**Appendix 1. Adjustments of anti-TB drugs in renal insufficiency**a

| **Drug** | **Recommended dose and frequency for patients with creatinine clearance <30 ml/min or for patients receiving haemodialysis (unless otherwise indicated dose after dialysis)** |
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| **Isoniazid** | No adjustment necessary |
| **Pyrazinamide** | 25–35 mg/kg per dose three times per week (not daily) |
| **Ethambutol** | 15–25 mg/kg per dose three times per week (not daily) |
| **Capreomycin** | 12–15 mg/kg per dose two or three times per week (not daily)b |
| **Kanamycin** | 12–15 mg/kg per dose two or three times per week (not daily)b |
| **Amikacin** | 12–15 mg/kg per dose two or three times per week (not daily)b |
| **Levofloxacin** | 750–1000 mg per dose three times per week (not daily) |
| **Moxifloxacin** | No adjustment necessary |
| **Cycloserine** | 250 mg once daily, or 500 mg/dose three times per weekc |
| **Terizidone** | Recommendations not available |
| **Prothionamide** | No adjustment necessary |
| **Ethionamide** | No adjustment necessary |
| **P-aminosalicylic acide** | 4 grams/dose, twice daily maximum dosed |
| **Bedaquiline** | No dosage adjustment is required in patients with mild to moderate renal impairment (dosing not established in severe renal impairment, use with caution). |
| **Delamanid** | No dosage adjustment is required in patients with mild to moderate renal impairment (dosing not established in severe renal impairment, use with caution). |
| **Linezolid** | No adjustment necessary |
| **Clofazimine** | No adjustment necessary |
| **Amoxicillin/ Clavulanate** | For creatinine clearance 10-30 ml/min dose 1000 mg of amoxicillin component twice daily; for creatinine clearance < 10 ml/min dose 1000 mg of amoxicillin component once daily |
| **Imipenem/Cilastatin** | For creatinine clearance 20-40 ml/min dose 500 mg every 8 hours; for creatinine clearance < 20 ml/min dose 500 mg every 12 hours |
| **Meropenem** | For creatinine clearance 20-40 ml/min dose 750 mg every 12 hours; for creatinine clearance < 20 ml/min dose 500 mg every 12 hours |
| **High Dose Isonizazid** | Recommendations not available |

a Adapted from *Tuberculosis Drug Information Guide 2nd Edition, 2012* published by the Francis J. Curry National Tuberculosis Center and California, Department of Public Health (13).

b Caution should be used with the injectable agents in patients with renal function impairment because of the increased risk of both ototoxicity and nephrotoxicity. If on dialysis, dose after dialysis.

c The appropriateness of 250 mg daily doses has not been established. There should be careful monitoring for evidence of neurotoxicity (if possible measure serum concentrations and adjust accordingly).

d Sodium salt formulations of PAS may result in an excessive sodium load and should be avoided in patients with renal insufficiency. Formulations of PAS that do not use the sodium salt can be used without the hazard of sodium retention and are the preferred formulation in patients with renal insufficiency.