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Towards personalized care for people living with HIV: Supporting open dialogue and informed treatment choices

Practice aid for HIV

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Oral ART regimen switches in individuals with a suppressed viral load: Guideline recommendations[1,2]

Oral **three-drug** regimen: **within** class switch*

- NRTI: TDF or ABC → TAF
- INSTI: RAL or EVG/c → BIC or DTG
- INSTI: DTG → BIC
- INSTI: BIC → DTG
- NNRTI: EFV → RPV or DOR
- NNRTI: RPV → DOR

Switch strategies **shown to be effective in clinical trials or likely to be effective** in those without underlying drug resistance.

Oral **three-drug** regimen: **between** class switch*

- Boosted PI → Second-generation INSTI (e.g. DTG, BIC)
- Boosted PI → RPV (NNRTI)
- Boosted PI → DOR (NNRTI)
- NNRTI → Second generation INSTI
- NNRTI → Boosted PI

Example switch **strategies shown to be effective in clinical trials or likely to be effective**, in those without underlying drug resistance.

Oral **two-drug** regimens for those switching from three drugs

- DTG/RPV (STR)
- DTG/3TC (STR)
- DTG + FTC
- Boosted PI (DRV/r, DRV/c, ATV/r, LPV/r) + 3TC[†‡]

Clinical-trial supported regimens for those with suppressed HIV (>3 months[§]) and no history of resistance. **None suitable for those with/at risk of HBV infection.**

Long-acting injectable CAB/RPV: Guideline recommendations[1,2]

A possible switch option in individuals with a suppressed viral load for:

At least 3 months (HHS)

At least 6 months (EACS)

A possible switch option in individuals with a suppressed viral load and:

No active HBV infection (HHS)

HBV immunity (EACS)

A possible switch option in individuals with a suppressed viral load and:

No historical resistance (HHS/EACS)

Country recommendations and approved indications vary by geography. Always consult local guidance and labels.

*EACS guidelines do not specify exact switch regimens but align with the principles shown here; [†]EACS guidelines recommend boosted DRV combined with either 3TC or FTC; [‡]Pill burden and possible side effects may be limitations compared to other two-drug regimens; [§]Six months in EACS guidelines.

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Key factors to consider in initial ART selection[1,2]

Person factors

- Treatment-limiting comorbidities
- Swallowing difficulties
- Likelihood of adherence
- Pregnancy or wish to conceive
- Individual preferences

Infection factors

- HIV RNA and CD4 count
- HIV resistance test results
- HIV acquired while on PrEP
- Presence of opportunistic infection
- TB infection
- HBV infection

Treatment factors

- HIV regimen efficacy
- Potential adverse effects
- Pill burden/dosing frequency
- Other medications that may interact
- Cost/access

- Recommended regimens should be considered first and are preferable for most people
- Alternative regimens should be considered if recommended regimens are not feasible
- Genotypic resistance testing recommended prior to initiation of ART (ideally at time of diagnosis) but should not delay ART initiation

Pill fatigue in individuals with a suppressed viral load: Potential questions and solutions[1,3,4]

Do you need help managing your medication?

- Is an STR an option if not already?
- Weekly/monthly pillboxes
- Reminders/alarms
- Automatic refills at pharmacy

Are side effects contributing to your pill fatigue?

- Can side effects be better managed?
- Is a regimen switch warranted to address side effects?

Is pill fatigue impacting your adherence?

- Is an STR an option if not already?
- Could an LA-regimen be suitable?
- Adherence support programmes

Do you have enough support?

- Patient organizations
- Therapist/counsellor
- Friends/family

Clinicians should always review current ART regimens; just because individuals are virologically suppressed, it should not be assumed that the person is well adapted and tolerating the current regimen[2]

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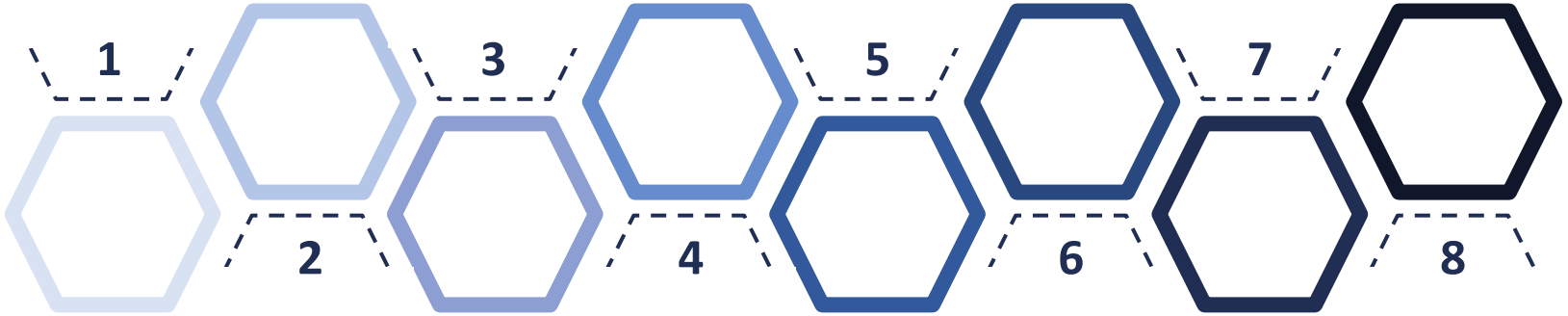
A framework for shared decision-making[5–8]

Seek participation: invite individual to be involved and listen actively

Provide clear evidence-based information: including about effectiveness and side effects

Evaluate understanding: check comprehension and address any questions

Arrange follow-up: to implement treatment and monitor progress



Explore preferences: understand values and what matters most

Discuss risks and benefits: through open discussion and information sharing

Make a collaborative decision: based on clinical evidence and individual preferences

Re-evaluate regularly: adjust treatment as needed

Abbreviations and references

Abbreviations

3TC, lamivudine; ABC, abacavir; ART, antiretroviral therapy; ATV/r, atazanavir/ritonavir; BIC, bictegravir; CAB, cabotegravir; DOR, doravirine; DRV/c, darunavir/cobicistat; DRV/r, darunavir/ritonavir; DTG, dolutegravir; EACS, European AIDS Clinical Society; EFV, efavirenz; EVG/c, elvitegravir/cobicistat; FTC, emtricitabine; HBV, hepatitis B virus; HHS, Human and Health Services; INSTI, integrase strand transfer inhibitor; LA, long-acting; LPV/r, lopinavir/ritonavir; NNRTI, non-NRTI; NRTI, nucleoside reverse transcriptase inhibitors; PI, protease inhibitor; PrEP, pre-exposure prophylaxis; RAL, raltegravir; RPV, rilpivirine; STR, single-tablet regimen; TAF, tenofovir alafenamide; TB, tuberculosis; TDF, tenofovir disoproxil fumarate.

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