72/72)
Cirrhosisd				
No	99% (176/177)	97% (177/183)	98% (181/184)	99% (178/180)

Yes	94% (32/34)	100% (33/33)	97% (32/33)	100% (36/36)

a. One patient was excluded from the LDV/SOF 12-week treatment arm and one patient was excluded from the LDV/SOF+RBV 24-week treatment arm as both patients were infected with genotype 4 CHC.

b. The denominator for relapse is the number of patients with HCV RNA < LLOQ at their last on-treatment assessment.

c. Other includes patients who did not achieve SVR and did not meet virologic failure criteria (e.g. lost to follow-up).

d. Patients with missing cirrhosis status were excluded from this subgroup analysis.

Previously treated adults with or without cirrhosis – ION-2 (study 0109) – Genotype 1

ION-2 was a randomised, open-label study that evaluated 12 and 24 weeks of treatment with ledipasvir/sofosbuvir with or without ribavirin (randomised 1:1:1:1) in genotype 1 HCV-infected patients with or without cirrhosis who failed prior therapy with an interferon-based regimen, including regimens containing an HCV protease inhibitor. Randomisation was stratified by the presence or absence of cirrhosis, HCV genotype (1a versus 1b) and response to prior HCV therapy (relapse/breakthrough versus non-response).

Table 12: Demographics and baseline characteristics in study ION-2

Patient disposition	LDV/SOF 12 weeks (n = 109)	LDV/SOF+RBV 12 weeks (n = 111)	LDV/SOF 24 weeks (n = 109)	LDV/SOF+RBV 24 weeks (n = 111)	TOTAL (n = 440)
Age (years): median (range)	56 (24-67)	57 (27-75)	56 (25-68)	55 (28-70)	56 (24-75)
Male gender	68% (74)	64% (71)	68% (74)	61% (68)	65% (287)
Race: Black/ African American	22% (24)	14% (16)	16% (17)	18% (20)	18% (77)
White	77% (84)	85% (94)	83% (91)	80% (89)	81% (358)
Genotype 1a	79% (86)	79% (88)	78% (85)	79% (88)	79% (347)
Prior HCV therapy					
PEG-IFN+RBV	39% (43)	42% (47)	53% (58)	53% (59)	47% (207)a

HCV protease inhibitor + PEG-IFN+RBV	61% (66)	58% (64)	46% (50)	46% (51)	53% (231)a
IL28CC genotype	9% (10)	10% (11)	14% (16)	16% (18)	13% (55)
FibroTest-Determined Metavir scoreb					
F0-F1	14% (15)	10% (11)	12% (13)	16% (18)	13% (57)
F2	28% (31)	26% (29)	28% (31)	30% (33)	28% (124)
F3-F4	58% (63)	64% (71)	58% (63)	54% (60)	58% (257)
Not interpretable	0% (0)	0% (0)	2% (2)	0% (0)	< 1% (2)

a. One patient in the LDV/SOF 24-week treatment arms and one patient in the LDV/SOF+RBV 24-week treatment arm were prior treatment failures of a non-pegylated interferon based regimen.

b. Non-missing FibroTest results are mapped to Metavir scores according to: 0-0.31 = F0-F1; 0.32-0.58 = F2; 0.59-1.00 = F3-F4.

Table 13: Response rates in study ION-2

	LDV/SOF 12 weeks (n = 109)	LDV/SOF+RBV 12 weeks (n = 111)	LDV/SOF 24 weeks (n = 109)	LDV/SOF+RBV 24 weeks (n = 111)
SVR	94% (102/109)	96% (107/111)	99% (108/109)	99% (110/111)
Outcome for patients without SVR				
On-treatment virologic failure	0/109	0/111	0/109	< 1% (1/111)
Relapsea	6% (7/108)	4% (4/111)	0/109	0/110
Otherb	0/109	0/111	< 1% (1/109)	0/111
SVR rates for selected subgroups				
Genotype				
Genotype 1a	95% (82/86)	95% (84/88)	99% (84/85)	99% (87/88)
Genotype 1b	87% (20/23)	100% (23/23)	100% (24/24)	100% (23/23)

Cirrhosis				
No	95% (83/87)	100% (88/88)c	99% (85/86)c	99% (88/89)
Yesd	86% (19/22)	82% (18/22)	100% (22/22)	100% (22/22)
Prior HCV therapy				
PEG-IFN+RBV	93% (40/43)	96% (45/47)	100% (58/58)	98% (58/59)
HCV protease inhibitor + PEG-IFN+RBV	94% (62/66)	97% (62/64)	98% (49/50)	100% (51/51)

a. The denominator for relapse is the number of patients with HCV RNA < LLOQ at their last on-treatment assessment.

b. Other includes patients who did not achieve SVR and did not meet virologic failure criteria (e.g. lost to follow-up).

c. Patients with missing cirrhosis status were excluded from this subgroup analysis.

d. Metavir score = 4 or Ishak score ≥ 5 by liver biopsy, or FibroTest score of > 0.75 and (APRI) of > 2.

Table 14 presents relapse rates with the 12-week regimens (with or without ribavirin) for selected subgroups. In non-cirrhotic patients relapses only occurred in the presence of baseline NS5A RAVs, and during therapy with ledipasvir/sofosbuvir without ribavirin. In cirrhotic patients relapses occurred with both regimens, and in the absence and presence of baseline NS5A RAVs.

Table 14: Relapse rates for selected subgroups in study ION-2

	LDV/SOF 12 weeks (n = 109)	LDV/SOF+RBV 12 weeks (n = 111)	LDV/SOF 24 weeks (n = 109)	LDV/SOF+RBV 24 weeks (n = 111)
Number of responders at end of treatment	108	111	109	110
Cirrhosis				
No	5% (4/86)a	0% (0/88)b	0% (0/86)b	0% (0/88)
Yes	14% (3/22)	18% (4/22)	0% (0/22)	0% (0/22)
Presence of baseline NS5A resistance-associated substitutionsc				
No	3% (3/91)d	2% (2/94)	0% (0/96)	0% (0/95)f

Yes	24% (4/17)e	12% (2/17)	0% (0/13)	0% (0/14)

a. These 4 non-cirrhotic relapsers all had baseline NS5A resistance-associated polymorphisms.

b. Patients with missing cirrhosis status were excluded from this subgroup analysis.

c. Analysis (by deep sequencing) included NS5A resistance-associated polymorphisms that conferred > 2.5-fold change in EC50 (K24G/N/R, M28A/G/T, Q30E/G/H/L/K/R/T, L31I/F/M/V, P32L, S38F, H58D, A92K/T, and Y93C/F/H/N/S for genotype 1a and L31I/F/M/V, P32L, P58D, A92K, and Y93C/H/N/S for genotype 1b HCV infection).

d. 3/3 of these patients had cirrhosis.

e. 0/4 of these patients had cirrhosis.

f. One patient who achieved a viral load < LLOQ at end of treatment had missing baseline NS5A data and was excluded from the analysis.

Previously treated adults with cirrhosis – SIRIUS – Genotype 1

SIRIUS included patients with compensated cirrhosis who first failed therapy with pegylated interferon (PEG-IFN) + ribavirin, and then failed a regimen consisting of a pegylated interferon + ribavirin + an NS3/4A protease inhibitor. Cirrhosis was defined by biopsy, Fibroscan (> 12.5 kPa) or FibroTest > 0.75 and an AST:platelet ratio index (APRI) of > 2.

The study (double-blind and placebo-controlled) evaluated 24 weeks of treatment ledipasvir/sofosbuvir (with ribavirin placebo) versus 12 weeks of treatment with ledipasvir/sofosbuvir with ribavirin. Patients in the latter treatment arm received placebo (for ledipasvir/sofosbuvir and ribavirin) during the first 12 weeks, followed by active blinded therapy during the subsequent 12 weeks. Patients were stratified by HCV genotype (1a versus 1b) and prior treatment response (whether HCV RNA < LLOQ had been achieved).

Demographics and baseline characteristics were balanced across the two treatment groups. The median age was 56 years (range: 23 to 77); 74% of patients were male; 97% were white; 63% had genotype 1a HCV infection; 94% had non-CC IL28B alleles (CT or TT).

Of the 155 patients enrolled, 1 patient discontinued treatment whilst on placebo. Of the remaining 154 patients, a total of 149 achieved SVR12 across both treatment groups; 96% (74/77) of patients in the ledipasvir/sofosbuvir with ribavirin 12-week group and 97% (75/77) of patients in the ledipasvir/sofosbuvir 24-week group. All 5 patients who did not achieve SVR12 relapsed after having end-of-treatment response.

Previously treated adults who have failed on sofosbuvir + ribavirin ± PEG-IFN

The efficacy of ledipasvir/sofosbuvir in patients who had previously failed treatment with sofosbuvir + ribavirin ± PEG-IFN is supported by two clinical studies. In study 1118, 44

patients with genotype 1 infection, including 12 cirrhotic patients, who had previously failed treatment with sofosbuvir + ribavirin + PEG-IFN or with sofosbuvir + ribavirin were treated with ledipasvir/sofosbuvir + ribavirin for 12 weeks; the SVR was 100% (44/44). In study ION-4, 13 HCV/HIV-1 co-infected patients with genotype 1, including 1 cirrhotic patient, who had failed a sofosbuvir + ribavirin regimen were enrolled; the SVR was 100% (13/13) after 12 weeks of treatment with ledipasvir/sofosbuvir.

HCV/HIV co-infected adults – ION-4

ION-4 was an open-label clinical study that evaluated the safety and efficacy of 12 weeks of treatment with ledipasvir/sofosbuvir without ribavirin in HCV treatment-naïve and treatment-experienced patients with genotype 1 or 4 CHC who were co-infected with HIV-1. Treatment-experienced patients had failed prior treatment with PEG-IFN + ribavirin ± an HCV protease inhibitor or sofosbuvir + ribavirin ± PEG-IFN. Patients were on a stable HIV-1 antiretroviral therapy that included emtricitabine/tenofovir disoproxil fumarate, administered with efavirenz, rilpivirine or raltegravir.

The median age was 52 years (range: 26 to 72); 82% of the patients were male; 61% were white; 34% were black; 75% had genotype 1a HCV infection; 2% had genotype 4 infection; 76% had non-CC IL28B alleles (CT or TT); and 20% had compensated cirrhosis. Fifty-five percent (55%) of the patients were treatment-experienced.

Table 15: Response rates in study ION-4

	LDV/SOF 12 weeks (n = 335)
SVR	96% (321/335)a
Outcome for patients without SVR	
On-treatment virologic failure	< 1% (2/335)
Relapseb	3% (10/333)
Otherc	< 1% (2/335)
SVR rates for selected subgroups	
Patients with cirrhosis	94% (63/67)
Previously treated patients with cirrhosis	98% (46/47)

a. 8 patients with genotype 4 HCV infection were enrolled in the study with 8/8 achieving SVR12.

b. The denominator for relapse is the number of patients with HCV RNA < LLOQ at their last on-treatment assessment.

c. Other includes patients who did not achieve SVR and did not meet virologic failure criteria (e.g. lost to follow-up).

HCV/HIV co-infected adults – ERADICATE

ERADICATE was an open-label study to evaluate 12 weeks of treatment with ledipasvir/sofosbuvir in 50 patients with genotype 1 CHC co-infected with HIV. All patients were treatment-naïve to HCV therapy without cirrhosis, 26% (13/50) of patients were HIV antiretroviral naïve and 74% (37/50) of patients were receiving concomitant HIV antiretroviral therapy. At the time of the interim analysis 40 patients have reached 12 weeks post treatment and SVR12 was 98% (39/40).

Patients awaiting liver transplantation and post-liver transplant – SOLAR-1 and SOLAR-2

SOLAR-1 and SOLAR-2 were two open-label clinical studies that evaluated 12 and 24 weeks of treatment with ledipasvir/sofosbuvir in combination with ribavirin in genotype 1 and 4 HCV-infected subjects who have undergone liver transplantation and/or who have decompensated liver disease. The two studies were identical in study design. Subjects were enrolled in one of the seven groups based on liver transplantation status and severity of hepatic impairment (see Table 16). Subjects with a CPT score >12 were excluded. Within each group, subjects were randomized in a 1:1 ratio to receive ledipasvir/sofosbuvir + ribavirin for 12 or 24 weeks.

Demographics and baseline characteristics were balanced across the treatment groups. Of the 670 treated subjects, the median age was 59 years (range: 21 to 81 years); 77% of the subjects were male; 91% were White; mean body mass index was 28 kg/m2 (range: 18 to 49 kg/m2); 94% and 6% had genotype 1 and 4 HCV infection, respectively; 78% of the subjects failed a prior HCV therapy. Among the subjects who had decompensated cirrhosis (pre- or post-transplant), 64% and 36% were CPT class B and C at screening, respectively, 24% had a baseline Model for End Stage Liver Disease (MELD) score greater than 15.

Table 16: Combined response rates (SVR12) in studies SOLAR-1 and SOLAR-2

	LDV/SOF+RBV 12 weeks (n = 307)a,b	LDV/SOF+RBV 24 weeks (n = 307)a,b
	SVR	SVR
Pre-transplant		
CPT B	87% (45/52)	92% (46/50)
CPT C	88% (35/40)	83% (38/46)

Post-transplant		
Metavir score F0-F3	95% (94/99)	99% (99/100)
CPT Ac	98% (55/56)	96% (51/53)
CPT Bc	89% (41/46)	96% (43/45)
CPT Cc	57% (4/7)	78% (7/9)
FCH	100% (7/7)	100% (4/4)

a. Twelve subjects transplanted prior to post-treatment Week 12 with HCV RNA<LLOQ at last measurement prior to transplant were excluded.

b. Two subjects who did not have decompensated cirrhosis and had also not received a liver transplant were excluded due to failure to meet the inclusion criteria for any of the treatment groups.

c. CPT = Child-Pugh-Turcotte, FCH = Fibrosing cholestatic hepatitis. CPT A = CPT score 5-6 (compensated), CPT B = CPT score 7-9 (decompensated), CPT C = CPT score 10-12 (decompensated).

Forty subjects with genotype 4 CHC were enrolled in SOLAR-1 and SOLAR-2 studies, SVR 12 were 92% (11/12) and 100% (10/10) in post-transplant subjects without decompensated cirrhosis and 60% (6/10) and 75% (6/8) in subjects with decompensated cirrhosis (pre- and post-liver transplantation) treated for 12 or 24 weeks, respectively. Of the 7 subjects who failed to achieve SVR12, 3 relapsed, all had decompensated cirrhosis and were treated with ledipasvir/sofosbuvir + ribavirin for 12 weeks.

Changes in MELD and CPT score from baseline to post-treatment Week 12 were analyzed for all patients with decompensated cirrhosis (pre- or post-transplant) who achieved SVR12 and for whom data were available (n = 123) to assess the effect of SVR12 on hepatic function.

Change in MELD score: Among those who achieved SVR12 with 12 weeks treatment with ledipasvir/sofosbuvir + ribavirin, 57% (70/123) and 19% (23/123) had an improvement or no change in MELD score from baseline to post-treatment week 12, respectively; of the 32 subjects whose MELD score was ≥ 15 at baseline, 59% (19/32) had a MELD score < 15 at post-treatment Week 12. The improvement in MELD scores observed was driven largely by improvements in total bilirubin.

Change in CPT score and class: Among those who achieved SVR12 with 12 weeks treatment with ledipasvir/sofosbuvir with ribavirin, 60% (74/123) and 34% (42/123) had an improvement or no change of CPT scores from baseline to post-treatment week 12, respectively; of the 32 subjects who had CPT C cirrhosis at baseline, 53% (17/32) had CPT B cirrhosis at post-treatment Week 12; of the 88 subjects who had CPT B cirrhosis at baseline, 25% (22/88) had CPT A cirrhosis at post-treatment Week 12. The

improvement in CPT scores observed was driven largely by improvements in total bilirubin and albumin.

Clinical efficacy and safety in genotype 2, 3, 4, 5 and 6

Ledipasvir/sofosbuvir has been evaluated for the treatment of non-genotype 1 infection in small Phase 2 studies, as summarised below.

The clinical studies enrolled patients with or without cirrhosis, who were treatment-naïve or with prior treatment failure after therapy with PEG-IFN + ribavirin +/- an HCV protease inhibitor.

For genotype 2, 4, 5 and 6 infection, therapy consisted of ledipasvir/sofosbuvir without ribavirin, given for 12 weeks (Table 17). For genotype 3 infection, ledipasvir/sofosbuvir was given with or without ribavirin, also for 12 weeks (Table 18).

Table 17: Response rates (SVR12) with ledipasvir/sofosbuvir for 12 weeks in patients with genotype 2, 4, 5 and 6 HCV infection

Study	GT	n	TEa	SVR12		Relapseb
				Overall	Cirrhosis	
Study 1468 (LEPTON)	2	26	19% (5/26)	96% (25/26)	100% (2/2)	0% (0/25)
Study 1119	4	44	50% (22/44)	93% (41/44)	100% (10/10)	7% (3/44)
Study 1119	5	41	49% (20/41)	93% (38/41)	89% (8/9)	5% (2/40)
Study 0122 (ELECTRON-2)	6	25	0% (0/25)	96% (24/25)	100% (2/2)	4% (1/25)

a. TE: number of treatment-experienced patients.

b. The denominator for relapse is the number of patients with HCV RNA < LLOQ at their last on-treatment assessment.

Table 18: Response rates (SVR12) in patients with genotype 3 infection (ELECTRON-2)

	LDV/SOF+RBV 12 weeks		LDV/SOF 12 weeks	
	SVR	Relapsea	SVR	Relapsea
Treatment-naïve	100% (26/26)	0% (0/26)	64% (16/25)	33% (8/24)

Patients without cirrhosis	100% (20/20)	0% (0/21)	71% (15/21)	25% (5/20)
Patients with cirrhosis	100% (6/6)	0% (0/5)	25% (1/4)	75% (3/4)
Treatment-experienced	82% (41/50)	16% (8/49)	NS	NS
Patients without cirrhosis	89% (25/28)	7% (2/27)	NS	NS
Patients with cirrhosis	73% (16/22)	27% (6/22)	NS	NS

NS: not studied.

a. The denominator for relapse is the number of patients with HCV RNA < LLOQ at their last on-treatment assessment.

Paediatric population

The European Medicines Agency has deferred the obligation to submit the results of studies with ledipasvir/sofosbuvir in one or more subsets of the paediatric population in the treatment of chronic hepatitis C.

- **Pharmacokinetic properties**

Absorption

Following oral administration of ledipasvir/sofosbuvir to HCV-infected patients, ledipasvir median peak plasma concentration was observed at 4.0 hours post-dose. Sofosbuvir was absorbed quickly and the median peak plasma concentrations were observed ~ 1 hour post-dose. Median peak plasma concentration of GS-331007 was observed at 4 hours post-dose.

Based on the population pharmacokinetic analysis in HCV-infected patients, geometric mean steady-state AUC0-24 for ledipasvir (n = 2,113), sofosbuvir (n = 1,542), and GS-331007 (n = 2,113) were 7,290, 1,320 and 12,000 ng•h/mL, respectively. Steady-state Cmax for ledipasvir, sofosbuvir and GS-331007 were 323, 618 and 707 ng/mL, respectively. Sofosbuvir and GS-331007 AUC0-24 and Cmax were similar in healthy adult subjects and patients with HCV infection. Relative to healthy subjects (n = 191), ledipasvir AUC0-24 and Cmax were 24% lower and 32% lower, respectively, in HCV-infected patients. Ledipasvir AUC is dose proportional over the dose range of 3 to 100 mg. Sofosbuvir and GS-331007 AUCs are near dose proportional over the dose range of 200 mg to 400 mg.

Effects of food

Relative to fasting conditions, the administration of a single dose of ledipasvir/sofosbuvir with a moderate fat or high fat meal increased the sofosbuvir AUC0-inf by approximately 2-fold, but did not significantly affect the sofosbuvir Cmax. The exposures to GS-331007 and ledipasvir were not altered in the presence of either meal type. Sofocruz LP can be administered without regard to food.

Distribution

Ledipasvir is > 99.8% bound to human plasma proteins. After a single 90 mg dose of [14C]-ledipasvir in healthy subjects, the blood to plasma ratio of [14C]-radioactivity ranged between 0.51 and 0.66.

Sofosbuvir is approximately 61-65% bound to human plasma proteins and the binding is independent of drug concentration over the range of 1 µg/mL to 20 µg/mL. Protein binding of GS-331007 was minimal in human plasma. After a single 400 mg dose of [14C]-sofosbuvir in healthy subjects, the blood to plasma ratio of [14C]-radioactivity was approximately 0.7.

Biotransformation

In vitro, no detectable metabolism of ledipasvir was observed by human CYP1A2, CYP2C8, CYP2C9, CYP2C19, CYP2D6 and CYP3A4. Evidence of slow oxidative metabolism via an unknown mechanism has been observed. Following a single dose of 90 mg [14C]-ledipasvir, systemic exposure was almost exclusively due to the parent drug (> 98%). Unchanged ledipasvir is also the major species present in faeces.

Sofosbuvir is extensively metabolised in the liver to form the pharmacologically active nucleoside analogue triphosphate GS-461203. The active metabolite is not observed. The metabolic activation pathway involves sequential hydrolysis of the carboxyl ester moiety catalysed by human cathepsin A or carboxylesterase 1 and phosphoramidate cleavage by histidine triad nucleotide-binding protein 1 followed by phosphorylation by the pyrimidine nucleotide biosynthesis pathway. Dephosphorylation results in the formation of nucleoside metabolite GS-331007 that cannot be efficiently rephosphorylated and lacks anti-HCV activity in vitro. Within ledipasvir/sofosbuvir, GS-331007 accounts for approximately 85% of total systemic exposure.

Elimination

Following a single 90 mg oral dose of [14C]-ledipasvir, mean total recovery of the [14C]-radioactivity in faeces and urine was 87%, with most of the radioactive dose recovered from faeces (86%). Unchanged ledipasvir excreted in faeces accounted for a mean of 70% of the administered dose and the oxidative metabolite M19 accounted for 2.2% of the dose. These data suggest that biliary excretion of unchanged ledipasvir is a major route of elimination with renal excretion being a minor pathway (approximately 1%). The median terminal half-life of ledipasvir in healthy volunteers following administration of ledipasvir/sofosbuvir in the fasted state was 47 hours.

Following a single 400 mg oral dose of [14C]-sofosbuvir, mean total recovery of the dose was greater than 92%, consisting of approximately 80%, 14%, and 2.5% recovered in urine, faeces, and expired air, respectively. The majority of the sofosbuvir dose recovered in urine was GS-331007 (78%) while 3.5% was recovered as sofosbuvir. This data indicate that renal clearance is the major elimination pathway for GS-331007 with a large part actively secreted. The median terminal half-lives of sofosbuvir and GS-331007 following administration of ledipasvir/sofosbuvir were 0.5 and 27 hours, respectively.

Neither ledipasvir nor sofosbuvir are substrates for hepatic uptake transporters, organic cation transporter (OCT) 1, organic anion-transporting polypeptide (OATP) 1B1 or

OATP1B3. GS-331007 is not a substrate for renal transporters including organic anion transporter (OAT) 1 or OAT3, or OCT2.

In vitro potential for ledipasvir/sofosbuvir to affect other medicinal products

At concentrations achieved in the clinic, ledipasvir is not an inhibitor of hepatic transporters including the OATP 1B1 or 1B3, BSEP, OCT1, OCT2, OAT1, OAT3, multidrug and toxic compound extrusion (MATE) 1 transporter, multidrug resistance protein (MRP) 2 or MRP4. Sofosbuvir and GS-331007 are not inhibitors of drug transporters P-gp, BCRP, MRP2, BSEP, OATP1B1, OATP1B3, OCT1 and GS-331007 is not an inhibitor of OAT1, OCT2 and MATE1.

Sofosbuvir and GS-331007 are not inhibitors or inducers of CYP or uridine diphosphate glucuronosyltransferase (UGT) 1A1 enzymes.

Pharmacokinetics in special populations

Race and gender

No clinically relevant pharmacokinetic differences due to race have been identified for ledipasvir, sofosbuvir or GS-331007. No clinically relevant pharmacokinetic differences due to gender have been identified for sofosbuvir or GS-331007. AUC and Cmax of ledipasvir were 77% and 58% higher, respectively, in females than males; however, the relationship between gender and ledipasvir exposures was not considered clinically relevant.

Elderly

Population pharmacokinetic analysis in HCV-infected patients showed that within the age range (18 to 80 years) analysed, age did not have a clinically relevant effect on the exposure to ledipasvir, sofosbuvir or GS-331007. Clinical studies of ledipasvir/sofosbuvir included 235 patients (8.6% of total number of patients) aged 65 years and over.

Renal impairment

The pharmacokinetics of ledipasvir were studied with a single dose of 90 mg ledipasvir in HCV negative patients with severe renal impairment (eGFR < 30 mL/min by Cockcroft-Gault, median [range] CrCl 22 [17-29] mL/min). No clinically relevant differences in ledipasvir pharmacokinetics were observed between healthy subjects and patients with severe renal impairment.

The pharmacokinetics of sofosbuvir were studied in HCV negative patients with mild (eGFR ≥ 50 and < 80 mL/min/1.73 m2), moderate (eGFR ≥ 30 and < 50 mL/min/1.73 m2), severe renal impairment (eGFR < 30 mL/min/1.73 m2) and patients with ESRD requiring haemodialysis following a single 400 mg dose of sofosbuvir. Relative to patients with normal renal function (eGFR > 80 mL/min/1.73 m2), the sofosbuvir AUC0-inf was 61%, 107% and 171% higher in mild, moderate and severe renal impairment, while the GS-331007 AUC0-inf was 55%, 88% and 451% higher, respectively. In patients with ESRD, relative to patients with normal renal function, sofosbuvir AUC0-inf was 28% higher when sofosbuvir was dosed 1 hour before haemodialysis compared with 60% higher when sofosbuvir was dosed 1 hour after haemodialysis. The AUC0-inf of GS-331007 in patients with ESRD administered with sofosbuvir 1 hour before or 1 hour after

haemodialysis was at least 10-fold and 20-fold higher, respectively. GS-331007 is efficiently removed by haemodialysis with an extraction coefficient of approximately 53%. Following a single 400 mg dose of sofosbuvir, a 4 hour haemodialysis removed 18% of administered sofosbuvir dose. The safety and efficacy of sofosbuvir have not been established in patients with severe renal impairment or ESRD.

Hepatic impairment

The pharmacokinetics of ledipasvir were studied with a single dose of 90 mg ledipasvir in HCV negative patients with severe hepatic impairment (CPT class C). Ledipasvir plasma exposure (AUCinf) was similar in patients with severe hepatic impairment and control patients with normal hepatic function. Population pharmacokinetics analysis in HCV-infected patients indicated that cirrhosis (including decompensated cirrhosis) had no clinically relevant effect on the exposure to ledipasvir.

The pharmacokinetics of sofosbuvir were studied following 7-day dosing of 400 mg sofosbuvir in HCV-infected patients with moderate and severe hepatic impairment (CPT class B and C). Relative to patients with normal hepatic function, the sofosbuvir AUC0-24 was 126% and 143% higher in moderate and severe hepatic impairment, while the GS-331007 AUC0-24 was 18% and 9% higher, respectively. Population pharmacokinetics analysis in HCV-infected patients indicated that cirrhosis (including decompensated cirrhosis) had no clinically relevant effect on the exposure to sofosbuvir and GS-331007.

Body weight

Body weight did not have a significant effect on sofosbuvir exposure according to a population pharmacokinetic analysis. Exposure to ledipasvir decreases with increasing body weight but the effect is not considered to be clinically relevant.

Paediatric population

The pharmacokinetics of ledipasvir, sofosbuvir and GS-331007 in paediatric patients have not been established.

- **Preclinical safety data**

Ledipasvir

No target organs of toxicity were identified in rat and dog studies with ledipasvir at AUC exposures approximately 7 times the human exposure at the recommended clinical dose.

Ledipasvir was not genotoxic in a battery of in vitro or in vivo assays, including bacterial mutagenicity, chromosome aberration using human peripheral blood lymphocytes and in vivo rat micronucleus assays.

Ledipasvir was not carcinogenic in the 6-month rasH2 transgenic mouse study at exposures up to 26-fold higher than human exposure. A carcinogenicity study in rats is ongoing.

Ledipasvir had no adverse effects on mating and fertility. In female rats, the mean number of corpora lutea and implantation sites were slightly reduced at maternal exposures 6-fold the exposure in humans at the recommended clinical dose. At the no observed effect

level, AUC exposure to ledipasvir was approximately 7- and 3-fold, in males and females, respectively, the human exposure at the recommended clinical dose.

No teratogenic effects were observed in rat and rabbit developmental toxicity studies with ledipasvir.

In a rat pre- and postnatal study, at a maternally toxic dose, the developing rat offspring exhibited mean decreased body weight and body weight gain when exposed in utero (via maternal dosing) and during lactation (via maternal milk) at a maternal exposure 4 times the exposure in humans at the recommended clinical dose. There were no effects on survival, physical and behavioural development and reproductive performance in the offspring at maternal exposures similar to the exposure in humans at the recommended clinical dose.

When administered to lactating rats, ledipasvir was detected in plasma of suckling rats likely due to excretion of ledipasvir via milk.

Sofosbuvir

In repeat dose toxicology studies in rat and dog, high doses of the 1:1 diastereomeric mixture caused adverse liver (dog) and heart (rat) effects and gastrointestinal reactions (dog). Exposure to sofosbuvir in rodent studies could not be detected likely due to high esterase activity; however, exposure to the major metabolite GS-331007 at doses which cause adverse effects was 16 times (rat) and 71 times (dog) higher than the clinical exposure at 400 mg sofosbuvir. No liver or heart findings were observed in chronic toxicity studies at exposures 5 times (rat) and 16 times (dog) higher than the clinical exposure. No liver or heart findings were observed in the 2-year carcinogenicity studies at exposures 17 times (mouse) and 9 times (rat) higher than the clinical exposure.

Sofosbuvir was not genotoxic in a battery of in vitro or in vivo assays, including bacterial mutagenicity, chromosome aberration using human peripheral blood lymphocytes and in vivo mouse micronucleus assays.

Carcinogenicity studies in mice and rats do not indicate any carcinogenicity potential of sofosbuvir administered at doses up to 600 mg/kg/day in mouse and 750 mg/kg/day in rat. Exposure to GS-331007 in these studies was up to 17 times (mouse) and 9 times (rat) higher than the clinical exposure at 400 mg sofosbuvir.

Sofosbuvir had no effects on embryo-foetal viability or on fertility in rat and was not teratogenic in rat and rabbit development studies. No adverse effects on behaviour, reproduction or development of offspring in rat were reported. In rabbit studies exposure to sofosbuvir was 6 times the expected clinical exposure. In the rat studies, exposure to sofosbuvir could not be determined but exposure margins based on the major human metabolite was approximately 5 times higher than the clinical exposure at 400 mg sofosbuvir.

Sofosbuvir-derived material was transferred through the placenta in pregnant rats and into the milk of lactating rats.

EXPIRY DATE

Do not use later than the date of expiry.

PACKAGING INFORMATION
28 tablets in HDPE container with silica gel desiccant and absorbent cotton.

STORAGE AND HANDLING INSTRUCTIONS
Store protected from moisture at a temperature not exceeding 30°C.
Do not use if seal over bottle opening is broken or missing
- Keep the container tightly closed
- Dispense in original container
- Keep out of reach of children

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