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HIV Postexposure Prophylaxis (PEP)

Updated May 2025

Following a potential exposure to human immunodeficiency virus (HIV), postexposure prophylaxis (PEP, nPEP [non-occupational PEP], or oPEP [occupational PEP]) can be used to reduce the risk of developing HIV infection.[1-3] Use this checklist to identify when and how to safely use PEP in adults. See our *Pre-Exposure Prophylaxis (PrEP) Checklist*, for info on pre-emptive meds in patients at risk of HIV exposure. The National Clinician Consultation Center can be used by US healthcare providers for clinical advice.[1]

1 Identify the type of exposure.

- **Occupational**: percutaneous (i.e., needle stick); mucous membrane; or non-intact skin exposure to blood, body fluids, or tissue that may contain HIV as a part of work-related duties.[4]
  - Considered potentially infectious with HIV:[3] cerebrospinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids.
  - Considered potentially infectious with HIV **if visibly bloody**:[3] feces, nasal secretions, saliva, sputum, sweat, tears, urine, or vomitus.
- **Non-occupational**: exposure to blood and/or semen or vaginal secretions that may contain HIV through sexual activity or contaminated needles (e.g., sharing needles for injection drug use).[4]

2 Determine the need for PEP.

- Follow workplace protocols after potential **occupational exposures**.
- After all possible exposures (occupational and non-occupational) consider the following:[2,3]
  - Determine the HIV status of the potentially exposed AND source patients, if possible.
  - **Do not delay starting PEP while waiting for HIV test results**. PEP can be discontinued if the source patient is found to be HIV-negative.
  - Assess risk of transmission based on type of exposure and the source to see if PEP is appropriate.

What is the likelihood the source patient has transmissible HIV?[1,2]	**Type of Non-Occupational Exposure**		
	High-risk (e.g., receptive anal sex, needle sharing)[1,2]	**Moderate-risk** (e.g., insertive anal sex, insertive or receptive vaginal sex)[1,2]	**Low-risk** (e.g., giving or receiving oral sex, oral-anal contact, biting, spitting **without visible blood**)[1,2]
Substantial (e.g., source patient: HIV positive without sustained viral suppression)	Offer/start PEP		PEP is not recommended
Low (e.g., source patient: unknown HIV status)	Can consider offering/starting PEP on a case-by-case basis		
Negligible (e.g., source patient: HIV negative)	PEP is not recommended		

3 Select a PEP regimen.

- For most patients with occupational or non-occupational exposure without contraindications, the preferred regimens are:
  - US:[1] tenofovir alafenamide (TAF) 25 mg, emtricitabine 200 mg, and bictegravir 50 mg (Biktarvy), all once daily. This is a single-tablet once daily regimen.[8,10]
  - US:[1] dolutegravir 50 mg and (tenofovir disoproxil fumarate [TDF] 300 mg OR TAF 25 mg) and (emtricitabine 200 mg OR lamivudine 300 mg), all once daily.
  - Canada:[2] TDF 300 mg plus emtricitabine 200 mg (e.g., Truvada) once daily and (dolutegravir 50 mg once daily OR raltegravir 400 mg twice daily) OR (darunavir 800 mg once daily plus ritonavir 100 mg once daily).
- There are multiple alternate regimens that can be considered based on various patient factors (e.g., kidney or liver function, pregnancy, concurrent medications, previous exposure to antivirals):
  - for CrCl 30 to 49 mL/min, TAF is generally preferred over TDF.[1] Adjust dose of TDF, if using.[1]
  - for CrCl <30 mL/min, generally avoid TDF. When using, dose adjustment is needed for TDF or lamivudine. Consider consultation with an infectious disease expert.
  - for pregnant patients, the above (US) preferred regimens can be used.[1] Despite a previous report (2018) of an increased risk of neural tube defects with dolutegravir, current evidence does not support this association.[1,6,9]
  - see CDC guidelines for additional alternative regimens.[1]

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3 Select a PEP regimen (continued).

- Address possible drug-drug interactions.[3] To assess drug-drug interactions, use the Liverpool interaction checker (https://www.hiv-druginteractions.org) or HIV/HCV Drug Therapy Guide website (https://hivclinic.ca/app/#drugInt).
- Consider consulting an infectious disease expert (e.g., https://nccc.ucsf.edu/clinician-consultation/pep-post-exposure-prophylaxis/ or 888-448-4911), especially when selecting a PEP regimen for infants or children, pregnant patients, reduced kidney function, or concomitant medications, and to discuss alternative PEP options.[1] However, keep in mind that PEP must be started promptly and can be adjusted if necessary following consultation.[1]

4 Promptly start PEP in appropriate patients.

- Start PEP as early as possible after the exposure (ideally within 24 hours).[1] Initiation of PEP is not recommended more than 72 hours after exposure.[1] Do not delay the first dose awaiting test results.[1] Continue PEP for a total of 28 days.[1-3]

5 Counsel patients.

- Counsel ALL patients to avoid condomless sex, blood/tissue donations, pregnancy, and if possible, breastfeeding, especially during the first six to 12 weeks postexposure.[3]
- Counsel and refer appropriate patients to local resources to assist with avoiding high-risk behaviors (e.g., unprotected sex, sharing needles).[3]
- Stress adherence to PEP for the full 28 days of therapy and adherence to appropriate follow-up.[1-3]
- Counsel about potential PEP side effects (e.g., rash, insomnia, gastrointestinal upset).[1-3]
- Ask patients not to add new meds or supplements without checking with a pharmacist or prescriber.[3]

6 Evaluate patients and assess laboratory tests.

- Get BASELINE TESTS in all exposed patients, and if possible, from source patients including HIV antigen/antibody test, hepatitis B serology, and (for exposed patient only) kidney and liver function and pregnancy test (if applicable). If exposure was sexual/non-occupational, test exposed and source patients for hepatitis C, syphilis, gonorrhea, and chlamydia.[1-3]
  - HIV rapid (point-of-care) test should be done, if available, at baseline.
  - If the source patient is determined to be HIV-negative, PEP can be discontinued and no follow-up HIV testing for the exposed patient is needed.[3]
- Conduct follow-up tests in all exposed patients after exposure:[1-3] four to six weeks:(US only): HIV, kidney and liver function, and pregnancy and if exposure was sexual, syphilis, gonorrhea, and chlamydia; 12 weeks: HIV, hepatitis A and C (Canada only); six months: HIV (six-month HIV testing is only necessary if combination antigen/antibody testing is not used, or if patients acquire hepatitis C during exposure).
- Refer patients who test positive for HIV at baseline or during follow-up to an HIV specialist.[1-3]

7 Monitor patients.

- Follow monitoring recommendations as specified in product labeling for PEP regimen.
- Promptly evaluate patients who develop acute symptoms (e.g., rash, fever, hematuria, jaundice).[3]
- Assess the appropriateness of patients for PIP (PEP-in-pocket), where PEP is prescribed in advance for patients to have on hand in case of an unexpected HIV exposure. Consider PIP for patients with infrequent exposures (zero to four per year), the potential for unanticipated HIV exposures (e.g., patients at risk of nonconsensual sex [e.g., sex workers]), or limited access to urgent care. Patients should see their prescriber within one week of self-initiating PIP for HIV and STI testing.[8]
- Offer PrEP to patients who require frequent or recurrent courses of PEP, due to high-risk behaviors. PrEP can be started immediately after completing PEP.[1]

8 Help patients afford PEP.

- In the US, 28 days of PEP can range in cost ~$2,140 to $4,700, depending on the regimen chosen.[5]Insurance often covers PEP.Options to help with costs include:
  - Sexual assault patients may qualify to have some or all of their medicines and care covered.[7]See the CDC PEP site and US Department of Justice's resource directory for more information (https://www.justice.gov/ovw/resources-for-survivors).
  - PEP after occupational exposure is often covered by insurance or worker's compensation.
  - Patients may qualify for manufacturer assistance programs (i.e., Truvada [https://www.gileadadvancingaccess.com/financial-support/uninsured], Tivicay [https://www.viivconnect.com/patient/get-savings-information/tivicay/], or Isentress [https://www.merckhelps.com/isentress]).

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8 Help patients afford PEP (continued).

- In Canada, 28 days of PEP costs up to ~$1,200. For provincial and territorial coverage see https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/diseases-conditions/summary-hiv-antiretroviral-medication-coverage/phac-drugcoveragedoc.pdf.

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