TREATMENT

ADOLESCENTS AND ADULTS (≥13 YEARS):

Sexually transmitted GC/CT and trichomonas infections: all meds administered on site by provider[4] - azithromycin I gram PO x I & ceftriaxone 250 mg IM x I & (if risk of vaginitis) metronidazole 2 grams PO x I.

HIV prophylaxis: TDF/FTC 300/200 mg (Truvada®) + dolutegravir 50 mg (Tivicay®) – 1 tab each PO daily x 28 days. If within the first trimester of pregnancy (post-LMP or by ultrasound dating) OR may become pregnant within the next 28 days, prescribe TDF/FTC 300/200mg (Truvada®) 1 tab PO daily + raltegravir 400mg (Isentress®) 1 tab PO twice a day x 28 days.[7,8] Administer first dose on site as soon as possible after rapid HIV negative status obtained[3] or non-rapid HIV test sent. TDF/FTC (Truvada®) should not be used for those with estimated CrCl less than 60 mL/min; an alternative regimen must be used in those circumstances.

Emergency contraception: for persons at risk of pregnancy with a negative pregnancy test. If prescribed dolutegravir, counsel on need for pregnancy prevention while on nPEP.

Administer 1 dose of hepatitis B vaccine (without hepatitis B immune globulin) to persons not previously vaccinated or incompletely vaccinated. If the exposure source is available for testing & is HBsAg positive, unvaccinated nPEP patients should receive both hepatitis B vaccine & hepatitis B immune globulin during the initial evaluation. Follow-up dose(s) should be administered as per vaccine package insert. Previously vaccinated exposed persons who did not receive postvaccination testing should receive a single vaccine booster dose.

For those 9-45 years inclusively, offer first HPV vaccination dose if not adequately vaccinated previously.[9]

BASELINE TESTS TO CONSIDER FOR PERSONS BEING SEEN FOR NONOCCUPATIONAL POST-EXPOSURE PROPHYLAXIS (nPEP):

Gonorrhea & chlamydia (GC/CT)[1] - swabs of all sites of sexual contact including oropharyngeal, rectal, and genital: urine testing may be considered in place of genital testing

Rapid HIV Ag/Ab testing[2,3]

Urine pregnancy test for persons at risk of pregnancy

Routine bloodwork in assessing renal & liver function (serum creatinine, ALT, AST: estimated creatinine clearance)

Syphilis Serology: RPR

Hepatitis B virus surface antigen (HBsAg) for those with known or probable prior HBV infection[10]

IF RAPID HIV TESTING RESULT IS "NEGATIVE" (NON-REACTIVE)[2], OFFER nPEP AND:

For persons at risk of pregnancy with a negative pregnancy test, offer emergency contraception.

For all post-sexual exposures (oral, vaginal, rectal exposures), offer on-site treatment for GC/CT, & for trichomonas (when risk of vaginitis).

INITIAL TREATMENT, PATIENT EDUCATION/ COUNSELING & FOLLOW-UP VISITS:

Follow-up must be scheduled at 72 hours & 4 weeks after initiating nPEP

Possible drug side effects: nausea, GI upset, headache, myalgias

Possible drug interactions: antacids, calcium, iron supplements

Stress adherence importance to nPEP regimen for 28 days without interruption

PrEP[6] initiation immediately after finishing 28-day nPEP prescription for those with ongoing risk

Syphilis serology at 4-6 weeks

HIV Ag/Ab testing at 6 weeks & 3 months after initial non-reactive test

HBV & HCV serology testing at 6 months after initial non-reactive test

FOR PEDIATRIC, DECREASED RENAL FUNCTION OR OTHER INSTRUCTIONS:

- Clinician Consultation Center PEPline at (888)448-4911 for assistance http://nccc.ucsf.edu/
- CDC's 2016 nonoccupational PEP guidelines, Tables 5-6: https://www.cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf.
- International Association of Forensic Nurses National Pediatric Protocol at kidsta.org

Footnotes:

1 For post-sexual assault patients, the need for STI testing should be considered.

2 Preferably a rapid 4th generation (Ag/Ab) test should be done, but if not available, non-rapid HIV testing should be done. If non-rapid testing is done, START nPEP immediately & arrange follow-up in I-2 days for HIV results.

3 If the HIV test is reactive/positive, the person should **NOT** be given nPEP, but be provided supportive counseling & connected to an HIV primary care or specialty care (ID) provider immediately (before being discharged).

4 Ceftriaxone is the recommended treatment for GC & should not be substituted with another antibiotic unless there are clear contraindications for its use. If contraindicated, refer to CDC 2015 STD Treatment guidelines for alternative: https://www.cdc.gov/std/tg2015/gonorrhea.htm

5 All persons offered nPEP should be prescribed a 28-day course of a 3-drug ARV regimen.

6 Pre-exposure prophylaxis (PrEP): contact the Clinician Consultation Center at 1-888-448-7737 for clinician-to-clinician advice.

7 Additional information on the use of dolutegravir in pregnancy can be found at: https://www.gsksource.com/pharma/content/dam/GlaxoSmithKline/US/en/Prescribing_Information/Tivicay/pdf/TIVICAY-PI-PIL.PDF

8 Raltegravir (Isentress®), to be dosed 400 mg PO twice a day, and NOT Isentress HD® 600 mg PO twice a day, for nPEP.

9 Expanded use of Gardasil: https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm622715.htm

10 Severe acute exacerbations of HBV have been reported in HBV-infected people who have discontinued Truvada®): http://www.gilead.com/~/media/Files/pdfs/medicines/hiv/truvada/truvada_pi.pdf

Contact us at info@aidsetc.org for more resources, questions or feedback.

VISIT AIDSETC.ORG

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DPH Georgia Department of Public Health

November 2019

nPEP

POST-SEXUAL EXPOSURE

nPEP

TREATMENT NEEDS POST-SEXUAL EXPOSURE

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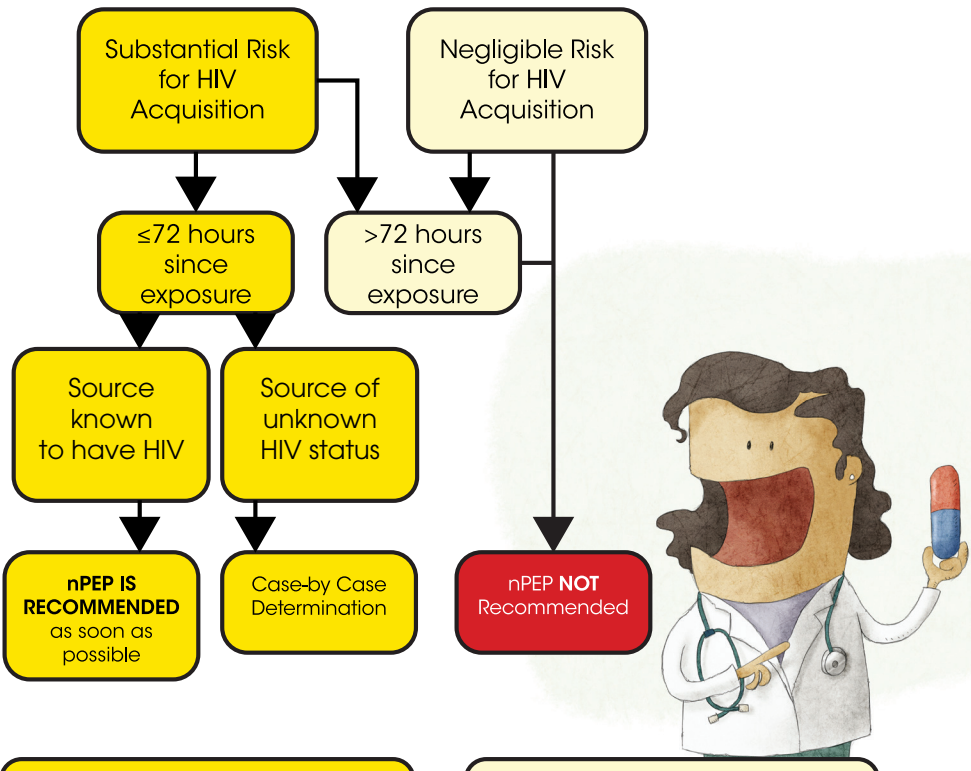

Substantial Risk for HIV Acquisition

Exposure of vagina, rectum, eye, mouth, or other mucous membrane,non-intact skin, or percutaneous contact

With blood, semen, vaginal secretions, rectal secretions, breast milk, or any body fluid that is visibly contaminated with blood

When the source is known to have HIV

Negligible Risk for HIV Acquisition

Exposure of vagina, rectum, eye, mouth, or other mucous membrane, non-intact skin, or percutaneous contact

With urine, nasal secretions, saliva, sweat, or tears if not visibly contaminated with blood

Regardless of the known or suspected HIV status of the source

Additional Information

- Health care providers should evaluate persons rapidly for nPEP when care is sought ≤72 hours after an exposure that presents a substantial risk for HIV acquisition. **The decision to recommend nPEP should not be influenced by the geographic location of the assault/exposure.**
- nPEP is not recommended when care is sought >72 hours after exposure. If >72 hours after exposure, consult with an expert or contact the Clinician Consultation Center PEPline.
- Regimens are available for children, and persons with decreased renal function.
- A case-by-case determination about nPEP is recommended when the HIV infection status of the source of the body fluids is unknown and the reported exposure presents a substantial risk for transmission if the source did have HIV infection.
- Follow-up for people receiving nPEP is important and should be provided by or in consultation with a clinician experienced in managing nPEP. Providers who do not have access to a clinician experienced in providing nPEP follow-up should make linkages with community providers with this experience or contact the Clinician Consultation Center PEPline at (888)448-4911 for assistance http://nccc.ucsf.edu/.

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