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Bixlenvo™ (bictegravir/lenacapavir) Use in Pregnancy

This document is in response to your request for information regarding Bixlenvo™ (bictegravir/lenacapavir [BIC/LEN]) or its components for the treatment of HIV-1 in women who are pregnant.

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The full indication, important safety information, and boxed warnings are available at: www.gilead.com/-/media/files/pdfs/medicines/hiv/BIXLENVO/BIXLENVO_pi.

Summary

Product Labeling[1]

Lower exposures of BIC were observed during pregnancy; therefore, viral load should be monitored closely in pregnant individuals.

Available data from observational studies and the APR with BIC use during pregnancy have not established a drug-associated risk of major birth defects, miscarriage or other adverse maternal or fetal outcomes.

Available data from a randomized, controlled trial with LEN use during pregnancy in individuals without HIV-1 have not identified a drug-associated risk for miscarriage, or adverse maternal or fetal outcomes when compared to an active control. The rate of major birth defects in LEN-exposed pregnancies did not exceed the background prevalence rates. The risk estimates are imprecise due to small numbers of exposed pregnancies.

APR Data on BIC and LEN Use in Pregnancy

The APR was established to monitor fetal outcomes among pregnant women exposed to ARV agents. To date, no increase (>2-fold for BIC) in the risk of overall birth defects has been detected following first-trimester exposure. Currently, there are insufficient exposure data on LEN to detect a pattern of increase in risk of birth defects.[2]

Clinical Data on BIC and LEN Use in Pregnancy

Participants with a positive pregnancy test result at screening were excluded from the phase 2/3 ARTISTRY-1 and ARTISTRY-2 studies that assessed the efficacy and safety of BIC + LEN in VS PWH.[3-6]

In a phase 3 study evaluating the efficacy and safety of twice-yearly SUBQ LEN for HIV-1 PrEP, the study authors determined that frequency of pregnancy outcomes – including rates of spontaneous abortions, stillbirths, preterm births, and small-for-gestational-age births – as well as congenital anomalies observed in the LEN group were consistent with background rates.[7-9] In a nested PK substudy of participants who were randomly assigned to the LEN

group and became pregnant during the study, LEN concentrations remained generally consistent throughout pregnancy and postpartum, with no evident trimester-related changes. Subsequent population PK analyses demonstrated no statistically significant differences in LEN exposure when comparing pregnancy trimesters, postpartum status, and non-pregnant individuals.[7]

A phase 1b, single-arm, open-label study evaluated PK parameters and virologic outcomes in pregnant women with HIV-1 treated with BIC/FTC/TAF for up to 38 weeks. PK parameters indicated that BIC crosses the placenta, and the median $t_{1/2}$ was longer in neonates than in postpartum women. All participants maintained virologic suppression during pregnancy and delivery and through postpartum Week 18. No treatment-emergent resistance or MTCT occurred. Most AEs were Grade 1/2 in severity and no AE-related discontinuations occurred.[10,11]

PK data from multiple studies suggest a decrease in BIC exposure during pregnancy.[12,13]

Product Labeling[1]

Dosage and Administration

BIC/LEN Use During Pregnancy

Lower exposures of BIC were observed during pregnancy; therefore, viral load should be monitored closely in pregnant individuals.

Use in Specific Populations

Pregnancy

Pregnancy exposure registry

There is a pregnancy exposure registry that monitors pregnancy outcomes in individuals exposed to BIC/LEN during pregnancy. Healthcare providers are encouraged to register patients by calling the APR at 1-800-258-4263.

Risk summary

Available data from observational studies and the APR with BIC use during pregnancy have not established a drug-associated risk of major birth defects, miscarriage or other adverse maternal or fetal outcomes. Available data from the APR show no statistically significant difference in the overall risk of major birth defects for BIC compared with the background rate for major birth defects of 2.7% in a U.S. reference population of the Metropolitan Atlanta Congenital Defects Program (MACDP). The rate of miscarriage is not reported in the APR. The estimated background rate of miscarriage in the clinically recognized pregnancies in the U.S. general population is 15-20%.

BIC safety has also been evaluated in an open-label trial in individuals with HIV-1 that demonstrated safety findings that were consistent with other trials in adults.

Available data from a randomized, controlled trial with LEN use during pregnancy in individuals without HIV-1 have not identified a drug-associated risk for miscarriage, or adverse maternal or fetal outcomes when compared to an active control. The rate of major

birth defects in LEN-exposed pregnancies did not exceed the background prevalence rates. The risk estimates are imprecise due to small numbers of exposed pregnancies.

Data: human data: bictegravir

A BIC-containing regimen was evaluated in an open-label clinical trial of 33 virologically suppressed (HIV-1 RNA < 50 copies/mL) pregnant adults with HIV-1 and no known substitutions associated with resistance to BIC. Pregnant adults were administered a BIC-containing regimen once daily from the second or third trimester through postpartum. Exposures of BIC were lower during pregnancy as compared to postpartum. All 32 adult participants who completed the study maintained viral suppression during pregnancy, at delivery, and through Week 18 postpartum. The median CD4+ cell count at baseline was 558 cells/µL, and the median change in CD4+ cell count from baseline to Week 12 postpartum was 159 cells/µL. All 29 neonate participants had negative/nondetectable HIV-1 PCR results at birth and/or at 4 to 8 weeks post-birth. The safety findings in this trial were consistent with other trials of BIC-containing regimens in adults.

Based on prospective reports to the APR of over 500 exposures to a BIC-containing regimen during pregnancy resulting in live births (including 423 exposed in the first trimester and 113 exposed in the second/third trimester), the prevalence of birth defects in live births was 4.3% (95% CI: 2.5% to 6.6%) and 1.8% (0.2%, 6.2%) following first and second/third trimester exposure, respectively, to a BIC-containing regimen.

Data: human data: lenacapavir

In a randomized, controlled trial of individuals without HIV-1 in Uganda and South Africa, there were 208 pregnancies exposed to LEN received via injection with known outcomes and 132 deliveries (both live and non-live). In the active control arm of this study, there were 109 pregnancies with known outcomes and 61 deliveries (both live and non-live). The adverse pregnancy outcomes of spontaneous abortion, stillbirth, preterm birth, and small for gestational age were similar across both treatment groups.

There were two major birth defects in the LEN arm. Both were ventricular septal defects. This resulted in a rate of major birth defects that fell within the background prevalence rate for major birth defects.

Concentrations of LEN received via injection during each trimester of pregnancy and postpartum were comparable to those in non-pregnant participants.

APR Data on BIC and LEN Use in Pregnancy

Healthcare providers are encouraged to register patients who become pregnant to the APR by calling 1-800-258-4263.

The APR is intended to provide an early signal of teratogenicity associated with prenatal use of ARVs. The registry is ongoing; healthcare providers are strongly encouraged to report eligible patients to the registry. Further information is available at https://apregistry.com/.

BIC/LEN Component Data in the APR[2]

The June 2026 interim report included prospective reports of 24,898 pregnancies with follow-up data through January 31, 2026. For BIC the prevalence of birth defects is now 4.18% (95% CI: 2.99 - 5.67), and is statistically significantly elevated compared with

MACDP (2.72%; 95% CI: 2.68 - 2.76). BIC has never been statistically significantly different from TBDR (5.17%; 95% CI: 5.16 – 5.19). Data continue to be monitored during each reporting period.

Table 1. APR: Number of Birth Defects by Trimester of Earliest Exposure[2]

Drug Regimen	Pregnancies Enrolled	First Trimester		Second/Third Trimester	
		Defects per Live Births[a]	Prevalence, % (95% CI)[b]	Defects per Live Births[a]	Prevalence, % (95% CI)[b]
Any ARV-containing	24,898	395/13,212	3.0 (2.7, 3.3)	297/10,349	2.9 (2.6, 3.2)
BIC-containing	1,233	39/933	4.2 (3.0, 5.7)	5/256	2.0 (0.6, 4.5)

[a]Proportion of defects was calculated by dividing the number of defects that met the CDC criteria by the number of live births reported.
[b]Prevalence and 95% CIs were reported for drugs associated with ≥200 defect-positive live births, where the earliest exposure to drug was the first trimester.

The current APR reported 8 cases of injectable LEN exposure during pregnancy. Currently, there are insufficient exposure data on LEN to detect a pattern of increase in risk of birth defects. Data continue to be monitored during each reporting period.

Clinical Data on BIC and LEN Use in Pregnancy

Pregnancy Data from Clinical Studies

ARTISTRY-1 and ARTISTRY-2 Studies

ARTISTRY-1 (GS-US-621-6289) is an ongoing, randomized, multicenter, open-label, phase 2/3 study designed to evaluate the efficacy and safety of switching to oral BIC/LEN (75mg/50 mg) vs continuing a complex ART regimen in VS PWH.[3]

ARTISTRY-2 (GS-US-621-6290) is an ongoing, randomized, multicenter, double-blind, active-controlled phase 3 study designed to evaluate the efficacy and safety of switching from BIC/FTC/TAF to oral BIC/LEN (75 mg/50 mg) vs continuing BIC/FTC/TAF in VS PWH.[5]

Participants with a positive serum pregnancy test result at screening or a positive pregnancy test result before day 1 randomization were excluded from both studies. Any participant who became pregnant after randomization could re-consent to remain in either study. Information on any such participants has not been published.[3-6]

PURPOSE-1 Study in Participants without HIV-1

PURPOSE 1 (NCT04994509) is an ongoing, phase 3, double-blind, randomized, active-controlled study evaluating the efficacy and safety of twice-yearly SUBQ LEN and once-daily oral FTC/TAF for HIV-1 PrEP in cisgender women and adolescent girls across South Africa and Uganda. Additionally, a third group was assigned once-daily oral FTC/TDF, which served as the active control. Participants who discontinued blinded study drug were given the option to take open-label FTC/TDF. Randomized participants had body weight ≥35 kg and eGFR ≥60 mL/min.[14]

A planned substudy evaluated endpoints including pregnancy outcomes, HIV acquisitions, AEs during pregnancy and postpartum, and observed and model-derived LEN plasma concentrations by pregnancy trimester and postpartum period.[7]

At the data cutoff, there were 509 pregnancies among 487 participants: 193 pregnancies in the LEN group, 218 in the FTC/TAF group, and 98 in the FTC/TDF group (Table 2).[7] The

study authors determined that pregnancy outcomes – including rates of spontaneous abortions, stillbirths, preterm births, and small-for-gestational-age births – were within the expected background rates reported in South Africa and Uganda.[7-9]

Overall, 10 congenital abnormalities were reported: LEN, n=6 (congenital hemangioma, umbilical hernia, left hand polydactyly, perimembranous ventricular septal defect, congenital ventricular septal defect, and congenital reducible umbilical hernia; each, n=1); FTC/TAF, n=4 (infant bilateral hydrocele; right inguinal hernia, umbilical hernia, and neonatal jaundice; Down syndrome; and clubfoot; each, n=1).[15] All congenital anomalies were assessed by investigators as unrelated to study drug except for one ventricular septal defect in the LEN group, which was considered treatment-related.[7] The participant with an infant with polydactyly had a reported strong maternal family history of polydactyly.[16] The heterogeneous anomalies observed were considered consistent with background incidence and did not suggest a drug-related pattern.

Table 2. PURPOSE 1: Pregnancy Outcomes[7]

Pregnancy Outcomes, n or n/N (%)	LEN (n=184)	FTC/TAF (n=208)	FTC/TDF (n=95)	Total (n=487)
Participants with confirmed pregnancies	184	208	95	487
Confirmed pregnancies	193	218	98	509
Pregnancy incidence rate per 100 person-years[a]	10.0	11.2	10.2	10.5
Total pregnancy outcomes[b]	195	219	98	512
Live births	128/195 (66)	119/219 (54)	56/98 (57)	303/512 (59)
At term (≥37 to ≤42 weeks' gestation)	105/128 (82)	93/119 (78)	40/56 (71)	238/303 (79)
Preterm (<37 weeks' gestation)	14/128 (11)	19/119 (16)	11/56 (20)	44/303 (15)
Post-term (>42 weeks' gestation)	9/128 (7)	7/119 (6)	5/56 (9)	21/303 (7)
Congenital abnormality[c]	6/127 (5)	4/117 (3)	0	10/300 (3)
Small for gestational age[d]	11/128 (9)	12/119 (10)	9/56 (16)	32/303 (11)
Pregnancy losses	60/195 (31)	89/219 (41)	41/98 (42)	190/512 (37)
Stillbirth[e]	5/195 (3)	6/219 (3)	3/98 (3)	14/512 (3)
Induced or elective abortions	35/195 (18)	50/219 (23)	23/98 (23)	108/512 (21)
Spontaneous abortions[f]	20/195 (10)	33/219 (15)	15/98 (15)	68/512 (13)
Pregnancies with unknown outcomes[g]	7/195 (4)	11/219 (5)	1/98 (1)	19/512 (4)

[a]Pregnancy incidence rate is the number of confirmed pregnancies divided by person-years of follow-up; person-years of follow-up are the sum of all participants' total number of years (365.25 days) in the randomised, masked phase for the primary analysis (LEN 1934.1 years, FTC/TAF 1943.5 years, FTC/TDF 956.7, and total 4834.4).

[b]Total pregnancy outcomes includes the number of live births, pregnancy losses, and pregnancies with unknown outcome; one pregnancy can include multiple outcomes or births (three sets of twins: two sets in participants randomly allocated to LEN [one set of stillborn twins and one set of liveborn healthy twins] and one set in participants randomly allocated to FTC/TAF [liveborn and premature]); birth outcomes are reported for each individual infant.

[c]Includes one infant reported to have had a healthy outcome at birth whose congenital abnormality of umbilical hernia was first detected at approximately 4 months of age.

[d]Small for gestational age was defined as a weight under the 10th percentile by sex and gestational age.

[e]Stillbirth or intrauterine fetal demise defined as occurring at 20 weeks' gestation or longer. There was one set of stillbirth twins in the LEN group.

[f]Spontaneous abortion defined as occurring at less than 20 weeks' gestation; estimated gestational age data are missing for one infant in the FTC/TAF group.

[g]Unknown due to participant discontinuation for the following reasons: pregnancy (LEN [two]; FTC/TAF [two]); investigator's discretion (FTC/TAF [one]); withdrawal of consent (LEN [five] and FTC/TAF [four]); and loss to follow-up (FTC/TAF [four]; FTC/TDF [one]).

Additional safety outcomes during pregnancy and postpartum are presented in Table 3.[7]

Table 3. PURPOSE 1: Safety Outcomes During Pregnancy and Postpartum[7]

AEs During Pregnancy and Postpartum,[a] n (%)		LEN (n=184)	FTC/TAF (n=208)	FTC/TDF (n=95)
Any AEs[b]		135 (73)	142 (68)	68 (72)
Grade ≥2		112 (61)	112 (54)	55 (58)
Grade ≥3		36 (20)	39 (19)	22 (23)
SAEs[b]		41 (22)	50 (24)	22 (23)
AEs leading to discontinuation of study drug[b]		1 (1)[c]	0	0
AEs occurring in ≥5% of participants in any randomized group[d]	Urinary tract infection	39 (21)	34 (16)	27 (28)
	Upper respiratory tract infection	20 (11)	16 (8)	6 (6)
	Vulvovaginal candidiasis	17 (9)	22 (11)	8 (8)
	Genitourinary chlamydia infection	16 (9)	10 (5)	8 (8)
	Vaginal discharge	13 (7)	6 (3)	6 (6)
	Vomiting	10 (5)	16 (8)	9 (9)
	Headache	10 (5)	15 (7)	4 (4)
	Malaria	10 (5)	6 (3)	4 (4)
	Nausea	7 (4)	10 (5)	8 (8)
	Morning sickness	3 (2)	5 (2)	6 (6)
	Death	0	0	0

[a]Adverse events and laboratory abnormalities that are reported here were those that occurred in participants who had received at least one dose of a study drug or placebo. Adverse events were coded according to the Medical Dictionary for Regulatory Activities (version 27.1) and graded according to the Division of AIDS Table for Grading the Severity of Adult and Pediatric Adverse Events version 2.1. The pregnancy and postpartum period were defined as the time from the last menstrual period through to 6 weeks after the pregnancy outcome.
[b]Injection site reactions to non-study medications are included, but injection site reactions to the study SUBQ injection are excluded.
[c]Spontaneous abortion (investigator assessed as unrelated to study drug).
[d]Injection site reactions and spontaneous abortions have been excluded.

In addition, supplemental pregnancy and birth outcome data for all pregnancies diagnosed through the end of the RBP were reported. A total of 712 pregnancies were identified among 665 participants, including 269 pregnancies in the LEN group, 302 in the FTC/TAF group, and 141 in the FTC/TDF group (Table 4).[7,16] Pregnancy and birth outcomes in this expanded follow-up period were generally consistent with those observed in the primary analysis.[7]

Table 4. PURPOSE 1: Supplemental Pregnancy Outcomes Through the End of the RBP[16]

Pregnancy Outcomes, n or n (%)	LEN (n=253)	FTC/TAF (n=280)	FTC/TDF (n=132)	Total (n=665)
Participants with confirmed pregnancies	253	280	132	665
Confirmed pregnancies	269	302	141	712
Total Pregnancy Outcomes[a]	272	304	141	717
Live births	172 (63)	167 (55)	84 (60)	423 (59)
At term (≥37 to ≤42 weeks'	139 (81)	127 (76)	61 (73)	327 (77)

Pregnancy Outcomes, n or n (%)	LEN (n=253)	FTC/TAF (n=280)	FTC/TDF (n=132)	Total (n=665)
gestation)				
Preterm (<37 weeks' gestation)	22 (13)	28 (17)	18 (21)	68 (16)
Post-term (>42 weeks' gestation)	11 (6)	12 (7)	5 (6)	28 (7)
Congenital abnormality	6 (3)	7 (4)	1 (1)	14 (3)
Small for gestational age[b]	22 (13)	15 (9)	10 (12)	47 (11)
Pregnancy losses	91 (33)	123 (40)	53 (38)	267 (37)
Stillbirth[c]	9 (3)	8 (3)	4 (3)	21 (3)
Induced or elective abortions	49 (18)	71 (23)	28 (20)	148 (21)
Spontaneous abortions[d]	33 (12)	44 (14)	21 (15)	98 (14)
Pregnancies with Unknown Outcomes[e]	9 (3)	14 (5)	4 (3)	27 (4)

[a]A single pregnancy may include multiple outcomes/births (five sets of twins: three sets in participants randomized to LEN and two sets in participants randomized to FTC/TAF). Birth outcomes were reported for each individual infant.
[b]Small for gestational age was defined as weight <10th percentile by sex/gestational age.
[c]Stillbirth/intrauterine fetal demise defined as occurring ≥20 weeks' gestation. There was one set of stillbirth twins in the LEN group.
[d]Spontaneous abortion defined as occurring at <20 weeks' gestation.
[e]Unknown due to participant discontinuation for the following reasons: pregnancy (LEN, n=3; FTC/TAF, n=4; FTC/TDF, n=1); investigator's discretion (FTC/TAF, n=2); withdrew consent (LEN, n=5; FTC/TAF, n=5); lost to follow-up (FTC/TAF, n=2; FTC/TDF, n=1); completed study (LEN, n=1; FTC/TAF, n=1; FTC/TDF, n=1); ongoing pregnancy (FTC/TDF, n=1).

A nested PK substudy of participants who were randomly assigned to the LEN group and became pregnant during the study was conducted to assess systemic LEN concentrations during pregnancy and postpartum, as well as LEN concentrations in breast milk and infants. Maternal plasma PK samples were collected in regular intervals throughout the first, second, and third trimesters, and maternal plasma, infant plasma, and breast milk samples were obtained at approximately 3 and 6 months postpartum.[7]

Overall, 601 participants were included in the population PK analysis, including 296 participants who became pregnant while receiving LEN and had at least one quantifiable PK sample collected during pregnancy. Pregnant participants received SUBQ LEN injections in the thigh or abdomen.[7] At Weeks 26, 52, and 78, C_{trough} data were available from 107 first-trimester, 99 second-trimester, 59 third-trimester, and 65 postpartum visits.[15]

No observable trimester-related trends in LEN were identified across pregnancy trimesters or during the postpartum period.[7] Model-derived LEN C_{max} and C_{trough} concentrations were comparable across participants between pregnancy trimesters, postpartum, and non-pregnant individuals.[15] Population PK analyses further demonstrated that gestational age, pregnancy trimester, and postpartum status were not statistically significant covariates of LEN exposure. LEN PK were also similar when LEN was injected in the thigh or the abdomen.[7]

BIC Phase 1b Study

A phase 1b, single-arm, open-label study evaluated PK parameters and virologic outcomes in 33 pregnant women with HIV-1 treated with BIC/FTC/TAF for up to 38 weeks. Participants were aged between 18 and 40 years, with a VL <50 c/mL on a stable ARV regimen for ≥6 months. Intensive steady-state PK sampling and HIV VL testing were performed during pregnancy and 6 to 12 weeks postpartum; neonates underwent sparse washout PK sampling (6 and 12 weeks).[10,11]

BIC plasma concentrations during the second/third trimesters were generally lower than those observed at postpartum Weeks 6 and 12; however, C_{trough} levels remained above the $paEC_{95}$ value of 0.162 mcg/mL. The mean BIC AUC_{τ} in pregnant women was similar to that observed in non-pregnant adult PWH (Table 5).[10,11]

Table 5. Phase 1b Study: BIC PK Outcomes[10,11]

Parameter, Mean (%CV)	Second Trimester (n=21)	Third Trimester (n=30)	Postpartum Week 6 (n=31)	Postpartum Week 12 (n=32)	Third Trimester vs Postpartum Week 12, %GLSM Ratio (90% CI)	Non-Pregnant Adult PWH
Total AUC_{τ}, h × mcg/mL	62.8 (32.2)	60.2 (29.1)	135 (26.9)	148 (28.5)	40.6 (36.8–44.8)	102 (26.9)
Unbound AUC_{τ}, h × mcg/mL	0.224 (42)	0.219 (33.9)	0.354 (34.2)	0.374 (32.2)	58.8 (52.7–65.7)	–
C_{max}, mcg/mL	5.82 (30.1)	5.37 (25.9)	9.77 (23.3)	11 (24.9)	48.2 (43–53.9)	6.15 (22.9)
C_{trough}, mcg/mL	1.05 (45.2)	1.07 (41.7)	3.53 (38.4)	3.64 (34.1)	29 (25.7–32.7)	2.61 (35.2)

Abbreviation: GLSM=geometric least-squares mean.

PK parameters indicated that BIC crosses the placenta (mean [%CV] cord blood to maternal blood plasma concentration ratio: 1.4 [35%]; n=29), and the median $t_{1/2}$ was longer in neonates than in postpartum women (43.1 hours [n=10] vs ~18 hours, respectively).[10,11]

All participants maintained virologic suppression during pregnancy and delivery and through to postpartum Week 18 (1 discontinuation due to protocol violation). No treatment-emergent resistance occurred during the study. No MTCT occurred.[10,11]

Most AEs were Grade 1/2 in severity (Table 6). No AE-related discontinuations occurred.[10,11]

Table 6. Phase 1b Study: Maternal and Neonatal Safety Outcomes[10,11]

Safety Outcomes, n (%)	Maternal Outcomes (N=33)	Neonatal Outcomes (N=29)
Any AE	26 (79)	12 (41)
Common AEs	Back pain: 4 (12) Gestational diabetes: 4 (12) Anemia: 3 (9); False labor: 3 (9) Preeclampsia: 3 (9)	Neonatal jaundice: 3 (10) Respiratory distress: 3 (10)
Grade ≥3 AEs	2 (6)[a]	1 (3)[b]
Drug-related AEs	1 (3)[c]	0
Serious AEs	6 (18)	5 (17)

[a]Gestational diabetes and pyrexia, n=1 each. [b]Neonatal asphyxia. [c]False labor.

BIC Phase 4 Study

A prospective, open-label, multicenter, phase 4 study (IMPAACT 2026) evaluated PK parameters and safety outcomes in pregnant women with HIV (N=27) who received 50 mg oral BIC once daily during the second and/or third trimester. Intensive steady-state 24-hour PK sampling and HIV VL testing were performed during pregnancy and 6 to 12 weeks postpartum. Relative to paired postpartum data (2-sided significance level, 0.1), the median BIC AUC_{0-24} and C_{max} were 46% (P=0.002) and 35% (P<0.1) lower, respectively, at the second trimester (n=12) and 52% (P<0.0001) and 44% (P<0.1) lower, respectively, at the third trimester (n=24). Three women had C_{trough} levels below the BIC $paEC_{95}$ during the third trimester. Seven of the 12 women (58%) with data in the second trimester and 16 of the 27 women (59%) in the third trimester had a BIC AUC <10th percentile for non-pregnant women, and none had an HIV VL ≥40 c/mL. Five women had ≥1 Grade 3 AE and none of the AEs were attributed to BIC use. All 15 infants with sufficient virologic test results

(defined as HIV- on two tests, taken after 1 month of age and after 4 months of age) were HIV-free; an additional 9 infants were determined to be probably HIV-free; 2 infants did not have a definitive HIV status. Two infants had Grade 1 congenital abnormalities (preauricular cyst, n=1; ventricular septal defect related to BIC, n=1).[12]

Additional BIC PK Data

Another study evaluated PK outcomes in pregnant women with HIV (N=9) during the third trimester and 4 to 6 weeks postpartum, as well as in cord blood at delivery. Blood samples were taken predose and at regular intervals up to 24 hours after dosing. Although BIC exposure was lower in the third trimester than at postpartum, C_{trough} levels remained above the estimated BIC $paEC_{95}$ in all participants throughout, and no incidences of virologic failure occurred. No infants acquired HIV, and no congenital anomalies were reported.[13]

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Abbreviations

%CV=percent coefficient of variation
AE=adverse event
APR=Antiretroviral Pregnancy Registry
ART=antiretroviral therapy
ARV=antiretroviral
AUC=area under the concentration-time curve
$AUC_{0–24}$=area under the concentration-time curve from time 0 through 24 hours post dose
AUC_T=area under the concentration-time curve over the dosing interval
BIC=bictegravir
c/mL=copies per mL
CDC=Centers for Disease Control
CI=confidence interval
C_{max}=peak concentration
C_{trough}=trough plasma concentration
eGFR=estimated glomerular filtration rate
FTC=emtricitabine
GLSM=geometric least-squares mean
LEN=lenacapavir
MACDP=Metropolitan Atlanta Congenital Defects Program
MTCT=mother-to-child transmission
$paEC_{95}$=protein-adjusted effective concentration to cause inhibition by 95%
PK=pharmacokinetic
PrEP=pre-exposure prophylaxis
PWH=people with HIV
RBP=randomized blinded phase
SUBQ=subcutaneous
$t_{1/2}$=elimination half-life
TAF=tenofovir alafenamide
TDF=tenofovir disoproxil fumarate
TBDR=Texas Birth Defects Registry
VL=viral load
VS=virologically suppressed

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Product Label

For the full indication, important safety information, and boxed warning(s), please refer to the BIXLENVO US Prescribing Information available at: www.gilead.com/-/media/files/pdfs/medicines/hiv/BIXLENVO/BIXLENVO_pi.

Follow-Up

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Gilead Global Patient Safety ☎ 1-800-445-3235, option 3 or
🖱 www.gilead.com/utility/contact/report-an-adverse-event

FDA MedWatch Program by ☎ 1-800-FDA-1088 or ✉MedWatch, FDA, 5600 Fishers Ln, Rockville, MD 20852 or 🖱 www.accessdata.fda.gov/scripts/medwatch

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