Pharmacokinetic Modeling of Warfarin II – Model-based Analysis of Warfarin Metabolites following Warfarin Administered either Alone or Together with Fluconazole or Rifampin

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Abbreviations:
CYP: cytochrome P450
DDI: drug-drug interaction
TMDD: target mediated drug disposition
PK: pharmacokinetic
PD: pharmacodynamic
CL: clearance
CL_f: formation clearance
CL_R: renal clearance
IRB: institutional review board
EBE: empirical bayes estimate
OFV: objective function value
IIV: inter-individual variability
LD: linkage disequilibrium
RUV: residual unexplained variability
V_d: volume of distribution
EM: expectation-maximization
BQL: below the quantification limit
IMP: importance sampling
RSE: relative standard error
SIR: sampling importance resampling
VPC: visual predictive check
CI: confidence interval
LLOQ: lower limit of quantification
Abstract

The objective of this study is to conduct a population pharmacokinetic (PK) model-based analysis on 10 warfarin metabolites (4’-, 6-, 7-, 8- and 10-hydroxylated (OH)-S- and R-warfarin), when warfarin is administered alone or together with either fluconazole or rifampin. One or two compartment PK models expanded from target mediated drug disposition (TMDD) models developed previously for warfarin enantiomers were able to sufficiently characterize the PK profiles of 10 warfarin metabolites in plasma and urine under different conditions. Model-based analysis shows CYP2C9 mediated metabolic elimination pathways are more inhibitable by fluconazole (% formation CL (CLf) of 6- and 7-OH-S-warfarin decrease: 73.2% and 74.8%) but less inducible by rifampin (% CLf of 6- and 7-OH-S-warfarin increase: 85% and 75%), compared with non-CYP2C9 mediated elimination pathways (% CLf of 10-OH-S-warfarin and CLR of S-warfarin decrease in the presence of fluconazole: 65.0% and 15.3%; % CLf of 4’- 8- and 10-OH-S-warfarin increase in the presence of rifampin: 260%, 127% and 355%), which potentially explains the CYP2C9 genotype-dependent DDIs exhibited by S-warfarin, when warfarin is administrated together with fluconazole or rifampin. Additionally, for subjects with CYP2C9 *2 and *3 variants, a model-based analysis of warfarin metabolite profiles in subjects with various CYP2C9 genotypes demonstrates CYP2C9 mediated elimination is less important and non-CYP2C9 mediated elimination is more important, compared with subjects without these variants. To our knowledge, this is so far one of the most comprehensive population-based PK analyses of warfarin metabolites in subjects with various CYP2C9 genotypes under different co-medications.
Significance Statement

The present study conducted population model-based analyses of 10 warfarin metabolites after racemic warfarin is administered either alone or together with metabolic inhibitors or inducers. The differential inhibition and induction of various elimination pathways of warfarin potentially explains the CYP2C9 genotype-dependent drug-drug interactions of S-warfarin. The analysis also facilitates a deeper understanding of warfarin disposition.
Introduction

Since being introduced into clinical practice in the 1950s, warfarin continues to be one of the most commonly prescribed anticoagulant drugs in the world nowadays (Shapiro, 1953; Asiimwe et al., 2021). Although highly effective in treating diseases such as atrial fibrillation and venous thromboembolism, the narrow therapeutic index, high inter-individual variability, and potentially life-threatening and dose-limiting toxicities, such as intracranial hemorrhage, compromise the clinical use of warfarin (Smith et al., 1990; Takahashi and Echizen, 2001; Hart et al., 2007; Ansell et al., 2008).

Following the oral administration of warfarin enantiomers, both R- and S-warfarin are absorbed rapidly and eliminated primarily through cytochrome P450 (CYP) mediated hepatic metabolism, to form multiple monohydroxylated metabolites (Kaminsky and Zhang, 1997; Ufer, 2005). S-warfarin, the pharmacologically more active enantiomer of warfarin, is primarily (>80%) metabolized by CYP2C9 to form either 7- or 6-hydroxy (OH)-S-warfarin, although 4’-, 8- and 10-OH-S-warfarin can also be formed via catalysis by other CYPs such as CYP2C19 and CYP3A4 (Rettie et al., 1992; Ufer, 2005; Pouncey et al., 2018). R-warfarin, in contrast, is metabolized by multiple CYP enzymes, such as CYP1A2, CYP2C19 and CYP3A4, to form 4’-, 6-, 7-, 8- and 10-OH-R-warfarin (Zhang et al., 1995; Wienkers et al., 1996; Ufer, 2005; Rettie and Tai, 2006; Pouncey et al., 2018). Following the formation of monohydroxylated metabolites, several warfarin metabolites, such as 4’-, 6-, 7- and 8-hydroxy S- or R-warfarin, can undergo either urinary excretion or further metabolism, such as glucuronidation, although the relative importance in vivo of these conjugation pathways is unclear to date (Jansing et al., 1992; Takahashi et al., 1997; Ufer, 2005; Zielinska et al., 2008; Miller et al., 2009; Jones et al., 2010b; Pugh et al., 2014). Diastereomeric warfarin alcohols, were also identified in human urine, the formation of which is CYP-independent (Lewis and Trager, 1970; Moreland and Hewick, 1975; Hermans and Thijssen, 1989; Ufer, 2005).

Numerous previous studies suggested that CYP2C9 contributes significantly to the high inter-individual variability (IIV) in S-warfarin exposure, complicating warfarin dosing (Rettie et al., 1994; Takahashi and Echizen, 2001; Hamberg et al., 2007; Flora et al., 2017; Xue et al., 2017). For enzymes encoded by the CYP2C9 gene with *2 (430C>T) and *3 (1075A>C) variants, in
*vitro* studies suggest the intrinsic clearance (CL) of CYP2C9 mediated S-warfarin 7-hydroxylation is approximately 5.5-fold and 27-fold lower, respectively, compared with enzyme encoded by wild type CYP2C9 gene (Rettie et al., 1994; Haining et al., 1996; Steward et al., 1997; Rettie et al., 1999; Ufer, 2005). A population pharmacokinetic (PK) analysis demonstrated that subjects homozygous with respect to CYP2C9 *2 or *3 exhibit a 72% and 85% reduction in S-warfarin CL, respectively, compared with subjects homozygous for CYP2C9 *1/*1 (Hamberg et al., 2007). Additionally, a previous study showed that the CYP2C9 *1B haplotype (characterized by -3089G_A and -2663delTG) is in linkage disequilibrium (LD) with CYP2C19 *2, which can impact the auto-induction of phenytoin (Chaudhry et al., 2010). The presence of CYP2C9 *1B haplotype is also associated with the lower maintenance doses of phenytoin in epileptic patients but not associated with warfarin maintenance doses in a Chinese patient population (Chaudhry et al., 2010). However, whether these genetic variants are associated with the PK of warfarin metabolites is largely unclear.

Despite many studies being conducted with warfarin, a comprehensive model-based analysis of the metabolic profiles of the warfarin enantiomers and their metabolites, following the administration of either warfarin alone or together with a CYP inhibitor or inducer, utilizing a population PK modeling approach is still lacking. The study presented here is the second manuscript of a two-part companion series describing warfarin kinetics. In the first analysis, we found that CYP2C9 genotypes are associated with the magnitude of S-warfarin CL changes when warfarin is co-administrated with CYP inhibitors or CYP inducers, so called CYP2C9 genotype-dependent drug-drug interactions (DDIs) (Cheng et al., concurrently published). However, the mechanism behind it is poorly understood. Taking advantage of the plasma and urine PK profiles collected for 10 warfarin metabolites (4’-, 6-, 7-, 8-, 10-OH-S- and R-warfarin), the goal of the herein presented work is to conduct a model-based analysis to provide more mechanistic insights behind the CYP2C9 genotype-dependent DDIs exhibited by S-warfarin shown in our companion analysis (Cheng et al., concurrently published). Interestingly, several unexpected findings were obtained in the current analysis of metabolite PK, such as the effect of CYP2C9 *1B on the magnitude of formation CL (CLf) changes of several metabolites following the administration of warfarin together with rifampin.
Methods

Data

Data used for developing the warfarin metabolite models were collected from an open-label, multi-phase and cross-over clinical pharmacogenetic study approved by the University of Minnesota’s Institutional Review Board (IRB). Details about the study population and study design are provided in the first manuscript of our companion manuscripts (Cheng et al., concurrently published). Briefly, 29 healthy subjects with CYP2C9 *1/*1 (n=8), CYP2C9 *1B/*1B (n=5), CYP2C9 *1/*3 (n=9), CYP2C9 *2/*3 (n=3) and CYP2C9 *3/*3 (n=4) were enrolled in the study with written informed consent.

Each subject underwent three treatment periods. For the first period, each subject was treated with a single 10 mg oral dose of warfarin followed by an 11-15 day sampling phase and a 7-day washout phase before entering the second period. For the second period, subjects were randomized and administered either 400 mg fluconazole or 300 mg rifampin orally once daily for 7 consecutive days to allow the concentration of fluconazole or rifampin to reach steady state. Afterwards, a single 10 mg oral dose of warfarin was administered for each subject followed by an 11-15 day sampling phase and a 7-day washout phase. Fluconazole or rifampin was continuously administered on a daily basis during the sampling phase. The design of the third period was the same as the second period with subjects crossing over to the alternative interacting drug.

Blood samples were taken at 2 hours (hr), 6 hr, 24 hr, 2 days (d), 3 d, 4 d, 5 d, 6 d, 7 d, 9 d and 11 d after the dose of warfarin for each subject. For subjects with CYP2C9 *1/*3, an additional blood sample was taken at 13 d and for subjects with CYP2C9 *2/*3 and *3/*3 genotypes, two more blood samples were taken at 13 d and 15 d since these subjects were assumed to exhibit a longer warfarin elimination half-life. Urine samples were collected at 24 hr intervals for each subject at 1 d, 4 d, 7 d and 10 d. Concentrations of 4’-, 6-, 7-, 8-, 10-OH-S and R-warfarin in both plasma and urine were analyzed by LC/MS with the methods described in the previous studies (Miller et al., 2009; Flora et al., 2017). The lower limit of quantifications (LLOQs) for 4’-, 6-, 7-, 8-, 10-OH-warfarin metabolites were 0.75, 0.4, 0.67, 0.5 and 0.75 ng/mL, respectively (Flora et al., 2017).
PK Model Development

The PK models for S- and R-warfarin metabolites were built subsequently on the basis of the PK models developed for S- and R-warfarin parent compounds (Cheng et al., concurrently published). After the development of the S- and R-warfarin models with CYP2C9 genotype and drug interaction covariate effects, the Empirical Bayes Estimates (EBE) of individual PK parameters were exported to the S- and R-warfarin metabolite data sets respectively to derive the metabolite PK profiles. The molecular weight difference between parent compounds (308 Da) and metabolites (324 Da) were adjusted during the model fitting process. The covariate effects of CYP2C9 genotypes and co-treatments were parameterized using the equations (1-2) as shown below.

\[ TVP = TVP_{ref} \times P_{Geno\ i} \] (1)

\[ TVP = TVP_{ref} \times P_{TRT} \] (2)

(\(TVP\): typical values of parameters; \(TVP_{ref}\): typical values of parameters in reference groups; \(P_{Geno\ i}\): CYP2C9 genotype effect on parameters (i = 1, 2, 3, 4, 5 represent CYP2C9 *1/*1, *1B/*1B, *1/*3, *2/*3, *3/*3 respectively); \(P_{TRT}\): co-treatment effect on parameters (TRT: Flu: fluconazole, Rif: rifampin))

If an association between CYP2C9 genotypes and \(P_{TRT}\) is identified by visual inspection, CYP2C9 genotype effects were added on \(P_{TRT}\) as a covariate using the equation (3) as shown below.

\[ P_{TRT} = P_{TRT\ Geno\ i} \] (3)

(\(P_{TRT\ Geno\ i}\): co-treatment effect on parameters for subjects with genotype i (i = 1, 2, 3, 4, 5 represent CYP2C9 *1/*1, *1B/*1B, *1/*3, *2/*3, *3/*3 respectively))

A covariate introducing a 3.84 decrease in objective function values (OFVs) with one degree of freedom at an \(\alpha\) level of 0.05 is considered to be statistically significant.

The schematic PK model structures for each warfarin metabolite are shown in Figure 1. For 4’-, 8- and 10-OH-S-warfarin, a one-compartment PK model with a urine compartment connected with the S-warfarin PK model with covariates was able to adequately describe the PK profiles for each metabolite in both plasma and urine under different conditions. For 6-, 7-OH-S-warfarin
and all the R-warfarin related metabolites, a two-compartment PK model with a urine compartment connected with either S- or R-warfarin PK model with covariates was able to adequately describe each metabolite’s PK profiles in both plasma and urine under different conditions.

Without studies conducted with each metabolite administrated by itself and prior knowledge about the fraction of parent compound converted to each metabolite (f_m), the volume of distribution (V_d) of each metabolite is theoretically not identifiable using only the metabolite plasma PK profiles following the administration of parent compound (Cosson et al., 2007). However, this can potentially be overcome if the plasma and urine PK profiles of each metabolite are fitted simultaneously assuming the metabolite produced is 100% excreted through urine. The model fitting for each warfarin metabolite performed in this study were based on this assumption with plasma and urine measurements fitted simultaneously. Although this assumption allows the V_d of each metabolite model to become estimable, this may lead to underestimation of metabolite V_d, especially for metabolites that undergo extensive phase II metabolism such as glucuronidation or sulphation. The underestimation of V_d can further lead to underestimation of CL_f of each metabolite. Indeed, several warfarin metabolites such as 4’-, 6-, 7- and 8-OH warfarin have been shown to undergo various extents of glucuronidation and the overall percentages of warfarin metabolites that undergo glucuronidation varies from 14% to 59% between patients as shown by previous studies (Zielinska et al., 2008; Jones et al., 2010b). Thus, the V_d and CL_f estimated in this study should be interpreted as the minimum possible values for each metabolite.

The baseline plasma concentrations for the warfarin only treatment period were assumed to be zero for all the metabolites during the entire modeling process. The baseline plasma concentrations in the second and third treatment periods were assumed to be non-zero for 4’-, 6-, 7-, 8-OH-S- and 7-, 10-OH-R-warfarin and parameters for baseline concentrations in the central and peripheral compartments were included for estimations. Additionally, the baseline plasma concentrations in the second and third treatment periods were assumed to be zero for 10-OH-S- and 4’-, 6-, 8-OH-R-warfarin since the baseline concentration parameters in the second and third treatment periods cannot be estimated with adequate precision for these metabolites.
IIV terms were parameterized by assuming a log-normal distribution. For each undesired IIV, a fixed 0.3% inter-individual variability was assumed to facilitate the optimization efficiency of the expectation-maximization (EM) based method (Chigutsa et al., 2017). Proportional error models were used for modeling residual unexplained variabilities (RUVs). All IIVs were assumed to be independent of each other, thus no off-diagonal matrix elements were estimated. Because of the existence of many plasma concentrations below the lower limit of quantification (LLOQ), the M3 method (Ahn et al., 2008; Bergstrand and Karlsson, 2009) proposed by Stuart Beal was used to account for the missing concentrations in the plasma PK profiles of each metabolite. NONMEM code for 7-OH-S-warfarin has been provided as an example in supplementary material (code for 7-OH-S-warfarin plasma).

Model Evaluations

The evaluations of model fitting were performed by visual prediction check (VPC) stratified by model covariates, such as CYP2C9 genotypes and co-medications, with 200 simulations. Because of the existence of plasma concentrations below LLOQ, a two panel VPC procedure was followed to evaluate model fitting in plasma for each metabolite (Bergstrand and Karlsson, 2009). The precision of the parameter estimations was evaluated with the relative standard error (RSE) generated with the covariance steps and 95% confidence intervals (CIs) constructed following the sampling importance resampling (SIR) procedure (Dosne et al., 2016).

Model-based Analysis

Percentage changes in CLf of each metabolite and percentage changes in renal CL (CLR) of each parent compound following the administration of fluconazole or rifampin were calculated with model parameters estimated by each metabolite model or parent compound model (Cheng et al., concurrently published) with equation (4) as shown below.

\[
\% \text{ changes in } CL_f (\text{or } CL_R) = \left| \frac{CL_{f,TRT} (\text{or } CL_{R,TRT})}{100} - 100\% \right| \quad (4)
\]

\(| CL_{f,TRT} (\text{or } CL_{R,TRT})-100\% |\) represent the absolute difference between co-treatment effects on CLf of each metabolite (or CLR of each parent compound) and 100% (TRT: Flu: fluconazole, Rif: rifampin))
The 95% CIs were constructed with RSE estimated from the covariance steps by assuming a symmetrical normal distribution.

For model-based analysis of warfarin and its metabolites, S- and R-warfarin CL, CL$_R$ and the covariate effects on them were extracted from our companion study (Cheng et al., concurrently published). The S- and R-warfarin CL, CL$_R$ and CL$_f$ for each warfarin metabolite in subjects with various CYP2C9 genotypes under different co-treatments were first calculated with the corresponding covariates. The percentages of CL$_f$ of each metabolite or CL$_R$ of each parent compound with respect to S- or R-warfarin CL, in subjects with various CYP2C9 genotypes under different co-treatments, were then calculated using the equation (5) as shown below.

$$\%\text{CL}_f \ (\text{or} \ %\text{CL}_R) = \frac{\text{CL}_f \ (\text{or} \ \text{CL}_R)}{\text{CL}} \ (5)$$

Data Analysis

Model fittings were implemented with the Importance Sampling algorithm (IMP) with interaction using “AUTO=1” option and mu-reference within NONMEM 7.4 (ICON Development Solutions, Ellicott City, Maryland) (Bauer, 2015). Perl-speaks-NONMEM (PsN 4.9.0, Uppsala, Sweden) within Pirana interface (Keizer et al., 2011) was utilized to facilitate the implementation of VPC and SIR. R 3.6.3 (The R Foundation for Statistical Computing) and RStudio 1.1.453 (RStudio, Inc., Boston, Massachusetts) were utilized for data pre- and post-processing and data visualization.
Results

Data

The number of plasma concentrations and urine samples included for developing each metabolite PK model are shown in Table S1. The plasma measurements are categorized into baseline concentrations, non-baseline concentrations above the LLOQ and non-baseline concentrations below LLOQ.

Parameters representing baseline plasma concentrations in the second and third treatment periods were initially included for 10-OH-S- and 4’-, 6-, 10-OH-R-warfarin, but relatively imprecise estimations (large RSE) were observed. Thus, for these compounds, no parameters related to baseline plasma concentrations were included and baseline plasma concentrations were assumed to be zero in all treatment periods. Additionally, poor fitting of the 10-OH-S-warfarin plasma PK profiles in three subjects was observed with all the structure models tested that resulted in an excessive influence on the overall model fitting and parameter estimations. Thus, the 10-OH-S-warfarin PK profiles for these three subjects were subsequently excluded during model fitting.

The plasma and urine PK profiles used for developing each metabolite model are shown in Figures 2 and 3, respectively. In general, plasma concentrations were readily detectable and substantial for most of the warfarin metabolites except for 4’-, 8-OH-S- and 7-OH-R-warfarin. The large number of plasma concentrations below the LLOQ indicate an extremely low plasma exposure of these metabolites (Table S1). In contrast, 4’-, 8-OH-S- and 7-OH-R-warfarin were readily detected in urine, suggesting that they are rapidly eliminated following their enzymatic generation. Additionally, despite substantial concentrations of 10-OH-S- and 10-OH-R-warfarin in plasma, these metabolites were only sparsely detected in urine.

Model parameters

The parameter estimations for 4’-, 6-, 7-, 8-, 10-OH-S- and R-warfarin are shown in Table S2-S11, respectively. Model parameters were estimated with reasonable precision as indicated by the RSE estimated from the covariance steps and 95% CIs generated following the SIR procedure. The inhibitory and inducing effects of fluconazole and rifampin, respectively, on the CLf of the warfarin metabolites was variable and metabolite dependent. As would be expected,
the CYP2C9 genotype impacted the CL\textsubscript{f} of 6- and 7-OH-S-warfarin, but, surprisingly, also 8-OH-S-warfarin.

For metabolites with sparse plasma PK profiles, such as 4'-OH-S-, 7-OH-R-, 8-OH-S-warfarin, large RUV estimations (128%, 2640% and 352%, respectively) for the plasma PK profile fits were observed (Table S2, S7 and S8). In addition, for these metabolites, several excessively large IIV estimations for CL and V\textsubscript{C} were also noted. It is suspected that the existence of the substantial number of plasma concentrations below the LLOQ contributed to the excessive amount of uncertainty (either IIV or RUV) estimated.

\textit{Model Evaluations}

Again, the model parameters were estimated with reasonable precision based on the RSEs generated with the covariance steps and the 95% CIs calculated with SIR overall (Table S2-S11). The visual prediction checks (VPCs), which are stratified by CYP2C9 genotypes and co-medications, suggested the developed models can predict the PK observations in both plasma and urine for each metabolite reasonably well (Figure S1-S10, A and C). Importantly, the observed fractions of concentrations below quantification limits (BQL) in plasma PK profiles align well with the model predicted fractions of concentrations BQL (Figure S1-S10, B), which indicate the appropriate use of the M3 method.

\textit{Model-based Analysis}

The estimated inhibitory effect of fluconazole and inducing effect of rifampin on the CL\textsubscript{f} of each metabolite or on the CL\textsubscript{R} of each parent compound are presented in Figure 4. Following the administration of fluconazole, the CL\textsubscript{f} of each metabolite and the CL\textsubscript{R} of each parent enantiomer decrease. Notably, the decrease in CL\textsubscript{R} is much less compared with the decrease in CL\textsubscript{f} of each metabolite, following the administration of fluconazole. In contrast, following the administration of rifampin, the CL\textsubscript{f} of each metabolite and the CL\textsubscript{R} of each parent compound increase, with a much lesser increase in CL\textsubscript{R} compared with the increase in CL\textsubscript{f} of each metabolite. Interestingly, our model identified that subjects with the CYP2C9 *1B/*1B genotype exhibit a greater induction of CL\textsubscript{f} (higher CL\textsubscript{f,Rif}) for 10-OH-S- and 10-OH-R-warfarin but a lesser effect on CL\textsubscript{f}}
(lower CLf_Rif) for 8-OH-R-warfarin following the administration of rifampin (Figure 4, B and D).

7- and 6-OH-S-warfarin are the most abundant metabolites of S-warfarin, the formation of which is mediated by CYP2C9 (Table 1). Following the administration of fluconazole, the percentage decrease in CLf of 7- and 6-OH-S-warfarin was similar to the decrease in CLf of 4’- and 8-OH-S-warfarin (Figure 4A). However, fluconazole had a lesser impact on 10-OH-S-warfarin CLf and a minimal impact on S-warfarin CLR (Figure 4A). Rifampin administration, however, increased the CLf of 7- and 6-OH-S-warfarin to a lesser extent than any of the other S-warfarin metabolites (Figure 4B).

The metabolic profiles for S-warfarin (the percentages of CLf of each metabolite or CLR of each parent compound with respect to S-warfarin CL), in subjects with various CYP2C9 genotypes under different co-treatments, are shown in Figure 5. For subjects with the CYP2C9 *2 and *3 variants, the proportion of CYP2C9 mediated S-warfarin CL occurring through the formation of 6- and 7-OH-S-warfarin decreases, but the proportion of non-CYP2C9 mediated warfarin clearance increases. Interestingly, the CLR of S-warfarin contributes more towards S-warfarin CL in subjects possessing the CYP2C9 *2 and *3 variants compared with wild-type subjects (CYP2C9 *1/*1), regardless of co-medications administered. Despite prior suggestions that the CLR of S-warfarin is generally inconsequential (Ufer, 2005), our results suggest for subjects with the CYP2C9 *2/*3 and *3/*3 variants, the CLR of S-warfarin can constitute up to 5.1% and 6.6% of overall S-warfarin CL respectively, when warfarin is administered alone. Furthermore, the CLR of S-warfarin can constitute up to 10.8% and 10.7% of overall S-warfarin CL, when warfarin is administered together with fluconazole.

The percentages of CLf for each metabolite or CLR for each parent enantiomer with respect to R-warfarin CL, in subjects with various CYP2C9 genotypes under different co-treatments, are shown in Figure 6. Unlike S-warfarin, no obvious CYP2C9 genotype-dependency is detected in the R-warfarin metabolic profiles. Following the administration of fluconazole, CLR contributes more and CLf through R-warfarin metabolites contributes less towards overall CL of R-warfarin. Following the co-administration of rifampin, CLR of R-warfarin contribute less towards overall CL. Interestingly, the formation of 4’-, 8-, 10-OH-R-warfarin play a more prominent role in R-
warfarin elimination following the co-administration of rifampin compared to the administration of warfarin alone. In contrast, the formation of the 6- and 7-OH-R-warfarin metabolites appears to play a lesser role in R-warfarin elimination, following co-administration of rifampin.
**Discussion**

In this study, we developed PK models for 10 warfarin metabolites on the basis of the S-and R-warfarin PK models built in our companion study (Cheng et al., concurrently published). Our models were able to characterize the plasma and urine PK profiles of 10 warfarin metabolites reasonably well, with reasonable parameter estimation precisions. Importantly, the developed warfarin metabolite models can provide more mechanistic insights about warfarin dispositions, following warfarin administered either alone or together with fluconazole or rifampin.

Many previous studies show 7- and 6-OH-S warfarin are the major metabolites for S-warfarin, the formation of which are mediated by CYP2C9 (Rettie et al., 1992; Kaminsky and Zhang, 1997; Ufer, 2005). As expected, our model-based analysis confirmed previous findings by showing 7- and 6-OH-S-warfarin are the most predominant metabolites for S-warfarin, the CLf of which is impacted by *CYP2C9* (Figure 5). Interestingly, our model detects a *CYP2C9* genotype-dependent elimination clearance (CLe) for 10-OH-S-warfarin. Subjects with more defective *CYP2C9* exhibit a higher CLe for 10-OH-S-warfarin. This potentially suggests further CYP-dependent metabolism or conjugation, such as glucuronidation, may be involved in the elimination of 10-OH-S-warfarin. Indeed, the involvement of subsequent metabolism steps may also explain the relatively low urine level of 10-OH-S-warfarin (Figure 3I). Interestingly, a previous study also suggests the exposure level of 10-OH-S-warfarin is related to *CYP2C9* genotypes (Pouncey et al., 2018). However, this study concluded that subjects who are *CYP2C9* extensive metabolizers may exhibit a lower concentration of 10-OH-S-warfarin, which is paradoxical with our analysis. Given that many studies show the formation of 10-OH-S-warfarin is mediated by CYP3A4 (Kaminsky and Zhang, 1997; Ngui et al., 2001; Pouncey et al., 2018), the impact of CYP2C9 on the elimination rather than the formation of 10-OH-S-warfarin demonstrated by our analysis provides additional insight about its disposition that warrants further investigation. The formation of 10-OH-R-warfarin is mediated by CYP3A4 as well (Ufer, 2005; Pouncey et al., 2018). The plasma concentration of 10-OH-R-warfarin appears to be the highest among the R-warfarin metabolites (Figure 2), but its PK have heretofore not been extensively assessed. Here, our model identified a relatively low CLf and Vd for 10-OH-R-warfarin (Table S11). The non-compartmental analysis reported in our previous study demonstrated that 10-OH-R-warfarin also has an uncommonly long terminal half-life (>100 hours) and exhibited elimination rate-limited
kinetics (Flora et al., 2017). In addition, the urinary excretion of 10-OH-R-warfarin appears to be very limited (Figure 3J). The mechanism behind the unusual PK behavior of 10-OH-R warfarin is unknown. However, as indicated in our previous study, we suspect that 10-OH-R-warfarin may undergo enterohepatic recirculation, fecal elimination and sequential metabolism to another metabolite (Flora et al., 2017). Interestingly, a previous study has reported 10-OH-metabolites of warfarin can potently inhibit the S-warfarin CYP2C9 metabolic clearance in a competitive manner (Jones et al., 2010a). Thus, more studies focused on the disposition of 10-OH-warfarin may be valuable for better understanding of the interplay between warfarin metabolites and the disposition of S-warfarin, the pharmacologically more active component in warfarin.

Our model also discovered that subjects with the CYP2C9 *1B/*1B genotype exhibit a lower 8-OH-R-warfarin CLf compared with subjects with other CYP2C9 genotypes. Interestingly, a strong linkage disequilibrium between CYP2C9*1B and CYP2C19 *2 was previously reported (Chaudhry et al., 2010). In addition, CYP2C19 *2 is known to be the most common mutation encoding a defective CYP2C19 protein (de Morais et al., 1994; Dehbozorgi et al., 2018). Since the formation of 8-OH-R-warfarin is mediated mainly by CYP2C19 (Pouncey et al., 2018), the higher probability of the existence of the CYP2C19 *2 genotype in subjects with the CYP2C9 *1B/*1B genotype may explain the lower 8-OH-R-warfarin CLf in these subjects. Our companion study also suggests that the increase in S- and R-warfarin CL following the co-administration of rifampin is similar between subjects with the CYP2C9 *1/*1 and CYP2C9 *1B/*1B (Cheng et al., concurrently published). However, the current study demonstrates that subjects with the CYP2C9 *1B/*1B exhibit a more pronounced induction of the CLf for CYP3A4-mediated 10-hydroxylation of both S- and R-warfarin (Figure 4, B and D, Table 1), but a less inducible CLf for CYP2C19-mediated 8-hydroxylation of R-warfarin (Figure 4B, Table 1). Interestingly, Chaudhry et al. also demonstrated that subjects with the CYP2C9 *1B variant tend to exhibit a greater induction of CYP3A4 but a lesser induction of CYP2C19, although both associations were not statistically significant (Chaudhry et al., 2010). The mechanism for the altered inducibility of CYP3A4 and CYP2C19 is speculated to be attributable to binding element changes in transcription factors, such as Yin Yang 1 (YY1), introduced by CYP2C9 *1B (Chaudhry et al., 2010).
In our companion study, we successfully utilized a target mediated drug disposition (TMDD) model to characterize warfarin PK profiles in both plasma and urine, when warfarin is administered either alone or together with fluconazole or rifampin. Our model-based analysis suggested the changes in S-warfarin CL, following the administration of warfarin together with fluconazole or rifampin, follows a $CYP2C9$ genotype-dependent manner (Cheng et al., concurrently published). As such, the study presented herein provides more mechanistic insights behind the $CYP2C9$ genotype-dependent DDIs exhibited by S-warfarin. Specifically, following the administration of fluconazole, the inhibitory effects on the $CL_f$ of $CYP2C9$ related metabolites, such as 7- and 6-OH-S-warfarin, are higher than some of the non-CYP2C9 related metabolites, such as 10-OH-S-warfarin, and are much higher than the $CL_R$ for S-warfarin (Figure 4A). Since for subjects possessing the $CYP2C9\, *2$ and *3 variants, $CL_f$ of CYP2C9 related metabolites represents a smaller proportion of the overall S-warfarin CL, compared to $CYP2C9\, *1/*1$ subjects (Figure 5), a higher inhibitability of CYP2C9-mediated $CL_f$ compared with other elimination pathways makes the S-warfarin CL in subjects with $CYP2C9\, *2$ and *3 variants less susceptible to fluconazole inhibition. In contrast, following the administration of rifampin, the inducing effects on $CL_f$ for the CYP2C9 related metabolites are less than the non-CYP2C9 related metabolites (Figure 4B). Since for subjects with $CYP2C9\, *2$ and *3 variants, $CL_f$ of non-CYP2C9 related metabolites represents a larger proportion of the overall S-warfarin CL compared to $CYP2C9\, *1/*1$ subjects (Figure 5), the greater induction of non-CYP2C9 mediated $CL$ makes subjects with the $CYP2C9\, *2$ and *3 variants subject to higher CL changes following the co-administration of rifampin.

The present study confirmed some previous findings. For example, Heimark et al. found in the presence of rifampin co-treatment, the CL of warfarin enantiomers and the $CL_f$ of 6-, 7- and 8-OH metabolites increase. Heimark et al. also found the percentages of R-warfarin dose excreted in the urine decrease as 6- and 7-OH metabolites, but increase as 4’- and 8-OH metabolites (Heimark et al., 1987). Additionally, following the co-administration of fluconazole, Douglas et al. found the CL of warfarin enantiomers and the $CL_f$ of 6-, 7-, 8- and 10-OH metabolites decrease. Fluconazole inhibits the formation of 6-, 7- and 8-OH S-warfarin to a similar extent, by around 70% (Black et al., 1996). These findings are consistent with the analysis presented in this study (Figure 4 and Figure 6).
Limitations to our models are recognized. Firstly, for metabolites such as 4′-OH-S-, 7-OH-R- and 8-OH-S-warfarin, the model predicted plasma PK profiles included a high proportion of concentrations below 0 (Figure S1, S6 and S7, A). This occurred because the estimated RUVs for these metabolites are excessively large (>100%). In addition, several IIV terms in PK models were also uncommonly large (Table S2, S7 and S8). We suspect that a significant proportion of the concentrations below LLOQ for these metabolites (Table S1) leads to substantial inflation in the estimations of IIVs and RUVs. However, given the sufficient urine measurements collected, the model parameters were still estimated with reasonable precision (Table S2, S7 and S8). In the future, more advanced analytical techniques with higher sensitivity for detection of these metabolites will be needed to better characterize their plasma PK profiles. Additionally, some systemic bias in model predictions were noticed. For example, the developed model for 4′-OH-S-warfarin appears to under-predict the urinary PK profiles in subjects with CYP2C9 *1B/*1B and inadequately characterize the urinary PK profiles in subjects with CYP2C9 *2/*3 when warfarin is administered together with fluconazole (Figure S1C).

Secondly, without the administration of each metabolite alone or any prior knowledge about the fraction of warfarin enantiomers metabolized to a particular metabolite, the Vd of each metabolite is theoretically not estimable based on metabolite plasma PK profiles alone when only the parent compound is administered (Cosson et al., 2007). A common approach to address this is to either fix the fraction of metabolism (fm) based on literature (Vanobberghen et al., 2016; Mian et al., 2019) or to assume a metabolite Vd (for instance, equal to Vd of parent compound) (Patel et al., 2017). However, the Vd of each metabolite becomes identifiable if the metabolite plasma and urine PK profiles are fitted simultaneously, if all the metabolites generated are excreted in the urine and only renally eliminated. In fact, in vitro studies conducted by Zielinska et al. suggest that 4′-, 6-, 7- and 8-hydroxywarfarin can undergo glucuronidation mediated by multiple UDP-glucuronosyltransferases (UGTs), such as UGT1A1 and UGT1A10 (Zielinska et al., 2008). Human studies also suggest the overall percentages of glucuronidation of monohydroxylated warfarin metabolites can vary between 14-59% (Miller et al., 2009; Jones et al., 2010b). This in vitro and in vivo evidence of phase II metabolism suggests that the metabolite PK models presented may potentially underestimate the actual Vd and CLf of each metabolite. Thus, the CLf estimated in our study should be considered as the minimum possible CLf for each metabolite. Nevertheless, despite the limitations discussed above, our collective
analyses presented in Figures 5 and 6 can still reasonably reflect the warfarin metabolic profiles in subject with various CYP2C9 under different co-treatments.

To our knowledge, our model-analysis of warfarin parent enantiomers and metabolites is the most comprehensive population PK analyses of warfarin disposition in subjects with different CYP2C9 to date. This study involved the development of population PK models for 10 warfarin metabolites and conduct a model-based analysis of the warfarin metabolic profiles. The differential effects of fluconazole inhibition and rifampin induction on the CLf of warfarin metabolites across CYP2C9 genotypes largely explains the CYP2C9 genotype-dependent effects on the warfarin enantiomers observed in our companion study (Cheng et al., concurrently published). In addition, the differential inhibitability and inducibility of several CYP enzymes elucidated by our study of warfarin metabolites is potentially useful in informing the predicted extent of DDIs of other drugs eliminated by similar metabolic pathways.

In conclusion, we developed population PK models for 10 warfarin metabolites and performed comprehensive model-based analysis. The model-based analysis provides mechanistic insights behind the CYP2C9 genotype-dependent DDIs exhibited by S-warfarin, as suggested in our companion study. In addition, our analysis provides a better understanding of warfarin disposition for subjects with various CYP2C9 genotypes following the administration of both inhibitor and inducer co-medications.
Author Contributions:

Participated in research design: Cheng, Flora, Rettie, Brundage, Tracy

Conducted experiments: Flora, Rettie, Tracy

Performed data analysis: Cheng, Brundage

Wrote or contributed to the writing of the manuscript: Cheng, Flora, Rettie, Brundage, Tracy
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Figure legends

Figure 1. PK model structures for warfarin parent and metabolites. Dark-blue frames: S-warfarin parent compound and metabolites models; Dark-red frames: R-warfarin parent compound and metabolites models. Notes: Periph: peripheral; Cent: central; R: receptors; DR: drug-receptor complexes. M-Cent: metabolite central compartment; M-periph: metabolite peripheral compartment; M-urine: metabolite urine compartment.

Figure 2. Plasma PK profiles for S-warfarin metabolites (left, 4’-(A), 6-(C), 7-(E), 8-(G) and 10-(I) OH-S-warfarin) and R-warfarin metabolites (right, 4’-(B), 6-(D), 7-(F), 8-(H) and 10-(J) OH-R-warfarin). Colors represent subjects’ CYP2C9 genotypes. Plots are on log scales.

Figure 3. Urine PK profiles for S-warfarin metabolites (left, 4’-(A), 6-(C), 7-(E), 8-(G) and 10-(I) OH-S-warfarin) and R-warfarin metabolites (right, 4’-(B), 6-(D), 7-(F), 8-(H) and 10-(J) OH-R-warfarin). Colors represent subjects’ CYP2C9 genotypes. Plots are on log scales.

Figure 4. Percentage changes in CLf or CLR of S-warfarin metabolites (A and B) and R-warfarin metabolites (C and D) following the administration of fluconazole (A and C) or rifampin (B and D). Colors represent the fluconazole and rifampin introduced inhibition and induction, respectively, as shown in the figure legend. Error bars represent 95% confidence intervals constructed with relative standard error (RSE) estimated from covariance steps assuming a symmetrical normal distribution.

Figure 5. S-warfarin metabolic profiles in subjects with different CYP2C9 genotypes following the administration of warfarin alone (A) and warfarin together with fluconazole (B) or rifampin (C). Color represents different elimination pathway as shown in the figure legend.

Figure 6. R-warfarin metabolic profiles in subjects with different CYP2C9 genotypes following the administration of warfarin alone (A) and warfarin together with fluconazole (B) or rifampin (C). Color represents different elimination pathway as shown in the figure legend.
Table 1. Summary of the major CYP enzymes involved in the formation of each metabolite.

<table>
<thead>
<tr>
<th>S-warfarin metabolites</th>
<th>CYPs</th>
<th>R-warfarin metabolites</th>
<th>CYPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>4’-OH-S-warfarin</td>
<td>2C19, 3A4, 2C8</td>
<td>4’-OH-R-warfarin</td>
<td>2C19, 3A4, 2C8</td>
</tr>
<tr>
<td>6-OH-S-warfarin</td>
<td>2C9 (major), 2C19 (minor)</td>
<td>6-OH-R-warfarin</td>
<td>1A2 (major), 2C19 (minor)</td>
</tr>
<tr>
<td>7-OH-S-warfarin</td>
<td>2C9 (major), 2C19 (minor)</td>
<td>7-OH-R-warfarin</td>
<td>2C19, 1A2, 2C8</td>
</tr>
<tr>
<td>8-OH-S-warfarin</td>
<td>2C19</td>
<td>8-OH-R-warfarin</td>
<td>2C19 (major), 1A2 (minor)</td>
</tr>
<tr>
<td>10-OH-S-warfarin</td>
<td>3A4</td>
<td>10-OH-R-warfarin</td>
<td>3A4</td>
</tr>
</tbody>
</table>

Notes: the information of CYPs is based on reference (Ufer, 2005) and (Pouncey et al., 2018)
Figure 1

[Diagram showing the metabolism of S-warfarin and R-warfarin, including pathways for 4′-OH-S-warfarin, 8-OH-S-warfarin, 10-OH-S-warfarin, 6-OH-S-warfarin, 7-OH-S-warfarin, 4′-OH-R-warfarin, 6-OH-R-warfarin, 7-OH-R-warfarin, and 8-OH-R-warfarin.]
Figure 2

(A) Concentration (ng/mL) vs. Time (h) for Warfarin.
(B) Concentration (ng/mL) vs. Time (h) for Warfarin + Fluconazole.
(C) Concentration (ng/mL) vs. Time (h) for Warfarin + Rifampin.

(D) Concentration (ng/mL) vs. Time (h) for Warfarin.
(E) Concentration (ng/mL) vs. Time (h) for Warfarin + Fluconazole.
(F) Concentration (ng/mL) vs. Time (h) for Warfarin + Rifampin.

(G) Concentration (ng/mL) vs. Time (h) for Warfarin.
(H) Concentration (ng/mL) vs. Time (h) for Warfarin + Fluconazole.
(I) Concentration (ng/mL) vs. Time (h) for Warfarin + Rifampin.

(J) Concentration (ng/mL) vs. Time (h) for Warfarin.

[Color codes for genotypes: CYP2C9 *1/*1, CYP2C9 *1/*3, CYP2C9 *2/*3, CYP2C9 *3/*3]
Figure 4

(A) % decrease in Cl_1 or Cl_R
(15.3%)

(B) % increase in Cl_1 or Cl_R
(200%)

(C) % decrease in Cl_1 or Cl_R
(24.8%)

(D) % increase in Cl_1 or Cl_R
(200%)

**Legend:**
- Fluconazole effects
- Rifampin effects for all CYP2C9 genotypes or CYP2C9 genotypes other than CYP2C9 *1B/*1B
- Rifampin effects if CYP2C9 *1B/*1B
Figure 6

A. Warfarin

B. Warfarin with fluconazole

C. Warfarin with rifampin

Legend:
- 4'-OH-R-warfarin
- 6-OH-R-warfarin
- 7-OH-R-warfarin
- 8-OH-R-warfarin
- 10-OH-R-warfarin
- Renal
Pharmacokinetic Modeling of Warfarin II – Model-based Analysis of Warfarin Metabolites following Warfarin Administered either Alone or Together with Fluconazole or Rifampin

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Figure S6. Visual prediction checks (VPCs) for 7-OH-R-warfarin plasma PK profiles (A), plasma concentrations below quantification limit (BQL) fractions (B) and urine PK profiles (C). For (A) and (C), blue dots represent the observations. Red solid lines represent the medians of model predictions. The lower and upper red dashed lines represent the 10th and 90th percentiles of the model predictions respectively. The black dashed lines represent the lower limit of quantification (LLOQ) for 7-OH-R-warfarin (0.67 ng/mL). For (B), Blue dots and lines represent the observed fraction BQL versus time. Red dashed lines represent the medians of model simulated fraction BQL. The red shaded areas represent the 95% confidence intervals of the medians of model simulated fraction BQL. All the figures are stratified by both CYP2C9 genotypes and co-treatments. No observations collected from subjects with CYP2C9 *1B/*1B under the treatment of warfarin plus fluconazole. Notes: Warf: warfarin; Flu: fluconazole; Rif: rifampin; *1/*1: CYP2C9 *1/*1; *1/*1B: CYP2C9 *1/*1B; *1/*3: CYP2C9 *1/*3; *2/*3: CYP2C9 *2/*3; *3/*3: CYP2C9 *3/*3
Figure S7. Visual prediction checks (VPCs) for 8-OH-S-warfarin plasma PK profiles (A), plasma concentrations below quantification limit (BQL) fractions (B) and urine PK profiles (C). For (A) and (C), blue dots represent the observations. Red solid lines represent the medians of model predictions. The lower and upper red dashed lines represent the 10th and 90th percentiles of the model predictions respectively. The black dashed lines represent the lower limit of quantification (LLOQ) for 8-OH-S-warfarin (0.5 ng/mL). For (B), Blue dots and lines represent the observed fraction BQL versus time. Red dashed lines represent the medians of model simulated fraction BQL. The red shaded areas represent the 95% confidence intervals of the medians of model simulated fraction BQL. All the figures are stratified by both CYP2C9 genotypes and co-treatments. No observations collected from subjects with CYP2C9 *1B/*1B under the treatment of warfarin plus fluconazole. Notes: Warf: warfarin; Flu: fluconazole; Rif: rifampin; *1/*1: CYP2C9 *1/*1; *1B/*1B: CYP2C9 *1B/*1B; *1/*3: CYP2C9 *1/*3; *2/*3: CYP2C9 *2/*3; *3/*3: CYP2C9 *3/*3
Figure S8. Visual prediction checks (VPCs) for 8-OH-R-warfarin plasma PK profiles (A), plasma concentrations below quantification limit (BQL) fractions (B) and urine PK profiles (C). For (A) and (C), blue dots represent the observations. Red solid lines represent the medians of model predictions. The lower and upper red dashed lines represent the 10th and 90th percentiles of the model predictions respectively. The black dashed lines represent the lower limit of quantification (LLOQ) for 8-OH-R-warfarin (0.5 ng/mL). For (B), Blue dots and lines represent the observed fraction BQL versus time. Red dashed lines represent the medians of model simulated fraction BQL. The red shaded areas represent the 95% confidence intervals of the medians of model simulated fraction BQL. All the figures are stratified by both CYP2C9 genotypes and co-treatments. No observations collected from subjects with CYP2C9 *1B/*1B under the treatment of warfarin plus fluconazole. Notes: Warf: warfarin; Flu: fluconazole; Rif: rifampin; *1/*1: CYP2C9 *1/*1; *1B/*1B: CYP2C9 *1B/*1B; *1/*3: CYP2C9 *1/*3; *2/*3: CYP2C9 *2/*3; *3/*3: CYP2C9 *3/*3
Figure S9. Visual prediction checks (VPCs) for 10-OH-S-warfarin plasma PK profiles (A), plasma concentrations below quantification limit (BQL) fractions (B) and urine PK profiles (C). For (A) and (C), blue dots represent the observations. Red solid lines represent the medians of model predictions. The lower and upper red dashed lines represent the 10th and 90th percentiles of the model predictions respectively. The black dashed lines represent the lower limit of quantification (LLOQ) for 10-OH-S-warfarin (0.75 ng/mL). For (B), Blue dots and lines represent the observed fraction BQL versus time. Red dashed lines represent the medians of model simulated fraction BQL. The red shaded areas represent the 95% confidence intervals of the medians of model simulated fraction BQL. All the figures are stratified by both CYP2C9 genotypes and co-treatments. No observations collected from subjects with CYP2C9 *1B/*1B under the treatment of warfarin plus fluconazole. Notes: Warf: warfarin; Flu: fluconazole; Rif: rifampin; *1/*1: CYP2C9 *1/*1; *1B/*1B: CYP2C9 *1B/*1B; *1/*3: CYP2C9 *1/*3; *2/*3: CYP2C9 *2/*3; *3/*3: CYP2C9 *3/*3
Figure S10. Visual prediction checks (VPCs) for 10-OH-R-warfarin plasma PK profiles (A), plasma concentrations below quantification limit (BQL) fractions (B) and urine PK profiles (C). For (A) and (C), blue dots represent the observations. Red solid lines represent the medians of model predictions. The lower and upper red dashed lines represent the 10th and 90th percentiles of the model predictions respectively. The black dashed lines represent the lower limit of quantification (LLOQ) for 10-OH-R-warfarin (0.75 ng/mL). For (B), Blue dots and lines represent the observed fraction BQL versus time. Red dashed lines represent the medians of model simulated fraction BQL. The red shaded areas represent the 95% confidence intervals of the medians of model simulated fraction BQL. All the figures are stratified by both CYP2C9 genotypes and co-treatments. No observations collected from subjects with CYP2C9 *1B/*1B under the treatment of warfarin plus fluconazole. Notes: Warf: warfarin; Flu: fluconazole; Rif: rifampin; *1/*1: CYP2C9 *1/*1; *1B/*1B: CYP2C9 *1B/*1B; *1/*3: CYP2C9 *1/*3; *2/*3: CYP2C9 *2/*3; *3/*3: CYP2C9 *3/*3
<table>
<thead>
<tr>
<th>Chirality</th>
<th>Metabolites</th>
<th>Number of plasma concentrations</th>
<th></th>
<th>Number of urine amounts</th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Baseline</td>
<td>Above quantification limit</td>
<td>Below quantification limit</td>
<td></td>
</tr>
<tr>
<td>S</td>
<td>4'-'OH-S-warfarin</td>
<td>1</td>
<td>73</td>
<td>848</td>
<td>267</td>
</tr>
<tr>
<td></td>
<td>6-OH-S-warfarin</td>
<td>1</td>
<td>465</td>
<td>456</td>
<td>304</td>
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<tr>
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<td>7-OH-S-warfarin</td>
<td>12</td>
<td>855</td>
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<td>8-OH-S-warfarin</td>
<td>0</td>
<td>18</td>
<td>903</td>
<td>239</td>
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<tr>
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<td>10-OH-S-warfarin</td>
<td>0</td>
<td>543</td>
<td>341</td>
<td>85</td>
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<td>R</td>
<td>4'-'OH-R-warfarin</td>
<td>0</td>
<td>448</td>
<td>473</td>
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<td>6-OH-R-warfarin</td>
<td>0</td>
<td>687</td>
<td>234</td>
<td>300</td>
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<td>7-OH-R-warfarin</td>
<td>7</td>
<td>83</td>
<td>838</td>
<td>190</td>
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<tr>
<td></td>
<td>8-OH-R-warfarin</td>
<td>0</td>
<td>466</td>
<td>455</td>
<td>295</td>
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<tr>
<td></td>
<td>10-OH-R-warfarin</td>
<td>15</td>
<td>893</td>
<td>28</td>
<td>92</td>
</tr>
</tbody>
</table>
Table S2: Parameter estimations for 4’-OH-S-warfarin

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Definitions</th>
<th>Estimates (RSE)</th>
<th>SIR medians (95% CIs)</th>
<th>IIV Estimates (RSE)</th>
<th>IIV SIR medians (95% CI)</th>
<th>Shrinkage</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>CL&lt;sub&gt;f&lt;/sub&gt;</td>
<td>Formation clearance</td>
<td>0.00396 (14%)</td>
<td>0.00397 (0.00300, 0.00501)</td>
<td>81.5% (16%)</td>
<td>85.5% (61.7%, 117.5%)</td>
<td>4%</td>
<td>L/hour</td>
</tr>
<tr>
<td>V&lt;sub&gt;c&lt;/sub&gt;</td>
<td>Central compartment volume of distribution</td>
<td>2.31 (51%)</td>
<td>2.57 (0.87, 4.91)</td>
<td>290% (35%)</td>
<td>456% (126%, 2330%)</td>
<td>41%</td>
<td>L</td>
</tr>
<tr>
<td>CL&lt;sub&gt;e&lt;/sub&gt;</td>
<td>Elimination clearance</td>
<td>55.8 (85%)</td>
<td>90.8 (28.5, 185.6)</td>
<td>12967% (21%)</td>
<td>46278% (2908%, 3124610%)</td>
<td>17%</td>
<td>L/hour</td>
</tr>
<tr>
<td>BL</td>
<td>Period 2 and 3 baseline concentration in central compartment</td>
<td>0.515 (1%)</td>
<td>0.513 (0.501, 0.528)</td>
<td></td>
<td></td>
<td></td>
<td>µg/L</td>
</tr>
<tr>
<td>CL&lt;sub&gt;e&lt;/sub&gt; Flu</td>
<td>% of CL&lt;sub&gt;e&lt;/sub&gt; when administered with fluconazole</td>
<td>22.4% (10%)</td>
<td>22.6% (18.4%, 26.9%)</td>
<td>33.6% (27%)</td>
<td>36.6% (20.8%, 53.7%)</td>
<td>31%</td>
<td></td>
</tr>
<tr>
<td>CL&lt;sub&gt;e&lt;/sub&gt; Rif</td>
<td>% of CL&lt;sub&gt;e&lt;/sub&gt; when administered with rifampin</td>
<td>360% (12%)</td>
<td>361% (288%, 443%)</td>
<td>49.1% (21%)</td>
<td>53.4% (34.1%, 75.2%)</td>
<td>21%</td>
<td></td>
</tr>
<tr>
<td>σ&lt;sub&gt;warf&lt;/sub&gt;</td>
<td>RUV for plasma</td>
<td>128% (16%)</td>
<td>133% (99%, 177%)</td>
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<td></td>
</tr>
<tr>
<td>σ&lt;sub&gt;warf_U&lt;/sub&gt;</td>
<td>RUV for warfarin alone phase urine</td>
<td>43.0% (11%)</td>
<td>43.4% (36.7%, 51.7%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>σ&lt;sub&gt;warf_Flu_U&lt;/sub&gt;</td>
<td>RUV for warfarin + fluconazole phase urine</td>
<td>39.0% (10%)</td>
<td>42.3% (35.9%, 48.5%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>σ&lt;sub&gt;warf_Rif_U&lt;/sub&gt;</td>
<td>RUV for warfarin + rifampin phase urine</td>
<td>44.3% (10%)</td>
<td>45.4% (38.3%, 52.9%)</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Notes: IIV: inter-individual variability; RUV: residual unexplained variability; RSE: Relative standard error; CI: confidence interval; Sources for parameter estimations are estimated except indicated otherwise. IIV terms are expressed as CV% (\(\sqrt{e^{\omega^2} - 1}\)); RUV terms are expressed as CV% (\(\sqrt{\sigma^2}\)); SIR: Sampling importance resampling.
### Table S3: Parameter estimations for 4′-OH-R-warfarin

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Definitions</th>
<th>Estimates (RSE)</th>
<th>SIR medians (95% CIs)</th>
<th>IV Estimates (RSE)</th>
<th>IV SIR medians (95% CI)</th>
<th>Shrinkage</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>CL&lt;sub&gt;f&lt;/sub&gt;</td>
<td>Formation clearance for subjects with CYP2C9 *1/*1 and *1B/*1B</td>
<td>0.000970 (10%)</td>
<td>0.000971 (0.000789, 0.001178)</td>
<td>26.7% (23%)</td>
<td>27.9% (18.2%, 38.3%)</td>
<td>18%</td>
<td>L/hour</td>
</tr>
<tr>
<td>V&lt;sub&gt;c&lt;/sub&gt;</td>
<td>Central compartment volume of distribution</td>
<td>1.76 (9%)</td>
<td>1.76 (1.45, 2.12)</td>
<td>37.0% (38%)</td>
<td>42.0% (24.2%, 62.1%)</td>
<td>15%</td>
<td>L</td>
</tr>
<tr>
<td>CL&lt;sub&gt;e&lt;/sub&gt;</td>
<td>Elimination clearance</td>
<td>0.0880 (10%)</td>
<td>0.0878 (0.0715, 0.1069)</td>
<td>41.8% (21%)</td>
<td>44.3% (29.4%, 61.3%)</td>
<td>9%</td>
<td>L/hour</td>
</tr>
<tr>
<td>CL&lt;sub&gt;D&lt;/sub&gt;</td>
<td>Distribution clearance</td>
<td>0.0523 (19%)</td>
<td>0.0529 (0.0351, 0.0782)</td>
<td>100% (14%)</td>
<td>98% (60%, 141%)</td>
<td>23%</td>
<td>L/hour</td>
</tr>
<tr>
<td>V&lt;sub&gt;p&lt;/sub&gt;</td>
<td>Peripheral compartment volume of distribution</td>
<td>3.33 (23%)</td>
<td>3.41 (1.94, 5.02)</td>
<td>72.8% (38%)</td>
<td>86.2% (44.3%, 150.3%)</td>
<td>44%</td>
<td>L</td>
</tr>
<tr>
<td>CL&lt;sub&gt;4_Geno345&lt;/sub&gt;</td>
<td>% of CL&lt;sub&gt;f&lt;/sub&gt; for subjects with CYP2C9 *1/*3, *2/*3 and *3/*3 (reference: CYP2C9 *1/*1 and *1B/*1B)</td>
<td>64.0% (12%)</td>
<td>64.2% (49.7%, 81.7%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CL&lt;sub&gt;4_Flu&lt;/sub&gt;</td>
<td>% of CL&lt;sub&gt;e&lt;/sub&gt; when administered with fluconazole</td>
<td>35.2% (13%)</td>
<td>35.8% (27.1%, 45.4%)</td>
<td>52.0% (24%)</td>
<td>56.3% (33.4%, 83.5%)</td>
<td>24%</td>
<td></td>
</tr>
<tr>
<td>CL&lt;sub&gt;4_Rif&lt;/sub&gt;</td>
<td>% of CL&lt;sub&gt;e&lt;/sub&gt; when administered with rifampin</td>
<td>306% (7%)</td>
<td>307% (266%, 352%)</td>
<td>31.8% (67%)</td>
<td>38.5% (22.7%, 60.7%)</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>CL&lt;sub&gt;4_Flu&lt;/sub&gt;</td>
<td>% of CL&lt;sub&gt;e&lt;/sub&gt; when administered with fluconazole</td>
<td>120% (14%)</td>
<td>123% (93%, 161%)</td>
<td>44.9% (28%)</td>
<td>50.0% (25.4%, 75.9%)</td>
<td>32%</td>
<td></td>
</tr>
<tr>
<td>CL&lt;sub&gt;4_Rif&lt;/sub&gt;</td>
<td>% of CL&lt;sub&gt;e&lt;/sub&gt; when administered with rifampin</td>
<td>133% (8%)</td>
<td>135% (113%, 159%)</td>
<td>36.3% (25%)</td>
<td>39.0% (25.0%, 33.6%)</td>
<td>16%</td>
<td></td>
</tr>
<tr>
<td>σ&lt;sub&gt;warf&lt;/sub&gt;</td>
<td>RUV for warfarin alone phase plasma</td>
<td>16.0% (6%)</td>
<td>16.6% (14.6%, 18.5%)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>σ&lt;sub&gt;warf_Flu&lt;/sub&gt;</td>
<td>RUV for warfarin + fluconazole phase plasma</td>
<td>22.2% (11%)</td>
<td>23.0% (18.5%, 28.1%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>σ&lt;sub&gt;warf_Rif&lt;/sub&gt;</td>
<td>RUV for warfarin + rifampin phase plasma</td>
<td>17.1% (8%)</td>
<td>18.0% (15.6%, 21.0%)</td>
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<tr>
<td>σ&lt;sub&gt;warf_U&lt;/sub&gt;</td>
<td>RUV for warfarin alone phase urine</td>
<td>67.7% (13%)</td>
<td>69.5% (52.6%, 87.3%)</td>
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<tr>
<td>σ&lt;sub&gt;warf_Flu_U&lt;/sub&gt;</td>
<td>RUV for warfarin + fluconazole phase urine</td>
<td>43.0% (17%)</td>
<td>46.0% (33.2%, 59.1%)</td>
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</tr>
<tr>
<td>σ&lt;sub&gt;warf_Rif_U&lt;/sub&gt;</td>
<td>RUV for warfarin + rifampin phase urine</td>
<td>46.9% (15%)</td>
<td>48.4% (35.8%, 61.4%)</td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

Notes: IIV: inter-individual variability; RUV: residual unexplained variability; RSE: Relative standard error; CI: confidence interval; Sources for parameter estimations are estimated except indicated otherwise. IIV terms are expressed as CV% (√e<sup>ω</sup> - 1); RUV terms are expressed as CV% (√σ<sup>2</sup>); SIR: Sampling importance resampling.
## Table S4: Parameter estimations for 6-OH-S-warfarin

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Definitions</th>
<th>Estimates (RSE)</th>
<th>SIR medians (95% CIs)</th>
<th>IIV Estimates (RSE)</th>
<th>IIV SIR medians (95% CI)</th>
<th>Shrinkage</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>$CL_f$</td>
<td>Formation clearance for subjects with CYP2C9 *1/*1</td>
<td>0.0273 (10%)</td>
<td>0.0268 (0.0222, 0.0321)</td>
<td>26.5% (16%)</td>
<td>29.5% (22.1%, 37.5%)</td>
<td>7%</td>
<td>L/hour</td>
</tr>
<tr>
<td>$V_C$</td>
<td>Central compartment volume of distribution</td>
<td>3.13 (23%)</td>
<td>3.01 (1.64, 4.51)</td>
<td>74.4% (37%)</td>
<td>90.0% (32.8%, 154.2%)</td>
<td>45%</td>
<td>L</td>
</tr>
<tr>
<td>$CL_e$</td>
<td>Elimination clearance</td>
<td>2.15 (7%)</td>
<td>2.17 (1.88, 2.44)</td>
<td>33.9% (16%)</td>
<td>35.6% (26.3%, 45.9%)</td>
<td>7%</td>
<td>L/hour</td>
</tr>
<tr>
<td>$CL_D$</td>
<td>Distribution clearance</td>
<td>4.18 (1%)</td>
<td>4.18 (4.11, 4.24)</td>
<td></td>
<td></td>
<td></td>
<td>L/hour</td>
</tr>
<tr>
<td>$V_P$</td>
<td>Peripheral compartment volume of distribution</td>
<td>14.2 (0%)</td>
<td>14.2 (14.1, 14.3)</td>
<td></td>
<td></td>
<td></td>
<td>L</td>
</tr>
<tr>
<td>BL</td>
<td>Period 2 and 3 baseline concentration in central compartment</td>
<td>0.117 (1%)</td>
<td>0.118 (0.115, 0.120)</td>
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<td>µg/L.</td>
</tr>
<tr>
<td>BL_P</td>
<td>Period 2 and 3 baseline concentration in peripheral compartment</td>
<td>0.0268 (1%)</td>
<td>0.0267 (0.0263, 0.0272)</td>
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<td></td>
<td></td>
<td>µg/L.</td>
</tr>
<tr>
<td>$CL_{Geno2}$</td>
<td>% of $CL_f$ for subjects with CYP2C9 *1B/*1B (reference: CYP2C9 *1/*1)</td>
<td>84.1% (16%)</td>
<td>85.4% (61.8%, 114.8%)</td>
<td></td>
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<tr>
<td>$CL_{Geno3}$</td>
<td>% of $CL_f$ for subjects with CYP2C9 *1/*3 (reference: CYP2C9 *1/*1)</td>
<td>61.9% (14%)</td>
<td>63.6% (46.8%, 82.6%)</td>
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<tr>
<td>$CL_{Geno4}$</td>
<td>% of $CL_f$ for subjects with CYP2C9 *2/*3 (reference: CYP2C9 *1/*1)</td>
<td>24.4% (19%)</td>
<td>25.1% (17.1%, 34.1%)</td>
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</tr>
<tr>
<td>$CL_{Geno5}$</td>
<td>% of $CL_f$ for subjects with CYP2C9 *3/*3 (reference: CYP2C9 *1/*1)</td>
<td>10.5% (17%)</td>
<td>10.7% (7.6%, 14.8%)</td>
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</tr>
<tr>
<td>$CL_{Flu}$</td>
<td>% of $CL_f$ when administered with fluconazole</td>
<td>26.8% (0%)</td>
<td>26.7% (26.5%, 27.0%)</td>
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<td></td>
</tr>
<tr>
<td>$CL_{Rif}$</td>
<td>% of $CL_f$ when administered with rifampin</td>
<td>185% (0%)</td>
<td>185% (183%, 187%)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>$CL_{Flu}$</td>
<td>% of $CL_f$ when administered with fluconazole</td>
<td>87.3% (1%)</td>
<td>87.2% (85.5%, 88.8%)</td>
<td></td>
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</tr>
<tr>
<td>$CL_{Rif}$</td>
<td>% of $CL_f$ when administered with rifampin</td>
<td>104% (1%)</td>
<td>104% (102%, 107%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$\sigma_{warf}$</td>
<td>RUV for warfarin alone phase plasma</td>
<td>36.6% (6%)</td>
<td>36.8% (32.8%, 41.9%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$\sigma_{warf_Flu}$</td>
<td>RUV for warfarin + fluconazole phase plasma</td>
<td>38.8% (8%)</td>
<td>39.0% (33.6%, 44.6%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$\sigma_{warf_Rif}$</td>
<td>RUV for warfarin + rifampin phase plasma</td>
<td>37.5% (7%)</td>
<td>37.7% (33.5%, 42.5%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$\sigma_{warf_U}$</td>
<td>RUV for warfarin alone phase urine</td>
<td>38.6% (8%)</td>
<td>38.3% (33.4%, 43.7%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$\sigma_{warf_Flu_U}$</td>
<td>RUV for warfarin + fluconazole phase urine</td>
<td>33.2% (10%)</td>
<td>32.9% (28.0%, 38.1%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$\sigma_{warf_Rif_U}$</td>
<td>RUV for warfarin + rifampin phase urine</td>
<td>42.0% (9%)</td>
<td>41.6% (36.0%, 47.0%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: IIV: inter-individual variability; RUV: residual unexplained variability; RSE: Relative standard error; CI: confidence interval; Sources for parameter estimations are estimated except indicated otherwise. IIV terms are expressed as CV% ($\sqrt{e\omega^2} - 1$); RUV terms are expressed as CV% ($\sqrt{\sigma^2}$); SIR: Sampling importance resampling.
Table S5: Parameter estimations for 6-OH-R-warfarin

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Definitions</th>
<th>Estimates (RSE)</th>
<th>SIR medians (95% CIs)</th>
<th>IIV Estimates (RSE)</th>
<th>IIV SIR medians (95% CI)</th>
<th>Shrinkage</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>$C_L$</td>
<td>Formation clearance</td>
<td>0.0207 (7%)</td>
<td>0.0208 (0.0183, 0.0232)</td>
<td>39.8% (20%)</td>
<td>42.8% (32.4%, 54.2%)</td>
<td>2%</td>
<td>L/hour</td>
</tr>
<tr>
<td>$V_C$</td>
<td>Central compartment volume of distribution</td>
<td>13.7 (5%)</td>
<td>13.7 (12.5, 14.8)</td>
<td>16.8% (86%)</td>
<td>19.5% (9.2%, 30.0%)</td>
<td>36%</td>
<td>L</td>
</tr>
<tr>
<td>$C_L_e$</td>
<td>Elimination clearance</td>
<td>1.05 (8%)</td>
<td>1.04 (0.91, 1.18)</td>
<td>35.9% (14%)</td>
<td>36.4% (27.4%, 45.2%)</td>
<td>9%</td>
<td>L/hour</td>
</tr>
<tr>
<td>$C_L_d$</td>
<td>Distribution clearance</td>
<td>0.817 (1%)</td>
<td>0.818 (0.806, 0.827)</td>
<td></td>
<td></td>
<td></td>
<td>L/hour</td>
</tr>
<tr>
<td>$V_P$</td>
<td>Peripheral compartment volume of distribution</td>
<td>2610 (0%)</td>
<td>2607 (2588, 2621)</td>
<td></td>
<td></td>
<td></td>
<td>L</td>
</tr>
<tr>
<td>$C_L_Flu$</td>
<td>% of $C_L$ when administered with fluconazole</td>
<td>43.2% (6%)</td>
<td>43.1% (39.0%, 47.3%)</td>
<td>24.3% (31%)</td>
<td>26.2% (18.2%, 35.7%)</td>
<td>21%</td>
<td></td>
</tr>
<tr>
<td>$C_L_Rif$</td>
<td>% of $C_L$ when administered with rifampin</td>
<td>205% (7%)</td>
<td>205% (181%, 231%)</td>
<td>32.9% (23%)</td>
<td>34.7% (25.0%, 44.9%)</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>$C_L_Flu$</td>
<td>% of $C_L$ when administered with fluconazole</td>
<td>86.6% (10%)</td>
<td>87.4% (73.0%, 101.6%)</td>
<td>35.7% (34%)</td>
<td>39.1% (25.8%, 54.7%)</td>
<td>28%</td>
<td></td>
</tr>
<tr>
<td>$C_L_Rif$</td>
<td>% of $C_L$ when administered with rifampin</td>
<td>85.9% (13%)</td>
<td>87.0% (70.6%, 106.2%)</td>
<td>62.2% (20%)</td>
<td>63.0% (44.7%, 85.3%)</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>RUV for warfarin alone phase plasma</td>
<td>$\sigma_{warf}$</td>
<td>32.6% (5%)</td>
<td>32.4% (29.9%, 34.9%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RUV for warfarin + fluconazole phase plasma</td>
<td>$\sigma_{warf_Flu}$</td>
<td>36.8% (6%)</td>
<td>37.5% (34.0%, 40.8%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RUV for warfarin + rifampin phase plasma</td>
<td>$\sigma_{warf_Rif}$</td>
<td>42.0% (7%)</td>
<td>42.0% (37.8%, 47.1%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RUV for warfarin alone phase urine</td>
<td>$\sigma_{warf_U}$</td>
<td>37.1% (8%)</td>
<td>38.1% (33.2%, 42.9%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RUV for warfarin + fluconazole phase urine</td>
<td>$\sigma_{warf_Flu_U}$</td>
<td>34.8% (11%)</td>
<td>34.3% (29.6%, 39.4%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RUV for warfarin + rifampin phase urine</td>
<td>$\sigma_{warf_Rif_U}$</td>
<td>44.6% (9%)</td>
<td>44.8% (38.7%, 51.4%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: IIV: inter-individual variability; RUV: residual unexplained variability; RSE: Relative standard error; CI: confidence interval; Sources for parameter estimations are estimated except indicated otherwise. IIV terms are expressed as CV% ($\sqrt{e^{\omega^2} - 1}$); RUV terms are expressed as CV% ($\sqrt{\sigma^2}$); SIR: Sampling importance resampling.
<table>
<thead>
<tr>
<th>Parameters</th>
<th>Definitions</th>
<th>Estimates (RSE)</th>
<th>SIR medians (95% CIs)</th>
<th>IIV Estimates (RSE)</th>
<th>IIV SIR medians (95% CI)</th>
<th>Shrinkage</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>$CL_f$</td>
<td>Formation clearance for subjects with CYP2C9 *1/*1</td>
<td>0.104 (10%)</td>
<td>0.104 (0.088, 0.120)</td>
<td>26.4% (21%)</td>
<td>27.8% (21.7%, 33.5%)</td>
<td>9%</td>
<td>L/hour</td>
</tr>
<tr>
<td>$V_C$</td>
<td>Central compartment volume of distribution</td>
<td>2.12 (25%)</td>
<td>2.08 (1.43, 2.68)</td>
<td>49.7% (54%)</td>
<td>49.8% (24.8%, 79.8%)</td>
<td>37%</td>
<td>L</td>
</tr>
<tr>
<td>$CL_e$</td>
<td>Elimination clearance</td>
<td>0.604 (7%)</td>
<td>0.606 (0.536, 0.675)</td>
<td>31.1% (21%)</td>
<td>32.1% (24.3%, 40.2%)</td>
<td>6%</td>
<td>L/hour</td>
</tr>
<tr>
<td>$CL_D$</td>
<td>Distribution clearance</td>
<td>3.28 (1%)</td>
<td>3.28 (3.22, 3.32)</td>
<td>9%</td>
<td></td>
<td></td>
<td>L/hour</td>
</tr>
<tr>
<td>$V_P$</td>
<td>Peripheral compartment volume of distribution</td>
<td>4.83 (11%)</td>
<td>4.82 (4.11, 5.64)</td>
<td>28.5% (66%)</td>
<td>30.9% (14.8%, 47.7%)</td>
<td>37%</td>
<td>L</td>
</tr>
<tr>
<td>$CL_f_{Geno2}$</td>
<td>% of $CL_f$ for subjects with CYP2C9 *1B/*1B (reference: CYP2C9 *1/*1)</td>
<td>103% (16%)</td>
<td>105% (79%, 132%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$CL_f_{Geno3}$</td>
<td>% of $CL_f$ for subjects with CYP2C9 *1/*3 (reference: CYP2C9 *1/*1)</td>
<td>58.6% (14%)</td>
<td>59.2% (47.7%, 71.8%)</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>$CL_f_{Geno4}$</td>
<td>% of $CL_f$ for subjects with CYP2C9 *2/*3 (reference: CYP2C9 *1/*1)</td>
<td>25.2% (20%)</td>
<td>25.7% (18.6%, 33.9%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$CL_f_{Geno5}$</td>
<td>% of $CL_f$ for subjects with CYP2C9 *3/*3 (reference: CYP2C9 *1/*1)</td>
<td>5.69% (17%)</td>
<td>5.80% (4.30%, 7.60%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$CL_f_{Flu}$</td>
<td>% of $CL_f$ when administered with fluconazole</td>
<td>25.2% (7%)</td>
<td>24.9% (22.5%, 27.6%)</td>
<td>20.8% (42%)</td>
<td>22.1% (12.8%, 30.6%)</td>
<td>26%</td>
<td></td>
</tr>
<tr>
<td>$CL_f_{Rif}$</td>
<td>% of $CL_f$ when administered with rifampin</td>
<td>175% (5%)</td>
<td>173% (160%, 189%)</td>
<td>11.2% (56%)</td>
<td>11.8% (5.0%, 17.9%)</td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td>$CL_f_{Flu}$</td>
<td>% of $CL_f$ when administered with fluconazole</td>
<td>70.1% (7%)</td>
<td>69.6% (62.3%, 78.6%)</td>
<td>25.2% (74%)</td>
<td>27.6% (16.4%, 40.0%)</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>$CL_f_{Rif}$</td>
<td>% of $CL_f$ when administered with rifampin</td>
<td>97.1% (6%)</td>
<td>96.6% (87.2%, 106.0%)</td>
<td>20.3% (26%)</td>
<td>20.8% (14.3%, 27.0%)</td>
<td>19%</td>
<td></td>
</tr>
<tr>
<td>$σ_{warf}$</td>
<td>RUV for warfarin alone phase plasma</td>
<td>30.2% (5%)</td>
<td>30.5% (28.2%, 32.9%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$σ_{warf}_{Flu}$</td>
<td>RUV for warfarin + fluconazole phase plasma</td>
<td>27.3% (5%)</td>
<td>27.3% (25.4%, 29.7%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$σ_{warf}_{Rif}$</td>
<td>RUV for warfarin + rifampin phase plasma</td>
<td>31.5% (5%)</td>
<td>31.7% (29.3%, 34.3%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$σ_{warf}$</td>
<td>RUV for warfarin alone phase urine</td>
<td>39.0% (8%)</td>
<td>39.1% (34.2%, 44.3%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$σ_{warf}_{Flu}$</td>
<td>RUV for warfarin + fluconazole phase urine</td>
<td>33.9% (9%)</td>
<td>35.8% (31.1%, 40.2%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$σ_{warf}_{Rif}$</td>
<td>RUV for warfarin + rifampin phase urine</td>
<td>40.4% (9%)</td>
<td>40.5% (35.0%, 45.9%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: IIV: inter-individual variability; RUV: residual unexplained variability; RSE: Relative standard error; CI: confidence interval; Sources for parameter estimations are estimated except indicated otherwise. IIV terms are expressed as CV% ($\sqrt{\omega^2 - 1}$); RUV terms are expressed as CV% ($\sqrt{\sigma^2}$); SIR: Sampling importance resampling.
### Table S7: Parameter estimations for 7-OH-R-warfarin

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Definitions</th>
<th>Estimates (RSE)</th>
<th>SIR medians (95% CIs)</th>
<th>IIV Estimates (RSE)</th>
<th>IIV SIR medians (95% CI)</th>
<th>Shrinkage</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>CL&lt;sub&gt;f&lt;/sub&gt;</td>
<td>Formation clearance</td>
<td>0.00331 (16%)</td>
<td>0.00327 (0.00232, 0.00425)</td>
<td>90.7% (16%)</td>
<td>94.9% (65.2%, 133.3%)</td>
<td>9%</td>
<td>L/hour</td>
</tr>
<tr>
<td>V&lt;sub&gt;c&lt;/sub&gt;</td>
<td>Central compartment volume of distribution</td>
<td>65.7 (83%)</td>
<td>87.0 (23.5, 181.6)</td>
<td>1349% (33%)</td>
<td>2033% (262%, 39104%)</td>
<td>28%</td>
<td>L</td>
</tr>
<tr>
<td>CL&lt;sub&gt;e&lt;/sub&gt;</td>
<td>Elimination clearance</td>
<td>17.6 (34%)</td>
<td>19.1 (10.6, 31.0)</td>
<td>203% (23%)</td>
<td>240% (123%, 529%)</td>
<td>11%</td>
<td>L/hour</td>
</tr>
<tr>
<td>CL&lt;sub&gt;d&lt;/sub&gt;</td>
<td>Distribution clearance</td>
<td>3.00 (1%)</td>
<td>3.00 (2.96, 3.04)</td>
<td></td>
<td></td>
<td></td>
<td>L/hour</td>
</tr>
<tr>
<td>V&lt;sub&gt;p&lt;/sub&gt;</td>
<td>Peripheral compartment volume of distribution</td>
<td>6600 (1%)</td>
<td>6591 (6506, 6679)</td>
<td></td>
<td></td>
<td></td>
<td>L</td>
</tr>
<tr>
<td>BL&lt;sub&gt;_P2&lt;/sub&gt;</td>
<td>Period 2 baseline concentration in central compartment</td>
<td>0.0310 (5%)</td>
<td>0.0311 (0.0280, 0.0342)</td>
<td></td>
<td></td>
<td></td>
<td>µg/L</td>
</tr>
<tr>
<td>BL&lt;sub&gt;_P3&lt;/sub&gt;</td>
<td>Period 3 baseline concentration in central compartment</td>
<td>0.0312 (7%)</td>
<td>0.0307 (0.0266, 0.0356)</td>
<td></td>
<td></td>
<td></td>
<td>µg/L</td>
</tr>
<tr>
<td>BL&lt;sub&gt;_F2&lt;/sub&gt;</td>
<td>Period 2 baseline concentration in peripheral compartment</td>
<td>0.0354 (4%)</td>
<td>0.0350 (0.0315, 0.0386)</td>
<td></td>
<td></td>
<td></td>
<td>µg/L</td>
</tr>
<tr>
<td>BL&lt;sub&gt;_F3&lt;/sub&gt;</td>
<td>Period 3 baseline concentration in peripheral compartment</td>
<td>0.0351 (6%)</td>
<td>0.0355 (0.0309, 0.0400)</td>
<td></td>
<td></td>
<td></td>
<td>µg/L</td>
</tr>
<tr>
<td>CL&lt;sub&gt;_F&lt;/sub&gt; Flu</td>
<td>% of CL&lt;sub&gt;f&lt;/sub&gt; when administered with fluconazole</td>
<td>11.6% (26%)</td>
<td>11.3% (6.7%, 16.4%)</td>
<td>74.3% (52%)</td>
<td>91.7% (36.1%, 179.9%)</td>
<td>41%</td>
<td></td>
</tr>
<tr>
<td>CL&lt;sub&gt;_R&lt;/sub&gt; Rif</td>
<td>% of CL&lt;sub&gt;f&lt;/sub&gt; when administered with rifampin</td>
<td>171% (24%)</td>
<td>175% (109%, 253%)</td>
<td>116% (27%)</td>
<td>127% (61%, 242%)</td>
<td>23%</td>
<td></td>
</tr>
<tr>
<td>CL&lt;sub&gt;_F&lt;/sub&gt; Flu</td>
<td>% of CL&lt;sub&gt;f&lt;/sub&gt; when administered with fluconazole</td>
<td>188% (1%)</td>
<td>188% (183%, 193%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CL&lt;sub&gt;_R&lt;/sub&gt; Rif</td>
<td>% of CL&lt;sub&gt;f&lt;/sub&gt; when administered with rifampin</td>
<td>218% (1%)</td>
<td>218% (215%, 221%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>σ&lt;sub&gt;warf&lt;/sub&gt; U</td>
<td>RUV for plasma</td>
<td>2640% (17%)</td>
<td>2750% (2102%, 3643%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>σ&lt;sub&gt;warf_U&lt;/sub&gt;</td>
<td>RUV for warfarin alone phase urine</td>
<td>44.5% (13%)</td>
<td>45.9% (35.8%, 56.0%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>σ&lt;sub&gt;warf_Flu_U&lt;/sub&gt;</td>
<td>RUV for warfarin + fluconazole phase urine</td>
<td>57.7% (13%)</td>
<td>58.7% (46.5%, 71.7%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>σ&lt;sub&gt;warf_Rif_U&lt;/sub&gt;</td>
<td>RUV for warfarin + rifampin phase urine</td>
<td>61.4% (16%)</td>
<td>63.9% (47.6%, 81.1%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: IIV: inter-individual variability; RUV: residual unexplained variability; RSE: Relative standard error; CI: confidence interval; Sources for parameter estimations are estimated except indicated otherwise. IIV terms are expressed as CV% ($\sqrt{\omega^2 - 1}$); RUV terms are expressed as CV% ($\sqrt{\sigma^2}$); SIR: Sampling importance resampling.
Table S8: Parameter estimations for 8-OH-S-warfarin

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Definitions</th>
<th>Estimates (RSE)</th>
<th>SIR medians (95% CIs)</th>
<th>IIV Estimates (RSE)</th>
<th>IIV SIR medians (95% CI)</th>
<th>Shrinkage</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLf</td>
<td>Formation clearance for subjects with CYP2C9 *1/*1</td>
<td>0.00209 (12%)</td>
<td>0.00205 (0.00168, 0.00249)</td>
<td>32.1% (17%)</td>
<td>32.9% (25.7%, 40.1%)</td>
<td>8%</td>
<td>L/hour</td>
</tr>
<tr>
<td>VC</td>
<td>Central compartment volume of distribution</td>
<td>51.0 (83%)</td>
<td>70.6 (30.8, 130.3)</td>
<td>324% (62%)</td>
<td>481% (167%, 2013%)</td>
<td>14%</td>
<td>L</td>
</tr>
<tr>
<td>CLe</td>
<td>Elimination clearance</td>
<td>7.80 (92%)</td>
<td>11.38 (5.63, 21.80)</td>
<td>83.7% (52%)</td>
<td>101.0% (58.4%, 160.1%)</td>
<td>29%</td>
<td>L/hour</td>
</tr>
<tr>
<td>BL</td>
<td>Period 2 and 3 baseline concentration in central compartment</td>
<td>0.00270 (1%)</td>
<td>0.00271 (0.00268, 0.00274)</td>
<td>81.0% (58.1%, 107.5%)</td>
<td>81.0% (58.1%, 107.5%)</td>
<td></td>
<td>µg/L</td>
</tr>
<tr>
<td>CLf_Geno2</td>
<td>% of CLf for subjects with CYP2C9 *1B/*1B (reference: CYP2C9 *1/*1)</td>
<td>82.2% (21%)</td>
<td>81.0% (58.1%, 107.5%)</td>
<td>70.5% (52.5%, 89.4%)</td>
<td>70.5% (52.5%, 89.4%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLf_Geno3</td>
<td>% of CLf for subjects with CYP2C9 *1/*1 (reference: CYP2C9 *1/*1)</td>
<td>71.1% (17%)</td>
<td>70.5% (52.5%, 89.4%)</td>
<td>35.4% (25.2%, 49.8%)</td>
<td>35.4% (25.2%, 49.8%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLf_Geno4</td>
<td>% of CLf for subjects with CYP2C9 *2/*3 (reference: CYP2C9 *1/*1)</td>
<td>35.3% (24%)</td>
<td>35.4% (25.2%, 49.8%)</td>
<td>33.0% (22%)</td>
<td>32.6% (22.2%, 43.9%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLf_Geno5</td>
<td>% of CLf for subjects with CYP2C9 *3/*3 (reference: CYP2C9 *1/*1)</td>
<td>33.0% (22%)</td>
<td>32.6% (22.2%, 43.9%)</td>
<td>227% (2%)</td>
<td>229% (224%, 234%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLf_Flu</td>
<td>% of CLf when administered with fluconazole</td>
<td>20.6% (1%)</td>
<td>20.7% (20.3%, 21.2%)</td>
<td>227% (2%)</td>
<td>229% (224%, 234%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLf_Rif</td>
<td>% of CLf when administered with rifampin</td>
<td>227% (2%)</td>
<td>229% (224%, 234%)</td>
<td>352% (99%)</td>
<td>487% (217%, 1041%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLf_Rif</td>
<td>RUV for plasma</td>
<td>352% (99%)</td>
<td>487% (217%, 1041%)</td>
<td>352% (99%)</td>
<td>487% (217%, 1041%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLf_Rif</td>
<td>RUV for warfarin alone phase urine</td>
<td>34.2% (10%)</td>
<td>34.0% (28.5%, 39.0%)</td>
<td>34.2% (10%)</td>
<td>34.0% (28.5%, 39.0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLf_Rif</td>
<td>RUV for warfarin + fluconazole phase urine</td>
<td>48.1% (11%)</td>
<td>48.6% (40.0%, 57.0%)</td>
<td>48.1% (11%)</td>
<td>48.6% (40.0%, 57.0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLf_Rif</td>
<td>RUV for warfarin + rifampin phase urine</td>
<td>47.3% (16%)</td>
<td>49.4% (39.6%, 60.4%)</td>
<td>47.3% (16%)</td>
<td>49.4% (39.6%, 60.4%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: IIV: inter-individual variability; RUV: residual unexplained variability; RSE: Relative standard error; CI: confidence interval; Sources for parameter estimations are estimated except indicated otherwise. IIV terms are expressed as CV% ($\sqrt{\text{e} \omega^2} - 1$); RUV terms are expressed as CV% ($\sqrt{\sigma^2}$); SIR: Sampling importance resampling.
Table S9: Parameter estimations for 8-OH-R-warfarin

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Definitions</th>
<th>Estimates (RSE)</th>
<th>SIR medians (95% CI)</th>
<th>IV Estimates (RSE)</th>
<th>IV SIR medians (95% CI)</th>
<th>Shrinkage</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLf</td>
<td>Formation clearance for subjects with CYP2C9 *1/*1</td>
<td>0.00796 (14%)</td>
<td>0.00803 (0.00635, 0.00989)</td>
<td>74.6% (12%)</td>
<td>72.8% (59.9%, 86.6%)</td>
<td>2%</td>
<td>L/hour</td>
</tr>
<tr>
<td>VC</td>
<td>Central compartment volume of distribution</td>
<td>5.82 (5%)</td>
<td>5.88 (5.43, 6.41)</td>
<td>22.2% (47%)</td>
<td>22.5% (12.9%, 31.3%)</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>CLcl</td>
<td>Elimination clearance</td>
<td>0.791 (6%)</td>
<td>0.794 (0.725, 0.875)</td>
<td>27.7% (32%)</td>
<td>27.6% (19.2%, 37.6%)</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>CVd</td>
<td>Distribution clearance</td>
<td>0.132 (0%)</td>
<td>0.132 (0.131, 0.133)</td>
<td>2%</td>
<td>2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VP</td>
<td>Peripheral compartment volume of distribution</td>
<td>2.94 (31%)</td>
<td>3.01 (1.57, 4.45)</td>
<td>201% (31%)</td>
<td>221% (108%, 505%)</td>
<td>21%</td>
<td>L</td>
</tr>
<tr>
<td>CLf_Geno2</td>
<td>% of CLf for subjects with CYP2C9 *1B/*1B (reference: CYP2C9 genotypes other than *1B/*1B)</td>
<td>32.8% (34%)</td>
<td>33.5% (18.1%, 51.8%)</td>
<td>23.8% (34%)</td>
<td>23.5% (18.1%, 51.8%)</td>
<td>16%</td>
<td></td>
</tr>
<tr>
<td>CLf_Flu</td>
<td>% of CLf when administered with fluconazole</td>
<td>12.5% (12%)</td>
<td>12.4% (10.3%, 14.9%)</td>
<td>57.8% (19%)</td>
<td>56.6% (41.7%, 73.0%)</td>
<td>24%</td>
<td></td>
</tr>
<tr>
<td>CLf_Rif_Geno1345</td>
<td>% of CLf when administered with rifampin for subjects with CYP2C9 genotypes other than *1B/*1B</td>
<td>384% (5%)</td>
<td>386% (353%, 419%)</td>
<td>23.5% (17%)</td>
<td>24.0% (18.6%, 29.8%)</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>CLf_Rif_Geno2</td>
<td>% of CLf when administered with rifampin for subjects with CYP2C9 *1B/*1B</td>
<td>168% (12%)</td>
<td>168% (137%, 199%)</td>
<td>20.3% (6%)</td>
<td>20.1% (18.2%, 22.1%)</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>CLf_Rif_Rif</td>
<td>RUV for warfarin alone phase plasma</td>
<td>38.4% (10%)</td>
<td>39.0% (32.9%, 46.1%)</td>
<td>14.5% (7%)</td>
<td>14.7% (13.2%, 16.3%)</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>CLf_Rif_U</td>
<td>RUV for warfarin + rifampin phase plasma</td>
<td>34.6% (8%)</td>
<td>34.9% (31.0%, 39.2%)</td>
<td>31.6% (7%)</td>
<td>33.0% (29.8%, 36.1%)</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>CLf_Rif_U</td>
<td>RUV for warfarin + rifampin phase plasma</td>
<td>42.0% (9%)</td>
<td>42.7% (37.0%, 48.4%)</td>
<td>42.0% (9%)</td>
<td>42.7% (37.0%, 48.4%)</td>
<td>10%</td>
<td></td>
</tr>
</tbody>
</table>

Notes: IIV: inter-individual variability; RUV: residual unexplained variability; RSE: Relative standard error; CI: confidence interval; Sources for parameter estimations are estimated except indicated otherwise. IIV terms are expressed as CV% ($\sqrt{e\omega^2} - 1$); RUV terms are expressed as CV% ($\sqrt{\sigma^2}$); SIR: Sampling importance resampling.
Table S10: Parameter estimations for 10-OH-S-warfarin

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Definitions</th>
<th>Estimates (RSE)</th>
<th>SIR medians (95% CIs)</th>
<th>IV Estimates (RSE)</th>
<th>IV SIR medians (95% CI)</th>
<th>Shrinkage</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLₐ</td>
<td>Formation clearance for subjects with CYP2C9 *1/*1, *1B/*1B and *1/*3</td>
<td>0.008007 (11%)</td>
<td>0.008009 (0.000688, 0.000950)</td>
<td>33.4% (20%)</td>
<td>33.5% (24.7%, 41.5%)</td>
<td>14%</td>
<td>L/hour</td>
</tr>
<tr>
<td>VC</td>
<td>Central compartment volume of distribution</td>
<td>10.3 (10%)</td>
<td>10.4 (8.9, 12.0)</td>
<td>22.3% (28%)</td>
<td>23.4% (15.5%, 30.0%)</td>
<td>34%</td>
<td>L</td>
</tr>
<tr>
<td>CLₑ</td>
<td>Elimination clearance</td>
<td>0.0205 (17%)</td>
<td>0.0197 (0.0146, 0.0257)</td>
<td>45.7% (39%)</td>
<td>50.4% (33.1%, 69.3%)</td>
<td>15%</td>
<td>L/hour</td>
</tr>
<tr>
<td>CLₑ_Geno45</td>
<td>% of CLₑ for subjects with CYP2C9 *2/*3 and *3/*3 (reference: CYP2C9 *1/*1, *1B/*1B and *1/*3)</td>
<td>67.7% (18%)</td>
<td>67.9% (50.1%, 88.5%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLₑ_Geno2</td>
<td>% of CLₑ for subjects with CYP2C9 *1B/*1B (reference: CYP2C9 *1/*1)</td>
<td>44.0% (30%)</td>
<td>48.6% (28.8%, 70.8%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLₑ_Geno3</td>
<td>% of CLₑ for subjects with CYP2C9 *1/*3 (reference: CYP2C9 *1/*1)</td>
<td>181% (22%)</td>
<td>184% (124%, 255%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLₑ_Geno4</td>
<td>% of CLₑ for subjects with CYP2C9 *2/*3 (reference: CYP2C9 *1/*1)</td>
<td>146% (35%)</td>
<td>152% (83%, 232%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLₑ_Geno5</td>
<td>% of CLₑ for subjects with CYP2C9 *3/*3 (reference: CYP2C9 *1/*1)</td>
<td>310% (31%)</td>
<td>311% (183%, 464%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLₐ_Flu</td>
<td>% of CLₑ when administered with fluconazole</td>
<td>35.0% (7%)</td>
<td>34.7% (31.3%, 38.8%)</td>
<td>26.2% (29%)</td>
<td>29.4% (20.9%, 38.7%)</td>
<td>21%</td>
<td></td>
</tr>
<tr>
<td>CLₑ_Flu</td>
<td>% of CLₑ when administered with rifampin for subjects with CYP2C9 genotypes other than *2/*3</td>
<td>455% (8%)</td>
<td>460% (399%, 516%)</td>
<td>32.4% (20%)</td>
<td>34.6% (25.8%, 44.0%)</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>CLₑ_Rif_Geno1345</td>
<td>% of CLₑ when administered with rifampin for subjects with CYP2C9 genotypes other than *2/*3</td>
<td>630% (15%)</td>
<td>629% (486%, 798%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLₑ_Rif_Geno2</td>
<td>% of CLₑ when administered with rifampin for subjects with CYP2C9 *2/*3</td>
<td>95.4% (11%)</td>
<td>95.0% (78.6%, 112.3%)</td>
<td>28.2% (38%)</td>
<td>33.5% (18.6%, 45.6%)</td>
<td>45%</td>
<td></td>
</tr>
<tr>
<td>CLₑ_Rif</td>
<td>% of CLₑ when administered with rifampin</td>
<td>299% (10%)</td>
<td>296% (250%, 343%)</td>
<td>40.1% (37%)</td>
<td>37.7% (23.8%, 52.1%)</td>
<td>21%</td>
<td></td>
</tr>
<tr>
<td>warf</td>
<td>RUV for warfarin alone phase plasma</td>
<td>15.0% (7%)</td>
<td>14.6% (13.0%, 16.2%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>warf_Flu</td>
<td>RUV for warfarin + fluconazole phase plasma</td>
<td>14.3% (8%)</td>
<td>14.5% (12.7%, 16.3%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>warf_Rif</td>
<td>RUV for warfarin + rifampin phase plasma</td>
<td>19.3% (6%)</td>
<td>20.2% (18.7%, 22.0%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>warf_U</td>
<td>RUV for urine</td>
<td>50.0% (11%)</td>
<td>53.1% (47.3%, 59.2%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: IIV: inter-individual variability; RUV: residual unexplained variability; RSE: Relative standard error; CI: confidence interval; Sources for parameter estimations are estimated except indicated otherwise. IIV terms are expressed as CV% (\(\sqrt{\omega^2} - 1\)); RUV terms are expressed as CV% (\(\sqrt{\sigma^2}\)); SIR: Sampling importance resampling.
**Table S11: Parameter estimations for 10-OH-R-warfarin**

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Definitions</th>
<th>Estimates (RSE)</th>
<th>SIR medians (95% CIs)</th>
<th>IV Estimates (RSE)</th>
<th>IV SIR medians (95% CI)</th>
<th>Shrinkage</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>CL&lt;sub&gt;f&lt;/sub&gt;</td>
<td>Formation clearance</td>
<td>0.000921 (8%)</td>
<td>0.000935 (0.000817, 0.001047)</td>
<td>18.8% (33%)</td>
<td>20.3% (14.4%, 26.4%)</td>
<td>15%</td>
<td>L/hour</td>
</tr>
<tr>
<td>V&lt;sub&gt;c&lt;/sub&gt;</td>
<td>Central compartment volume of distribution</td>
<td>0.455 (10%)</td>
<td>0.464 (0.395, 0.527)</td>
<td>32.4% (18%)</td>
<td>31.4% (21.4%, 37.8%)</td>
<td>8%</td>
<td>L</td>
</tr>
<tr>
<td>CL&lt;sub&gt;e&lt;/sub&gt;</td>
<td>Elimination clearance</td>
<td>0.0106 (8%)</td>
<td>0.0107 (0.0094, 0.0119)</td>
<td>17.5% (58%)</td>
<td>19.3% (13.0%, 26.0%)</td>
<td>20%</td>
<td>L/hour</td>
</tr>
<tr>
<td>CL&lt;sub&gt;d&lt;/sub&gt;</td>
<td>Distribution clearance</td>
<td>0.0249 (12%)</td>
<td>0.0253 (0.0205, 0.0303)</td>
<td>51.0% (30%)</td>
<td>48.0% (33.2%, 61.7%)</td>
<td>15%</td>
<td>L/hour</td>
</tr>
<tr>
<td>V&lt;sub&gt;p&lt;/sub&gt;</td>
<td>Peripheral compartment volume of distribution</td>
<td>0.573 (8%)</td>
<td>0.579 (0.501, 0.652)</td>
<td>22.4% (34%)</td>
<td>21.8% (14.4%, 29.2%)</td>
<td>19%</td>
<td>L</td>
</tr>
<tr>
<td>BL</td>
<td>Period 2 and 3 baseline concentration in central compartment</td>
<td>0.334 (40%)</td>
<td>0.349 (0.172, 0.579)</td>
<td>480% (19%)</td>
<td>508% (245%, 1100%)</td>
<td>12%</td>
<td>µg/L</td>
</tr>
<tr>
<td>BL&lt;sub&gt;p&lt;/sub&gt;</td>
<td>Period 2 and 3 baseline concentration in peripheral compartment</td>
<td>0.0234 (62%)</td>
<td>0.0248 (0.0051, 0.0515)</td>
<td>40.1% (80%)</td>
<td>46.0% (15.4%, 76.4%)</td>
<td>89%</td>
<td>µg/L</td>
</tr>
<tr>
<td>CL&lt;sub&gt;f&lt;/sub&gt; Flu</td>
<td>% of CL&lt;sub&gt;f&lt;/sub&gt; when administered with fluconazole</td>
<td>26.5% (5%)</td>
<td>26.6% (24.3%, 28.8%)</td>
<td>21.9% (20%)</td>
<td>22.9% (17.3%, 28.7%)</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>CL&lt;sub&gt;f&lt;/sub&gt; Rif_Geno1345</td>
<td>% of CL&lt;sub&gt;f&lt;/sub&gt; when administered with rifampin for subjects with CYP2C9 genotypes other than *1B/*1B</td>
<td>463% (4%)</td>
<td>463% (434%, 494%)</td>
<td>17.5% (44%)</td>
<td>18.1% (13.2%, 23.7%)</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>CL&lt;sub&gt;f&lt;/sub&gt; Rif_Geno2</td>
<td>% of CL&lt;sub&gt;f&lt;/sub&gt; when administered with rifampin for subjects with CYP2C9 *1B/*1B</td>
<td>538% (9%)</td>
<td>538% (466%, 618%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CL&lt;sub&gt;f&lt;/sub&gt; Flu</td>
<td>% of CL&lt;sub&gt;f&lt;/sub&gt; when administered with fluconazole</td>
<td>59.1% (5%)</td>
<td>59.4% (54.4%, 64.3%)</td>
<td>15.6% (79%)</td>
<td>17.7% (8.0%, 26.3%)</td>
<td>37%</td>
<td></td>
</tr>
<tr>
<td>CL&lt;sub&gt;f&lt;/sub&gt; Rif</td>
<td>% of CL&lt;sub&gt;f&lt;/sub&gt; when administered with rifampin</td>
<td>165% (6%)</td>
<td>165% (149%, 182%)</td>
<td>30.1% (15%)</td>
<td>30.0% (23.3%, 36.0%)</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>σ&lt;sub&gt;warf&lt;/sub&gt;</td>
<td>RUV for warfarin alone phase plasma</td>
<td>8.41% (5%)</td>
<td>8.48% (7.78%, 9.18%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>σ&lt;sub&gt;warf_Flu&lt;/sub&gt;</td>
<td>RUV for warfarin + fluconazole phase plasma</td>
<td>15.4% (7%)</td>
<td>15.4% (14.0%, 16.9%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>σ&lt;sub&gt;warf_Rif&lt;/sub&gt;</td>
<td>RUV for warfarin + rifampin phase plasma</td>
<td>10.5% (6%)</td>
<td>10.5% (9.6%, 11.4%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>σ&lt;sub&gt;warf_U&lt;/sub&gt;</td>
<td>RUV for urine</td>
<td>62.7% (12%)</td>
<td>61.9% (52.9%, 72.0%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:** IIV: inter-individual variability; RUV: residual unexplained variability; RSE: Relative standard error; CI: confidence interval; Sources for parameter estimations are estimated except indicated otherwise. IIV terms are expressed as CV% (√e<ω2>−1); RUV terms are expressed as CV% (√σ2); SIR: Sampling importance resampling.
Pharmacokinetic Modeling of Warfarin II – Model-based Analysis of Warfarin Metabolites following Warfarin Administered either Alone or Together with Fluconazole or Rifampin

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Supplemental Material: 7-OH-S-warfarin PK model NONMEM code
7-OH-S-warfarin PK model NONMEM code

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$PROBLEM PK
$INPUT C ID TIME DV AMT CMT EVID MDV GENO COMP TRT PERIOD URINE
SPILL NTIME SUBJECT BLQ STRAT KA1I CL20I V2I KONI KOFFI
RBLI CLD25I V5I BLI BLPI
$DATA 052720_S7.CSV IGNORE=C
$SUBROUTINE ADVAN13 TRANS=1 TOL=8
$MODEL NCOMP=8 COMP(DEPOT1) COMP(CENT1) COMP(RECEPTOR) COMP(DR)
COMP(PERI) COMP(METABOL) COMP(URINE INITIALOFF)
COMP(METABOLPERI)
$PK

;;;DUMMY VARIABLES

IF (TRT.EQ.2) FLU = 1  ;FLU
IF (TRT.EQ.3) RIF = 1  ;RIF

PERIOD1 = 0
PERIOD2 = 0
PERIOD3 = 0

IF(PERIOD.EQ.1) PERIOD1=1
IF(PERIOD.EQ.2) PERIOD2=1
IF(PERIOD.EQ.3) PERIOD3=1

;;;PARENT COMPOUND PARAM

KA1 = KA1I
CL20 = CL20I
V2 = V2I
CLD25 = CLD25I
V5 = V5I
KON = KONI
KOFF = KOFFI
RBL = RBLI
BL = BLI
BLP = BLPI

;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;DEFINEMU

LTVCL26 = LOG(THETA(1))

;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;CL26GENO START
IF(GENO.EQ.1) CL26GENO = 0  ;1/1
IF(GENO.EQ.2) CL26GENO = LOG(THETA(12)) ;1B/1B
IF(GENO.EQ.3) CL26GENO = LOG(THETA(13)); 1/3
IF(GENO.EQ.4) CL26GENO = LOG(THETA(14)); 2/3
IF(GENO.EQ.5) CL26GENO = LOG(THETA(15)); 3/3

LCL26 = LTVCL26 + CL26GENO
MU_1 = LCL26

MU_2 = LOG(THETA(2)); V6
MU_3 = LOG(THETA(3)); CL60
MU_4 = LOG(THETA(4)); BLM PERIOD2 & 3
MU_5 = LOG(THETA(5)); CLD68
MU_6 = LOG(THETA(6)); V8
MU_7 = LOG(THETA(7)); BLMP

MU_8 = LOG(THETA(8)); FLU
MU_9 = LOG(THETA(9)); RIF

MU_10 = LOG(THETA(10)); FLU
MU_11 = LOG(THETA(11)); RIF

CL26TRT = DEXP((MU_8 + ETA(8))*FLU)*DEXP((MU_9 + ETA(9))*RIF)
CL60TRT = DEXP((MU_10 + ETA(10))*FLU)*DEXP((MU_11 + ETA(11))*RIF)

CL26 = DEXP(MU_1 + ETA(1))*CL26TRT
V6 = DEXP(MU_2 + ETA(2))
CL60 = DEXP(MU_3 + ETA(3))*CL60TRT

IF(TRT.EQ.1) BLM=0
IF(TRT.NE.1) BLM=DEXP(MU_4 + ETA(4))

CLD68 = DEXP(MU_5 + ETA(5))
V8 = DEXP(MU_6 + ETA(6))

IF(TRT.EQ.1) BLMP=0
IF(TRT.NE.1) BLMP=DEXP(MU_7 + ETA(7))

;-----------------------------DEFINE SECONDARY PARAM-----------------------------

;DEFINE KD
KD = KOFF/KON

;CLEARANCE BESIDES CL26
CL2  = CL20-CL26

;DEFINE K
K20      = CL20/V2
K26      = CL26/V2
K60      = CL60/V6

;Define S
S2       = V2
S6       = V6*(308/324) ;CORRECT FOR MW
S7       = (1/1000)*(308/324) ;ng TO ug & CORRECT FOR MW

;---------------------------- DEFINE BASELINE AMOUNT --------------------------
A_0(2) = BL*V2
A_0(3) = (KOFF*RBL)/(KON*BL+KOFF)
A_0(4) = (KON*BL*RBL)/(KON*BL+KOFF)
A_0(5) = BLP*V5
A_0(6) = BLM*V6
A_0(8) = BLMP*V8

$DES
C2=A(2)/V2
C5=A(5)/V5
C6=A(6)/V6
C8=A(8)/V8

DADT(1)= -KA1*A(1)
;DEPOT1 S AMT
DADT(2)= KA1*A(1) - CL20*C2 - KON*A(2)*A(3)+ KOFF*A(4)*V2 - CLD25*(C2 - C5)
;CENT1 S AMT
DADT(3)= -KON*C2*A(3)+ KOFF*A(4)
;RECEPTOR CONC
DADT(4)= KON*C2*A(3) - KOFF*A(4)
;DR S CONC
DADT(5)= CLD25*(C2 - C5)
;PERI S AMT

DADT(6)= CL26*C2 - CL60*C6 - CLD68*(C6 - C8)
;METABOL 7S AMT
DADT(7)= CL60*C6
;URINE 7S AMT
DADT(8)= CLD68*(C6 - C8)
;METABOLPERI 7S AMT

$ERROR
CC2=A(2)/V2
CC3=A(3)
CC4=A(4)
CC5=A(5)/V5
RMAX = A(3) + A(4)

CC6 = A(6)/(V6*(308/324))
CC7 = A(7)/((1/1000)*(308/324))

;;; DUMMY VARIABLE START
TRT1 = 0
TRT2 = 0
TRT3 = 0

  IF (TRT.EQ.1) TRT1 = 1
  IF (TRT.EQ.2) TRT2 = 1
  IF (TRT.EQ.3) TRT3 = 1

;;; DUMMY VARIABLE END

;;; SD START
SD1 = THETA(16)
SD2 = THETA(17)
SD3 = THETA(18)
SD = SD1*TRT1 + SD2*TRT2 + SD3*TRT3

;;; SD END

LLOQ = 0.67

IF (CMT.EQ.6.AND.BLQ.EQ.0) THEN  ; BLQ = 0 EQUALS TO DV > LLOQ
  F_FLAG = 0
  IPRED = CC6
  Y = IPRED + IPRED*SD*ERR(1)
ENDIF

IF (CMT.EQ.6.AND.BLQ.EQ.1) THEN  ; BLQ = 1 EQUALS TO DV < LLOQ
  IPRED = CC6
  F_FLAG = 1
  Y = PHI((LLOQ - IPRED) / (SD*IPRED))
  MDVRES = 1
ENDIF

IF (CMT.EQ.7.AND.TRT.EQ.1) THEN
  IPRED = CC7
  Y = IPRED*(1 + ERR(2))
ENDIF

IF (CMT.EQ.7.AND.TRT.EQ.2) THEN
  IPRED = CC7
  Y = IPRED*(1 + ERR(3))
ENDIF

IF (CMT.EQ.7.AND.TRT.EQ.3) THEN
  IPRED = CC7
Y=IPRED*(1+ERR(4))
ENDIF

IF(COMACT==1) PREDV=IPRED ;carry out PRED as PREDV

$THETA
(0.001,0.107) ; CL26 1/1 WAR ALONE
(0.001,1.89) ; V6
(0.001,0.613) ; CL60
(0.001,0.934) ; BLM PERIOD2&3
(0.001,3.28) ; CLD68
(0.001,4.79) ; V8
(0.001,0.0533) ; BLMP PERIOD2&3
(0.001,0.248) ; CL26TRT FLU
(0.001,1.7) ; CL26TRT RIF
(0.001,0.691) ; CL60TRT FLU
(0.001,0.94) ; CL60TRT RIF
(0.001,0.93) ; CL26GENO 1B/1B
(0.001,0.558) ; CL26GENO 1/3
(0.001,0.257) ; CL26GENO 2/3
(0.001,0.0603) ; CL26GENO 3/3
(0.001,0.299) ; TRT1 PLASMA
(0.001,0.274) ; TRT2 PLASMA
(0.001,0.316) ; TRT3 PLASMA

$OMEGA
0.0656 ; CL26
0.218 ; V6
0.0921 ; CL60
0.0779 ; BLM PERIOD2&3
0.00001 FIX ; CLD68 FIXED TO SMALL VALUE TO OPTIMIZE RUNNING OF EM
0.0837 ; V8
0.00001 FIX ; BLMP PERIOD2&3 FIXED TO SMALL VALUE TO OPTIMIZE RUNNING OF EM
0.0437 ; CL26 FLU
0.0122 ; CL26 RIF
0.0625 ; CL60 FLU
0.0401 ; CL60 RIF

$SIGMA
1 FIX ; TRT1 PLASMA
0.149 ; TRT1 URINE
0.136 ; TRT2 URINE
0.169 ; TRT3 URINE

$ESTIMATION METHOD=IMP LAPLACE INTERACTION AUTO=1 PRINT=1 SIGL=6
MCETA=100 GRD=TS(16,17,18)
$COVARIANCE UNCONDITIONAL MATRIX=R PRINT=E
$TABLE ID TIME DV CMT IPRED PRED PREDV MDV GENO PERIOD TRT SPILL CWRES STRAT BLQ KA1 CL20 K20 V2 KON KOFF RBL KD BL BLP RMAX CLD25 V5 KD CL2 CL26 V6 CL60 BLM CLD68 V8 BLMP CC2