HHS Adult and Adolescent Antiretroviral Treatment Guidelines: September 2022 Updates

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Disclaimer

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Poll

How many of your patients/clients are currently receiving long-acting, intramuscular cabotegravir for HIV PrEP?

A) 0

B) 1-5

C) 6-10

D) >10

Poll

How many of your patients/clients are currently receiving long-acting, intramuscular cabotegravir/rilpivirine for HIV treatment?

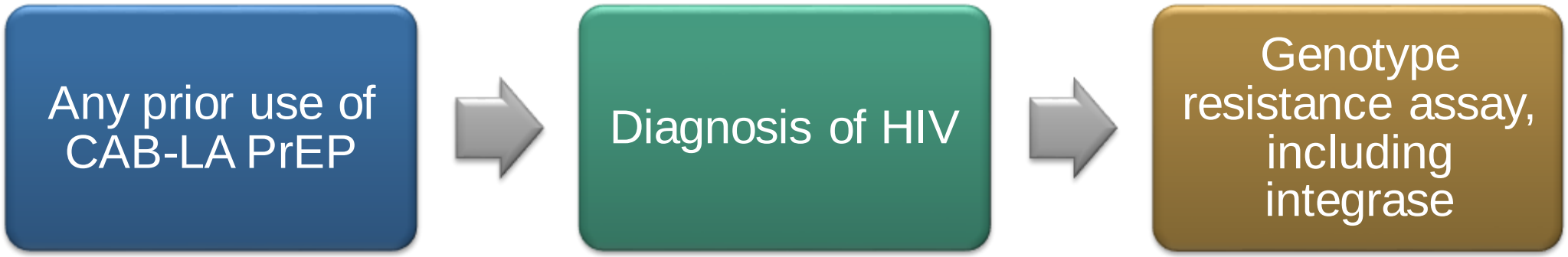
A) 0

B) 1-5

C) 6-10

D) >10

Selection of ART for individuals who acquire HIV after having received long-acting cabotegravir (CAB-LA) for PrEP



HHS Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Updated Sept. 21, 2022. (http://www.clinicalinfo.hiv.gov)

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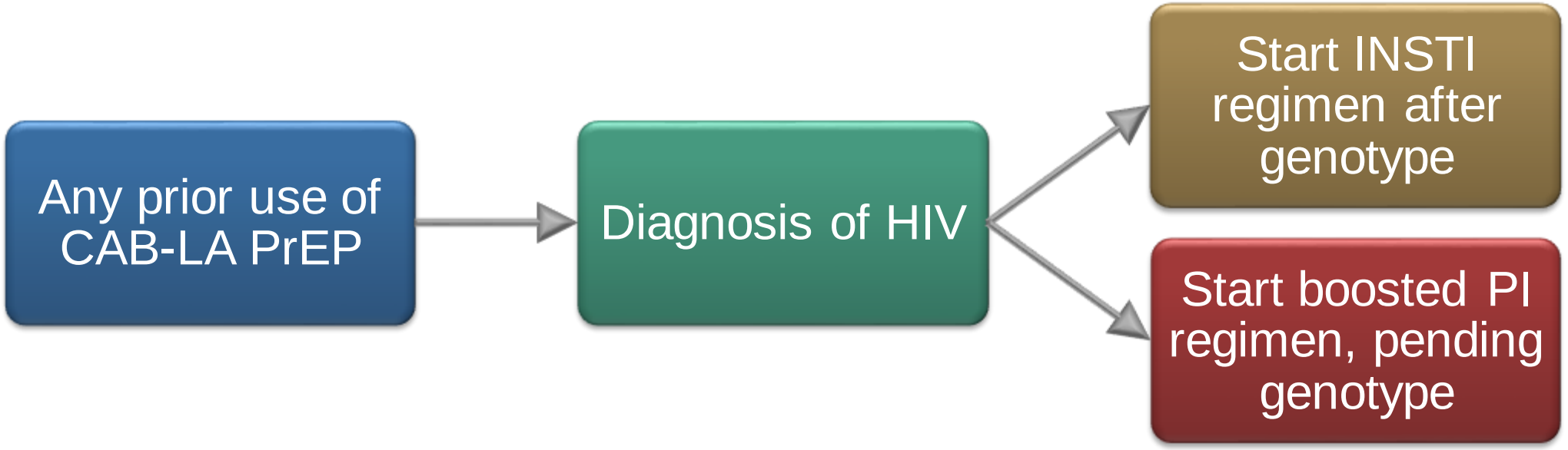

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HHS Recommended Initial Regimens for Most People with HIV
For People Who Do Not Have a History of Using CAB-LA PrEP

INSTI + 2 NRTIs	Abbreviation
Bictegravir-tenofovir alafenamide-emtricitabine	BIC-TAF-FTC
Dolutegravir-abacavir-lamivudine (only if HLA-B*5701 negative and no HBV)	DTG-ABC-3TC
Dolutegravir + tenofovir alafenamide-emtricitabine	DTG + TAF-FTC
Dolutegravir + [tenofovir DF-emtricitabine *or* tenofovir DF-lamivudine]	DTG + [TDF-FTC *or* TDF-3TC]
INSTI + 1 NRTI	**Abbreviation**
Dolutegravir-lamivudine (except: HIV RNA >500,000 copies/mL, HBV, no genotype)	DTG-3TC

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HHS Recommended Initial Regimens for Most People with HIV
For People Who Have a History of Using CAB-LA PrEP

Boosted PI + 2 NRTIs	Abbreviation
Boosted darunavir + (tenofovir alafenamide or tenofovir DF) + (emtricitabine or lamivudine) (pending integrase genotype resistance result)	(DRV/cobi or DRV + rtv) + (TAF or TDF) + (FTC or 3TC)

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Dolutegravir and Neural Tube Defects (NTDs)
Updated Data from Tsepamo Study

Exposure Group	NTD Prevalence Difference (%) (95% CI)
Dolutegravir (DTG) at conception vs. non-DTG at conception	0.06 (-0.03, 0.20)
DTG at conception vs. efavirenz at conception	0.09 (-0.00, 0.23)
DTG at conception vs. DTG started during pregnancy	0.10 (-0.03, 0.24)
DTG at conception vs. non-DTG started during pregnancy	0.08 (-0.04, 0.23)
DTG at conception vs. persons without HIV	0.09 (0.01, 0.23)

Source: Zash R, et al. IAS Conference 2021. Abstract 2562.

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What to Start
Recommended ART Options During Pregnancy

DHHS Perinatal Guidelines				
	Preferred	Alternative	Insufficient Data	Not recommended
NRTI	TAF or TDF+FTC or 3TC ABC/3TC	AZT/3TC		
INSTI	Dolutegravir Raltegravir (BID)		Bictegravir	Elvitegravir/cobicistat Cabotegravir/rilpivirine
Boosted PI	Atazanavir/ritonavir Darunavir/ritonavir (BID)	Lopinavir/ritonavir		Atazanavir/cobicistat Darunavir/cobicistat
NNRTI		Efavirenz Rilpivirine	Doravirine	Cabotegravir/rilpivirine

Abbreviations: NRTI = nucleoside reverse transcriptase inhibitor; NNRTI = non-nucleoside reverse transcriptase inhibitor; INSTI = integrase strand transfer inhibitor; PI = protease inhibitor; TAF = tenofovir alafenamide; TDF = tenofovir disoproxil fumarate; FTC = emtricitabine; 3TC = lamivudine; ABC = abacavir; AZT = zidovudine

HHS Recommendations for Use of Antiretroviral Drugs During Pregnancy (http://clinicalinfo.hiv.gov)

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Recommended Frequency of Viral Load (VL) and CD4 Monitoring

Clinical Scenario	VL Monitoring
After initiating ART	Within 4 to 8 weeks, then every 4 to 8 weeks until suppressed
During first 2 years of ART	Every 3 months
After 2 years of ART (assuming suppressed)	Can extend to every 6 months
After modifying ART	4 to 8 weeks after modification
Change in clinic status (HIV symptoms, corticosteroids, chemo)	Every 3 months

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Recommended Frequency of Viral Load (VL) and CD4 Monitoring

Clinical Scenario	CD4 Monitoring
After initiating ART	3 months after initiation
During first 2 years of ART	Every 3 months if <300 cells/mm^3 Every 6 months if ≥300 cells/mm^3
After 2 years of ART (assuming VL suppressed)	Every 6 months if <300 cells/mm3 Every 12 months if 300-500 cells/mm^3 Optional if >500 cells/mm^3
After modifying ART due to virologic failure	Every 3 to 6 months
Change in clinical status	Check, repeat as clinically indicated

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Virologic Response Definitions

Optimal viral suppression:
HIV RNA below lower limit of detection (e.g., <20 copies/mL)

Viral blip:
after viral suppression, isolated detectable HIV RNA level, followed by a return to virologic suppression

Low-level viremia:
persistent HIV RNA level quantifiable below 200 copies/mL

Virologic failure:
inability to achieve or maintain suppression to HIV RNA <200 copies/mL

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Indication for Drug-Resistance Testing Based on Viral Load Response

The Panel now recommends drug-resistance testing for people with virologic failure and HIV-RNA level >200 copies/mL

>1,000 copies/mL (AI)	501-1,000 copies/mL (AII)	201-500 copies/mL (CIII)

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Long-acting CAB/RPV
Two new recommendations related to suboptimal adherence

The panel recommends **against** LAI CAB/RPV for people who have detectable viral loads due to suboptimal ART adherence and who have ongoing challenges with retention in HIV care, except in a clinical trial (AIII)

Resistance testing (including integrase) should be performed for all persons with virologic failure on LAI CAB/RPV, **regardless of amount of time** since last dosage (AIII)

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Updated Drug-Drug Interaction Tables

Antiretroviral	Tecovirimat (Orthopoxvirus Antiviral)
Doravirine, Rilpivirine (oral)	Decreased doravirine or rilpivirine concentration, likely not clinically significant
Rilpivirine (IM)	Decreased rilpivirine concentration; likely not clinically significant, but do not initiate IM cabotegravir/rilpivirine within 2 weeks of tecovirimat treatment

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