Decision Making in HIV PEP

HIV post-exposure prophylaxis (PEP) is a 28 day course of antiretroviral (ARV) drugs prescribed to reduce the risk of transmission of human immunodeficiency virus (HIV) following HIV exposure.

For complete Australian HIV post-exposure prophylaxis (PEP) guidelines see: pep.guidelines.org.au

FUNDAMENTALS OF HIV PEP PRESCRIBING

- **Start PEP as soon as possible and within 72 hours of exposure.**
- **Take daily for 28 days.**
- PEP is not recommended for any sexual exposure with a person living with HIV with undetectable viral load (U=U) https://www.unaids.org/sites/default/files/media_asset/undetectable-untransmittable_en.pdf
- Provide the whole 28-day course at the initial visit. If a starter-pack is given, ensure there is a clear process for obtaining the remaining supply.
- Order baseline pathology for all people presenting for PEP.
- Provide education on the importance of PEP adherence.
- Strongly encourage transition directly to PrEP after completion of the PEP course where there are likely to be ongoing HIV exposures and/or there have been multiple previous PEP courses.
- Consult with a paediatric ID specialist for minors under 16 years of age.

HIV RISK ASSESSMENT

- Date and time of exposure
- Exposure type
- HIV status of source/partner
- HIV viral load (VL) where source is a person living with HIV
- Co-factors increasing HIV transmission:
  - Detectable HIV VL in the source
  - Uncircumcised status of exposed person for insertive penile-anal and penile-vaginal exposures
  - Presence of blood, trauma, or STI
- Date of last HIV test
- Use of PrEP by exposed person or source (see *Prescribing HIV PEP in the context of PrEP use* box).

MANAGEMENT OF OTHER CONDITIONS

- Test and treat those with STI symptoms empirically www.sti.guidelines.org.au
- Consider Doxy-PEP for STI prevention in MSM sexual exposures https://ashm.org.au/resources/doxy-pep-decision-making-tool/
- Consider hepatitis B immunoglobulin (HBIG) if the exposed person is non-immune and the source has hepatitis B (HBV) https://immunisationhandbook.health.gov.au/
- PEP can safely be commenced in people with HBV. Seek specialist advice for ongoing management.

GP PRESCRIBING OF HIV PEP

- Unlike PrEP, PEP is not PBS listed. However, all GPs can prescribe generic 2-drug PEP on private prescription: Tenofovir disoproxil 300 mg / Emtricitabine 200 mg (28 days, no repeat).
- Contact your local HIV/sexual health/ED/ID specialist if a third drug is required.

TESTING

Test	Baseline	Week 6[A]	Week 12
HIV Ag/Ab	X	X	X
Hepatitis B (HBV) HBsAg, Anti-HBs, Anti-HBc[B]	X		X
Hepatitis C (HCV) Ab[C]	X		X
Chlamydia & gonorrhoea PCR[D]	X	X	X
Syphilis serology[E]	X	X	X
UEC (including eGFR)[F]	X	X	
Pregnancy test[G]	X	X	

[A] Where PEP has not been prescribed (i.e. low risk exposure or outside 72 hour window), a negative HIV test 45 days post exposure is definitive and requires no further follow-up. Recall at 4 weeks if considering transitioning directly to PrEP.

[B] HBV surface antigen; HBV surface antibody; HBV core antibody. PEP can be safely commenced in people with HBV (HBsAg positive). Seek specialist consultation in regard to safely ceasing PEP in those with HBV: https://ashm.org.au/about/news/b-referred/ Non-immune individuals (Anti-HBs <10 mIU/mL) should be offered immunisation and follow-up to 6 months.

[C] Where HCV Ab positive and no known HCV treatment Hx, recall for HCV PCR. Consider PCR and LFT at 6 weeks for occupational exposures.

[D] Sexual exposures. Conduct a full STI screen from all relevant sites as per Hx.

[E] Sexual exposures.

[F] Seek specialist input for recommendation of alternative PEP drugs if eGFR<60.

[G] Consider emergency contraception.

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EXPOSURE AND PEP RECOMMENDATION

Exposure	HIV status unknown	Source known to have HIV	
		Viral load (VL) not detected (<200 copies/mL)	Not on ARVs, VL >200 copies/mL, or VL unknown
PEP for non-occupational exposures			
Receptive anal intercourse with or without ejaculation	Recommend 2 drugs if source is a man who has sex with men (MSM), trans or gender diverse (TGD), or from a high prevalence country (HPC)*	Not recommended†	Recommend 3 drugs
Insertive anal intercourse (uncircumcised)	Recommend 2 drugs if source is MSM, TGD, or from HPC*	Not recommended†	Recommend 3 drugs
Insertive anal intercourse (circumcised)	Consider 2 drugs if source is MSM, TGD, or from HPC* and STI, trauma or blood	Not recommended†	Recommend 3 drugs
Receptive vaginal intercourse	Consider 2 drugs if source is MSM, TGD, or from HPC*	Not recommended†	Recommend 3 drugs
Insertive vaginal intercourse	Consider 2 drugs if source is TGD or from HPC*	Not recommended†	Recommend 3 drugs
Receptive and insertive fellatio or cunnilingus	Not recommended	Not recommended†	Not recommended‡
Semen splash to the eye	Not recommended	Not recommended	Not recommended
Human bite	Not recommended	Not recommended	Not recommended
Shared contaminated injecting equipment	Recommend 2 drugs if source is MSM/TGD or from HPC*	Consider 2 drugs	Recommend 3 drugs
Needlestick injury (NSI) from discarded needle in community	Not recommended	Not applicable	Not applicable
PEP for occupational exposures			
Needlestick or sharps exposure	Consider 2 drugs	Consider 2 drugs§	Recommend 3 drugs
Mucous membrane and non-intact skin	Consider 2 drugs	Consider 2 drugs§	Recommend 3 drugs

* To determine country HIV prevalence, see https://aidsinfo.unaids.org/

† Provided source is adherent to medication, attends regular follow up and has no inter-current STI.

‡ PEP (2 drugs) may be recommended for receptive fellatio with ejaculation if the exposed person has a significant breach in their oral mucosa.

§ Co-factors that may influence decision-making following occupational exposures: (a) deep trauma; (b) bolus of blood injected.

OCCUPATIONAL HIV PEP

- In occupational settings the source is usually able to be tested for HIV. PEP should be initiated while awaiting the source HIV result, and either continued, modified, or ceased based on the result.
- PEP may also be considered where the source has HIV risk factors but cannot be tested.
- PEP should be offered to any healthcare worker with a significant exposure to a source who is known to have HIV.
- It is likely that U=U also applies to occupational exposures, but there is a lack of data to support this currently.

WHAT TO PRESCRIBE

Standard 2-drug regimen*
Tenofovir disoproxil† 300mg / Emtricitabine 200mg
orally daily for 28 days

Standard 3-drug regimen*
As above
plus
Dolutegravir‡ 50mg orally daily for 28 days
For drug-drug interactions go to
https://www.hiv-druginteractions.org/checker

* Prescriptions may be written for 30 days in keeping with pack size.
† Several bioequivalent generic formulations in Australia.
‡ Where use of Dolutegravir is contraindicated use Raltegravir 1200 mg daily.

FURTHER HIV EXPOSURES WHILST ON HIV PEP

Exposure	How long to extend PEP course after most recent exposure
Anal sex	48 hours
Receptive vaginal sex – cis women and TGD persons on gender affirming hormones	7 days
Sharps or blood exposure	28 days

PRESCRIBING HIV PEP IN THE CONTEXT OF PrEP USE

- If exposed person or source has taken PrEP as prescribed*, PEP not required.
- If exposed person or source has not taken PrEP as prescribed*, conduct risk assessment as for person not on PrEP.

* Note: For casual partners, source adherence is often unknown.

RESOURCES AND CONTACTS

GETPEP Website: https://www.getpep.info/

National PEP Guidelines:
https://pep.guidelines.org.au/

PEP Phonelines: VIC 1800 889 887; NSW 1800 737 669; QLD 1343 2584; WA 1300 767 161; SA 1800 022 226

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