Gabapentin

Clinical use

Anti-epileptic – adjunctive treatment of partial seizures with or without secondary generalisation

Neuropathic pain

Dose in normal renal function

300 mg on day 1, 300 mg twice daily on day 2, 300 mg three times daily on day 3, then increased according to response to 1.2 g daily (in three divided doses). If necessary may be further increased in steps of 300 mg daily to a maximum 2.4 g daily. Usual range 0.9–1.2 g daily; maximum period between doses should not exceed 12 hours

Neuropathic pain: loaded as above but maximum 1.8 g daily

Pharmacokinetics

Molecular weight (daltons) 171.2
% Protein binding <3
% Excreted unchanged in urine ≈100
Volume of distribution (L/kg) 1.0
Half-life – normal/ESRF (hrs) 5–7/prolonged

Dose in renal impairment

GFR (mL/min)

60–90  400 mg three times daily
30–60  300 mg twice daily
15–30  300 mg once daily
<15   300 mg on alternate days

Dose in patients undergoing renal replacement therapies

CAPD  Probably dialysed. Dose as in GFR < 15 mL/min
HD    Dialysed. Loading dose of 300–400 mg in patients who have never received gabapentin. Maintenance dose of 200–300 mg after each HD session
CAV/VVHD  Dialysed. Dose as in GFR = 15–30 mL/min

Important drug interactions

Potentially hazardous interactions with other drugs

• Antacids reduce absorption
• Antidepressants: antagonism of anticonvulsive effect (convulsive threshold lowered)

Administration

Reconstitution –

Route
• Oral

Rate of administration –

Comments –

Other information

• Can cause false positive readings with some urinary protein tests
• In patients with moderate to severe renal impairment, start with the lowest possible dose and titrate upwards according to response
Ganciclovir

**Clinical use**

Antiviral agent
- **IV:** treatment of life- or sight-threatening cytomegalovirus (CMV) in immunocompromised people and for CMV prophylaxis in immunosuppressed patients secondary to organ transplantation
- **Oral:** maintenance treatment of CMV retinitis in AIDS patients (licensed), prophylaxis and maintenance against CMV infection in immunosuppressed patients (unlicensed use)

**Dose in normal renal function**

**IV treatment:**
- Induction/Treatment of active CMV disease: 5 mg/kg 12-hourly for 14–21 days
- Maintenance for CMV retinitis: 6 mg/kg per day for 5 days per week or 5 mg/kg per day 7 days per week
- Prevention of CMV retinitis: as per treatment except induction length 7–14 days
- **Oral treatment:** Maintenance for CMV retinitis, or prophylaxis in immunosuppressed patients: 1000 mg three times per day

**Pharmacokinetics**

- Molecular weight (daltons) 277
- % Protein binding <2
- % Excreted unchanged in urine 90–100
- Volume of distribution (L/kg) 0.47
- Half-life-normal/ESRF (hrs) 2.9/30

**Dose in renal impairment**

**GFR (mL/min)**

- 20–50 See ‘Other information’
- 10–20 See ‘Other Information’
- <10 See ‘Other Information’

**Dose in patients undergoing renal replacement therapies**

- **CAPD** Dialysed. Oral and IV: dose as in GFR = <10 mL/min
- **HD** Dialysed. IV: 1.25 mg/kg every day, given post dialysis on dialysis days. PO: 500 mg three times a week, given post dialysis on dialysis days
- **CAV/VVHD** Dialysed. IV: 2.5 mg/kg per day. PO: 500 mg once daily

**Important drug interactions**

**Potentially hazardous interactions with other drugs**
- Increased risk of myelosuppression with other myelosuppressive drugs
- Profound myelosuppression with zidovudine
- Generalised seizures reported with imipenem-cilastatin

**Administration**

**Reconstitution**
- Reconstitute 1 vial (500 mg) with 10 mL water for injection (50 mg/mL)
- Then transfer dose to 100 mL sodium chloride 0.9%

**Route**
- IV peripherally in fast-flowing vein or centrally – see below

**Rate of administration**
- Over 1 hour

**Comments**
- May give 50% dose over 15 minutes after HD in washback (unlicensed)

**Other information**

**IV dosage:**

<table>
<thead>
<tr>
<th>Creatinine clearance (mL/min)</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;70</td>
<td>5 mg/kg 12-hourly</td>
</tr>
<tr>
<td>50–69</td>
<td>2.5 mg/kg 12-hourly</td>
</tr>
<tr>
<td>25–49</td>
<td>2.5 mg/kg 24-hourly</td>
</tr>
<tr>
<td>10–24</td>
<td>1.25 mg/kg 24-hourly</td>
</tr>
<tr>
<td>&lt;10</td>
<td>1.25 mg/kg 24-hourly, given after haemodialysis on dialysis days</td>
</tr>
</tbody>
</table>

**Oral dose:**

<table>
<thead>
<tr>
<th>Creatinine clearance (mL/min)</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;70</td>
<td>1000 mg three times a day</td>
</tr>
<tr>
<td>50–69</td>
<td>1500 mg daily</td>
</tr>
<tr>
<td>25–49</td>
<td>1000 mg daily</td>
</tr>
<tr>
<td>10–24</td>
<td>500 mg daily</td>
</tr>
<tr>
<td>&lt;10</td>
<td>500 mg three times a week</td>
</tr>
</tbody>
</table>

- Monitor patient for myelosuppression, particularly in patients receiving prophylactic co-trimoxazole therapy
- Pre-dialysis therapeutic blood levels in range 5–12 mg/L
- Not to be infused in concentrations over 10 mg/mL peripherally
- Bioavailability of oral ganciclovir is 5%, so this should only be used for maintenance/prophylactic therapy
**Gemcitabine hydrochloride**

### Clinical use

- Palliative treatment, or first-line treatment with cisplatin, of locally advanced or metastatic non-small-cell lung cancer
- Treatment of pancreatic cancer
- Treatment of bladder cancer in combination with cisplatin

### Dose in normal renal function

- NSLC: 1000 mg/m² weekly for 3 weeks, 1 week rest then repeat
- Pancreatic: 1000 mg/m² weekly for 7 weeks, rest for 1 week then weekly for 3 weeks out of 4
- Dose is reduced according to toxicity

### Pharmacokinetics

- Molecular weight (daltons): 299.7
- % Protein binding: negligible
- % Excreted unchanged in urine: <10
- Volume of distribution (L/kg): 12.4 L/m² (women); 17.5 L/m² (men)
- Half-life – normal/ESRF (hrs): 42–94 minutes

### Dose in renal impairment

<table>
<thead>
<tr>
<th>GFR (mL/min)</th>
<th>Dose</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>20–50</td>
<td>As in normal renal function</td>
<td></td>
</tr>
<tr>
<td>10–20</td>
<td>Use with caution. Reduce dose</td>
<td></td>
</tr>
<tr>
<td>&lt;10</td>
<td>Avoid</td>
<td></td>
</tr>
</tbody>
</table>

### Dose in patients undergoing renal replacement therapies

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Dose</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAPD</td>
<td>Likely to be dialysed. Dose as in GFR = 10–20 mL/min</td>
<td></td>
</tr>
<tr>
<td>HD</td>
<td>Likely to be dialysed. Dose as in GFR = 10–20 mL/min</td>
<td></td>
</tr>
<tr>
<td>CAV/VVHD</td>
<td>Likely to be dialysed. Dose as in GFR = 10–20 mL/min</td>
<td></td>
</tr>
</tbody>
</table>

### Important drug interactions

- **Potentially hazardous interactions with other drugs**
  - None known

### Administration

- **Reconstitution**
  - Reconstitute with sodium chloride 0.9%, 5 mL to 200 mg vial and 25 mL to 1 g vial
  - Can be further diluted in sodium chloride 0.9% if required

- **Route**
  - IV

- **Rate of administration**
  - 30 minutes

- **Comments**
  - 

### Other information

- Gemcitabine causes reversible haematuria with or without proteinuria in about 50% of patients
- There is no evidence for cumulative renal toxicity with repeated dosing of gemcitabine
- Haemolytic uraemic syndrome (HUS) has been reported with a crude incidence rate of 0.015%
- A study looking at the use of gemcitabine 500–1000 mg/m² administered IV on days 1, 8 and 15 every 28 days in patients with renal dysfunction, concluded that this regimen was well tolerated in patients with a GFR as low as 30 mL/min
- Another study in patients with serum creatinines in the range 130–420 micromol/L at doses of 650–800 mg/m² weekly for 3 weeks out of a 4-week cycle, found dose-limiting toxicities, including neutropenia, fever, raised transaminases and increased serum creatinine. It was concluded that a reduced dose of gemcitabine may be appropriate in patients with established renal impairment
## Gemfibrozil

### Clinical use

Hyperlipidaemias of types IIa, IIb, III, IV and V

### Dose in normal renal function

1.2 g daily, usually in two divided doses; range 0.9–1.5 g daily

### Pharmacokinetics

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Molecular weight (daltons)</td>
<td>250</td>
</tr>
<tr>
<td>% Protein binding</td>
<td>95</td>
</tr>
<tr>
<td>% Excreted unchanged in urine</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Volume of distribution (L/kg)</td>
<td>–</td>
</tr>
<tr>
<td>Half-life – normal/ESRF (hrs)</td>
<td>1.5/1.5–2.4</td>
</tr>
</tbody>
</table>

### Dose in renal impairment

<table>
<thead>
<tr>
<th>GFR (mL/min)</th>
<th>Dose</th>
<th>Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>20–50</td>
<td>Initially 900 mg daily</td>
<td>Monitor carefully</td>
</tr>
<tr>
<td>10–20</td>
<td>Initially 900 mg daily, Monitor carefully</td>
<td></td>
</tr>
<tr>
<td>&lt;10</td>
<td>Initially 900 mg daily, Monitor carefully</td>
<td></td>
</tr>
</tbody>
</table>

### Dose in patients undergoing renal replacement therapies

- **CAPD**: Not dialysed. Dose as in GFR = <10 mL/min
- **HD**: Not dialysed. Dose as in GFR = <10 mL/min
- **CAV/VVHD**: Not dialysed. Dose as in GFR = 10–20 mL/min

### Important drug interactions

**POTENTIALLY HAZARDOUS INTERACTIONS WITH OTHER DRUGS**

- Enhanced anticoagulant effect seen with acenocoumarol, phenindione and warfarin
- Ciclosporin: Parke-Davis have one report on file of an interaction with ciclosporin where serum ciclosporin levels were decreased. No effects on muscle were noted
- Statins: increased risk of myopathy

### Administration

**RECONSTITUTION**

- 

**ROUTE**

- Oral

**RATE OF ADMINISTRATION**

- 

**COMMENTS**

- 

### Other information

- Adverse effects have not been reported in patients with renal disease, but such patients should start treatment at 900 mg daily, which may be increased after careful assessment of response and renal function
- Rare cases of rhabdomyolysis may be increased in those with renal impairment
- Approximately 60–70% is excreted in the urine as both conjugated and unconjugated drug
- Gemfibrozil alone has caused myalgia and myositis, but the effects appear to occur much more frequently and are more severe when an HMG CoA reductase inhibitor is also used. The combination is therefore not recommended
Gentamicin

**Clinical use**
Antibacterial agent

**Dose in normal renal function**
3–7 mg/kg (ideal body weight) daily (divided into 1–4 doses). CAPD peritonitis – see local policy and below

**Pharmacokinetics**
- Molecular weight (daltons): 1418
- % Protein binding: 0–20
- % Excreted unchanged in urine: 95
- Volume of distribution (L/kg): 0.23–0.26
- Half-life – normal/ESRF (hrs): 2/20–60

**Dose in renal impairment**

**GFR (mL/min)**
See ‘Other information’ for dosage for dialysis and for single daily dosing regimen

- 30–70: 80 mg 12-hourly (60 mg if <60 kg)
- 10–30: 80 mg 24-hourly (60 mg if <60 kg)
- 5–10: 80 mg 48-hourly (60 mg if <60 kg) or post dialysis if on HD

**Dose in patients undergoing renal replacement therapies**

- **CAPD**: Dialysed. CAPD clearance is about 3 mL/min. Dose as in GFR = 5–10 mL/min. Monitor levels
- **HD**: Dialysed. Dose as in GFR = 5–10 mL/min. Give after dialysis
- **CAV/VVHD**: Dialysed. Dose in GFR = 10–30 mL/min and measure levels

**Important drug interactions**

- **Potentially hazardous interactions with other drugs**
  - Ciclosporin: increased risk of nephrotoxicity
  - Muscle relaxants: effect of tubocurarine enhanced
  - Cytotoxics: increased risk of nephrotoxicity with cisplatin
  - Cholinergics: antagonism of effect of neostigmine and pyridostigmine
  - Botulinum toxin: neuromuscular block enhanced (risk of toxicity)

**Administration**

**Reconstitution**

- **Route**
  - **Bolus IV injection or short infusion** – maximum 100 mL

**Rate of administration**

- **Bolus IV**: over not less than 3 minutes. Short infusion: over not more than 20 minutes

**Comments**

- **Other information**
  - **Adjustment for renal impairment**: Dialysis patients – 80 mg (or up to 2 mg/kg) post dialysis
  - **Single daily dosing regimen**: GFR >80: 5.1 mg/kg every 24 hours
    GFR 60–80: 4.0 mg/kg every 24 hours
    GFR 40–60: 3.5 mg/kg every 24 hours
    GFR 30–40: 2.5 mg/kg every 24 hours
    GFR 20–30: 4.0 mg/kg every 48 hours
    GFR 10–20: 3.0 mg/kg every 48 hours
    GFR <10: 2.0 mg/kg every 48 hours
  - **Concurrent penicillins may result in sub-therapeutic blood levels**
  - **Monitor blood levels. 1 hour post-dose, peak levels must not exceed 10 mg/L. Pre-dose trough levels should be less than 2 mg/L**
  - **Empirical IP therapy for CAPD peritonitis in conjunction with vancomycin. A common regimen used is gentamicin 4–5 mg/L + vancomycin IP at dose of 1–2 g stat on days 1 and 7 of course. Monitoring of blood levels is advisable, as absorption is increased by inflamed peritoneum**
  - **Potential nephrotoxicity of the drug may worsen residual renal function**
  - **Long-term concurrent use of gentamicin with teicoplanin causes additive ototoxicity**
Glibenclamide

Clinical use
Non-insulin-dependent diabetes mellitus

Dose in normal renal function
Initially 5 mg daily (elderly patients – 2.5 mg) adjusted according to response; maximum 15 mg daily

Pharmacokinetics
- Molecular weight (daltons) 494
- % Protein binding 98–99
- % Excreted unchanged in urine <5
- Volume of distribution (L/kg) 0.15–0.2
- Half-life – normal/ESRF (hrs) 5–10/

Dose in renal impairment

<table>
<thead>
<tr>
<th>GFR (mL/min)</th>
<th>Initial dose</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>20–50</td>
<td>1.25–2.5 mg once a day</td>
<td>Monitor closely</td>
</tr>
<tr>
<td>10–20</td>
<td>1.25–2.5 mg once a day</td>
<td>Monitor closely</td>
</tr>
<tr>
<td>&lt;10</td>
<td>1.25–2.5 mg once a day</td>
<td>Use with caution with continuous monitoring</td>
</tr>
</tbody>
</table>

Dose in patients undergoing renal replacement therapies

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Initial Dose</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAPD</td>
<td>Not dialysed. Dose as in GFR = &lt;10 mL/min</td>
<td></td>
</tr>
<tr>
<td>HD</td>
<td>Low dialysability. Dose as in GFR = &lt;10 mL/min</td>
<td></td>
</tr>
<tr>
<td>CAV/VVHD</td>
<td>Unknown dialysability. Dose as in GFR = 10–20 mL/min</td>
<td></td>
</tr>
</tbody>
</table>

Important drug interactions

Potentially hazardous interactions with other drugs
- Analgesics: azapropazone, phenylbutazone and possibly other NSAIDs enhance effect
- Antibacterials: chloramphenicol, co-trimoxazole, 4-quinolones, sulphonamides and trimethoprim enhance effect
- Antifungals: fluconazole and miconazole increase glibenclamide plasma concentration
- Uricosurics: sulfinpyrazone enhances effect of glibenclamide

Administration

Reconstitution
- Route
  - Oral
Rate of administration
- Comments
  - Take with breakfast

Other information

- The metabolites of glibenclamide are only weakly hypoglycaemic, this is not clinically relevant where renal and hepatic functions are normal. If CLcr <10 mL/min, accumulation of metabolite and unchanged drug in plasma may cause prolonged hyperglycaemia
- Company information states that use is contra-indicated in severe renal impairment
- Compensatory excretion via bile in faeces occurs in renal impairment
Gliclazide

Clinical use
Non-insulin-dependent diabetes mellitus

Dose in normal renal function
Initially: 40–80 mg daily, adjusted according to response up to 160 mg as a single dose, with breakfast; higher doses divided. Maximum 320 mg daily

Pharmacokinetics
Molecular weight (daltons) 323
% Protein binding 85–95
% Excreted unchanged in urine <5
Volume of distribution (L/kg) 0.24
Half-life – normal/ESRF (hrs) 8–11/prolonged

Dose in renal impairment
GFR (mL/min)
20–50 Initially 20–40 mg daily. Use with caution and monitor
10–20 Initially 20–40 mg daily. Use with caution and monitor
<10 Initially 20–40 mg daily. Use with great caution and monitor closely

Dose in patients undergoing renal replacement therapies
CAPD Unlikely dialysability. Dose as in GFR = <10 mL/min
HD Unlikely dialysability. Dose as in GFR = <10 mL/min
CAV/VVHD Unknown dialysability. Dose as in GFR = 10–20 mL/min

Important drug interactions
Potentially hazardous interactions with other drugs
• Analgesics: azapropazone, phenylbutazone and possibly other NSAIDs enhance effect
• Antibacterials: chloramphenicol, co-trimoxazole, 4-quinolones, sulphamides and trimethoprim enhance effect
• Antifungals: fluconazole and miconazole increase gliclazide plasma concentration
• Uricosurics: sulfinpyrazone enhances effect

Administration
Reconstitution
–
Route
• Oral
Rate of administration
–
Comments
–

Other information
• Care should be exercised in patients with hepatic and/or renal impairment and a small starting dose should be used with careful patient monitoring
• Company contra-indicates prescribing of Diamicron in severe renal impairment which they define as CLcr below 40 mL/min
Glimepiride

Clinical use
Non-insulin-dependent diabetes mellitus

Dose in normal renal function
1–4 mg daily. Maximum 6 mg daily taken shortly before or with first main meal

Pharmacokinetics
Molecular weight (daltons) 490.6
% Protein binding >99
% Excreted unchanged in urine 58–60 (as metabolites)
Volume of distribution (L/kg) 8.8
Half-life – normal/ESRF (hrs) 5–9/prolonged

Dose in renal impairment
GFR (mL/min)
20–50  Dose as in normal renal function
10–20  Dose as in normal renal function
<10   Contra-indicated

Dose in patients undergoing renal replacement therapies
CAPD  Unlikely dialysability. Dose as in GFR = <10 mL/min
HD    Unlikely dialysability. Dose as in GFR = <10 mL/min
CAV/VVHD  Unlikely dialysability. Dose as in GFR = 10–20 mL/min

Important drug interactions

POTENTIALLY HAZARDOUS INTERACTIONS WITH OTHER DRUGS
• Azapropazone, phenylbutazone and possibly other NSAIDs enhance effect of sulphonylureas
• Antibacterials: chloramphenicol, co-trimoxazole, 4-quinolones, sulphonamides and trimethoprim enhance effect
• Antifungals: fluconazole and miconazole increase sulphonylurea plasma concentration
• Sulfinpyrazone enhances effect

Administration
RECONSTITUTION
–
ROUTE
• Oral
RATE OF ADMINISTRATION
–
COMMENTS
–

Other information
–
Glipizide

Clinical use
Non-insulin-dependent diabetes mellitus

Dose in normal renal function
Initially 2.5–5 mg daily, adjusted according to response; maximum 20 mg daily; up to 15 mg may be given as a single dose before breakfast; higher doses divided

Pharmacokinetics
Molecular weight (daltons) 445
% Protein binding 97
% Excreted unchanged in urine 4.5–7
Volume of distribution (L/kg) 0.13–0.16
Half-life – normal/ESRF (hrs) 3–7/

Dose in renal impairment
GFR (mL/min)
20–50 Initially 2.5 mg daily. Use with caution
10–20 Initially 2.5 mg daily. Use with caution
<10 Contra-indicated

Dose in patients undergoingenal replacement therapies
CAPD Dialysability insignificant, however contra-indicated if GFR <10 mL/min
HD Dialysability insignificant, however contra-indicated if GFR <10 mL/min
CAV/VVHD Dialysability insignificant. Dose as in GFR = 10–20 mL/min

Important drug interactions
Potentially hazardous interactions with other drugs
• Azapropazone, phenylbutazone and possibly other NSAIDs enhance effect of sulphonylureas
• Antibacterials: chloramphenicol, co-trimoxazole, 4-quinolones, sulphonamides and trimethoprim enhance effect
• Antifungals: fluconazole and miconazole increase glipizide plasma concentration
• Sulfinpyrazone enhances effect

Administration
Reconstitution
–
Route
• Oral
Rate of administration
–
Comments
–

Other information
• Company does not recommend the use of Glibenese in patients with renal insufficiency
• Renal or hepatic insufficiency may cause elevated blood levels of glipizide (increased risk of serious hypoglycaemic reactions)
Granisetron

Clinical use
Prevention or treatment of nausea and vomiting induced by cytotoxic chemotherapy, radiotherapy or post-operative nausea and vomiting

Dose in normal renal function
Cytotoxic chemotherapy or radiotherapy:
PO: 1–2 mg within 1 hour before start of treatment, then 2 mg daily in 1–2 divided doses during treatment
IV: 3 mg before start of cytotoxic therapy; up to two additional 3 mg doses can be given within 24 hours no less than 10 minutes apart
Operative procedures: IV: 1 mg before induction of anaesthesia; treatment: 1 mg (maximum 2 mg in one day)

Pharmacokinetics
Molecular weight (daltons) 312.4 (348.9 as hydrochloride)
% Protein binding ≈65
% Excreted unchanged in urine <20
Volume of distribution (L/kg) 3
Half-life – normal/ESRF (hrs) 3.0–4.0/unchanged

Dose in renal impairment
GFR (mL/min)
20–50  Dose as in normal renal function
10–20  Dose as in normal renal function
<10   Dose as in normal renal function

Dose in patients undergoing renal replacement therapies
CAPD   Unknown dialysability. Dose as in normal renal function
HD     Unknown dialysability. Dose as in normal renal function. Company recommend timing HD for greater than 2 hours after granisetron dose
CAV/VVHD Unknown dialysability. Dose as in normal renal function

Important drug interactions
Potentially hazardous interactions with other drugs
• None known

Administration
Reconstitution
–
Route
• Oral, IV bolus, IV infusion
Rate of administration
• IV bolus: diluted in 5 mL sodium chloride 0.9% over not less than 30 seconds
• IV infusion: 20–50 mL over 5 minutes
Comments
• Compatible with sodium chloride 0.9%, sodium chloride 0.18% and glucose 4% solution, glucose 5%, Hartmann’s solution, compound sodium lactate, 10% mannitol
• Maximum administered dose over 24 hours should not exceed 9 mg

Other information
• No special dosing adjustments necessary in patients with renal or hepatic failure
Griseofulvin

Clinical use
Antifungal agent: dermatophyte infections of the skin, scalp, hair and nails

Dose in normal renal function
500 mg daily, in divided doses or as a single dose In severe infection dose may be doubled

Pharmacokinetics
Molecular weight (daltons) 353
% Protein binding 84
% Excreted unchanged in urine 1
Volume of distribution (L/kg) 1.6
Half-life – normal/ESRF (hrs) 9.5–21/20

Dose in renal impairment
GFR (mL/min)
20–50  Dose as in normal renal function
10–20  Dose as in normal renal function
<10   Dose as in normal renal function

Dose in patients undergoing renal replacement therapies
CAPD  Not dialysed. Dose as in normal renal function
HD    Not dialysed. Dose as in normal renal function
CAV/VVHD  Not dialysed. Dose as in normal renal function

Important drug interactions

Potentially hazardous interactions with other drugs
• Anticoagulants: metabolism of acenocoumarol and warfarin accelerated (reduced anticoagulant effect)
• Metabolism of oral contraceptives accelerated (reduced contraceptive effect)
• Ciclosporin: griseofulvin possibly reduces plasma – ciclosporin concentration. (Two reports of such an interaction in literature.)

Administration
Reconstitution
–
Route
• Oral
Rate of administration
–
Comments
–

Other information
• Use with extreme caution in patients with SLE