The Pacific AETC (AIDS Education and Training Center) HIV Essentials and Quick HIV Clinical Guides compilation consists of seven of our most popular clinical reference guides used in primary care, urgent care, and emergency room clinical settings. The recommendations are based on HRSA, CDC, IDSA, and WHO guidelines, along with current practices used by our expert clinicians.

This compilation starts with two “Essentials” documents which can be printed on single letter-sized pieces of paper and folded into a pocket for quick reference during a busy clinic. The protocols and quick clinical guides provide more details for implementation, and each document can be printed separately and used on their own.

Seven of our most popular clinical reference guides used in primary care, urgent care, and emergency room clinical settings.

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Have questions? Need clinical help?

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Outside the Pacific Region contact the AETC National Coordinating Resource Center: aidsetc.org, 973-972-5141, info@aidsetc.org.

National HIV Consultation Line for HIV testing and care/treatment questions: 800-933-3413
You can reach a live consultant 6 am-5 pm PST, M-F (voicemail available after hours) or submit consultation requests online at nccc.ucsf.edu. For specific expertise about....

Post-exposure prophylaxis (PEP) questions: 888-448-4911
Peri-natal HIV testing & reproductive care questions: 888-448-8765
Pre-exposure prophylaxis (PrEP) questions: 855-448-7737
Hepatitis C Consultation Line 844-437-4636
Substance Use Consultation Line 855-300-3595

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Special thanks to the following people for their review and contributions:

E. Michael Reyes, MD, MPH and JaDawn Wright on the compilation of guides; Carolyn Chu, MD on the Essentials; Alan McCord, Shannon Weber, Laura Lazar, Juliet Stoltey, MD, Juliana Grant, MD, Adrian Barraza, Betsie Cialino, Karen Mark, MD, Robert Grant, MD, Shrey Goel, David Gonzalez, Jessica Bloome, MD on the PrEP quick clinical guide; the HIV ACCESS care teams for their feedback on the HIV testing and rapid ART guides.

Feedback/questions: paetc@ucsf.edu.
HIV testing

How should I test for HIV?

Test everyone ages 13+

Use ICD-10 code Z11.4.

- Order this lab for most people:
  HIV 4th generation antibody + antigen test
For recent risk of exposure in the last month:
HIV RNA PCR test (HIV viral load)

- Offer as a normal part of labs:
  “We test everyone’s cholesterol, sugars, liver, kidneys and for HIV.” Or: “It looks like we need to check your cholesterol and sugars again, but we haven’t checked HIV yet. The HIV test is a normal part of health screening for everyone. I’m going to add it to your labs. OK?”
  (*Be sure to mention you are ordering an HIV test so the patient is informed and has the chance to opt out.)

How do I interpret 4th gen HIV test results?

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How do I disclose a positive result?

1. Call your HIV linkage coordinator as soon as you see the result to coordinate a warm-handoff to HIV care.

2. Call the patient for an in-person visit to discuss lab results. Disclose in-person ideally the same day as the confirmed result, and when not possible, aim for within 5 working days.

3. When the patient is sitting, calmly and neutrally let them know.

   “Your lab results show that you have HIV.” Give them a few moments and listen.

   “Would you be willing to share your thoughts, feelings or questions about this?” Listen, address concerns: “We have really good treatment to help you live as long and healthy as possible. May I introduce you to (your HIV linkage coordinator)? They will help answer questions and connect you with HIV care.”

Rapid ART: immediate HIV treatment

Rapid ART increases retention in care and viral load suppression. Disclosure and an ART Rx the same day as confirmed diagnosis is ideal, but when not possible, aim for within 5 working days.

1. New diagnosis with confirmed labs: contact HIV linkage coordinator ASAP to schedule disclosure, with same-day warm hand-off to HIV intake, education and medical visit.

2. Obtain baseline labs as soon as possible: If not done before first HIV visit, can be done the same day the ART Rx is written.

Baseline labs (priority): HIV 4th gen if only rapid test result; HIV RNA PCR viral load, HIV genotype, CD4 (Quest lymphocyte panel 4), CBC, CMP, hep B sAg/sAb/Ab, hep C Ab w/ reflex, UA, GC/CT (exposed sites), RPR.


4. Offer an ART prescription: choose one of preferred regimens:

   Tivicay® + Truvada® (or Descovy®): dolutegravir 50 mg + tenofovir/emtricitabine, 1 pill each PO daily

   Or Biktarvy® (bictegravir/tenofovir/emtricitabine) 1 pill PO daily

   Or Symtuza™ (darunavir/cobicistat/emtricitabine/tenofovir AF) 1 pill PO daily

   Or for those who could become pregnant, use: Isentress® + Truvada®: Raltegravir 2x600 mg + tenofovir/emtricitabine, 3 pills total PO daily

5. Follow-up labs and meds in 5-7 days.

PEP: HIV Post-Exposure Prophylaxis

PEP should be started within 72 hours of exposure; the sooner, the better.

1. Assess risk for HIV. High risk—offer PEP: condomless receptive anal or vaginal sex, sharing needles. Consider PEP for: condomless insertive anal or vaginal sex.

2. Screen for acute HIV infection: if they have fevers, flu-like or mono-like sx, rash, sore throat, order HIV viral load.


4. If appropriate, prescribe 28-days of PEP. Preferred regimens include:

   Truvada® (tenofovir DF/emtricitabine) + Tivicay® (dolutegravir), 1 pill each PO daily

   Or Biktarvy® (bictegravir/tenofovir/emtricitabine) 1 pill PO daily

   Or for those who could become pregnant, use Isentress+Truvada regimen listed above.

   (click on med name for drug assistance programs)

5. Repeat HIV 4th gen test in 6 and 12 weeks.

Candidates for PrEP: anyone requesting PrEP, has condomless anal sex, injects drugs, has recent STIs, or HIV+ partners

Recommended PrEP regimen:

- **Truvada®:**
  - Tenofovir\(^1,2\) (300 mg) PO Daily + Emtricitabine\(^1,2\) (200 mg) PO once daily

  Do not use Descovy®

  1. Truvada side effects: headache, insomnia, nausea, vomiting, diarrhea, rash. Usually resolve in a month. Also active against Hep B, so beware of Hep B flare when stopping. Precautions also in chronic kidney disease and with nephrotoxic meds. (Renal dysfunction seen in 1-2% of patients).

  2. Further information about drug interactions: [hiv-druginteractions.org](http://hiv-druginteractions.org)

Contraindications:

- **Absolute:** acute or chronic HIV infection (Rx ART), estimated GFR<60 by serum creatinine, unwilling to take daily meds or have lab follow-up.

- **Relative:** HBV with cirrhosis/transaminitis (refer to specialist), osteoporosis or history of fragility fracture.

Time to achieve protection:

- **7 days in rectal tissue** (anal receptive intercourse).

- **20 days in penile and cervico-vaginal tissue** (anal insertive and vaginal intercourse).

- **20 days in blood** (IDU).

First visit:

- Evaluate for exposures in the last 72 or so hours and need for PEP (post-exposure prophylaxis).

- Evaluate for appropriateness for PrEP: discuss efficacy, side effects, support for and importance of adherence, insurance coverage and support for continuity, plan for refills and follow-up.

- Labs: BMP, 4th gen HIV test, GC/CT (throat, rectal, urine), UPrEG, RPR, HepBsAg, sAb, cAb, HCV Ab.

- If symptoms of acute HIV infection in past month (fever, flu- or mono-like symptoms, rash, sore throat), get HIV viral load (positive at 10 days). Do not start PrEP unless viral load neg.

- If HIV test neg and no symptoms of acute HIV infection, write rx for 1-month supply, no refill.

1-month follow-up visit:

- Evaluate adherence and side effects. Rx for 2-month supply, no refill.

Follow-up visit every 3 months:

- 4th gen HIV test, GC/CT (throat, rectal, urine), UPreg, RPR, BMP (BMP can be Q6 months).

- Refill for 3-month supply only if HIV test negative; refer to immediate linkage to care if HIV test positive.

- At every visit assess for adherence, side effects, exposures (number of partners, anal/vaginal insertive/receptive exposures, condom use, drug use), desires around sexual wellness and continued PrEP use.

- Counsel to return for HIV test if off of PrEP for > 1 week and had possible exposure.

Every 12 months:

- Hepatitis C screen, U/A (check for +protein), evaluate continued desire/need for PrEP.


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New HIV Diagnosis

At diagnosis, screen for:

- CD4 and HIV viral load
- HIV Resistance Testing (HIV Genotype)
- G6PD
- HAV IgG, HBV cAb, sAg, sAb, HCV Ab - for evidence of coinfection and immunity.
- IGRA or PPD to r/o latent TB
- HLA–B*5701 for abacavir hypersensitivity.
- CBC w/ diff, complete metabolic panel, LFTs, lipids, fasting glucose or HgA1c.
- STI screen: RPR, GC/CT (incl. extra-genital), trichomonas.
- Toxo IgG for evidence of prior exposure (counsel to avoid exposure if negative).
- Consider CMV IgG for lower -risk patients (i.e. non-MSM and non-PWID): if negative, avoid CMV+ blood products.
- Consider VZV antibody and vaccinate if non-immune and CD4>200 cells/mm$^3$.
- Perform full physical and mental health assessment at diagnosis and at each follow-up visit as clinically indicated.

Recommended follow-up visits:

- 1 week after ART initiation
- every month until viral load suppression, then every 3-6 months

Chronic HIV

Treatment: ART should be started as soon as possible.

- DHHS Recommended initial regimens for most people living with HIV (2 NRTIs + 1 INSTI):
  - Biktarvy®: Bictegravir/emtricitabine/TAF
  - Triumeq®: Dolutegravir*/abacavir/lamivudine (only if HLA-B5701 negative)
  - Tivicay® + Truvada® or Descovy®: Dolutegravir* + tenofovir/emtricitabine (TDF or TAF ok)
  - Isentress® + Truvada® or Descovy®: Raltegravir + tenofovir/emtricitabine (TDF or TAF ok)
  - Also consider for an initial regimen:
    - Symtuza™: Darunavir/emtricitabine/cobicistat/TAF

Check the following labs:

- CD4: Q3-6 months in first 2 years after initiation of ART. After 2 years of ART with consistently suppressed viral load: CD4>300-500 cells/mm$^3$ monitor annually. CD>500 cells/mm$^3$: monitoring is optional.
- Viral load: 2-8 weeks after ART initiation, then every 4-8 weeks until suppressed. First 2 years of ART: Every 3-4 months. After 2 years of ART with consistently suppressed viral load: Q6 months.
- Cr, LFTs, CBC w/ diff: Q3-6 mos. UA for proteinuria Q6-12 months if on TDF or TAF.
- Fasting lipid panel: Annually, if abnormal, Q6 months.
- Fasting glucose or HgA1c: Annually, if abnormal, Q3-6 months.
- TB screen: Annual IGRA (e.g., Quantiferon) or PPD.
- Repeat resistance testing: In setting of treatment failure on ARVs—ensure that INSTI resistance testing is included if patient has been exposed to integrase inhibitors.

*Avoid or discuss potential risks of initiating dolutegravir-containing regimens in patients who are pregnant <8 weeks from sure LMP, or in patients with childbearing potential.
**STI screening**
- Screen for STIs annually at minimum, more frequently (Q3-6 months) as clinically indicated if presence of behaviors that elevate risk for STIs
- GC/CT vaginal/cervical/urine for sexually active patients
- GC/CT oropharyngeal swab for patients reporting receptive oral sex
- GC/CT rectal swab for patients reporting receptive anal sex
- Syphilis (RPR)
- Hepatitis C and hepatitis B serologies

**Opportunistic Infection Prophylaxis:**
- P. Jiroveci (PCP) if CD4 <200 cells/mm³
- Toxoplasmosis if CD4 <100 cells/mm³
- Mycobacterium avium complex (MAC) if CD4 <50 cells/mm³
- CMV retinitis screen if CD4 <50 cells/mm³

**Immunizations:**
- HBV: Give series at double dose (40mcg). Check titers (HBsAb) if received standard series prior and if not immune, repeat series at double dose.
- HAV for at-risk patients
- Flu shot annually (inactivated; not live)
- Pneumococcal vaccine (PCV 13 and PPNV23)
- Tdap
- HPV vaccine (all men and women up to 45 years old)

**Age-Appropriate cancer screening:**
- Cervical cytology at baseline and repeat 6-12 months later, then annual thereafter if neg (refer for colposcopy if abnormal). If 3 consecutive pap smears are negative, may spread out pap smears to Q3 years. Avoid HPV co-testing for patients <30 years old. See OI guidelines for screening frequency if HPV co-testing available.
- Consider annual anal cytology for patients reporting receptive anal sex, patients with anal warts, patients with cervical dysplasia present (no clear consensus in DHHS guidelines currently; discuss risk:benefit of screening).
- All other cancer screenings follow routine primary care healthcare maintenance guidelines for general population (i.e. mammography, colorectal screening).

**Screen for co-morbidities and address psychosocial well-being, including:**
- Ask about current priorities: “What is most important to you right now?”
- Screen and offer support for mental health and psychiatric conditions including depression, anxiety, PTSD
- Screen and offer support/treatment for substance, tobacco, and alcohol use disorder
- Screen and offer support for unstable housing and food insecurity
- Screen and offer support for history of (and/or current) trauma
- Identify and troubleshoot strengths and barriers to medication adherence
- Assess family planning desires and sexual health and well-being for all patients
- Conduct comprehensive transmission risk reduction counseling (i.e. Treatment as Prevention, “Undetectable=Untransmittable”). Offer PEP or PrEP if indicated/appropriate for HIV-negative partners.
- Offer support for disclosure of diagnosis to partners, family and friends

**Author:** Monica Hahn MD MPH MS AAHIVS. Clinical Director, Pacific AIDS Education Training Center. Assistant Clinical Professor, UCSF Department of Family and Community Medicine. **Contributors:** Carolyn Chu MD and Sophy Wong MD.

**Sources:**
Primary Care Guidelines for the Management of Persons Infected with Human Immunodeficiency Virus: 2013 Update by the HIV Medicine Association of the Infectious Diseases Society of America. Clinical Infectious Diseases 58; 2013; 58 : 1 -34

This project was supported by funds received from the State of California, Department of Public Health, Office of AIDS. This project was also supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under cooperative agreement #5 U10HA29292, Regional AIDS Education and Training Centers. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Pill photos: US DHHS National Institutes of Health (NIH) and Test Positive Aware Network (TPAN).

**Feedback/questions:** paetc@ucsf.edu.
Whom should I test for HIV?

Everyone ages 15-65!
- all patients ages 15-65 at least once (US Preventive Services Task Force Grade A).
- repeat testing every 6 months for people at high risk: people with HIV+ partners, MSM, STIs, multiple sexual partners, IVDU.

Also test any patients coming in for/as/with:
- STI testing or treatment
- Tuberculosis
- Pregnant women, including undocumented HIV status at delivery
- Hepatitis B and C
- History of handling blood, receiving, donating or selling blood in areas without a securely screened blood supply
- Consider diagnostic HIV testing for... flu-like symptoms 2-8 weeks after a risky exposure (get HIV RNA viral load and 4th gen test), oral thrush, herpes zoster, unexplained anemia, thrombocytopenia, ↑WBCs, recurrent infections

Which HIV test do I use? Billing code?
- For most people: HIV 4th generation antibody+antigen test.
- For recent risk exposure in the last month: HIV RNA PCR test.
- Use ICD-10 code Z11.4: Encounter for screening for HIV.

How do I interpret 4th gen HIV test results?

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<th>HIV Ab/Ag reactive &amp; HIV1/2 neg &amp; RNA neg: negative likely false pos Ab result but if high risk, check HIV2 DNA</th>
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What if a patient refuses to get an HIV test?
- Try to ask about and address their fears.
- Be sensitive; they may have a risk that they are scared to disclose.
- Try asking again later; they may be eventually willing to test.

How do I offer the HIV test to a patient?
Offer it neutrally, as a normal part of baseline labs.

"We test everyone for cholesterol, sugars, liver, kidneys and for HIV and hepatitis, so I’ll order these tests for you. Sound OK?"

How do I offer the HIV test to a follow-up patient?
Offer it neutrally, as part of their next lab draw.

“We need to check your cholesterol and sugars again, and it looks like we haven’t checked for HIV yet. The HIV test is a normal part of preventive health for everyone. I’d like to add it to your labs. OK?"

How do I disclose a positive result?
1. Call the patient in for an in-person visit to discuss “lab results.”
2. Disclose in-person within one week of the result.
3. Ideally, coordinate with the HIV team to be available so you can do an immediate warm-handoff and linkage to HIV services.
4. When the patient is sitting, calmly and neutrally let them know.

“Your lab results show that you have HIV.”
Give them a few moments to let the information sink in.

“If you are willing to share your thoughts, feelings or questions about this?”

Listen and address what comes up.

“We have really good treatment and services to help you live as long and healthy as possible. May I introduce you to ______, who will help answer your questions and connect you with care with a specialist here?”

How do I link the patient to HIV care, PEP or PrEP?
Call your HIV linkage navigator:
______________ to coordinate linkage to HIV specialty care, PEP or PrEP. Treatment reduces transmission by 96%!

Questions?
Call the National HIV Consultation Line (UCSF) for HIV clinical questions: 800-933-3413

Author: Sophy S. Wong, MD; with many thanks to the HIV ACCESS care teams for their feedback.

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HIV testing and linkage protocol

**POLICY:** In accordance with the US Preventive Services Task Force and CDC guidelines, our primary care clinics provide opt-out HIV antibody testing for:

- All asymptomatic patients ages 15-65 at least once in their lifetime.
- All pregnant women at least once during their pregnancy.
- Patients with ongoing potential exposures (including men who have sex with men (MSM) or transgender or cisgender women) who engage in condomless anal sex, particularly receptive anal sex, every 3 months—also offer HIV PrEP (pre-exposure prophylaxis).
- Patients with STIs with each new or recurrent diagnosis.
- Patients with certain comorbid conditions, which would alter or require therapy: hepatitis B, hepatitis C, tuberculosis, varicella zoster in adults, and any other opportunistic illness that suggests an immunocompromised state.

In addition, our community-based HIV programs provide free confidential or anonymous rapid HIV antibody testing to any member of the community.

**PROCEDURE:** Clinic testing

**Opt-out HIV testing**

1. Include the 4th gen HIV antibody/antigen test with other screening tests:
   a. "4th gen: HIV Ab/Ag" Quest #91431 (window period is 14 days)
   b. ICD-10: use Z11.4 as the billing code
2. Notify the patient what you will be testing them for. Example: "We test everyone’s cholesterol, sugar, liver and kidney function, and or hepatitis and HIV." Or "Looks like you haven’t been tested for HIV or hepatitis B/C, so let’s add those tests to your next labs."
3. No documentation is necessary unless the patient refuses the test. If the patient refuses, then document "HIV test refused" and the reason (if known) in the chart.
4. Test counseling is optional, but we strongly recommend asking patients about their sexual and drug use history, especially during intake and physical exams.

### HIV Ab/Ag non-reactive: Negative results
- Let patients know at the time of testing: "We’ll let you know if we need follow-up. If you don’t hear from us, the result is negative."
- Repeat testing every 3 months for MSM, PWID and others with active exposures and repeat test with others who have potential exposures since last test.

### HIV Ab/Ag reactive & HIV1/2 neg & RNA neg Discordant/negative results
- HIV infection is unlikely. There is a small chance that this may be an acute (within 14-day) infection or recent HIV-2 infection.
- If no exposures within the last 14 days, the test is negative; no need for further tests.
- If patient is high risk (e.g. has recent sexual or needle exposure), retest for RNA in 5-10 days to check for acute HIV-1 and consider testing for HIV-2 viral load: Quest test code 34977x. Call your HIV linkage contact for help.

### HIV Ab/AG reactive & HIV1/2 or RNA detected: Positive for acute or chronic HIV
- The patient has confirmed HIV infection
- Use ICD-10 dx code: B20
- Immediate follow up is critical!
- Notify patient to come in for result disclosure within 1 week
- Notify your HIV linkage contact for help with disclosure and immediate linkage
- Counsel on risk reduction (condoms, abstinence, treatment, clean IDU works)
- For women of reproductive age, assess for pregnancy and counsel on birth control and prevention of mother to child transmission.
- Please see the rapid ART protocol.
**Purpose:** To provide patient-centered service while promoting public health, by reducing barriers to medical care and supporting people newly-diagnosed with HIV to access treatment as soon as they want. Patients with acute HIV infection, AIDS, HIV nephropathy, hepatitis coinfection, or are pregnant are especially encouraged to start treatment immediately for individual and community benefit.

**Rationale:** National (DHHS) and international (WHO) guidelines recommend initiating HIV antiretroviral therapy (ART) “as soon as possible” for all patients with HIV, regardless of CD4 count. Initiating ART early, especially in acute or recent infection, may reduce the viral reservoir for that individual patient (Jain 2013), preserve CD4 function (Saez-Cirion 2013), increase retention in care (Pilcher 2017, Rosen 2016, Koenig 2016) as well as reduce viral load during a time when the patient may be at highest risk for transmission to others (Bacon 2018, Pilcher 2017, Cohen 2011).

The SF General RAPID pilot program, including 86 patients who did not have private health insurance (100%), were non-white (66%), homeless (28%), had mental health disorders (42%), substance abuse disorders (42%) demonstrated shorter time to virologic control (65 vs. 170 days), higher retention at 6 months after diagnosis (90% vs. 85%), and higher rates of ART acceptance (100% vs. 85%) among the 39 patients randomized to rapid ART compared to usual care (Pilcher 2016 and 2017, JAIDS). In the international randomized START trial, researchers found that ART-naïve patients receiving immediate ART had significant improvements in their self-assessed quality of life scores (Lifson, AIDS 2017). In the South African RapIT trial (Rosen 2016), people randomized to receive same-day ART had 36% increased uptake of ART and 26% higher rates of viral suppression. A same-day ART randomized study with 762 patients in Haiti showed significantly better 12-month retention in care (54% vs. 42%) and likelihood of being alive (80% vs. 72%) compared to patients in standard care (ART at 21 days) (Koenig, AIDS 2016).

For patients who are not newly diagnosed with HIV but are re-engaging in care, we have less data on the benefits of rapid ART. We try to aim for the intake/orientation appointment and an initial HIV medical visit as soon as the system allows, within 5 days of presenting for care. Data from Project CONNECT (Mugavero, 2008) demonstrated significantly increased linkage to HIV medical care at 6-months when intake/orientation visits were within 5 days of the initial referral call or patient request.

### Rapid ART linkage for patients newly diagnosed with HIV

1. **New diagnosis with confirmation and same-day rapid ART linkage:** The clinician confirms diagnosis with laboratory documentation of a positive HIV RNA viral load, positive HIV antibody test or 4th generation HIV Ab/Ag test with an HIV 1/2 differentiation, Western Blot or RNA confirmation. For point-of-care rapid HIV tests, wait until the test is confirmed positive to initiate rapid ART. If you have a high suspicion for hyper-acute HIV infection (within the last month), then send an RNA test and consider same-day ART before you receive the RNA result.

   a. If there are any questions, the clinician may call the **HIV Warmline:** 800-933-3413.

   b. **Immediately call the HIV linkage coordinator at your care site to initiate the rapid ART disclosure and linkage process.**

   c. The goal is for the rapid ART intake and clinic orientation appointment to be on the same day as the diagnosis is disclosed to the patient. The testing clinician is responsible for in-person disclosure of the positive test result to the patient, and the linkage coordinator can provide support. If the testing clinician is not available in a timely way, the linkage coordinator and intake nurse/provider may also disclose.

2. **Obtain baseline labs as soon as the diagnosis is confirmed or if patients are referred without baseline labs:** Please refer to the list of baseline labs on the third page of this protocol to order labs on the same day as diagnosis is confirmed. If ART is prescribed before baseline labs were drawn, we recommend that baseline labs drawn as soon as possible. The starred labs (★) are of highest priority.
3. **Same-day disclosure and intake/orientation appointments:**
   a. The HIV linkage coordinator will be available by work cell to meet the patient the same day as disclosure and facilitate a same-day provide warm hand-off to a rapid-ART nurse/provider appointment, labs, and medication and health insurance coverage assistance.
   b. For patients without insurance, these benefits can often be activated the same-day: Ryan White, ADAP; in CA, presumptive Medi-Cal, FamilyPact can be activated the same-day
   c. HIV providers at each site will have at minimum one drop-in slot available each day to accommodate same-day immediate rapid ART linkage appointments. When these drop-in slots are not filled, the same-day appointment can be made available to other patients.
   d. When HIV providers are not available, please schedule same-day appointments for providers willing to prescribe rapid ART and/or support the providers with this protocol.

4. **Clinical sign-out:** The diagnosing clinician, if not the same as the HIV care nurse/provider, provides a case sign-out to the HIV nurse/provider in-person, via phone, EHR or HIPAA-secure encrypted email.

5. **Linkage facilitation:** The clinician calls the HIV linkage coordinator who will:
   a. **Arrange for a same-day intake appointment with a nurse or provider who can conduct a brief evaluation and provide a prescription for HIV ART.**
   b. Keep track of the patient to ensure a warm hand-off and successful linkage to care.
   c. **HIV education counseling and eligibility evaluation:** on the same day as diagnosis, the HIV linkage coordinator provides the patient with an intake, including HIV health education counseling and evaluation for insurance coverage if needed.
   d. **ADAP:** The patient should immediately enroll in ADAP (AIDS Drug Assistance Program). ADAP will also help pay for co-pays for those with high share-of-costs and premiums.
   e. Facilitate the patient to receive partner counseling and community services as needed.

6. **During the rapid ART nurse/provider appointment:**
   a. The patient’s information is entered into the EHR HIV template (if applicable)
   b. The nurse/provider conducts a brief, targeted medical history and exam.
      i. Ask about current priorities: “What is most important to you right now?”
      ii. HIV history:
         1. Date of last negative HIV test and prior HIV tests
         2. PrEP and PEP use history
         3. Any other HIV medication use (e.g. ART sold on the street or given by friends)
         4. Sexual practices and serostatus of partners, if known
      iii. Medical history:
         1. Co-morbidities (especially renal/liver problems)
         2. Medications
         3. Drug allergies
         4. Review of systems (to assess for OIs or seroconversion syndrome)
   c. If not already obtained, the nurse/provider orders baseline labs (see below).
   d. If the patient has no contraindications, the nurse/provider offers a rapid ART prescription.
Recommended Rapid ART regimens

Biktarvy®: bictegravir/emtricitabine/tenofovir alafenamide,
1 tab once daily

Tivicay® + Truvada® (or Descovy®):
dolutegravir 50 mg tenofovir/emtricitabine,
1 tab each (2 tabs total) daily

Symtuza™:
darunavir/cobicistat/emtricitabine/tenofovir alafenamide,
1 tab once daily

For non-pregnant cis women and some transmen of reproductive age, we recommend:
Isentress®+Truvada®: Raltegravir 2x600 mg +
Tenofovir/Emtricitabine, 3 tabs total daily

There are few, but contraindications include: a complicated or unknown ART history with possibility of acquired resistance; or a medical contraindication, e.g. suspected intracranial opportunistic illness such as cryptococcal meningitis; pulmonary or GI Kaposi’s Sarcoma (ask about sub-acute meningitis symptoms, hemoptysis, GI bleeding)

If the patient accepts rapid ART, the provider, or the nurse with precepting provider:

i. prescribes a 30-day supply of medication.
ii. calls the pharmacy to notify for immediate fill.
iii. notifies the linkage coordinator to follow-up on medication coverage and successful prescription fill within 1-3 days.
iv. schedules a follow-up appointment within 5-7 working days to discuss laboratory results and assess medications use and treatment plan.

If the patient declines rapid ART, use Motivational Interviewing techniques to discuss his/her reasons and preferences, and schedule a follow-up appointment within 5-7 working days to discuss laboratory results and assess treatment plan.

Baseline labs

When possible, please order these baseline labs as soon as diagnosis and disclosure is made. The ★starred labs are of highest priority, in case the patient would like to split up the lab draws. Some Quest lab codes are provided for HIV labs for your reference. Quantiferon tests are processed Monday-Thursday afternoons.

Highest priority labs

★ If only point-of-care rapid test has been done, order a 4th gen HIV Ab/Ag test; Quest 91431
★ HIV viral load; Quest 40085; CPT code 87536
★ CD4 count and %; Quest 3061N; CPT code 86360
★ HIV genotype; Quest code 91692; CPT codes 87900, 87901, 87906
★ CBC with differentiation
★ Complete metabolic panel, including renal and liver function
★ Hepatitis B sAg
★ Hepatitis C Ab +/- reflex to RNA
★ Urinalysis with microscopy; you may consider checking microalbumin
★ HLA B*5701 if considering Abacavir; Quest 19774; CPT code 81381

Additional baseline labs

- Hepatitis A total Ab
- Hepatitis B sAb, cAb
- Lipid profile
- HgA1C
- VZV IgG
- GC/CT NAAT (urethral, vaginal, rectal, pharyngeal depending on exposure)
- RPR
- Quantiferon TB IGRA
- Toxoplasmosis IgG
Rapid ART for patients re-engaging in care or transferring care

1. If the patient was previously diagnosed but does not have documentation of the test result or past history: if available, conduct a rapid HIV test and send a lab-based HIV 4th gen Ab/Ag test. You may consider a positive rapid test as sufficient proof to start the rapid ART process.

2. If the rapid test is positive or they have documentation of their HIV diagnosis,
   a. and they HAVE NOT been on ART before and are willing to start, conduct the intake, baseline labs, brief visit and ART Rx on the same day when possible. See the steps above.
   b. and they HAVE been on ART before and can provide the names of their meds and adherence history with some degree of confidence, conduct intake, get baseline labs, sign a release for medical and pharmacy history, contact the pharmacy to verify most recent ART regimen, facilitate a brief visit and ART prescription on the same day when possible, or as soon as possible within 5 working days.

Rapid ART eligibility and medication coverage as of September 2018

1. If the patient is:
   • Insured with affordable co-pay: they are covered; ensure referral to accepting provider.
   • Insured with high co-pay: see co-pay assistance programs below.
   • In CA: Uninsured ≥ 5x FPL: enroll in Covered California plan & ADAP co-pay if needed.
   • In CA: Uninsured <138% FPL ($16,753 for single person in 2018): enroll in Medi-Cal; presumptive Medi-Cal can be activated on the same-day at some clinical sites.
   • In CA: Uninsured, <5x FPL and Medi-Cal ineligible: enroll in ADAP and HPAC (for Alameda County), and if this cannot be activated rapidly, use the patient assistance programs below.


3. Co-pay assistance programs
   i. If patient has a high co-pay, Gilead (maker of Truvada) has a co-pay assistance program: gileadadvancingaccess.com, 877-505-6986
   ii. Merck (maker of raltegravir) also has a co-pay assistance program: activatethecard.com/7726/#
   iii. Updated co-pay assistance resources can be found on the NASTAD website.

4. Uninsured patients: Patient Assistance Programs for medications:
   - Truvada®, Stribild® and Biktarvy®: The Gilead Advancing Access Program can provide a 30-day supply at no cost for those without coverage, <500% FPL: gileadadvancingaccess.com/
     1. Go to the website to download the most current enrollment form.
     2. Send in application and if you have one, call Gilead designated agent after 20 minutes.
     3. Gilead can provide a same-day voucher: Fax letter of necessity to 855-330-5478: The letter needs name, DOB, social security number, date of exposure, any kind of income, household size, and state that this is necessary for new or acute infection.
     4. Call 800-226-2056 (Monday - Friday, 6 am-5pm PST) to get help, voucher and bin number to take to pharmacy, and patient should be able to get the medication.
   - Biktarvy® starter kits may be available to you
     1. A Gilead Therapeutic Specialist may be able to provide packs to each facility.
     2. These starter kits are patient resources and designed to help with each facility's current rapid ART protocol or in situations where the provider has decided to a regimen switch is appropriate.
3. Each kit includes a bottle with 7 pills of Biktarvy®.

4. The starter kits can be replenished by calling the Gilead Therapeutic Specialist. There may be limited amount so please discuss with your representatives as to what is an appropriate amount for your facility.

5. The starter kits must be signed by an HCP-program designated prescribing provider aligned to each clinic at the time of drop off.

6. Your representative can give you more information as to which HCP provider can sign for the starter kits. If other providers are interested in signing for the starter kits, your Gilead Therapeutic Specialist can submit the appropriate paperwork. This process can take up to 3 months.

**Raltegravir (Isentress®; by mail only):**

The Merck Patient Assistance Program can provide a next-day delivery of raltegravir for acute cases, but it’s mailed from the East Coast, so you must call before 11:30 am PST in order to get next-day delivery.

1. For acute cases: Call **800-850-3430** before 11:30 am to get same-day processing. They are open 6 AM – 3 PM PST. Let the service representative know that this is an urgent acute case and requires same-day processing and next-day delivery.

2. For all cases, the representative can walk you through the process and ask you to fill out the form, which is available online: merckhelps.com/ISENTRESS

3. The patient’s delivery information must be provided, and someone must be available to sign for the delivery. Deliveries may also be made to the clinic.

**Dolutegravir (Tivicay®):**

The Viiv Healthcare Patient Assistance Program will provide a same-day voucher for a 30-day supply of dolutegravir at a local pharmacy.

1. Fill out the enrollment form: viivconnect.com/get-started/

2. An advocate must call. Any healthcare staff can become an advocate on the same day by calling: **844-588-3288**, 5am–5pm PST, best to call by 4 pm. You will get an advocate number and patient ID to complete the voucher.

3. The patient brings the voucher and the prescription to a local pharmacy.

4. Do not fax the form before the patient picks up the medications. Faxing the form initiates the mail-order refill service and invalidates the initial voucher number. After the patient picks up the first 30-day supply, you can determine if ADAP will not be in place for the next fill and mail order service is needed.

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►**Rapid ART tracking and Quality Management**

1. Track the following dates for each newly diagnosed patient and previously diagnosed patient who is re-engaging in care.

   a. **Diagnosis/lab result date:** date that HIV confirmatory lab results were available for review.

   b. **Referral date:** date when the patient confirmed s/he wanted to establish care with your site.

   c. **Intake date:** date the patient came in to see a member of your team to establish care (e.g. had diagnosis documented, received orientation and eligibility, Ryan White enrollment).

   d. **First medical visit date:** date the patient came in to see a clinical provider and received any care related to HIV (does not have to be with an HIV specialist or provider).

   e. **ART date:** date the patient received the first ART prescription from your site.

   f. **Viral load suppression date:** the first date the patient had a viral load <200.
2. Set the rapid ART metrics and goals for the patient population you want to track, for example:

   a. **San Francisco’s RAPID ART definition = diagnosis to visit in 5 days + visit to Rx in 1 day**
      - **Diagnosis to visit within 5 days** = number of patients whose date of confirmed HIV lab result to the date of first HIV-related medical visit was within 5 days.
      - **And visit to Rx (prescription) within 1 day** = number of patients whose date of first HIV-related medical visit to the date of first ART prescription was within 1 day.

   b. **HIV ACCESS Rapid ART definition = intake to Rx in 1 day**
      - **Intake to Rx (prescription) within 1 day** = number of patients whose date of intake to date of first ART prescription was within 1 day.

   c. **New diagnosis rapid ART metric** = % of newly diagnosed patients in the last 12 months who meet the rapid ART definition you’ve chosen (SF’s or HIV ACCESS definition above).

   d. **Re-engagement rapid ART metric** = % of patients re-engaging in care and not on ART in the last 12 months whose date of referral to date of ART prescription was within 5 days.

3. Set your goals, time-frame and action plan. Some examples:

   a. From January 2018 to June 2018, we aim to increase % meeting the SF RAPID new diagnosis definition from 60% to 80% using the steps outlined in this protocol.

   b. From January 2018 to June 2018, we aim to increase the % for people re-engaging in HIV care with an ART Rx within 5 days of referral using the steps outlined in this protocol.

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**Case example for a newly diagnosed patient with HIV**

On Tuesday, 1/9/2018 Berkeley Free Clinic called your team’s linkage contact person about a patient who received confirmation for an HIV positive test result on Friday, 1/5/2018 and spent the weekend deciding on which clinic to get care. The patient came in to see the linkage coordinator at your clinic on Tuesday, 1/9/2018 and saw a medical provider for an ART prescription on the same day.

**Diagnosis date:** 1/5/2018  **Referral date:** 1/9/2018

**Intake date:** 1/9/2018  **First medical visit date:** 1/9/2018  **ART date:** 1/9/2018

If the newly diagnosed patient rapid ART metric is defined as time from referral to ART, then this patient meets both the SF RAPID and the HIV ACCESS definition for same-day rapid ART. Her time from diagnosis to medical visit was 3 working days (and 5 days overall), and the time from medical visit to ART is 0 days (same day). Her time from intake to ART is 0 days (same day).

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**Case example for a patient re-engaging in care**

On Tuesday, 1/9/2018 Berkeley Free Clinic called your team’s linkage contact person about a patient who’s been out of care, re-tested HIV positive and wants to come to your clinic. The patient is not totally sure when he was first diagnosed but is guessing it was 5 years ago at Highland Hospital. He gets on the phone and confirms he wants to be seen at your clinic and provides his contact information to the linkage coordinator over the phone. The patient came in to see the linkage coordinator on Wednesday, 1/10/2018 and saw a medical provider for an ART prescription on the same day.

**Diagnosis date:** 2013 (estimated)  **Referral date:** 1/9/2018

**Intake date:** 1/10/2018  **First medical visit date:** 1/10/2018  **ART date:** 1/10/2018

If the patient re-engaging in care rapid ART metric is defined as date of referral to date of ART prescription within 5 days, then this patient meets the criteria for re-engaging patients and rapid ART. His time from referral to ART is 1 day.
Quick Clinical Guide: HIV Non-occupational Post-Exposure Prophylaxis (PEP)

1. Assess risk for HIV based on exposure.
   *PEP should be started within 72 hours of exposure; the sooner, the better.

<table>
<thead>
<tr>
<th>Level of risk</th>
<th>Types of exposures</th>
</tr>
</thead>
</table>
   | High risk  ► offer PEP | • Condomless receptive anal sex  
   |               | • Condomless receptive vaginal sex  
   |               | • Sharing needles |
   | Moderate risk  ► consider PEP, discuss with patient | • Condomless insertive anal sex  
   |               | • Condomless insertive vaginal sex |
   | Low risk  ► would not offer PEP | • Insertive or receptive oral sex (consider for receptive if significant bleeding, ulcerations or trauma in mouth and ejaculation)  
   |               | • Sharing cookers, cotton or other drug paraphernalia  
   |               | • Blood or semen splash on intact skin  
   |               | • Exposure to urine |

2. Screen for symptoms of Acute HIV Infection.
   • Current high fever, fatigue, rash, pharyngitis or sore throat; if symptoms are present, order HIV PCR viral load and ensure close follow-up.

3. Order labs.
   • 4th generation HIV Ab/Ag test (Quest lab #91431) OR rapid HIV test  
   • HIV RNA PCR (Quest lab #40085)  
   • Serum creatinine (eGFR), Hepatitis B surface antigen (HBV sAg), urine pregnancy test (if applicable)

4. Choose a PEP regimen (Duration for all regimens is 28 days).
   Use a 3-drug regimen below; consider ability to access, pay for, and adhere to dosing of regimen:

   **Preferred regimens**
   - Truvada® (tenofovir DF/emtricitabine) + Tivicay® (dolutegravir), each 1 pill PO daily
   - Or Biktarvy® (bictegravir/tenofovir/emtricitabine) 1 pill PO daily
   - Or Truvada® 1 pill PO daily + Isentress® (raltegravir) 2 x 600 mg pills daily
   (Raltegravir regimen recommended for people at risk for pregnancy)

   *Avoid using tenofovir (Truvada®) in patients with known kidney disease (eGFR/eCrCL < 60 mL/min) Descovy® (Tenofovir alafenamide (TAF) 25mg/emtricitabine 200mg) can be substituted for Truvada®
5. Counsel patient on possible side effects and importance of taking meds daily for full 28 days.
   b. Adherence tips: Use a pill box, electronic/phone reminder, link dosing to a daily routine.

6. Advise patient to have repeat 4th generation HIV test in 6 and 12 weeks.

7. Consider offering patient PEP ➔ PrEP.
   Patients should be considered for PrEP with Truvada® (tenofovir/emtricitabine) immediately after completing 28 days of PEP if they report:
   a. receiving ≥ 1 course of PEP in the past year, or
   b. situations that pose a recurring risk for future HIV exposures.

8. Advise patient on options for PEP follow-up or if HIV test is positive.
   Contact your in-house HIV linkage staff or HIV providers. If you do not have in-house staff, please refer to your local health department.

Have questions?

National Clinicians’ Post-Exposure Prophylaxis Hotline
nccc.ucsf.edu/clinician-consultation/pep-post-exposure-prophylaxis/
Phone: 888-448-4911
Hours: 6am-5pm PST Monday-Friday, and 8am-5pm on weekends & holidays.

Additional info on paying for PEP:

Insured patients
- Most private insurers cover PEP
- Medi-Cal covers PEP; ask the pharmacy to bill to “Medi-Cal HIV carve-out”
- ICD-10 code is Z20.6 – contact with and (suspected) exposure to human immunodeficiency virus [HIV]
- If patient has a high co-pay, use the following co-pay assistance programs:
  » Gilead (Truvada®): gileadadvancingaccess.com
  » Merck (Isentress®): activatethecard.com/7574/#
  » Viiv (Tivicay®): viivconnect.com
Uninsured patients

Truvada®, Stribild® and Biktarvy®:

Patient Assistance Programs will provide a same-day 30-day supply at no cost for those who are without coverage, <500% FPL, meet medical necessity and are within 72 hours of exposure:

1. Complete online enrollment form with patient:
   gileadadvancingaccess.com/financial-support-uninsured

2. Fax letter of necessity to 855-330-5478; The letter needs name, DOB, social security number, date of exposure, any kind of income, household size, and needs to state that this is a necessary drug due to exposure.

3. Call 800-226-2056 (M-F, 6am-5pm PST) to get voucher and bin number to take to pharmacy.

4. Call local pharmacy to ensure the medication is available; with voucher/bin number, the patient should be able to get same-day access to medication at no cost.

Biktarvy® starter kits may be available to you

1. A Gilead Therapeutic Specialist may be able to provide packs to each facility.
2. These starter kits are patient resources and designed to help with each facility’s current rapid ART protocol or in situations where the provider has decided to a regimen switch is appropriate.
3. Each kit includes a bottle with 7 pills of Biktarvy®.
4. The starter kits can be replenished by calling the Gilead Therapeutic Specialist.
5. The starter kits must be signed by an HCP-program designated prescribing provider at drop-off.
6. Your representative can give you more information as to which HCP provider can sign for the starter kits. If other providers are interested in signing for the starter kits, your Gilead Therapeutic Specialist can submit the appropriate paperwork. This process can take up to 3 months.

Raltegravir (Isentress®; by mail only):

The Merck Patient Assistance Program provides next-day delivery of raltegravir.
It’s mailed from the East Coast, so you must call before 11:30am PST in order to get next-day delivery.

1. Call 800-727-5400 before 11:30am to get same-day processing. They are open 5am-5pm PST. Let the service representative know that this is an urgent PEP case and requires same-day processing and next-day delivery.

2. They will talk you through the process and ask you to fill out the form, which is available online: merckhelps.com/ISENTRESS

3. The patient’s delivery information must be provided, and someone must be available to sign for the delivery. Deliveries may also be made to the provider’s office.

Dolutegravir (Tivicay®):

The Viiv Healthcare Patient Assistance Program can provide a same-day voucher for a 30-day supply of dolutegravir at a local pharmacy.

1. Fill out the enrollment form: viivconnect.com/get-started/

2. An advocate must call. Any healthcare staff can become an advocate on the same day by calling: 877-784-4842, 5am-5pm PST, best to call by 4 pm. You will get an advocate number and patient ID to complete the voucher.

3. The patient brings the voucher and the prescription to a local pharmacy.

4. Do not fax the form before the patient picks up the medications. Faxing the form initiates the mail-order refill service (which is not needed) and invalidates the initial voucher number.

Authors: Stephanie Cohen, MD, MPH; Samali Lubega, MD; Sophy S. Wong, MD

This project was supported by funds received from the State of California, Department of Public Health, Office of AIDS. This project was also supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under cooperative agreement #5 U10HA29292, Regional AIDS Education and Training Centers. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Feedback/questions: paetc@ucsf.edu.
**Quick Clinical Guide:**

**HIV PrEP**

**Pre-Exposure Prophylaxis**

Updated November 2018

Daily emtricitabine/tenofovir DF (Truvada®) is safe and effective for significantly reducing the risk of HIV infection in sexually active individuals (including adolescents) and people who inject drugs (PWID) when used consistently. This document is a brief “how-to guide,” including medication coverage options for California state, and links to patient assistance programs for low-income patients. For resources and referrals, go to PleasePrEPMe.org. All web links are clickable in this document.

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1. **Identify patients who may benefit from PrEP**

HIV-negative individuals, including adolescents, men who have sex with men (MSM), and cis/transgender women, who may benefit from PrEP include:

- People who ask for PrEP
- People with sexual exposures: condomless anal sex; bacterial sexually transmitted infections (STI); multiple sex partners; transactional sex (such as sex for money, housing, favors, etc.); HIV-positive partners; partners at high risk for HIV; those receiving post-exposure prophylaxis (PEP) multiple times; those using stimulant drugs, such as methamphetamine, while engaging in sexual activity
- People with injection drug exposures

2. **Discuss PrEP with your patient**

Ask your patient what they are currently doing to protect themselves from HIV infection. Ask:

- What do you know about PrEP? Do you know anyone on PrEP?
- What makes you want to start PrEP? What do you hope PrEP will do for you?
- What barriers do you foresee? How long do you foresee being on PrEP?

Inform your patient about the potential risks and benefits of PrEP. Important points include:

**Potential side effects**

- **Nausea**, which improves in the first few weeks
- **Minor weight loss**
- **Mild kidney dysfunction (<1%)**, which improves upon discontinuation of Truvada®
- **Slightly decreased bone density**, but no increased risk of fractures
- Many people on PrEP experience no side effects

**Adherence**

Adherence is correlated with higher effectiveness. Tailor adherence strategies to patient needs and lifestyle (pillbox, phone or online reminders, cell phone alarms, etc.). Many people who inject drugs are capable of adhering to PrEP.

- For rectal exposures, no transmissions were seen in patients with detectable drug blood levels equivalent to ≥4 doses/week
- For vaginal/front exposures, no transmissions were seen in patients with detectable drug blood levels equivalent to 6-7 doses/week

**Risk of Resistance**

Resistance to HIV medications can occur if acute HIV is not identified quickly while on PrEP. A negative HIV test result should be confirmed before initiating PrEP and every 3 months thereafter. The patient should report immediately to clinic if they develop symptoms compatible with acute HIV infection (fever with sore throat, rash, or headache).

**Time to protection**

Time to protection varies by site of exposure

- Approximately 7 daily doses after starting PrEP in rectal tissue
- Approximately 20 daily doses in cervico-vaginal tissue
- Approximately 20 daily doses for blood exposures for people who inject drugs
3. Take a medical, sexual, substance use history and review of symptoms.

   Check for:
   
   • HIV exposures in the prior 3 days; if present, offer three-drug post-exposure prophylaxis (PEP).
   • Recent symptoms of a mono-like illness: if present, test for acute HIV (HIV RNA PCR and HIV 4th generation Ab/Ag test) and consider deferring PrEP until test results are back.
   • Any history of renal or liver disease, or osteoporosis: if present, use caution or avoid using tenofovir.
   • Willingness and ability to 1) take a medication every day, and 2) return for regular appointments and labs while taking PrEP.

4. Assess how your patient will pay for PrEP

   ▪ Insured patients
     
     • Many private insurers cover PrEP but may require prior authorization (PA). Approval for coverage typically requires documentation of all of the following:
       » Patient has been determined to be at high risk for HIV infection
       » Patient has received counseling on safer sex practices and HIV infection risk reduction
       » Patient has no clinical symptoms consistent with acute viral infection
       » Patient has no recent (<1 month) suspected HIV exposures
       » Patient has a confirmed negative HIV status within the past week
     
     • Medi-Cal does not require a prior authorization for PrEP. We recommend writing a note to the pharmacy to “bill to the State Medi-Cal HIV carve-out” instead of the managed-care plan to help ensure Medi-Cal coverage.
     
     • ICD-10 codes for PrEP include:
       » Z20.6: Contact with and (suspected) exposure to human immunodeficiency virus [HIV]
       » Z20.2 Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission
       » Z71.7 Human Immunodeficiency Virus (HIV) counseling
       » Other codes are on p.42 of the CDC Clinician Supplement: tinyurl.com/CDCPrEPsupp2017
     
     • If patient needs help with co-pays, Gilead (maker of Truvada®) has a co-pay assistance program for up to $7,200 annually: gileadadvancingaccess.com or 877-505-6986
     
     • Other payment assistance programs are listed on the Fair Pricing Coalition website: tinyurl.com/FPCcopays
     
     • The California PrEP Assistance Program (PrEP-AP) helps low income [≤ 500% Federal Poverty Line (FPL)] insured patients pay for PrEP-related out-of-pocket costs, such as medical visits and labs, and also assists with Truvada® co-payments after the $7,200 Gilead benefit is exhausted: tinyurl.com/prepap

   ▪ Uninsured patients
     
     • The Gilead Advancing Access PrEP medication assistance program will provide monthly Truvada® deliveries to the patient or clinic at no cost for those without prescription coverage and who meet income guidelines (≤ 500% FPL).
       » Call 800-226-2056 for inquiries or to apply by phone, Monday-Friday, 6am-5pm PST
       » Fax the completed application and proof of income to 855-330-5478: tinyurl.com/GileadEnrollment or services.gileadhiv.com/content/pdf/gilead_enrollment_form.pdf
       » If approved, one bottle (30-day supply) will be shipped to the clinic in 3-14 days; or for quicker pickup at any non-Kaiser pharmacy, provide an ID, bin, group, or PCN number (provided by Gilead).
       » A Gilead representative will call the provider before the 2nd bottle is sent to confirm refill if continuing to ship to clinic. Otherwise, refills can be coordinated with retail pharmacy of choice.
       » Patients must re-apply (i.e. resubmit proof of eligibility) every 12 months.
       » U.S. and undocumented residents are eligible. SSN is not required. Proofs of income include: W2, 1040 tax return, 2 pay stubs from the last 90 days or letter stating monthly income. Letter may also state residence address. Letter must be signed and dated, but does not need to be notarized.
     
     • The California PrEP-AP (tinyurl.com/prepap) serves uninsured low-income patients (<500% FPL) as a payer of last resort for PrEP-related medical costs (e.g. labs, visits, STI treatment) and must be used in conjunction with Gilead Patient Assistance Program.
5. Obtain baseline testing

<table>
<thead>
<tr>
<th>HIV test:</th>
<th>All patients need a negative HIV antibody test (4th generation recommended) prior to initiation of PrEP. In patients with acute HIV symptoms or who report a possible HIV exposure in the last month, test with both an HIV RNA PCR and HIV 4th generation Ab/Ag test. If the patient has HIV infection, refer them to an HIV care provider; Truvada® alone is inadequate therapy for HIV infection.</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV antibody test (4th gen Ab/Ag recommended) +/- HIV RNA test</td>
<td></td>
</tr>
<tr>
<td>Serum Creatinine (e.g. as part of a basic or complete metabolic panel)</td>
<td>Estimated GFR or CrCl by serum labs should be ≥60 ml/min (Cockcroft-Gault) to safely use tenofovir DF. An online calculator can be found here: tinyurl.com/CrClcalculator</td>
</tr>
<tr>
<td>Hepatitis B surface antigen (HBsAg)</td>
<td>Truvada® is active against hepatitis B virus (HBV). Patients with chronic HBV can use Truvada® for PrEP but should have liver function tests monitored regularly during PrEP use and after discontinuing PrEP; hepatitis can flare if Truvada® is discontinued. Patients who are HBsAg negative should be offered HBV vaccination if not previously infected or immunized.</td>
</tr>
<tr>
<td>Hepatitis C antibody</td>
<td>Determine baseline hepatitis C infection status and obtain repeat testing at least yearly among PWID and others with ongoing risks of exposure.</td>
</tr>
<tr>
<td>STIs (based on patient sexual practices)</td>
<td>Test patients on PrEP for syphilis and for urethral, rectal, and pharyngeal GC and CT based on reported exposure routes (not based on gender/sexuality) every 3 months.</td>
</tr>
<tr>
<td>Pregnancy test (when appropriate)</td>
<td>People able to become pregnant (reproductive-age cis women, some transgender men) should receive a pregnancy test and have contraception plans reviewed. In patients trying to conceive, PrEP should be coordinated with prenatal care with attention to the patient’s reproductive and breastfeeding plans. Perinatal HIV/AIDS consultation is available 24/7 at 888-448-8765.</td>
</tr>
</tbody>
</table>

6. Initiate PrEP

If there are no contraindications and the patient wants to use PrEP, PrEP can be initiated.

- **Same-day PrEP prescriptions are encouraged when possible.** The California Office of AIDS and Pacific AIDS Education and Training Center strongly encourage writing a prescription and starting PrEP on the same day a patient comes in for consultation when:
  1. the patient has had no exposures since last negative HIV test
  2. all laboratory testing is obtained that day, and
  3. the patient has no symptoms of acute HIV infection.

Patients with a negative HIV test within the last 2 weeks, no exposures since last test, normal renal function, and lack of acute HIV symptoms can be started on same-day PrEP without repeat labs. If it has been more than 2 weeks since baseline labs were obtained, repeat an HIV test and start PrEP the same-day while awaiting results of the repeat HIV test.

**Prescribe Truvada® 1 tablet PO daily, 30-day supply with 0-2 refills for first dispensation.**

Do not use Descovy® (emtricitabine/tenofovir AF) for PrEP. Although currently being studied, it has not been approved by the FDA for PrEP.

- Provide adherence counseling and anticipatory guidance about common side effects. Discuss patient strategies for daily adherence.
- Counsel patients on risk reduction and using condoms–in addition to PrEP–to decrease risk of STIs and provide additional HIV risk reduction.
7. Monitor and provide ongoing support for patients using PrEP

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>30 days after initiation</strong></td>
<td>• Assess for:</td>
</tr>
<tr>
<td></td>
<td>» Side effects and patient interest in continuing.</td>
</tr>
<tr>
<td></td>
<td>» Adherence: reinforce importance of daily use and address any</td>
</tr>
<tr>
<td></td>
<td>challenges patient has faced.</td>
</tr>
<tr>
<td></td>
<td>» Ongoing risk and provide risk reduction counseling.</td>
</tr>
<tr>
<td></td>
<td>» Signs and symptoms of acute HIV infection.</td>
</tr>
<tr>
<td></td>
<td>• Prescribe additional 60-day supply with no refills.</td>
</tr>
<tr>
<td><strong>Every 3 months</strong></td>
<td>• At visit: adherence and risk reduction counseling.</td>
</tr>
<tr>
<td></td>
<td>• HIV test: 4th generation antibody/antigen test preferred.</td>
</tr>
<tr>
<td></td>
<td>• Serum Creatinine: stop if eGFR declines or &lt;60 ml/min.</td>
</tr>
<tr>
<td></td>
<td>• STI screening for syphilis and for urethral, rectal, and pharyngeal</td>
</tr>
<tr>
<td></td>
<td>GC and CT based on reported exposure routes (not based on gender/</td>
</tr>
<tr>
<td></td>
<td>sexuality).</td>
</tr>
<tr>
<td></td>
<td>• Pregnancy test for appropriate patients.</td>
</tr>
<tr>
<td></td>
<td>• Prescribe 90-day supply if HIV test negative at each visit.</td>
</tr>
<tr>
<td><strong>Every 12 months or more often based on assessed risk</strong></td>
<td>• Hepatitis C antibody, particularly for MSM and PWID.</td>
</tr>
</tbody>
</table>

8. What if my patient tests positive for acute or chronic HIV while on PrEP?

a. Discontinue Truvada® to avoid development of HIV resistance

b. Start patient on HIV treatment as soon as possible in accordance with HIV Treatment Guidelines ([tinyurl.com/HIVTreatmentGuidelines](tinyurl.com/HIVTreatmentGuidelines)), and/or refer to an HIV provider ASAP. For questions and support, call the National HIV Clinicians Consultation Center: 800-933-4313.

c. Order HIV genotype and document results

d. Report the test result to your local health department

Have questions?
The national HIV PrEPLine for clinicians provides guidance on PrEP:
855-448-7737, 8am – 3pm PST

Go to PleasePrEPMe for a location-responsive California PrEP provider directory, online chat navigation in English/Spanish, and many resource pages including for patients, providers, youth, trans and non-trans women: pleaseprepme.org

Further information about PrEP can be found at:
- CDC website: cdc.gov/hiv/risk/prep/index.html
- New York State clinical guidelines: health.ny.gov/diseases/aids/general/prep/#prep
- San Francisco City Clinic’s website: sfcityclinic.org/services/prep.asp
- Project Inform provider, staff, and patient resources: projectinform.org/prep

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This project was supported by funds received from the State of California, Department of Public Health, Office of AIDS. This project was also supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under cooperative agreement #5U10HA29292, Regional AIDS Education and Training Centers. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Feedback/questions: paetc@ucsf.edu
Triage needs on the first visit; deal with life-threatening issues and start ART as soon as possible. Once the patient is stabilized, fill in the history. Remember to use open-ended questions for assessing risks. Topics that should be discussed in the first stable visit are highlighted with a star ★ and in red; the other topics can wait for the next 2-3 visits.

### Current needs and history

| ★ What is most important to you right now? |
| ★ How do you want to feel? |
| ★ HIV: beliefs around HIV, first known positive test, seroconversion, HIV risk factors, prior HIV meds, PEP, CD4, viral loads, genotypes and ART/partner ART history. |
| ★ OIs: drem symptoms (zoster hx), PCP, toxo, MAC, CMV (GI or retinitis), crypto, histo, cocci, thrush, TB, bacillary angiomatosis (Bartonella), recurrent bacterial infections |
| ★ Concurrent medical conditions: diabetes, CAD, htn, lipids, renal insufficiency, neuropathy, hepatitis |
| ★ TB: PPD hx, LTBI treatment, CXR hx, prior TB tx |
| ★ STI: hx and tx, particularly GC/CT, syphilis, HPV, HSV |
| ★ Mental health hx: look out for bipolar disorder and affective instability, any history of psychiatric treatment |
| ★ Reproductive health hx: for women, pregnancies since HIV+ diagnosis, family planning desires, plans for future pregnancies |
| ★ Use of complementary medicine |
| ★ Most recent dental and eye exams |
| ★ Vaccination history |

### Medication History

| ★ ART history, such as PEP, PrEP or treatment of HIV |
| ★ Drug allergies |
| ★ Complementary & OTC medicine: herbs, pills, etc. |
| ★ Steroids, body-building supplements, other hormones |

### Health-Related Behaviors

| ★ Partner notification and testing: ask, “Please tell me about your partners (sexual and IDU). Would you like our help to let them know and offer HIV testing and services?”; offer help with testing |
| ★ Sexual behavior: ask, “How is your sex life? How do you enjoy sex? How do you prefer we refer to your genitals?” |
| ★ STI risk reduction: serodifferent partner(s); barrier methods; use this as a chance to discuss condoms/PrEP (AIII) |
| ★ Sexual orientation, gender identity: ask about how they identify and what name they use |
| ★ Drug use: methamphetamines (what form? IVDU, muscled, smoked, snorted, ingested), cocaine/crack, heroin, street narcotics, MJ, GHb, ecstasy, ketamine (Special K), alcohol, tobacco |
| ★ Substance use disorder treatment/rehab and quit history; current interest in rehab |
| ★ Substance use harm reduction: needle exchange |
| ★ Exercise |
| ★ Diet: consider taking a 3-day diet history |

### Family History

- Premature CAD
- Malignancies
- G6PD, sickle cell
- Psychiatric disorder

### Social History

- Take an “HIV IQ:” What do they know already about HIV transmission, natural history, prognosis, CD4, viral loads, treatments, OIs, prevention? Have they known others living with HIV? What are those relationships like?
- Health beliefs: What have their experiences with health care been like? How do they feel about HIV? How do they feel about taking HIV medications?
- Current priorities: What is most important to you right now? What do you care about most right now?
- Future beliefs: What are your hopes for your future?
- Partner hx: Health of relationships, disclosure status, partner(s) tested? Need help with disclosure/testing? Children in need of HIV testing?
- Social supports: Friends, family, community
- Spiritual support: Spiritual practice and/or community
- Intimate partner violence (IPV): Past and current
- Incarceration hx
- Homelessness: Current and historical
- Food: Sources, reliability

### Physical Exam

General physical exam; pay special attention to:

- Skin: dermatitis, folliculitis, skin fungus, molluscum, KS
- HEENT: retinal exam with CD4 < 200, look in mouth for OHL, candida, dentition
- Lymph Nodes: cervical, axillary, inguinal
- Abdomen: liver and spleen
- Neurologic status: mental status, cognition, sensation
- Genital & rectal findings: discharge, ulcers, warts, fissures, abscesses
### Baseline Labs

**(IDSA, US PHS rating system) Strength of Recommendation:**
- **A:** strong  
- **B:** moderate  
- **C:** optional  
- **D:** should usually not be offered  
- **E:** should never be offered

**Quality of Evidence for Recommendation:**
- **I:** at least one RCT with clinical results  
- **II:** clinical trials with lab results  
- **III:** expert opinion

Labs highlighted in light blue are repeated for most patients.

<table>
<thead>
<tr>
<th>Test</th>
<th>Repeat Frequency</th>
<th>DHHS</th>
<th>IDSA</th>
<th>Evidence</th>
<th>Reasons &amp; Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV Ab/Ag</td>
<td>None if confirmed</td>
<td>Y</td>
<td>Y</td>
<td>Ala</td>
<td>Confirm &amp; document diagnosis; helps benefits eligibility</td>
</tr>
</tbody>
</table>
| CD4 absolute and %       | -Baseline and repeat 4 weeks later (D, H, I) 
                          | -Q3-6 mo (I, P, D) until VL UD x 1-2yrs (see notes) | Y    | Y    | - Ala for baseline; 
- All for confirmation 
- CIII for CD4/CD8 
- If CD4=300-500 & VL UD x2yrs: check CD4 Qyear (BII, IDSA AII) 
- If CD4>500 & VL UD x2yrs: CD4 is optional (CIII) |
| Viral Load               | -Baseline, Q4-8wks till UD, then Q3-6 mo (see notes) 
                          | -also at initiation, tx failure, 4 wks after start/blip/switch | Y    | Y    | - Ala for baseline; 
- All for virologic failure 
- All for preg 
- Q3mo for monitoring tx response 
- If VL UD x1 year, can check Q6 months (All; IDSA All for VL UD x2yr) 
- If VL>50, recheck in 4 wks (All) |
| Genotype: RT and PI      | Baseline for all patients with HIV; can start ART while waiting for results; repeat with virologic failure while on ART | Y    | Y    | - Ala for baseline 
- All for virologic failure 
- All for preg 
- In early infection: more likely to pick up transmitted resistant strains 
- later on, to guide ART regimen 
- Add INSTI genotype if concern for INSTI failure, not for all baselines |
| Metabolic panel & LFTs   | Q3-6 months      | Y    | Y    | Ala      | Monitor toxicity, liver and renal function                                                                                                |
| CBC                      | Q3-6 months      | Y    | Y    | Ala      | Monitor toxicity, check cytopenias                                                                                                        |
| Hep A total Ab           | Verify once after vax | Y    | Y    | Ala      | If neg and at risk, vaccinate (AI)                                                                                                          |
| Hep B sAg, sAb, cAb      | Baseline and verify once after vax, may repeat if sAg neg at baseline and sAb neg | Y    | Y    | Ala      | - If neg, vaccinate, check sAb in 2mo 
- If cAb+ and sAb-, check DNA and consider vax if DNA neg (AllII) |
| Hep C Ab                 | Repeat Qyear if at risk | Y    | Y    | Ala      | - Check RNA if Ab pos to check for chronic infection; consider tx (AI)                                                                      |
| VZV Ab                   | Baseline & verify after vax | Not listed | Y    |  | - AllII for VZV1G 
- BII for adult vax 
- All for peds vax 
- Give VZV1G if Ab neg and exposed to active VZV in 96h (All) 
- VZV vax if Ab negative and CD4>200 (BII) |
| Toxo IgG                 | Baseline only    | Y    | Y    | BIII - Repeat CIII | - If negative, counsel prevention (pork, lamb, cat litter) 
- If positive, prophylaxis when CD4<100 |
| RPR or VDRL syphillis screen | Q3-6 months, based on risk | Y    | Y    | - Ala, BII for repeat 
- All for LP in neuro or ocular sxs | - If new infection, treat! 
- check LP/CSF w/neuro sxs (AI), active tertiary, tx failure (<4-fold↑) |
| Lipids                   | -HRSA req Qyr total chol 
                          | -baseline, then 6wks after starting PIs; Qyr if normal | Y    | Y    | Ala      | - Assess need to tx 
- following PI/NNRTI side effects 
- HRSA requirement |
| Glucose/AIC              | Check fasting glucose with lipids, Qyr | Y    | Y    | Ala, A/B (USPSTF) | See lipid notes above |
| UA, creatinine clearance | -Baseline 
                          | - Definitely before starting TDF or IDV | Y    | Y    | Ala      | - HIV confers an increased risk of nephropathy - TDF and IDV are nephrotoxic |
| GC/CT (3-sites PRN), trich | Baseline for all, trich for women; Q3-6mo if pos/risk | Y    | Y    | Ala      | - Patients at risk: at least annual test (AI) 
- Retesting for all patients by expert opinion (AllII) |
| HLA-B*5701 for ABC use   | If considering abacavir as part of ART regimen | Y    | Y    | - Ala for before starting ABC 
- If positive, avoid abacavir use (AI) 
- document result in medical chart (AI) |
| Tropism for MVC use      | If considering or on maraviroc (CCR5 inhibitor) | Y    | Y    | - AI for CCR5 tx 
- BII for failure | - Get phenotypic test (AI) 
- predicts if CCR5 antagonist (maraviroc) will work |
Consider the following tests in certain patients:

- **Urine pregnancy**: Screen in cis women and some transmen of reproductive age.
- **G6PD**: Screening in patients with family history, African or Mediterranean descent; G6PD deficiency leads to a higher risk of hemolysis to the use of dapsonate and primaquine and less to sulfa. (IDSA AII, note that it can be an expensive test, ~$200).
- **CMV IgG**: In low-risk patients (patients with history of anal intercourse are very likely to be CMV IgG+); if negative, use CMV-neg blood products; if positive and CD4<50, patients need a dilated eye exam (IDSA, score AI).
- **STI screening details**: Trichomonas and GC/CT NAAT for women, GC/CT rectal sample culture for patients reporting anal receptive sex, GC/CT pharyngeal sample culture for patients reporting oral receptive sex, GC/CT NAAT first-void specimen for men with urinary symptoms; repeat annually for sexually-active patients and Q3-6 months for patients at higher risk (IDSA, AI).

**Testosterone**: Check morning total testosterone level in men with fatigue, weight loss, libido loss, erectile dysfunction, depression, or evidence of bone mineral density loss; repeat once to confirm; treat hypogonadism if <300 (IDSA AII).

**Not recommended**: Baseline CrAg or MAC blood culture not recommended for asymptomatic screening (IDSA AII).

### Baseline Studies

<table>
<thead>
<tr>
<th>Test</th>
<th>Frequency, comments</th>
<th>Evidence, who recommends</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anal Pap and DRE for anal cancer screen, in pts with hx anal receptive sex</strong></td>
<td>-Annual anal pap if remains active and baseline normal -Use polyester swab and Thin Prep, 1&quot;, 15 sec swab -Refer ASCUS, LSIL, HSIL to anoscopy w/bx</td>
<td>At this time, no national guidelines exist for routine screening for anal cancer. MSM have 20-fold increased risk of anal cancer. DRE: BII for annual; anal pap IDSA score CII</td>
</tr>
<tr>
<td><strong>Cervical Pap for women: pap testing alone (any age) or pap with HPV co-testing (for 30+ yo)</strong></td>
<td>-Baseline and repeat 6 or 12 months later, then annual -If 3 consecutive paps are negative, then every 3 years -Avoid co-testing with HPV for women &lt;30 yo -If at all abnormal, get colposcopy (abn colpos in 64% with CD4&lt;200, 34% with CD4&gt;400)</td>
<td>AI for baseline CII for 6-month repeat after baseline BII for annual pap BII for pap every 3 years</td>
</tr>
<tr>
<td><strong>GC/CT rectal, pharyngeal swabs for pts having anal and/or oral sex</strong></td>
<td>-Repeat Q6 months to annually if sexually active</td>
<td>BII</td>
</tr>
<tr>
<td><strong>GC/CT cervical and trichomonas for women</strong></td>
<td>-Do baseline a sx; repeat when sx's present -Repeat when doing paps (P)</td>
<td>AI for baseline and sx's</td>
</tr>
<tr>
<td><strong>Dental exam and cleaning</strong></td>
<td>-Q6 months; also ask about flossing, gum-stimulation</td>
<td></td>
</tr>
<tr>
<td><strong>Dilated eye exam for CD4&lt;50</strong></td>
<td>-CMV retinitis screen for CD4&lt;50 *Don't let the eye exam delay ART!</td>
<td></td>
</tr>
<tr>
<td><strong>Colorectal cancer screening for pts ≥50 yo</strong></td>
<td>-Annual FOBT x 3 -or sigmoid Q5 years -or colonoscopy Q10 years</td>
<td>USPSTF score A</td>
</tr>
<tr>
<td><strong>Mammogram for women &gt; 40 or 50 yo</strong></td>
<td>-Ages 40-49 Q1-2 years optional, discuss risks and benefits of screening with patient -Ages 50-69 Q1-2 years -Ages 70+ Q2 years</td>
<td>USPSTF score B IDSA score A1</td>
</tr>
<tr>
<td><strong>DXA bone densitometry for at-risk, post-menopausal women and men ≥50 yo</strong></td>
<td>-Baseline for pts at risk, post-menon women, men 50+ -Risks: thin female smokers &gt;40 yo, history of 2 weeks or more on steroids (prednisone 5 mg or more) -After 2+ years on bisphosphonates (afterward, no data)</td>
<td>USPSTF score B for &gt;65 and postmenopausal women &lt;65 + increased risk of osteoporosis. USPSTF score I for men &gt;50. IDSA BII</td>
</tr>
<tr>
<td><strong>BMI</strong></td>
<td>-Annual, counsel on results</td>
<td>USPSTF score B</td>
</tr>
</tbody>
</table>

### Other routine health care maintenance practices:

- Annual blood pressure check, annual depression screen, Q2-3 year eye exam with tonometry for patients aged ≥50
- In men who have ever smoked, aged 65-75, abdominal ultrasound to screen for abdominal aortic aneurysm
- **CXR**: Definitely in positive PPD or QFT; consider in patients with underlying lung disease for a baseline (IDSA, AI)

### Prophylactic Medications (recommended by all guidelines)

<table>
<thead>
<tr>
<th>Pathogen</th>
<th>CD4</th>
<th>Agent</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumocystis jiroveci (PCP)</td>
<td>CD4 &lt;200 [DC when CD4 &gt;200 x 12 wks on ART]</td>
<td>TMP-SMX DS 160/800 mg daily; alt: dapsonle 100 mg Qday (+ pyrimethamine for toxo) or atovaquone 1500 mg Qday</td>
<td>CID 40, 2005 -MMWR 51, 2002</td>
</tr>
<tr>
<td>Toxoplasma gondii</td>
<td>CD4 &lt;100 In + toxo IgG [DC when CD4&gt;200 x 12 wks on ART]</td>
<td>TMP-SMX DS 160/800 mg daily -Alt: dapsonle 50 mg Qday + pyrimethamine 50 mg Qwk+ leucovorin 25 mg Qwk</td>
<td>-CID 40, 2005</td>
</tr>
<tr>
<td>Mycobacterium avium complex (MAC)</td>
<td>CD4 &lt;50 [DC when CD4&gt;100 x 12 wks on ART]</td>
<td>Azithromycin 1200mg Qwk or clarithromycin 500 mg Q12' -Alt: rifabutin 300 mg Qday, but watch for interactions</td>
<td>-NEJM 342, 2000 -AIDS 13, 1999</td>
</tr>
<tr>
<td>Mycobacterium tuberculosis (MTB)</td>
<td>Any CD4 Look out for hx of PPD= 5mm, QFT+</td>
<td>If LTBI (neg CXR, no e/o active d2), INH 300 mg Qday + Vit. B 650 mg Qday x6-9mo(AI)</td>
<td>All</td>
</tr>
</tbody>
</table>
**Vaccines**

<table>
<thead>
<tr>
<th>Test</th>
<th>Repeat Frequency</th>
<th>DHHS</th>
<th>IDSA</th>
<th>Evidence</th>
<th>Reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumococcal PCV13/PPV23</td>
<td>PCV13 x 1, then PPV23 at least 8 wks later; -if previous vax w/PPV23, give PCV13 1yr after -repeat PPV23x 1 after 5 yrs</td>
<td>Y</td>
<td>Y</td>
<td>Al</td>
<td>Prevent bacteremia</td>
</tr>
<tr>
<td>Influenza</td>
<td>Annually</td>
<td>Y</td>
<td>Y</td>
<td>Al</td>
<td>Higher incidence in HIV+</td>
</tr>
<tr>
<td>Hep A</td>
<td>At 0, 6 months; test total Ab</td>
<td>Y</td>
<td>Y</td>
<td>Al if at risk</td>
<td>Prev fulminant hep, esp in HCV</td>
</tr>
<tr>
<td>Hep B</td>
<td>Give double-dose (40 µg) at 0, 1, 6 mo; test sAb</td>
<td>Y</td>
<td>Y</td>
<td>Al if at risk</td>
<td>40 µg → increased response</td>
</tr>
<tr>
<td>Tetanus (Td)</td>
<td>Q10 yr boost; Tdap once</td>
<td>n/m</td>
<td>Y</td>
<td>-</td>
<td>Higher incidence in IVDU</td>
</tr>
<tr>
<td>HiB</td>
<td>Once</td>
<td>n/m</td>
<td>Y</td>
<td>Alia</td>
<td>In asplenia or recurrent HiB (I)</td>
</tr>
<tr>
<td>Varicella</td>
<td>Peds at 0, 3 mo; test Ab</td>
<td>n/m</td>
<td>Y</td>
<td>Al for kids</td>
<td>In CD4 &gt;200 with neg Ab</td>
</tr>
<tr>
<td>Zoster</td>
<td>Once for adults (Zostavax)</td>
<td>Y</td>
<td>-</td>
<td>-</td>
<td>Consider in &gt;60yo + CD4 ≥200</td>
</tr>
<tr>
<td>HPV</td>
<td>At 0, 2, 6 mo for up to age 45</td>
<td>Y</td>
<td>Al</td>
<td>-</td>
<td>To prevent HPV-related cancers</td>
</tr>
<tr>
<td>MenACWY</td>
<td>At 0, 2 mo; then Q3 yrs if &lt;7yo, Q5y if &gt;7yo</td>
<td>ACIP, 6/2016</td>
<td>5-24x risk in HIV</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Do not give live vaccines (yellow fever, OPV, BCG, live typhoid)** to HIV+ patients except for the measles vaccine.
- **Consider**: IPV Polio (don’t use OPV) catch-up; MMR catch-up in CD4%≥15; meningococcal for 11-12 yo +2nd dose 8 wks later
- **With travel**: Meningococcal in epidemic areas; IPV catch-up; rabies; inactivated typhoid (AAHIVM)

**Follow-up Frequency for Medical Visits**

- 1 week after ART initiation
- every month until viral suppression
- then every 3-6 months

**At each visit:**
- Monitor adherence (AIII)
- Screen for risk behaviors (AI): sexual risk, STI exposure, IVDU
- STI symptoms (AI)
- **Q3 months if early asymptomatic HIV**
- **Q1 months if late-stage HIV, symptomatic, or initiating ART till stabilized**
- At least yearly (and ideally at each visit), substance abuse and mental health screening, HIV partner counseling (safer sex—caddoms, PrEP for HIV-negative partners, needle exchange, etc.) (AI).

**Screening in Transgender Patients** (from The Center of Excellence for Transgender Health [http://transhealth.ucsf.edu/])

- **Trans men:**
  - Assess masculinization, total testosterone, hgb/hct 3, 6, 12 mo after initiation, then yearly and PRN.
  - Other labs: SHBG, albumin at 3, 6, 12 mo months after initiation, HgA1C and lipids as per USPSTF guidelines.
  - **Cervical cancer screening and (if has not had double mastectomy)** breast cancer screening following guidelines for non-transgender women; cervical cancer screening should not be a requirement for testosterone therapy.

- **Trans women:**
  - Assess feminization and CMP 3, 6, 12 mo after initiation, then yearly and PRN.
  - Other labs: estradiol, total testosterone, SHBG and albumin at 3, 6, 12 months after initiation, then PRN. Prolactin levels only if symptoms of prolactinemia, and A1C and lipids as per USPSTF guidelines.
  - Breast cancer screening: “As with the age of onset, given the likely lower incidence in transgender women, it is recommended that screening mammography be performed every 2 years, once the age of 50 and 5-10 years of feminizing hormone use criteria have been met. Providers and patients should engage in discussions that include the risks of over-screening and an assessment of individual risk factors (Grading: T 0 W).”

**References:**

- Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration; National Institutes of Health, HIV Medicine Association of the Infectious Diseases Society of America. Incorporating HIV prevention into the medical care of persons living with HIV. Recommendations of CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR Recomm Rep 2003;52(RR-12):1-104.
- Center of Excellence for Transgender Health, Department of Family and Community Medicine, University of California San Francisco. Guidelines for the Primary and Gender-