HIV/STI Post-Sexual Exposure Prophylaxis:
Policy and Procedure Template

† This template was created by the AIDS Education & Training Center (AETC) Program Rural Health Committee to provide a framework for healthcare facilities to use for creating a policy and procedure for providing medical care to patients seen following possible sexual exposures to HIV and common sexually transmitted infections. Recommendations in this document are based on the most recent guidelines of the U.S. Centers for Disease Control and Prevention (CDC) at the time of its writing, August 2018. This template may be adapted for use in your healthcare facility without permission from the authors. The project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U1OHA28686 (AIDS Education and Training Centers National Coordinating Resource Center) awarded to the François-Xavier Bagnoud Center, Rutgers University School of Nursing. No percentage of this project was financed with non-governmental sources. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by, HRSA, HHS or the U.S. Government.
POLICY
The purpose of this policy is to promote the recommended medical treatment of all patients who present for care after possible sexual exposure to HIV through sexual assault or consensual sexual activity receive CDC recommended preventative care options for HIV, common sexually transmitted infections, and pregnancy.

- A 28-day course of HIV non-occupational post-exposure prophylaxis (nPEP) should be considered for all HIV-negative persons who seek care ≤72 hours after a sexual exposure to blood, genital secretions, or other potentially infectious body fluids of a person who is living with HIV (PLWH) or is of unknown HIV status, if that exposure represents a substantial risk for HIV acquisition.
- Adherence to nPEP medications is critical for nPEP effectiveness; thus, it is preferable to prescribe regimens that minimize the likelihood of side effects and the number of pills per day.
- For persons seeking care after a risky sexual exposure, common sexually transmitted infections should be treated presumptively, and emergency contraception should be offered when indicated.

PROCEDURE
1. Evaluation
Evaluation of the exposed patient should be conducted with the highest level of sensitivity and confidentiality. The algorithm for evaluation and treatment shown in Figure 1 will be used to determine the risk for HIV acquisition and the indication for nPEP.

Figure 1. Algorithm for evaluation and treatment of possible non-occupational HIV exposures

\[\text{Substantial risk for HIV Acquisition} \]
\[\begin{align*}
\text{≤72 hours since exposure} & \quad \text{Source patient known to be HIV-positive} \\
& \quad \text{nPEP recommended}
\end{align*}\]

\[\begin{align*}
\text{≥73 hours since exposure} & \quad \text{Source patient of unknown HIV status} \\
& \quad \text{Case-by-case determination}
\end{align*}\]

\[\text{Negligible risk for HIV Acquisition} \]

\[\text{Substantial Risk for HIV Acquisition} \]
\[\begin{align*}
\text{Exposure of} & \quad \text{vagina, rectum, eye, mouth, or other mucous membrane, nonintact skin, or percutaneous contact} \\
\text{With} & \quad \text{blood, semen, vaginal secretions, rectal secretions, breast milk, or any body fluid that is visibly contaminated with blood} \\
\text{When} & \quad \text{the source is known to be HIV-positive}
\end{align*}\]

\[\text{Negligible Risk for HIV Acquisition} \]
\[\begin{align*}
\text{Exposure of} & \quad \text{vagina, rectum, eye, mouth, or other mucous membrane, intact of nonintact skin, or percutaneous contact} \\
\text{With} & \quad \text{urine, nasal secretions, saliva, sweat or tears if not visibly contaminated with blood} \\
\text{Regardless} & \quad \text{of the known source or suspected HIV status of the source}
\end{align*}\]
Potential risks of nPEP outweigh benefits for persons with perceived exposures that are of negligible or no conceivable risk of HIV acquisition, and nPEP is generally not indicated under these circumstances. Clinicians should be willing to decline requests for nPEP and provide supportive counseling and referrals in these situations.

The following circumstances of the sexual exposure and decisions about nPEP management should be recorded in the medical record:

**EXPOSURE:** Date and time of possible HIV exposure (was the possible exposure within the past 72 hours?)

**EXPOSURE TYPE:** Details of the sexual exposure, including the type (seminal, vaginal, blood) and route of exposure (oral, rectal, vaginal, other mucosal membrane exposure).
- The exposure should be evaluated for risk of HIV acquisition based on (1) the type of body fluid, (2) route of exposure, and (3) HIV status of the source patient (see Figure 1).
- Decisions about whether to prescribe nPEP should be individualized, weighing the likelihood of HIV transmission with the potential benefits and risks of nPEP use.
- The decision to initiate nPEP is based on whether a significant exposure risk has occurred (see Figure 1), rather than on the age or identity of the alleged assailant.

**SOURCE:** Details about exposure source person, if available
- HIV, hepatitis B, and hepatitis C status
- If the potential source person is a person living with HIV, try to ascertain their recent HIV viral load, CD4 count, current and previous antiretroviral therapy use, and antiretroviral resistance information.

**PATIENT:** Details about the exposed patient
- HIV status; hepatitis A (HAV), hepatitis B (HBV), and hepatitis C status; vaccination history (HAV, HBV, human papilloma virus [HPV])
- Chronic medical conditions, drug allergies, and current medications including pre-exposure prophylaxis (PrEP) use, and medication adherence
- Pregnancy status, conception plans, and breastfeeding status
- The likelihood of pre-existing (but undiagnosed) HIV infection should be determined for all individuals who present for nPEP. The following information should be obtained:
  - Has the patient ever been tested for HIV, and if so, what was the result and date of their most recent HIV test?
  - The frequency, timing, and types of HIV risk behaviors since the last negative HIV test result. The likelihood of pre-existing HIV infection should be reviewed with the patient prior to nPEP prescription.
  - Screen for acute HIV infection (e.g., the patient has symptoms such as fever or flu-like symptoms, lymphadenopathy, rash).
  - If pre-existing HIV infection is suspected, and the current (today’s) HIV antigen/antibody or HIV antibody test (see below) is negative (or “non-reactive”), a blood-based HIV nucleic acid amplification test (NAAT, or “viral load”) should be done to verify the presence or absence of acute HIV infection.
- If patient reports ongoing risk behaviors and is HIV-negative, counsel on the option of PrEP; transition to PrEP can occur immediately after completion of nPEP (if nPEP is not prescribed, PrEP initiation can occur once the patient is confirmed to be HIV negative and has adequate renal function)
- If the patient is already known to be HIV-positive, are they receiving HIV care? Are they on antiretroviral therapy and virally suppressed?
If not, contact an HIV expert or infectious disease (ID) provider to link to care as soon as possible.

An HIV-positive patient does not need nPEP (but does need evaluation and empiric treatment for other sexually transmitted infections [STIs], as below).

- **With the information you have gathered, use the Evaluation and Treatment Algorithm (Figure 1) to determine the level of risk of HIV infection and the recommendation regarding nPEP.**
- **If the patient is at risk of HIV infection from the reported sexual exposure (see Figure 1), they should be offered nPEP and started on it as soon as possible (preferably within 1-2 hours of the exposure, but as soon as possible if not), unless they test HIV-positive as part of the current evaluation (see 2. Laboratory Tests, below).**

### 2. Laboratory Tests

- HIV test (preferably 4th generation HIV Ag/Ab test) at the current visit (baseline) and again (for persons treated with nPEP) at 4-6 weeks and 3 months after nPEP initiation.
- Alanine transaminase (ALT), aspartate aminotransferase (AST), serum creatinine and estimated glomerular filtration rate (eGFR), at baseline and 4-6 weeks follow-up if taking a tenofovir DF (TDF)-based regimen.
- Hepatitis C antibody, HBV surface antigen, HBV core antibody, and HBV surface antibody at baseline and, if negative and the sexual exposure was vaginal or rectal, again at 6 months post-exposure.
- Pregnancy test (for women of reproductive age with vaginal exposure to semen).
- Syphilis serology (usually RPR or VDRL)
- If HIV seroconversion occurs during or after nPEP (HIV test is “reactive” or positive after a baseline “non-reactive” or negative test), contact an HIV expert or ID provider immediately and provide guidance to the patient as recommended by an expert. Immediate linkage to care for antiretroviral therapy and HIV primary care is essential.

### 3. nPEP Medication Regimen

**EARLY treatment of the exposed patient is the PRIORITY and should NOT be delayed while waiting for lab results.**

**START nPEP if the patient has a substantial risk for infection, and the HIV test is negative (“non-reactive”).**

**INITIATE nPEP within 1-2 hours of exposure or as soon as possible and continue for 28 days.**

If a significant exposure occurred but the patient is too distraught (e.g., following a sexual assault) to engage in a discussion about the nPEP regimen at the initial assessment, the clinician should offer a first dose of the medications and arrange for follow-up within 24 hours to further discuss the indications for nPEP.
Preferred nPEP regimen for adolescents and adults (≥ 13 years old) with normal renal function (creatinine clearance >59 mL/min):

<table>
<thead>
<tr>
<th>Regimen</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tenofovir DF/emtricitabine (TDF/FTC) 300/200 mg (Truvada®), 1 tablet PO daily + dolutegravir (Tivicay®)* 50 mg, 1 tablet PO daily for 28 days**</td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td>TDF/FTC 300/200 mg (Truvada®) 1 tablet PO daily + raltegravir (Isentress®) 400 mg, 1 tablet PO BID for 28 days</td>
</tr>
<tr>
<td>OR ALTERNATIVE</td>
<td>TDF/FTC 300/200 mg (Truvada®) 1 tablet once daily + darunavir (Prezista®) 800 mg, 1 tablet daily + ritonavir (Norvir®) 100 mg, 1 tablet daily for 28 days</td>
</tr>
</tbody>
</table>

* If the patient is a woman who may conceive while on the medication, or is in the early stages of pregnancy, do not prescribe dolutegravir.
** If pharmacist will not dispense less than a 30-day supply of nPEP medications (because of cost to pharmacist of removing tablets from a 30-day bottle), then a prescription for a 30-day supply should be given.

Preferred nPEP regimen for adults and adolescents aged ≥ 13 years with renal dysfunction (creatinine clearance ≤ 59 mL/min):

<table>
<thead>
<tr>
<th>Regimen</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zidovudine and lamivudine with both doses adjusted to the degree of renal function + raltegravir (Isentress®) 400 mg, 1 tablet PO BID for 28 days</td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td>Zidovudine and lamivudine with both doses adjusted to degree of renal function + dolutegravir (Tivicay®)* 50 mg, 1 tablet PO daily for 28 days</td>
</tr>
<tr>
<td>OR ALTERNATIVE</td>
<td>Zidovudine and lamivudine with both doses adjusted to degree of renal function + darunavir (Prezista®) 800 mg, 1 tablet PO daily + ritonavir (Norvir®) 100 mg, 1 tablet PO daily, all taken at the same time, with food, for 28 days</td>
</tr>
</tbody>
</table>

* If the patient is a woman who may conceive while on the medication, or is in the early stages of pregnancy, do not prescribe dolutegravir.

- The dosing of TDF and FTC should be adjusted in patients with baseline creatinine clearance ≤ 59 mL/min. TDF should be used with caution in individuals with renal insufficiency or who are taking nephrotoxic medications. Fixed-dose combinations should not be used in patients who need dose adjustment.
- NOTE: It is recommended that all individuals be tested for the presence of chronic HBV before initiating medications that are active against HBV. This would include several medications that may be used in nPEP regimens: tenofovir (TDF or TAF), emtricitabine, and lamivudine. Severe acute exacerbations of HBV (including decompensated liver disease and liver failure) have been reported in patients who discontinue HBV-active medications. Patients with HBV should be closely monitored with both clinical and laboratory follow-up for at least several months after stopping Truvada® (TDF/emtricitabine) or other HBV-active medications. If appropriate, initiation of chronic anti-hepatitis B therapy may be warranted: https://www.aasld.org/sites/default/files/HBVGuidance_Terrault_et_al-2018-Hepatology.pdf.
4. Pregnancy

- For women of childbearing potential, document last menstrual period, and perform rapid urine pregnancy test. If the pregnancy test is negative, and vaginal exposure to semen occurred, offer emergency contraception on site.
- Pregnancy should not preclude nPEP use, but if the patient is in the early stages of pregnancy (i.e., < 8 weeks) or at risk of conceiving while on nPEP, dolutegravir should not be used.4
- If the woman is < 8 weeks pregnant or reports wanting to become pregnant and has normal renal function (creatinine clearance >59 mL/min), the recommended nPEP regimen is:
  
  TDF/FTC (Truvada®) 300/200 mg, 1 tablet PO daily + raltegravir (Isentress®) 400 mg, 1 tablet PO BID for 28 days

- Counsel on the risk of breastfeeding after a possible HIV exposure (there is a risk of transmission to the infant through breastfeeding if the mother becomes infected with HIV).5

5. Treatment for Sexually Transmitted Infections

Gonorrhea (GC), chlamydia (CT), and trichomonas (for women) should be treated presumptively if oral, vaginal, and/or anal sex occurred.3 Testing for GC/CT (DNA swab testing or urine testing instead of genital swabbing) may be performed if requested by patient, but is not necessary since empiric treatment should be given, and results will not reflect the current possible exposure. Syphilis serology should be ordered with other blood tests.

- For adolescents (≥ 13 years) and adults, treat for GC and CT with ceftriaxone 250 mg IM once, and azithromycin 1 gram PO once, preferably at the same time and under directly observed therapy to ensure completion of treatment.
- For women, treat empirically for trichomonas with metronidazole 2 grams PO once OR tinidazole 2 grams PO once (have her take it after discharge from the emergency department/clinical site) if alcohol has been consumed in the prior 24 hours or if emergency contraception was taken, to minimize potential side effects and drug interactions).3
- For patients 9-26 years old who have not completed human papillomavirus (HPV) vaccinations, offer the HPV vaccine. HPV vaccination is recommended for females aged 9–26 years and males aged 9–21 years. For males who have sex with males (MSM) who have not received HPV vaccine or who have been incompletely vaccinated, vaccine can be administered through age 26 years. The vaccine should be administered at the initial examination, and follow-up dose(s) administered according to the usual vaccination schedule.3 Assist in referring the patient for completion of the HPV vaccine series.
- Post-exposure hepatitis B vaccination (without HBIG) should be given if the hepatitis B status of the source person is unknown and the patient has not been vaccinated previously. If the source person is known to be HBV surface Ag-positive, unvaccinated exposed patients should receive both hepatitis B vaccine and HBIG. The vaccine and HBIG, if indicated, should be administered at the time of the initial evaluation, and follow-up doses of vaccine should be administered as per the usual vaccination schedule. Patients who were previously vaccinated but did not receive a post-vaccination test confirming immunity should receive a single vaccine booster dose.3

For questions, contact your HIV experts/ID providers or consult with the National Clinician Consultation Center PEP Hotline (PEPline): 1-888-448-4911
If alternative nPEP medication is required (i.e., in case of renal insufficiency, a pediatric patient, etc.), consult an HIV expert or ID provider immediately, or consult with a clinician from the National Clinician Consultation Center PEPline 888-HIV-4911 (888-448-4911) 9 a.m. – 8 p.m. ET Monday – Friday 11 a.m. – 8 p.m. ET on Saturday, Sunday, & holidays

PATIENT EDUCATION

• Instruct the patient to use condoms during vaginal and/or anal sex or to abstain from sex until HIV transmission has been ruled out (i.e., negative HIV test results 3 months after the possible exposure) or the source person has been found to be HIV negative.

• Educate the patient on possible nPEP side effects (nausea, GI upset, headache, and myalgias are the most common) and consider prescribing an anti-emetic to be taken before the HIV nPEP.

• Educate the patient on the importance of close adherence with the nPEP medications....

• Reinforce the need for follow-up appointments within 24-72 hours of the initial assessment, at 4-6 weeks, and at 3 months, and assist with referring/setting appointments before the patient is discharged.

Figure 2. Sequence of appearance of laboratory markers of HIV-1 infection

Note. Units for vertical axis are not noted because their magnitude differs for RNA, p24 antigen, and antibody.

REFERENCES


LABORATORY ORDER FORM

Date: __________________________

Patient’s Name: ________________________________________________ DOB: ______________________

Medical Record #: ________________________________________________

Diagnosis/Reason for Blood Work: ______________________________________________________________

Laboratory:

☐ HIV test (HIV Ag/Ab, if available)
☐ Hepatitis A Total Antibody
☐ Hepatitis C Antibody
☐ Hepatitis B Surface Antigen
☐ Hepatitis B Surface Antibody
☐ Hepatitis B Core Antibody
☐ Pregnancy Test
  For those being prescribed a TDF/FTC (Truvada®)-based regimen:
  ☐ Serum creatinine for calculated eGFR
  ☐ Alanine transaminase (ALT)
  ☐ Aspartate aminotransferase (AST)

For sexual exposures and with patient’s consent:

☐ Syphilis serology
☐ GC/CT urine NAAT
  ☐ GC/CT genital swab NAAT ☐ GC/CT pharyngeal swab NAAT
  (if urine NAAT not available) ☐ GC/CT rectal swab NAAT

☐ Other ___________________________________________________________

☐ Other ___________________________________________________________
PATIENT DISCHARGE INSTRUCTIONS

You may be at risk of becoming infected with the human immunodeficiency virus (HIV) because of your sexual exposure or assault, and you have been counseled on HIV infection risk, and on medications for HIV prevention called nPEP.

- **nPEP is most effective if started as soon as possible (within 1-2 hours after the exposure or as soon as possible if), but no later than 72 hours** after the exposure. nPEP should be taken for 28 days to decrease the likelihood of becoming infected with HIV.
- **It is very important to take the nPEP medicines every day, without interruption.**
- Sometimes the medicines can cause unpleasant side effects like nausea and fatigue as well as diarrhea, headaches and rashes.
- The most common medication side effect is nausea. If you experience nausea, take the prescribed anti-nausea medicine ½ hour before taking the nPEP medications.
- Some nPEP medications can interact with other prescriptions, street drugs, or over the counter medications, so please inform your healthcare provider if you are using any other medicines or drugs in addition to the nPEP medicines.
- Please call your healthcare provider if any side effects become concerning to you, because these medications SHOULD NOT be discontinued once started unless side effects are severe or life-threatening.

You will need a follow-up appointment with __________________________ within the next few days, at the following location __________________________ and phone number __________________________ to:

- review your lab results and check in about any side effects that you may be having or any other any problems with taking the nPEP medications
- determine if you should continue to take the medications

**You will be taking these medications (circled or checked):**

For adults and adolescents aged ≥ 13 years with normal renal function (creatinine clearance > 59mL/min):

- **□ ** Truvada® 300/200 mg, one tablet once daily by mouth with dolutegravir* (Tivicay®) 50 mg, one tablet by mouth once daily, with or without food for 28 days.
  * Non-pregnant women at risk of pregnancy and who are not using reliable birth control; and, women early in pregnancy should NOT take dolutegravir.
  
- **OR**
  - **□ ** Truvada® 300/200 mg, one tablet by mouth once daily with raltegravir (Isentress®) 400mg, one tablet by mouth twice daily, with or without food for 28 days.
  
- **OR**
  - **□ ** Truvada® 300/200 mg, one tablet by mouth once daily with darunavir (Prezista®) 800 mg, one tablet by mouth once daily + ritonavir (Norvir®) 100 mg, one tablet by mouth once daily for 28 days. This is a total of 3 pills all taken at the same time, with food.
For adults and adolescents aged ≥ 13 years with renal dysfunction (creatinine clearance ≤ 59mL/min):

- zidovudine + lamivudine + raltegravir (Isentress®) 400 mg, one tablet by mouth twice daily for 28 days.

- zidovudine + lamivudine + dolutegravir (Tivicay®) 50 mg, one tablet by mouth once daily, with or without food for 28 days.

- zidovudine + lamivudine + darunavir (Prezista®) 800 mg, one tablet by mouth once daily + ritonavir (Norvir®) 100 mg, one tablet by mouth once daily, all taken at the same time with food for 28 days.

FOR NAUSEA:

- Ondansetron (Zofran®) 8 mg, one tablet by mouth once — take ½ hour before you take nPEP medications (if needed for nausea)

It is important that you:

- take all nPEP medications as prescribed and at the same time every day
- use a condom during sex (or abstain from sex) until we are certain you have not been infected with HIV (with negative HIV test results 3 months from today) or the source person has been found to be HIV negative.
- complete follow-up HIV testing and any additional testing/monitoring as instructed

Thank you for taking the difficult step to receive help.
Clinician Follow-up Evaluations for nPEP Patients

✓ Do follow-up HIV tests and any other indicated laboratory tests (see table below)
✓ Consider changing the nPEP regimen if indicated by side effects or results of initial testing (of exposed patient or source person)
✓ Provide additional counseling and support for medication adherence and HIV prevention, if indicated
✓ Consider prescribing pre-exposure prophylaxis (PrEP) to take after the nPEP (28-day regimen) is completed (i.e., to continue taking TDF/FTC one tablet once daily) if the patient is HIV negative and ongoing HIV risk behaviors are likely

Date seen in the emergency department/urgent care: _________________________________

Date initiated nPEP: _________________________________

**nPEP Regimen Prescribed:**

- [ ] TDF/FTC (Truvada®) 300/200 mg, 1 tablet daily + dolutegravir (Tivicay®) 50 mg, 1 tablet daily
- [ ] TDF/FTC (Truvada®) 300/200 mg, 1 tablet daily + raltegravir (Isentress®) 400 mg, 1 tablet BID
- [ ] TDF/FTC (Truvada®) 300/200 mg, 1 tablet daily + darunavir (Prezista®) 800 mg, 1 tablet daily + ritonavir (Norvir®) 100 mg, 1 tablet daily
- [ ] zidovudine ______ and lamivudine ______ + raltegravir (Isentress®) 400 mg, 1 tablet BID
- [ ] zidovudine ______ and lamivudine ______ + dolutegravir (Tivicay®) 50 mg, 1 tablet daily
- [ ] zidovudine ______ and lamivudine ______ + darunavir (Prezista®) 800 mg, 1 tablet daily + ritonavir (Norvir®) 100 mg, 1 tablet daily
- [ ] Other _______________________________________________________________________

**nPEP Adherence Questions:**

- “How many pills have you missed (if any) since starting the medication?” __________

- “Have you experienced any difficulties/barriers/worries related to taking the medication?”
  If yes, please explain:
  ________________________________________________________________________________

- “Have you experienced any side effects since starting the medication?”
  If yes, please explain: ____________________________________________________________________________
<table>
<thead>
<tr>
<th>Recommended Baseline and Follow-up Labs¹</th>
<th>Baseline</th>
<th>4–6 weeks after exposure</th>
<th>3 months after exposure</th>
<th>6 months after exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Test</strong></td>
<td>For all persons considered for or prescribed nPEP for any exposure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Ag/Ab testing² (or antibody testing if Ag/Ab test unavailable)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓³</td>
</tr>
<tr>
<td>Hepatitis B serology, including:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>hepatitis B surface antigen</td>
<td>✓</td>
<td>N/A</td>
<td>N/A</td>
<td>✓³</td>
</tr>
<tr>
<td>hepatitis B surface antibody</td>
<td>✓</td>
<td>N/A</td>
<td>N/A</td>
<td>✓³</td>
</tr>
<tr>
<td>hepatitis B core antibody</td>
<td>✓</td>
<td>N/A</td>
<td>N/A</td>
<td>✓³</td>
</tr>
<tr>
<td>Hepatitis C antibody test</td>
<td>✓</td>
<td>N/A</td>
<td>N/A</td>
<td>✓³</td>
</tr>
<tr>
<td><strong>For persons considered for or prescribed nPEP for sexual exposure and requesting STI testing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syphilis serology</td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
<td>✓</td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>For persons prescribed</strong></td>
<td>tenofovir DF + emtricitabine + raltegravir</td>
<td>OR</td>
<td>tenofovir DF + emtricitabine + dolutegravir</td>
<td></td>
</tr>
<tr>
<td>Serum creatinine (for calculating estimated creatinine clearance)</td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Alanine transaminase, aspartate aminotransferase</td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>For all persons with HIV infection confirmed at any visit</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV viral load</td>
<td>✓³</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV genotypic resistance</td>
<td>✓³</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Abbreviations:** Ag/Ab, antigen/antibody combination test; HIV, human immunodeficiency virus; nPEP, nonoccupational postexposure prophylaxis; tenofovir DF, tenofovir disoproxil fumarate.

² Any positive or indeterminate HIV antibody test should undergo confirmatory testing of HIV infection status.
³ Only if hepatitis C infection was acquired during the original exposure; delayed HIV seroconversion has been seen in persons who simultaneously acquire HIV and hepatitis C infection.
⁴ If exposed person susceptible to hepatitis B at baseline.
⁵ If exposed person susceptible to hepatitis C at baseline.

If determined to be infected with syphilis and treated, should undergo serologic syphilis testing 6 months after treatment.

Testing for chlamydia and gonorrhea should be performed using nucleic acid amplification tests. For patients diagnosed with a chlamydia or gonorrhea infection, retesting 3 months after treatment is recommended.

- For men reporting insertive vaginal, anal, or oral sex, a urine specimen should be tested for chlamydia and gonorrhea.
- For women reporting receptive vaginal sex, a vaginal (preferred) or endocervical swab or urine specimen should be tested for chlamydia and gonorrhea.
- For men and women reporting receptive anal sex, a rectal swab specimen should be tested for chlamydia and gonorrhea.
- For men and women reporting receptive oral sex, an oropharyngeal swab should be tested for gonorrhea.


⁶ If not provided presumptive treatment at baseline, or if symptomatic at follow-up visit.
⁷ If woman of reproductive age, not using effective contraception, and with vaginal exposure to semen.

¹ eCrCl = estimated creatinine clearance calculated by the Cockcroft-Gault formula; eCrClCG = [(140 – age) x ideal body weight] ÷ (serum creatinine x 72) ÷ 0.85 for females.

² At first visit where determined to have HIV infection.

Follow-up:

✓ Does patient have enough medicine (nPEP regimen and anti-nausea medication if needed) for 28-day course?
✓ Are any changes in the nPEP regimen needed?
✓ Is there a clear plan for follow-up with lab results?
✓ Are appointments set for follow-up at 2-4 weeks, 3 months, and 6 months if necessary?

For Clinician-to-Clinician Assistance with nPEP, Contact:

AETC National Clinician Consultation Center’s Post-Exposure Prophylaxis Hotline (PEPline):
888-HIV-4911 (888-448-4911)
9 a.m. – 8 p.m. ET Monday – Friday
11 a.m. – 8 p.m. ET on Saturday, Sunday, & holidays

http://ncc.ucsf.edu/clinician-consultation/PEP-post-exposure-prophylaxis/