nPEP PRESCRIBING MYTHS

- **MYTH:** Initiating HIV non-occupational post-exposure prophylaxis (nPEP) anytime within 72 hours after the exposure is equally efficacious (ie, starting 1 hour after the exposure is as effective as starting it 48 or 70 hours after the exposure).

- **REALITY:** To be most efficacious, nPEP should be started as soon as possible after the exposure, but not later than 72 hours after the exposure. Ideally, the first dose should be taken within 1-2 hours after the exposure, & **taken daily for 28 days**.[1-3]

- **MYTH:** Only infectious disease HIV specialists should provide nPEP & nPEP follow-up care.

- **REALITY:** Any provider (MD, DO, NP, PA) can initiate nPEP &/or provide follow-up care for nPEP therapy. Learn more here: aidsetc.org/nPEP

- **MYTH:** HIV antiretroviral (ARV) medications are very toxic, & the side effects & adverse reactions are commonly worse than the potential benefit for individuals at greatest risk of HIV acquisition.

- **REALITY:** ARV medications currently used for nPEP are better tolerated, have milder side effects than former regimens, & are highly efficacious if used as recommended. Initiating nPEP as soon as possible after a substantial risk for HIV acquisition is critical for prevention of new infections. The benefit of nPEP as an HIV prevention method far outweighs the risk of possible medication related side effects.

- **MYTH:** Medication assistance programs only help people without insurance get nPEP.

- **REALITY:** Although nPEP medications are very expensive, currently-recommended nPEP meds can be obtained at no cost for MOST patients regardless of insurance status. These programs are easy to access & eligible individuals are often approved immediately. Ideally, the provider dispenses the **initial dose on site** **&** gives **ENOUGH** extra **doses** to take until the remainder of medications are accessed.

- **MYTH:** nPEP is only indicated in urban settings, as HIV is not an issue in rural communities.

- **REALITY:** The decision to use nPEP should be based on the acquisition risk & NOT on the HIV prevalence in a specific region. In the South, 23% of new HIV diagnoses are in suburban & rural areas, & in the Midwest 21% are suburban or rural—higher proportions than in the Northeast & West. The South's larger & more geographically dispersed population of people living with HIV creates unique challenges for prevention & treatment.[4]

- **MYTH:** It is best not to prescribe nPEP because the person receiving the medication will just continue to engage in risk behaviors & be back for the same prescription again.

- **REALITY:** If someone uses nPEP multiple times, &/or is at a higher risk for acquiring HIV on an ongoing basis, it is an opportunity to discuss moving from nPEP to pre-exposure prophylaxis (PrEP).

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2 Otten RA, et al. Efficacy of postexposure prophylaxis after intravaginal exposure of pig-tailed macaques to a human-derived retrovirus (human immunodeficiency virus type 2). J Virol. 2000 Oct;74(20):9771-5.

3 Beymer MR, et al. Differentiating Nonoccupational Postexposure Prophylaxis Seroconverters and Non-Seroconverters in a Community-Based Clinic in Los Angeles, California. Forum Infect Dis. 2017 Apr 4;4(2):ofx061. doi: 10.1093/ofid/ofx061.

4 https://www.cdc.gov/hiv/statistics/overview/geographicdistribution.html

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