HIV Antiretroviral (ARV) Treatment: Guidelines and Strategies

1. National guidelines for ARV treatment and OI prophylaxis and treatment for HIV-1 infected persons exist (**http://AIDSinfo.nih.gov**) and are updated approximately every 6 months.

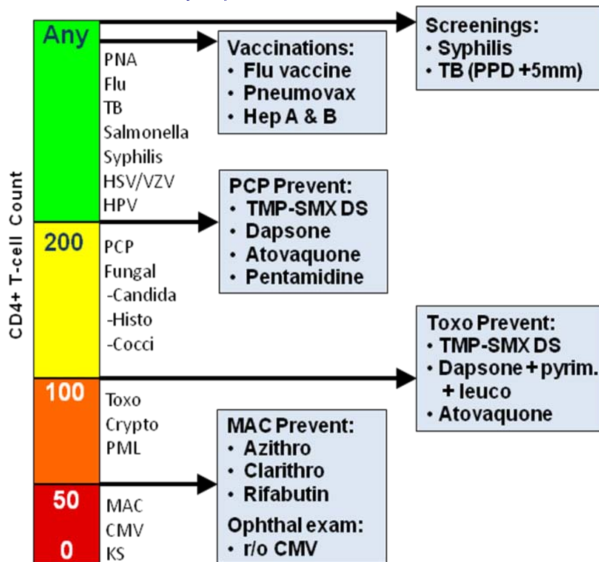
   The National HIV/AIDS Clinicians' Consultation Center is free **Mon.-Fri., 6am-5pm PST:**

   HIV Warmline: 1-800-933-3413

2. When prescribing ARV drugs, assume drug interactions and the need for renal or hepatic dose adjustments, or careful monitoring of ARVs and other meds in relation to renal/hepatic function.
   LOOK THINGS UP OR ASK FOR HELP.

   HIV InSite Database of ARV Drug Interactions:
   http://arv.ucsf.edu

3. It is **URGENT** to **START** HIV-infected persons on recommended OI prophylaxis or treatment. OI prophylaxis is usually started based on CD4 cell counts and/or symptoms:



4. ARV treatment is primarily recommended based on CD4 cell counts and symptoms. HIV RNA (viral load) levels are less important for starting ARVs, but very important for monitoring ARV treatment.

Indications for Initiating ARV Therapy
• History of AIDS-defining illness • CD4 cell count <350 cells/mm^3 • CD4 cell count 350-500 cells/mm^3 • Pregnancy • HIV-associated nephropathy • Co-infection with hepatitis B virus, when treatment for HBV is indicated

5. It is **RARELY EMERGENT** to **START** the first ARV regimen for an asymptomatic HIV-1 infected person.

   However, when ARVs are recommended and accepted by the patient, it is NOT okay to delay.

   Before starting ARVs on a naïve patient, HIV drug resistance should be checked (**genotype test).** If ARV therapy is being resumed a genotype/phenotype may be needed.

6. The necessity for patient adherence to life-long HIV treatment should be discussed in depth. Potential barriers to adherence should be identified and addressed before therapy is initiated.

7. It is **URGENT** to **CONTINUE** ARV therapy once treatment is started. Reasons include:
   1) Preventing resistance.
   2) Preventing an imbalance of drug levels due to drug interactions with ARVs.
   3) Preventing a flare of co-morbid conditions (e.g., hepatitis).

8. Strategies exist to safely stop all ARVs if dangerous side effects occur. The patient may need staged withdrawal, substitution or adjustment of other meds when 1 or more ARVs need to be discontinued.

9. Current DHHS guidelines recommend that **initial** ARV drug combination menus include:
   - 1 NNRTI + 2NRTI **or**
   - 1 PI boosted with ritonavir + 2NRTI **or**
   - Integrase inhibitor + 2 NRTI.

   ARVs are supplied in single-drug and multi-drug combinations. Check both ***brand names*** and ***generic names*** of all medicines to avoid med errors.

10. Detainees may not remember their ARV history, but they often remember where they got the medications or who prescribed them:
    - Patients coming into care from another prison or jail who report being on meds but do not have documentation should have meds verified ASAP.
    - Providers should familiarize themselves with local and regional HIV care providers, networks and support agencies. Intake nurses should identify contacts from feeder facilities and figure out how to best share information (fax, computer, phone).
    - Community providers (should) expect to be called and prefer to be called for accurate ARV history and current regimens. Pharmacies, local HIV/AIDS organizations, and public health departments may have contact numbers.
    - Commercial pharmacies may also be contacted for med lists in the event a community provider cannot be reached.