32 mm

5 mm

5 mm

5 mm

5 mm

67.5 mm

69 mm

105 mm

242 mm

ATAZOR™-300

3097

3097

ATAZOR™-300

Name of Product:
Atazor-300 (Atazanavir Capsules 300mg)

Name & Strength of Active Substance:
Atazanavir Sulfate equivalent to Atazanavir 300mg

Dosage form: Oral Capsules.

Product Description:
Atazor Capsules -300 : Size '00' Capsules two piece grey cap and white body, hard gelatin capsules printed in white with 'ATV 300' on cap and in black with 'ATV 300' on body, filled with white to light yellow granules which may appear as powder.

Pharmacodynamics:
Pharmacotherapeutic group: protease inhibitor, ATC code: J05A E08
Atazanavir is an azapeptide HIV-1 protease inhibitor. The compound selectively inhibits the virus-specific processing of viral Gag-Pol proteins in HIV-1 infected cells, thus preventing formation of mature virions.

Antiviral activity in cell culture:
Atazanavir exhibits anti-HIV-1 activity with a mean 50% effective concentration (EC50) in the absence of human serum of 2 to 5 nM against a variety of laboratory and clinical HIV-1 isolates grown in peripheral blood mononuclear cells, macrophages, CEM-SS cells, and MT-2 cells. ATV has activity against HIV-1 Group M subtype viruses A, B, C, D, AE, AG, F, G and J isolates in cell culture. ATV has variable activity against HIV-2 isolates (1.9 to 3.2 nM), with EC50 values above the EC50 values of failure isolaes. Two-drug combination antiviral activity studies with ATV showed no antagonism in cell culture with NNRTIs (delaviridin, efavirenz, and nevirapine) and additive antiviral activity Cell Culture with the PIS (Amprenavir, Indinavir, lopinavir, nelfinavir, ritonavir, and saquinavir), NRTIS (abacavir, didnosine, emtricitabine, lamivudine, stavudine, tenofovir, zalcitabine and zidovudine), the HIV-1 fusion inhibitor enfuvirtide, and two compounds used in the treatment of viral hepatitis, adefovir and rivavirin, without enhanced cytotoxicity.

Pharmacokinetics:
Absorption:
Atazanavir is rapidly absorbed with as Tmax of approximately 2.5 hours. Atazanavir demonstrates nonlinear pharmacokinetics with greater than dose –proportional increases in AUC and Cmax values over the dose range of 200 – 800 mg once daily. Steady state is achieved between days 4 and 8, with an accumulation of approximately 2.3-fold.

Food effect:
Administration of atazanavir with food enhances bioavailability and reduces pharmacokinetic variability. Administration of a single 400 mg-dose of atazanavir with a light meal (357 kcal,8.2 g fat, 10.6 g protein) resulted in a 70% increase in AUC and 57% increae in Cmax relative to the fasting state. Administration of a single 400-mg ose of atazanavir with a high-fat meal (721 kcal, 37.3g fat, 29.4g protein) resulted in a mean increase in AUC of 35% with no change in Cmax relative to the fasting state. Administration of atazanavir with either a light meal of high-fat meal decreased the coefficient of variation of AUC and Cmax by approximately one half compared to the fasting state.
Coadministration of a single 300-mg dose of atazanavir and a 100-mg dose of ritonavir with a light meal (336 kcal, 5.1g fat, 9.3g protein) resulted in a 33% increase in the AUC and a 40% increase in both the Cmax and the 24-hour concentration of atazanavir relative to the fasting state. Coadministration with a high-fat meal(951 kcal, 54.7 g fat, 35.9g protein) did not affect the AUC of atazanavir relative to fasting conditions and the Cmax was within 11% of fasting values. The 24-hour concentration following a high-fat meal was increased by approximately 33% due to delayed absorption; the median Tmax increased from 2.0 to 5.0 hours. Coadministration of atazanavir with ritonavir with either a light or a high-fat meal decreased the coefficient of variation of AUC and Cmax by approximately 25% compared to the fasting state.

Distribution: Atazanavir is 86% bound to human serum proteins and protein binding is independent of concentration. Atazanavir binds to both alpha-1-acid glycoprotein (AAG) and albumin to a similar extent (89% and 86% respectively).

Metabolism: Atazanavir is extensively metabolized in humans. The major biotransformation pathways of atazanavir in humans consisted of monooxygenation and dioxygenation. Other minor biotransformation pathways for atazanavir or its metabolites consisted of glucuronidation, N-dealkylation, hydrolysis, and oxygenation with dehydrogenation. Two minor metabolites of atazanavir in plasma have been characterised. Neither metabolite demonstrated in vitro antiviral activity. In vitro studies using human liver microsomes suggeseted that atazanavir is metabolized by CYP3A.

Elimination: Following a single 400-mg dose of 14C-atazanavir, 79% and 13% of the total radioactivity was recovered in the faeces and urine, respectively. Unchanged drug accounted for approximately 20% and 7% of the administered dose in the faeces and urine, respectively.

Indication: Therapeutic indications
Atazor is indicated for the treatment of HIV-1 infected, antiretroviral treatment experienced adults, in combination with other antiretroviral medicinal products.

Recommended Dose:
Therapy should be initiated by a physician experienced in the management of HIV infection in treatment experienced patients.

Adults: the recommended dose of ATAZOR is 300 mg once daily taken with ritonavir 100 mg once daily and with food. Ritonavir is used as a booster of atazanavir pharmacokinetics. If ATAZOR with ritonavir is co-administered with didanosine, it is recommended that didanosine be taken 2 hours after ATAZOR with ritonavir taken with food.

Infants, toddlers, children, and adolescents: The experience in children is limited.

Patients with renal impairment: no dosage adjustment is needed.

Patients with hepatic impairment: ATAZOR with ritonavir should be used with caution in patients with mild hepatic insufficiency. ATAZOR should not be used in patients with moderate to severe hepatic insufficiency. Atazanavir with ritonavir has not been studied in patients with hepatic insufficiency.
Atazanavir without ritonavir is not recommended for treatment-experienced patients with prior virologic failure.

Elderly: A dose adjustment for age is not recommended.

Route of Administration: Oral

Contraindication:
- Hypersensitivity to the active substance or to any of the excipients in ATAZOR.
- Patients with moderate to severe hepatic insufficiency.
- Coadministration of ATAZOR with simvastatin or lovastatin is contraindicated.
- Combination of rifampicin and ATAZOR with concomitant low dose ritonavir is contraindicated.
- The PDE5 inhibitor sildenafil is contraindicated when used for the treatment of pulmonary arterial hypertension (PAH) only.
- ATAZOR with ritonavir must not be used in combination with medicinal products that are substrates of the CYP3A4 isoform of cytochrome P450 and have narrow therapeutic windows (e.g., quetiapine, alfuzosin, astemizole, terfenadine, cisapride, pimozide, quinidine, bepridil, triazolam, midazolam administered orally (for caution on parenterally administered midazolam), and ergot alkaloids, particularly, ergotamine, dihydroergotamine, ergonovine, methylergonovine)
- ATAZOR must not be used in combination with products containing St. John's wort *(Hypericum perforatum)*
- ATAZOR must not be used in combination with products containing St. John's wort *(Hypericum perforatum)*

Warning & Precaution:
While effective viral suppression with antiretroviral therapy has been proven to substantially reduce the risk of sexual transmission, a residual risk cannot be excluded. Precautions to prevent transmission should be taken in accordance with national guidelines.
Coadministration of ATAZOR with ritonavir at doses greater than 100 mg once daily has not been evaluated. The use of higher ritonavir doses may alter the safety profile of atazanavir (cardiac effects, hyperbilirubinaemia) and therefore is not recommended. Only when atazanavir with ritonavir is coadministered with efavirenz, a dose increase of ritonavir to 200 mg once daily could be considered. In this instance, close clinical monitoring is warranted.

Patients with coexisting conditions
Hepatic impairment: Atazanavir is primarily hepatically metabolised. The safety and efficacy of REYATAZ has not been established in patients with significant underlying liver disorders. Patients with chronic hepatitis B or C and treated with combination antiretroviral therapy are at an increased risk for severe and potentially fatal hepatic adverse reactions.
Patients with preexisting liver dysfunction, including chronic active hepatitis, have an increased frequency of liver function abnormalities during combination antiretroviral therapy and should be monitored according to standard practice.
If there is evidence of worsening liver disease in such patients, interruption or discontinuation of treatment must be considered.

Renal impairment: No dosage adjustment is needed in patients with renal impairment. However, ATAZOR with ritonavir is not recommended in patients undergoing haemodialysis.

QT prolongation: Caution should be used with medicinal products known to induce PR prolongations. In patients with preexisting conduction problems (second degree or higher atrioventricular or complex bundle branch block), ATAZOR should be used with caution and only if the benefits exceed the risk. Particular caution should be used when prescribing ATAZOR in association with medicinal products which have the potential to increase the QT interval and/or in patients with preexisting risk factors (bradycardia, long congenital QT, electrolyte imbalances).

Haemophiliac patients: There have been reports of increased bleeding, including spontaneous skin haematomas and haemarthroses, in type A and B haemophiliac patients treated with protease inhibitors. In some patients additional factor VIII was given. Haemophiliac patients should be made aware of the possibility of increased bleeding.

Fat redistribution and metabolic disorders
Combination antiretroviral therapy has been associated with the redistribution of body fat (lipodystrophy) in HIV patients. The long-term consequences of these events are currently unknown. Knowledge about the mechanism is
incomplete. A connection between visceral lipomatosis and protease inhibitors and lipoatrophy and nucleoside reverse transcriptase inhibitors has been hypothesised. A higher risk of lipodystrophy has been associated with individual factors such as older age, and with drug related factors such as longer duration of antiretroviral treatment and associated metabolic disturbances. Clinical examination should include evaluation for physical signs of fat redistribution.
Combination antiretroviral therapy (CART), including ATAZOR (with or without ritonavir)-based CART, is associated with dyslipidaemia. Consideration should be given to the measurement of fasting serum lipids and blood glucose. Lipid disorders should be managed as clinically appropriate.
The selection of antiretroviral therapy must be guided principally by antiviral efficacy. Consultation with standard guidelines for management of dyslipidaemia is recommended.

Hyperglycaemia
New onset diabetes mellitus, hyperglycaemia, and exacerbation of existing diabetes mellitus have been reported in patients receiving protease inhibitors. In some of these, the hyperglycaemia was severe and in some cases also associated with ketoacidosis.

Hyperbilirubinaemia
Hepatic transaminase elevations that occur with elevated bilirubin in patients receiving ATAZOR should be evaluated for alternative etiologies. Alternative antiretroviral therapy to ATAZOR may be considered if jaundice or scleral icterus is unacceptable to a patient. Dose reduction of atazanavir is not recommended because it may result in a loss of therapeutic effect and development of resistance.
Indinavir is associated with indirect (unconjugated) hyperbilirubinaemia due to inhibition of UDPglucuronosyl transferase (UGT). Combinations of ATAZOR and indinavir and coadministration of these medicinal products is not recommended.

Cholelithiasis
Cholelithiasis has been reported in patients receiving ATAZOR. If signs or symptoms of cholelithiasis occur, temporary interruption or discontinuation of treatment may be considered.

Nephrolithiasis
Nephrolithiasis has been reported in patients receiving ATAZOR. In some cases, nephrolithiasis has been associated with acute renal failure or renal insufficiency. If signs or symptoms of nephrolithiasis occur, temporary interruption or discontinuation of treatment may be considered.

Immune reactivation syndrome
In HIV infected patients with severe immune deficiency at the time of institution of combination antiretroviral therapy (CART), an inflammatory reaction to asymptomatic or residual opportunistic pathogens may arise and cause serious clinical conditions, or aggravation of symptoms. Typically, such reactions have been observed within the first few weeks or months of initiation of CART. Relevant examples are cytomegalovirus retinitis, generalised and/or focal mycobacterial infections, and Pneumocystis carinii pneumonia. Any inflammatory symptoms should be evaluated and treatment instituted when necessary. Autoimmune disorders (such as Graves' disease) have also been reported to occur in the setting of immune reactivation; however, the reported time to onset is more variable and these events can occurs many months after initiation of treatment.

Osteonecrosis
Although the etiology is considered to be multifactorial (including corticosteroid use, alcohol consumption, severe immunosuppression, higher body mass index), cases of osteonecrosis have been reported particularly in patients with advanced HIVdisease and/or longterm exposure to combination antiretroviral therapy (CART). Patients should be advised to seek medical advice if they experience joint aches and pain, joint stiffness or difficulty in movement.

Rash and associated syndromes
Rashes are usually mild to moderate maculopapular skin eruptions that occur within the first 3 weeks of starting therapy with ATAZOR.
Stevens Johnson syndrome (SJS), erythema multiforme, toxic skin eruptions and drug rash with eosinophilia and systemic symptoms (DRESS) syndrome have been reported in patients receiving ATAZOR. Patients should be advised of the signs and symptoms and monitored closely for skin reactions. ATAZOR should be discontinued if severe rash develops.
The best results in managing these events come from early diagnosis and immediate interruption of any suspect medicines. If the patient has developed SJS or DRESS associated with the use of ATAZOR, ATAZOR may not be restarted.

Lactose
Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucosegalactose malabsorption should not take this medicinal product.

Paediatric population
Safety
Asymptomatic PR interval prolongation was more frequent in paediatric patients than adults. Asymptomatic first and second degreeAV block was reported in paediatric patients. Caution should be used with medicinal products known to induce PR prolongations. In paediatric patients with preexisting conduction problems (second degree or higher atrioventricular or complex bundlebranch block), ATAZOR should be used with caution and only if the benefits exceed the risk. Cardiac monitoring is recommended based on the presence of clinical findings (e.g., bradycardia).

Efficacy
Atazanavir/ritonavir is not effective in viral strains harbouring multiple mutations of resistance. While in adults no benefit can be expected in patients with ⩾4 PI mutations, in treatment experienced children even lower numbers of PI mutations may be predictive of a lack of benefit.

Interaction with other Medicament:
When ATAZOR and ritonavir are co-administered, the metabolic drug interaction profile for ritonavir may predominate because ritonavir is a more potent CYP3A4 inhibitor than atazanavir. The Summary of Product Characteristics for ritonavir must be consulted before initiation of therapy with Atazanavir and ritonavir. Atazanavir is metabolised in the liver through CYP3A4. It inhibits CYP3A4. Therefore, ATAZOR with ritonavir is contraindicated with medicinal products that are substrates of CYP3A4 and have a narrow therapeutic index: astemizole, terfenadine, cisapride, pimozide, quinidine, bepridil and ergot alkaloids, particularly ergotamine and dihydroergotamine.

Antiretroviral agents
Nucleoside/nucleotide reverse transcriptase inhibitors (NRTIs):
Interaction studies with stavudine, lamivudine and zidovudine with atazanavir without ritonavir based on that ritonavir is not expected to have a significant impact on the pharmacokinetics of NRTIs, the co-administration of atazanavir and ritonavir with these medicinal products is not expected to significantly alter the exposure of the co-administered drugs. The same conclusion applies to the co-administration with abacavir.

VIN'S
151019

286 mm

Product Name	**Atazor 300**	**Sap code :**	**516000242MY01**	**Reference Artwork**	**----------**
Packaging Material	**Pack Insert**	**Reason of change :**	**New Text**	**Proof 1**	**26.04.2019**
Size : Foil Width	**------**	**Country :**	**Malaysia**	**Proof 2**	**25.09.2019**
Size : Foil Repeat Length	**------**	**Pack Size :**	**30 Tab**	**Proof 3**	**11.10.2019**
Size : Strip Size	**------**	**Barcode No. :**	**----------**	**Proof 4**	**15.10.2019 (Size Change)**
Size : Carton/Label	**----------**	**Pharmacode :**	**3097**		
Size : PI - Open Size PI - Close Size	**L. 286 x H. 242 mm** **L. 32 x H. 32 mm**	**No. of colours :**	**1**		
PM Style/Type :	**----------**	**Min. Font Size :**	**7 Pt.**		
Remark (If any) :	**------**			**Developed For :**	Emcure - Hinjawadi Mr. Chandrashekhar

Black

5 mm 5 mm 5 mm 5 mm 32 mm

Considering that ATAZOR with ritonavir should be administered with food, didanosine should be taken 2 hours after ATAZOR with ritonavir.

Tenofovir disoproxil fumarate: When tenofovir disoproxil fumarate 300 mg was administered with atazanavir 300 mg and ritonavir 100 mg, an increase in concentrations of tenofovir was observed. Higher tenofovir concentrations could potentiate tenofovir-associated adverse events, including renal disorders.

Non-nucleoside reverse transcriptase inhibitors (NNRTIs)
Efavirenz: Coadministration of efavirenz with ATAZOR /ritonavir is not recommended.
If the coadministration of ATAZOR with an NNRTI is required, an increase in the dose of both ATAZOR and ritonavir
to 400 mg and 200 mg, respectively, in combination with efavirenz could be considered with close clinical monitoring.

Nevirapine: Coadministration of nevirapine with ATAZOR /ritonavir is not recommended. This decrease in atazanavir
concentration, might negatively impact the efficacy of atazanavir. The mechanism of nevirapine/atazanavir interaction is CYP3A4 induction.

Protease inhibitors
Indinavir: indinavir is also associated with indirect (unconjugated) hyperbilirubinemia due to inhibition of UGT. Co-administration of ATAZOR and indinavir is not recommended.
Ritonavir: Ritonavir 100 mg once daily is used as a booster of atazanavir pharmacokinetics.

Other medicinal products
Antacids and medicinal products containing buffers: reduced plasma concentrations of atazanavir may be the consequence of increased gastric pH if antacids, including buffered medicinal products, are administered with ATAZOR with ritonavir. ATAZOR with ritonavir should be administered 2 hours before or 1 hour after antacids or buffered medicinal products.

Antiarrhythmics (amiodarone, systemic lidocaine, quinidine): concentrations may be increased when co-administered with atazanavir with ritonavir. Caution is warranted and therapeutic concentration monitoring is recommended when available. The concomitant use of quinidine is contraindicated.

Antineoplastics: atazanavir inhibits UGT and may interfere with the metabolism of irinotecan, resulting in increased irinotecan toxicities.

Calcium channel blockers: co-administration of bepridil with atazanavir is contraindicated. Co-administration of diltiazem (180 mg once daily) with atazanavir (400 mg once daily) reported an increase in the maximum PR interval compared to atazanavir alone. Co-administration of diltiazem and atazanavir with ritonavir has not been studied. An initial dose reduction of diltiazem by 50% is recommended, with subsequent titration as needed and ECG monitoring. Verapamil may also have its serum concentrations increased by atazanavir with ritonavir; therefore, caution should be exercised when verapamil is co-administered with atazanavir with ritonavir.

Fluticasone propionate (interaction with ritonavir): Greater effects may be expected when fluticasone propionate is inhaled. Systemic corticosteroid effects including Cushing's syndrome and adrenal suppression have been reported in patients receiving ritonavir and inhaled or intranasally administered fluticasone propionate; this could also occur with other corticosteroids metabolized via the P450 3A pathway, eg, budesonide. Consequently, concomitant administration of atazanavir /ritonavir and these glucocorticoids is not recommended unless the potential benefit of treatment outweighs the risk of systemic corticosteroid effects. A dose reduction of the glucocorticoid should be considered with close monitoring of local and systemic effects or a switch to a glucocorticoid, which is not a substrate for CYP3A4 (eg, beclomethasone). Moreover, in case of withdrawal of glucocorticoids, progressive dose reduction may have to be performed over a longer period. The effects of high fluticasone systemic exposure on ritonavir plasma levels is yet unknown.

HMG-CoA reductase inhibitors (simvastatin, lovastatin, atorvastatin): simvastatin and lovastatin are highly dependent on CYP3A4 for their metabolism and co-administration with atazanavir with ritonavir may result in increased concentrations. Concomitant use of simvastatin or lovastatin is contraindicated due to an increased risk of myopathy including rhabdomyolysis. The risk of myopathy including rhabdomyolysis may also be increased when used in combination with atorvastatin, which is also metabolised by CYP3A4. Coadministration of atorvastatin with ATAZOR is not recommended. If the use of atorvastatin is considered strictly necessary, the lowest possible dose of atorvastatin should be administered with careful safety monitoring.

Immunosuppressants (cyclosporin, tacrolimus, sirolimus): concentrations of cyclosporin, tacrolimus, or sirolimus may be increased when co-administered with atazanavir with ritonavir. More frequent therapeutic concentration monitoring of these medicinal products is recommended until plasma levels have been stabilised.
Macrolide antibiotics:A dose reduction of clarithromycin may result in subtherapeutic concentrations of 14-OH clarithromycin. No recommendation regarding dose reduction can be made; therefore, caution should be exercised if ATAZOR plus ritonavir is co-administered with clarithromycin.

Oral contraceptives: If an oral contraceptive is administered with ATAZOR with ritonavir, it is recommended that the oral contraceptive contain at least 30 µg of ethinyloestradiol and that the patient be reminded of strict compliance with this contraceptive dosing regimen. Coadministration of ATAZOR with ritonavir with other hormonal contraceptives or oral contraceptives containing progestogens other than norgestimate has not been studied, and therefore should be avoided. An alternate reliable method of contraception is recommended.

Proton pump inhibitors: Coadministration of ATAZOR with proton pump inhibitors is not recommended. If the combination of ATAZOR with a proton pump inhibitor is judged unavoidable, close clinical monitoring is recommended in combination with an increase in the dose of ATAZOR to 400 mg with 100 mg of ritonavir; doses of proton pump inhibitors comparable to omeprazole 20 mg should not be exceeded.

Rifabutin: When given with ATAZOR with ritonavir, the recommended dose of rifabutin is 150 mg 3 times per week on set days (for example Monday-Wednesday-Friday). Increased monitoring for rifabutin associated adverse reactions including neutropenia and uveitis is warranted due to an expected increase in exposure to rifabutin. Further dosage reduction of rifabutin to 150 mg twice weekly on set days is recommended for patients in whom the 150 mg dose 3 times per week is not tolerated. It should be kept in mind that the twice weekly dosage of 150mg may not provide an optimal exposure to rifabutin thus leading to a risk of rifamycin resistance and a treatment failure. No dose adjustment is needed for ATAZOR with ritonavir.

Rifampicin: The combination of rifampicin and ATAZOR with concomitant low dose ritonavir is contraindicated

PDE5 Inhibitors: Sildenafil, tadalafil, and vardenafil are metabolised by CYP3A4. Coadministration with ATAZOR with ritonavir may result in increased concentrations of the PDE5 inhibitor and an increase in PDE5 associated adverse events, including hypotension, visual changes, and priapism. The mechanism of this interaction is CYP3A4 inhibition. Patients should be warned about these possible side effects.

Antifungal agents: Ketoconazole and itraconazole should be used cautiously with ATAZOR with ritonavir. High doses of ketoconazole and itraconazole (>200 mg/day) are not recommended. Coadministration of voriconazole and ATAZOR with ritonavir is not recommended, unless an assessment of the benefit/risk justifies the use of voriconazole.
In the majority of patients with at least one functional CYP2C19 allele, a reduction in both voriconazole and atazanavir exposures are expected. In a small number of patients without a functional CYP2C19 allele, significantly increased voriconazole exposures are expected.

Warfarin: co-administration with atazanavir with ritonavir has the potential to produce a decrease or, less often, an increase in INR (International Normalised Ratio). It is recommended that the INR be monitored carefully during treatment with atazanavir and ritonavir, especially when commencing therapy.

St. John's wort (Hypericum perforatum): ATAZOR is contraindicated when used concomitantly with products containing St. John's wort since it may be expected to result in significant reduction in plasma levels of atazanavir. This effect may be due to an induction of CYP3A4. There is a risk of loss of therapeutic effect and development of resistance.
Concomitant use of salmeterol and ATAZOR with ritonavir may result in increased cardiovascular adverse events
associated with salmeterol. Coadministration of salmeterol and ATAZOR is not recommended.
The absorption of atazanavir may be reduced in situations where gastric pH is increased irrespective of cause.
Atazanavir is metabolised principally by CYP3A4. Coadministration of ATAZOR with ritonavir and medicinal products that induce CYP3A4 is not recommended.

Pregnancy & Lactation:
There are no adequate data from the use of atazanavir in pregnant women. Studies in animals have not shown evidence of selective developmental toxicity or effects on reproductive function and fertility . Atazanavir should be used during pregnancy only if the potential benefit justifies the potential risk. It is not known whether atazanavir administered to the mother during pregnancy will exacerbate physiological hyperbilirubinemia and lead to kernicterus in neonates and infants. In the prepartum period, additional monitoring and alternative therapy to atazanavir should be considered.
It is not known whether atazanavir is excreted in human milk. Studies in rats have demonstrated that atazanavir is excreted in the milk. It is therefore recommended that mothers being treated with ATAZOR not breast-feed their infants. As a general rule, it is recommended that HIV infected women not breast-feed their infants in order to avoid transmission of HIV.

Side Effect:
Effects on ability to drive and use machines
Patients should be informed that dizziness has been reported during treatment with regimens containing atazanavir.

Undesirable effects
Immune system disorders: uncommon: hypersensitivity
Metabolism and nutrition disorders: uncommon: diabetesa, hyperglycaemia, weight decreased, weight gain, anorexia, appetite increased
Psychiatric disorders: uncommon: depression, disorientation, anxiety, insomnia, sleep disorder, abnormal dream
Nervous system disorders: common: headache; uncommon: peripheral neuropathy, syncope, amnesia, dizziness, somnolence, dysgeusia
Eye disorders: common: ocular icterus
Cardiac disorders: uncommon: torsades de pointes; rare: QTc prolongationa, oedema, palpitation
Vascular disorders: uncommon: hypertension
Respiratory, thoracic and mediastinal disorders: uncommon: dyspnoea
Gastrointestinal disorders: common: vomiting, diarrhoea, abdominal pain, nausea, dyspepsia; uncommon: pancreatitis, gastritis, abdominal distension, stomatitis aphthous, flatulence, dry mouth
Hepatobiliary disorders: common: jaundice; uncommon: hepatitis, cholelithiasis, cholestasis; rare: hepatosplenomegaly, cholecystitis
Skin and subcutaneous tissue disorders: common: rash; uncommon: erythemia multiforme, toxic skin eruptions,drug rash with eosinophilia and systemic symptoms (DRESS) syndrome, angioedemaa, urticaria, alopecia, pruritus; rare: Stevens Johnson syndrome, vesiculobullous rash, eczema,vasodilatation
Musculoskeletal and connective tissue disorders: uncommon: muscle atrophy, arthralgia, myalgia; rare: myopathy
Renal and urinary disorders: uncommon: nephrolithiasisa, hematuria, proteinuria, pollakiuria, interstitial nephritis; rare: kidney pain
Reproductive system and breast disorders: uncommon: gynaecomastia
General disorders and administration site conditions: common: lipodystrophy syndrome, fatigue; uncommon: chest pain, malaise, pyrexia, asthenia; rare: gait disturbance

Symptoms & Treatment of Overdosage:
Human experience of acute overdose with atazanavir is limited. Single doses up to 1,200mg have been taken without symptomatic untoward effects. At high doses that lead to high drug exposures, jaundice due to indirect (unconjugated) hyperbilirubinemia (without associated liver function test changes) or PR interval prolongations may be observed.
Treatment of overdose with atazanavir should consist of general supportive measures, including monitoring of vital signs and ECG, and observations of the patient's clinical status. If indicated, elimination of unabsorbed atazanavir should be achieved by emesis or gastric lavage. Administration of activated charcoal may also be used to aid removal of unabsorbed drug. There is no specific antidote for overdose with atazanavir. Since atazanavir is extensively metabolised by the liver and is highly protein bound, dialysis is unlikely to be beneficial in significant removal of this medicinal product.

Storage condition: Store below 30°C.

Shelf life: 36 Months

Dosage form and packaging available:
30 capsules are packed in 100cc white opaque HDPE container

Manufactured by :
Emcure Pharmaceuticals Limited
Plot No. P1 & P2, I.T.B.T. Park, Phase II,
M.I.D.C., Hinjawadi, Pune - 411057, Maharashtra State, India.
TM Trade Mark Owners.

51600242MY01

Date of Revision : June 2020

242 mm

286 mm