



DECISION MAKING FOR HIV PrEP PRESCRIBING IN NSW

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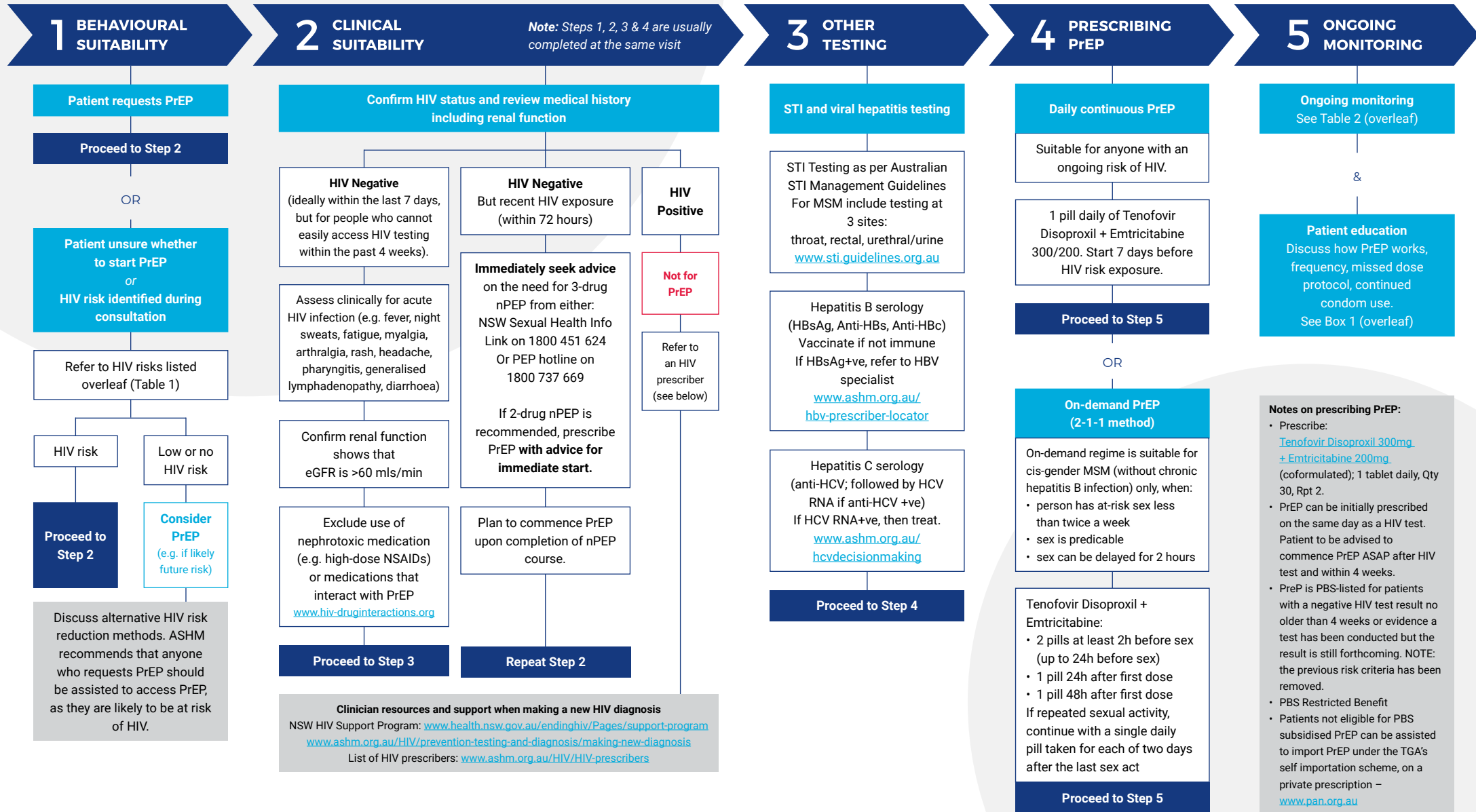


TABLE 1: HIV RISK

Men who have sex with men (MSM)	Trans & gender diverse people	Heterosexual people	People who inject drugs
<ul style="list-style-type: none"> Receptive CLI with any male partner of uncertain HIV status Rectal gonorrhoea, rectal chlamydia or infectious syphilis. Methamphetamine use. CLI with a regular HIV+ partner who is not on treatment and/or has a detectable viral load. 	<ul style="list-style-type: none"> Receptive CLI with any male partner of uncertain HIV status Rectal or vaginal gonorrhoea, chlamydia or infectious syphilis. Methamphetamine use. CLI with a regular HIV+ partner who is not on treatment and/or has a detectable viral load. 	<ul style="list-style-type: none"> Receptive CLI with any MSM partner of uncertain HIV status A woman in a serodiscordant heterosexual relationship, who is planning natural conception in the next 3 months. CLI with a regular HIV+ partner who is not on treatment and/or has a detectable viral load. 	<ul style="list-style-type: none"> Shared injecting equipment with an HIV+ individual or with MSM of uncertain HIV status.

- If a partner is known to be living with HIV, on antiretroviral treatment and has an undetectable viral load, then there is no risk of HIV transmission from this partner.
- The risks listed above confer a **risk of HIV**, and hence should prompt a clinician to recommend that a patient start PrEP. However, this list is not exhaustive, and patients who do not report these circumstances may still benefit from PrEP.
- A person is considered to be at risk if they have had these risks in the previous 3 months, or if they foresee these risks in the upcoming 3 months.

CLI: Condomless intercourse; MSM: Men who have sex with men, **cis-gender men**: assigned male at birth.

BOX 1: PATIENT EDUCATION

- Discuss the role of condoms to prevent STIs, and emphasize role of regular STI testing.
- Discuss safer injecting practices, if applicable.
- Discuss PrEP adherence at every visit.
- Ongoing monitoring every 3 months is required. If adherence is suboptimal then earlier monitoring may be required**
- Discuss potential side effects, early (e.g. headache, nausea) and longer term (e.g. renal toxicity, lowered bone density).
- Ask about nephrotoxic medications, eg NSAIDs.

STOPPING PrEP:

- Only cis-gender MSM taking daily or on-demand PrEP can stop 48 hours after last exposure.
- Non-MSM patients on daily PrEP should continue PrEP for 28 days after last exposure.
- Patients who stop PrEP need a plan to re-start PrEP if their HIV risk increases again.

TABLE 2: LABORATORY EVALUATION AND CLINICAL FOLLOW-UP OF INDIVIDUALS WHO ARE PRESCRIBED PrEP

Test	Baseline (Week 0)	About day 30 after initiating PrEP (optional but recommended in some jurisdictions)	90 days after initiating PrEP	Every subsequent 90 days on PrEP	Other frequency
HIV testing and assessment for signs or symptoms of acute infection	✓	✓	✓	✓	
Assess side effects	✗	✓	✓	✓	
Hepatitis A serology, Vaccinate if non-immune	✓	✗	✗	✗	
Hepatitis B serology, Vaccinate if non-immune	✓	✗	✗	✗	If patient required hepatitis B vaccine at baseline, test anti-HBs at next PrEP visit, at least one month after final vaccine dose
Hepatitis C serology	✓	✗	✗	✗	12 monthly but, more frequently if ongoing risk e.g. non-sterile injection drug use and MSM with sexual practices that pre-dispose to anal trauma
STI (i.e. syphilis, gonorrhoea, chlamydia) as per http://www.sti.guidelines.org.au/	✓	✗	✓	✓	
eGFR at 3 months and then every 6 months	✓	✗	✓	✗	At least every 6 months or according to risk of CKD
Urine protein creatinine ratio (PCR) baseline	✓	✗	✓	✗	Every 6 months
Pregnancy test (for those of child-bearing age and not on effective contraception)	✓	✓	✓	✓	

CKD: chronic kidney disease; eGFR: estimated glomerular filtration rate; PrEP: pre-exposure prophylaxis; PWID: people who inject drugs; STI: sexually transmissible infection