PRESCRIBING HIV PRE-EXPOSURE PROPHYLAXIS (PrEP) IN AOTEAROA NEW ZEALAND

Burnett Foundation Aotearoa

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

1 BEHAVIOURAL ELIGIBILITY

Patient requests PrEP
or
Patient unsure whether to start PrEP
or
HIV risk identified during consultation

Refer to HIV risks listed overleaf (table 1)

Elevated HIV risk

Proceed to Step 2

Low or no HIV risk

Discuss condoms & other risk reduction methods

Consider PrEP if likely future risk

2 CLINICAL ELIGIBILITY

Confirm HIV status and review medical history including renal function

HIV Negative
(tested within last 14 days)

Assess clinically for acute HIV infection (e.g. fever, night sweats, fatigue, myalgia, arthralgia, rash, headache, pharyngitis, generalised lymphadenopathy, diarrhoea)

Confirm normal renal function (eGFR > 60 mL/min)

Exclude use of nephrotoxic medication (e.g. high-dose NSAIDS) or medications that interact with PrEP

www.hiv-druginteractions.org

Proceed to Step 3

HIV Negative
But recent HIV exposure (within 72 hours)

Offer PEP (refer to full guidelines). If 2-drug PEP is recommended, prescribe PrEP **with advice for immediate start.**

Plan to commence PrEP upon completion of PEP course.

Repeat Step 2

HIV Positive

Not for PrEP

Refer to a local ID or sexual health service

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

3 OTHER TESTING

Assess for STIs and viral hepatitis (see table 3 overleaf)

STI testing as per the Aotearoa New Zealand STI Management Guidelines
www.sti.guidelines.org.nz

Hepatitis B serology (HBsAg, Anti-HBs)
Vaccinate if not immune
If HBsAg+ve, manage as per local Health Pathways

Hepatitis C serology (anti-HCV; followed by HCV RNA if anti-HCV +ve)
If HCV RNA+ve, then treat.
www.hepatitisfoundation.org.nz

Proceed to Step 4

Table 2: Suitability for daily vs event-driven PrEP for sexual exposure

People	Daily PrEP	Event-driven PrEP
Cisgender men	Yes	Yes*
Cisgender women	Yes	No
Trans men	Yes	No
Trans women using exogenous oestrogen	Yes	No
Trans women who are NOT using exogenous oestrogen	Yes	Yes*
Non-binary people assigned male at birth, using exogenous oestrogen	Yes	No
Non-binary people assigned male at birth, who are NOT using exogenous oestrogen	Yes	Yes*
Non-binary people assigned female at birth	Yes	No

* Where a person expresses a preference for event-driven PrEP, sex is infrequent and a person feels they can plan ahead for sex at least 2 hours in advance.

4 PRESCRIBING PrEP

Daily continuous PrEP

1 pill daily of tenofovir/emtricitabine. Protection is conferred after 7 days of daily dosing.

Populations eligible for event-driven PrEP can start 2 pills 2–24 hours before sex, then daily thereafter (see table 2).

Proceed to Step 5

OR

Event-driven PrEP (2-1-1 method)

Suitable **only** for certain populations (see table 2). Contraindicated if chronic hepatitis B infection.

tenofovir/emtricitabine:

- 2 pills at least 2h before sex (up to 24h before sex)
- 1 pill 24h later
- 1 pill 48h after first dose

If repeated sexual activity, then continue with 1 pill daily until 48h after last sexual contact.

Proceed to Step 5

5 EDUCATION & MONITORING

Patient education

- Discuss the role of condoms to prevent HIV and STIs, and emphasise role of regular STI testing.
- Discuss safer injecting practices, if applicable.
- Discuss potential side effects, early (eg headache, nausea) and longer term (eg renal toxicity, lowered bone density).

STOPPING PrEP:

- Populations eligible for event-driven PrEP can stop 48 hours after last exposure.
- All other patients on daily PrEP should continue PrEP for 7 days after last exposure.
- Patients who stop PrEP need a plan to re-start PrEP if their HIV risk increases again.

&

Ongoing monitoring

- Ongoing monitoring is required every 3 months, also for event-driven PrEP (see table 3 overleaf)
- Discuss PrEP adherence at every visit.
- Ask about nephrotoxic medications, eg NSAIDs.

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

TABLE 1: ELEVATED HIV RISK

Men (cis or trans) who have sex with men	Transwomen and non-binary people who share sexual networks with MSM	Heterosexual people	People who inject drugs
• Condomless intercourse (CLI) with a regular HIV+ partner who is not on treatment and/or has a detectable viral load > 200 copies/mL • CLI with any casual or non-exclusive MSM partner • Rectal gonorrhoea, rectal chlamydia or infectious syphilis • Methamphetamine use		• CLI with a regular HIV+ partner who is not on treatment and/or has a detectable viral load > 200 copies/mL • CLI with any casual MSM partner of unknown HIV status • Overseas travel to a high HIV prevalence country, and condomless sex with partners of unknown HIV status	• Shared injecting equipment with an HIV+ individual or with MSM of unknown HIV status

Notes on prescribing PrEP:

- Apply for special authority SA2138
- Prescribe: Tenofovir disoproxil 245 mg* + Emtricitabine 200mg (coformulated); 1 tablet daily for 90 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
- Patient to be advised to commence PrEP within 14 days of negative HIV test.
- Patients not eligible for publicly funded healthcare can self-fund from a NZ pharmacy (approx NZ$30/month, depending on pharmacy mark-up)

- If a partner is known to be living with HIV, on antiretroviral treatment and has an undetectable viral load, then there is no risk of HIV transmission from this partner.
- The risks listed above confer an **elevated risk of HIV**, and hence should prompt a clinician to recommend that a patient start PrEP.
  However, this list is not exhaustive, and patients who do not report these circumstances may still benefit from PrEP. See full guidelines for more information.
- A person is considered to be at elevated risk if they had these risks in the previous 3 months, and/or if they foresee these risks in the upcoming 3 months.

CLI: Condomless intercourse; **MSM:** Men who have sex with men.

TABLE 3: LABORATORY EVALUATION AND CLINICAL FOLLOW-UP OF INDIVIDUALS WHO ARE PRESCRIBED PrEP, INCLUDING EVENT-DRIVEN PrEP

Test	Baseline (Week 0)	About day 30 after initiating PrEP (recommended if recent HIV risk before starting PrEP)	90 days after initiating PrEP	Every subsequent 90 days on PrEP	Other frequency
HIV testing and assessment for signs or symptoms of acute infection	Y	Y	Y	Y	
Assess side effects	N	Y	Y	Y	
Hepatitis B serology. Vaccinate if non-immune.	Y	N	N	N	If patient required hepatitis B vaccine at baseline, confirm immune response to vaccination 1 month after last vaccine dose
Hepatitis C serology	Y	N	N	N	12 monthly but, more frequently if ongoing risk e.g. non-sterile injection drug use
STI (i.e. syphilis, gonorrhoea, chlamydia) as per www.sti.guidelines.org.nz	Y	N	Y	Y	
eGFR at 3 months and then every 6 months	Y	N	Y	N	At least every 6 months or according to risk of CKD
Urine protein creatinine ratio (PCR)	Y	N	Y	N	Every 6 months
Pregnancy test (if risk)	Y	Y	Y	Y	
Liver function (LFT)	Y	N	N	N	

CKD: chronic kidney disease; **eGFR:** estimated glomerular filtration rate; **PrEP:** pre-exposure prophylaxis; **STI:** sexually transmitted infection

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