

Disease-drug and drug-drug interaction in COVID-19: risk and assessment

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Abstract

COVID-19 is announced as a global pandemic in 2020. The emergent outbreak of COVID-19 prompted by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) keeps spreading globally. Its mortality and morbidity rate are rapidly increasing, and medication options are still limited. A patient's immune response plays a pivotal role in the pathogenesis of COVID-19. Hyperinflammatory state may sparks significant imbalances in transporters and drug metabolizing enzymes, and subsequent alteration of drug pharmacokinetics that may result in unexpected therapeutic response. The present scenario has accounted the requirement for therapeutic opportunities to relive and overcome this pandemic. Despite the fact, the diminishing developments of COVID-19, there is no drug still approved to have significant effects with no side effect. Based on the evidence, many antiviral and anti-inflammatory drugs have been authorized by the Food and Drug Administration (FDA) to treat the COVID-19 patients even though not knowing the possible drug-drug interactions. Hydroxychloroquine is the first medicine chosen for the treatment of disease. Remdesivir, favipiravir, and molnupiravir are deemed the most hopeful antiviral agent; by improving health of infected patients. The dexamethasone saved the lives of seriously ill patients. Many randomized and controlled clinical trials are taking place to further corroborate these agent's safety and efficacy in handling COVID-19. The current review summarizes the involvement of drug transporters and drug metabolizing enzymes for the existing drugs and gives the opinion on the potential drug-drug interactions in inflammatory state. This may permit individualization of these drugs thereby enhancing the safety and efficacy.

Key Words: COVID-19, Drug transporters, CYPs, Remdesivir, Dexamethasone, Molnupiravir,

Introduction

SARS-CoV-2 was initially recognized and designated as COVID-19 infection (Helmy et al., 2020). The National Health Commission of China confirmed the information of the first appearance of COVID-19 in pneumonia patients appeared in the city of Wuhan in China in

December 2019 (WHO, 2020). Initially, pneumonia patients stated the normal respiratory infection which promptly transformed into acute respiratory syndrome (Huang et al., 2020). By the end of December 2020, almost 77 million cases have been reported, with the death toll of about 1.7 million deaths.

There is a very urgent prerequisite to discovering a novel antiviral drugs against COVID-19. Based on the evidence, Food and Drug Administration (FDA) approved some drugs that have been already used in the treatment of SARS-CoV and MERS-CoV. In these, remdesivir and favipiravir showed the most promising effect against COVID-19 (Sheahan et al., 2017). The anti-retroviral (ARV) drug lopinavir, that has been used for COVID-19 in combination with ritonavir (potent anti-HIV drug). This lopinavir-ritonavir combination showed to be efficient against COVID-19 (Martinez, 2020). Anti-malarial drug hydroxychloroquine has demonstrated more promising results against COVID-19, and it is used in higher frequency. Alone and in combination with other many drugs (Mitja & Clotet, 2020), (Rismanbaf, 2020). Regardless of the antiviral drug, dexamethasone has proved little relief against COVID-19. In the initial clinical trial, it lowered the death by one-third on severe patients that were on a ventilator (Ledford, 2020). Fluvoxamine has also shown the potential in COVID-19 infected outpatients (Lenze et al., 2020). Molnupiravir is used to treat COVID-19 infection, It can block the transmission of SARS-CoV-2 within 24 hours (Cox, Wolf, & Plemper, 2020). Many drugs and peptide some under clinical trial that have been used for treating COVID-19 (N. Trivedi, Verma, & Kumar, 2020), has shown in table 1. Vaccine development is typically a long game and many more vaccines against COVID-19 are in clinical trials and few are in the final stage (N. Trivedi et al., 2020). We will have to wait and see how things play out (Mullard, 2020).

Many determinants of the pharmacokinetics of used possible COVID-19 medications, including absorption distribution metabolism and elimination can be modified disease state or during inflammatory response (Fig 1.). Chronic inflammation is produced when an antigen is persisted, and the immune system continuously acts against this antigen. This chronic inflammation is associated with alteration in the level of drug binding proteins (Don & Kaysen, 2004; Moshage, Janssen, Franssen, Hafkenscheid, & Yap, 1987; Ruot, Bechereau, Bayle, Breuille, & Obled, 2002), in addition, the downregulation of various hepatic and extrahepatic drug metabolizing enzyme (Morgan, 2009; Morgan et al., 2008). More recently inflammation-mediated changes in the expression of numerous membranes associated drug transporters have been reported (Cressman, Petrovic, & Piquette-Miller, 2012). In the case of co-administration of many drugs, the risk of drug interaction increases, nevertheless in

COVID-19, a more complicated diseases-drug-drug interaction is anticipated. The SARS-CoV-2 infection has shown an increasing frequency of hospitalization and intensive care unit (ICU) admission (Grasselli G, 2020). This is considered as a major clinical concern mainly when considering that critically ill patients are more influenced drug interaction that CYPs and efflux pumps are involved in the metabolism and transport respectively of commonly prescribed drugs in ICU (HJ., 2006). During highly prevalent acute and chronic inflammatory conditions, the alteration in the expression and activity of transporters and DMEs of these may modify the pharmacokinetic and pharmacodynamic properties of therapeutic drugs used in COVID-19 treatment.

This article will focus on the current state of knowledge and assume a pharmacokinetic disease -drug and drug-drug interaction potential of therapeutic agents used for common comorbidities, or frequently used in intensive care for COVID-19 patients. Herein, we also reviewed the updated status of the supportive roles of several antivirals, some antibiotics, and some therapeutics peptides that have tested their efficacy in the worldwide treatment of COVID-19.

Alteration of drug transporters mechanisms in response to inflammation

Inflammation is associated with various cytokines response. Cytokines are the broad class of small cell signaling proteins accountable for keeping homeostasis of the immune system. Proinflammatory cytokines interleukin-1 (IL-1), interleukin-6 (IL-6), and tumor necrosis factor (TNF- α) are mainly responsible for an acute immune response (Furuta et al., 2013). During infection, these locally producing cytokines can circulate in the bloodstream and produce a systemic effect by interacting with cell membrane receptors, transporters on the vascular endothelium, and parenchymal cells of numerous organs. Inflammation and immune reaction represent a significant factor in many acute and chronic diseases which are clearly involved in changing drug clearance by altering drug transporters mechanism and drug metabolizing enzyme activity.

P-glycoprotein (Pgp) is one of the most comprehensively explored ABC transporter that has been studied against the response of inflammations. Several studies suggested the association of IL-6 as direct administration of this cytokine diminished the Pgp mRNA level and protein expression in hepatic cell lines as well as *in vivo* in mice (G. Lee & Piquette-Miller, 2001; Sukhai, Yong, Kalitsky, & Piquette-Miller, 2000). In humans, intestinal epithelium showed a decrease in Pgp expression in inflammatory conditions (Blokzijl et al., 2007). Caco-2 is

human enterocyte cell line and universal model for permeability experiment was treated with TNF- α resulted in to decrease in Pgp expression and activity (Belliard, Lacour, Farinotti, & Leroy, 2004; Buyse, Radeva, Bado, & Farinotti, 2005). Second, most comprehensively explored ABC transporter, BCRP (breast cancer resistance protein) was studied in recent years. Like Pgp, BCRP activity and expression were downregulated in primary human hepatocytes after treating with IL-6, while TNF- α treatment led to induction of BCRP (Le Vee, Lecureur, Stieger, & Fardel, 2009). The effect of IFN- γ on primary human hepatocytes, significantly decreased the mRNA expression of BCRP (Le Vee, Jouan, Moreau, & Fardel, 2011). The human brain cell line showed significant decreases in the expression and activity of BCRP after treating by IL- β 1, IL-6, and TNF- α (Poller, Drewe, Krahenbuhl, Huwyler, & Gutmann, 2010). It is also believed that proinflammatory cytokines are key mediators of MRP2. It was recently revealed that IL- β 1, IL-6, and TNF- α , all considerably down-regulate the mRNA and protein expression of MRP2 in hepatic cell lines of human and rat (Diao, Li, Brayman, Hotz, & Lai, 2010; Le Vee, Gripon, Stieger, & Fardel, 2008). Overall, alteration in the expression of Pgp, BCRP, MRP2, and several other key transporters is mediated by acute inflammatory response (Buyse et al., 2005; Langmann et al., 2004; Mak, Cheung, Cone, & Marks, 2006; Suzuki, Miyamoto, Yasui, Sugie, & Tanaka, 2007; van der Heijden, Dijkmans, Scheper, & Jansen, 2007; van Herwaarden et al., 2003). One study on inflammatory bowel diseases (IBD) patients revealed the effect of inflammation on SLC transporters (Wojtal et al., 2009). SLC transporters (ENT1, ENT2, CNT2, OATP2B1, OATP4A1) mRNA level was dysregulated in IBD patients, which is associated with the inflammation of the tissue and presents an indication about the inflammatory signaling in the regulation of SLC expression (Wojtal et al., 2009). Many transcription factors are also activated during inflammation and play a key role in the regulation of transporters and drug-metabolizing enzymes (Ho & Piquette-Miller, 2007; Kameyama et al., 2008; W. Pan, Yu, Hsuchou, & Kastin, 2010; Teng & Piquette-Miller, 2008; Yu et al., 2008). Many excellent reviews have been published on the molecular mechanism of the transporters regulations during inflammation have been described elsewhere (Kosters & Karpen, 2010; Teng & Piquette-Miller, 2008; Tirona, 2011).

Alteration of drug metabolizing enzymes activity in response to inflammation

CYPs are widely involved as the main contributor to metabolic biotransformation of most drugs (Harvey & Morgan, 2014). Like drug transporters, regulation of CYPs has also been associated with inflammation in several metabolic and infectious diseases including viral infection (Wu & Lin, 2019). Inflammatory induced alteration in hepatic CYPs expressions and activity are caused by signal molecules which are mainly cytokines, formed during the

inflammation process (Morgan, 1997). It has been reported that multiple cytokines may play a part in regulating a single enzyme, whereas a subclass of enzymes can be regulated by a specific cytokine. The regulation is extremely important when considering drug interactions because drug pharmacokinetics will ultimately be altered depending on disease type and its released cytokines, as well as the administered (Aitken & Morgan, 2007; Muntane-Relat, Ourlin, Domergue, & Maurel, 1995). Many studies have described cytokine induced CYPs activity alteration in different mammals (Calleja et al., 1998; Monshouwer, Witkamp, Nuijmeijer, Van Amsterdam, & Van Miert, 1996; Tapner, Liddle, Goodwin, George, & Farrell, 1996) including humans (Abdel-Razzak et al., 1993; Rubin et al., 2015) using hepatocytes as well as *in vivo* in mice (J. Pan, Xiang, & Ball, 2000), rats (Morgan, 1993), and humans (Frye, Schneider, Frye, & Feldman, 2002). Inflammatory mediators also suppressed the extrahepatic CYPs (Bertilsson, Olsson, & Magnusson, 2001; Liptrott et al., 2009; Nicholson & Renton, 1999, 2001). Most proinflammatory cytokines are IL-1 (Dickmann, Patel, Wienkers, & Slatter, 2012; Iber, Chen, Cheng, & Morgan, 2000; Parmentier et al., 1993), IL-6, TNF- α , and IFN- γ that have displayed suppression of CYPs expression and activity (Bleau, Levitchi, Maurice, & du Souich, 2000; Donato, Guillen, Jover, Castell, & Gomez-Lechon, 1997; Nadin, Butler, Farrell, & Murray, 1995). Other cytokines IL-2 and IL-10 also showed the same effect (Elkahwaji et al., 1999; Gorski et al., 2000; Tinel et al., 1995). IL-6 has been identified as the major inflammatory factor that elicits a significant repressive effect on the expression and activity of different CYPs. Human recombinant IL-6 has exhibited concentration dependent inhibition of phenobarbital mediated induction of CYP2B1/2 in rat hepatocytes (Williams, Bement, Sinclair, & Sinclair, 1991) and reduced activity of different CYPs with variable levels (Y. L. Chen et al., 1992). Human recombinant IL-6 treatment markedly suppressed at mRNA level of CYP1A1, CYP1A2, and CYP3A3 in different human hepatoma cell lines (Y. L. Chen et al., 1992). Chronic inflammatory response, induced by turpentine or bacterial lipopolysaccharide, showed significant suppression in hepatic CYP1A2, CYP2A5, CYP2C1, and CYP3A11 in rats (Morgan, 1989; Siewert et al., 2000). Several studies have assessed the impact of IL-6 on CYPs, triggered by malignancies (Robertson et al., 2003). The vital role of IL-6 in cancer mediated suppression of hepatic CYP3A has been exhibited by mitigating such effect via monoclonal antibody against IL-6 (Kacevska et al., 2013) or IL-6 receptor (Mimura et al., 2015). Anti-IL-6 antibody intrusion was also tested in IL-6 treated primary human hepatocytes. CYP1A1, CYP1A2, CYP2B6, and CYP3A4 expression and activity were inhibited by IL-6, and It was also efficient of intervening CYP1A2 and CYP3A4, induced by omeprazole and rifampicin, respectively. The cytokine induced suppression of CYPs activity is not fully expounded but it is believed that strongly suggested that a decrease in the CYPs mRNA strongly recommended

a transcriptional mechanism affecting several transcriptional factors (Hayden, West, & Ghosh, 2006; Zordoky & El-Kadi, 2009). Nuclear factor Kappa B (NF- κ B) and the aryl hydrocarbon receptor are the regulatory transcription factor in the inflammatory and immune response, they regulate the gene expression of many CYPs in human, rats, and mice (Hayden et al., 2006; Ke, Rabson, Germino, Gallo, & Tian, 2001; Tian, Rabson, & Gallo, 2002; Zordoky & El-Kadi, 2009). For example, pyrrolidine dithiocarbamate is an inhibitor of NF- κ B that has the capability to block the inflammatory reduction in CYP1A2 activity (Kourylko, Fradette, Arcand, & du Souich, 2006; H. Yang et al., 2017). Pregnane X Receptor (PXR) is targeted to many genes most notably CYP3A4. PXR is regulated by NF- κ B factors and NF- κ B is regulated by inflammatory stimuli results manipulation of Hepatic CYPs expressions (Gu et al., 2006; J. Yang et al., 2010; C. Zhou et al., 2006). Activation of NF- κ B outcomes in suppressing the glucocorticoid receptors (GR), thus down-regulating constitutive androsterone receptor (CAR) expression and its associated CYP genes (Assenat, Gerbal-chaloin, Maurel, Vilarem, & Pascussi, 2006). It has been described that proinflammatory cytokines such as IFN- γ , TNF- α , GM-CSF (granulocyte macrophage colony stimulating factor), MC-SF (macrophage colony stimulating factor), IL-1, IL-6, IL-12 elevated in peripheral blood of COVID-19 patients (Guo et al., 2020; Huang et al., 2020). IL-6 was found the most important target for anti-cytokine therapy as it is believed to be the key point in the process and its elevation is associated with poor prognosis (Moore & June, 2020; C. Zhang, Wu, Li, Zhao, & Wang, 2020; F. Zhou et al., 2020).

It is well known that change in the expression of a transporter and the activity of DMEs, can lead to alterations in the pharmacokinetics of prescribed drug therefore prescribed medication during inflammation may be an important contributor to interindividual variability in drug efficacy and toxicity. In the case of co-administration of multiple drugs, the risk of drug interactions is increased. Most prescribed drugs are given below, and their drug interaction potential are shown in the table 1.

Agents Used to Treat COVID-19

Remdesivir

Remdesivir (GS-5734) is an adenosine triphosphate analog and that has been put forth to treat the Ebola and Coronavirus (Li & De Clercq, 2020). Remdesivir halts the viral replication by inhibiting the essential replicating enzymes RNA dependent RNA Polymerase. It supports the premature termination of viral transcription by eluding the proofreading activity of exoribonuclease (Agostini et al., 2018). Remdesivir has broad-spectrum activity against many

viruses, including, SARS-CoV, and MERS-CoV (Martinez, 2020), (Sheahan et al., 2017). Clinical pharmacokinetics data are still unclear. Moreover, safety data on humans are available online (Mulangu et al., 2019). It is now in phase 3 clinical trial for severe and moderate COVID-19 infected patients for finding out the clinical efficacy ("Medrxiv News. from, <https://times.hinet.net/mobile/news/22831665>. [Accessed 20 March 2020].", 2020). Remdesivir has already shown the successful inhibition with sub micromolar concentration in tissue culture experiment against human CoV, and Zoonotic CoV (A. J. Brown et al., 2019), (Ko et al., 2020). Similar efficacy was also found in MERS-CoV infected nonhuman primate (rhesus monkey) (de Wit et al., 2020). Currently, many clinical trials are ongoing for COVID-19 patients. It may give the direction for a potential treatment for COVID-19 infected patients (NIH, 2020e).

Favipiravir

Favipiravir is an antiviral drug that was used to treat influenza infection in 2014 in Japan (Favipiravir, 2020). Favipiravir was also used against the Ebola virus, in the absence of a standard cure for Ebola (Oestereich et al., 2014). It was finally accepted for the treatment of Ebola virus infection (Bai et al., 2016), (Shiraki & Daikoku, 2020). Favipiravir also showed the immune response in viral clearance in nonhuman primates (Madelain et al., 2020). Other studies have also described that the active metabolite of favipiravir (favipiravir ribofuranosyl-50-triphosphate) directly halt the transcription by inhibiting the RNA dependent RNA polymerase (Dong, Hu, & Gao, 2020), (Delang, Abdelnabi, & Neyts, 2018). The clinical evidence for the efficacy and safety was observed in open label, nonrandomized control clinical trial (Cai et al., 2020). Recently, phase-3 clinical trials for COVID-19 favipiravir with tablet was initiated in India ("Glenmark begins Phase-3 clinical trials on antiviral drug Favipiravir for COVID-19 patients in India. <https://www.thehindu.com/news/national/glenmark-begins-phase-3-clinical-trials-on-antiviral-drug-favipiravir-for-covid-19-patients-in-india/article31563198.ece> Accessed 25 May 2020.

," 2020). The clearance has granted Appili Therapeutics for evaluating safety and efficacy of favipiravir in the tablets form to control COVID-19 in long-term care services. FDA granted approval to Appili Therapeutics to investigate the broad-spectrum antiviral therapy for favipiravir.

Lopinavir/ritonavir

Lopinavir (LPV) is a potent anti-HIV drug that is used to treat HIV infection along with ritonavir (RTV). Ritonavir inhibits the hepatic drug metabolism of lopinavir to enhance the

half-life and activity. Infectious Diseases Society of America (IDSA) advised ritonavir-boosted combination as first line therapy for HCV patients ("Lopinavir, Ritonavir. <https://www.drugbank.ca/unearth/q?utf8=%E2%9C%93&query¼lopinavir%2Fritonavir&searcher¼drugs> Accessed 02 April 2020

", 2020). LPV/RTV has proven anti SARS-CoV-2 activity *in vitro* by preventing the protease in Vero E6 cells (Choy et al., 2020). In a comparative study (Chu et al., 2004), LPV/RTV along with ribavirin displayed a risk in SARS-CoV. Furthermore, SARS patients revealed that lopinavir-ritonavir plays an important role to explain the clinical consequences (Yao, Qian, Zhu, Wang, & Wang, 2020). Another comparative study (Yao et al., 2020), LPV/RTV treatment alone and combination with IFN enhanced clinical outcomes on some MERS patients. LPV/RTV was found to 40% decrease in the risk of MERS infection (Park et al., 2019). In India, EMR division has advised the dosing program for this drug combination for clinical management of COVID-19 ("Government of India Ministry of Health & Family Welfare Directorate General of Health Services (EMR Division). Guidelines on Clinical Management of COVID e 19 dated 17th March 2020. <https://www.aiims.edu/images/pdf/notice/Guidelines%20Clinical%20Management%20COVID19-23-3-20.pdf>," 2020). One randomized open-label clinical trial (B. Cao et al., 2020) for LPV/RTV is conducted on patients. The authors did not gain more advantage of LPV/RTV to clinical benefits outside the standard of care, while it was found to have an advantage except secondary endpoints. The efficacy of the LPV/RTV was approved, and future trials will verify the results (B. Cao et al., 2020). Currently, many clinical trials are proceeding for LPV/RTV along with other drug involvement (NIH, 2020f).

Ribavirin

Ribavirin is a guanosine analog and a broad-spectrum antiviral drug. In combination with interferon, it has been used as a treatment option for hepatitis C infected critically ill patients. It demonstrated lower risk and reduced death in ARDS (Acute respiratory distress syndrome) infection in combination LPV/RTV with than LPV/RTV only (Chu et al., 2004). Though, in recent *in-vitro* studies, ribavirin indicated a high effective concentration against COVID-19 (M. Wang et al., 2020), (Chan et al., 2015). However, ribavirin developed an unexpected adverse effect, which was very harmful to ADRS patients (Martinez, 2020).

Chloroquine, Hydroxychloroquine

The two aminoquinolines, chloroquine (CQ) and hydroxychloroquine (HCQ) are primarily used for malaria and rheumatic diseases. They showed the activity against the COVID-19 in Vero E6 cells (J. Liu et al., 2020) and recommended it as a primary treatment option for the

COVID-19 (Biot et al., 2006),(Devaux, Rolain, Colson, & Raoult, 2020; Fantini, Di Scala, Chahinian, & Yahi, 2020). CQ and HCQ have weak diprotic features and they could increase the pH of the endosome during the fusion of the virus to host cell (Mauthe et al., 2018). Several clinical trials were preceded in China for CQ and HCQ on COVID-19 infected patients. One of them disclosed that hopeful results in a reduction of the disease progression (Gao, Tian, & Yang, 2020). Temporarily, one clinical trial was performed in France for finding the efficacy of HCQ using at different doses, and along with azithromycin on COVID-19 infected patients. The clinical demonstration noticed that the treated rate was considerably higher in HQC used in combination with azithromycin (Gautret et al., 2020). Even though this study showed favorable results, large clinical data are required to confirm the efficacy and safety of HQC with azithromycin (Geleris et al., 2020). Similarly, a postexposure prophylaxis clinical trial (NCT04308668) using an oral dosing regimen has been conducted in the USA.

Umifenovir

Umifenovir, is also known as Arbidol, is a broad-spectrum antiviral drug (Pecher et al., 2016). Umifenovir worked to prevent the fusion of endosome membrane to virus particles (Boriskin, Pecher, & Polyak, 2006; Pecher et al., 2007; Villalain, 2010). It was discovered to interact with the virus hemagglutinin and enhance the hemagglutinin stability, thus inhibiting the hemagglutinin transition into a functional state(Leneva, Russell, Boriskin, & Hay, 2009). Umifenovir also disclosed the immunomodulatory and macrophage activation(Q. Liu et al., 2013). LPV/RTV and umifenovir was earlier used to treat acute SARC-CoV in clinical practice. The clinical safety and efficacy of the umifenovir monotherapy were analyzed in COVID-19 patients and compared with LPV/RTV therapy. Umifenovir was found better than LVP/RTV for treating COVID-19 (Zhu et al., 2020). Central Drug Research Institute (CDRI) has acquired the approval for proceeding with the phase III clinical trial of umifenovir. In this randomized, double-blind, placebo-controlled trial, the efficacy, safety, and tolerability are going to be tested.

Nitazoxanide

Nitazoxanide is an antiparasitic and broad-spectrum antiviral drug. It has shown potential against SARS-CoV-2 and MERS-CoV in Vero E6 cells. Nitazoxanide prevents viral infection by enhancing the specific host mechanism (Jasenovsky et al., 2019). The *in-vitro* activity of nitazoxanide against the SARC-CoV-2 suggested that more clinical data are required to assess the efficacy and safety against COVID-19 (Choy et al., 2020; Pepperrell, Pilkington, Owen, Wang, & Hill, 2020). While evaluating the efficacy of nitazoxanide alone and in

combination with HQ, it reduced the requirement of insidious ventilator support for COVID-19 patients. Currently, many clinical trials for nitazoxanide are proceeding with various doses to treat COVID-19 patients (Calderon, Zeron, & Padmanabhan, 2020). FDA has granted the approval to Azidus Brasil for nitazoxanide to carry on phase II clinical trial (FDA, 2020).

Ivermectin

Ivermectin is an effective antiparasitic agent that was approved by the FDA. Ivermectin has shown activity against many viruses (Ketkar, Yang, Wormser, & Wang, 2019). Recently, one *in-vitro* study revealed that ivermectin strongly impeded the replication of COVID-19 (Caly, Druce, Catton, Jans, & Wagstaff, 2020). Its antiviral activity may play a vital role and deliver as a potential candidate to treat COVID-19 (Chaccour, Hammann, Ramon-Garcia, & Rabinovich, 2020; Heidary & Gharebaghi, 2020). Finally, FDA declared a report for self-administration of ivermectin in COVID-19 patients (News, 2020d). Ivermectin is broadly offered, due to its inclusion on the WHO model list of necessary medicines.

Interferons

Interferon (IFN) is a broad-spectrum antiviral agent that inhibits viral replication via interaction with toll-like receptors (TLR) (Uematsu & Akira, 2007). It established antiviral resistance in cells (Kotenko et al., 2003; Sheppard et al., 2003). Moreover, a member of this family (IFN- λ 4) was discovered for viral clearance (Prokunina-Olsson et al., 2013). IFN- λ was found to be more efficient with a slight increase in inflammation and tissue damage (Davidson et al., 2016; Galani et al., 2017), and potentially controlled viral spreading from the nasal epithelium to the upper respiratory tract (Klinkhammer et al., 2018), with efficacy as compared to IFN α -based therapies (Muir et al., 2014). IFN α and β displayed activity against the SARS-CoV *in-vitro* (Hensley et al., 2004; Stroher et al., 2004). IFN β indicated the potential in inhibiting MERS-CoV replication (Chan et al., 2013; Hart et al., 2014). Mainly type I IFN showed a fast decrease of viral load in mild to moderate COVID-19 patients. In the severe COVID-19 infection, IFN revealed the antiviral response with increased lung cytokine levels, reduced the T cell response, and acute clinical relapse (Jamilloux et al., 2020).

Dexamethasone

Dexamethasone is a corticosteroid immunosuppressor. It lessens the ability of B cells to synthesize antibodies (Giles et al., 2018). Dexamethasone regulates cytokine's damaging effects by reducing the level of cytokine (H. Chen et al., 2019). Moreover, dexamethasone

prevents macrophages and natural killer cells from clearance secondary nosocomial pathogens (Cohn, 1991). Clinical evidence does not recommend the use of corticosteroids in COVID-19 infection (Russell, Millar, & Baillie, 2020). Even though corticosteroid has been associated to an increase in the viral load, it persisted in the viral load even after survival of patients from SARS-CoV (N. Lee et al., 2004). By contrast, a clinical trial proved that dexamethasone saved the life of seriously ill COVID-19 infected patients in the United kingdom (UK) (Ledford, 2020). UK government stated that dexamethasone was approved as an immediate treatment option for hospitalized patients that were seriously ill and on ventilator (Group et al., 2020). WHO added the dexamethasone in the essential medicine list that is readily available at low cost. In the USA, NIH issued the guideline to recommend dexamethasone as a treatment option for COVID-19 infected patients (Bethesda, 2020; C., 2020).

Tetracyclines

Tetracycline is an antibiotic. It can be used as a possible treatment option for COVID-19 patients because of its well-known activity to decrease the level of inflammatory cytokines such as IL-1b and IL-6 (Henehan, Montuno, & De Benedetto, 2017). Both IL-1b and IL-6 levels were significantly increased during COVID-19 infection (Yoshikawa, Hill, Li, Peters, & Tseng, 2009). Tetracycline also revealed that it lessened the inflammatory agent in the circulation and induced programmed cell death (Sandler et al., 2005). Investigators proposed that tetracycline must be a better therapeutic option to treat inflammatory disorders (Kritas et al., 2020; Sandler et al., 2005). Previously it was documented for the treatment of HIV, west nile virus (WNV), and viral encephalitis diseases (Dutta & Basu, 2011) and also used for the prevention of septic shock induced by ARDS (Griffin, Fricovsky, Ceballos, & Villarreal, 2010). It could be selected, as a potential treatment option for COVID-19 infection (Bharadwaj, Lee, Dwivedi, & Kang, 2020), and could be used as a comedication option (Gautam, Gautam, Garg, & Singh, 2020).

Teicoplanin

Teicoplanin is an antiviral drug that can inhibit the replication and transcription of the competent virus. It also worked against the MERS and SARS as well (Y. Wang et al., 2016). Mechanistic studies revealed that teicoplanin inhibits the activity of the host cell's cathepsin L and cathepsin B, these proteins are responsible for cleaving the viral glycoprotein allowing contact of the receptor binding domain of its core genome and subsequent release into the cytoplasm of the host cell (Baron, Devaux, Colson, Raoult, & Rolain, 2020; N. Zhou et al., 2016). Therefore, these studies suggested that the teicoplanin could be used as a therapeutic

option for treating COVID-19 because SARS-CoV-2 is a cathepsin L dependent virus. According to Ceccarelli et al, teicoplanin has shown efficacy in COVID-19 infected subjects (Ceccarelli et al., 2020). Teicoplanin was recommended as a hopeful option for the treatment of COVID-19 even though its safety and efficacy data in humans is still required.

Atazanavir

Atazanavir (ATV) is an HIV-1 protease inhibitor (PI) currently suggested as a first line treatment for naïve HIV infected patients as well as switch regimens for patients showing intolerance to other antiretroviral drugs (ARVs) ("Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1 infected adults and adolescents. ," 2012). ATV, alone or in combination with RTV, has shown the potential to inhibit the SARS-CoV-2 replication and pro-inflammatory cytokine production (Fintelman-Rodrigues et al., 2020; Rahmani et al., 2020). ATV diminished IL-6 release in COVID-19 infected human primary monocytes. Cellular mortality and cytokine storm associated intermediaries were lowered after treatment with ATV (Fintelman-Rodrigues et al., 2020). The ATV or ATV-RTV has demonstrated new therapeutic option among clinically approved drugs that should be considered as an effective treatment for COVID-19 infected patients.

Azithromycin

Azithromycin (Pfizer, NY USA) was revealed to be active in vitro against Ebola (Madrid et al., 2015). Moreover, azithromycin is considered to have the ability in preventing severe respiratory tract infection Orally used azithromycin is distributed to a variety of tissues particularly the lungs (Bacharier et al., 2015). Azithromycin was used to treat COVID-19 patients in combination with HCQ (Arshad et al., 2020).

Darunavir

Darunavir is an HIV protease inhibitor, approved in combination with cobicistat (pharmacoenhancer) for the treatment of both naïve and experienced patients infected with HIV-1 ("Prezcobix prescribing information. https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/205395s001lbl.pdf," 2020; "Rezolsta Summary of product characteristics. https://www.ema.europa.eu/en/documents/product-information/rezolsta-epar-product-information_en.pdf ," 2020). The safety and efficacy profile of this combination is already established based on III phase clinical trials (Orkin et al., 2013; Tashima et al., 2014). Existing data on the therapeutic effect of HIV protease inhibitors are from thorough in the COVID-19 patients. The inaccessibility of *in-vitro* activity against SARS-CoV-2, darunavir

could not be endorsed to use as the treatment option for COVID-19. Consequently, darunavir in combination with cobicistat or with RTV should remain exclusively for the treatment of HIV patients (De Meyer et al., 2020). In one study, darunavir-cobicistat combination therapy was found to be connected with considerable survival gain in critically ill patients of COVID-19 (Kim et al., 2020). Its safety and efficacy data in humans are still required.

Ruxolitinib

Ruxolitinib is routinely used for the care of myelofibrosis including polycythemia vera (Vannucchi et al., 2015; Verstovsek et al., 2012). It is a Janus kinase inhibitor and inhibits the JAK-STAT signaling (Venugopal, Bar-Natan, & Mascarenhas, 2020). Ruxolitinib is being continued to investigate against placebo for COVID-19 patients with ARDS in two randomized phase III clinical trials (NCT04363137 and NCT04377620) and which is currently evaluating the requirement of mechanical ventilation for COVID-19 patients with ARDS (El Bairi et al., 2020). Ruxolitinib might be effective against the outcomes of the elevated levels of cytokines in COVID-19 patients (Y. Cao et al., 2020). Its safety and efficacy data in humans are still required in critically ill conditions.

Baricitinib

Baricitinib is used as a therapeutic option for rheumatoid arthritis. It also a reversible JAK-inhibitor (Grasselli et al., 2020; Jin & Tong, 2020; Mehta et al., 2020). The JAK-STAT signaling intervenes in the signaling of several cytokines and interfering with this pathway may be an appealing approach to alter the immunopathology of SARS-CoV-2 (Fragoulis, McInnes, & Siebert, 2019; Jamilloux et al., 2020; Richardson, Corbellino, & Stebbing, 2020). Further, many drugs within this class exhibit antiviral effects, albeit often at supra-therapeutic concentration, by targeting host factors that viruses usurp for cell entry (Pu et al., 2018; P. Richardson et al., 2020). Baricitinib has the advantage of providing in vitro antiviral activity at concentration achieved with approved dosing (P. J. Richardson et al., 2020). Baricitinib plus remdesivir comedication was shown promise for treating COVID-19. This comedication therapy was superior upon remdesivir alone in lowering recovery and accelerating improvement in clinical status. This combination has been shown fewer serious adverse effects (Kalil et al., 2020).

Imatinib

Imatinib is a tyrosine kinase inhibitor, used to treat chronic myelogenous leukemia, gastrointestinal stromal tumors, and the number of other malignancies. It has been pointed out as an unexplored SARS-CoV-2 infection (Gasmi et al., 2020). One case report on

COVID-19 patients exhibited that who received imatinib due to clinical relapse even with dual therapy with HCQ and lopinavir/ritonavir (Morales-Ortega et al., 2020). One study was conducted for finding the efficacy and safety of oral administration of imatinib combined with the best conventional care (BCC) versus placebo in hospitalized COVID-19 patients (Emadi, Chua, Talwani, Bentzen, & Baddley, 2020).

Fluvoxamine

Fluvoxamine is a strong S1R agonist (Cobos, Entrena, Nieto, Cendan, & Del Pozo, 2008; Hashimoto, 2015) is used as an antidepressant. It is extremely hydrophilic and has fast intracellular uptake (Hallifax & Houston, 2007). One study was conducted on adult symptomatic COVID-19 patients, Fluvoxamine was given orally to outpatients (Lenze et al., 2020). However, this study was restricted by a small sample size. This study was triggered by a hypothesis including the influence on the S1R-IRE1 pathway. Cytokine reduction resulting from S1R activation would fit with this recent finding of benefits of the other anti-inflammatory drugs for COVID-19 (Deftereos et al., 2020; Sterne et al., 2020). The potential advantage of fluvoxamine for outpatient treatment of COVID-19 includes its safety (Omori et al., 2009) widespread availability, low cost, and oral administration. QT prolongation is not promoted by Fluvoxamine like other SSRIs (Assimon, Brookhart, & Flythe, 2019). Nonetheless, fluvoxamine has adverse effects and can cause drug-drug interaction, via inhibition of CYP1A2 and CYP2C19 (Christensen et al., 2002).

Tocilizumab

Tocilizumab is a recombinant monoclonal antibody. Tocilizumab is mainly used to treat rheumatoid arthritis. It was conceived as an IL-6 receptor blocker to diminish inflammation. IL-6 drastically increases in patients when COVID-19 infection is produced (Yoshikawa et al., 2009). This's why tocilizumab is used as a therapeutic option for treating COVID-19 patients (Luo et al., 2020; News, 2020d). In COVID-19 infected patients, T-lymphocyte and macrophages generate IL-6 to cause the cytokine storm and severe inflammatory responses mainly in the lungs. Therefore, it is turned into an effective therapeutic drug for the treatment of severe COVID-19 infected patients (X. Xu et al., 2020; C. Zhang et al., 2020). Tocilizumab exhibited a trend association towards lowered mortality among ICU patients (Ip et al., 2020). The Genentech has been given approval by FDA continuing the phase III clinical trial for tocilizumab to assess the safety and efficacy of severe COVID-19 infected patients (News, 2020a).

Itolizumab

Itolizumab is a recombinant monoclonal antibody for CD6 (Cluster of Differentiation 6) of IgG1 (Immunoglobulin G1). It is basically used for the treatment psoriatic patients (Dogra, Uprety, & Suresh, 2017). Itolizumab has shown the reduction of inflammatory cytokines, such as IFN- γ , TNF- α , and IL-6 (Aira et al., 2016; Aira et al., 2014; Nair, Melarkode, Rajkumar, & Montero, 2010). It could be used as a treatment option for COVID-19 infection (Loganathan, Athalye, & Joshi, 2020). It showed the reduction of IL-6 in critically ill patients (Saavedra et al., 2020). The pharmaceutical company Biocon has acquired consent for itolizumab from the DGCI (Drugs Controller General of India) for the treatment of COVID-19 patients in emergency state (News, 2020b). Cuban regulatory agency has approved for the trial to use of itolizumab for COVID-19. Itolizumab might interrupt the hyperinflammatory cascade and stop COVID-19 morbidity and mortality (Caballero et al., 2020).

Meplazumab

Meplazumab is a humanized monoclonal antibody for CD147. It efficiently inhibited virus replication in Vero E6 cells (Ke Wang, 2020). One study has been conducted to ascertain the clinical results of meplazumab and revealed progress in the COVID-19 infected patients (Huijie Bian, 2020). It was previously reported that meplazumab exhibited activity against the Chauge-Strauss syndrome (Wechsler et al., 2017). Phase I clinical trial (NCT04369586) in the healthy volunteers of maplazumab has been achieved for finding the safety, efficacy, tolerability, PK attributes, and dosage regimen for Phase II clinical trial (NIH, 2020c). Phase II clinical trials are going in the USA to find the safety and efficacy of meplazumab injection in COVID-19 infected patients (NCT04275245). This trial will be completed in December 2020 (NIH, 2020a).

Eculizumab

Eculizumab is a monoclonal antibody for complement C5 protein. It prevents cleavage to C5a and C5b and impedes the creation of the membrane attack complex (MAC) C5b-9 to stop lysis of the cell (Jodele et al., 2020). Eculizumab was disclosed to be an effective therapeutic option for hematological and neuroinflammatory diseases (Jodele et al., 2020; Nunius, Buttner-Herold, Bertz, Schiffer, & Buchholz, 2020; Olson et al., 2018; Roselli, Karasu, Volpe, & Huber-Lang, 2018). Evermore, evidence (Wong et al., 2004) shows that complement is also a key mediator of lung damage notably during CoV infection. Therefore, eculizumab might work as an emergency therapy to treat COVID-19 patients associated with ARDS. Some studies (Diurno et al., 2020), (NIH, 2020b) supported the eculizumab use as a treatment for severe COVID-19. Studies were performed along with ruxolitinib for

confirming the efficacy of Eculizumab in severe COVID-19 patients (Giudice et al., 2020), (Risitano et al., 2020). It has been approved for continuing the clinical trial.

AMY101

AMY101 is a highly selective complement C3 inhibitor that was developed by Amyndas Pharmaceuticals (Mastellos et al., 2015; Silasi-Mansat et al., 2015; van Griensven et al., 2019). It is a small sized cyclic peptide that indicated more promising efficacy in non-human primates (Zimmerman, Dellinger, Straube, & Levin, 2000). AMY101 has effectively completed the phase I clinical trial with acceptable safety and tolerability, and now it is in phase II clinical trial (NCT04395456) (NIH, 2020d), (Reis et al., 2018). Some studies (Magro et al., 2020; Risitano et al., 2020) have shown the proinflammatory response by the activation of the complement system (C3) in COVID-19 patients. AMY101 could be a unique therapeutic option to overcome the complement mediated inflammatory response in COVID-19 patients. The recent clinical study (Mastaglio et al., 2020), AMY101 revealed the safety and efficacy in patients with severe ARDS due to COVID-19 infection.

ARDS-003

Cannabinoid (CBD) is also a probable treatment for severe COVID-19 patients (N. Trivedi et al., 2020; N. V. Trivedi, A. Kumar, D., 2020). It was designed as an injectable form to treat a serious case of coronavirus “acute respiratory distress syndrome (ARDS)”. This syndrome generated a cytokine storm to create inflammation. It will have the advantage of impacting several pro-inflammatory signaling pathways, by enhancing the effectiveness of the drug to rapidly diminish the release of the cytokines and avert acute outcomes like ARDS. The cannabinoid drug named, ARDS-003, has been approved for the phase I clinical trial. It is still being tested by Tetra Bio-Pharma (<https://www.forbes.com/sites/emilyearlenbaugh/2020/08/20/synthetic-cannabinoid-drug-for-covid-19-approved-for-phase-1-clinical-trials/#314337063329>, 2020). Firstly, the FDA emphasized that the nonclinical study results were appropriate for starting a study in COVID-19 infected patients (<https://ir.tetrabiopharma.com/newsroom/press-releases/news-details/2020/FDA-Provides-Positive-Feedback-on-Tetra-Bio-Pharmas-Pre-Investigational-New-Drug-Application-for-ARDS-003-to-Be-Studied-in-COVID-19-Patients-at-Risk-of-Developing-Acute-Respiratory-Distress-Syndrome-ARDS/default.aspx>, 2020).

LCB1

LCB1 revealed as the SARS-CoV-2 neutralizing antibody. It is a computer designed mini protein that has been synthesized by the researchers of the University of Washington School of Medicine. It binds firmly to SARS-CoV-2 spikes proteins and hinders them from infecting cells. LCB1 appeared to protect the Vero E6 cells from SARS-CoV-2 infection. This synthesized antiviral candidate was conceived to overcome the infection by interfering with the mechanism that coronavirus uses to break into and enter cells. LCB1 is presently being evaluated in rodents (News, 2020c). These hyper stable mini-binders provide the starting point for COVID-19 therapeutics (Longxing Cao, 2020).

Molnupiravir

Molnupiravir (MK448/EIDD-2801) is a prodrug of synthetic nucleoside derivative N4-hydroxy-cytidine and applies its antiviral action via the introduction of copying error during viral RNA replication (Sheahan et al., 2020). Institute for Biomedical Sciences, Georgia State University, developed this antiviral drug. After being found to be active against SARS-CoV-2, MK448/EIDD-2801 was analyzed in the preliminary human study for safety, tolerability, and pharmacokinetics in healthy volunteers in the UK and US (NCT04392219). On October 19, 2020, Merck has started one-year stage 2/3 trial aimed at hospitalized patients (NCT04575584). MK448/EIDD-2801 can block the transmission of SARS-CoV-2 within 24 hours (Cox et al., 2020). Plemper's team repurposed molnupiravir against COVID-19 and applied a ferret model to test the effect of it on containing the spread of the COVID-19 (Cox et al., 2020).

Table 1. Drug-drug interaction potential of therapeutic agents used to treat COVID-19

	Drug	Drug Transporter	reference	Metabolism	reference
1	Remdesivir	^s Pgp, ^s OATPB1, ^l OATPB1, ^l OATPB3, ^l BSEP, ^l MRP4, ^l NTCP	(K. Yang, 2020)	^s CYP2C8, ^s CYP2D6, ^s CYP3A4, ^l CYP3A4	(K. Yang, 2020)
2	Favipiravir	^l OAT1, ^l OAT3	(Mishima, Anzai, Miyazaki, & Abe, 2020)	^s AO	(Mishima et al., 2020)
3	Ribavirin	^s NT, ^s ENT1	(Fukuchi, Furihata, Hashizume, Iikura, & Chiba, 2010; Karbanova et al., 2019)	Phosphorylation, Deribosylation, Amide hydrolysis	(Hodge et al., 2020)
4	Interferons	^s OAT2	(C. Chen, Han, Yang, & Rodrigues, 2011)	^s CYP1A2, ^s UGT2B7, ^l CYP3A, ^l CYP2D6	(Becquemont et al., 2002; C. Chen et al., 2011)
5	Lopinavir	^s Pgp, ^s MRP1, ^s MRP2, ^s OATP1A2, ^s OATP1B1 ^l Pgp, ^l BCRP,	(Kiser et al., 2008; Rakhmanina et al., 2011; van Waterschoot et al., 2010) (Gupta, Zhang, Unadkat,	^l CYP3A4	(Kiser et al., 2008; Rakhmanina et al., 2011; van Waterschoot et

		¹ OATP1B1, ¹ OATP1B3, ¹ OATP2B1	& Mao, 2004; Janneh, Jones, Chandler, Owen, & Khoo, 2007; Storch, Theile, Lindenmaier, Haefeli, & Weiss, 2007; Weiss et al., 2007)		al., 2010)
6	Ritonavir	^{\$} Pgp, ^{\$} MRP1, ^{\$} MRP2, ¹ Pgp, ¹ MRP1 ¹ , BCRP, ¹ OATP1A2, ¹ OATP2B1, ¹ OATP1B1, ¹ OATP1B3, ¹ OCT1, OCT2	(Rakhmanina et al., 2011) (Marzolini, Gibbons, Khoo, & Back, 2016) (Cvetkovic, Leake, Fromm, Wilkinson, & Kim, 1999; Gupta et al., 2004; Huisman et al., 2002; Jung et al., 2008; M. D. Perloff, von Moltke, & Greenblatt, 2002; Tirona, Leake, Wolkoff, & Kim, 2003; van der Sandt et al., 2001; Weiss et al., 2007; L. Zhang et al., 2000)	^{\$} CYP1A2, ^{\$} CYP2C8, ^{\$} CYP2C9, ^{\$} CYP2C19, ¹ CYP3A4, ¹ CYP2D6	(Aungst, Nguyen, Bulgarelli, & Oates-Lenz, 2000) (Marzolini et al., 2016)
7	Chloroquine	^{\$} OATP1A2	(Sortica et al., 2017; C. Xu et al., 2016)	^{\$} CYP2C8, ^{\$} CYP3A4 ^{\$} CYP2D6	(Babayeva & Loewy, 2020; Elewa & Wilby, 2017)
8	Hydroxy chloroquine	¹ Pgp, ¹ OATP1A2	(Sortica et al., 2017; Weiss, Bajraktari-Sylejmani, & Haefeli, 2020; C. Xu et al., 2016)	^{\$} CYP2C8, ^{\$} CYP3A4 ^{\$} CYP2D6	(Babayeva & Loewy, 2020; Elewa & Wilby, 2017; J. Y. Lee et al., 2016)
9	Dexamethasone	^{\$} Pgp, ^{\$} MRP2	(Courtois, Payen, Guillouzo, & Fardel, 1999; Manceau et al., 2012)	^{\$} CYP3A4	(Pascussi et al., 2001)
10	Umifenovir	Unclear		^{\$} CYP3A4 and ^{\$} FMOs	(Deng et al., 2013)
11	Teicoplanin	Unclear		Unclear Metabolic path	(Bernareggi et al., 1992)
12	Nitazoxanide	unclear		^{\$} Deacetylase, ^{\$} UGT	(Broekhuysen, Stockis, Lins, De Graeve, & Rossignol, 2000)
13	Ivermectin	¹ Pgp, ¹ BCRP, ¹ MRP1, ¹ MRP2, ¹ MRP3	(Houshaymi, Nasreddine, Kedeas, & Soayfane, 2019; Jani et al., 2011; Lespine et al., 2006)	¹ CYP2C9, ¹ CYP2C19 ¹ CYP2D6, ¹ CYP3A4	(Neodo, Schulz, Huwyler, & Keiser, 2019)
14	Atazanavir	^{\$} Pgp, ^{\$} MRP1, ^{\$} MRP2, ¹ OATP2B1	(Kis, Zastre, Hoque, Walmsley, & Bendayan, 2013; E. S. Perloff, Duan, Skolnik, Greenblatt, & von Moltke, 2005) (Bousquet et al., 2008; Storch et al., 2007; Weiss et al., 2007; Zastre et al., 2009)	¹ CYP3A4, ¹ UDGT	(E. S. Perloff et al., 2005)
15	Azithromycin	^{\$} Pgp and ^{\$} MRP2 ^{\$} OATP	(Lan et al., 2009; Sugie et al., 2004)	^{\$} CYP3A4	(Galetin, Burt, Gibbons, &

					Houston, 2006; Westphal, 2000)
16	Darunavir	^S Pgp, ^S OATP1A2, OATP1B1, ^I Pgp, ^I OATP2B1	(Holmstock, Mols, Annaert, & Augustijns, 2010) (K. C. Brown, Paul, & Kashuba, 2009; Fujimoto et al., 2009; Tong et al., 2007)	^I CYP3A4	(Holmstock, Gonzalez, Baes, Annaert, & Augustijns, 2013; Vermeir et al., 2009)
17	Ruxolitinib	^S OATP1B1, and ^S OCT1, ^S NTCP, ^I Pgp, ^I BCRP	(Holmstock et al., 2013; Vermeir et al., 2009)	^S CYP1A2, ^S CYP2B6, ^S CYP2C9 ^S CYP3A4	(Aslanis et al., 2019; Febvre-James, Bruyere, Le Vee, & Fardel, 2018)
18	Baricitinib	^S P-gp, ^S BCRP, ^S OAT3, ^S MATE-K	(Hodge et al., 2020; Posada et al., 2017)	^S CYP3A4	(Hodge et al., 2020; Takahashi, Luzum, Nicol, & Jacobson, 2020)
19	Imatinib	^S Pgp, ^S OATP1B3	(Mlejnek, Kosztyu, Dolezel, Bates, & Ruzickova, 2017; Yamakawa et al., 2011)	^S CYP2C8, ^S CYP3A4	(Filppula, Neuvonen, Laitila, Neuvonen, & Backman, 2013; Gschwind et al., 2005)
19	Fluvoxamine	Unclear		^S CYP1A2, ^S CYP2C19, ^S CYP2D6, ^S CYP3A4 ^I CYP1A2, ^I CYP2C19	(Iga, 2016; Kashuba et al., 1998) (Christensen et al., 2002)
20	Canabinoids	^S Pgp, ^S BCRP, ^S MRPs	(Alsherbiny & Li, 2018)	^S CYPs, ^S UGT	(Alsherbiny & Li, 2018; Stout & Cimino, 2014)
21	Molnupiravir	Unclear		Unclear	
22	Itolizumab	Unclear		Unclear	
23	Tocilizumab	Unclear		Unclear	
24	Meplazumab	Unclear		Unclear	
25	Eculizumab	Unclear		Unclear	
26	AMY101	Unclear		Unclear	
27	ARDS-003	Unclear		Unclear	
28	LCB1	Unclear		Unclear	

^S-substrate of, ^I-Inhibitor of, Pgp; P-glycoprotein, OAT; Organic Anion Transporter, OATP; Organic Anion Transporter Protein, BCRP; Breast Cancer Resistance Protein, MRP, Multidrug Resistance Associated Protein, OCT; Organic Cation Transporter, NT; Nucleotide Transporter, ENT; Equilibrative Nucleoside Transporter, NTCP; Sodium/Taurocholate Co-transporting polypeptide, BSEP; Bile Salt Export Pump, CYP; Cytochrome P450, UGT, UDP-Glucuronosyltransferase, AO; Aldehyde Oxidase, FMO; Flavin-containing Monooxygenase

Conclusions

The present review pointed out the possibilities of risk of drug interaction of mentioned drug in tackling COVID-19. The inflammatory response enforces changes in the expression and activity of transporters and DMEs. Disposition of drugs used to treat COVID-19 infection involves drug metabolism CYPs enzymes and drug transported by ABC and SLC

transporters. However, it is already known that ABC and SLC transporters play a central role in the disposition of mostly antiviral drugs and can participate in many drug-drug interactions. Most importantly, the involvement of CYPs in used drug in COVID-19 infection, drug-drug interaction has been comprehensively known but some drugs are still unknown. That's why in COVID-19 infection, inflammatory responses play a key role in disease-drug or drug-drug interactions. Alteration in the transporters and DMEs can lead to changes in the pharmacokinetic parameters of used the drug. Hence, inflammation might play an important role in drug efficacy and toxicity. The risk of drug interactions should not be prohibited since they are frequently manageable and convenient. LPV/RTV is being used in combination with other drugs. HCQ in combination with azithromycin and with LPV/RTV has been used in COVID-19 Patients. These medications have been classified as having a risk of developing torsades de points (TdP). Moderate to severe QTc prolongation was observed during these pharmacological treatments (Padilla et al., 2020). The ATV-RTV have shown new option among clinically approved drugs and should be considered as an effective treatment option. Another combination of remdesivir with bericitinib has shown the serious side effect even though this combination has shown promise for COVID-19 with accelerating improvement in clinical status (Kalil et al., 2020). The consumption of a single drug may possibly not be more effective but, during co-medication of multiple drugs, the risk of drug interaction must be increased. The potential of drug-drug interaction or disease-drug interaction is an important consideration when identifying optimal treatment regimens for individual patients.

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