

Antiretroviral Drugs for Treatment and Prevention of HIV in Adults: 2024 Recommendations of the International Antiviral Society–USA Panel

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IMPORTANCE New data and new antiretroviral drugs and formulations continue to become available for the prevention and management of HIV infection.

OBJECTIVE To provide updated recommendations for HIV treatment and clinical management and HIV prevention.

METHODS A panel of volunteer expert physician scientists were appointed to provide updated consensus recommendations for 2024. Relevant evidence in the literature since the last report was identified from PubMed and Embase searches (which initially yielded 3998 unique citations, of which 249 were considered relevant); from ongoing monitoring of the literature by the panel members; from data submitted by product manufacturers; and from studies presented at peer-reviewed scientific conferences between June 2022 and October 2024.

FINDINGS Antiretroviral therapy continues to be recommended for all individuals with HIV. For most people with HIV, initial regimens composed of an integrase strand transfer inhibitor (INSTI), specifically bictegravir or dolutegravir, with 2 (and in some cases 1) nucleoside or nucleotide reverse transcriptase inhibitors are recommended. Recommendations are made for those with particular clinical circumstances, such as pregnancy and active opportunistic diseases, as well as for those unable to take INSTIs. Regimens may need to be changed for virologic failure, adverse effects, convenience, or cost, among other reasons. Long-acting injectable therapy is available for those who prefer not to take daily oral medications and for people struggling with adherence to daily therapy. Recommendations are provided for laboratory monitoring, management of substance use disorders and weight changes, as well as use of statins for cardiovascular disease prevention. For HIV prevention, oral (daily or intermittent) and injectable long-acting medications are effective options for people at increased likelihood of HIV exposure. Further, new tools for maintaining health and well-being among people with HIV, such as doxycycline postexposure prophylaxis to avert sexually transmitted infection, and strategies to treat substance use disorders, are recommended. Disparities in HIV acquisition and care access are discussed and solutions proposed.

CONCLUSIONS New approaches for treating and preventing HIV offer additional tools to help end the HIV epidemic, but achieving this goal depends on addressing disparities and inequities in access to care.

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Because of effective antiretroviral therapy (ART), many people with HIV will live a normal or near-normal lifespan.¹ Management of HIV continues to improve, with increasing options for initial therapy, novel approaches for switching therapy, and effective strategies for managing co-infections. In addition, there are new tools for preventing cardiovascular disease in people with HIV and for reducing the incidence of sexually transmitted infections (STIs). HIV prevention through preexposure prophylaxis (PrEP) remains a dynamic field, with several recent advances. However, improving care of people with HIV who have substance use disorder (SUD) and addressing HIV care disparities remain challenges and high priorities. Here, updated recommendations for HIV treatment and clinical management as well as HIV prevention based on the latest data are provided, and challenges that need additional attention and dedicated resources are highlighted.

Methods

Appointment of the Panel

A volunteer international panel of experts in HIV research and clinical care and the panel leadership were appointed by the International Antiviral (formerly AIDS) Society-USA (IAS-USA). Panel members were screened for expertise, involvement in research and clinical care, financial relationships with commercial entities, and ability to work toward consensus. The panel convened in person and by video conference calls from November 2023 to October 2024. Teams and a team leader were appointed for each primary section and evaluated relevant evidence and drafted recommendations for full-panel review. Details of the recommendations development process, along with members of the volunteer leadership board, recommendations panel, and working sections, are available in the eMethods and eBoxes 1 through 3 in the [Supplement](#).

Identification of the Evidence

New evidence on antiretroviral drugs was identified in the literature (published between June 2022 and July 2024), major scientific conference presentations, and safety reports.² Literature searches were conducted using Pubmed and Embase by a panel member (C.d.R.), which identified 2998 unique citations. These were reviewed by another panel member (M.S.S.), who identified 249 possibly relevant publications. The relevant citations were categorized by section of the paper for review by each section lead. After July 2024, the panel closely monitored the literature through October 2024 for new evidence that informed the recommendations. Abstracts presented at scientific conferences between June 2022 and October 2024 were identified by panel members and teams. In addition, antiretroviral drug manufacturers were asked to submit a list of relevant publications and abstracts (same criteria as above), which were reviewed by section leads. Details of the evidence collection are available in eTables 1 through 3 in the [Supplement](#).

Process

The recommendations address antiretroviral drugs for prevention and management of HIV in adults in settings in which most antiretroviral drugs are available. Recommendations are rated for the strength of the recommendation and the quality of the supporting

Table 1. Strength of Recommendation and Quality of Evidence Rating Scale^a

Category, rating	Definition
Strength of recommendation	
A	Strong panel support for the recommendation
B	Moderate panel support for the recommendation
C	Limited or weak panel support for the recommendation
Quality of evidence	
Ia	Evidence from 1 or more randomized clinical trials published in the peer-reviewed literature
Ib	Evidence from 1 or more randomized clinical trials presented in abstract form at peer-reviewed scientific meetings
IIa	Evidence from nonrandomized clinical trials or cohort or case-control studies published in the peer-reviewed literature
IIb	Evidence from nonrandomized clinical trials or cohort or case-control studies presented in abstract form at peer-reviewed scientific meetings
III	Recommendation based on the panel's analysis of the accumulated available evidence

^a Adapted in part from the Canadian Task Force on Periodic Health Examination.^{2,3}

evidence ([Table 1](#)).^{2,3} For recommendations that have not changed substantially or for which few new data have become available since 2022, the previous iterations of the recommendations provide background information and relevant evidence.² Key recommendations for each section are listed in a text box, with new or updated recommendations highlighted. Abbreviations used for antiretroviral drugs are available in eTable 4 in the [Supplement](#). Antiretroviral drug combinations that are coformulated are noted with slashes (eg, drug A/drug B/drug C). Tables and further details about the process, panel, evidence identification, and the IAS-USA and its policies are available in the [Supplement](#).

ART for Individuals With HIV

All individuals with HIV should receive ART ([Box 1](#)).² Recommended initial ART regimens remain as described in the last publication ([Box 2](#)).^{2,4} Regimens composed of the integrase strand transfer inhibitors (INSTIs) bictegravir (BIC) or dolutegravir (DTG) are recommended as initial treatment for most people with HIV due to high viral suppression rates, excellent tolerability, infrequent toxicity, limited drug-drug interactions, a high barrier to resistance, and a low pill burden (evidence rating: A1a).

Tenofovir alafenamide (TAF) or tenofovir disoproxil fumarate (TDF) (herein TXF) and emtricitabine (FTC) or lamivudine (3TC) (herein XTC) remain the recommended nucleoside or nucleotide reverse transcriptase inhibitor (NRTI) components of an initial ART regimen (evidence rating: A1a).²

The single recommended 2-drug regimen for initial ART is DTG/3TC (evidence rating: A1a). However, it should not be used if lamivudine resistance is detected on HIV genotyping, HIV RNA level is 500 000 copies/mL or higher, or hepatitis B (HBV) co-infection is present (evidence rating: A1a). Thus, DTG/3TC is not recommended for ART initiation in the absence of those laboratory results. DTG/3TC also should not be initiated during pregnancy because of limited data in

this setting. There are limited data on using DTG/3TC for initial therapy in people who have CD4⁺ cell counts below 200/μL.

Initial boosted darunavir (DRV)-containing regimens are recommended when INSTI resistance is suspected before the results of resistance testing are returned, particularly when there has been prior exposure to long-acting cabotegravir (CAB-LA) as PrEP (evidence rating: AIIb).² The treatment can be modified to an INSTI or nonnucleoside reverse transcriptase inhibitor (NNRTI)-based therapy once results of the test excludes resistance to these drug classes.

In a person who acquires HIV-1 while taking TXF/XTC for PrEP, dolutegravir or bictegravir in combination with TXF/XTC can be started before resistance testing results are available. However, results of resistance testing (when available) should inform which regimen is continued.

ART and Pregnancy

Immediate initiation of ART is recommended for all individuals with HIV who are pregnant for reasons of maternal health and to prevent perinatal and sexual transmission (evidence rating: AIIa). Dolutegravir with TAF/FTC (or TDF/XTC if TAF/FTC is not available) is the recommended ART regimen in pregnancy and in persons who plan to become pregnant⁵ because of high antiviral efficacy⁶ and low rates of adverse birth outcomes (evidence rating: AIIa).⁷ BIC/TAF/FTC is an alternative regimen (evidence rating: BIIa). Recent pharmacokinetic studies found that bictegravir levels were sufficient during pregnancy, and the low rates of birth defects in infants born to persons with first-trimester exposure are reassuring.^{8,9} Persons found to be pregnant while receiving BIC/TAF/FTC should continue this regimen if it is tolerated and effective (evidence rating: AIIa). When dolutegravir is not an option or when HIV has been acquired after receiving long-acting cabotegravir for preexposure prophylaxis, TXF/XTC plus twice-daily darunavir (600 mg) plus ritonavir 100 mg is recommended (see Box 2) (evidence rating: AIIa). Recommended regimens to use if dolutegravir, darunavir, or bictegravir are not an option are summarized in Table 2.

Cobicistat (COBI)-containing treatment regimens should not be used during pregnancy owing to low drug levels that can reduce efficacy (AIIb). So far there are insufficient data to recommend dolutegravir (DOR)-containing regimens, injectable long-acting cabotegravir plus long-acting rilpivirine, or DTG/3TC during pregnancy (evidence rating: AIII). If pregnancy occurs in someone receiving long-acting cabotegravir plus long-acting rilpivirine, switching to an oral triple-drug regimen is recommended (evidence rating: AIII).¹⁰

Considerations for Other Initial ART Regimens

Other initial regimen options appear in Table 2. Despite the fact that INSTI-based regimens are recommended as initial regimens for the majority of individuals, there are circumstances in which other regimens need to be used.

ART in the Setting of Opportunistic Infections

Recommendations for ART in this setting appear in Box 1. As previously recommended for persons with an opportunistic infection,² ART should be initiated within 2 weeks of starting treatment for most opportunistic infections. Exceptions to this recommendation are tuberculosis meningitis and cryptococcal meningitis as detailed below. For people with HIV and active tuberculosis excluding tuberculosis meningitis, ART initiation is recommended within 2 weeks

Box 1. Recommendations for When to Start Antiretroviral Therapy

- Initiation of ART is recommended as soon as possible after diagnosis, ideally within 7 days, including on the same day as diagnosis or at the first clinic visit if the individual is ready and there is no suspicion for a concomitant opportunistic infection (evidence rating: AIII).
- Structural barriers that could delay receipt of ART (including same-day) and impede care engagement, continuous ART access, and ART adherence should be addressed using evidence-informed strategies (evidence rating: AIIa).
- Initiation of ART at the time of diagnosis of acute HIV infection or in a person who is pregnant is recommended (evidence rating: AIIa).
- Initiation of ART is recommended within 2 weeks of initiation of treatment for most opportunistic infections:
 - For persons with active tuberculosis without evidence of tuberculous meningitis, ART should be initiated within 2 weeks after initiation of tuberculosis treatment, especially for those with CD4⁺ cell count below 50/μL (evidence rating: AIIa).
 - For those with tuberculous meningitis, high-dose corticosteroids and tuberculosis treatment should be initiated immediately at diagnosis, and ART initiation is recommended when tuberculous meningitis is under control, based on clinical improvement and changes toward normal in CSF parameters, within 2 to 4 weeks thereafter (evidence rating: BIIa).
 - For persons with cryptococcal meningitis who can be closely monitored and treated for increased intracranial pressure and immune reconstitution inflammatory syndrome, ART initiation is recommended 2 to 4 weeks after starting antifungal therapy, with earlier initiation at 2 weeks after starting antifungal therapy for those who have clinically improved, have control of intracranial pressure, have negative CSF cultures with use of antifungal therapy and can continue to be closely monitored, and 4 weeks after starting antifungal therapy for those who do not meet these criteria (evidence rating: BIII).
 - For ART-naïve individuals with asymptomatic cryptococcal antigenemia and a negative lumbar puncture, immediate ART and preemptive fluconazole are recommended (evidence rating: BIII).
- Initiation of ART is recommended immediately in the setting of a new diagnosis of cancer with attention to drug-drug interactions (evidence rating: AIIa).

Adapted from Gandhi et al.² ART indicates antiretroviral therapy; CSF, cerebrospinal fluid.

after starting treatment for tuberculosis, particularly if the CD4⁺ cell count is below 50/μL (evidence rating: AIIa). For those with tuberculous meningitis, treatment for tuberculosis and high-dose corticosteroids should be initiated immediately at diagnosis of tuberculous meningitis, and ART initiation is recommended when tuberculous meningitis is under control, based on clinical improvement and changes toward normal in CSF parameters, generally 2 to 4 weeks thereafter (evidence rating: BIIa).¹¹

For persons with cryptococcal meningitis who can be closely monitored and treated for increased intracranial pressure and immune reconstitution inflammatory syndrome, ART initiation is recommended within 2 to 4 weeks after starting antifungal therapy, with earlier initiation at 2 weeks after starting antifungal therapy for those who have clinically improved, have control of intracranial pressure, have negative CSF cultures with use of antifungal therapy, and can

Box 2. Recommended Initial Antiretroviral Therapy Regimens**Recommended for Most People With HIV**

- The following are recommended (in alphabetical order by anchor drug) for most people with HIV:
 - BIC/TAF/FTC (evidence rating: A1a)
 - Dolutegravir plus TXF/XTC (evidence rating: A1a)
 - DTG/3TC (only if HIV RNA level <500 000 copies/mL, if lamivudine resistance is not present, and if HBV co-infection not present)(evidence rating: A1a). There are limited data on using DTG/3TC for initial therapy in people who have CD4⁺ cell counts below 200/μL. This regimen should not be used for rapid ART initiation when genotype, HIV RNA, and HBV serology results are not yet available (evidence rating: A1II).
- Persons who acquired HIV while receiving preexposure prophylaxis with TAF/FTC or TDF/FTC should have a blood sample for genotyping drawn prior to initiating therapy and a 3-drug regimen, preferably dolutegravir or bictegravir plus TXF/XTC, should be initiated if ART is to be started before genotype results are available (evidence rating: A1II).
- Persons who acquired HIV after exposure to cabotegravir for preexposure prophylaxis should have a blood sample for InSTI genotyping drawn prior to beginning therapy with an InSTI-based regimen (evidence rating: A1II).
 - If therapy is desired before genotype results are available or if InSTI resistance is present or suspected, ritonavir- or cobicistat-boosted darunavir and TXF/XTC should be used (evidence rating: A1Ib).

Recommended During Pregnancy

- TAF/XTC plus dolutegravir (evidence rating: A1a), with TDF/XTC plus dolutegravir a suitable alternative if tenofovir alafenamide is not available (evidence rating: A1a).
- The following drugs may be used if dolutegravir is not an option:
 - Darunavir (600 mg) plus ritonavir (100 mg), both given twice daily (evidence rating: A1a) with TAF/XTC or TDF/XTC; in people who have previously received long-acting cabotegravir for preexposure prophylaxis, this regimen is recommended over InSTI-based regimens.
 - BIC/TAF/FTC (evidence rating: B1Ib)
 - Persons found to be pregnant while receiving effective BIC/TAF/FTC should continue this regimen if it is tolerated (evidence rating: A1a).
 - When dolutegravir, darunavir, and bictegravir are not options during pregnancy, other options are available (Table 2).
 - If pregnancy is diagnosed in an individual receiving long-acting cabotegravir plus long-acting rilpivirine, switching to an oral triple-drug regimen is recommended (evidence rating: A1II).

Not Recommended to Initiate During Pregnancy Because of Inadequate Data to Support Use (Evidence Rating: AIII for All)

- Doravirine-containing regimens
- Long-acting cabotegravir plus long-acting rilpivirine
- DTG/3TC
- DTG/RPV

If an individual is stable with use of a doravirine-containing regimen, or a 2-drug regimen such as DTG/3TC or DTG/RPV, and wishes to continue the treatment during pregnancy, counsel patient about uncertainties regarding safety and efficacy during pregnancy and switch to a recommended regimen or monitor HIV RNA levels more frequently.

Should Not Be Used During Pregnancy Because of Inadequate Drug Levels

- Cobicistat-containing regimens (evidence rating: A1Ib)

Recommended During Latent or Active Tuberculosis Treatment (in Alphabetical Order by Anchor Drug)

- TXF/XTC is recommended with 1 of the following^a:
 - Dolutegravir (50 mg once daily) during tuberculosis preventive therapy with 3HP (evidence rating: A1a)
 - Dolutegravir (50 mg twice daily) (evidence rating: B1a) during tuberculosis preventive therapy with 1HP
 - Dolutegravir (50 mg twice daily) (evidence rating: A1a) during treatment for active tuberculosis with a rifamycin-containing regimen
 - Efavirenz (600 mg) (evidence rating: A1a)
- A ritonavir-boosted protease inhibitor regimen with TXF/XTC may be used only if it is not possible to use any of the above regimens; in that case, rifabutin (150 mg) should be substituted for rifampin (evidence rating: A1II).
- Darunavir boosted with ritonavir or cobicistat, doravirine, EVG/COBI, long-acting cabotegravir plus long-acting rilpivirine, etravirine, and rilpivirine are not recommended with rifampin due to drug-drug interactions (evidence rating: A1a).
- DTG/3TC and BIC/TAF/FTC are not currently recommended with rifampin due to drug-drug interactions and inadequate data (evidence rating: A1II).

Regimens are listed in alphabetical order by first drug in the regimen. Drug components separated with a virgule (/) indicate these are available as co-formulations. ART indicates antiretroviral therapy; BIC, bictegravir; COBI, cobicistat; DTG, dolutegravir; EVG, elvitegravir; FTC, emtricitabine; HBV, hepatitis B virus; InSTI, integrase strand transfer inhibitor; RPV, rilpivirine; TAF, tenofovir alafenamide; TDF, tenofovir disoproxil fumarate; TXF, tenofovir alafenamide or tenofovir disoproxil fumarate; XTC, emtricitabine or lamivudine; 1 HP, daily rifapentine + isoniazid for 1 month; 3HP, weekly rifapentine + isoniazid for 3 months; 3TC, lamivudine.

^a There is a pharmacokinetic interaction between rifampin and tenofovir alafenamide; clinical data with coadministration are limited; however, in a healthy volunteer study of tenofovir alafenamide and emtricitabine with rifampin, intracellular tenofovir-diphosphate concentrations were higher than those achieved by tenofovir disoproxil fumarate, suggesting that tenofovir alafenamide can be used with caution and close monitoring of HIV RNA levels.⁴

continue to be closely monitored; those who do not meet these criteria should initiate ART 4 weeks after starting antifungal therapy (evidence rating: B1II).^{11,12} All patients should be closely monitored and treated for increased intracranial pressure. For individuals who are ART-naïve with asymptomatic cryptococcal antigenemia and negative findings on CSF examination, immediate ART and preemptive fluconazole are recommended (evidence rating: B1II).¹³

Careful attention to the potential for drug-drug interactions is particularly important for people receiving treatment for latent or ac-

tive tuberculosis. Newer data have altered the landscape for InSTI-based ART regimens in this setting. In a phase 1/2 single-group study of individuals treated for latent tuberculosis infection with once-daily dolutegravir-based regimens and once-weekly isoniazid and rifapentine for 3 months (3HP) as preventive therapy for tuberculosis, rifapentine decreased dolutegravir exposure by 26%, but trough concentrations remained above the dolutegravir 90% minimum inhibitory concentration for all but 1 participant, and all participants maintained undetectable viral loads.¹⁴ In another recent study, once-daily

dolutegravir-based ART and 3HP were initiated simultaneously in persons who required preventive therapy for tuberculosis, with similar results.¹⁵ In a pharmacokinetic study of daily isoniazid and rifampentine given for 1 month (1HP) for tuberculosis preventive therapy, dolutegravir was administered twice daily with dolutegravir trough concentrations higher than when dolutegravir was dosed once daily without rifampentine; all but 1 participant had viral load levels below 50 copies/mL at the end of the 1HP treatment.¹⁶ Last, data from an ongoing phase 3 trial of standard once-daily dolutegravir plus tenofovir disoproxil fumarate and lamivudine administered with 1HP, 92.6% of participants evaluated had dolutegravir concentrations above the protein binding adjusted inhibitory concentration. Of the 252 participants enrolled, proportions with HIV RNA levels below 50 copies/mL were 95.2% at week 24 and 97.7% at week 48.¹⁷

New but less robust data are also available for bictegravir. In a single-group study, 48 people with HIV and latent tuberculosis infection virally suppressed with use of BIC/TAF/FTC were treated with 1HP; 44 (91.7%) remained virally suppressed on day 15 of 1HP treatment, and all were suppressed at months 3 and 6 after completion of 1HP treatment.¹⁸ Bictegravir trough concentrations remained above the 95% effective concentration for 56% of participants with measurements on day 15 and 37% of those with measurements on day 29 but returned to threshold levels above the 95% effective concentration thereafter; all participants remained virally suppressed at 52 weeks. Last, in a randomized trial in persons with HIV and active tuberculosis receiving a rifampin-containing tuberculosis treatment regimen for up to 8 weeks, BIC/TAF/FTC given twice daily was compared with dolutegravir given twice daily plus once-daily TDF/FTC. Viral suppression to HIV RNA levels below 50 copies/mL at week 24 was observed for 97% of participants in both groups, and tuberculosis outcomes were the same.¹⁹

In aggregate, these studies support the use of dolutegravir-containing regimens for ART in the setting of latent or active tuberculosis. For treatment of latent tuberculosis infection, persons with HIV receiving 1HP treatment should receive dolutegravir at a dosage of 50 mg twice daily (evidence rating: BIIa), and those receiving 3HP treatment should receive dolutegravir at a standard 50-mg once-daily dose (evidence rating: AIIa). For active tuberculosis, persons with HIV being treated with a rifamycin-containing regimen should receive dolutegravir at a dosage of 50 mg twice daily (evidence rating: AIIa) until longer-term follow-up data from studies evaluating once-daily dolutegravir in this setting become available. The data with bictegravir are less robust at this point, but emerging information suggests that bictegravir-containing ART might be considered an alternative in these settings if dolutegravir-containing regimens cannot be used. If none of these regimens can be used, ritonavir-boosted atazanavir or lopinavir with TXF/XTC may be used with rifabutin (150 mg daily) (evidence rating: AIII).

HIV and Cancer

As deaths from AIDS-defining diseases have declined in people with HIV, there has been an increase in the proportion of deaths due to cancer.^{20,21} People with HIV have an increased incidence of non-AIDS-defining malignancies, primarily due to factors such as smoking, alcohol consumption, and low CD4⁺ cell counts.²² Cancer presently contributes to 20% to 30% of all HIV-related deaths^{23,24}; therefore, prioritizing cancer screening, including for cervical and anal cancer, in people with HIV is recommended (evidence rating: AIIa).¹¹

Table 2. Other Recommended Initial Antiretroviral Therapy^a

Regimens ^{b,c}	Potential uses and cautions
DRV/COBI/TAF/FTC ^d	Recommended for individuals with prior long-acting cabotegravir PrEP exposure when an INSTI genotype is not available or before the results are returned
Darunavir plus cobicistat or ritonavir plus TXF/XTC	Recommended for those with prior long-acting cabotegravir PrEP exposure when an INSTI genotype is not available or before the results are returned. Darunavir plus ritonavir plus TXF/FTC is recommended during pregnancy when there has been prior exposure to long-acting cabotegravir for PrEP
DOR/TDF/3TC ^d or doravirine plus TXF/XTC	May be useful in people with HIV who have intolerance to INSTIs
EFV (600 or 400 mg)/TDF/FTC ^d or lamivudine ^d	Potential use in people with HIV receiving tuberculosis treatment Potential use in people with pregnancy or pregnancy intention, if dolutegravir, darunavir, or bictegravir are not an option
Raltegravir plus TXF/XTC	Potential use in people who are pregnant or have pregnancy intention, if dolutegravir, darunavir, or bictegravir are not an option
RPV/TAF/FTC ^d or rilpivirine plus TDF/3TC ^e	Small pill size Only use if pretreatment HIV RNA level is <100 000 copies/mL and CD4 ⁺ cell count is >200/μL Potential use in people who are pregnant or have pregnancy intention, if dolutegravir, darunavir, or bictegravir are not an option
Ritonavir plus atazanavir plus TXF/XTC	Potential use in people who are pregnant or have pregnancy intention, if dolutegravir, darunavir, or bictegravir are not an option

Abbreviations: 3TC, lamivudine; COBI, cobicistat; DOR, doravirine; DRV, darunavir; EFV, efavirenz; FTC, emtricitabine; INSTI, integrase strand transfer inhibitor; PrEP, preexposure prophylaxis; RPV, rilpivirine; TAF, tenofovir alafenamide; TDF, tenofovir disoproxil fumarate; TXF, tenofovir alafenamide or tenofovir disoproxil fumarate; XTC, emtricitabine or lamivudine.

^a Adapted from Gandhi et al.²

^b The recommended initial antiretroviral regimens appear in Box 2.

^c The regimens are listed in alphabetical order by first drug in the regimen. Drug components separated with a virgule (/) indicate that these are available as coformulations.

^d Available as a single-tablet coformulation.

^e Available in generic formulations in many countries.

For people with HIV without prior ART who have cancer, immediate initiation of ART is recommended (evidence rating: AIIa). The management of cancer in people with HIV requires careful assessment of potential drug-drug interactions between ART and various anticancer agents (eg, chemotherapy, immunotherapy) and other commonly prescribed drugs for people with cancer (eg, antifungals, antivirals, immunosuppressive agents). Guidance on drug-drug interactions is available through the University of Liverpool and Toronto General Hospital (<https://www.hiv-druginteractions.org/checker>; <https://hivclinic.ca/app/#drugInt>).^{25,26}

Some cancer treatments may be associated with a decline in CD4⁺ cell count, even in individuals stable while receiving ART. The need for opportunistic infection prophylaxis varies depending on the cancer, the treatment regimen, and the CD4⁺ cell count and should be discussed with the oncologist and other members of the care team.

When and How to Switch Antiretroviral Regimens

Recommendations for switching regimens are listed in Box 3.

Switching Therapy in the Setting of Virologic Suppression

People with HIV and virologic suppression may be receiving regimens that are no longer recommended due to short- and long-term

Box 3. Key Recommendations for Switching Antiretroviral Therapy Regimens

Switching Therapy in the Setting of Virologic Suppression

People with HIV and virologic suppression may be receiving regimens that are no longer recommended due to short- and long-term adverse effects, inconvenience, regimen complexity, anticipated drug-drug interactions, progressive kidney disease, risk of cardiovascular disease, or cost. Switching ART to one of the recommended initial ART regimens in these circumstances is frequently the optimal strategy, provided that virologic suppression can be maintained (evidence rating: A1a).

Individuals with virologic suppression receiving regimens that contain a boosted protease inhibitor and 2 NRTIs can be switched to dolutegravir plus TXF/XTC or BIC/FTC/TAF regardless of known or likely prior resistance to the NRTI pair and provided there is no history of InSTI resistance (evidence rating: A1a).

Switching individuals receiving boosted protease inhibitors plus 2 NRTIs to NNRTI or first-generation InSTI regimens (raltegravir or elvitegravir) plus 2 NRTIs is not recommended in the presence of previous NRTI resistance (evidence rating: A1a).

Individuals with NRTI resistance who switch to dual NRTI plus dolutegravir or bictegravir regimens should be monitored more closely in the first year after the switch, especially if there are concerns about taking the new regimen regularly (evidence rating: A1II).

Injectable long-acting cabotegravir plus long-acting rilpivirine is recommended for persons who experience stigma or other adverse consequences of taking pills daily or in response to strong patient preference (evidence rating: A1b).

Long-acting cabotegravir plus long-acting rilpivirine is not recommended in individuals with documented or suspected resistance to either agent (evidence rating: A1a) or with chronic hepatitis B (evidence rating: A1a).

Switching Therapy With Blips, Low-Level Viremia, or Virologic Failure

Virologic failure occurs when ART fails to achieve or maintain an HIV RNA level below 200 copies/mL (evidence rating: A1a).

Intermittent detection of HIV RNA at levels between 20 and 200 copies/mL (often referred to as a "blip") and persistent low-level viremia at this level should not prompt changing treatment (evidence rating: A1IIa). Evaluation should include review of ART adherence and the possibility of interacting drugs or supplements. Ideally, the patient should be receiving a treatment that has a high barrier to resistance, such as those including bictegravir, dolutegravir, or boosted darunavir.

For people who have stopped ART, resuming the most recent dolutegravir- or bictegravir-based regimen is recommended even before the results of the resistance genotype test have been returned, provided adherence is good and the individual is amenable (evidence rating: A1IIb).

In individuals with virologic failure with extensive multiclass resistance (including to InSTIs), agents with novel mechanisms of action such as ibalizumab, fostemsavir, or lenacapavir are recommended, ideally in combination to allow for 2 fully active drugs (evidence rating: A1a).

For those unable to take oral ART with advanced HIV disease, long-acting cabotegravir plus long-acting rilpivirine in conjunction with intensive case management and adherence support may be considered for people with viremia who meet the criteria below when no other treatment options are effective (evidence rating: A1a under the conditions described):

- Unable to take oral ART consistently despite extensive efforts and clinical support
- High risk of HIV disease progression (CD4⁺ cell count <200/μL or history of AIDS-defining complications)
- Virus susceptible to both cabotegravir and rilpivirine

If applicable, individuals should also be referred for treatment of substance use disorders or mental illness.

ART indicates antiretroviral therapy; BIC, bictegravir; FTC, emtricitabine; InSTI, integrase strand transfer inhibitor; NNRTI, nonnucleoside reverse transcriptase inhibitor; NRTI, nucleoside or nucleotide reverse transcriptase inhibitor; TAF, tenofovir alafenamide; TXF, tenofovir alafenamide or tenofovir disoproxil fumarate; XTC, emtricitabine or lamivudine.

adverse effects, inconvenience, regimen complexity, anticipated drug-drug interactions, progressive kidney disease, risk of cardiovascular disease, or cost. Switching ART to one of the recommended initial ART regimens in these circumstances is frequently the optimal strategy, provided that virologic suppression can be maintained. Successful ART switches require a detailed review of prior treatment history, resistance testing (if available), comorbid medical conditions, the potential for drug-drug interactions, presence of chronic hepatitis B virus (HBV) infection (which requires continuing a tenofovir-containing regimen), and potential financial barriers to obtaining the new treatments. Many patients without previous documented virologic failure or drug resistance can switch to either DTG/3TC or DTG/RPV, 2-drug regimens that were highly effective in clinical trials. Both are available in coformulated single tablets and are particularly attractive options for those who cannot take tenofovir and do not have chronic HBV infection. When such switches are undertaken, short-term increased frequency of clinical and laboratory monitoring is warranted to avoid unanticipated toxicities, pharmacy dispensing errors, or inadvertent misunderstanding from the patient regarding the correct dosing.

Prospective clinical trials indicate that individuals with virologic suppression who are receiving regimens that contain a boosted protease inhibitor and 2 NRTIs can be switched to dolutegravir plus TXF/XTC or BIC/FTC/TAF regardless of likely prior resistance to the NRTI pair (evi-

dence rating: A1a), provided there is no history of InSTI resistance.²⁷⁻²⁹ This switch may be particularly advantageous in people with HIV who require medications that interact with boosted protease inhibitors or have cardiovascular risk factors or hyperlipidemia that may be exacerbated by boosted protease inhibitors. By contrast, switching those receiving boosted protease inhibitors plus 2 NRTIs to NNRTI or first-generation InSTI regimens (raltegravir or elvitegravir) plus 2 NRTIs is not recommended in the presence of previous NRTI resistance due to increased risk of virologic failure and emergent resistance to the NNRTI and InSTI classes (evidence rating: A1a).

The increased use of dolutegravir-containing regimens globally has raised concerns that InSTI resistance would become more frequent. Although observational studies show an association between NRTI resistance and subsequent virologic failure and InSTI resistance, thus far the incidence of this resistance occurring is uncommon and related to poor medication adherence and viremia at the time of switch.³⁰⁻³² People with NRTI resistance who switch to dual NRTI plus dolutegravir or bictegravir regimens should be monitored more closely in the first year after the switch, especially if there are concerns about taking the new regimen regularly (evidence rating: A1II). As with other switches, a viral load checked at 1 month and then every 3 months for a year is reasonable to ensure ongoing viral suppression.

Long-acting cabotegravir plus long-acting rilpivirine provides an option that may be particularly attractive for persons who experience stigma or other adverse consequences of taking pills daily (evidence rating: A1b). Since the injections are administered in outpatient clinics, this regimen is more resource intensive for clinicians and clinic staff than self-administered oral ART. As a result, clinical sites that offer this option must have the personnel available for obtaining the medications, administering the injections, and scheduling the follow-up. In addition, since long-acting cabotegravir plus long-acting rilpivirine and other tenofovir-sparing regimens do not provide treatment for or protection against HBV infection, rescreening for HBV may be warranted, along with immunization if indicated. Patients unable to attend their scheduled injections need additional close attention and interventions to bring them back to care. Long-acting cabotegravir plus long-acting rilpivirine should only be used in persons with chronic HBV infection if HBV treatment is also continued.

An important limitation of injectable cabotegravir and rilpivirine is a low (1%-2%) incidence of virologic failure with emergence of 2-class resistance even with adherence to the scheduled injections, a risk not observed with adherence to currently available oral ART.³³⁻³⁵ In prospective clinical trials, risk factors for virologic failure included rilpivirine-associated resistance at baseline as detected by proviral DNA genotyping, viral subtype A6, and a body mass index greater than 30 (calculated as weight in kilograms divided by square of height in meters).³⁶ Clinicians should discuss the possibility of treatment failure with patients prior to switching to long-acting cabotegravir plus long-acting rilpivirine, including the potential for viral transmission if virologic rebound occurs and future limitations of treatment options. To minimize the risk of treatment failure, long-acting cabotegravir plus long-acting rilpivirine is not recommended in individuals with documented or suspected resistance to either agent (evidence rating: A1a).

Definition and Management of Virologic Failure

Virologic failure occurs when ART fails to achieve or maintain an HIV RNA level below 200 copies/mL. Intermittent detection of HIV RNA at levels between 20 and 200 copies/mL (often referred to as a "blip") is common with the current quantitative HIV polymerase chain reaction assays and should not prompt changing treatment, although ART adherence should be discussed and the possibility of interacting drugs or supplements, such as those containing multivalent cations (including calcium, magnesium, iron, or zinc), which impair absorption of INSTIs, should be evaluated. Less often, some people with HIV may have persistent low-level viremia between 20 and 200 copies/mL despite confirmed excellent adherence to ART, which may be caused by a large HIV reservoir, clonal expansion of long-lived resting CD4⁺ cells with latent HIV, or impaired immune responses to the virus.³⁷ In addition, people with low-level viremia may have more adverse virologic and clinical outcomes than those who do not.^{38,39} Patients with low-level viremia and confirmed adherence are unlikely to benefit from ART intensification (evidence rating: A1a). Studies in such individuals show no reduction in low-level viremia by changing therapy or intensifying their ART regimen.⁴⁰ As a result, such changes are not recommended (evidence rating: A1a) provided the patient is already receiving a regimen that has a high barrier to resistance, such as those including bictegravir, dolutegravir, or boosted darunavir.

The most common cause of virologic failure is suboptimal adherence to ART. While assessing potential causes of a patient's dif-

ficulty taking ART regularly, clinicians should order a genotype test to assess for drug resistance that might warrant a regimen change. Due to the high resistance barrier in most contemporary regimens that contain dolutegravir or bictegravir, many individuals will have no drug resistance detected. Prospective studies suggest that resuming the most recent regimen will have high rates of virologic suppression, provided adherence is good. As a result, resuming these treatments if people are amenable is recommended, even before the results of the resistance genotype test have been returned (evidence rating: A1a).^{41,42}

Contemporary clinical trials of virologic failure have consisted of 2 distinct patient populations. In the first, individuals with virologic failure receiving an initial regimen of 2 NRTIs plus 1 NNRTI received new regimens with or without real-time resistance testing. In aggregate, these studies demonstrated that use of dolutegravir along with TXF/XTC provided rates of virologic suppression comparable or superior to those of a boosted protease inhibitor plus 2 NRTIs.^{29,43,44} These favorable results were observed even in the presence of NRTI resistance at the time of treatment failure. In 1 study, however, there was a low risk of emergent dolutegravir resistance in the dolutegravir-treated groups.⁴³

Other studies evaluated the role of novel agents in managing virologic failure with multiclass drug resistance, often including resistance to INSTIs.⁴⁵ This degree of multidrug resistance is uncommon and often reflects years of nonsuppressive regimens in people treated in the early ART era, or those with perinatal HIV and long periods of intermittent medication adherence. In this setting, newer agents with novel mechanisms of action such as ibalizumab, fostemsavir, or lenacapavir (LEN) are recommended, ideally in combination to allow for 2 fully active drugs (evidence rating: A1a). Also, continued treatment with NRTIs such as TXF/XTC is recommended, since they retain partial activity even in the presence of extensive resistance mutations (evidence rating: A1a).

Persistent Virologic Failure in the Setting of Poor Oral Medication Adherence

A small proportion of people in HIV care have difficulty taking oral ART despite the availability of simple, highly effective regimens and consequently have persistent virologic failure. Some clinical programs have reported success in caring for such individuals using injectable long-acting cabotegravir plus long-acting rilpivirine every 4 weeks initially (and subsequently every 8 weeks), in conjunction with intensive case management services, as a way to achieve and maintain virologic control.^{46,47} As recommended recently,⁴⁸ based on the high risk of disease progression or death in persons with advanced HIV disease who are not taking ART, injectable long-acting cabotegravir plus long-acting rilpivirine in conjunction with intensive case management and adherence support may be considered for people with viremia who meet the criteria below when no other treatment options are effective (A1a under the conditions described):

- Unable to take oral ART consistently despite extensive efforts and clinical support
 - High risk of HIV disease progression (CD4⁺ cell count <200/ μ L or history of AIDS-defining complications)
 - A virus susceptible to both cabotegravir and rilpivirine
- If applicable, individuals should also be referred for treatment of SUD or mental health concerns.

Table 3. Laboratory Monitoring Recommendations for Persons With HIV^a

Laboratory test	At HIV diagnosis and start of ART	During ART	At virologic failure
HIV RNA level	✓	Four to 6 wk after ART initiation; then every 3 mo until suppressed; then every 6 mo	✓
CD4 ⁺ cell count	✓	Every 6 mo until >250/μL for 1 y, then stop	✓
HIV reverse transcriptase–protease (RT-pro) genotype	✓		✓
HIV integrase genotype	If partner is known to have HIV and receiving a failing ART regimen that includes an InSTI or when a person acquires HIV after exposure to cabotegravir for PrEP		If failing ART regimen included an InSTI
Viral tropism			Before start of maraviroc
CrAG screening if CD4 ⁺ cell count ≤100 cells/μL	✓		
Age-appropriate cancer screening	✓	✓	
Safety laboratory tests, lipid profiles, and co-infection screening (STIs, viral hepatitis)	✓	✓	✓

Abbreviations: ART, antiretroviral; CrAG, serum cryptococcal antigen; InSTI, integrase strand transfer inhibitor; PrEP, preexposure prophylaxis; STI, sexually transmitted infection.

^a See text for strength of the recommendation, quality of the evidence, and frequency.

Further support for the use of injectable long-acting cabotegravir plus long-acting rilpivirine in people who struggle taking oral medications comes from a randomized trial in those with virologic failure.⁴⁹ After providing economic incentives for participants to achieve viral suppression with oral ART, the trial then randomly assigned them to continue oral therapy or switch to injectable therapy. At a preplanned interim review by an independent data and safety monitoring board, the study results demonstrated that the injectable therapy was superior to oral ART in rates of virologic and treatment failure. As a result, the randomization was stopped, and participants were notified of the outcome and offered the option to continue or switch to long-acting therapy with continued follow-up.

An additional study evaluating long-acting cabotegravir and long-acting rilpivirine in individuals with viremia is planned. When the trial is available, clinicians are encouraged to refer eligible individuals to generate more robust data on the risks and benefits of this strategy.

Laboratory Monitoring in Individuals With Established HIV

Recommendations for laboratory monitoring are summarized in Table 3.

At HIV Diagnosis and Starting ART

Prior to initiating ART, recommended laboratory tests should assess (1) HIV RNA level; (2) CD4⁺ cell count (evidence rating: AIIa); (3) general health (lipid levels, kidney and liver function, complete blood cell count, glucose level and, in people of childbearing potential, pregnancy status) (evidence rating: AIIa); (4) ART resistance (reverse transcriptase–protease genotype) (evidence rating: AIIa); and (5) potential co-infections (ie, viral hepatitis A, B, and C; latent tuberculosis; and STIs) (evidence rating: AIIa). Considering the continued low frequency of transmitted InSTI resistance, testing for InSTI resistance is not recommended in people newly diagnosed with HIV

unless the person has previously taken cabotegravir-containing PrEP or there is reason to believe that the person's HIV was acquired from a partner with an InSTI-resistant virus (evidence rating: BIII). If the initial CD4⁺ cell count is less than 100 cells/μL, then testing for cryptococcal antigen is recommended (evidence rating: AIIa). If there are symptoms consistent with acute infections (eg, STIs, *Mycobacterium avium* complex, tuberculosis, cryptococcus), then testing is recommended (evidence rating: AIIa). Immediate follow-up of these results is recommended to maximize safety, but the results of these diagnostic tests should not delay starting ART (evidence rating: AIII).

During ART

At 4 to 6 weeks after starting ART, HIV RNA levels should be measured, and adherence and tolerability of ART should be assessed (evidence rating: AIII) (Table 3). A genotype based on the person's regimen is advised if, after 12 to 24 weeks of therapy, HIV RNA levels have not decreased to below 200 copies/mL and adherence seems adequate (evidence rating: AIIa).

Every clinical encounter should include an evaluation for medication toxicity, general health maintenance assessments, need for vaccinations, and age- and risk-appropriate screening for cancer (evidence rating: AIIa). If there are potential exposures or there is clinical concern, testing should be performed for co-infections such as STIs (at all exposed mucosal sites), tuberculosis, and viral hepatitis (evidence rating: AIII). Regular screening and treatment for anal and cervical cancer should follow established guidelines (evidence rating: AIIa).^{11,50,51} Monitoring of urine glucose and protein levels should be performed in individuals starting tenofovir disoproxil fumarate and at least once a year after that (evidence rating: BIII). If the person remains clinically stable, virally suppressed, and adherent to ART, then HIV RNA levels should be monitored every 3 months until suppressed for at least 1 year (evidence rating: AIIa). Following viral suppression with ART, CD4⁺ cell counts should be assessed every 6 months until they are consistently above 250 cells/μL for a minimum of a year; after that, no further CD4⁺ assessments are warranted unless virologic failure is identified or if the person experiences

an immunosuppressive condition (evidence rating: BIII). If the person remains clinically stable, virologically suppressed, and adherent for greater than a year, then safety laboratory and HIV RNA monitoring can be reduced to every 6 months (evidence rating: AIIa); if greater than 5 years and the person prefers less monitoring, viral and ART safety laboratory monitoring can be reduced to once per year (evidence rating: BIII), although other health maintenance visits should occur as needed. Viral load and CD4⁺ cell count testing should occur any time a person is clinically unstable, not virally suppressed, or nonadherent to ART (evidence rating: AIIa).

For people who are virologically suppressed and do not have a documented pre-ART reverse transcriptase-protease genotype or who have an incomplete treatment history and wish to start long-acting cabotegravir plus long-acting rilpivirine, proviral RT-protease genotype is an option but of unclear benefit since proviral genotyping has not been validated. If rilpivirine-associated mutations are present on genotypic testing, long-acting cabotegravir plus long-acting rilpivirine should be avoided (evidence rating: AIIa).

At the Time of Virologic Failure and Before Starting New ART Regimen

If an HIV RNA level above 50 copies/mL is detected during ART following previous suppression (<50 copies/mL), a repeat measurement of HIV RNA level is recommended in 2 to 4 weeks, and adherence to medication and tolerability should be assessed (evidence rating: AIIa). If HIV RNA level is above 200 copies/mL on 2 consecutive measurements, then an HIV RNA reverse transcriptase-protease genotype should be obtained, and if the person is receiving an INSTI, an INSTI genotype assay should be ordered (evidence rating: AIII). Some commercial HIV genotype assays require an HIV RNA level above 500 to 1000 copies/mL to be performed. (See the Definition and Management of Virologic Failure section above for discussion on management of intermittent or persistent low-level viremia between 50 and 200 copies/mL.) Before starting maraviroc, testing for viral tropism should be performed, and maraviroc should not be used if at any time X4 or dual-tropic virus is detected (evidence rating: AIIa). If abacavir use is being considered, testing for HLA-B*5701 should be done first and, if present, abacavir avoided (evidence rating: AIIa).²

Weight Gain and Cardiometabolic Comorbidities

Recommendations for weight gain and cardiometabolic comorbidities are summarized in **Box 4**.

There is large variability in weight change associated with antiretroviral drugs, with the majority of people receiving ART having weight change of less than 5% of body weight and a minority gaining more than 10% of their body weight.⁵² Weight gain can occur following ART initiation or after switching regimens. Some studies show greater weight gain with regimens containing INSTIs than those containing boosted protease inhibitors or NNRTIs.^{2,53} Greater weight gain with regimens containing tenofovir alafenamide than with those containing tenofovir disoproxil fumarate also has been observed.² Of note, tenofovir disoproxil fumarate and efavirenz are associated with less weight gain as initial therapy and with weight loss when switching to these drugs, complicating comparisons using these agents. Weight gain with use of ART is more likely to occur in women

Box 4. Recommendations for Weight Gain and Cardiometabolic Comorbidities

- Documentation of weight and body mass index at baseline and every 6 months is recommended for individuals initiating or switching to an INSTI- or tenofovir alafenamide-based regimen to identify those with excessive weight gain (evidence rating: AIIa).
- Monitoring blood pressure at each clinical visit is recommended to diagnose and treat incident hypertension (evidence rating: AIII).
- Changing regimens because of weight gain (evidence rating: BIIa), hypertension (evidence rating: BIII), or insulin resistance (evidence rating: BIII) is not recommended.
- People with or at high risk for cardiovascular disease who are receiving an abacavir-containing regimen should switch to a non-abacavir-containing regimen if an active regimen is available (evidence rating: AIIb).
- Counseling about potential cardiometabolic complications and the importance of lifestyle changes (exercise and diet) is recommended for all persons beginning ART, especially those at increased likelihood of weight gain with use of INSTI- and tenofovir alafenamide-based regimens (evidence rating: AIII) and for those at increased risk for cardiovascular disease due to hypertension, insulin resistance/diabetes, smoking, or other factors (evidence rating: AIII).
- Persons with HIV and 10-year ASCVD risk above 20% or low-density lipoprotein cholesterol level of 190 mg/dL (4.92 mmol/L) or higher should receive a high-intensity statin; those with diabetes should receive at least a moderate-intensity statin (evidence rating: AIIa).
- Persons with HIV aged 40 to 75 years with low to intermediate (5% to <20%) 10-year ASCVD risk should receive at least a moderate-intensity statin (pitavastatin [4 mg] [evidence rating: AIIa], atorvastatin [20 mg] [evidence rating: AIIa], or rosuvastatin [10 mg] [evidence rating: AIIa]).
- Among those with 10-year ASCVD risk below 5%, a moderate-intensity statin also is recommended (evidence rating: CIIa) and, in this group, considerations supporting starting a statin include the presence of traditional factors that increase ASCVD risk as well as HIV risk-enhancing factors (history of delayed ART initiation, current/nadir CD4⁺ count <350 cells/μL, HIV treatment failure, metabolic syndrome, lipodystrophy, fatty liver disease, and hepatitis C co-infection).

ART indicates antiretroviral therapy; ASCVD, atherosclerotic cardiovascular disease; INSTI, integrase strand transfer inhibitor.

and Black persons and mostly occurs within the first year following initiation or switch.² Weight gain in some patients is not solely a "return to health" phenomenon. Mechanisms, predictors, and determinants of weight gain are being investigated.⁵⁴

The reversibility of weight gain with use of antiretroviral drugs also is being studied, with a return to pretherapy weight being rarely observed. In the DEFINE study,⁵⁵ switching to DRV/COBI/TAF/FTC following weight gain with use of INSTI-based ART resulted in no significant change in weight. Mean changes in weight and fat also were similar after switching to the investigational combination doravirine/islatravir,⁵⁶ compared with continuing BIC/FTC/TAF. Conversely, women (but not men) in the ADVANCE trial who were randomly assigned to initial TAF/FTC plus dolutegravir and who later switched to TDF/3TC/DTG had reductions in weight,⁵⁷ likely due to the weight suppressive effect of tenofovir disoproxil fumarate. Likewise, weight loss was seen in the Swiss HIV Cohort Study when people switched from tenofovir alafenamide to tenofovir disoproxil fumarate.⁵⁸

Documentation of weight and body mass index every 6 months is recommended for individuals initiating or switching to an InSTI- or tenofovir alafenamide-based regimen to identify those with excessive weight gain (evidence rating: AllA). Currently, because of the known toxicities of tenofovir disoproxil fumarate and lack of benefit seen when changing from an InSTI to a boosted protease inhibitor, changing regimens because of weight gain is not recommended (evidence rating: AllB). Lifestyle changes should be emphasized, including diet and exercise, especially for those at increased likelihood of weight gain with use of InSTI- and tenofovir alafenamide-based regimens (evidence rating: AllI). The efficacy of glucagon-like peptide-1 receptor agonists for weight loss among people with HIV is similar to that seen in the general population. Loss of muscle mass, a particular concern in older people at risk for sarcopenia, may occur with glucagon-like peptide-1 receptor agonist therapy.⁵⁹⁻⁶² In persons with HIV and lipohypertrophy, a randomized clinical trial found that once-weekly semaglutide is associated with decreased abdominal visceral and subcutaneous adipose tissue, and overall body fat, compared with placebo.⁶³

Cardiovascular Disease and Antiretroviral Therapy

Although reductions over time in age-standardized atherosclerotic cardiovascular disease (ASCVD)-related mortality have been reported from 2 large cohorts,^{23,64} a 1.5- to 2-fold excess risk of ASCVD persists in people with HIV, compared with the general population, likely associated with chronic immune activation and inflammation. Rates of traditional ASCVD risk factors remain high in people with HIV, including smoking, hypertension, dyslipidemia, insulin resistance and diabetes, body composition changes, and SUDs.⁶⁵ ASCVD risk calculators have consistently been shown to underestimate ASCVD risk in people with HIV, particularly for women and Black/African American individuals.⁶⁶

Some individual antiretroviral drugs and classes have been associated with cardiometabolic adverse effects leading to an increased risk of ASCVD. Of the antiretroviral drugs currently in use, boosted darunavir and recent or current abacavir use have been associated with increased cardiovascular events.^{2,67,68} People with or at high risk for cardiovascular disease who are receiving an abacavir-containing regimen should switch to a non-abacavir-containing regimen if an active regimen is available (evidence rating: AllB). Data suggesting an association between cardiovascular disease and InSTIs are conflicting.^{69,70} No association with ASCVD events was found in people without prior treatment who initiated an InSTI-based regimen compared with other regimens in 2 different simulated clinical trial analyses,^{69,71} although an observational cohort found that initiation of InSTI-based regimens was associated with increased ASCVD events in the first 2 years of InSTI-based therapy.⁷⁰

Prevention of Cardiovascular Disease

Data from the REPRIEVE trial have changed the approach to primary prevention of ASCVD for people with HIV. REPRIEVE, a placebo-controlled trial of pitavastatin (4 mg daily) in people with HIV, aged 40 to 75 years, receiving ART, and with low to intermediate (median, 4.5%) 10-year ASCVD event risk,⁷² demonstrated a 36% reduction in major adverse cardiovascular events for the pitavastatin group (hazard ratio, 0.64 [95% CI, 0.48-0.84]).^{73,74} Although benefit also was seen for persons with lower risk estimates, the number who need to be treated to prevent 1 major adverse cardiovas-

cular event was lower (53 or below) for those with a 10-year risk score of at least 5%, compared with 149 or higher for those with risk scores of 5% or below. Based on existing recommendations for the general population, persons with a risk estimate of 20% or higher, or a low-density lipoprotein cholesterol level of 190 mg/dL (4.92 mmol/L) or higher, should receive a high-intensity statin, and those with diabetes should receive at least a moderate-intensity statin (evidence rating: AllA). Based on results from the REPRIEVE trial, a statin of at least moderate intensity is recommended for persons with HIV aged 40 to 75 years with ASCVD risk estimates of 5% or higher (evidence rating: AllA). Among those with risk estimates below 5%, a moderate-intensity statin also is recommended (evidence rating: AllC) and, in this group, considerations supporting starting a statin include the presence of traditional factors that increase ASCVD risk as well as HIV risk-enhancing factors (history of delayed ART initiation, current or nadir CD4⁺ cell count <350/ μ L, HIV treatment failure, metabolic syndrome, lipodystrophy, fatty liver disease, and hepatitis C virus [HCV] co-infection). People with HIV younger than 40 years were not included in the REPRIEVE trial. General population guidelines should be followed when considering statin initiation in people with HIV younger than 40 years. In this population, HIV risk-enhancing factors or long-standing HIV infection due to perinatal acquisition may increase risk for ASCVD; however, there currently are limited data to inform decision-making for individualized statin therapy in this group. In REPRIEVE, adverse events that were more frequent in the pitavastatin group than in the placebo group included incident diabetes (5.3% vs 4.0%, respectively) and muscle-related symptoms (2.3% vs 1.4%, respectively). Counseling on modifiable lifestyle changes is essential, regardless of whether a statin is used.

Moderate-intensity doses of atorvastatin (20 mg) (evidence rating: AllA) or rosuvastatin (10 mg) (evidence rating: AllA) may be substituted for pitavastatin. When prescribing statins, especially to people taking an HIV protease inhibitor or cobicistat, attention must be paid to drug-drug interactions associated with cytochrome P-450 metabolism and drug transporter interactions (although less frequent with pitavastatin).^{56,75}

Increased prevalence of hypertension has been reported with InSTI use in some analyses.⁷⁶ However, data supporting an association between dolutegravir and hypertension are inconclusive, and data on bictegravir are lacking. In several cohorts and a post hoc analysis of the ADVANCE and NAMSAL trials, dolutegravir-based regimens were associated with higher rates of hypertension than NNRTI- or protease inhibitor-based regimens.^{25,77,78} However, dolutegravir-based regimens were associated with greater weight gain, which might contribute to a higher incidence of hypertension. In a subset analysis from the REPRIEVE trial, hypertension was more common among persons receiving dolutegravir than those receiving non-InSTI regimens.⁷⁹ In contrast, no significant difference in incident hypertension was seen in the NEATO22 study, in which people 50 years or older with viral suppression and a Framingham Risk Score above 10% were randomly assigned to continue their protease inhibitor-based regimen or to switch to a dolutegravir-based regimen.⁸⁰ Likewise, an analysis from the African Cohort Study of 2935 participants with and without HIV showed no association between dolutegravir and incident hypertension among those receiving dolutegravir compared with participants without HIV.⁸¹ In a US retrospective study of more than 5500 PrEP initiators,⁸² incidence

Box 5. Recommendations for Persons at Risk for and With HIV Who Use Substances and Who Have Substance Use Disorders

- Provide screening, diagnosis and treatment for SUDs to all persons at risk for and with HIV (evidence rating: A1a).
- SUD treatment should be integrated into HIV prevention and treatment services (evidence rating: A1a).
- Rapid HIV testing and linkage to rapid ART or preexposure prophylaxis provision, when indicated, are recommended for persons who use substances and who have SUDs (evidence rating: A1a).
- Harm reduction services, including naloxone, safe injection education, fentanyl and xylazine drug test strips, and referral to syringe service programs and safe injection sites should be offered to all persons who report drug use (evidence rating: A1a).
- Persons who use drugs should be offered either oral TDF/FTC for injection drug use risk or oral (TDF/FTC or TAF/FTC) or injectable PrEP (long-acting cabotegravir) to reduce sexual risk of HIV acquisition (evidence rating: A1a).
- Persons with SUDs and HIV infection or at risk for HIV should receive integrated SUD treatment with
 - pharmacotherapy for opioid, alcohol, and tobacco use disorders (evidence rating: A1a)
 - contingency management for stimulant use disorders and in certain situations medication treatment (evidence rating: A1a)
- Persons with opioid use and alcohol use disorders should be offered timely initiation of medications for SUD, regardless of HIV and HCV treatment plans (evidence rating: A1a).
- Peer/patient support staff, telehealth, extended hours, mobile clinics, mobile pharmacies, pharmacy delivery services and walk-in clinic options should be available to persons who use substances and/or have SUDs who are receiving HIV treatment or prevention (evidence rating: A1Ib).

ART indicates antiretroviral therapy; FTC, emtricitabine; HCV, hepatitis C virus; PrEP, preexposure prophylaxis; TAF, tenofovir alafenamide; TDF, tenofovir disoproxil fumarate; SUD, substance use disorder.

of hypertension was low and similar between the tenofovir alafenamide and tenofovir disoproxil fumarate groups. Monitoring blood pressure at each clinical visit is recommended to diagnose and treat incident hypertension (evidence rating: AIII).

In persons who initiate ART in the US, the overall incidence of diabetes in 1 large cohort was almost twice that of the general population.⁸³ InSTI-based regimens are associated with new-onset diabetes and hyperglycemia in some cohort studies; however, the data are inconclusive.⁸⁴ As with weight gain, changing regimens due to hypertension or insulin resistance is not recommended (evidence rating: BIII); instead, lifestyle modifications, exercise, and diet intervention are recommended (evidence rating: AIII).

Substance Use in Persons at Risk for and With HIV

Recommendations for persons at risk for and with HIV who use substances and who have SUDs are summarized in Box 5. Substance use (eg, opioids, stimulants, alcohol) and SUD can interfere with HIV prevention and HIV care. Persons who use such substances have increased risk of acquiring HIV through sharing injection drug use (IDU) equipment and condomless sexual intercourse. Substance use may also adversely affect HIV outcomes by interfering with ART adherence and HIV RNA suppression.²

People with HIV are more likely to have SUDs than the general population. Despite the high prevalence, only a small number of people with HIV are referred for and receive treatment for SUD or harm reduction. Integration of SUD screening, diagnosis, and treatment into HIV prevention and treatment services is recommended (evidence rating: A1a) (eTables 5 and 6 in the Supplement).² Reducing substance use (even if abstinence is not achieved) is associated with improved HIV outcomes. Therefore, addiction treatment, including pharmacotherapy, behavioral-based therapies, and harm reduction are recommended for all persons (evidence rating: A1a).

All US Food and Drug Administration (FDA)-approved medications for opioid use disorder (buprenorphine, methadone, and extended-release naltrexone) reduce nonmedical opioid use and risk of HIV and HCV acquisition (eTable 7 in the Supplement).^{85,86} Similarly, FDA-approved medications for alcohol use disorder (eg, extended-release naltrexone, oral naltrexone) reduce alcohol use and risk of HIV acquisition (eTable 8 in the Supplement). Medication treatment of opioid use disorder and alcohol use disorder improves ART adherence and viral suppression and is recommended with ART (eFigures 1 and 2 in the Supplement) (evidence rating: A1a).²

Medications for SUDs have few clinically significant drug-drug interactions with ART and HCV direct-acting antivirals²; therefore, medication treatments for SUDs should not be withheld for those receiving ART or direct-acting antivirals (evidence rating: A1a). Clinical guidelines recommend pharmacotherapies for stimulant use disorders in certain situations, although there are no FDA-approved medications to treat stimulant use disorders (eg, cocaine use disorder, amphetamine-type use disorder). Currently the most efficacious form of treatment for stimulant use disorders is contingency management, a behavioral form of incentivized treatment, such as financial incentives (cash or gift cards) for periods of recovery from stimulants or other nonmedical substances. Contingency management is recommended for stimulant use disorders (evidence rating: A1a).⁸⁷ Tobacco use is common among people with HIV and contributes to an excess risk of cardiovascular disease; therefore, strategies to promote tobacco cessation are recommended, including pharmacotherapies (evidence rating: A1a).⁸⁸

Harm reduction services, including naloxone dispensation, safe use education, fentanyl and xylazine drug test strips, and referral to syringe services and safe injection sites, should be offered to all who report drug use (evidence rating: A1a).^{89,90}

Interventions that reduce substance use, including medications for opioid use disorder and alcohol use disorder, may improve HIV prevention. TAF/FTC and injectable long-acting cabotegravir PrEP have not yet been fully evaluated for IDU-related HIV prevention among persons who inject drugs (PWID), but TDF/FTC is approved for IDU-related HIV prevention. However, for PWID who are at sexual risk of HIV acquisition, oral or injectable PrEP to reduce sexual risk is recommended (evidence rating: A1a).⁹¹

Substance use and SUDs can create an additional hurdle for retention in HIV prevention and treatment services. Screening for barriers to retention in care, including lack of transportation, insurance, and housing—as well as criminal legal barriers, poverty, mental illness, and stigma—should all be addressed. Innovative service delivery options, including extended hours, mobile clinics and pharmacies, walk-in clinics, telehealth, pharmacy delivery options, and

Box 6. Recommendations for HIV and Sexually Transmitted Infection Prevention^a**Generally Recommended HIV Prevention Approach**

- Adopt a serostatus-neutral approach to reduce HIV stigma, ensuring rapid care linkage for individuals diagnosed and PrEP navigation for those who test negative (evidence rating: AllA).
- Offer PrEP to all sexually active individuals, anyone requesting it, and those using nonprescription drugs or substances, without specific risk criteria or screening tools (evidence rating: AllI).
- Offer PrEP to all sexual partners of individuals with HIV and to those who share injection drug works with individuals with HIV or of unknown HIV status (evidence rating: AllA). For monogamous sexual partners of persons with HIV who are known to be receiving ART and have viral loads below 200 copies/mL, it is a reasonable and appropriate decision to defer PrEP; if such a patient requests PrEP; however, it is also reasonable to provide it because of the possibility that there are undisclosed exposures occurring.
- Condoms are recommended for all penetrative sexual acts (evidence rating: AllI).

Rapid PrEP Start

- If HIV test results from within the past 7 days are negative, initiate PrEP while awaiting further diagnostics and safety assessments (evidence rating: AllA).
- If no recent HIV test result is available, conduct testing and initiate PrEP once results are negative, assuming good remote communication (evidence rating: AllI).
- For substantial HIV exposure within 72 hours, initiation of a 3-drug PEP regimen is recommended (evidence rating: AllA).
 - Transition to PrEP after PEP completion if HIV test results are negative is recommended (evidence rating: AllA).

Laboratory Testing

- At initiation or after a long hiatus, HIV screening should include an HIV RNA test and a laboratory-based antigen-antibody test (evidence rating: AllA).
 - If RNA testing is unavailable, initiation of PrEP after a rapid HIV antibody test and while awaiting a laboratory-based antigen/antibody test result is recommended (evidence rating: AllI).
- For long-acting cabotegravir PrEP follow-up, a rapid HIV antibody test and laboratory-based antigen/antibody test, not routine RNA testing, is recommended (evidence rating: AllB).
- If RNA testing is not available, repeat antigen/antibody testing 1 month after starting or resuming tenofovir-based oral PrEP (evidence rating: AllI).

Bacterial STI Prevention^b

- DoxyPEP (doxycycline [200 mg]) is recommended within 72 hours after condomless sex for cisgender men who have sex with men and transgender women, regardless of HIV status (evidence rating: AllA).
 - Dosing is recommended no more frequently than daily (evidence rating: AllB).
- Pharmacokinetic modeling suggests that doxyPEP is effective for vaginal exposures and is recommended on a case-by-case basis for cisgender women at risk (evidence rating: AllI).
- Prescribe 30 doses (60 tablets or capsules) of doxyPEP at a time (evidence rating: AllI).
- Quarterly STI screening of contact sites and blood syphilis testing is recommended (evidence rating: AllA).

ART indicates antiretroviral therapy; PEP, postexposure prophylaxis; PrEP, preexposure prophylaxis; STI, sexually transmitted infection.

^a See text for recommended PrEP regimens.

^b See text for details.

staff who are patient navigators, peers, near-peers, or community health workers are recommended (evidence rating: AllB).^{92,93} Rapid HIV testing and linkage to rapid ART or PrEP provision, when indicated, are recommended for persons who use substances and who have SUDs (evidence rating: AllA).²

Prevention of HIV Infection

Recommendations for PrEP with currently available agents are outlined in **Box 6**.

Biomedical tools to prevent HIV acquisition are highly effective. To reduce stigma associated with HIV testing, treatment, and prevention efforts, a serostatus-neutral approach is recommended (evidence rating: AllA). This approach ensures that people diagnosed with HIV are rapidly linked to care and those who test negative are informed about and navigated to receive PrEP services if desired or indicated. Rapid viral suppression for persons with HIV has substantial health benefits for the individual and eliminates sexual transmission of HIV (undetectable = untransmittable, or U = U). Condoms are a cornerstone of prevention for all penetrative sex acts to reduce the acquisition of STIs, including HIV, and are recommended (evidence rating: AllI). Other effective HIV prevention strategies for applicable populations include medical circumcision for heterosexual males in high-prevalence settings, medications for opioid use disorder, and syringe service programs.

PrEP should be discussed and offered to all sexually active persons, all persons requesting PrEP, and anyone who injects nonprescription drugs, uses substances (alcohol, stimulants, opioids), or who has an SUD, without need to limit access to specific criteria for sexual or drug use behavior, or required use of screening tools (evidence rating: AllI).⁹⁴ Populations with disproportionately high HIV incidence rates should be particularly encouraged to consider PrEP as part of their HIV prevention plans. These populations include cisgender men, transgender persons, and nonbinary persons who have sex with cisgender men; young adults and adolescents (up to age 24 years); people whose sexual partners are from regions with high HIV incidence; individuals who report transactional sex; persons who use or inject drugs; incarcerated persons and their partners; and anyone with an STI acquired in the past year (evidence rating: AllA).

Recommended PrEP Regimen

Current PrEP agent options for a given individual based on population and risk behavior are provided in **Box 6** and **Table 4**.

The optimal PrEP regimen for a given person is the one that is most acceptable and congruent with their routes of potential HIV exposure; preference for modality of administration, including ability to take oral tablets reliably; ability to plan sexual or IDU activity; and adverse effect profile of the regimen. The initially chosen PrEP regimen, and whether ongoing PrEP is needed or of interest, should be reevaluated based on ongoing assessments of the same issues.

Table 4. Recommendations for Currently Approved Biomedical HIV Prevention by Type of Exposure^a

Type of exposure	Daily TDF/FTC	On-demand ("2-1-1") TDF/FTC	Daily TAF/FTC	Every-other-month intramuscular long-acting cabotegravir ^b
Insertive anal/vaginal sex	✓	✓	✓	✓
Receptive anal sex	✓	✓	✓	✓
Receptive vaginal sex	✓			✓
Receptive neovaginal sex	✓			✓
Injection drug use ^c	✓			
Recommended for pregnant and breastfeeding women	✓			✓
Initiate with a double dose	✓	✓		
Recommended for individuals with reduced creatinine clearance (30-60 mL/min) or who have osteopenia or osteoporosis			✓	✓

Abbreviations: FTC, emtricitabine; TAF, tenofovir alafenamide; TDF, tenofovir disoproxil fumarate.

^a Adapted from Gandhi et al.²

^b Additional recommendations for long-acting cabotegravir: An optional 4- to 5-week oral lead-in is available before starting injections and is recommended for individuals with severe atopic histories or on request. The oral lead-in is not recommended for those who have difficulty adhering to daily oral dosing. Overlapping the first injection with 7 days of oral preexposure prophylaxis (PrEP) is recommended for maximal protection. Oral cabotegravir tablets are recommended for the overlap if an oral cabotegravir lead-in is used to initiate long-acting cabotegravir; otherwise tenofovir-containing oral PrEP can be

used for the overlap. Providing a 1-month supply of tenofovir-based oral PrEP is recommended for injection delays exceeding 7 days. Administer gluteal injections at 600 mg, with the first 2 injections spaced 4 weeks apart and subsequent injections every 8 weeks. If injections are delayed by 8 weeks or more, resume with 2 injections 4 weeks apart before returning to the every-8-weeks schedule. If long-acting cabotegravir is discontinued but HIV protection is still required, transitioning to an alternative prevention method is recommended.

^c Persons who inject drugs should also be assessed for sexual routes of exposure to HIV, and PrEP choice made considering that route of exposure as well (see text for the strength of the recommendations and quality of the data).

Oral PrEP

Daily oral TDF/FTC (including generic tenofovir disoproxil fumarate formulations) remains a recommended oral PrEP regimen for all populations likely to be exposed to HIV (evidence rating: A1a) (Box 6 and Table 4). Daily oral dosing should be initiated with a double dose of TDF/FTC followed by a single tablet thereafter. When discontinuing, daily dosing should continue until 2 doses after last sexual activity for rectal exposures. For vaginal, neovaginal, or "front-hole" exposures, a similar double dose of TDF/FTC is recommended to initiate dosing, with dosing to be continued until at least 7 days after last sexual activity (evidence rating: BIII). Recent data suggest that 4 or more doses per week on average will provide high-level protection against both rectal and vaginal HIV acquisition; for rectal exposures, 2 or more doses per week is estimated to provide 79% to 88% reduction in probability of HIV acquisition.^{95,96}

TDF/FTC daily oral PrEP is also the recommended oral regimen for people who are pregnant or breast/chest feeding (evidence rating: AIIa). Long-acting cabotegravir has a growing and robust safety and pharmacokinetic profile in pregnancy and breast/chest feeding, and can be used safely in these settings (evidence rating: BIIa).⁹⁷

On-demand (2-1-1) oral dosing of TDF/FTC is recommended for cisgender men (evidence rating: AIa) and others (evidence rating: AIII) having planned receptive anal (but not receptive vaginal or neovaginal) sex. On-demand dosing is initiated with a double dose of TDF/FTC 2 to 24 hours before sexual activity, followed by single additional doses of TDF/FTC 24 and 48 hours after the first dose. If additional sexual activity occurs after the initial sex event, daily single dosing should be continued until 2 doses after the last activity. Of note, with 2-1-1 dosing, TDF/FTC should be administered with food for transgender women using gender-affirming hormone therapy, because rectal tissue concentrations of tenofovir-diphosphate

(TFV-DP) may be lower early after starting 2-1-1 regimens, which can be largely mitigated by dosing with food.² Insufficient data exist to support on-demand use to prevent HIV acquisition through IDU alone or through vaginal exposures.

Daily oral TAF/FTC use should be limited to cisgender men and others whose exposures do not include receptive vaginal sex (including neovaginal sex) or IDU alone (evidence rating: AIa). Daily TAF/FTC is recommended for individuals with creatinine clearance between 30 and 60 mL/min and for individuals with known osteopenia or osteoporosis (evidence rating: AIa). Bone density scans are not necessary before initiating tenofovir-based PrEP (evidence rating: AIII).

Details for prescribing oral PrEP regimens are in Table 4 of the 2022 guidelines.²

Rapid PrEP Start

Any delay in starting PrEP in an individual likely to be exposed to HIV may be a missed opportunity to prevent HIV acquisition. If negative HIV serologic test results are available from blood drawn within 7 days or a rapid (point-of-care) HIV antibody test result is negative on the day of PrEP initiation, PrEP initiation is recommended while awaiting additional diagnostics and safety assessments (evidence rating: AIIa); see below for details of recommended laboratory testing at PrEP initiation. Absent signs/symptoms of acute or primary HIV infection, if a rapid or laboratory-based HIV test result within the past 7 days is not available, such testing is recommended. PrEP may be initiated remotely without the need for an additional clinic visit once baseline HIV tests have been confirmed to have negative results (evidence rating: BIII). If there is a concern for substantial HIV exposure within the past 72 hours, a 3-drug postexposure prophylaxis (PEP) regimen is recommended (evidence rating: AIIa) for a duration of 28 days, with seamless transition to PrEP after PEP completion, if an

HIV test (ideally an antigen/antibody and RNA assay) result at the conclusion of PrEP is negative (evidence rating: AllA).

Injectable PrEP

Long-acting cabotegravir received regulatory approval for the prevention of sexual acquisition of HIV across populations based on 2 large randomized clinical trials and is recommended for people likely to be exposed to HIV sexually (evidence rating: AllA).² Data do not exist for use in injection drug exposures but PWID may also be exposed to HIV through sexual routes; therefore, the use of long-acting cabotegravir PrEP is recommended in PWID who are at risk for acquiring HIV through sexual exposures (evidence rating: AllI).

An oral cabotegravir lead-in of 4 to 5 weeks is optional prior to initiating long-acting cabotegravir injections. However, the oral lead-in is recommended for those with severe atopic histories or those who request it (evidence rating: BIII). An oral lead-in is not recommended in those challenged by adhering to daily dosing of oral tablets (evidence rating: AllA). To allow time for maximal protection from long-acting cabotegravir after first injection, an oral PrEP regimen to overlap the first injection by 7 days is recommended (evidence rating: BIII). This overlap is recommended with oral cabotegravir tablets for those transitioning to long-acting cabotegravir from an oral cabotegravir lead-in (evidence rating: BIII). For those initiating long-acting cabotegravir from no recent oral PrEP or without interruption from a tenofovir-based oral PrEP regimen, initiation or continuation of an exposure-appropriate tenofovir-based PrEP regimen is recommended for the overlap period (evidence rating: BIII). Persons receiving long-acting cabotegravir should have a 1-month supply of an appropriate tenofovir-based oral PrEP agent in hand for oral bridging in the case of injection delays of 7 days or more (evidence rating: BIII).

Injections by gluteal administration are recommended at a dose of 600 mg (3 mL), with the first 2 injections separated by 4 weeks and subsequent injections by 8 weeks (evidence rating: AllA). Because the timing of onset of protection is unknown but is likely to be approximately 7 days after first injection, barrier protection or a tenofovir-based oral regimen as noted above is recommended in the first week of the first injection cycle. There are insufficient data to recommend use of any alternative injection site; anterior thigh injections did not reach pharmacokinetic targets with repeated 2-month interval injections and had poor tolerability.^{98,99} If injections are to be resumed 8 or more weeks late (that is, 12 or more weeks from previous for injection 2, or 16 or more weeks from previous for injections 3 and beyond), "reloading" is recommended, with a 4-week interval between the 2 injections after the hiatus before returning to every-8-week dosing (evidence rating: AllA). This guidance for the interval of delay requiring reloading is distinct from the current FDA package insert.^{100,101}

For individuals who are stopping injectable PrEP but continue to need protection against HIV acquisition, transition is recommended to another form of HIV prevention (evidence rating: AllI), including (but not limited to) a tenofovir-based oral PrEP regimen appropriate for the individual and their exposures. That regimen, or best available nonpharmacologic HIV prevention strategies, should be continued as long as the exposures continue.

Dose adjustment of rifabutin is recommended if it is coadministered with long-acting cabotegravir, and long-acting cabotegravir should not be used with potent inducers of UGT1A1 (evidence rat-

ing: AllA for both) (Table 4 in the 2022 guidelines).² Also, long-acting cabotegravir should be used with caution in individuals with gluteal implants or fillers.

The PURPOSE-1 study, in which lenacapavir was administered as an every-6-month subcutaneous injection, found no detected HIV infections among cisgender women in Southern and Eastern Africa, in a population in which the background HIV incidence was approximately 2.41 per 100 person-years. The similarly designed PURPOSE-2 trial in cisgender men, transgender people, and nonbinary individuals had only 2 incident HIV infections (HIV incidence 0.10/100 person-years) in a population with an estimated HIV incidence of 2.37 per 100 person-years (96% reduction in HIV incidence).^{102,103} After approval by regulatory authorities and when available, lenacapavir is recommended for prevention of HIV infection for all routes of sexual exposure (evidence rating: AllA). The first subcutaneous injection should be overlapped with 2 daily oral doses of lenacapavir (600 mg) (evidence rating: AllA). There are ongoing trials of lenacapavir for PrEP in other populations.

Both injectable cabotegravir and injectable lenacapavir have been associated with injection site reactions, which often diminish in severity over time.

Laboratory Testing

Frequency and type of safety laboratory testing by PrEP regimen is provided in Table 4 in the 2022 guidelines,² with one important update. HIV screening should include a fourth- or fifth-generation laboratory-based antigen-antibody assay for all tenofovir-based PrEP regimens. HIV screening at initiation (or resumption after a hiatus of 6 months or longer with long-acting cabotegravir or of more than 14 days with tenofovir-based oral PrEP) should ideally include an HIV RNA (viral load) test with a lower limit of quantification of 50 copies/mL or lower and a laboratory-based antigen-antibody test (evidence rating: AllA). For oral and injectable PrEP, if HIV RNA testing is not available or not feasible, PrEP is still recommended after a rapid point-of-care HIV antibody test and while awaiting a laboratory-based antigen/antibody test (evidence rating: BIII).¹⁰⁴ With a negative rapid antibody test result, dosing of tenofovir-based oral PrEP or long-acting cabotegravir may begin while awaiting laboratory test results. Follow-up testing for cabotegravir PrEP breakthrough infections should not routinely include HIV RNA testing but should include a point-of-care rapid HIV antibody test and a laboratory-based antigen/antibody test. RNA testing as part of routine monitoring for PrEP failure is not recommended because such testing has a low positive predictive value and false-positive results have significant negative sequelae (evidence rating: AllB).¹⁰⁵ With the use of tenofovir-based oral PrEP, if an HIV RNA test is not available at PrEP initiation or resumption after a hiatus, as noted above, available antigen/antibody testing should be repeated at a visit 1 month after starting or restarting the oral PrEP regimen (evidence rating: AllI).

Diagnosis of HIV in the setting of PrEP failure can be challenging, particularly when using long-acting PrEP agents, due to delayed and inconsistent detection of viremia, antigen, and antibodies, termed *LEVI* (long-acting early viral inhibition).¹⁰⁰ Discordant or difficult-to-interpret HIV test results should be discussed with experts, including at the PrEP Warmline at the US National Clinician Consultation Center at 1-(855)-HIVPrEP in the US.¹⁰⁶ In the setting of long-acting cabotegravir PrEP, 2 sequential testing algorithm

results in which HIV RNA is detected, at any level (even if below the limit of quantification of the assay), is highly predictive of true HIV infection.¹⁰⁵

Adherence and Persistence/Retention

Individuals with high likelihood of HIV exposure are also among the most challenged by adhering to and persisting with PrEP medication and services, with high rates of loss to follow-up after 12 to 18 months in key populations. Various structural barriers contribute to these findings, which appear to also be applicable to long-acting cabotegravir PrEP.^{107,108} PrEP adherence and persistence/retention should be supported through techniques such as PrEP navigators where available; video telehealth; smartphone-based reminders for pill-taking or injections; use of mobile health units or mobile retail pharmacies^{93,109}; peer support/administration; community health worker/visiting nurse/ pharmacy administration services to deliver PrEP; and more conventional strategies such as pill boxes and adherence check-ins by telephone or short message service.

ART Choice for PrEP Breakthrough Infections

See the Antiretroviral Therapy for Individuals With HIV section above.

Postexposure Prophylaxis

Recommendations for PEP remain the same as in the 2022 IAS-USA guidelines.² All individuals completing PEP for nonoccupational exposure indications should be assessed for ongoing HIV exposure. If potential for HIV exposure persists, the individual should be transitioned without interruption to PrEP.

Prevention of Bacterial STIs

Doxycycline (200 mg) taken after condomless anal or oral sex (doxyPEP) is recommended for gay, bisexual, and other men who have sex with men (MSM) and transgender women with a diagnosis of gonorrhea, chlamydia, or syphilis within the past 12 months, given data that it reduces the incidence of bacterial STIs in these populations regardless of HIV status (evidence rating: Aa). DoxyPEP is also recommended, using a shared decision-making approach, for MSM and transgender women who have not had a bacterial STI during the previous year but have a high likelihood of condomless exposure to STIs (evidence rating: AIII). Initiating oral doxyPEP is recommended as quickly as possible (but certainly within 72 hours) after condomless sexual exposure for cisgender MSM and transgender women (evidence rating: Aa).^{110,111} This intervention reduces the incidence of chlamydia by 70% to 88% and early syphilis by 73% to 87%. Effects on gonorrhea are less and inconsistent, presumably due to high rates of tetracycline resistance. Dosing may be taken as frequently as daily (evidence rating: BII). One study of doxyPEP for cisgender women in Kenya did not show a protective effect, but drug levels suggested low adherence. Pharmacokinetic modeling suggests that doxyPEP should be effective for vaginal exposures and should be considered on a case-by-case basis with individuals with likelihood of STI acquisition via vaginal exposure (evidence rating: BIII).¹¹²

DoxyPEP prescriptions are recommended in quantities of 30 doses (60 tablets/capsules) at a time (evidence rating: CIII). Screening of sites/orifices with sexual contact as well as blood testing for syphilis is recommended quarterly (evidence rating: Aa). It should be noted that there is concern that break-

through syphilis infections in the setting of doxyPEP may have aberrant or attenuated rapid plasma reagin characteristics, although limited data are currently available on this topic. Complex cases should be discussed with local public health or STI experts. In the US, practitioners may contact the STI consultation service at the Centers for Disease Control and Prevention (CDC) by calling +1-800-232-4636 or via electronic submission at <http://www.STDCCN.org/>. The long-term effects on gonococcal (and other) bacterial resistance to tetracyclines remains an unresolved issue and should be monitored.

Although observational data suggest that the meningitis B vaccine may be associated with reduced incidence of gonorrheal infections, a randomized clinical trial did not show a statistically significant effect on gonorrhea incidence among cisgender MSM in France.¹¹¹ Additional trials are ongoing across populations, but there are insufficient data to recommend use of the meningitis B vaccine for gonorrhea prevention at this time.

Promoting Equity in HIV Treatment and Prevention

Despite a 39% reduction in new HIV diagnoses globally, new HIV infections are still on the rise in eastern Europe, Central Asia, Latin America, the Middle East, and North Africa.¹¹³ In the US, HIV disproportionately affects Black and Hispanic people, those who live in the Southern US, cisgender gay and bisexual men and transgender individuals, and people who use drugs.¹¹⁴ In a CDC analysis that included only sex assigned at birth and not gender identity,¹¹⁵ from 2017 to 2021, there was a significant increase in Black-White relative disparities and for males aged 13 to 24 years and males living in the Western US. This increase over time was predominantly driven by transmission via male-to-male sexual contact (6%), injection drug use (175% in those assigned male at birth, 68% in those assigned female at birth), and those reporting male-to-male sexual contact and IDU (12%).¹¹⁵ Populations born outside the US have a higher prevalence of HIV than the population born in the US and may present with advanced disease; therefore, testing for HIV and linkage to care are essential.¹¹⁶ In the European Union and European Economic Area, 44% of new diagnoses in 2019 were among individuals born outside of Europe.^{117,118}

Inadequate global rollout of PrEP and disparities in PrEP utilization limit its effect on reducing HIV acquisition.¹¹⁹ Moreover, the lack of availability of long-acting cabotegravir for PrEP, its cost, and the implementation complexity will likely widen disparities. In middle-income countries, which are usually out of the Medicine Patent Pool, an estimated 2.4 million people who might benefit from long-acting cabotegravir will not have access to it.¹¹⁹ With the advent of effective injectables for PrEP (eg, long-acting cabotegravir currently; lenacapavir in the future), a global commitment to universal access is crucial for equitable implementation and scale-up.

Criminalization laws, such as those in Uganda against LGBTQ+ individuals,¹²⁰ policies that criminalize harm reduction and drug use, and those that limit female reproductive health¹²¹ and transgender hormone-affirming care in the US, are examples of hostile public policies that worsen inequities and disparities while restricting access to care and prevention.¹²²

Ending the HIV epidemic for all will require resources as well as policies to address societal disparities, measures to reduce stigma as a root cause of HIV risk, and elimination of laws that target people with and at risk for HIV.¹²³

Future Directions in ART and Prevention

Antiretroviral Therapy

New long-acting ART regimens are on the horizon. As of October 2024, only 1 long-acting injectable ART regimen (long-acting cabotegravir plus long-acting rilpivirine) is available either once monthly or every other month. Other strategies are in clinical development, including a once-weekly combination of islatravir and lenacapavir. The initial investigation of this combination was stopped when higher doses of islatravir were associated with lymphopenia.¹²⁴ In a follow-up phase 2b investigation at a lower (2 mg) weekly dose of islatravir, the combination maintained a high rate of viral suppression at 48 weeks that was similar to that of BIC/TAF/FTC, with no effect on lymphocyte count.¹²⁵ Several exploratory studies of long-acting broadly neutralizing antibodies (bNAbs) to maintain HIV RNA suppression in people with HIV switching off oral therapy have been presented, including 2 bNAbs with lenacapavir^{126,127} and a single bNAb with cabotegravir.¹²⁸ The combination of the 2 bNAbs with lenacapavir is an every-6-months regimen and is now being tested in a phase 2b trial in which people with suppressed virus with use of oral ART are randomly assigned to switch to the every-6-months regimen or remain using their oral regimen (NCT05729568).

Simplifying ART has been a consistent goal over the last decade. A single daily pill of LEN/BIC is being studied in a phase 3 trial in persons with multidrug-resistant virus without known integrase resistance who are taking multiple drug/multiple pill regimens. The phase 2b study of the 2 agents given separately effectively maintained suppression at a high rate that was comparable to continued oral multiple agent therapy.¹²⁹

Preexposure Prophylaxis

MK-8527, a nucleoside reverse transcriptase translocation inhibitor, is in phase 2 clinical trials as a monthly oral tablet. Lenacapavir is also being studied for HIV prevention in cisgender women and PWID in the US (NCT06101329, NCT06101342), but it is unclear if the data from PWID will be sufficient or available at the time of initial regulatory approvals. Combinations of intravenous and

subcutaneously administered long-acting broadly neutralizing antibodies (passive immunization) are in development for HIV prevention. Vaginal rings containing tenofovir or dapivirine that would be expected to last for 3 months or more, with potential for also providing hormonal contraception in the same product, are in earlier stages of development; a 1-month dapivirine vaginal ring has not been approved by the FDA despite a recommendation by the World Health Organization. A novel formulation of long-acting cabotegravir to be administered intramuscularly at 4-month intervals is currently in clinical trials.

Limitations

There are several limitations to these recommendations. First, the recommendations were developed for high- and medium-income settings, in which most of the drugs and tools are available. The recommendations may not be applicable in all low-income settings. Second, the approach to HIV treatment and prevention continues to rapidly evolve, necessitating frequent updates to these guidelines. For example, the landscape of treatment and prevention is likely to change as additional long-acting injectable options become available.

Conclusions

HIV therapy continues to improve, with well-tolerated and highly effective oral regimens as well as long-acting injectable treatment for people who prefer to not take, or who have difficulty adhering to, daily therapy. In addition, there are new approaches to maintaining health in people with HIV, including expanded indications for statins to reduce cardiovascular events and a new biomedical strategy, doxyPEP, to decrease STIs. HIV prevention through daily oral PrEP or long-acting injectables are crucial tools for ending the HIV epidemic in the US and around the world. However, although the tools are available, efforts must be redoubled to reduce disparities and address inequities to realize the promise of ending the HIV epidemic.

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