PRESCRIBING HIV POST-EXPOSURE PROPHYLAXIS (PEP) IN AOTEAROA NEW ZEALAND

Burnett Foundation Aotearoa

NZSHS THE NEW ZEALAND SEXUAL HEALTH SOCIETY INCORPORATED SEXUAL HEALTH FOR ALL

PEP consists of 28 days of HIV antiretroviral therapy which must be commenced within 72 hours of a high risk exposure, ideally within 24 hours. PEP can be prescribed by any relevant prescriber, including (but not limited to) GPs and nurse practitioners.

1 ELIGIBILITY

Potential HIV exposure within past 72 hours

- **No** → Discuss condom use and other risk reduction methods. Offer PrEP if indicated.
  - **Offer HIV and STI screening** www.sti.guidelines.org.nz
- **Yes** → PEP recommended? **(see table 1 overleaf)**
  - **No** → Discuss condom use and other risk reduction methods. Offer PrEP if indicated.
  - **Yes** → **Proceed to Step 2**

2 ASSESSMENT

Review of medical history and medications

If any of the following, discuss with infectious diseases or sexual health physician before commencing PEP:

- Known or suspected antiretroviral resistance in the source
- Renal impairment
- Pregnancy or breastfeeding
- Drug interactions: www.hiv-druginteractions.org/checker
- Chronic Hepatitis B
- Allergy or adverse drug reaction

Request baseline laboratory testing (see table 2)

DO NOT WAIT for results before commencing PEP

Proceed to Step 3

3 PRESCRIBING PEP

Apply for special authority SA2139 (see box 1).

Exposed persons with appropriate risk who do not meet Pharmac criteria can be offered self funded PEP, approx NZ$30 (2-drug) or NZ$1345 (3-drug) PEP, depending on pharmacy mark-up

Prescribe PEP (see box 2 overleaf)

Patient education

- PEP is not 100% effective at preventing HIV
- Importance of adherence
- Seek medical attention if unwell or concerns
- Discuss potential side effects eg headache, GI effects, or renal toxicity (rare)

Proceed to Step 4

4 FOLLOW UP

- Review at 4–6 weeks and 3 months for laboratory monitoring (see table 2)
- Risk reduction practices until seronegative status confirmed at follow up
- If ongoing HIV risk likely, offer transition to PrEP at the 4 week follow up if the HIV test remains negative

Making an HIV diagnosis

Refer patient to local infectious diseases or sexual health service. Peer support and counselling available from community organisations:

- www.bodypositive.org.nz
- www.burnettfoundation.org.nz
- www.positivewomen.org.nz
- www.toituteao.org

See www.sti.guidelines.org.nz for further information

TABLE 2: LABORATORY MONITORING OF INDIVIDUALS WHO ARE PRESCRIBED PEP

Test	Baseline (Week 0)	Week 4–6	Month 3
HIV serology	x	x	x
Syphilis	x	x	x
Hepatitis B*	x		x
Hepatitis C	x		x
FBC, LFT, Creat, eGFR	x		
STI testing †	x	x	x
Pregnancy test^	x	x	

Notes:

* Individuals with evidence of previous immunity to hepatitis B (HBsAb positive) will require no further follow-up. Patients who have already commenced PEP whose baseline serology is consistent with chronic/active hepatitis B should have LFTs +/- viral load monitored. Advice from a specialist in the management of viral hepatitis should be sought.

† As per Aotearoa New Zealand STI Management Guidelines for use in Primary Care. See www.sti.guidelines.org.nz

^ If clinically indicated.

Box 1: PEP special authority criteria for non-occupational exposure

The Pharmac criteria for funded PEP are BOTH:

1. **Treatment course to be initiated within 72 hours post exposure; and**
2. **Any of the following:**
   a. Patient has had condomless anal intercourse or receptive vaginal intercourse with a known HIV-positive person with an unknown or detectable viral load greater than 200 copies per ml; or
   b. Patient has shared intravenous injecting equipment with a known HIV-positive person; or
   c. Patient has had non-consensual intercourse and the clinician considers that the risk assessment indicates prophylaxis is required; or
   d. Patient has had condomless anal intercourse with a person from a high HIV prevalence country or risk group* whose HIV status is unknown.

* this includes men who have sex with men (MSM)

This guidance is based on the NZSHS PrEP & PEP Guidelines for Aotearoa New Zealand (2023)

TABLE 1: PEP RECOMMENDATIONS

NB: Decisions to follow these recommendations must be based on the professional judgment of the clinician and consideration of individual patient circumstances.

	Source known HIV-positive		Source of unknown HIV status	
	HIV VL unknown or detectable	HIV VL undetectable	Source known to be MSM or from high-prevalence country	Source from other (low-prevalence) population
Sexual exposure				
Receptive anal sex	3 drug	Not recommended	2 drug	Not recommended
Insertive anal sex uncircumcised	3 drug	Not recommended	Consider 2 drug	Not recommended
Insertive anal sex circumcised	3 drug	Not recommended	Consider 2 drug	Not recommended
Receptive vaginal sex	3 drug	Not recommended	Consider 2 drug[a]	Not recommended
Insertive vaginal sex	3 drug	Not recommended	Not recommended	Not recommended
Fellatio	Not recommended[b]	Not recommended	Not recommended	Not recommended
Cunnilingus	Not recommended	Not recommended	Not recommended	Not recommended
Semen splash into eye	Not recommended	Not recommended	Not recommended	Not recommended
Occupational and other exposures				
Shared injecting equipment	3 drug	3 drug[c]	Consider 3 drug	Not recommended
Occupational needle-stick injury	3 drug	3 drug[c]	Generally not recommended[d]	Not recommended
Mucosal exposure/ splash injury to infectious fluids	3 drug	Generally not recommended[e]	Generally not recommended	Not recommended
Human bite	Not recommended[f]	Not recommended	Not recommended	Not recommended
Needle-stick injury from a discarded needle in community			Not recommended	Not recommended

VL: viral load

Notes:

PEP is not recommended for any exposure when the source is from a low-prevalence population or where the source is taking HIV pre-exposure prophylaxis (PrEP). Decisions to prescribe PEP when source is using PrEP can still be considered on a case-by-case basis due to potential for non-adherence of the source.

a. Where the source is from a high-risk group and normally resides outside NZ, the risk may be greater. Other factors that may influence decision-making include breaches in the mucosal barrier, multiple exposures within the previous 72 hours, STI in either partner. Where there is doubt, PEP should be given.

b. PEP may be recommended for receptive oral intercourse with ejaculation if the exposed person has a breach in their oral mucous membrane.

c. The risk of transmission is likely to be low, but in the absence of evidence to support U=U in the setting of a percutaneous exposure, the authors support offering PEP in this situation.

d. In the occupational setting, the source is usually able to be identified and tested for HIV, and PEP is usually only prescribed or continued for those who have definitely been exposed to HIV. If the source is unable to be tested immediately, the exposed healthcare worker should be commenced on PEP without waiting for the results if the source is at high risk of being HIV-positive. If the source is unable to be identified or tested, then the risk of the source being HIV-positive must be assessed from any epidemiological or other information available. The use of PEP should be decided on a case-by-case basis, and it is recommended that an expert is always consulted in this situation. It is reasonable to always offer PEP to a healthcare worker who has had a significant exposure to a source who is HIV-positive, even if the source has an undetectable HIV viral load.

e. Very low risk of transmission; however, 2 drug PEP could be considered for an occupational exposure based on the professional judgment of the clinician and consideration of individual patient circumstances.

f. PEP could be considered for patients who fulfil ALL of the three following criteria: a) the biter's saliva was visibly contaminated with blood; b) the biter is known or suspected to have a plasma HIV viral load >1000 copies/ml; and c) the bite has resulted in severe and/or deep tissue injuries.

Box 2: Prescribing PEP

- Patients should receive a prescription for the full course.
- PEP must be commenced **within 72 hours** of exposure, ideally within 24 hours.

TWO-DRUG PEP

- Co-formulated Tenofovir disoproxil 245mg* with emtricitabine 200mg
- One tablet once daily for 28 days

THREE-DRUG PEP

- Co-formulated Tenofovir disoproxil 245mg* with emtricitabine 200mg
- One tablet once daily for 28 days

PLUS

- Dolutegravir 50mg once daily for 28 days

*Tenofovir disoproxil fumarate 300 mg, tenofovir disoproxil maleate 300 mg, and tenofovir disoproxil succinate 300 mg are all equivalent to tenofovir disoproxil 245 mg