

LAMIVUDINE/STAVUDINE + EFAVIRENZ (3TC/d4T + EFV)

GENERAL INFORMATION

- Therapeutic class: Two NRTI (in a fixed-dose combination) + one NNRTI in a co-pack.
- WHO guidelines: Indicated for first-line for children. WHO 2009 guidelines also recommended to move away from d4T first-line in adults and adolescents.^{6,22} WHO updated the 2006 guidelines to recommend a reduction in dose of d4T 40mg to d4T 30mg for all weight categories of patients.²⁷²
- Originator company and product brand name: No originator product exists.
- First approval by U.S. Food and Drug Administration (FDA): Not applicable.
- WHO Model List of Essential Medicines (EML): Individual medicines included in the 17th edition. The WHO Expert Committee on the Selection and Use of Essential Medicines recommends and endorses the use of fixed-dose combinations and the development of appropriate new fixed-dose combinations.²⁴
- Patents: Individual patents on lamivudine (3TC), stavudine (d4T) or efavirenz (EFV) also affect this combination.

PRICE INFORMATION

Developing country prices in US\$ per patient per year, as quoted by companies.

The price in brackets corresponds to the price of one kit of 3 tablets. Products quality-assured by US FDA or WHO prequalification (as of May 2011) are in **bold**.

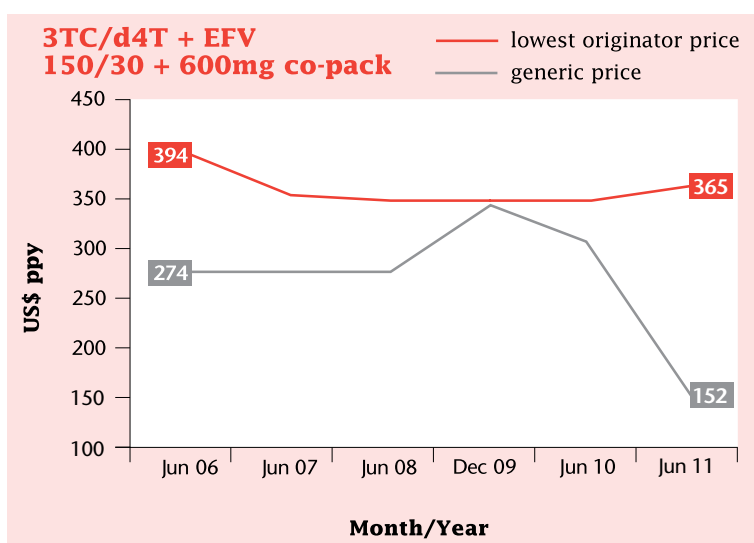
	Daily dose	Ranbaxy	Strides
Who can access this price?		See annex 2	
3TC/d4T + EFV 150/30 + 600mg tablets (co-pack)	1 kit (3 tablets)	152 (0.417)	106 (0.290)

Evolution of the lowest price quoted for developing countries since 2006:

As of May 2011, one generic source of 3TC/d4T + EFV 150/30 + 600mg co-pack was quality-assured by US FDA or WHO prequalification. Its price is shown here.

As there is no originator co-pack, the price shown for the originator product is the sum of the three individual originator products.

Since 2006, the sum of the originator prices has decreased by 7%, while generic prices have dropped by 45%.



Continued overleaf ❖

SPOTLIGHT ON ACCESS ISSUES

In 2010, WHO released new recommendations for antiretroviral therapy for HIV in adults and adolescents. These new recommendations advise countries to phase out d4T-based regimens because of their long-term irreversible side effects and to move towards zidovudine- (AZT) or tenofovir-based (TDF) first-line regimens.⁷

For many years, the stavudine- (d4T) containing regimen played a crucial role in ART scale-up in resource-limited settings, due to its availability in a fixed-dose combination and, most importantly, its low cost. d4T remains a widely used ARV in first-line regimens.

During the review of the marketing authorisation of this medicine in February 2011, the European Medicines Agency (EMA) decided to severely restrict its use in both adults and children, recommending that in view of its long-term toxicities, d4T be used for as short a time as possible and only when no appropriate alternatives⁸ exist.

It is time for countries to invest in a more robust, TDF-containing first-line regimen, such as TDF/3TC/EFV or TDF/FTC/EFV, which are both one pill, once a day or TDF/3TC + NVP (available in co-pack). While the price today is still higher than a d4T-based regimen, there is a need to generate greater demand which will, in turn, increase the competition and the economies of scale needed to further decrease prices.⁷

We can therefore expect to see a decrease in the use of this formulation in the future.

Patents

Generic companies in certain developing countries were able to develop this co-blister because patents on the individual components contained in the combination did not exist.

This product is not available in developed countries or in China because of various patents on 3TC, d4T and/or EFV.

Paediatrics

In its 2010 guidelines for antiretroviral therapy for HIV in infants and children, WHO recommends 3TC/d4T as one of the possible combinations to be given with either an NNRTI or a PI in the first-line.²²

Because of the long-term risks of toxicity, particularly lipoatrophy in children treated with d4T-containing regimens, the use of AZT is preferred. Toxicity risks are also associated with AZT, with possible anaemia developing over the first few months of therapy, but the drug remains much better tolerated than d4T.²² WHO guidelines recommend a preferential order of NRTIs to be used in first-line regimens, with AZT preferred over ABC, and ABC preferred over d4T.

As there is still no established dosing of EFV for children less than three years of age, there is an urgent need to establish the dosing of EFV for this age group for children with HIV/TB co-infection.

In the absence of such data, treatment options for children remain limited, particularly for HIV/TB co-infected young children who cannot be given NVP because of interactions between NVP and TB drugs.

Currently a co-pack of d4T/3TC + EFV for children does not exist.