

Human Immunodeficiency Virus (HIV) Care Guide



OCTOBER 2025

Information contained in the Care Guide is not a substitute for a health care professional's clinical judgment. Evaluation and treatment should be tailored to the individual patient and the clinical circumstances. Furthermore, using this information will not guarantee a specific outcome for each patient. Refer to "Disclaimer Regarding Care Guides" for further clarification.

<https://cchcs.ca.gov/clinical-resources/>

Contents

SUMMARY..... 3

HIV TESTING ALGORITHM..... 5

MONITORING HIV PATIENTS..... 6

RECOMMENDED IMMUNIZATIONS FOR HIV POSITIVE ADULTS..... 8

 Recommended for All HIV Positive Adults..... 8

 Recommended for Some HIV Positive Adults..... 9

ANTIRETROVIRAL THERAPY (ART): REGIMENS RECOMMENDED FOR TREATMENT - NAIVE PATIENTS..... 10

 RECOMMENDED INITIAL REGIMENS IN PREGNANCY..... 10

 ALTERNATIVE RECOMMENDED INITIAL REGIMENS FOR USE IN CERTAIN CLINICAL SCENARIOS 10

 ALERTS WHEN SELECTING INITIAL REGIMENS FOR PEOPLE WITH CERTAIN CONDITIONS 10

 ANTIRETROVIRAL THERAPY (ART): APPROACH TO TREATMENT FAILURE AND SWITCHING REGIMENS 11

HIV-ASSOCIATED COMORBIDITIES..... 13

PROPHYLAXIS TO PREVENT THE FIRST EPISODE OF OPPORTUNISTIC INFECTION (OI)..... 15

PRESENTATION OF COMMON OPPORTUNISTIC INFECTIONS AND CONDITIONS 17

HIV PRE-EXPOSURE PROPHYLAXIS (PrEP) 18

DOXYCYCLINE FOR STI POST-EXPOSURE PROPHYLAXIS (DoxyPEP) 18

PATIENT NONOCCUPATIONAL POST-EXPOSURE PROPHYLAXIS (nPEP) 19

MEDICATIONS 21

Attachment A: Obtaining and Ordering Anal Cytology 26

Attachment B: Cervical Cancer Screening for Women with HIV 27

Attachment C: HIV Exposure and Potential Transmission Guidance..... 28

Attachment D: HIV/STI Education and Testing Campaign Toolkit..... 31

Attachment E: Public Health Flyers 32

Patient Education (English)..... PE-1 to PE-6

Patient Education (Spanish)..... PE-7 to PE-12

DIAGNOSTIC CRITERIA / EVALUATION (SEE PAGE 5 FOR HIV TESTING ALGORITHM)

*** ALL HIV INFECTED PATIENTS TO BE MANAGED BY A CCHCS HIV SPECIALIST**

Contact the HIV Program mailbox with questions: CPHCSHIVQuestions@cdcr.ca.gov

SUMMARY

GOALS

- Offer HIV screening to all
 - Identify newly diagnosed cases of HIV/Acquired Immunodeficiency Syndrome (AIDS)
 - Identify acute HIV seroconversion
 - Initiate antiretroviral therapy (ART) for all patients with HIV as soon as possible
- Refer all patients with HIV to HIV specialist as soon as possible
- Perform annual sexual history and risk reduction counseling for every patient with HIV
 - Screen and evaluate the patients with substance use disorder (SUD) as a transmission risk factor (see CCHCS Substance Use Disorder Care Guide)
 - Link patients living with HIV to care on parole

ALERTS

INAPPROPRIATE OR SUBOPTIMAL TREATMENT REGIMENS

- Patients receiving only one HIV medication rather than a multi-drug combination (note that some co-formulations exist)
- Patients on treatment with a persistently detectable viral load
- Patients with CD4 <200 cells/mm³ who are not on Pneumocystis jiroveci (PCP) prophylaxis (see page 15)

RED FLAGS

ANY CD4

- New fever
- Weight loss >10%
- Fatigue
- Night sweats

CD4 <200

- Dyspnea
- Cough
- Fever

CD4 <100

- Headache
- Blurry or lost vision
- Diarrhea

DIAGNOSIS

Consider HIV in the following circumstances:

- Patients with known high-risk behaviors prior to or during incarceration (tattoos, injection drug use, sexual exposure)
- Patients with symptoms suggesting acute HIV or immunocompromised state (e.g., unexplained weight loss (>10%), recurring fevers, rashes, diarrhea, enlarged lymph nodes, recurrent infections, thrush)

INITIAL EVALUATION

- | | | |
|---|---|--|
| <ul style="list-style-type: none"> • Date of diagnosis • Transmission risk factors | <ul style="list-style-type: none"> • History of opportunistic infections • Opportunistic infection (OI) prophylaxis • History of tuberculosis/sexually transmitted diseases/RPR • Vaccination history | <ul style="list-style-type: none"> • Smoking/substance use history • Thorough review of systems • Transmission and risk reduction strategies, Sexual risk screen form (340b) • Baseline labs |
| <ul style="list-style-type: none"> • HIV medication, tolerance, and resistance history • Lowest (nadir) CD4 count | | |

TREATMENT**TREATMENT INITIATION AND OPTIONS: WHEN TO START AND WHAT TO USE**

- Do not initiate, change, or discontinue HIV medications without consulting an HIV specialist. (EHRS order: Consult to HIV, Outlook: CPHCSHIVQuestions@cdcr.ca.gov or EHRS HIV message pool)

WHEN TO START HIV TREATMENT:

- ART is recommended for all HIV infected individuals as soon as possible, regardless of CD4 counts. ART should be initiated ONLY in consultation with an HIV specialist. Patients starting ART need to commit to treatment and receive counseling to understand the risks and benefits of treatment and the importance of adherence. Patients and/or providers may elect to defer therapy based on clinical or psychosocial factors. A small proportion of patients may have an undetectable viral load without ART (“elite controllers”). These patients should also be started on ART as soon as possible

WHAT TO USE:

- Monotherapy is NEVER acceptable for HIV treatment. In general, agents from 2 or 3 different classes are used in combination. See page 10 for recommended initial HIV combination treatment regimens. See pages 21-24 for treatment precautions and side effects: noting specific contraindications and interactions between HIV medications and the patient’s existing medications.
- Ensure a sexual history is performed annually and provide risk reduction counseling and education. Order ART and complete the EHRS electronic Sexually Transmitted Infection (STI) Risk Screen under "ADHOC" forms (tab on the top grey banner bar). Education for health care staff on conducting a sexual history can be found on the Center for Disease Control’s website: <https://www.cdc.gov/sti/hcp/clinical-guidance/taking-a-sexual-history.html> or contact the HIV Central Team at the addresses above.

PREVENTION

Who’s at risk: People who inject drugs, people who have unprotected sex, and long-term sex partners of persons with HIV, regardless of the use of protection.

Screening: HIV antigen/antibody (4th generation) and STI screening on all patients upon or soon after arrival, periodically based on risk and STI history (use ad hoc STI screening form), and prior to parole. Repeat HIV testing at least annually is prudent for all patients at risk from sex or Injection Drug Use (IDU).

Education: All patients with HIV should be screened for SUD. Educate on practical risk-reduction techniques with IDU. Counsel on safe sex practices and the availability of condoms at all facilities through self-serve dispensers. Educate on preventable STI vaccines such as Mpox, human papillomavirus (HPV), and hepatitis B virus (HBV).

Intervention: Assess all at risk patients for appropriateness of HIV Pre-Exposure Prophylaxis (PrEP) upon arrival, for any patients with an STI or other risk factors during incarceration, and prior to parole. (See HIV PrEP Care Guide: [PrEP Care Guide](#))

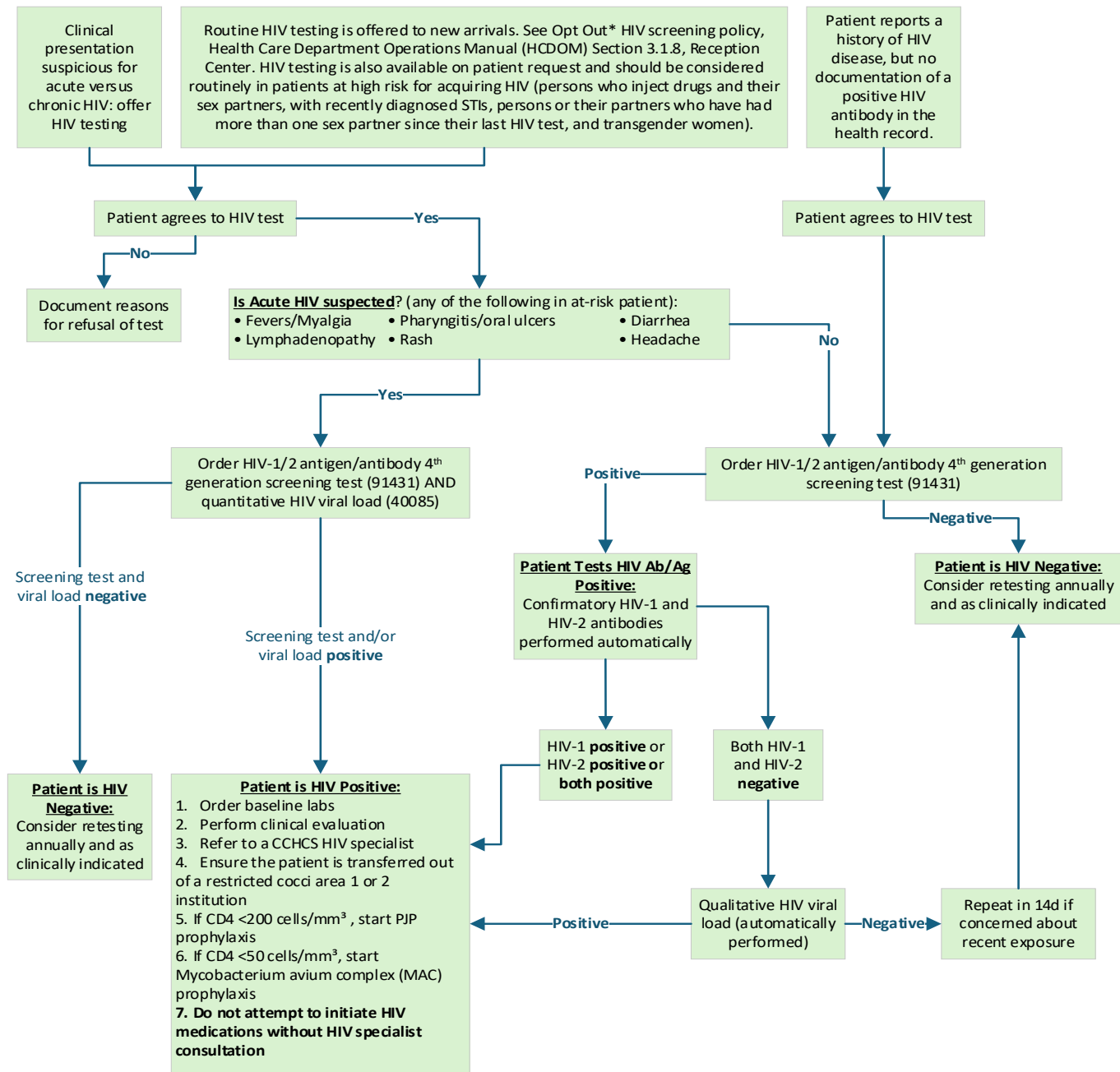
MONITORING

Clinic visits are recommended as clinically indicated during treatment.

Components of the clinical evaluation include:

- Review of systems (fever, weight loss, cough, diarrhea, etc.).
- Physical examination (vitals/BMI, oropharynx, lymph nodes, skin, etc.).
- Initial assessment: date of diagnosis, note CD4, viral load, h/o OI, HIV medication regimen, previous medications.
- Follow up visits quarterly to biannually with viral load monitoring quarterly for first 2 years, then biannually if viral suppression maintained.
- Education: health engagement, discuss risk reduction, adherence.
- Evaluation of health maintenance, immunizations, cardiovascular (CV) risk factor control and CV Risk %, cancer screening, and STI screening.

HIV TESTING ALGORITHM



*Patient has the option to decline HIV test. Signed consent/refusal not required. Patient declination recorded in progress notes.

HIV Screening Test Result Interpretation

HIV-1/2 antigen/antibody 4th generation	Reflex HIV-1 and HIV-2 antibodies	Reflex Qualitative HIV viral load	Diagnosis:
Positive	HIV-1 positive and/or HIV-2 positive	Not performed	HIV Positive
Positive	HIV-1 and HIV-2 negative	Positive	HIV Positive Acute HIV
Positive	HIV-1 and HIV-2 negative	Negative	False Positive HIV Ab/Ag test. No further testing recommended
Negative	Not performed	Not performed	HIV Negative. No further testing recommended

Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in adults and adolescents living with HIV. Department of Health and Human Services. February 27, 2024. Available at <https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/whats-new-guidelines>

MONITORING HIV PATIENTS								
Parameter	Baseline ¹	On Treatment						Treatment Failure
		Starting treatment ²	4-8 wks after start or change	q3-4 mos	q6 mos	Every year	If clinically indicated	At time of failure
CD4 Count (lymphocyte subset panel 5)	✓	✓		✓3	✓3	✓3	✓	✓
HIV Viral Load (HIV-1 RNA Quantitative PCR) (40085)	✓	✓	✓4	✓4	✓4		✓	✓
HIV Genotype (including integrase genes) (91692)	✓5	✓5					✓	✓5
HIV Proviral DNA resistance (94807)							✓6	
HIV Coreceptor Tropism Test (94014)							✓	✓7
CBC with differential and PLT	✓	✓	✓8	✓8	✓8	✓8	✓	
Comprehensive Metabolic Panel	✓	✓	✓		✓	✓	✓	
Random or Fasting Lipid Panel /CVD risk assessment	✓9					✓9	✓9	
Random or Fasting Glucose	✓	✓10				✓10	✓10	
Urinalysis	✓				✓11		✓11	
Serum Phosphorus	✓12	✓12	✓12		✓12		✓12	
Pregnancy Test ¹³	✓13	✓13					✓13	
Rapid Plasma Reagin (RPR)	✓					✓	✓	
Sexually Transmitted Infection Screening/Education form (340b)	✓14					✓14		
Gonorrhea/chlamydia (NAAT)	✓					✓15,16	✓15,16	
Trichomoniasis screen (NAAT)	✓						✓16	
Hepatitis A Antibody total	✓						✓	
Hepatitis B Surface Antibody Immunity Quantitative	✓						✓17	
Hepatitis B Core Antibody Total (Not IGM)	✓						✓	
Hepatitis B Surface Antigen	✓18						✓18	
Hepatitis B Viral Load (DNA)	✓18,19						✓18,19	
Hepatitis C Antibody with Reflex to Viral Load (8472) or Hepatitis C RNA if previously Ab positive (11348)	✓					✓	✓	
Varicella-Zoster Antibody, IgG	✓						✓17	
Toxoplasma Antibody, IgG	✓						✓	
Glucose-6-phosphate dehydrogenase (G6PD)	✓							
HLA-B5701	✓							
TB Screening (TST or IGRA)	✓						✓	
PA and lateral CXR if not in health record	✓						✓	
Cryptococcal Serum Antigen	✓20						✓20	
Measles Titer	✓21							
Anal Cancer Screening	✓22					✓		
Coccidioides Complement Fixation/Immunodiffusion (10567)	✓23				✓23			

Footnotes

1. ART should be instituted as soon as possible after baseline results are available. If treatment is delayed, CD4, CBC, and CMP should be monitored every 3 months and glucose, lipids, RPR/STI screen and CVD risk assessment monitored annually.
2. If ART started soon (2-3 months) after dx/entry into care, repeat not needed.
3. Obtain CD4 every 3-6 months during 1st 2 years of HIV treatment. After 1st 2 years, if CD4 300-500, may increase interval to every 12 months, if CD4 >500, CD4 re-check is optional. If CD4 <300, continue checking every 3-6 months.
4. Obtain HIV viral load every 4-8 weeks after starting treatment until it is undetectable, then every 3-4 months. If consistently undetectable x2 years, may increase interval to every 6 months.
5. Obtain HIV genotype (including integrase genes) at baseline, in people with suboptimal viral load reduction, and at the time of treatment failure (prior to or within 4 weeks of discontinuation of failing regimen).
6. May be useful in patients with undetectable viral load or low-level viremia (where a RNA genotype assay is unlikely to be successful) if planning to change ART.
7. Only obtain tropism testing if considering maraviroc in next HIV regimen.
8. Obtain CBC after ~4 weeks on treatment if on AZT; check CBC if CD4 ordered, and annually.
9. Repeat fasting if abnormal and non-fasting. If abnormal or other cardiovascular risk factors are present, repeat annually, otherwise repeat every 5 years. ASCVD Risk calculators underestimate the risk in persons with HIV. HIV is an independent CV risk enhancer. Moderate intensity statin therapy has been shown to decrease risk for major CVD events by 35% in persons with HIV who are at low to moderate risk by risk calculators. AHA and DHHS guidelines recommend at least moderate intensity statin therapy for persons with HIV aged 40-75 whose 10-year ASCVD risk estimates are 5-20% and high intensity statin for risk >20%. Guidelines favor moderate intensity for those with risk <5%.
10. Repeat fasting if abnormal, non-fasting, and no history of diabetes. If abnormal fasting, check hemoglobin A1C. Repeat annually to screen for diabetes.
11. UA pre-treatment and every 6 months if regimen contains tenofovir; monitor glucose and protein, more often as clinically indicated in patients with CKD.
12. In patients with chronic kidney disease who are on tenofovir disoproxil fumarate (TDF) - containing regimens.
13. In women of childbearing potential.
14. From EHRS banner bar "ADHOC" form tab.
15. Offer annual 3-site testing (urogenital/pharyngeal/rectal) for gonorrhea/chlamydia if clinically indicated.
16. Offer gonorrhea, chlamydia, and trichomonas screening to all patients with vaginal sex in the past 12 months and then annually if ongoing.
17. Confirm Ab response 1-2 mos post vaccination and revaccinate non-responders or those whose immunity wanes (sAb<10). If possible, vaccinate when CD4>200.
18. If a patient has HBV infection (as determined by a positive HBsAg or HBV DNA test result), TDF or TAF plus either FTC or 3TC should be used as part of the ARV regimen to treat both HBV and HIV infection.
19. Check HBV viral load (DNA) if HBV Core Antibody is positive with either negative HBV Surface Antibody or positive HBV Surface Antigen.
20. Consider cryptococcal antigen in patients with CD4 <100 and symptoms or newly diagnosed with HIV without signs of meningitis.
21. Measles titer not needed if born in US prior to 1957 or documentation of previous vaccination.
22. Anal cancer screening should be done for adults ≥35 who are men who have sex with men and transgender women, and all others >45, IF high-resolution anoscopy (HRA) is available (contact HIV team for HRA provider list). See page 10 for management of results and page PE4 for details on how to perform or instruct patients to self-swab.
23. Coccidioides antibody testing should be done at baseline for all patients and q6 monthly if antibody negative and CD4 <250 while residing at institution in cocci endemic areas.

RECOMMENDED IMMUNIZATIONS FOR HIV POSITIVE ADULTS – See CDC and HHS Guidelines Please note that vaccinations can cause a transient increase in HIV viral load within a few weeks after administration. This increase should resolve over time and does not usually indicate the development of antiretroviral drug resistance.		
Immunization Name	Dosage	Comments and Warnings
Recommended for All HIV Positive Adults		
COVID-19	Unvaccinated immunocompromised have series of 3 mRNA or 2 Novavax. Unvaccinated non-immunocompromised have 1 mRNA or 2 Novavax. Check the latest CDC Interim Clinical Considerations and Advisory Committee on Immunization Practices (ACIP) recommendations	<p>All persons with HIV should receive a COVID-19 vaccine regardless of CD4 count or viral load. Guidelines evolve rapidly. Please check current CDC recommendations.</p> <p>For previously unvaccinated persons: (see CDC guidelines for persons who have previously received 1 or more vaccines).</p> <p>Persons with advanced HIV (CD4 <200 and/or OI) or not virally suppressed and other immunocompromised: Pfizer-BioNTech updated (2024-2025 Formula): 3 dose series with first 2 doses 3 weeks apart and 3rd dose at least 4 weeks after 2nd dose. Moderna updated (2024-2025 Formula): 3 dose series with first 2 doses 4 weeks apart and 3rd dose at least 4 weeks after 2nd dose. Novavax updated (2024-2025 Formula): 2 dose series given 3 weeks apart.</p> <p>Persons living with HIV and virally suppressed - as general population: 1 dose of either Moderna or Pfizer-BioNTech updated (2024-2025 Formula) vaccine, OR 2 doses of Novavax 2024-2025 formula vaccine given 3-8 weeks apart (only one Novavax dose needed if previously received 1 or more doses of any vaccine).</p> <p>Note: CDC states that providers who care for moderately or severely immunocompromised patients may administer mRNA COVID-19 vaccines outside of the FDA and CDC dosing intervals based on clinical judgement when the benefits of vaccination are deemed to outweigh the potential and unknown risks.</p>
Hepatitis B Virus (Heplisav)	Two injections over a 1 month period (given at least 4 weeks apart)	Recommended unless: 1. Already immune (Hepatitis BsAb > 10 mIU/mL), 2. Chronic active HBV (Hepatitis BsAg positive). Consider vaccination if isolated HBV cAb positive and HBV DNA/viral load negative. Check Hepatitis BsAb 1-2 months after completion of immunization series. Use current formulary 2 shot series (Example; Heplisav-B®). Additional injections (may be necessary if antibody levels are < 10 after completion of an initial series. For information on interchangeability of vaccine brands, see CDC on Heplisav-B® . Consider waiting for CD4>200 to vaccinate if possible.
Hepatitis A Virus (Havrix, Vaqta)	Two injections 6-12 months apart (Havrix) or 6-18 months apart (Vaqta)	Patients living with HIV should be tested for immunity. Recommended for all non-immune (Hepatitis A IgG negative) HIV infected patients. Note that the HBV/HAV combination vaccine is no longer favored and for those patients with both HAV and HBV non-immune status, use the 2 dose HBV vaccine (see above) and the 2 dose Hepatitis A series (4 shots total).
Influenza	One injection	Should be given every year. Only injectable flu vaccine should be given to those who are positive. The nasal spray vaccine (FluMist®/LAIV) is contraindicated.
Meningococcal (MenACWY)	Two injections; two months apart	Recommended also for college students, military recruits, people who do not have a spleen, and people traveling to certain parts of the world. Revaccinate every 5 years.

<p>Pneumococcal (PCV21)* *PCV13, PCV15, and PPSV23 are no longer available in CDCR. PCV20 is nonformulary</p>	<p>For those who have previously received PCV20, no additional pneumococcal vaccine is needed. For those who have not previously received any pneumococcal vaccine: single dose PCV21. No additional pneumococcal vaccine is needed. For those who have only received PPSV23: 1 dose of PCV21 administered at least one year after the most recent PPSV23 vaccination. For those who have only received PCV13: 1 dose PCV21 at least one year after PCV13. For those who have received PCV13 and 1 dose PPSV23: For ages 19-64, give 1 dose of PCV21 at least 5 years after the last pneumococcal vaccine. For age >65, if PPSV23 was given before age 65, give one dose PCV21 at least 5 years after the last pneumococcal vaccine. If PPSV23 was given at or after age 65, use shared clinical decision-making to decide whether to give 1 dose PCV21, at least 5 years after last pneumococcal vaccine dose. See CDC guidelines for more information and/or utilize CDC VaxAdvisor PneumoRecs</p>	
<p>Tetanus and Diphtheria (Td and Tdap)</p>	<p>One injection</p>	<p>1 dose Tdap, then Td or Tdap booster every 10 years (if at risk wound occurs, boost if last dose > 5 years ago)</p>
<p>Zoster (Shingrix)</p>	<p>Two injections; at least 4 weeks apart (1-6 months)</p>	<p>Recommended for all people with HIV age 18 years old and older and regardless of previous herpes zoster or history of Zostavax (ZVL). Do not give during an acute episode of herpes zoster. Consider delaying vaccination until the patient is virologically suppressed on ART and CD4 count >200 cells/mm³ to maximize response to vaccine. See Jan 2022 CDC MMWR</p>
<p>Recommended for Some HIV Positive Adults</p>		
<p>Human Papillomavirus (Gardasil)</p>	<p>Three injections over 24 weeks (0, 1-2 months, 6 months)</p>	<p>Recommended for HIV infected men and women under 26 years of age. Routine vaccination is not recommended for patients living with HIV between 26-45 years old but can be considered after shared decision making. The two-dose regimen is not recommended in patients living with HIV.</p>
<p>Varicella</p>	<p>Two injections; three months apart</p>	<p>People born before 1980 do not need to receive this vaccine. Recommended for all others unless there is evidence of immunity (IgG) or CD4 count is 200 cells/mm³ or below. Not recommended to be given during pregnancy.</p>
<p>Respiratory Syncytial virus (RSV)</p>	<p>One injection</p>	<p>Recommended for all persons age ≥75 and can be considered for persons ≥60 who are at increased risk for severe RSV disease on the basis of moderate or severe immunocompromise. Adult Immunization Schedule Notes Vaccines & Immunizations CDC</p>
<p>Mpox (Jynneos®)</p>	<p>Two injections 4 weeks apart</p>	<p>Recommended for individuals ≥18 years old with HIV who are at high risk of or who have been exposed to mpox within the past 14 days and for whom vaccination may reduce the risk of infection or decrease symptoms if infection has occurred. JYNNEOS contains live vaccinia virus but is considered safe to use in adults with HIV regardless of viral load or CD4 cell count. See link for most up to date information. Adult Immunization Schedule Notes Vaccines & Immunizations CDC</p>
<p>Measles, Mumps, and Rubella (MMR)</p>	<p>One or two injections</p>	<p>People born before 1957 do not need to receive this vaccine. HIV positive adults with CD4 counts < 200 cells/mm³ or clinical symptoms of HIV should not get the MMR vaccine. Each component can be given separately if needed to achieve adequate antibody titer levels.</p>

ANTIRETROVIRAL THERAPY (ART): REGIMENS RECOMMENDED FOR TREATMENT - NAIVE PATIENTS	
<p>See HHS Guidelines DO NOT initiate, change, or discontinue HIV medications without first consulting an HIV specialist at CPHCSHIVQuestions@cdcr.ca.gov</p>	
<p>RECOMMENDED REGIMENS - Those with optimal and durable efficacy, favorable tolerability and toxicity profile, and ease of use (BOLD = FORMULARY)</p>	
RECOMMENDED INITIAL REGIMENS FOR MOST PEOPLE FOR PEOPLE WHO DO NOT HAVE HISTORY OF USING CABOTEGRAVIR FOR PREP	RECOMMENDED INITIAL REGIMEN FOR PEOPLE WHO DO HAVE HISTORY OF USING CABOTEGRAVIR FOR PREP
<ul style="list-style-type: none"> Bictegravir/emtricitabine/tenofovir alafenamide (Biktarvy[®]) Dolutegravir (Tivicay[®]) <u>with</u> tenofovir alafenamide/ emtricitabine (Descovy[®]) <u>or</u> tenofovir disoproxil fumarate/ emtricitabine (Truvada[®])^{1,2} Dolutegravir/lamivudine (Dovato[®])^{3,2} 	<p>*For people who have used cabotegravir-LA for PrEP, INSTI genotype resistance testing should be performed before starting ART. If ART must be started prior to results, the following regimen is recommended:</p> <ul style="list-style-type: none"> Darunavir/cobicistat <u>or</u> darunavir/ritonavir, <u>with</u> tenofovir alafenamide/ emtricitabine (Descovy[®]) <u>or</u> tenofovir disoproxil fumarate/ emtricitabine (Truvada[®])^{1,2,5}
RECOMMENDED INITIAL REGIMENS IN PREGNANCY	
PEOPLE WHO DO NOT HAVE HISTORY OF USING CABOTEGRAVIR FOR PREP	PEOPLE WHO DO HAVE HISTORY OF USING CABOTEGRAVIR FOR PREP
Dolutegravir <u>with</u> (tenofovir alafenamide <u>or</u> tenofovir disoproxil fumarate) <u>and</u> (emtricitabine <u>or</u> lamivudine) ^{1,2}	Darunavir/ritonavir (given twice daily) <u>with</u> (tenofovir alafenamide <u>or</u> tenofovir disoproxil fumarate) <u>and</u> (emtricitabine <u>or</u> lamivudine) ^{1,2}
Dolutegravir/abacavir/lamivudine (Triumeq [®]) ^{4,2}	Darunavir/ritonavir <u>with</u> abacavir <u>and</u> lamivudine ⁴
ALTERNATIVE RECOMMENDED INITIAL REGIMENS FOR USE IN CERTAIN CLINICAL SCENARIOS	
REGIMEN	CLINICAL SCENARIOS
Dolutegravir/abacavir/lamivudine (Triumeq [®]) ^{4,2}	Chronic Kidney Disease (CKD) or concern about loss of bone mineral density
(Darunavir/cobicistat <u>or</u> darunavir/ritonavir) <u>with</u> tenofovir alafenamide/ emtricitabine (Descovy [®]) <u>or</u> tenofovir disoproxil fumarate/ emtricitabine (Truvada [®]) ^{1,2,5}	Suspected or documented INSTI resistance
(Darunavir/cobicistat <u>or</u> darunavir/ritonavir) <u>with</u> abacavir <u>and</u> lamivudine ^{4,5}	Suspected or documented INSTI resistance <u>and</u> CKD or concern about loss of bone mineral density
Doravirine <u>with</u> (tenofovir alafenamide <u>or</u> tenofovir disoproxil fumarate) <u>and</u> (emtricitabine <u>or</u> lamivudine) ^{1,2}	Suspected or documented INSTI resistance <u>and</u> need to avoid PI-associated drug interactions
Rilpivirine <u>with</u> tenofovir alafenamide <u>and</u> emtricitabine ⁶	Suspected or documented INSTI resistance <u>and</u> need to avoid PI-associated drug interactions and desire single-tablet with NNRTI and tenofovir alafenamide
ALERTS WHEN SELECTING INITIAL REGIMENS FOR PEOPLE WITH CERTAIN CONDITIONS	
CONDITION	ALERTS
Chronic kidney disease	Avoid tenofovir disoproxil fumarate and cobicistat if CrCl < 70, avoid tenofovir alafenamide if CrCl < 30
Hepatitis B coinfection	Use regimen containing tenofovir <u>with</u> (emtricitabine <u>or</u> lamivudine). Switching from a regimen containing these drugs to one without hepatitis B activity can precipitate life-threatening hepatitis flare in patients with occult HBV. Do not use emtricitabine or lamivudine alone.
Osteoporosis	Avoid tenofovir disoproxil fumarate
Cardiovascular disease or high risk for CVD	Consider avoiding abacavir-containing regimens
Hyperlipidemia	Consider avoiding protease inhibitor (darunavir)-based regimens
Depression, anxiety, suicidality	Consider avoiding rilpivirine-containing regimens

Tenofovir: Use with caution in patients with renal insufficiency; **tenofovir disoproxil fumarate** not recommended if CrCL<70; **tenofovir alafenamide** not recommended if CrCL < 30, unless on dialysis.

Tenofovir, emtricitabine, and lamivudine: Are active against hepatitis B (HBV). Switching from a regimen containing these drugs to one without hepatitis B activity can precipitate life-threatening hepatitis flare in patients with occult HBV. Lamivudine has a high resistance rate for HBV and is no longer first line.

Dolutegravir/lamivudine: Do not use in patients with HIV RNA >500,000 copies/mL, HBV coinfection or in whom ART would be started before genotype or HBV testing results are available.

Abacavir and Abacavir/lamivudine and Dolutegravir/Abacavir/ lamivudine: Only for patients without chronic hepatitis B infection. Abacavir should not be used in the patients who test positive for HLA-B5701 due to risk of potentially fatal hypersensitivity syndrome.

Cobicistat: Do not use if retreatment CrCl < 70 mL/min. Cobicistat is potent CYP3A inhibitor and can increase concentration of many drugs. Many drug-drug interactions (DDI) exist.

Rilpivirine: Do not use if pretreatment viral load >100,000copies/mL or CD4 count <200 cells/(mm³).

Guidelines for the use of antiretroviral agents in adults and adolescents with HIV. Department of Health and Human Services. September 12, 2024. Available at <https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/whats-new-guidelines> Antiretroviral Drugs for Treatment and Prevention of HIV Infection in Adults. 2018 Recommendations of the International Antiviral Society-USA Panel. JAMA. July 24, 2018. Available at <https://jamanetwork.com/journals/jama/article-abstract/2688574>.

ANTIRETROVIRAL THERAPY (ART): APPROACH TO TREATMENT FAILURE AND SWITCHING REGIMENS

TREATMENT RESPONSE DEFINITIONS

- **Virologic suppression:** Achieving and maintaining HIV-RNA level below the level of detection of available assays.
- **Low-level viremia (LLV):** HIV-1 plasma viral load above the limit of quantification of clinical assays (20-50 copies/mL), but less than 200 copies/mL.
- **Viral blip:** an episode of LLV that is preceded and followed by suppression below the quantification limit. Usually do not correlate with HIV resistance and unclear if increases risk of virologic failure. Changing ART regimen NOT recommended. Assess adherence and food and drug interactions.
- **Persistent LLV/Non-suppressible viremia:** At least two consecutive episodes of LLV. In some individuals LLV can be persistent-intermittent, with episodic viral load below the limit of quantification and/or detection. Likely due to release of virus from reservoirs and not active replication. Associated with slightly higher risk of future virologic failure, but ART intensification or change is not effective and is not recommended. Assess adherence and food and drug interactions and monitor viral load every 3 months.
- **Virologic failure:** repeated HIV-1 plasma viral load of >200 copies/mL after >6m of ART. Expert consultation is advised. If > 1000 copies/mL, a prompt change in ART is warranted (with consultation and genotyping), **once non-adherence has been ruled out as a cause of failure**.

CAUSES OF VIROLOGIC FAILURE

It is imperative to explore all potential causes of failure and address any adherence problems, barriers to dosing, and drug interactions prior to switching therapy.

Virologic failure may occur with or without drug resistance. Resistance to one or more medications in a regimen may result from transmitted resistance not documented on prior resistance testing, or from acquired resistance resulting from inadequate or inconsistent plasma drug levels.

Causes of low drug levels include:

Malabsorption, drug-food interactions affecting absorption, drug-drug interactions affecting absorption or increasing drug metabolism, poor adherence.

Factors associated with low adherence include:

High pill burden, drug side effects/intolerance, dosing frequency, prescribing and dispensing errors or delays, stigma, SUD, mood and thought disorders, neurocognitive impairment.

CONSIDERATIONS WHEN SELECTING SECOND-LINE OR SALVAGE REGIMENS	
<ul style="list-style-type: none"> • Expert consultation is advised CPHCSHIVQuestions@cdcr.ca.gov • Base decision on patient’s ART history and prior resistance testing history, and results of current resistance testing performed while patient is still taking failing regimen or within 4 weeks of discontinuing (genotype should include INSTI resistance). • Utilize tools to assist in interpretation. HIV Drug Resistance Database (stanford.edu) • When possible, use drugs from classes the patient has not taken before, or new drugs in existing classes that are predicted to be fully active. • Regimen should include at least two fully active drugs, one with a high genetic barrier to resistance (second-generation INSTI or boosted darunavir), when possible. 	<p>If two fully active drugs are not available, include one fully active drug with high resistance barrier and two partially active NRTIs.</p> <ul style="list-style-type: none"> • Despite drug-resistance mutations, some NRTIs, PIs, and second-generation INSTIs may still have partial activity and may be retained as part of a salvage regimen, although dosing of some drugs (e.g. darunavir and dolutegravir) may need to be increased. • If resistance to NNRTIs and first generation INSTIs (elvitegravir and raltegravir) is present, they are not likely to remain active and should be discontinued. • In patients with HBV coinfection, tenofovir should be continued or entecavir should be added. Do not use lamivudine or emtricitabine alone. • Do not interrupt therapy between regimens.
SWITCHING OR SIMPLIFYING REGIMENS FOR PEOPLE WITH VIRAL SUPPRESSION	
<p>People who have consistently undetectable HIV RNA on a regimen have multiple options to optimize regimens to simplify therapy, minimize pill burden, or address side effects / medication intolerance, including opting for injectable ART. Consult HIV Central Team CPHCSHIVQuestions@cdcr.ca.gov and see Optimizing Antiretroviral Therapy in the Setting of Virologic Suppression NIH (hiv.gov)</p>	
LONG-ACTING INJECTABLE CABOTEGRAVIR PLUS RILPIVIRINE (LA-CAB/RPV) (Cabenuva®)	
<p><i>LA CAB/RPV (Cabenuva®) has not been studied in ART-naive participants and is not recommended as initial therapy</i></p>	
<p><u>LA CAB/RPV (Cabenuva®) may be used in people who:</u></p> <ul style="list-style-type: none"> • Have sustained viral suppression for > 3 months. • No history of documented or suspected resistance to either cabotegravir or rilpivirine (consider archived DNA genotyping in people with prior NNRTI exposure). • No active HBV infection (unless continuing tenofovir or entecavir for HBV). • Not pregnant or anticipating pregnancy. • Not paroling in < 6 months. 	<ul style="list-style-type: none"> • LA CAB/RPV requires HIV specialist review and approval. • May be given once monthly or every 2 months, and may be initiated with or without oral lead-in dosing. Loading injection dosing is required. Use Cabenuva powerplans to order. • Rilpivirine has significant DDIs; check Liverpool HIV Interactions (hiv-druginteractions.org) • In the event of missed doses, see label (fda.gov) for dosing or oral bridging recommendations.

HIV-ASSOCIATED COMORBIDITIES		
Overall, persons living with HIV (PLWH) have a higher risk of certain comorbid conditions, <i>even when virologically suppressed</i> , compared with the general population, due, in part, to chronic inflammation and immune activation from HIV, side effects of ART, higher rates of traditional risk factors such as alcohol and tobacco use, and increased risk and pathogenicity of infections associated with cancer. These conditions occur at younger age relative to general population.		
CONDITION	RISK	APPROACH
Anal cancer	Risk increased by 30-fold. Increased risk of high-risk HPV, precancerous lesions, and invasive anal cancer.	Annual anal Pap + high risk HPV (hrHPV) testing for adults ≥35 who are men who have sex with men and transgender women. All others ≥45, regardless of HPV vaccination status, IF high-resolution anoscopy (HRA) is available. If cytology and hrHPV both negative, continue annually. If hr HPV (16/18) or E6/E7 positive, regardless of cytology, refer for HRA. If cytology = ASCUS or LSIL and hrHPV negative, repeat in 12 months. If cytology = HSIL, refer for HRA. If HRA biopsy negative or LSIL, repeat HRA in 1 year. If HRA biopsy=HSIL, treat and repeat HRA every 6 months. If subsequent HRA negative x 2, stop HRA and continue annual testing as above. If HRA is not available, screen all MSM/TG >35 and all others >45 for anorectal symptoms and with digital anorectal exam (DARE). DARE should be performed AFTER cytology collection. Inquire annually about any anal symptoms. Promote smoking cessation. See Attachment A: Obtaining and ordering anal cytology, page 26 , and patient education handouts pages PE 2-3)
Cervical cancer	Risk of cancer increased ~6-fold and increased mortality. Risk increases with decreasing CD4. Increased risk of precancerous lesions.	Pap smear for persons with a cervix < 30 years of age; Pap + HPV testing for women ≥30 years of age per guidelines: See Attachment B, page 27 . Promote smoking cessation.
Other non-AIDS defining cancer	Increased incidence and mortality from Hodgkin lymphoma, liver cancer, lung cancer, thyroid cancer and melanoma. Increased risk of multiple myeloma, leukemia, and cancer of head, neck, bone, brain, intestine, ovary, testis, and pancreas.	Aggressive screening and treatment for cancer-associated infections (HPV, HBV, HCV), and HCC screening in cirrhosis from any cause. Age-appropriate cancer screening per US Preventative Services Task Force (USPSTF) and American Cancer Society guidelines for the general population. Attention to higher rate of tobacco use among PLWH and smoking cessation. Screening and treatment for alcohol use disorder. Use of sunscreen.
Atherosclerotic cardiovascular disease (ASCVD)	Risk of myocardial infarction and stroke approximately double that of general population. Higher rates of hypertension.	Baseline and annual screening with ASCVD risk calculation if additional risk factors are present, otherwise screening every 5 years. AHA and DHHS guidelines recommend at least moderate intensity statin therapy for persons with HIV aged 40-75 years whose 10-year ASCVD risk estimates are 5-20% and high intensity statin for risk >20%. Guidelines favor moderate intensity statin for those with risk <5%. Moderate intensity statin therapy has been shown to decrease risk for major CVD events by 35% in persons with HIV who are at low to moderate risk by risk calculators. Pitavastatin to Prevent Cardiovascular Disease in HIV Infection New England Journal of Medicine (nejm.org) Promote smoking cessation.

CONDITION	RISK	APPROACH
Obesity, Diabetes, and Metabolic dysfunction-associated steatotic liver disease (MASLD)	HIV and treatment with INSTI-based ART associated with increased risk of obesity, and obesity-related morbidities. High prevalence of risk factors for MASLD (hypertension, hyperlipidemia, diabetes). Prevalence of steatosis 30-60%. MASLD may present at lower BMI relative to general population.	<p>Screen patients at risk for MASLD per guidelines with LFTs and FIB4 calculation. [NAFLD Care Guide page 10].</p> <p>Consider MASLD in any patient with abnormal LFTs, after ruling out other causes such as viral hepatitis and consider co-existing MASLD in patients with liver disease from other causes.</p> <p>Risk factor modification and treatment for diabetes, hypertension, hyperlipidemia.</p> <p>Referral to the Central Team [HIV Central Team]. Use of pioglitazone, GLP-1 agonists, vitamin E, and resmetirone in select patients per relevant guidelines [Medical Services - Non-Alcoholic Fatty Liver Disease (NAFLD).pdf - All Documents (sharepoint.com)].</p>
Substance use disorder (SUD)	Higher prevalence relative to general population and polysubstance use common.	<p>Screen all patients for SUD at entry into care with NIDA Quick Screen. Address and explore SUD issues with patients at least annually or as clinically indicated. [Medical Services - SUD-CG.pdf - All Documents (sharepoint.com)]</p>
Mental Health disorders	Increased risk of depression and anxiety disorders	<p>Clinical vigilance and consider screening all patients for depression and anxiety disorder and refer to Mental Health as appropriate.</p>
Age-related frailty and cognitive impairment	Higher rates of osteoporosis, decrease in muscle mass, weight, physical strength, energy, and physical activity; accelerated age-related cognitive impairment and HIV-related neurocognitive disorder.	<p>Clinical vigilance in older patients for signs and symptoms of cognitive decline, early referral for neurocognitive testing.</p> <p>Clinical vigilance and consider screening all patients over 50 for frailty. (download (mass.gov) Attention in older patients to diet, screening for osteopenia/osteoporosis, polypharmacy, mobility impairment, and sensory impairment.</p> <p>Consider baseline bone densitometry (DXA) screening for osteoporosis in postmenopausal women and men aged ≥50 years. There is insufficient evidence to guide recommendations for bone density testing in transgender or nonbinary individuals. Screening for transgender people should follow national recommendations based upon their sex at birth and individualized based on risk for osteoporosis.</p>
Oral Health	Higher rates of periodontal disease, dental caries, and oral candidiasis in uncontrolled HIV.	<p>Annual routine comprehensive dental examination, dental care referral as needed, and oral care education. Promote smoking cessation. <i>Otherwise PLWH do not require special precautions or prophylaxis for dental care beyond standard precautions and routine dental care.</i></p>

Clinical Practice Guidance for Persons With Human Immunodeficiency Virus: 2020 Update by HIVMA/IDSA *Clinical Infectious Diseases*, Volume 73, Issue 11, 1 December 2021, Pages e3572–e3605, <https://doi.org/10.1093/cid/ciaa1391>; Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection: Recommendations for a Public Health Approach. 2nd edition. Geneva: World Health Organization; 2016. 5, CLINICAL GUIDELINES: MANAGING COMMON COINFECTIONS AND COMORBIDITIES. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK374304/>; Considerations for ART use in Special Patient Populations: HIV and the Older Person, Dept Health and Human Services, December, 2019. Found at: [Special Populations: HIV and the Older Person | NIH](#)

PROPHYLAXIS TO PREVENT THE FIRST EPISODE OF OPPORTUNISTIC INFECTION (OI)			
SEE HHS GUIDELINES			
CONDITION	WHEN TO START AND STOP	PREFERRED	ALTERNATIVE
<i>Pneumocystis jiroveci</i> pneumonia (PCP)	<p>START: CD4 count 100 - 200 cells/mm³ if HIV RNA is detectable, or CD4 count < 100 cells/mm³ regardless of HIV RNA</p> <p>STOP: CD4 count increased from <200 cells/mm³ to >200cells/ mm³ for >3 months in response to ART</p> <p>Can consider when CD4 count is 100–200 cells/mm³ and HIV RNA remains below limit of detection of the assay used for ≥3 – 6 months</p> <p>RESTART: If CD4 count <100 cells/mm³ regardless of HIV RNA, or CD4 count 100–200 cells/mm³ and HIV RNA above detection limit of the assay used</p>	<p>Trimethoprim-sulfamethoxazole (TMP-SMX), one double strength orally daily (first choice)</p> <p>or</p> <p>one single strength orally daily</p>	<p>TMP-SMX, orally one double strength three times a week</p> <p>or</p> <p>dapsone 100mg orally once daily or 50mg orally twice daily</p> <p>or</p> <p>dapsone 50mg orally daily and pyrimethamine 50mg orally weekly and leucovorin 25 mg orally weekly</p> <p>or</p> <p>dapsone 200mg orally weekly and pyrimethamine 75mg orally weekly and leucovorin 25 mg orally weekly</p> <p>or</p> <p>Aerosolized pentamidine 300mg via Respigard II® nebulizer every month</p> <p>or</p> <p>atovaquone 1,500mg orally daily</p> <p>or</p> <p>atovaquone 1,500mg and pyrimethamine 25mg and leucovorin 10mg orally daily</p>
<i>Toxoplasma gondii</i> encephalitis	<p>START: Toxoplasma IgG positive patients with CD4 count <100 cells/mm³ Seronegative patients receiving PCP prophylaxis not active against toxoplasmosis should have toxoplasma serology retested if CD4 count declines to <100 cells/mm³</p> <p>STOP: CD4 count increased from <200 cells/mm³ to >200 cells/ mm³ for >3 months in response to ART. Can consider when CD4 count is 100–200 cells/mm³ and HIV RNA remains below limit of detection of the assay used for ≥3 – 6 months</p> <p>RESTART: If CD4 count <100 cells/mm³ regardless of HIV RNA, or CD4 count 100–200 cells/mm³ and HIV RNA above detection limit of the assay used</p>	<p>TMP-SMX, one double strength orally daily</p>	<p>TMP-SMX orally one double strength three times a week</p> <p>or</p> <p>TMP-SMX orally one single strength daily</p> <p>or</p> <p>dapsone 50mg orally daily and pyrimethamine 50mg orally weekly and leucovorin 25mg orally weekly</p> <p>or</p> <p>dapsone 200mg and pyrimethamine 75mg and leucovorin 25mg orally weekly</p> <p>or</p> <p>Atovaquone 1,500mg with/without pyrimethamine 25mg and leucovorin 10 mg orally daily</p>

CONDITION	WHEN TO START AND STOP	PREFERRED	ALTERNATIVE
<i>Mycobacterium tuberculosis</i> (Latent TB infection (LTBI) treatment)	No evidence of active TB disease and: • (+) diagnostic test for LTBI ¹ , and no prior history of treatment for active or latent TB • (-) diagnostic test for LTBI, but close contact with a person with infectious pulmonary TB • history of untreated or inadequately treated healed TB regardless of diagnostic tests for LTBI *Multiple drug-drug interactions exist between RIF, RPT, and HIV medications. Consultation with HIV specialist or pharmacist strongly advised	Rifapentine (RPT) (weight-based dosing: 32.1-49.9 kg: 750 mg; ≥50kg: 900mg) orally once weekly plus isoniazid (INH) 15 mg/kg orally once weekly (900 mg maximum) plus pyridoxine 50 mg orally once weekly for 12 weeks or Isoniazid (INH) 300 mg orally daily plus rifampin (RIF) 600 mg orally daily plus pyridoxine 25–50 mg orally daily for 3 months	Isoniazid (INH) 300 mg orally daily plus pyridoxine 25–50 mg orally daily for 6 to 9 months or Rifampin (RIF) 600mg orally daily for four months or Isoniazid (INH) 300 mg orally daily plus rifapentine (weight based) orally daily plus pyridoxine 25–50 mg PO daily for 4 weeks For persons exposed to drug-resistant TB, selection of drugs after consultation with public health authorities is advised
Disseminated <i>Mycobacterium avium</i> complex (MAC) disease	START: Not on ART or viremic on ART with no options for a suppressive ART regimen AND CD4 count <50 cells/mm ³ after ruling out active MAC infection STOP: Initiation of effective ART RESTART: CD4 count <50 cells/mm ³ <i>only if not on fully suppressive ART</i>	Azithromycin 1,200mg orally once weekly or Clarithromycin 500mg orally twice a day or Azithromycin 600mg orally twice weekly	Rifabutin (RFB) 300mg orally daily (dosage adjustment based on drug-drug interactions with ART); rule out active TB before starting RFB
<i>Coccidioidomycosis</i> disease	START: ONLY indicated for NEWLY positive IgM and/or IgG, and No sign of active coccidioidomycosis, and CD4 count <250 cells/mm ³ STOP: CD4 count ≥250 cells/mm ³ with suppressive ART (with close clinical follow-up)	Fluconazole 400 mg orally once daily	
Primary prophylaxis against the following conditions is NOT recommended: CMV, cryptococcal disease, histoplasmosis infection, candidiasis. For guidance on secondary prophylaxis and treatment of OIs, consult HHS guidelines . For treatment of STI’s including syphilis, see the CDC STI Guidelines .			

¹ Either tuberculin skin test (TST) or interferon gamma release assay (IGRA or Quantiferon)

Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV. Department of Health and Human Services. September 25, 2023.

Available at [HIV Clinical Guidelines: Adult and Adolescent Opportunistic Infections - What's New in the Guidelines](#)

PRESENTATION OF COMMON OPPORTUNISTIC INFECTIONS AND CONDITIONS		
See: HIV Clinical Guidelines: Adult and Adolescent Opportunistic Infections - What's New in the Guidelines Clinicalinfo.HIV.gov		
CD4 Range	Condition	Presentation and Diagnosis
Any CD4	Tuberculosis (TB) Medical Services - Tuberculosis-CG.pdf - All Documents (sharepoint.com)	Fever, weight loss, night sweats, cough. CXR with cavitation, upper lobe disease in CD4>200, but atypical CXR common if CD4<200, with reticulonodular disease, lower lobe disease. Extrapulmonary involvement common with low CD4: lymphadenitis, pleural and pericardial effusion, meningitis. Diagnose with sputum smear/PCR/culture.
	Syphilis Medical Services - STI-CG.pdf - All Documents (sharepoint.com)	Symptoms of primary and secondary syphilis may overlap; rash, fever, arthralgias, headache, lymphadenopathy. More frequent meningeal involvement that may present as only ocular or otic symptoms (uveitis, keratitis, tinnitus, hearing loss). Low threshold for lumbar puncture. Diagnose with treponemal (FTA-ABS) and non-treponemal (RPR/VDRL) serologies.
	Non-Hodgkins lymphoma	Intermediate to high grade disease with lymphadenopathy, extranodal disease (liver, lung, GI, CNS, bone marrow). Fever, weight loss, night sweats. Diagnosis typically by biopsy of node.
≤500	Community-acquired pneumonia	Recurrent infections due to S. pneumoniae., H. influenza, Staphylococcus. With CD4<100, also Pseudomonas, Legionella. Higher rate of bacteremia, particularly with pneumococcal disease. Diagnose with chest imaging, sputum and blood culture, urinary antigen testing.
≤200	Pneumocystis pneumonia (PCP)	Indolent onset of fever, dry cough, progressive dyspnea with exertion. CXR with diffuse, homogenous, bilateral ground-glass interstitial disease spreading outward from hila. Hypoxia, elevated LDH, B-D glucan. Diagnose with induced sputum or BAL for stain, PCR.
	Kaposi's sarcoma	Initially hyperpigmented purple macular or nodular skin lesions, may progress to extremity edema, visceral involvement. Soft palate lesions common. Diagnose with biopsy for histology and cell markers.
	Histoplasmosis	Consider in patients from Mississippi/Ohio river valleys, southern Mexico, Central America. Typically, pulmonary disease with fever, cough, chest pain, weight loss in CD4>300. At lower CD4 more multi organ system involvement (GI, liver, CNS) including fulminant/septic presentation. Diagnose with urine antigen test.
	Bacterial enteric infections	Self-limiting gastroenteritis to prolonged severe bloody diarrhea, fever, weight loss, from Salmonella, Shigella, Campylobacter. Salmonella bacteremia more common, with relapsing disease at lower CD4 counts. Diagnose via stool molecular testing, culture, and blood culture.
	Coccidioidomycosis Medical Services - Cocci Care Guide	Consider in patients from or traveling through endemic area. Focal pneumonia (cough, fever, pleuritic pain) more common with CD4>250, but at lower CD4 increasing diffuse reticulonodular pneumonia, mediastinal lymphadenopathy, osteoarticular disease, meningitis. Diagnose with serology, histology, culture. PLWH should not be housed at institutions in cocci endemic areas. Those at medium risk may request a waiver for placement in cocci 1 institutions if they meet waiver criteria. HIV SharePoint
≤100	Toxoplasmosis	Occurs in patients positive for toxoplasmosis IgG, with focal neurologic findings (weakness), headache, fever, seizure and ring-enhancing lesions on CT or MRI. Diagnosis requires biopsy, but is usually made based on above findings, ruling out other causes, and clinical and imaging responses to empiric therapy.
	Cryptococcal meningitis	Subacute onset of headache, fever, malaise progressing to altered mentation, lethargy, memory loss. Classic meningeal signs only present in minority of patients. Diagnosis by serum and CSF cryptococcal antigen and/or staining, lymphocytic pleocytosis in CSF with elevated opening pressure.
≤50	Mycobacterium avium complex (MAC)	Disseminated disease with fever, weight loss, night sweats, fatigue, diarrhea, abdominal pain. Elevated alkaline phosphatase and disproportionate anemia, hepatosplenomegaly. Diagnose with AFB blood culture (slow growing), with molecular or PCR speciation.
	CMV	Symptoms of retinitis (scotoma, visual field deficits, floaters, decreased acuity), distal esophageal ulcers (odynophagia), colitis (fever, weight loss, abdominal pain, diarrhea). CNS involvement (radiculopathy, myelitis, encephalitis) less common; pneumonitis rare. Diagnosed by retinal exam with typical findings or biopsy of affected GI tract.

HIV PRE-EXPOSURE PROPHYLAXIS (PrEP)

HIV PrEP comprises the use of specific oral or injectable antiretroviral medications to prevent HIV infection in persons who are at significant risk of exposure to HIV through sexual or injection drug use practices. When taken as directed by persons at significant risk, HIV PrEP is ~99% efficacious, well-tolerated, and cost-effective, with minimal toxicity and drug interactions. **See HIV PrEP Mini-Care Guide** for screening, regimens, and monitoring information. Order consult to HIV Central Team utilizing **“STI Prevention/PrEP Consult”** order.

DOXYCYCLINE FOR STI POST-EXPOSURE PROPHYLAXIS (DoxyPEP)

Doxycycline, 200 mg, taken ideally within 24 hours, but no later than 72 hours after condomless oral, anal, or vaginal sex has been shown to substantially reduce the risk of syphilis, chlamydia, and gonorrhea among men who have sex with men and transgender women, both with and without HIV infection. Doxycycline can be taken daily depending on sexual activity, but no more than 200 mg every 24 hours. Screen for GC and CT at all anatomic sites of exposure (urogenital, pharyngeal, and/or rectal), as well as test for syphilis and HIV (if not known PLWH) at initiation of doxy-PEP and every three months. [CDPH Doxy-PEP Recommendations for Prevention of STIs \(ca.gov\)](https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/STI/STI-Prevention/STI-Prevention-Recommendations-for-Prevention-of-STIs.aspx)

PRE-PAROLE PLANNING

- Ensure that patients are seen by Transitional Case Management Team or institutional discharge planner to arrange post-parole follow-up and transition of care.
- Assess post-parole risk for HIV acquisition among HIV-uninfected patients, and risk for STIs and Mpox among all patients and offer HIV Pre-exposure prophylaxis (PrEP), doxycycline for STI post-exposure prophylaxis (DoxyPEP), and Mpox, HPV, HBV and HAV vaccination as appropriate.
 - Utilize **“HIV PrEP/DoxyPEP for Parole” Powerplan** or order consult to HIV Central Team utilizing **“STI Prevention/PrEP Consult”** order.
- Ensure that patients are up to date on health care maintenance and vaccinations for preventable diseases.
- At time of parole, all patients receive: 60-day supply of medications (including ART and MAT), 5 condoms, and naloxone.

Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV. Department of Health and Human Services. September 25, 2023. Available at [HIV Clinical Guidelines: Adult and Adolescent Opportunistic Infections - What's New in the Guidelines | Clinicalinfo.HIV.gov](https://clinicalinfo.hiv.gov/en/guidelines/5909).

PATIENT NONOCCUPATIONAL POST-EXPOSURE PROPHYLAXIS (nPEP)
For employee occupational exposures, contact employee’s supervisor (do not use this Care Guide)
 Refer all patients receiving nPEP to HIV Central Team CPHCSHIVQuestions@cdcr.ca.gov

DIAGNOSTIC CRITERIA/EVALUATION			
Risk Level	HIGHER	LOWER	NEGLIGIBLE RISK
Exposure	<ul style="list-style-type: none"> Receptive or insertive vaginal or anal intercourse Bites with blood exposure Needle sharing Hollow-bore needle sticks 	<ul style="list-style-type: none"> Receptive and insertive oral-vaginal, oral-anal, or oral-penile contact 	<ul style="list-style-type: none"> Kissing Mouth to mouth resuscitation Non-bloody human bites Solid bore needle sticks Percutaneous injury from non-bloody sharps Mutual masturbation without blood or skin breakdown
Source HIV Status	Positive or unknown	YES if: <ul style="list-style-type: none"> HIV positive and HIV viral load is elevated Mucosa is not intact (gingival disease, oral lesions) Blood exposure noted Genital ulcer disease Otherwise: NO	Any negative, positive or unknown
nPEP Warranted?	YES		NO

TREATMENT OPTIONS (Use EHR PowerPlans: HIV POST-exposure prophylaxis—Exposed patient and Potential HIV exposure—evaluation of source patient)

***Start nPEP Within 72 Hours Of Exposure For 28 Days**
Preferred Regimens For Post Exposure Prophylaxis (Pep) (Indicated Combinations Below)

Medication (2 pill regimen) *see pages 21-26 for side effects	Dose and directions	Quantity to prescribe	Notes
Tenofovir disoproxil fumarate/emtricitabine (Truvada)	200mg/300mg 1 orally daily	28	Include: For post-exposure. Do not exceed 28 days.
with Dolutegravir (Tivicay) (<i>preferred</i>)	50 mg 1 orally daily	28	Include: For post-exposure. Do not exceed 28 days.
or Raltegravir (Isentress)	400 mg 1 orally twice daily	56	Include: For post-exposure. Do not exceed 28 days.

MONITORING Recommended laboratory evaluation for exposed and source patients in setting of HIV nPEP

Test	Baseline	Week 4	Week 12	Week 24	
HIV 4th gen Antigen/Antibody test with reflex to viral load	E, S ¹	E	E		<ol style="list-style-type: none"> HIV testing of source is indicated for sources of unknown serostatus Recommended for sexual exposure only Start HBV vaccination if evidence of non-immunity Additional testing for pregnancy, STIs, HBV as clinically indicated If determined to be HIV positive on follow up testing Syphilis only unless clinically indicated If exposed person is susceptible to Hep B at baseline If exposed person is found to be infected with Hepatitis C at baseline
Serum liver enzymes	E	E			
Blood Urea Nitrogen (BUN)/creatinine	E	E			
STD screen (gonorrhea, chlamydia, syphilis)	E, S ²	E		E ⁶	
Hepatitis B Virus (HBV) serology (HBsAb, HBsAg, HBcAb)	E ³ , S	E ⁴		E ⁷	
Hepatitis C Virus (HCV) serology with reflex	E, S			E ⁸	
Pregnancy test (for women of reproductive age)	E	E ⁴			
HIV viral load	S	E ⁵	E ⁵		
HIV resistance testing	S	E ⁵			

E=Exposed, S = Source

Centers for Disease Control and Prevention. Updated Guidelines for Antiretroviral Post-exposure Prophylaxis

After Sexual, Injection Drug Use, or Other Non-occupational Exposure to HIV United States, 2016:

<https://www.cdc.gov/mmwr/volumes/65/wr/mm6517a5.htm>

POST-EXPOSURE PUBLIC HEALTH RESPONSE

In the event of an HIV transmission event inside CDCR, the HIV/Hepatitis Central Team and Public Health nursing conduct an HIV/STI Education and Testing campaign. Individuals possibly exposed, and those residing in the housing unit where the transmission occurred are offered education on STI, HIV, and viral hepatitis symptoms and prevention, hepatitis B vaccination if non-immune, and mpox vaccination. Individuals are tracked to ensure each receives education, and offered HIV/STI and hepatitis testing, including HIV antigen/antibody with reflex to RNA; Hepatitis B surface antigen, surface antibody, and core antibody; Hepatitis C antibody; RPR; Urine gonorrhea and chlamydia.

****IMPORTANT**** Always consult the HIV Central Team and Public Health Team. Due to stigma and high concern for patient harm, a typical STI exposure response should NOT occur. In a potential transmission/exposure situation, the index case should be gently encouraged to give consent to disclose transmission risk to any sexual or drug partners. **If consent is not obtained, avoid disclosure in nearly all cases** (except in the case of pregnancy to prevent transmission to the baby). Please see Attachment C: HIV Exposure and Transmission Guidance and Attachment D for HIV/STI Education and Testing Campaign toolkit materials.

MEDICATIONS

HHS Guidelines and Antiretroviral Drugs for Treatment and Prevention of HIV Infection in Adults: 2022 Recommendations of the International Antiviral Society–USA Panel - IAS-USA (iasusa.org) (NOTE: Do not initiate, change or discontinue HIV medications without first consulting an HIV specialist)

General Guidance	<ul style="list-style-type: none"> • Current recommended minimum effective combination consists of three antiretroviral medications from a minimum. of two classes. DO NOT PRESCRIBE MONOTHERAPY FOR HIV. If any medication is discontinued due to toxicity or other reason, discontinue. • Monitor for hepatotoxicity; use with caution in patients with chronic hepatitis B or C or end stage liver disease. • Weight gain has been associated with use of INSTIs, particularly in combination with TAF. • Monitor for renal dysfunction and consult with an HIV specialist for dosing in renal dysfunction. • Multiple concerns regarding drug-drug interactions (DDI) exist. Liverpool HIV Interactions (hiv-druginteractions.org) (See page 25 for more information). Pravastatin is the least likely statin to interfere with ART, atorvastatin and rosuvastatin may also be considered. Be sure to check DDIs with estrogens, progestins and hormone therapy. • Patients with HIV/HBV coinfection should receive ART that includes tenofovir and either emtricitabine or lamivudine. Regimens with only one agent with anti-HBV activity are not recommended. Lamivudine and emtricitabine are no longer first line therapies for HBV due to high rates of acquired resistance. • ART should be initiated in all patients with HCV/HIV coinfection, regardless of CD4 T lymphocyte cell count. All patients with co-infection should have liver fibrosis staging, (fibrotest preferred if treatment naïve). HBV reactivation can occur and it is imperative that HBV serology is done before HCV treatment, and HBV treatment started before HCV treatment if chronic HBV is present. See HHS HCV/HIV Co-infected Guidelines. • A long-acting ARV regimen, such as the combination of injectable cabotegravir and rilpivirine, is a formulary optimization option for patients with extreme pill fatigue or problems with oral medication compliance, but who are engaged with their health care, virologically suppressed on oral therapy for 3 to 6 months, who are capable of making the frequent clinic visits needed to receive the injectable drugs and are not paroling within 6-12 months. Clinical judgement can be used for patients not suppressed but who may benefit from cabotegravir and rilpivirine. • For patients with poor CD4 recovery despite viral suppression, additional ARV drugs are NOT recommended and interventions to increase CD4 counts are not recommended outside of a clinical trial. • For patients with virologic failure, a new regimen can include two fully active drugs if at least one with a high resistance barrier is included (e.g., DTG or boosted darunavir). Clinical trial data shows that in these patients, a new regimen containing two fully antiretroviral (ARV) drugs can effectively achieve viral suppression, provided that one of the two drugs has a high barrier to resistance. • See review of factors to consider for treatment experienced: HHS Optimizing Antiretroviral Therapy in the Setting of Virologic Suppression). • To check resistance mutations in treatment when prescribing ART: Stanford HIV Mutation Database.
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Nucleoside/ Nucleotide Reverse Transcriptase Inhibitors (NRTI)	<p>Many NRTIs are associated with:</p> <ul style="list-style-type: none"> • Hepatic steatosis • Lactic acidosis (rare but potentially fatal): look for nausea, vomiting, abdominal pain, fatigue, weakness, dyspnea with an associated metabolic acidosis. Discontinue all potential offending agents immediately • Lipodystrophy
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Medication	Formulation	Side Effects	Special Notes
ABACAIVIR (ZIAGEN®, ABC) \$\$\$	Solution: 20mg/ml	<ul style="list-style-type: none"> • Hypersensitivity reaction; potentially FATAL if re-challenged 	<ul style="list-style-type: none"> • Hypersensitivity associated with positive HLA-B5701: screen prior to initiation • Hypersensitivity reaction: look for fever, rash, GI symptoms, cough, dyspnea, pharyngitis. Do NOT rechallenge. • Adjust dose for hepatic dysfunction • Avoid in treatment naïve patient if HIV viral load >100,000 copies/ml

Medication	Formulation	Side Effects	Special Notes
DIDANOSINE* (VIDEX-EC®, DDI) \$\$\$	Delayed release capsule: 200mg, 250mg , 400mg Powder for solution: 2gm, 4gm	<ul style="list-style-type: none"> Peripheral neuropathy Pancreatitis Lactic acidosis – See above 	<ul style="list-style-type: none"> Weight based dosing Adjust dose for renal dysfunction Adjust dose if given with tenofovir Avoid in combination with stavudine Contraindicated with ribavirin Prolonged exposure associated with noncirrhotic portal hypertension with esophageal varices
EMTRICITABINE (EMTRIVA®, FTC) \$\$\$\$\$	Capsule: 200mg	<ul style="list-style-type: none"> Skin discoloration/hyperpigmentation 	<ul style="list-style-type: none"> Active against chronic hepatitis B Severe acute exacerbation of chronic hepatitis B can occur with abrupt discontinuation in patients with HBV Dose adjustment for renal dysfunction Contraindicated for use with lamivudine
LAMIVUDINE* (EPIVIR®, 3TC) \$\$\$	Tablet: 100mg, 150mg , 300mg Solution: 10mg/ml		<ul style="list-style-type: none"> Active against chronic hepatitis B Severe acute exacerbation of chronic hepatitis B can occur with abrupt discontinuation in patients with HBV Adjust dose for renal dysfunction Contraindicated with emtricitabine
TENOFOVIR ALAFENAMIDE (TAF)	Only available in fixed-dose combinations with other agents	<ul style="list-style-type: none"> Headache Nausea Diarrhea <p>Weight gain, when used with INSTIs</p>	<ul style="list-style-type: none"> Active against chronic hepatitis B Severe acute exacerbation of chronic hepatitis B can occur with abrupt discontinuation in patients with HBV Adjust dose for renal dysfunction Nephrotoxicity and decreased bone mineral density less common with TAF than TDF
TENOFOVIR DISOPROXIL FUMARATE (VIREAD®, TDF) \$	Tablet: 150mg, 200mg, 250mg, 300mg Powder: 40mg/gm	<ul style="list-style-type: none"> Asthenia, headache, diarrhea, nausea, vomiting, flatulence Renal impairment Fanconi's Syndrome Decreased bone mineral density 	<ul style="list-style-type: none"> Active against chronic hepatitis B Severe acute exacerbation of chronic hepatitis B can occur with abrupt discontinuation in patients with HBV Adjust dose for renal dysfunction Adjust dose if given in combination with didanosine and/or atazanavir
ZIDOVUDINE (RETROVIR®, AZT)\$\$\$*	Tablet: 300mg Syrup: 50mg/ml Capsule: 100mg	<ul style="list-style-type: none"> Bone marrow suppression Anemia (usually macrocytic) Myopathy Nausea 	<ul style="list-style-type: none"> Contraindicated for use with stavudine Caution in use with other agents that cause bone marrow suppression Adjust dose for renal dysfunction

• **MEDICATIONS**
(NOTE: Do not initiate, change or discontinue HIV medications without first consulting an HIV specialist)

• **Non-nucleoside Reverse Transcriptase Inhibitors (NNRTI)**

- Some NNRTIs are associated with rash and potential Stevens Johnson Syndrome: monitor for rash during initiation of these medications and discontinue if severe or accompanied by mucous membrane involvement or systemic symptoms. Less severe rash may be treated with antihistamines and followed closely.
- Long half-life: consult HIV specialist if possible, prior to discontinuation to avoid the emergence of resistant mutations.
- Multiple concerns regarding drug-drug interactions. (See page 25 for more information).

Medication	Formulation	Side Effects	Special Notes
EFAVIRENZ* (SUSTIVA®, EFV) \$\$\$\$\$	Tablet: 600mg Capsule: 50mg, 200mg	<ul style="list-style-type: none"> CNS side effects: dizziness, bizarre dreams Rash Elevated transaminases QT prolongation False positive cannabinoid test 	<ul style="list-style-type: none"> Avoid taking with a high fat meal <p>Immediate evaluation is recommended for psychiatric symptoms such as severe depression or suicidal ideation</p>

Medication	Formulation	Side Effects	Special Notes
DORAVIRINE (P FELTRO [®] , DOR) \$\$\$\$	Tablet: 100mg	<ul style="list-style-type: none"> Nausea Dizziness Abnormal Dreams 	
ETRAVIRINE* (INTELENCE [®] , ETR) \$\$\$\$	Tablet: 25mg 100mg, 200mg	<ul style="list-style-type: none"> Hepatotoxicity Hypersensitivity reaction Nausea 	
NEVIRAPINE* (VIRAMUNE [®] , NVP) \$\$\$	Tablet: 200mg Solution: 50mg/5 ml XR tablet: 100mg 400mg	<ul style="list-style-type: none"> Hepatotoxicity including necrosis Rash, Stevens-Johnson syndrome Monitor LFTs baseline, 2 weeks after initiation, and monthly for the first 18 weeks; discontinue if clinical hepatitis or severe rash occurs and do not re-challenge. 	<ul style="list-style-type: none"> Contraindicated in moderate to severe hepatitis. Avoid starting nevirapine in women with baseline CD4 >250 cells/mm³ or men with CD4 >400 cells/mm³. Once the patients on NVP reach a CD4 cell count higher than these cut-offs, they are not required to discontinue unless otherwise indicated. Dose escalation with initiation: 200mg daily for two weeks, then 400mg daily, one twice daily or two once daily.
RILPIVIRINE (EDURANT [®] , RPV) \$\$\$\$	Tablet: 25mg	<ul style="list-style-type: none"> Depression Insomnia Headache Rash Hepatotoxicity QT prolongation 	<ul style="list-style-type: none"> Requires an acid environment for optimal absorption. Contraindicated for use with proton pump inhibitors; specific dosing recommendations for use with other acid lowering agents. Consult an HIV specialist or package insert for specifics. Use with caution in patients with baseline viral load >100,000 copies/ml.
Integrase Strand Transfer Inhibitors (INSTI)	Absorption reduced by polyvalent cations: Mg++ or Ca++containing antacids should be taken 2 hrs before or 6 hrs after INSTI		
DOLUTEGRAVIR (TIVICAY, DTG) \$\$\$\$	Tablet: 50mg	<ul style="list-style-type: none"> Hypersensitivity reaction: rash, constitutional findings Diarrhea Weight gain 	<ul style="list-style-type: none"> Not recommended for Child Pugh Class C patients. Recommended as a preferred regimen in pregnant women regardless of trimester. Inhibits tubular secretion of creatinine without affecting GFR.
Integrase Strand Transfer Inhibitors (INSTI)	Absorption reduced by polyvalent cations: Mg++ or Ca++containing antacids should be taken 2 hrs before or 6 hrs after INSTI		
RALTEGRAVIR (ISENTRISS [®] , RAL) \$\$\$\$	Tablet: 400mg, 600mg Chew:25mg 100mg Suspension: 100mg/ml	<ul style="list-style-type: none"> Asthenia Nausea Diarrhea Headache CPK elevation 	<ul style="list-style-type: none"> Inhibits tubular secretion of creatinine without affecting GFR.
ELVITEGRAVIR (EVG)	(Only available in fixed dose tablets, see below)	<ul style="list-style-type: none"> Diarrhea Nausea Headache Fatigue 	<ul style="list-style-type: none"> Inhibits tubular secretion of creatinine without affecting GFR.
BICTEGRAVIR (BIC)	(Only available in fixed dose tablets, see below)	<ul style="list-style-type: none"> Diarrhea Nausea Headache Weight gain 	<ul style="list-style-type: none"> Inhibits tubular secretion of creatinine without affecting GFR.
CABOTEGRAVIR (Vocabria [®] , CAB) (Apretude, injectable for PrEP only) \$\$\$\$ (See bottom of page 12 for injectable Cabenuva [®])	Tablet: 30mg Solution for injection: 600 mg / 3 mL	<ul style="list-style-type: none"> Dizziness Fever Headache Insomnia Myalgias Nausea Rash 	<ul style="list-style-type: none"> Requires HIV specialist review and approval. Contraindicated with phenytoin, phenobarbital, oxcarbazepine, carbamazepine, rifampin, rifapentine. Do not use in pregnancy, severe liver disease or uncontrolled depression. Do not use if paroling in <6 months.

Guidelines for the use of antiretroviral agents in adults and adolescents with HIV. Department of Health and Human Services. February 27, 2024. Available at <https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/whats-new-guidelines>; Saag, M., et al. Antiretroviral Drugs for Treatment and Prevention of HIV Infection in Adults, 2020 Recommendations of the International Antiviral Society-USA Panel. -AMA. 2020;324(16):1651-166g. **Bold** = Formulary *Infrequently used

MEDICATIONS (NOTE: Do not initiate, change or discontinue HIV medications without first consulting an HIV specialist)

Protease Inhibitors (PI)	Many PIs are associated with:		
	<ul style="list-style-type: none"> • Hyperlipidemia • Hyperglycemia • Lipodystrophy/fat redistribution • Elevated transaminases • GI intolerance: nausea, vomiting, diarrhea • Hepatotoxicity especially in the patients with underlying liver disease or coinfection with hepatitis B or C • Increased bleeding in hemophiliacs • Most PIs are prescribed in combination with ritonavir in order to achieve more optimal drug levels • Multiple concerns regarding drug-drug interactions (See page 25 for more information) 		
Medication	Formulation	Side Effects	Special Notes
ATAZANAVIR* (REYATAZ®, ATV) \$\$\$\$\$	Capsule: 100mg 150mg 200mg 300mg Powder for oral suspension: 50mg	<ul style="list-style-type: none"> • Indirect hyperbilirubinemia: jaundice, scleral icterus rarely a cause for discontinuation • PR prolongation • Nephrolithiasis, cholelithiasis • Rash • Hyperlipidemia 	<ul style="list-style-type: none"> • Requires an acidic environment for optimal absorption; specific dosing recommendations for use with proton pump inhibitors, H2 blockers, antacids: Consult an HIV specialist or package insert for specifics • Adjust dose for hepatic dysfunction • Do not give unboosted in ART-experienced patients or with tenofovir
DARUNAVIR (PREZISTA®, DRV) \$\$\$\$\$	Tablet: 75mg150mg 600mg 800mg Suspension: 100mg/ml	<ul style="list-style-type: none"> • Rash • Diarrhea, nausea • Elevated transaminases • Hyperglycemia • Hepatotoxicity • Headache 	<ul style="list-style-type: none"> • Contains sulfonamide moiety. Though incidence of reported severe reactions similar in those with or without sulfonamide allergy, Stevens-Johnson and erythema multiforme have been reported • Should always be used with ritonavir or cobicistat
FOSAMPRENAVIR* (LEXIVA®, LEX) \$\$\$\$\$	Tablet: 700mg Suspension: 50mg/ml	<ul style="list-style-type: none"> • Rash; caution if sulfonamide allergy • Diarrhea, nausea, vomiting • Headache • Nephrolithiasis (rare) 	<ul style="list-style-type: none"> • Dose adjustment for hepatic dysfunction
LOPINAVIR/RITONAVIR* (KALETRA®, LPV) \$\$\$\$\$	Tablet: 200mg - 50mg 100mg - 25mg Solution: 80mg - 20mg/ml	<ul style="list-style-type: none"> • GI intolerance: nausea, vomiting, diarrhea • Pancreatitis • Hypertriglyceridemia • Insulin resistance • Fat maldistribution • PR and QT prolongation 	<ul style="list-style-type: none"> • Co-formulated with ritonavir • Avoid once daily dosing in patients on HD
NELFINAVIR* (VIRACEPT®, NLF) \$\$\$\$\$	Tablet: 250mg 625mg	<ul style="list-style-type: none"> • Diarrhea • Nausea, bloating • Rash • Abdominal pain 	<ul style="list-style-type: none"> • Do not use with ritonavir
TIPRANAVIR* (APTIVUS®, TPV) \$\$\$\$\$	Capsule: 250mg Solution: 100mg/ml	<ul style="list-style-type: none"> • Rash; caution if sulfonamide allergy • Diarrhea • Hypertriglyceridemia • Elevated transaminases • Potentially fatal hepatotoxicity • Intracranial hemorrhage 	<ul style="list-style-type: none"> • Requires co-administration of ritonavir

Guidelines for the use of antiretroviral agents in adults and adolescents with HIV. Department of Health and Human Services. February 27, 2024. Available at <https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/whats-new-guidelines>

Bold = Formulary *Infrequently used

Medications (NOTE: Do not initiate, change or discontinue HIV medications without first consulting an HIV specialist)			
MEDICATIONS FOR PRIMARY PROPHYLAXIS OF OPPORTUNISTIC INFECTIONS (Bold = Formulary)			
CONSULT AN HIV SPECIALIST OR CPHCSHIVQuestions@cdcr.ca.gov PRIOR TO DISCONTINUING PROPHYLAXIS			
Medication	Formulation	Side Effects	Notes
ATOVAQUONE (MEPRON®) \$\$\$\$	Suspension: 750mg/5 ml	<ul style="list-style-type: none"> Rash GI intolerance 	<ul style="list-style-type: none"> Alternative agent for pneumocystis prophylaxis
AZITHROMYCIN (ZITHROMAX®) \$\$	Tablet: 250mg 500mg 600mg	<ul style="list-style-type: none"> Rash Diarrhea Nausea Abdominal pain Headache 	<ul style="list-style-type: none"> Preferred agent for mycobacterium avium complex prophylaxis
CLARITHROMYCIN (BIAXIN®) \$	Tablet: 250mg 500mg	<ul style="list-style-type: none"> Rash Diarrhea Nausea Abdominal pain Pseudomembranous colitis 	<ul style="list-style-type: none"> Alternative agent for mycobacterium avium complex prophylaxis
DAPSONE \$	Tablet: 25mg 100mg	<ul style="list-style-type: none"> Rash, hypersensitivity reaction Hematologic abnormalities Hemolytic anemia (G6PD related) Neuropathy 	<ul style="list-style-type: none"> Contraindicated in G6PD deficiency Alternative agent for pneumocystis prophylaxis Component of alternative prophylaxis for toxoplasmosis (with pyrimethamine)
PENTAMIDINE (NEBUPENT®) \$\$\$\$	Solution: 300mg	<ul style="list-style-type: none"> Rash Renal impairment Bronchospasm Arrhythmia Hematologic abnormalities 	<ul style="list-style-type: none"> Given via nebulizer as alternative agent for pneumocystis prophylaxis Dose adjustment for renal dysfunction
PYRIMETHAMINE (DARAPRIM®) \$\$\$\$	Tablet: 25mg	<ul style="list-style-type: none"> Nausea Neutropenia Thrombocytopenia Megaloblastic anemia Rash 	<ul style="list-style-type: none"> Component of alternative prophylaxis for toxoplasmosis (with pyrimethamine) Contraindicated in folate deficiency and hypersensitivity to pyrimethamine Use with caution if G6PD deficient, renal or hepatic dysfunction or history of seizure disorder
TRIMETHOPRIM-SULFAMETHOXAZOLE (TMP-SMX SS OR DS, BACTRIM SS® OR DS®) \$	Tablet: 160mg/800mg	<ul style="list-style-type: none"> Rash, Stevens Johnson Syndrome Hematologic abnormalities Photosensitivity Nausea, vomiting, dyspepsia 	<ul style="list-style-type: none"> Preferred agent for pneumocystis and toxoplasmosis prophylaxis Caution in G6PD deficiency
Drug-Drug Interactions			
<p>Multiple drug-drug interactions exist between many antiretroviral medications and other medication classes including, but not limited to, certain antimicrobials, analgesics, antiarrhythmics, oral contraceptives, anxiolytics, lipid lowering agents, acid lowering agents, herbal preparations, corticosteroids, and anticonvulsants.</p> <p>Prior to adding to or adjusting the medication profile of an HIV patient, consider consulting:</p> <ul style="list-style-type: none"> An HIV specialist or pharmacist Liverpool DDI Checker: Liverpool HIV Interactions (hiv-druginteractions.org) DHHS: Overview: Drug-Drug Interactions between Antiretrovirals and Other Drugs NIH (hiv.gov) or contact the CCHCS HIV Warmline at CPHCSHIVQuestions@cdcr.ca.gov or via the HIV Message Pool in the EHRS. 			

Guidelines for the use of antiretroviral agents in adults and adolescents with HIV. Department of Health and Human Services. February 27, 2024. Available at <https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/whats-new-guidelines>. Guidelines for the prevention and treatment of opportunistic infections in adults and adolescents with HIV. Department of Health and Human Services. May 2, 2024. Available at [HIV Clinical Guidelines: Adult and Adolescent Opportunistic Infections - What's New in the Guidelines | Clinicalinfo.HIV.gov](https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infections/whats-new-in-the-guidelines)

Attachment A: Obtaining and Ordering Anal Cytology

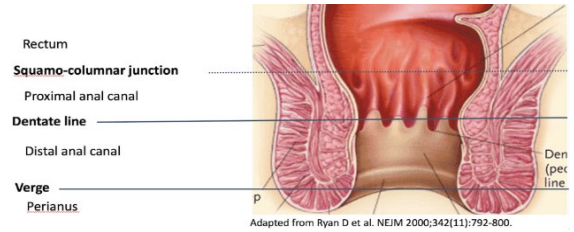
An anal Pap smear can be performed by the provider, or the patient can self-collect, however provider collection is preferred. For patient self-collection procedure, see page PE3. This must be performed in patient bathroom adjacent to or in the laboratory. It cannot be collected in housing units. The order for self-collect is LAB COLLECT, NO RN order.

- Patients are asked not to douche or have an enema or insert anything into their anus for 24 hours prior to an anal cytology exam.
- Lubricants should not be used prior to obtaining a cytology sample because the lubricant may interfere with the processing and interpretation of the sample.
- Use ThinPrep® anal cytology specimen collection (order "C01"). Any Dacron swab may be used instead of the brush and spatula in the cytology kit which may be more uncomfortable during collection.
- (Do NOT use the Aptiva Kit used for chlamydia/GC.) Dacron swabs can be ordered as "S17".

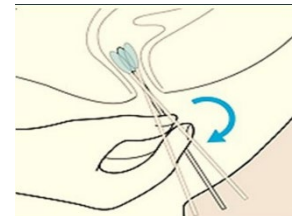


For provider collection and patient self-collection education:

- The buttocks are retracted to visualize the anal opening and a Dacron or polyester tipped swab moistened in tap water is inserted for approximately 2 to 3 inches into the anus. The swab can be felt to pass through the internal sphincter, so the sample is obtained from the junction of the anus and rectum (squamocolumnar junction), which is where most of the HPV-related lesions are found. This area is slightly above the region that corresponds anatomically to the dentate line.



- The swab is rotated 360 degrees with firm lateral pressure applied to the end of the swab, such that it is bowed slightly and then it is slowly withdrawn over a period of 15 to 30 seconds from the anus, continuing to rotate the swab in a circular fashion. The lateral pressure ensures that the mucosal surface, rather than rectal contents are sampled.



- Rinse the swab as quickly as possible in the PreservCyt® solution by rotating the swab in the solution 10 times while pushing against the vial wall. Swirl the device vigorously to release any remaining material. Discard the swab in biohazard waste. (Do NOT break swab off and leave in the vial.) Tighten the cap so that the torque line on the cap passes the torque line on the vial.



- Record the patient's name and CDCR# on the vial and place the vial in specimen bag for transport to lab.



- Perform Digital Anorectal Exam (DARE) after sample collection, not before.

To order cytology and high-risk HPV testing:

- Utilize the "Anal cytology and HPV (Pap)" Powerplan in Cerner. This plan combines 2 orders: 1) "Cytology, non-gyn" (10676), and 2) "HPV reflex GT" (92810).
- One specimen will be sent to two different Quest labs. The order comment should state **"one specimen for both 10676 cytology first, then please forward to San Juan Capistrano for 92810 HPV"**.
- Check "nurse collect" ONLY for provider-collected specimens, handled by nursing.

EHRs Anal Cytology and HPV Power Plan

Component	Status	Dose ...	Details	Order Com...
Anal Cytology and HPV (pap) (Planned Pending)				
Laboratory				
One swab for both 10676 and 92810. Send cytology (10676) first, then please forward sample to quest San Juan cap for 92810				
Collection kit to use is only: ThinPrep anal cytology specimen collection kit. Do not use Aptima multi-test				
<input checked="" type="checkbox"/>			Cytology, Non-Gyn	Anal-Rectal, Timed Study collect, T+21;05...
<input checked="" type="checkbox"/>			HPV mRNA E6/E7 rfx Geno 16,18/45-92810	Anal-Rectal, Timed Study collect, T+21;05...

Attachment B: Cervical Cancer Screening for Women with HIV

Screening for cervical cancer is of particular importance for patients with HIV infection and in other immunocompromised states.

Studies suggest that the incidence of cervical intraepithelial neoplasia (CIN), as confirmed by colposcopy, is four to five times higher in patients with HIV compared to patients without HIV but with high-risk sexual behaviors.

Women with HIV infection cervical Pap test age < 30 years (regardless of HPV vaccination history):

- Baseline Pap test beginning at age 21 or at diagnosis if over 21.
- Then repeat Pap test every 12 months from baseline.
- After 3 consecutive Pap tests with normal results, perform Pap tests q3 years.
- Pap tests for < 30 years of age do NOT need human papillomavirus (HPV) co-testing with Pap test.

Women with HIV infection cervical Pap test age ≥ 30 years:

- Baseline Pap test with HPV co-testing at diagnosis.
- Then repeat Pap test every 12 months from baseline.
- If 3 consecutive negative HPV tests, along with normal Pap test results, perform Pap tests q3 years.
- Cervical cancer screening should continue throughout a woman's lifetime (and not, as in the general population, end at 65 years of age).

If test HPV positive:

- Pap testing with HPV test again in 12 months (unless HPV 16 or 18*).
- If HPV test positive a second time, refer for colposcopy.

*If initial or at any time, HPV testing is positive specifically for HPV 16/18, referral to colposcopy is recommended even if pap smear is normal. Do not wait another year as for other subtypes.

Abnormal Pap Test Results

The American Society for Colposcopy and Cervical Pathology consensus guidelines advise that patients with HIV **at any age** with abnormal screening results be managed as follows:

- **Cytology-negative, HPV-positive** – Repeat co-testing in 12 months (unless genotype testing for 16 or 16/18 is positive).
 - If the initial HPV results identify HPV 16 or HPV 16/18, then colposcopy is recommended.
 - If either of the co-tests at 12 months is abnormal (i.e., abnormal cytology or HPV-positive), colposcopy should be performed.
- **Atypical squamous cells of undetermined significance (ASC-US).**
 - If reflex HPV testing is positive, colposcopy should be performed.
 - If HPV testing is not available or not done, repeat cytology in 6 to 12 months.
 - For any result equal to or more severe than ASC-US on repeat cytology, colposcopy should be performed.
- **Low-grade squamous epithelial lesion (LSIL) or more severe lesions** (including high-grade squamous intraepithelial lesion [HSIL], atypical squamous cells cannot exclude HSIL [ASC-H], or atypical glandular cells [AGC]) – Colposcopy should be performed.

1. Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. Human Papillomavirus Disease. Updated August 18, 2021. Accessible at: <https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection/human-papillomavirus-disease>
2. Robinson, William R. Screening for cervical cancer in patients with HIV infection and other immunocompromised states. UpToDate. Updated September g, 2021. Accessible at: <https://www.uptodate.com/contents/screening-for-cervical-cancer-in-patients-with-hiv-infection-and-other-immunocompromised-states>

Attachment C: HIV Exposure and Potential Transmission Guidance

Due to stigma and high concern for patient harm, a typical STI exposure response should NOT occur. In a potential transmission/exposure situation, the index case should be gently encouraged to give consent to disclose transmission risk to any sexual or drug partners. If consent is not obtained, **avoid disclosure in nearly all cases** (except in the case of pregnancy to prevent transmission to the baby).



What to do

- **Always notify the HIV Central Team: CPHCSHIVQuestions@cdcr.ca.gov, and the Public Health Branch: CDCRCPHCSPublicHealth@cdcr.ca.gov.**
- It is imperative to keep a non-judgmental, non-punitive attitude.
- After telling the patient you are obligated by law to report any sexual assault, diplomatically and empathetically ask if any assault or non-consensual acts have occurred.
 - If there has been any suspected PREA violations, report to the institution CME and Chief Physician and Surgeon who can assist with contacting the Watch Commander, the Warden's office, and the Investigational Services Unit (ISU).



What NOT to do

- **Do NOT unduly pressure the patient to discuss with you who their partners are**
- **Do NOT disclose the possible transmission of HIV to any potential sexual or drug partners without consent from the index patient**
- **Do NOT wait to alert institutional leadership to a potential or alleged PREA violation**



Goals for Patient Interviews

- Interviews and discussions with the index patient can gently encourage them to give consent to disclose transmission risk to any sexual or drug partners and to encourage the partner(s) to seek medical care and testing. Acknowledge the discomfort the patient may be experiencing.
- Remind them that the medical team can carry out the discussions with partners for them.
- Educate them that partners can take HIV PrEP (only 1 pill a day and well tolerated) to prevent transmission in the future (place **Consult to STI for PrEP discussion** and prescriptions. See PrEP Care Guide- *place link when posted*).
- In most cases, the safest way to attempt partner testing is via a targeted (housing unit) or global STI testing campaign for all persons. The public health leadership, public health nursing leadership, and institutional leadership should be involved.
 - The institution conducts education, offers HIV/STI and hepatitis testing, and vaccines. Tests include:

- **Lab testing (batch ordering available):**
 - HIV ½ Antigen/Antibody Fourth Generation w/ Reflex -91431
 - Hepatitis C Antibody with Reflex to HCV RNA, PCR w/ Reflex to Genotype, LIPA -94345
 - Hepatitis C RNA, Quant, PCR Reflex to Genotype -11348 (for patients already HCV Antibody positive)
 - RPR (Diagnosis) with Reflex to Titer and Confirmatory Testing -36126
 - Chlamydia/N. gonorrhoeae RNA, TMA, Urogenital -11363
 - Hepatitis B Surface Antibody, Quantitative -8475
 - Hepatitis B Surface Ag, Quant, Monitor -94333
 - Hepatitis B Core Antibody -501
- There are vaccine power plans in the EHRS for Hepatitis B, Hepatitis A, and Mpox.
 - There is a Post-Exposure Power Plan and a PrEP Power Plan in the EHRS for providers.
 - Patient educational information is available in the HIV Exposure Toolkit at the end of this HIV Care Guide (Attachment D).

HIV/STD/Hepatitis Awareness Patient Education Material Examples

- What You Should Know About HIV (PE-1 and 6)
 - Protect Yourself from Infection when Using Hypodermic Needles (PE-5 and 10)
 - You Can Prevent Hepatitis
 - Protect Yourself from Mpox Virus
 - Know Your Status
- See guidance for a newly diagnosed HIV Case Interview Suggestions in Attachment C-a (next page).
 - Please be sure to fill out the ERS STI Risk Assessment Form. (See grey link 'AdHoc' above the blue banner bar). It is quick and easy.

Attachment C-a: Newly Diagnosed HIV Case-Questionnaire

Background Information

The goal for the patient interview is to learn more about whether they inject drugs or have other risk behaviors and to ensure no concern for sexual assault. This information is sensitive and as such should be kept confidential and should only be used for public health purposes. Patients should be counseled that answering any of these questions is voluntary. Patients may decline to answer any question that they may not feel comfortable answering. Prior to the interview, please conduct a medical record review to familiarize yourself with the patient’s medical history.

Case information

- Name: _____
- CDCR Number: _____
- Institution: _____
- Date of Interview: _____
- Notes from chart review to keep in mind during the interview:

Patient questionnaire:

Illness history

1. When did you first notice you were ill?
2. When did you seek care?
3. How are you feeling now?

Sexual Risk Assessment

1. Are you currently sexually active?
2. Since being a resident within CCHCS have you been sexually active?
3. Have any of your sexual encounters been non-consensual? *(I must report your answers)*
4. If you are sexually active, do you use condoms?
5. Have you ever had or been treated for a sexually transmitted infection?
6. If yes, when was the last time you were treated?

Drug Use History

1. Have you ever injected drugs?
2. Have you ever snorted drugs?
3. If yes, have you injected drugs within the last three months?
4. If yes, which drugs have you injected in the last three months?
5. When was the last time you have injected?
6. If you have ever snorted drugs, have you snorted drugs within the last three months?
7. When was the last time you snorted drugs?

Drug Preparation and Storage

1. Where do you get your drugs?
2. Do you share needles?
3. Have any of your needle sharing partners been sick or disclosed they had an infection?
4. How do you prepare your drugs and needle?
5. How do you clean your needle if you inject?
6. If you snort drugs, do you share straws with other people?
7. Have any of your straw sharing partners been sick or disclosed they had an infection?

Substance Use Disorder Treatment

1. Are you currently in the MAT program?
2. If you are currently enrolled—do you ever find it difficult to take your medication or consider using additional drugs because of cravings?
3. If you are not enrolled in the MAT program, would you like to be referred?

Attachment D: HIV/STI Education and Testing Campaign Toolkit

HIV/STD Education and Testing Campaign log


A	B	C	D	E	F	G	H	I	J	K	L	M	N
Building	Cell Bed	CDCR#	Last Name	Age	Ethnicity	Care Team	Previous confirmed HIV. Order HCV lab instead, if not prior + HCV	Education documentation (Date)	LAB ORDER Date (HBV, HCV, HIV, Syphilis)	Lab Refusal Date	Urine ORDER Date (GC & Chlamydia)	Urine Refusal Date	Comments


Lab testing (batch order when possible):

- HIV 1/2 Antigen/Antibody Fourth Generation w/ Reflex -91431
- Hepatitis C Antibody with Reflex to HCV RNA, PCR w/ Reflex to Genotype, LIPA -94345
- Hepatitis C RNA, Quant, PCR Reflex to Genotype -11348 (for patients already HCV Antibody positive)
- RPR (Diagnosis) with Reflex to Titer and Confirmatory Testing -36126
- Chlamydia/N. gonorrhoeae RNA, TMA, Urogenital -11363
- Hepatitis B Surface Antibody, Quantitative -8475
- Hepatitis B Surface Ag, Quant, Monitor -94333
- Hepatitis B Core Antibody -501

Vaccine Powerplans:

 Hepatitis B Vaccine (Heplisav-B)

 Hepatitis A Vaccine (Havrix)

 Mpox Vaccine Standard Regimen (JYNNEOS Sub-Q)

HIV/STD/Hepatitis Awareness Patient Education Materials

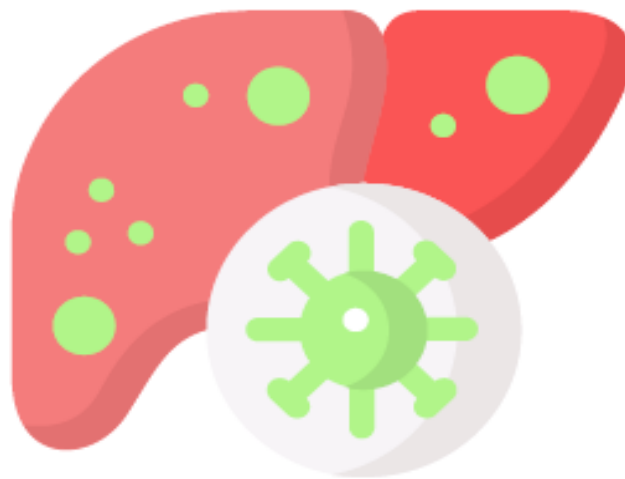
1. What You Should Know About HIV (PE-1 and 6)
2. Protect Yourself from Infection when Using Hypodermic Needles (PE-5 and 10)
3. You Can Prevent Hepatitis
4. Protect Yourself from Mpox Virus
5. Know Your Status

Attachment E: Public Health Flyers



You can prevent hepatitis!

- Ask about vaccines for hepatitis A and B.
- Avoid sharing needles for tattoos, or injecting drugs.
- Know your status--ask your health care provider to test you for HIV, Hepatitis B and C.



Submit a 7362 to learn more about hepatitis vaccines, and to know your status.



KNOW YOUR STATUS

HEPATITIS C AND HIV CAN BE SPREAD
THROUGH SHARING NEEDLES OR
HAVING SEX.

GET CHECKED

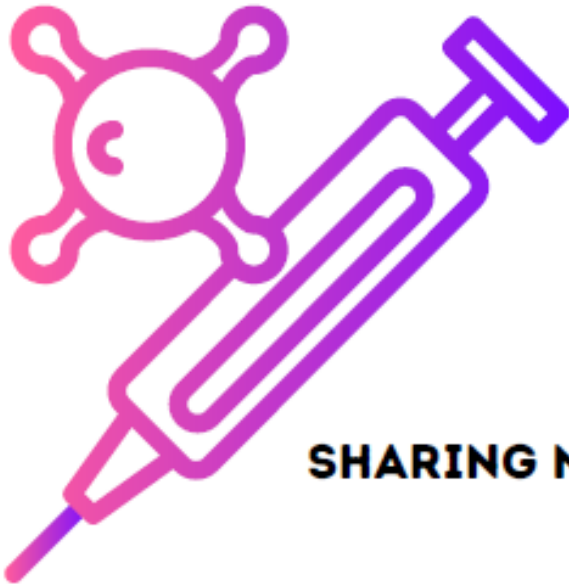
GET TREATED



Submit a 7362 to see a provider and get tested.



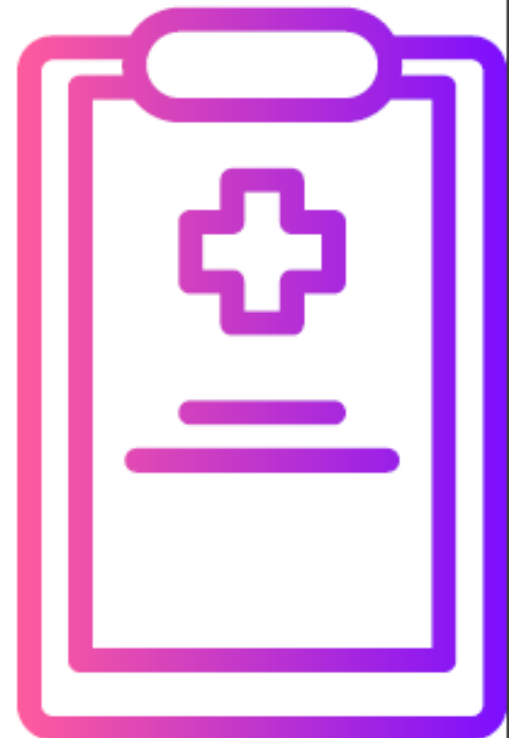
**KNOW YOUR STATUS?
IT'S EASY TO GET A TEST.
CCHCS CAN TREAT HIV AND HEPATITIS C.
SUBMIT A 7362 TO GET CHECKED.**



**SHARING NEEDLES CAN LEAD TO SHARING
HEPATITIS AND HIV**

**GET TESTED IF YOU HAVE EVER:
GOTTEN A TATTOO
SHARED A NEEDLE OR INJECTED DRUGS
HAD SEX**

**CCHCS CAN TREAT HEPATITIS
AND HIV
CCHCS CAN HELP WITH
SUBSTANCE USE.
SUBMIT A 7362 TODAY.**



Anexo E: Volantes de Salud Pública



¡Tú Puedes Prevenir la Hepatitis!

- Pregunte sobre las vacunas para la hepatitis A y B.
- Evite compartir agujas para tatuajes o para inyectarse drogas
- Conozca su estado: pida a su proveedor de salud que la haga las pruebas de VIH, hepatitis B y C



Envíe un formulario 7362 para ver a un proveedor y hacerse la prueba



CONOZCA SU ESTADO

La hepatitis C y el VIH pueden transmitirse al compartir agujas o tener relaciones sexuales

Hágase la prueba

Reciba tratamiento



Envíe un formulario 7362 para ver a un proveedor y hacerse la prueba

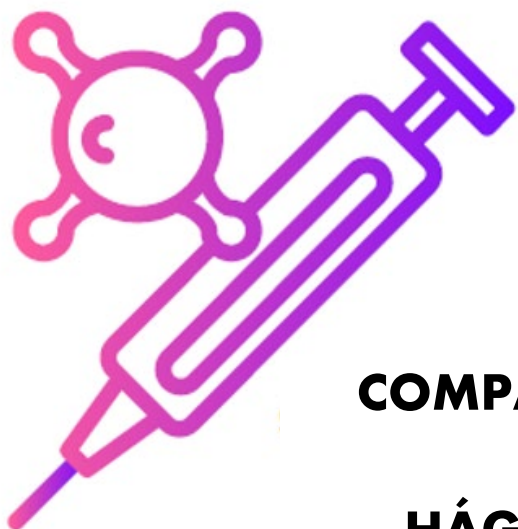


¿CONOZCA SU ESTADO?

Es fácil hacerse la prueba

CCHCS puede tratar el VIH y la hepatitis C

Envíe un formulario 7362 para ver a un proveedor y hacerse la prueba



**COMPARTIR AGUJAS PUEDE TRANSMITIR
HEPATITIS Y VIH**

HÁGASE LA PRUEBA SI ALGUNA VEZ:

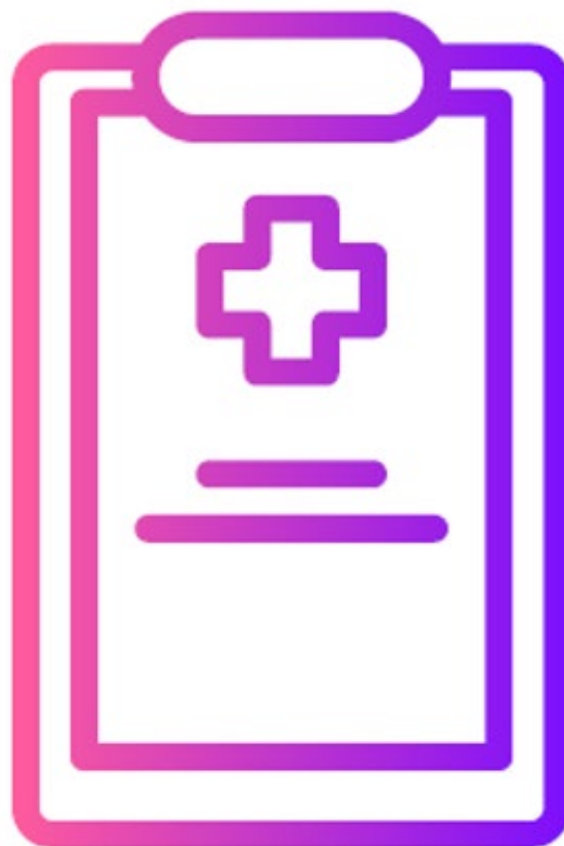
SE HIZO UN TATUAJE

**COMPARTIÓ UNA AGUJA O SE INYECTÓ
DROGAS**

**CCHCS PUEDE TRATAR LA
HEPATITIS Y EL VIH**

**CCHCS TAMBIÉN PUEDE AYUDAR
CON EL CONSUMO DE
SUSTANCIAS**

**ENVÍE UN FORMULARIO 7362
HOY MISMO**



Patient Education: Human Immunodeficiency Virus (HIV)

WHAT YOU SHOULD KNOW ABOUT HIV

- HIV is a virus that attacks your body's immune system, making it harder for you to fight off other infections.
- You can have HIV for years and not feel sick.
- If HIV is not treated, it can slowly destroy your immune system. You may get other serious and maybe deadly infections.
- AIDS (Acquired Immunodeficiency Syndrome) often occurs in the patients with untreated HIV. This is the most severe stage of HIV.
- There is no cure or vaccine for HIV, but treatment can help you live longer and prevent other painful and serious problems.
- Early treatment can save your life.

KNOW YOUR STATUS

- Ask your health care provider for an HIV test if you have never been tested. HIV may take weeks to show up in your blood.

KNOW HOW HIV IS SPREAD

- By having sex with a person who has HIV and either doesn't know it or is not taking medications for it.
- By sharing needles and works to inject drugs.
- Through pregnancy, birth, or breastfeeding.

KNOW HOW HIV IS NOT SPREAD

- HIV is not spread by kissing, shaking hands, hugging, sharing utensils or food, or sharing toilets.
- HIV is not spread by coming into contact with tears, saliva, or sweat, or through coughs or sneezes, or by insects or pets.

KNOW HOW TO PROTECT YOURSELF

- Choose sexual activities that have lower risk, like oral sex.
- Use condoms with anal or vaginal sex.
- If you inject drugs, only use new needles, syringes, and works every time.
- Get tested for HIV and sexually transmitted infections which can make it easier to get HIV.
- Talk to your health care provider about HIV Pre-exposure Prophylaxis (PrEP), medication that can help keep you from getting HIV.

IF YOU THINK YOU HAVE BEEN EXPOSED, SEE YOUR HEALTH CARE PROVIDER

ESPECIALLY IF YOU HAVE ANY OF THE FOLLOWING:

- Fever
- Weight loss
- White patches in your mouth
- Diarrhea
- Swollen glands
- Vaginal yeast infections
- Night sweats
- Fatigue

IF YOU ARE ON HIV MEDICINES, TAKE THEM EVERY DAY

- Missed doses may cause your medicine to stop working to control your HIV. Tell your health care provider if you are not able to take your HIV medicines due to bad side effects or other reasons.

Anal Cancer Risk and Prevention

What are the risk factors?

HPV (human papillomavirus) infection

HPV is the virus that causes warts. Infection with HPV is the most important risk for anal cancer. HPV can spread from one person to another during skin-to-skin contact, especially through sex. Certain types of HPV are more likely to cause anal cancer. The virus infects the skin and lining of the anus and causes changes that can eventually lead to cancer.

HIV infection

People infected with HIV (the human immunodeficiency virus), the virus that causes AIDS, are much more likely to get anal cancer than those not infected with this virus.

Anal warts

People who have had anal warts are more likely to get anal cancer. Warts do not become cancer, but people who are infected with the types of HPV that cause anal and genital warts are also more likely to be infected with the types of HPV that cause anal cancer.

Sexual activity

Having multiple sex partners increases the risk of infection with HIV and HPV. It also increases the risk of anal cancer. Receptive anal sex also increases the risk of anal cancer in both men and women. Because of this, men who have sex with men have a higher risk of anal cancer.

Smoking

Smoking increases the risk of anal cancer, and the more someone has smoked, the higher their risk of developing anal cancer. People who currently smoke are more likely to have cancer of the anus compared with people who do not smoke or have quit smoking.

Preventing Anal Cancer

HPV vaccines

Vaccines are available that protect against the types of HPV that are linked to warts and anal cancer. These vaccines can only be used to help prevent HPV infection – they do not help treat an existing infection. To work best, the vaccine should be given to children at a young age before they become sexually active.

Treating HIV

For people with HIV, it's very important to take medicines to help keep the HIV infection under control. This can also lower the risk of long-term HPV infection and pre-cancerous lesions which might help lower the risk of anal cancer.

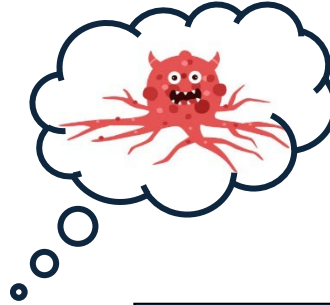
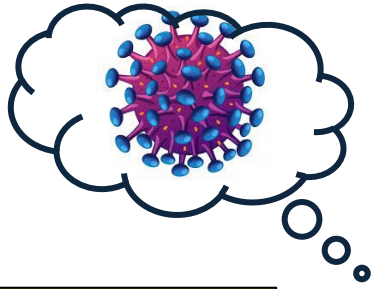
Anal "Pap" smear

For people with HPV, a health care provider can perform a test called a Pap smear to test for pre-cancerous changes in the anal canal. If these changes are found, there are procedures that can treat these areas and reduce the chance that they turn into cancer.

Not smoking

Quitting smoking greatly reduces the risk of developing anal cancer and many other cancers.

“I’m living with HIV. Do I need anal cancer screening??”



What is Anal Cancer?
Anal cancer begins when abnormal cells develop in the anus, the opening at the end of the colon where waste exits the body. Anal cancer occurs in both men and women. **People living with HIV have a much higher risk of getting anal cancer.**

Most anal cancers are caused by HPV, a common virus spread through any type of sexual contact. There are several types of HPV. Many types don't cause problems. Some types of HPV can lead to anal cancer.



Your health care provider can perform a simple test in the exam room that can tell if you need treatment to reduce the risk of anal cancer.

Don't be embarrassed. **Know your risk.** Talk to your health care provider about anal cancer.

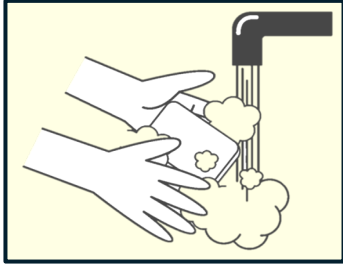


Anal Cancer Screening



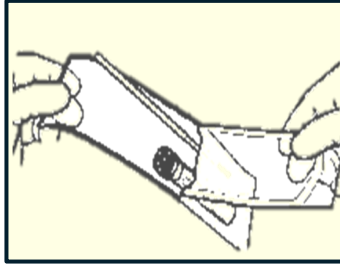
CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

TEST YOURSELF Self-collected Rectal Swab



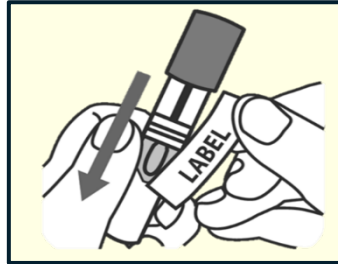
1

Wash your hands with soap and water for at least 20 seconds.



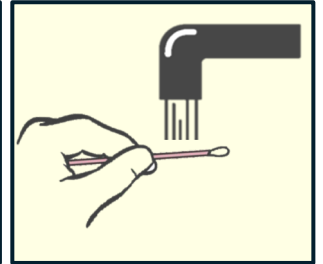
2

Remove the tube and swab from the packaging.



3

Place your label on the tube.



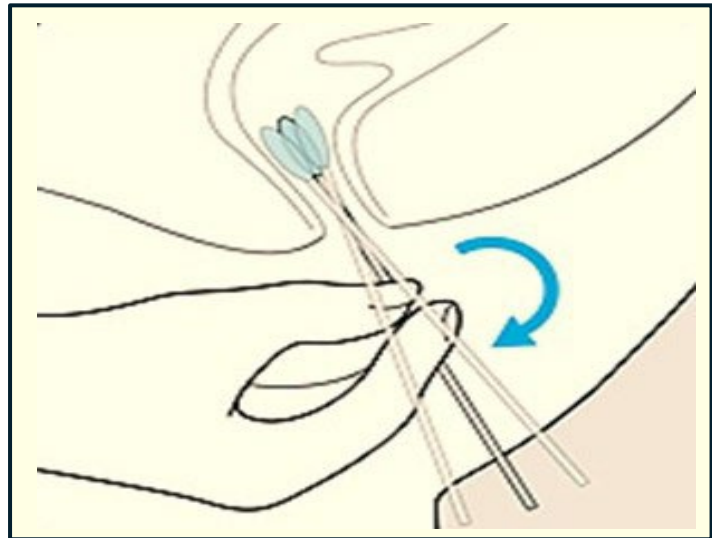
4

Wet the tip of the swab with tap water.



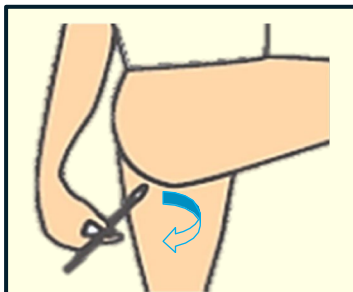
5

Get into a comfortable position that allows you to access your anus.



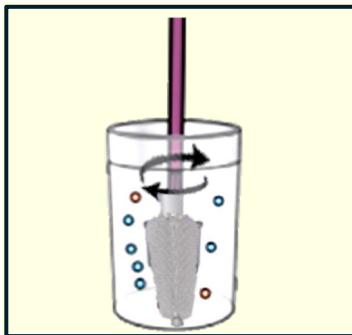
6

Gently insert the swab 2-3 inches into the anus. Move the swab **ONCE** in a large circle, pressing gently against the inside.



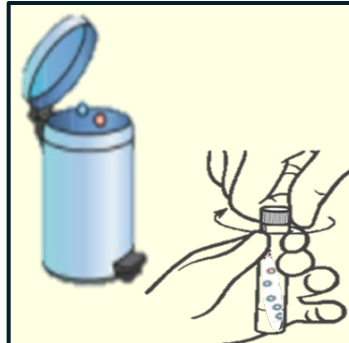
7

Slowly pull the swab out over a period of 15 to 30 seconds, moving in a circle.



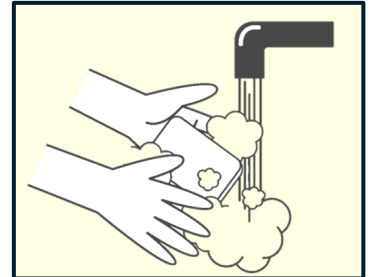
8

Swish the swab around in the liquid several times.



9

Throw away swab. Place cap back on the tube and twist it closed.



10

Wash your hands with soap and water and return to lab.

PROTECT YOURSELF FROM INFECTIONS

when using hypodermic needles



Clean your skin first!



- To clean the skin before injecting, use soap and water or alcohol wipes.
- Germs can cause skin infections (like boils or abscesses). Germs can also cause blood, heart, and bone infections.
- All these infections can give you blood poisoning called sepsis.

SEPSIS IS AN EMERGENCY!

If you have fever, chills, skin redness (including streaks from the site of injection), swelling, or abscess (boils) please notify health care staff immediately and submit a 7362.

Only use new needles and syringes!



- If you inject drugs or medicines with a needle used by someone else, you can get HIV, or Hepatitis B or C.
- Drugs can be used in a lot of ways. Out of all the ways to use drugs, injection is most risky.
- Try to use a brand-new needle for each injection, even if you are not sharing with anyone else.
- Cleaning your needle can reduce the germs but does not kill them all.

Did you know...?



The hepatitis C virus can live in a needle for two months!



Each time a needle is used, it gets more dull. This makes it more likely to hurt or cause problems in your body.



Bleach is better than CellBlock 64 at killing germs like HIV, hepatitis B, and hepatitis C, but does not kill all the germs every time.

Get tested, get treated!

If you do inject drugs, talk to your doctor about infections and get tested at least once a year for hepatitis B and C, and HIV. Treatment is safe and available to you at no charge!

If you think you have a substance use disorder, there are medicines and other treatments which can help you! You can ask any health care staff at any appointment or submit a 7362.

For more information, talk to your health care provider about Integrated Substance Use Disorder Treatment.

July 7, 2023

MPOX

Protect yourself from mpox virus

Mpox is a virus that can cause a painful rash. It spreads mostly through prolonged skin-to-skin contact, especially sexual contact. It can also be spread by touching items that someone with mpox has touched. Anyone can get mpox, but men who have sex with men and people who have multiple sexual partners have been more likely to get mpox.



To protect yourself:

- ✓ If you think you might be at risk for getting mpox, ask health services staff about getting vaccinated
- ✓ Wash your hands often with soap and water
- ✗ Avoid skin-to-skin and sexual contact with people who have a rash that looks like mpox
- ✗ Don't share eating utensils, cups, bowls, or personal items
- ✗ Don't share bed linens, towels, or clothes

If you are exposed to someone who has mpox

- You might be offered a vaccine to help prevent infection.
- Check yourself for symptoms for 21 days:
 - » Itchy/painful rash that looks like sores or blisters
 - » Fever, chills, headache, or muscle aches
- If symptoms develop, let health services know as quickly as possible.
 - » Your rash might be tested for the virus.
 - » While you are waiting for the results, you might be housed in a separate room away from other people.



If you test positive for mpox

- You should be housed in a separate room until the rash heals.
- You might be offered treatment to help the rash heal more quickly, if needed.
- Wear a mask and cover the rash if you have to be around others.



CS33985-A | 12/02/2022

Educación del Paciente: Virus de la Inmunodeficiencia Humana (VIH)

LO QUE DEBE SABER SOBRE EL VIH

- El VIH es un virus que ataca el sistema inmunológico del cuerpo, lo que le dificulta combatir otras infecciones.
- Puede tener VIH durante años y no sentirse enfermo.
- Si el VIH no se trata, puede destruir lentamente el sistema inmunitario. Es posible que contraiga otras infecciones graves y tal vez mortales.
- El SIDA (Síndrome de Inmunodeficiencia Adquirida) a menudo ocurre en pacientes con VIH no tratado. Esta es la etapa más grave del VIH.
- No existe cura ni vacuna para el VIH, pero el tratamiento puede ayudarle a vivir más tiempo y prevenir otros problemas dolorosos y graves.
- El tratamiento temprano puede salvarle la vida.

CONOZCA SU ESTADO

- Pídale a su proveedor de atención médica que le haga la prueba del VIH si nunca se ha hecho la prueba. El VIH puede tardar semanas en aparecer en la sangre.

SEPA CÓMO SE PROPAGA EL VIH

- Al tener relaciones sexuales con una persona que tiene el VIH y no lo sabe o no está tomando medicamentos para ello.
- Al compartir agujas y obras para inyectarse drogas.
- Durante el embarazo, el parto o la lactancia.

SEPA CÓMO NO SE CONTAGIA EL VIH

- El VIH no se transmite al besarse en seco, al darse la mano, al abrazarse, al compartir utensilios o alimentos, o al compartir baños.
- El VIH no se transmite al entrar en contacto con las lágrimas, la saliva o el sudor, ni al toser o estornudar, ni por insectos o mascotas.

SEPA CÓMO PROTEGERSE

- Elija actividades sexuales que tengan un riesgo más bajo, como el sexo oral.
- Usar condones con el sexo anal o vaginal.
- Si se inyecta drogas, solo use agujas, jeringas y dispositivos de trabajo nuevos cada vez.
- Hágase la prueba del VIH y de las infecciones de transmisión sexual, lo que puede facilitar el contagio del VIH.
- Hable con su proveedor de atención médica sobre la profilaxis previa a la exposición al VIH (PrEP, por sus siglas en inglés), un medicamento que puede ayudar a evitar que contraiga el VIH

SI CREE QUE HA ESTADO EXPUESTO, CONSULTE A SU PROVEEDOR DE ATENCIÓN MÉDICA

ESPECIALMENTE SI TIENES ALGUNO DE LOS SIGUIENTES:

- Fiebre
- Pérdida de peso
- Manchas blancas en la boca
- Diarrea
- Glándulas inflamadas
- Infecciones vaginales por hongos
- Sudores nocturnos
- Fatiga

SI ESTÁ TOMANDO MEDICAMENTOS CONTRA EL VIH, TÓMELOS TODOS LOS DÍAS

- Las dosis olvidadas pueden hacer que su medicamento deje de funcionar para controlar el VIH. Dígale a su proveedor de atención médica si no puede tomar sus medicamentos contra el VIH debido a efectos secundarios graves u otras razones.

Cáncer anal: riesgo y prevención

¿Cuáles son los factores de riesgo?

Infección por VPH (virus del papiloma humano)

El VPH es el virus que causa las verrugas. La infección por VPH es el riesgo más importante para el cáncer anal. El VPH puede transmitirse de una persona a otra durante el contacto piel con piel, especialmente a través de las relaciones sexuales. Ciertos tipos de VPH tienen más probabilidades de causar cáncer anal. El virus infecta la piel y el revestimiento del ano y causa cambios que eventualmente pueden conducir al cáncer.

Infección por VIH

Las personas infectadas con el VIH (el virus de la inmunodeficiencia humana), el virus que causa el SIDA, son mucho más propensas a contraer cáncer anal que las que no están infectadas con este virus.

Verrugas anales

Las personas que han tenido verrugas anales son más propensas a contraer cáncer anal. Las verrugas no se convierten en cáncer, pero las personas que están infectadas con los tipos de VPH que causan verrugas anales y genitales también tienen más probabilidades de infectarse con los tipos de VPH que causan cáncer anal.

Actividad sexual

Tener múltiples parejas sexuales aumenta el riesgo de infección por el VIH y el VPH. También aumenta el riesgo de cáncer anal. El sexo anal receptivo también aumenta el riesgo de cáncer anal tanto en hombres como en mujeres. Debido a esto, los hombres que tienen relaciones sexuales con hombres tienen un mayor riesgo de cáncer anal.

Tabaquismo

Fumar aumenta el riesgo de cáncer anal, y cuanto más ha fumado una persona, mayor es su riesgo de desarrollar cáncer anal. Las personas que fuman actualmente tienen más probabilidades de tener cáncer de ano en comparación con las personas que no fuman o que han dejado de fumar.

Prevención del cáncer anal

Vacunados contra el VPH

Hay vacunas disponibles que protegen contra los tipos de VPH que están relacionados con las verrugas y el cáncer anal. Estas vacunas solo se pueden usar para ayudar a prevenir la infección por VPH, no ayudan a tratar una infección existente. Para que funcione mejor, la vacuna debe administrarse a los niños a una edad temprana antes de que sean sexualmente activos.

Tratamiento del VIH

Para las personas con VIH, es muy importante tomar medicamentos para ayudar a mantener la infección por el VIH bajo control. Esto también puede reducir el riesgo de infección por VPH a largo plazo y lesiones precancerosas, lo que podría ayudar a reducir el riesgo de cáncer anal.

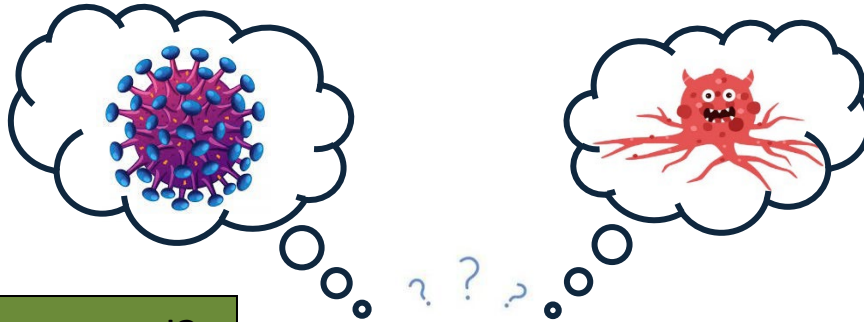
Frotis anal "Pap"

Para las personas con VPH, un proveedor de atención médica puede realizar una prueba llamada prueba de Papanicolaou para detectar cambios precancerosos en el canal anal. Si se detectan estos cambios, existen procedimientos que pueden tratar estas áreas y reducir la posibilidad de que se conviertan en cáncer.

No fumar

Dejar de fumar reduce en gran medida el riesgo de desarrollar cáncer anal y muchos otros tipos de cáncer.

“Estoy viviendo con VIH. ¿Necesito una prueba de detección de cáncer anal?”



¿Qué es el cáncer anal?

El cáncer anal comienza cuando se desarrollan células anormales en el ano.

El cáncer anal ocurre tanto en hombres como en mujeres. **Las personas que viven con VIH tienen un riesgo mucho mayor de padecer cáncer de ano.**

La mayoría de los cánceres anales son causados por el VPH, un virus común que se transmite a través de cualquier tipo de contacto sexual. Hay varios tipos de VPH. Algunos tipos de VPH pueden provocar cáncer de ano.

Su proveedor de atención médica puede realizar una prueba sencilla en la sala de examen que puede indicar si necesita tratamiento para reducir el riesgo de cáncer anal.

No te avergüences. **Conozca su riesgo.** Hable con su proveedor de atención médica sobre el cáncer de ano.



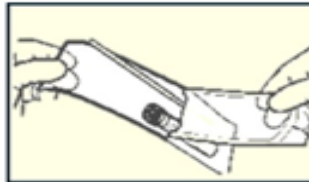


PONTE A PRUEBA

Hisopado rectal recogido por el propio paciente



1 Lavarse las manos con agua y jabón durante al menos 20 segundos.



2 Sacar el tubo y la torunda rosa del envase.



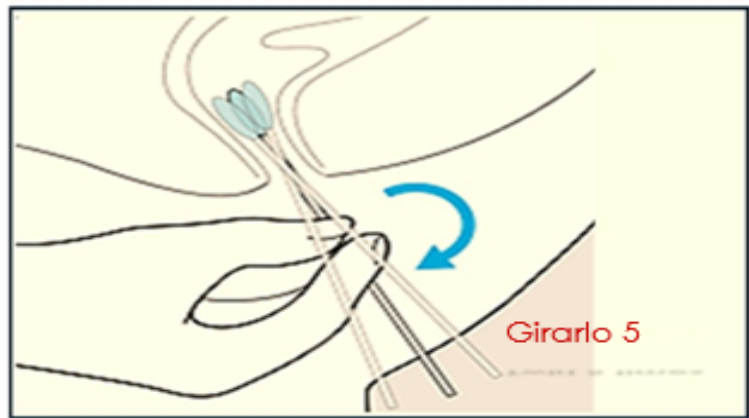
3 Colocar la etiqueta en el tubo.



4 Sujetar firmemente la torunda por encima de la línea discontinua (cerca



5 Colocarse en una posición cómoda que le permita acceder al ano.



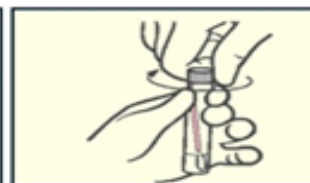
6 Introducir suavemente la torunda 2,5 cm en el recto y girar la torunda en círculo 5 veces.



7 Desenroscar el tapón del tubo de transporte.



8 Colocar la torunda en el tubo de transporte. Colocar la torunda en la línea discontinua.



9 Volver a colocar el tapón en el tubo de transporte y cerrarlo.



10 Lavarse las manos con agua y jabón y volver al laboratorio.

PROTÉJASE DE LAS INFECCIONES

— cuando utilice agujas hipodérmicas —



¡Limpia primero la piel!



- Para limpiar la piel antes de la inyección, utiliza agua y jabón o toallitas con alcohol.
- Los gérmenes pueden causar infecciones cutáneas (como forúnculos o abscesos). Los gérmenes también pueden causar infecciones sanguíneas, cardíacas y óseas.
- Todas estas infecciones pueden provocar una infección sanguínea llamada sepsis.

¡LA SEPSIS ES UNA EMERGENCIA!

Si tienes fiebre, escalofríos, enrojecimiento de la piel (incluidas las marcas en la zona de punción), hinchazón o absceso (forúnculos), notifíquelo inmediatamente al personal médico y envíe un 7362.

¡Utiliza únicamente agujas y jeringas nuevas!



- Si te inyectas drogas o medicamentos con una aguja utilizada por otra persona, puedes contraer el VIH o la hepatitis B o C.
- Las drogas pueden consumirse de muchas maneras. Entre todas las formas de consumir drogas, el uso de jeringas es el más arriesgado.
- Procura utilizar una aguja nueva para cada inyección, aunque no la compartas con nadie.
- Limpiar la aguja puede reducir los gérmenes, pero no los elimina todos.

¿Sabías que...?



¡El virus de la hepatitis C puede permanecer vivo en una aguja durante dos meses!



Cada vez que se utiliza una aguja, se desafilan más. Esto hace que sea más probable que duela o cause problemas en el cuerpo.



La lejía es mejor que el bloque celular 64 para matar gérmenes como el VIH, la hepatitis B y la hepatitis C, pero no mata todos los gérmenes siempre.

Hazte la prueba, ¡hazte el tratamiento!

Si te inyectas drogas, habla con tu médico sobre las infecciones y hazte la prueba de la hepatitis B y C y del VIH al menos una vez al año. ¡El tratamiento es seguro y gratuito!

Si crees que padeces un trastorno por consumo de sustancias, existen medicamentos y otros tratamientos que pueden ayudarte. Puedes preguntar a cualquier miembro del personal de la salud en cualquier consulta o presentar un 7362.

Para obtener más información, hable con su proveedor de atención médica sobre el Tratamiento integrado de los trastornos por consumo de sustancias.

VIRUELA SÍMICA

Protéjase del virus de la viruela símica (mpox en inglés)

El virus de la viruela símica puede causar un sarpullido doloroso. Se propaga mayormente a través del contacto prolongado de piel a piel, especialmente el contacto sexual. También se puede propagar mediante el contacto con los objetos que haya tocado una persona con la viruela símica. Cualquier persona puede contraer la viruela símica, pero los hombres que tienen relaciones sexuales con hombres y las personas que tienen múltiples parejas sexuales han tenido más probabilidades de contraerla.



Para protegerse:

- ✓ Si cree que podría estar en riesgo de contraer la viruela símica, pregúntele al personal de servicios de salud sobre la vacunación.
- ✓ Lávese las manos con agua y jabón frecuentemente.
- ✗ Evite el contacto de piel a piel y sexual con quienes tengan un sarpullido que se parezca al de la viruela símica.
- ✗ No comparta cubiertos, vasos, tazas, tazones o artículos personales.
- ✗ No comparta ropa de cama, toallas o ropa.

Si se expone a alguien que tiene viruela símica

- Se le podría ofrecer una vacuna para ayudar a prevenir la infección.
- Revítese durante 21 días por si presenta síntomas:
 - » Sarpullido con la apariencia de llagas o ampollas que pica o duele.
 - » Fiebre, escalofríos, dolor de cabeza o dolores musculares.
- Si presenta síntomas, avísele a servicios de salud lo más rápido posible.
 - » Podrían hacerle pruebas de detección del virus al sarpullido.
 - » Mientras espera los resultados, podrían pasarlo a un área separada de los demás.



Si la prueba de viruela símica da positivo

- Deberían pasarlo a un área separada hasta que sane el sarpullido.
- Podrían ofrecerle tratamiento para ayudar a que el sarpullido sane más rápido, si lo necesita.
- Póngase una mascarilla y cúbrase el sarpullido si debe estar alrededor de otras personas.



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