HIV/AIDS Quick Sheet

DEFINITIONS	
ART = antiretroviral therapy	NRTI = nucleoside reverse transcriptase inhibitor
CrCl = creatinine clearance	NNRTI = non-nucleoside reverse transcriptase inhibitor
INSTI = Integrase Strand Transfer Inhibitor	PI = protease inhibitor

ANTIRETROVIRAL ABBREVIATIONS		
ABC = Abacavir	DTG = Dolutegravir	NVP = Nevirapine
ATV/cobi = Atazanavir/cobicistat	EFV = Efavirenz	RAL = Raltegravir
ATV/r = Atazanavir/ritonavir	ETR = Etravirine	RPV = Rilpivirine
cobi = Cobicistat	EVG = Elvitegravir	RTV = ritonavir
d4T = Stavudine	FTC = Emtricitabine	SQV = Saquinavir
ddC = Zalcitabine	3TC = Lamivudine	T20 = Fuzeon
ddI = Didanosine	FPV = fosamprenavir calcium	TDF = Tenofovir disoproxil fumarate
DRV/cobi = Darunavir/cobicistat	IDV: Indinavir	TPV = Tipranavir
DRV/r = Darunavir/ritonavir	LPV/r = Lopinavir/ritonavir	ZDV = Zidovudine

Initiating Antiretroviral (ARV) Therapy in Treatment-Naive Patients

Optimal ARV regimen consists of two NRTIs in combination with a 3rd active ARV drug from 1 of 3 drug classes:

(2) NRTI's + **INSTI**
(2) NRTI's + **boosted PI (boosted with Norvir or Cobicistat)**
(2) NRTI's + **NNRTI**

ANTIRETROVIRAL (ARV) REGIMENS FOR ART-NAÏVE PATIENTS

Recommended Regimen Options

INSTI Based		PI Based
• DTG + ABC**/3TC*	Triumeq™	• DRV/r (once daily) + TDF/FTC* or TAF/FTC
• DTG + TDF/FTC* or TAF/FTC		
• EVG/cobi***/TDF/FTC	Stribild™	
• EVG/cobi***/TAF/FTC	Genvoya™	
• RAL + TDF/FTC* or TAF/FTC		(TAF: Tenofovir Alafenamide)

Alternative Regimen Options

Effective and tolerable, but have potential disadvantages when compared with the above recommended regimens, have limitations for use in certain patient population, or have less supporting data from randomized clinical trials. An alternative regimen may be the preferred regimen for some patients.

NNRTI Based		PI Based
• EFV + TDF/FTC*	Atripla™	• (ATV/cobi*** or ATV/r) + TDF/FTC* or TAF/FTC
• EFV + TAF/FTC		• (DRV/cobi*** or DRV/r) + ABC**/3TC*
• RPV# + TDF/FTC*	Complera™	• DRV/cobi*** + TDF/FTC* or TAF/FTC
• RPV# + TAF/FTC*	Odefsey™	

Other Regimen Options

Regimens that, in comparison with Recommended and Alternative regimens, may have reduced virologic activity, limited supporting data from large comparative clinical trials, or other factors such as greater toxicities, higher pill burden, drug interaction potential, or limitations for use in certain patient populations.

INSTI Based	NNRTI Based	PI Based	If TDF, TAF or ABC cannot be used
• RAL + ABC**/3TC*	• EFV + ABC**/3TC* (##)	• (ATV/cobi*** or ATV/r) + ABC**/3TC* (##)	• DRV/r + RAL# (twice daily) • LPV/r (twice daily) + 3TC (twice daily)

**** 3TC may be substituted for FTC or vice versa***

***** Use ABC only for HLA-B*5701 negative patients***

****** Use cobi/TDF only for patients with pre-ART CrCl ≥ 70 mL/min***

****** Use Genvoya™ only for patients with pre-ART CrCl ≥ 30 mL/min***

 # Use regimen only for patients with pre-treatment HIV RNA < 100,000 copies/mL and CD4 cell count >200 cells/mm3

regimen only for patients with pre-treatment HIV RNA < 100,000 copies/mL

Antiretroviral Regimens or Components That Should Not Be Offered At Any Time *Not generally recommended due to suboptimal antiviral potency, unacceptable toxicities, or pharmacologic concerns*	
Monotherapy with NRTI,NNRTI, entry inhibitor, PI or INSTI	ATV + IDV
2-NNRTI combination	ddI + d4T
EFV in 1st trimester or with significant child-bearing potential	ddI + TDF
NVP in pre-ARV CD4 > 250 in women or > 400 in men	d4T + ZDV
Unboosted DRV, SQV or TPV	FTC+ 3TC
Unboosted RTV doses (e.g., 600mg BID)	ETR + TPV/r
Dual or Triple NRTI Regimens Except Possibly: ABC/ZDV/3TC or TDF/ZDV/3TC	ETR + ARV/r or FPV
	ETR + unboosted PI

Selection of a regimen should be individualized on the basis of virologic efficacy, toxicity, pill burden, dosing frequency, drug-drug interaction potential, resistance testing results, comorbid conditions, and cost.

Do not dispense partial regimens. The patient must have all prescribed medications; otherwise they are at risk for developing medication resistance (and potential class-cross resistance) from taking a partial regimen. Counsel patients to take prescribed medications the same time daily, and avoid gaps in treatment.

A specialist in HIV should be consulted if questions arise concerning an individual's HIV regimen.

Recommendations for Use of Antiretroviral Drugs during Pregnancy

	NRTIs	NNRTIs	PIs	Entry Inhibitors	Integrase Inhibitors
Preferred	ABC*/ 3TC TDF/ (3TC or FTC)		ATV/r DRV/r (twice daily)		RAL (twice daily)
Alternate	ZDV/ 3TC	RPV EFV***	LPV/r (twice daily)		
Insufficient Data	TAF/FTC	Odefsey™	FPV	MVC	DTG Stribild™ (cobi) Genvoya™
Not Recommended	ABC*/3TC/ZDV ddI + d4T# ddC	NVP** EFV*** ETR	SQV/r IDV/r TPV/r NFV RTV (as single PI)	T20	
**** Use ABC only for HLA-B*5701 negative patients***			***** Use with caution: use only if CD4 count < 250***		
****** anencephaly, microphthalmia, cleft palate***					
# Implicated in death of a client: severe lactic acidosis with hepatic steatosis with or without pancreatitis					

ATV/r: Use of ATV not recommended for treatment-experienced pregnant women taking TDF and an H2-receptor antagonist. Use increased dose (400 mg ATV plus 100 mg RTV once daily with food) during the 2nd and 3rd trimesters. Some experts recommend increased ATV dosing in all women during the 2nd and 3rd trimesters, the package insert recommends increased ATV dosing only for ARV-experienced pregnant women in the 2nd and 3rd trimesters also receiving either TDF or an H2-receptor antagonist.

DRV/r: Once-daily dosing is not recommended during pregnancy. Twice-daily dosing recommended for all pregnant women. Increased twice-daily DRV dose (DRV 800 mg plus RTV 100 mg with food) during pregnancy is being investigated. No pregnancy PK/safety data for DRV/COBI co-formulation, so not recommended for use in pregnancy.

LPV/r: Once daily dosing is not recommended during pregnancy. Some experts recommend that an increased dose (LPV 600 mg plus RTV 150 mg twice daily without regard to meals) should be used in the 2nd and 3rd trimesters, especially in PI- experienced pregnant women and women who start treatment during pregnancy with a baseline viral load >50 copies/mL. If standard dosing is used, monitor virologic response and LPV drug levels, if available.

Efavirenz (EFV): Although increasing data on its use in pregnancy are reassuring, because of concerns regarding potential teratogenicity, EFV is not recommended for initiation in ARV-naive women in the first 8 weeks of pregnancy. Because the risk of neural tube defects is restricted to the first 5–6 weeks of pregnancy and pregnancy is rarely recognized before 4–6 weeks of pregnancy, and because unnecessary ARV drug changes during pregnancy may be associated with loss of viral control and increased risk of perinatal transmission, EFV may be continued in pregnant women presenting for prenatal care in the 1st trimester who have achieved virologic suppression on the regimen. Women in their reproductive years who are not using effective birth control should avoid EFV. Non-pregnant women of childbearing potential should undergo pregnancy testing before initiation of EFV and counseling about the potential risk to the fetus and desirability of avoiding pregnancy while on EFV-containing regimens.

Food Requirements:	**With or Without Food**	**With Food**	**Empty Stomach**
NRTI	ABC, FTC, d4T, TDF, AZT	3TC	ddI
NNRTI	DLV, NVP	ETR[##], RPV[¥]	EFV
PI	FPV*, LPV/r**, TPV/r[₱]	ATV[¥¥], DRV/r, NFV[‡], RTV, IDV[‡‡], SQV/r[€€], TPV/r[₱₱]	
Entry Inhibitor	T-20, MVC		
INSTI	DTG, RAL[#]	EVG[€]	
PK Enhancer		Cobi	
Combination therapy	Combivir™, Epzicom™, Truvada™, Trizivir™, Triumeq™, Descovy™	Stribild™, Genvoya™, Complera™[¥], Odefsey™	Atripla™

**** Adults: oral suspension without food. Children: oral suspension with food***

***** Oral solution with food***

[#] Chewable tablets may be chewed or swallowed

[##] Always after a meal. Can dissolve tablets in a small amount of water

[¥] Always with at least a 400 calorie meal. A protein drink alone does not replace a meal.

[¥¥] Do not open the capsules

[‡] Can dissolve tablets or powder in a small amount of water

[‡‡] Take with water at least 1 hour before or 2 hours after a meal Or with a light meal that is low in calories, fat, and protein

[€] Oral suspension must be mixed with water before use and given within 30 minutes of mixing

[€€] Take with full meal or up to 2 hours after a meal. Capsules can be opened & contents mixed with 15 mL of sugar, syrup or jam

[₱] Capsules or oral solution, taken with or without meals

[₱₱] Tablets, take only with meals

REMINDERS

- Regimens should include at least (3) fully active medications
- Check for "incomplete" regimens; NEVER dispense partial regimens
- Counsel patients to take all regimen components to reduce risk of developing medication resistance

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C-Section

Recommend C-Section at 38 Weeks
IF HIV RNA > 1000 copies/mL or Unknown

AZT at the Time of Delivery

IV AZT: Administer
If HIV RNA >1000 copies/ml

All HIV-Exposed Infants

Neonate: 6 Weeks of AZT Therapy

2016 Update

4-week chemoprophylaxis may be considered

High Risk Deliveries

Consider 3 doses of Nevirapine for high risk

HIV Infected Newborns

DO NOT delay triple therapy while awaiting studies
AZT/3TC/Nevirapine