Effect of Coadministration of Single and Multiple Doses of Rifampicin on the Pharmacokinetics of Fexofenadine Enantiomers in Healthy Subjects

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ABSTRACT

The effect of rifampicin on the pharmacokinetics of fexofenadine enantiomers was examined in healthy subjects who received fexofenadine alone or with single or multiple doses of rifampicin (600 mg). A single coadministered dose of rifampicin significantly decreased the oral clearance (CL\textsubscript{tot}/F) and renal clearance (CL\textsubscript{r}) of S- and R-fexofenadine by 76 and 62%, and 73 and 62%, respectively. Even after multiple doses, rifampicin significantly decreased these parameters, although the effect on the CL\textsubscript{tot}/F was slightly blunted. Multiple doses of rifampicin abolished the difference in the CL\textsubscript{tot}/F of fexofenadine enantiomers, whereas the stereoselectivity in the CL\textsubscript{r} persisted. Rifampicin inhibited the uptake of fexofenadine enantiomers by human hepatocytes via organic anion transporter (OAT) OATP1B3 and its basal-to-apical transport in Caco-2 cells, but not OAT3-mediated or multidrug and toxic compound extrusion 1 (MATE1)-mediated transport. The plasma-unbound fraction of S-fexofenadine was 1.8 times higher than that of R-fexofenadine. The rifampicin-sensitive uptake by hepatocytes was 1.6 times higher for R-fexofenadine, whereas the transport activities by OATP1B3, OAT3, MATE1, or P-glycoprotein were identical for both enantiomers. S-fexofenadine is a more potent human histamine H1 receptor antagonist than R-fexofenadine. In conclusion, rifampicin has multiple interaction sites with fexofenadine, all of which contribute to increasing the area under the curve of fexofenadine when they are given simultaneously, to surpass the effect of the induction of P-glycoprotein elicited by multiple doses.

INTRODUCTION

Drug-drug interactions (DDIs) involving metabolism and/or excretion processes alter the pharmacokinetics of victim drugs, and consequently their pharmacological/adverse effects. They are one of the leading causes of withdrawal of new drugs from the market. Recent progress in the study of membrane transport has expanded our understanding of the mechanisms underlying pharmacokinetic DDIs involving transporters (Giacomini et al., 2010; Yoshida et al., 2012).

Fexofenadine, a selective and nonsedative histamine H1 receptor antagonist, is one of the most frequently used treatments for seasonal allergic rhinitis and chronic urticaria. Because fexofenadine is hardly metabolized by cytochrome P450, transporters play an indispensable role in fexofenadine pharmacokinetics. Actually, it is a substrate of OATP1A2, OATP1B3, OATP2B1, OAT3, MATE1, BSEP, MRP2, MRP3, and P-glycoprotein (P-gp) (Cvetkovic et al., 1999; Nozawa et al., 2004; Shimizu et al., 2005; Tahara et al., 2005, 2006; Matsushima et al., 2008a, 2009; Tian et al., 2008). A number of drug interaction studies have been conducted in healthy subjects where fexofenadine was used as victim drug. These studies show the impact of inhibition of P-gp-mediated efflux in the small intestine by erythromycin, itraconazole, ketoconazole, ritonavir and verapamil on the systemic exposure of fexofenadine (Dresser et al., 2002; Tachibana et al., 2009) and the impact of inhibition of OAT3 and MATE1 by benzenecid and cimetidine, respectively, on the urinary excretion and systemic exposure of fexofenadine (Yasui-Furukori et al., 2005; Tahara et al., 2005, 2006; Matsushima et al., 2009). However, the impact of inhibition of hepatic elimination on fexofenadine pharmacokinetics remains to be evaluated although hepatic elimination is the major elimination pathway of fexofenadine from the systemic circulation (Lappin et al., 2010).

We suggested that OATP1B3, a multispecific organic anion transporter (OAT) predominantly expressed in the liver, mediates the hepatic uptake of fexofenadine based on in vitro experiments.
was simultaneously administered 60 mg of fexofenadine hydrochloride with
volunteers received 600 mg rifampicin (Rifadin; Daiichi-Sankyo Pharmaceu-
received 60 mg of fexofenadine hydrochloride (Allegra; Aventis Pharma Ltd,
was negligible when fexofenadine was given to the subjects. Furthermore,
fexofenadine is administered therapeutically as a racemic mixture of S- and R-enantiomers. The plasma concentration of S-
fexofenadine in humans is about 1.5 times lower than that of the corresponding R-fexofenadine, although the underlying mechanism of this difference remains unknown (Robbins et al., 1998; Miura et al., 2007). Notably, the impact of DDI on the CL\(_{\text{u}}\)/F of fexofenadine is stereoselective: a single dose of itraconazole or multiple doses of carbamazepine blunted the stereoselective pharmacokinetics of fexofenadine enantiomers (Tateishi et al., 2008; Sakugawa et al., 2009; Akamine et al., 2012).

We designed this clinical study to investigate the effect of co-
administered rifampicin on the pharmacokinetics of fexofenadine enantiomers in healthy subjects who receive single and multiple doses of rifampicin, and we conducted in vitro studies to support the clinical data.

Materials and Methods

\( ^{[}\text{H}]\text{Estrone-3-sulfate (54.3 Ci/mmol) and [pyridinyl-5-}^{[}\text{H}]\text{-pyrilamine (tH}-\text{mepyramine, 20 Ci/mmol) were purchased from PerkinElmer Life and Analytical Sciences (Boston, MA), and [tH]HCCK-8 (9.75 Ci/mmol) from Amersham Biosciences UK Ltd. (Little Chalfont, Buckinghamshire, UK). R- and S-fexofenadine were purchased from Toronto Research Chemicals Inc. (ON, Canada), and cetirizine was purchased from Sigma-Aldrich (St. Louis, MO). All other chemicals used were commercially available and of analytical grade. Cryopreserved human hepatocytes (TDH and 03-013) were purchased from In Vitro Technologies Inc. (Baltimore, MD) and Life Technologies (Durham, NC), respectively, and kept in liquid nitrogen until use.

Clinical Study in Healthy Subjects. Clinical study was conducted at
Hirosaki University. Twelve healthy Japanese volunteers (eight men and four
women) were enrolled in this study after giving informed written consent. Each
subject was physically normal according to clinical examination and routine
laboratory testing and had no history of significant medical illness or
hypersensitivity to any drugs. Their mean values for age and body weight
were 5.6 years (range, 20–6 years) and 55.7 ± 7.8 kg (range, 42–70 kg), respectively. The Ethics Committee of Hirosaki University School of
Medicine approved this study.

This randomized open-label study consisted of two (control and 6-day
treatment) phases and four study days. In the control phase, the volunteers
received 60 mg of fexofenadine hydrochloride (Allegra; Aventis Pharma Ltd,
Tokyo, Japan) at 8:00 AM after an overnight fast. In the treatment phase, the
volunteers received 600 mg rifampicin (Rifadin; Daiichi-Sankyo Pharmacual-
tical, Tokyo, Japan) at 8:00 AM for 6 days. On days 1, 3, and 6, each subject
was simultaneously administered 60 mg of fexofenadine hydrochloride with
rifampicin after an overnight fast. The order of the two phases was randomly
assigned for each volunteer. Six volunteers started the control phase first, and
their treatment phase was started more than 24 hours after the last blood
sampling of the control phase. The remaining subjects started the treatment
phase first, and their control phase was started more than 2 weeks after the last
sampling. The volunteers did not take any other medication or consume fruit
juice for at least 7 days before each phase, and no food or beverages were
allowed until 3 hours after fexofenadine administration.

Blood samples (10 ml each) were drawn before and at 0.5, 1, 1.5, 2, 3, 4, 6,
8, 12, and 24 hours after fexofenadine administration. Time points for blood
sampling follow those previously reported (Yasui-Furukori et al., 2005). A spot
of urine was collected as a blank sample before fexofenadine administration;
thereafter, the urine was collected until 24 hours after administration. Plasma
and urine concentrations of fexofenadine were determined by the high-pressure liquid chromatography method developed in our laboratory (Miura et al., 2007). Plasma and urine samples from the treatment phase did not have any
interfering peak for the assay, and the plasma and urine samples before
fexofenadine administration had no detectable fexofenadine peak.

The maximum plasma concentration (C\(_{\text{max}}\)) and the time to reach C\(_{\text{max}}\) (t\(_{\text{max}}\)) were determined directly from the observed data. The elimination rate constant (\(k_{\text{e}}\)) was obtained by linear regression analysis by use of at least three sampling points of the terminal log-linear declining phase to the last measurable concentration. The elimination half-life (t\(_{1/2}\)) was calculated as 0.693 divided by k\(_{\text{e}}\). The area under the plasma concentration–time curve from time zero to
infinity (AUC\(_{0}\infty\)) was calculated using AUC (0–12) + C\(_{\text{tr}}/k_{\text{e}}\), where C\(_{\text{tr}}\) was the plasma drug concentration at 12 hours. The oral clearance (CL\(_{\text{r}}\)), apparent volume of distribution (V\(_{\text{D}}\)), and renal clearance (CL\(_{\text{r}}\)) were used obtaining the equations:

\[
\text{CL}_{\text{tot}}/F = \text{Dose}/\text{AUC}_{0}\infty
\]

and

\[
\text{CL}_{\text{r}} = \text{AUC}_{0}\infty/\text{C}_{\text{tr}}
\]

Determination of the Uptake of Fexofenadine by cDNA-Transfected Cells. OATP1B1-, OATP1B3-, OAT3-, MATE1-, and MATE2-K-expressing HEK293 cell lines were constructed previously (Deguchi et al., 2004; Hirano et al., 2004; Matsushima et al., 2009). The transport study was performed as described previously (Hirano et al., 2004). Briefly, the cells were incubated with Krebs-Henseleit buffer (118 mM NaCl, 23.8 mM NaHCO\(_3\), 4.83 mM KCl, 0.96 mM KH\(_2\)PO\(_4\), 1.20 mM MgSO\(_4\), 12.5 mM HEPES, 5.0 mM glucose, and 1.53 mM CaCl\(_2\) adjusted to pH 7.4) containing radiolabeled or nonradiolabeled compounds at 37°C in the presence or absence of inhibitors. Uptake was terminated by the addition of ice-cold buffer after removal of the incubation buffer. The fexofenadine concentration associated with the cell specimens was determined by liquid chromatography–tandem mass spectrometry (LC–MS/MS) analysis.

Determination of the Uptake of Fexofenadine by Cryopreserved Human Hepatocytes. The uptake of fexofenadine was determined in cryopreserved human hepatocytes as reported previously, with minor modifications (Shitara et al., 2003). Briefly, hepatocytes were suspended in Krebs-Henseleit buffer to give a cell density of 1.0 \(\times\) 10\(^6\) viable cells/ml for the uptake study. After preincubation at 37°C for 3 minutes, uptake was initiated by adding labeled and unlabeled substrates to the cell suspension, and was terminated at the designated time by separating the cells from the substrate solution using a layer of oil mixture (density 1.015, a mixture of silicone oil and mineral oil; Sigma-Aldrich) and centrifugation for 10 s in a tabletop centrifuge (10,000g; Beckman Microfuge E; Beckman Coulter, Inc., Fullerton, CA). During this process, the hepatocytes passed through the oil layer into the lower layer of 2 N NaOH for estrone-3-sulfate and CCK-5 or 5 M ammonium acetate for fexofenadine. The amount of substrate in each compartment was measured with a liquid scintillation counter or LC–MS/MS analysis.

Determination of Transcellular Transport of Fexofenadine across Caco-2 Cells. Briefly, Caco-2 cells were cultured on Transwell membrane inserts (6.5 mm diameter, 0.4-μm pore size; Corning Life Sciences, Lowell, MA) for 25–30 days. Cells were first washed with Krebs-Henseleit buffer at 37°C. Subsequently, fexofenadine and inhibitors (1 μl) were added to the basolateral compartment to start the experiments. Simultaneously, inhibitors were added to

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the apical compartment (250 μl). After 90 minutes of incubation, 100 μl of the buffer in the apical compartment was collected.

Quantification of Fexofenadine and Celiprolol by LC–MS/MS. Concentrations of fexofenadine and celiprolol were measured on an AB SCIEX QTRAP 5500 mass spectrometer (Applied Biosystems, Foster City, CA) equipped with a Prominence high-pressure liquid chromatography system (Shimadzu Corporaton, Kyoto, Japan) operated in the positive electrospray ionization mode. Chromatographic separation was achieved on an Inertsil ODS-4 column (30 mm × 2.1 mm internal diameter, 3 μm; GL Science, Tokyo, Japan) in binary gradient mode at a flow rate of 0.4 ml/min. The mobile phase comprised 0.1% formic acid and acetonitrile. The acetonitrile concentration was initially 5 or 20%; it was then linearly increased to 80% or 90% over 1 or 2 minutes, and maintained for a further 0.5 or 1.2 minutes. Finally, the column was re-equilibrated with acetonitrile at a concentration of 5 or 20% for 1 minute. Mass-to-charge transitions of fexofenadine, and 380.1–251.2 for celiprolol, respectively.

Membrane Preparation and Binding Assay. Human histamine H1 receptor (D28481.1) was cloned from a human cerebral cortex cDNA library. Transient transfection of HEK293 cells was performed using pcDNA3.1(+) (Life Technologies Corporation, Carlsbad, CA) and FuGENE HD (Roche, Roche Applied Science, Penzberg Upper Bavaria, Germany) according to the manufacturers’ protocols. The [3H]-pyrilamine binding assay was performed as described previously (Ohuchi et al., 1998; Gillard and Chatelain, 2006). Briefly, membranes prepared from the cDNA transfectants (25 μg of protein) were incubated for 60 minutes at 37 °C in 0.5 ml of 50 mM Na2/K phosphate buffer (pH 7.4) containing [3H]-mepyramine (3 nM) and competing drugs. Samples were rapidly filtered by vacuum through 0.1% polyethylenimine-pretreated 24-mm glass fiber filters (Whatman GF/C; Whatman, Clifton, NJ), and the filters were washed 4 times with 2 ml of ice-cold Na2/K phosphate buffer. Nonspecific binding was defined as the amount of [3H]-pyrilamine bound in the presence of 10 μM cetrizine. Radioactivity retained on the filter was measured in a liquid scintillation counter (LS 6000SE; Beckman Instruments, Fullerton, CA). Data were analyzed according to the model proposed by Motulsky and Mahan (1984).

Statistical Analysis. The data are presented as means ± standard error (S.E.). The Student’s two-tailed nonpaired t test and a one-way analysis of variance followed by Dunnett’s post hoc test were used to identify significant differences between groups where appropriate. P < 0.05 was considered significant.

Results

Effect of Single and Multiple Doses of Rifampin on the Pharmacokinetics of Fexofenadine. No clinically undesirable signs or symptoms attributable to the administration of fexofenadine and rifampicin were recognized during the study. All subjects completed the study successfully according to the protocol.

Plasma concentrations of fexofenadine enantiomers in healthy subjects who received fexofenadine alone or with single or multiple doses of rifampin are shown in Fig. 1. The plasma concentration of fexofenadine enantiomers at last sampling point (24 after the administration) was below the lower limit of quantification. The pharmacokinetic parameters of fexofenadine enantiomers are summarized in Table 1. There was no sex difference in the pharmacokinetic parameters of fexofenadine enantiomers (data not shown). A single dose of rifampicin significantly decreased the CLtot/F and CLr, by 77 and 62%, respectively, for S-fexofenadine, and by 73 and 61%, respectively, for R-fexofenadine. Rifampicin also significantly decreased the CLtot/F and CLr of S-fexofenadine by 66 and 54%, respectively and for R-fexofenadine by 57 and 54%, respectively, after multiple doses. Individual data are shown in Fig. 2. The CLtot/F and CLr of S-fexofenadine were 1.5 and 1.7 times larger than those of R-fexofenadine (Table 1). Multiple doses of rifampicin abolished the difference in the CLtot/F of fexofenadine enantiomers, whereas the stereoselectivity in the CLr persisted both after single and multiple doses. The unbound fraction of fexofenadine in human plasma, measured using equilibrium dialysis, was stereoselective: 1.8 times higher for S-fexofenadine than for R-fexofenadine (0.235 ± 0.019 versus 0.134 ± 0.005 mean ± S.E.).

Effect of Rifampicin on the Uptake of R- and S-Fexofenadine by OATP1B3. The uptake of fexofenadine enantiomers was determined in two batches of cryopreserved human hepatocytes (lot TDH and lot 03-013), which were characterized by the difference in the uptake of an OATP1B3 reference substrate, CCK-8 (Fig. 3A). The uptake of both R- and S-fexofenadine was higher in lot TDH than in lot 03-013. Rifampicin significantly inhibited the uptake of fexofenadine only in lot TDH. The level of uptake of fexofenadine that remained in the presence of rifampicin was similar in the two lots. The rifampicin-sensitive uptake of R-fexofenadine was 1.6 times higher than that of S-fexofenadine.

The effect of rifampicin on the uptake of fexofenadine enantiomers was determined in HEK293 cells expressing OATP1B3 (OATP1B3-HEK) (Fig. 3B). The uptake of fexofenadine enantiomers was significantly greater in OATP1B3-HEK than in control mock vector-transfected cells. Rifampicin inhibits OATP1B3-mediated uptake of fexofenadine enantiomers, and the specific uptake by OATP1B3 was abolished at 2 μM. There was no detectable stereoselectivity in the transport activities by OATP1B3 and the inhibition potency of rifampicin. The uptake of fexofenadine enantiomers (microliters per milligram of protein per 5 minutes) was similar in mock vector-transfected and OATP1B1-HEK cells, at 1.92 ± 0.19 and 2.17 ± 0.15 for R-fexofenadine, and 1.78 ± 0.11 and 2.00 ± 0.18 for S-fexofenadine, respectively (mean ± S.E., n = 3–6).

Effect of Rifampicin on the Uptake of R- and S-Fexofenadine by OAT3 and MATE1. The uptake of fexofenadine enantiomers was also determined in OAT3- and MATE1-HEK in the presence and absence of rifampicin or the representative inhibitors (benzylpenicillin for OAT3 and tetraethylammonium for MATE1 and MATE2-K) (Fig. 4). Compared with mock vector-transfected cells, OAT3- and MATE1-HEK cells showed significantly greater uptake of fexofenadine enantiomers, which was markedly inhibited by the representative inhibitors, but not by rifampicin at 80 μM.
Effect of Rifampicin on Fexofenadine Pharmacokinetics

Table 1: Pharmacokinetic parameters of the pharmacokinetics of fexofenadine enantiomers in control and rifampicin-treated subjects.

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Control</th>
<th>Single Dose</th>
<th>Multiple Doses</th>
<th>Ratio to Control</th>
<th>Ratio to Control</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(mg)</td>
<td>(mg)</td>
<td>(mg)</td>
<td>(Single Dose)</td>
<td>(Multiple Doses)</td>
</tr>
<tr>
<td>S-Fexofenadine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>t1/2 (h)</td>
<td>3.3 (2.8–3.8)†††</td>
<td>3.1 (2.8–3.5)†††</td>
<td>2.9 (2.5–3.3)</td>
<td>1.02 (0.82–1.21)</td>
<td>0.92 (0.76–1.09)</td>
</tr>
<tr>
<td>tmax (h)</td>
<td>1.8 (1.0–4.0)</td>
<td>1.8 (1.0–3.0)</td>
<td>2.0 (1.0–4.0)</td>
<td>1.41 (0.94–1.88)</td>
<td>1.38 (0.85–1.92)</td>
</tr>
<tr>
<td>Cmax (ng/ml)</td>
<td>127 (92–163)†††</td>
<td>443 (371–515)†††</td>
<td>318 (252–385)***</td>
<td>4.15 (2.97–5.33)</td>
<td>2.94 (2.22–3.66)</td>
</tr>
<tr>
<td>AUC0–24 (ng/ml)</td>
<td>698 (490–937)†††***</td>
<td>2489 (2100–2877)†††***</td>
<td>1674 (1400–1949)***</td>
<td>4.56 (3.19–5.94)</td>
<td>3.13 (2.13–4.13)</td>
</tr>
<tr>
<td>CLr (l/h)</td>
<td>6.6 (4.2–8.9)†††**</td>
<td>2.5 (1.6–3.4)†††***</td>
<td>3.0 (2.3–3.7)***</td>
<td>0.49 (0.29–0.64)</td>
<td>0.69 (0.38–0.99)</td>
</tr>
<tr>
<td>R-Fexofenadine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>t1/2 (h)</td>
<td>3.8 (3.3–4.4)</td>
<td>3.5 (3.2–3.9)</td>
<td>3.2 (2.7–3.6)</td>
<td>0.96 (0.84–1.07)</td>
<td>0.86 (0.74–0.98)</td>
</tr>
<tr>
<td>tmax (h)</td>
<td>1.8 (0.5–4.0)</td>
<td>2.0 (1.0–4.0)</td>
<td>2.0 (1.0–4.0)</td>
<td>1.85 (0.67–3.04)</td>
<td>1.59 (0.90–2.28)</td>
</tr>
<tr>
<td>Cmax (ng/ml)</td>
<td>160 (117–202)</td>
<td>502 (427–577)***</td>
<td>331 (261–401)***</td>
<td>3.65 (2.73–4.57)</td>
<td>2.46 (1.74–3.18)</td>
</tr>
<tr>
<td>AUC0–24 (ng/ml)</td>
<td>1011 (695–1327)</td>
<td>3243 (2759–3727)***</td>
<td>1922 (1635–2210)***</td>
<td>3.86 (2.92–4.80)</td>
<td>2.40 (1.62–3.17)</td>
</tr>
<tr>
<td>CLr (l/h)</td>
<td>37 (28–46)</td>
<td>10 (8–12)***</td>
<td>16 (14–19)***</td>
<td>0.32 (0.23–0.41)</td>
<td>0.55 (0.37–0.73)</td>
</tr>
<tr>
<td>Ae0–24 (mg)</td>
<td>3.4 (2.5–4.3)</td>
<td>4.4 (3.6–5.3)</td>
<td>3.4 (2.4–4.3)</td>
<td>2.00 (0.81–3.12)</td>
<td>1.44 (0.59–2.29)</td>
</tr>
<tr>
<td>CLr (l/h)</td>
<td>3.9 (2.5–5.4)</td>
<td>1.5 (1.1–2.0)***</td>
<td>1.8 (1.3–2.2)***</td>
<td>0.50 (0.31–0.70)</td>
<td>0.64 (0.41–0.87)</td>
</tr>
<tr>
<td>RS ratio of AUC</td>
<td>1.50 (1.35–1.65)</td>
<td>1.32 (1.23–1.43)</td>
<td>1.17 (1.05–1.20)*</td>
<td>0.91 (0.80–1.03)</td>
<td>0.80 (0.70–0.91)</td>
</tr>
<tr>
<td>RS ratio of CLr</td>
<td>0.60 (0.55–0.66)</td>
<td>0.63 (0.59–0.66)</td>
<td>0.59 (0.52–0.66)</td>
<td>1.07 (0.95–1.19)</td>
<td>1.00 (0.83–1.16)</td>
</tr>
</tbody>
</table>

RS, R-fexofenadine/S-fexofenadine; Ae0–24, the amount of fexofenadine recovered in the urine for 24 hours after dosing.

*P < 0.05; †P < 0.01; ††P < 0.001 between control phase and rifampicin phase.

††P < 0.001 between S-fexofenadine and R-fexofenadine.

Effect of Rifampicin on the Basal-to-Apical Transport of R- and S-Fexofenadine in Caco-2 Cells. The basal-to-apical transport of fexofenadine across a monolayer of Caco-2 cells was 7.1-fold higher than the apical-to-basal transport (Papp 4.97 ± 0.16 × 10^6 cm/s). Verapamil significantly inhibited this basal-to-apical transport by 61%, but did not affect the apical-to-basal transport (data not shown). Celiprolol was used as the reference P-gp substrate (Fig. 5A). Rifampicin significantly inhibited the transport of R- and S-fexofenadine for individual subjects; the points representing the same individual are connected to one another by dotted lines. The horizontal line in each column indicates the mean values. *P < 0.05, **P < 0.01, and ***P < 0.001 between control phase and rifampicin phase.
S-fexofenadine with similar potency (Fig. 5B). It also inhibits the basal-to-apical transport of celiprolol, but the inhibition potency for celiprolol was lower than that for fexofenadine enantiomers (Fig. 5).

There was no detectable stereoselectivity in the basal-to-apical transport of \( R \) - and \( S \) -fexofenadine (Fig. 5).

**Stereoselectivity of \( R \) - and \( S \) -Fexofenadine Binding to Human H1 Receptor.**

Transient transfection of human H1 receptor cDNA induces specific binding of \(^{3}H\)-mepyramine with a \( K_d \) and \( B_{\text{max}} \) of \( 3.7 \pm 0.5 \) nM and \( 3.8 \pm 0.1 \) pmol/mg protein, respectively. The competition of fexofenadine with \(^{3}H\)-mepyramine binding was examined, through which the \( K_i \) values of \( R \) - and \( S \) -fexofenadine were determined to be \( 30 \pm 3 \) and \( 13 \pm 3 \) nM, respectively (Fig. 6A).

Kinetic analyses of the inhibition \(^{3}H\)-mepyramine binding by fexofenadine enantiomers were also performed (Fig. 6B). Based on the dissociation of \(^{3}H\)-mepyramine (\( k_{\text{off}} = 1.43 \) min\(^{-1}\)), the association constant (\( k_{\text{on}} \)) and dissociation constant (\( k_{\text{off}} \)) of \( R \) - and \( S \) -fexofenadine were calculated to be \( 0.86 \pm 0.13 \) and \( 0.92 \pm 0.02 \) ml/nmol per minutes, and \( 0.032 \pm 0.008 \) and \( 0.017 \pm 0.002 \) min\(^{-1}\), respectively.

**Discussion**

This study examined the effect of single and multiple doses of rifampicin on the pharmacokinetics of fexofenadine enantiomers in healthy subjects to demonstrate the impact of OATP1B3 inhibition.

A single dose of rifampicin significantly decreased the CL\(_{\text{tot/F}}\) and CL\(_{r}\) of fexofenadine enantiomers. Based on the reported contribution of urinary excretion to systemic elimination [38% (Lappin et al., 2010)], the magnitude of the interaction of rifampicin with the CL\(_{\text{tot/F}}\) of fexofenadine cannot be explained only by the reduction in CL\(_{r}\). Coadministration of rifampicin also inhibits the hepatic elimination of fexofenadine and/or increases its bioavailability. Because of a negligible hepatic first-pass effect, the bioavailability of fexofenadine, which was reported to be 0.30 at its therapeutic dose (Lappin et al., 2010), is attributable to its absorption and solubility in the intestine. Given that rifampicin increases the bioavailability of fexofenadine, the inhibition of intestinal efflux can be the underlying mechanism.

To evaluate the relevance of the inhibition of hepatic elimination by rifampicin, in vitro inhibition studies were conducted in cryopreserved human hepatocytes and cDNA-transfected cells. Two batches of cryopreserved hepatocytes were used in this study. The two batches of hepatocytes showed very similar transport activity of the OATP1B1.
reference substrate, but hepatocytes from batch number 03-013 showed 5-fold lower transport activity of the OATP1B3 reference substrate than batch TDH (Fig. 3A). The uptake of fexofenadine by TDH hepatocytes, but not by 03-013 hepatocytes, was inhibited by rifampicin (Fig. 3A), suggesting that rifampicin-sensitive uptake of fexofenadine in the hepatocytes could be related to their OATP1B3 activity. We speculate that OATP1B3 makes a greater contribution than OATP1B1 to rifampicin-sensitive uptake in hepatocytes. Although the specific uptake of fexofenadine was not observed in OATP1B1- and OATP2B1-expressing HEK cells, this does not exclude their involvement in the hepatic uptake of fexofenadine enantiomers. In fact, a transcellular transport study using OATP1B1 and MRP2 double transfectants clearly showed that transfection of OATP1B1 is required to mediate directional transport of fexofenadine in MDCK cells (Matsushima et al., 2008a). Specific uptake of fexofenadine by OATP2B1 was reported previously in OATP2B1-expressing Xenopus laevis oocytes, and HEK293 cells (Nozawa et al., 2004; Imanaga et al., 2011). Because rifampicin was given orally, the in vivo relevance of the interactions in hepatic elimination should be evaluated using the unbound rifampicin concentration at the inlet to the liver, which was estimated to be a maximum of 4.6 μM at the dose of 600 mg (Maeda et al., 2011). Given the in vitro inhibition potency of rifampicin (Fig. 3B), this concentration is sufficient to cause a marked inhibition of OATP1B3 in vivo. Assuming a negligible effect of rifampicin on intestinal absorption, the hepatic clearance of fexofenadine enantiomers is decreased to 4% of the control values by coadministration of rifampicin.

Although the CLr of fexofenadine was significantly decreased by rifampicin (Table 1), this effect is not explained by an inhibition of the candidate transporters OAT3 and MATE1 (Tahara et al., 2006; Matsushima et al., 2009), because rifampicin did not show any inhibitory effect on these transporters (Fig. 4). The absence of an effect of rifampicin on OAT3 is consistent with clinical data showing that a simultaneous dose of rifampicin did not affect the renal clearance of another OAT3 substrate, pravastatin (Maeda et al., 2011). Tubular secretion of fexofenadine may involve other unknown transporters that are sensitive to rifampicin. Based on the observation that probenecid, a potent inhibitor of OAT3, inhibited the tubular secretion of fexofenadine almost completely (Yasu-Furukori et al., 2005; Tahara et al., 2006), the site of interaction with rifampicin may be the luminal efflux process. Further studies are necessary to elucidate the mechanism of this DDI.

In addition to the hepatic and renal elimination, the effect of rifampicin on the CLra/F of fexofenadine may involve inhibition of P-gp in the small intestine. We found that rifampicin inhibited the basal-to-apical transport of fexofenadine enantiomers in Caco-2 cells (Fig. 5). Tachibana et al., (2009) proposed an apparent volume of the small intestine lumen based on published DDI data to associate the DDI risk...
for P-gp and CYP3A4 (11–28 liters and 2.8–9.4 liters, respectively) with the doses of inhibitors. When a volume of 11–28 liters is used, the estimated concentration of rifampicin in the lumen is 26–66 μM, which is high enough to cause a moderate inhibition of P-gp-mediated efflux of fexofenadine in the small intestine. Notably, the effect of rifampicin on P-gp will be substrate dependent, as the same concentration did not affect the basal-to-apical transport of celiprolol (Fig. 5).

Hamman et al., (2001) reported that multiple doses of rifampicin significantly increased the CL\textsubscript{tot}/F of fexofenadine. It is well known that multiple doses of rifampicin induce expression of P-gp in the small intestine (Shimizu et al., 2006) and consequently lower bioavailability of P-gp substrates including fexofenadine (Hamman et al., 2001; Akamine et al., 2012). Rifampicin also induces OATP1B1 expression in primary cultured human hepatocytes (Sahi et al., 2006), and this may contribute to reducing the AUC of fexofenadine. In this study, even after multiple doses, when the two drugs were given simultaneously, rifampicin significantly decreased the CL\textsubscript{tot}/F of fexofenadine although the magnitude of the interaction on the CL\textsubscript{tot}/F was slightly blunted compared with that after a single dose (Fig. 2). Thus, the impact on inhibition of drug transporters by rifampicin surpasses its impact on P-gp and OATP1B1. Multiple doses of rifampicin decrease its AUC; however, the C\textsubscript{max} of rifampicin was slightly blunted compared with that after a single dose (Fig. 2).

In conclusion, rifampicin interacts with fexofenadine at multiple sites in the body, with a simultaneous dose inhibiting the hepatic and renal transporters (OATP1B3 and an unknown transporter, respectively), and presumably the intestine efflux transporter P-gp, all of which contribute to decreasing the AUC of fexofenadine to surpass the effect of the induction of P-gp elicited by multiple doses.

**Authorship Contributions**

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Effect of Rifampicin on Fexofenadine Pharmacokinetics


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