ART During Pregnancy GUIDANCE FOR MEDICAL PROVIDERS

- Among persons with HIV, approximately 68% of pregnancies are unplanned.[1]
  - Continually discuss reproductive desires with persons of childbearing potential.
    - Support shared decision-making about ART.[1]
  - Offer contraception as appropriate.
    - Scan the QR code to the right for more guidance regarding contraceptives.

Scan here for guidance on drug interactions between ART and hormonal contraceptives.

National Clinical Consultation Center: Perinatal HIV/AIDS: 888-HIV-8765 (888-448-8765) Available 24/7

DHHS GUIDELINE HIGHLIGHTS: INITIAL REGIMENS FOR PREGNANT PEOPLE WHO ARE ART NAIVE[1]

Preferred Regimens

Dual NRTI Backbones	INSTI + Preferred Dual NRTI	PI + Preferred Dual NRTI
ABC/3TC*[g] HLA-B*5701 negative	DTG Preferred in Acute HIV with TDF or TAF plus FTC or 3TC	ATV/r [g]
TAF + FTC or 3TC TDF + FTC or 3TC	RAL Must be dosed twice daily	DRV/r Must be dosed twice daily

Alternative Regimens

Dual NRTI Backbones	NNRTI + Preferred Dual NRTI
ZDV/3TC	EFV [g] Screen for depression antenatal and postpartum
	RPV Not recommended with VL > 100,000 copies/mL or CD < 200 cells/mm^3 Viral rebound possible in 2nd/3rd trimester, consider monitoring VL more frequently (every 1-2 months)

Not Recommended

ATV/c, DRV/c, EVG/c	Changes in pharmacokinetics in 2nd/3rd trimesters result in risk of low drug levels, viral breakthroughs have occurred
IM CAB/RPV	Limited data in pregnancy

Insufficient Data

BIC/TAF/FTC	DOR	2 drug regimens (DTG/RPV, DTG/3TC)	IBA

[1]. Panel on Treatment of HIV During Pregnancy and Prevention of Perinatal Transmission. Recommendations for the Use of Antiretroviral Drugs During Pregnancy and Interventions to Reduce Perinatal HIV Transmission in the United States. Available at https://clinicalinfo.hiv.gov/en/guidelines/perinatal. Accessed 3/7/2023 [pages iii, B-1, B-2, C-38, C-150, E11, Table 4, Table 5].

[g] ABC/3TC plus ATV/r or EFV is not recommended if pretreatment HIV RNA is >100,000 copies/mL [1]

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ART During Pregnancy GUIDANCE FOR SPECIFIC SITUATIONS

In general, persons on a fully suppressive, well tolerated regimens who become pregnant should continue their regimens.[1]

- Changes in regimens carry a risk of viral rebound, decisions to change or continue current ART should consider the risks and benefits of each option.

Scan here for full discussion on ART for specific situations - including restarting ART and selecting new ART when regimens are not tolerated or effective.

HIGHLIGHTS FOR CONTINUING ART FOR PEOPLE WHO BECOME PREGNANT ON A FULLY SUPPRESSIVE, WELL-TOLERATED REGIMEN[1]

RPV (oral)	Continue with more frequent viral load monitoring • PK changes in 2nd/3rd trimester can result in low drug levels
DTG/3TC[a]	Switch or add additional agents or Continue with frequent viral load monitoring
DTG/RPV[a]	Continue with frequent viral load monitoring
ATV/c, DRV/c, EVG/c	Continue with frequent viral load monitoring or consider switching • PK changes in 2nd/3rd trimester can result in low drug levels
IM CAB/RPV	Insufficient data, not recommended. Switch to a recommended oral regimen • Timing of switch must factor the long half-life of injectable • Change should occur within 4 weeks of last IM CAB/RPV dose
BIC/TAF/FTC[b]	Insufficient Data
DOR[b]	Insufficient Data
On a regimen with: d4T, ddI, FPV, IDV, NFV, RTV (as sole PI), SQV, TPV, or ABC/ZDV/3TC	These medications should NOT be used in pregnancy. Switch to a recommended regimen.

a No data exists on oral two-drug regimens in pregnancy. DHHS guidelines recommend if pregnant persons present to care on DTG/3TC or DTG/RPV and are virally suppressed, they can continue with more frequent viral load monitoring (every 1-2 months).[1]

b For virally suppressed persons who present to care on regimens with insufficient data (BIC, DOR), providers should weigh whether to continue or change the regimen, as changes carry risk of viral rebound. Viral load should be monitored more frequently if the regimen is continued.[1]

Key: **3TC** = lamivudine; **ABC** = abacavir; **ART** = antiretroviral therapy; **ARV** = antiretroviral; **ATV/c** = atazanavir/cobicistat; **ATV/r** = atazanavir/ritonavir; **BIC** = bictegravir; **CAB** = cabotegravir; **CD4** = CD4 T lymphocyte cell; **d4T** = stavudine; **ddI** = didanosine; **DOR** = doravirine; **DRV** = darunavir; **DRV/c** = darunavir/cobicistat; **DRV/r** = darunavir/ritonavir; **DTG** = dolutegravir; **EFV** = efavirenz; **EVG/c** = elvitegravir/cobicistat; **FPV** = fosamprenavir; **FTC** = emtricitabine; **FTR** = fostemsavir; **IBA** = ibalizumab; **IDV** = indinavir; **IM** = intramuscular; **IM CAB and RPV** = long-acting intramuscular formulations of cabotegravir and rilpivirine; **INSTI** = integrase strand transfer inhibitor; **NFV** = nelfinavir; **NNRTI** = non-nucleoside reverse transcriptase inhibitor; **NRTI** = nucleoside reverse transcriptase inhibitor; **NTD** = neural tube defects; **PI** = protease inhibitor; **PK** = pharmacokinetic; **RAL** = raltegravir; **RPV** = rilpivirine; **RTV** = ritonavir; **SQV** = saquinavir; **TAF** = tenofovir alafenamide; **TDF** = tenofovir disoproxil fumarate; **TPV** = tipranavir; **VL** = Viral load; **ZDV** = zidovudine

A note about Dolutegravir: The latest data from Botswana indicates there is no longer a significant difference in NTDs when comparing DTG to non-DTG containing regimens at time of conception[1]

1. Panel on Treatment of HIV During Pregnancy and Prevention of Perinatal Transmission. Recommendations for the Use of Antiretroviral Drugs During Pregnancy and Interventions to Reduce Perinatal HIV Transmission in the United States. Available at https://clinicalinfo.hiv.gov/en/guidelines/perinatal. Accessed 3/7/2023 [pages iii, B-1, B-2, C-38, C-150, E11, Table 4, Table 5].

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