

# POST-EXPOSURE PROPHYLAXIS (PEP)

April 25, 2017



When discussing HIV risk with your clients before they go on PrEP, you may discover that they had a very recent exposure (within the past 72 hours). This changes the conversation from PrEP to PEP, or post-exposure prophylaxis. It's extremely important to assess the situation and see if PEP is appropriate at this time.

PEP is a course of HIV drugs taken daily for 28–30 days after a known or possible exposure to HIV in order to prevent chronic infection. If your client believes they were or may have been exposed to HIV through sex, by sharing needles, from sexual assault or from an accident like getting stuck by a syringe, then PEP may be appropriate.

- On the back is a chart of transmission risks that may help decide whether PEP is appropriate.
- PEP is believed to be up to 80% effective at reducing the risk of chronic HIV infection when started as soon as possible after an exposure.
- PEP must be started within 72 hours of the exposure but as soon as possible. Otherwise, it is significantly less likely to prevent chronic infection.
- When available, a rapid HIV antibody/antigen test should be done before starting PEP to rule out infection that may have occurred two or more weeks before the current exposure. Measuring both antibodies (proteins produced by our immune system that fight infection) and antigen (pieces of HIV) allows detecting HIV infection much earlier than testing for antibodies alone.
- A prescription must be obtained from a medical provider for PEP.
- The meds that are prescribed can vary. A typical regimen includes an integrase inhibitor—Isentress (raltegravir) or Tivicacy (dolutegravir)—plus Truvada (emtricitabine/ tenofovir DF). Truvada alone may be prescribed, but the CDC recommends including a third drug. Sometimes other HIV meds are used along with Truvada, such as the protease inhibitor Prezista (darunavir) in place of the integrase inhibitor. The regimen is decided by a clinician in consultation with the federal PEP guidelines or local medical protocols.
- Most insurance plans cover the cost of PEP medications, although the patient's cost of copays or deductibles may be a barrier for some.
- If a person is under- or uninsured, the companies that make PEP medications have Patient Assistance Programs (PAPs) to help cover their cost. Eligibility differs for each company. For contact information for each HIV med, go to [tinyurl.com/PEPpharmaPAPs](http://tinyurl.com/PEPpharmaPAPs). These PAPs generally respond quickly in PEP situations.
- During weekday business hours, individuals seeking PEP can consult their physicians, local STI clinics or other public clinics, such as Planned Parenthood. Outside of business hours, PEP Produced with the support of Project Inform and California State Office of AIDS. For more information, email [contact@pleaseprepme.org](mailto:contact@pleaseprepme.org). seekers should go to an emergency room or urgent care facility. Certain cities may also have PEP clinics, such as City Clinic in San Francisco, LGBT Center in Los Angeles, Huntridge Family Clinic in Las Vegas, Kind Clinic in Austin or Fenway Clinic in Boston. Local health departments may also be able to direct individuals to PEP services.
- PEP starter packs of 3 to 7 doses are sometimes provided by medical services. Prescriptions may be filled at pharmacies in the above medical settings or at retail pharmacies. However, some pharmacies may not carry the medications, so plan on a backup pharmacy or two.

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- Unfortunately, many clinicians are unfamiliar with prescribing PEP for sexual, needle-sharing or sexual assault exposures. Therefore, individuals may need to explain PEP and refer clinicians to these medical resources:

Clinician Consultation Center's PEpline: [888 448.4911](tel:8884484911), [tinyurl.com/UCSFpepline](http://tinyurl.com/UCSFpepline)

CDC PEP Guidelines: <https://stacks.cdc.gov/view/cdc/38856>

## AVERAGE RISK OF HIV TRANSMISSION PER EXPOSURE TO INFECTED SOURCE:

### NON-SEXUAL MODES\*

	PERCENTAGE	ODDS
Blood Transfusion	90%	9 in 10
Needle sharing (injection drug use)	.67%	1 in 149
Needlestick (percutaneous, through the skin)	.30%	1 in 333
Biting, spitting, throwing body fluids (including semen, saliva), sharing sex toys	negligible	negligible

### ORAL SEX\*

Receptive partner (example: giving a blow job)	0%-0.04%	0-1 in 2,500
Insertive partner (example: getting a blow job)	~0%	About 0

### VAGINAL SEX\*\*

Risk to female with HIV-positive male partner		
High-income countries	0.08%	1 in 1,250
Low-income countries	.30%	1 in 333
Risk to male with HIV-positive female partner		
High-income countries	0.04%	1 in 2,500
Low-income countries	.38%	1 in 263

### ANAL SEX\*\*\*

Insertive partner's risk (circumcised)	0.11%	1 in 909
Insertive partner's risk (uncircumcised)	0.62%	1 in 161
Receptive partner's risk (without ejaculation)	0.68%	1 in 154
Receptive partner's risk (with ejaculation)	1.43%	1 in 70

\*J Fox, et al, *Quantifying Sexual Exposure to HIV within an HIV-Serodiscordant Relationship: Development of an Algorithm*. AIDS, 2011. \*\* Summarized from Boile MC, et al, *Heterosexual Risk of HIV-1 Infection Per Sexual Act: Systematic review and meta-analysis of Observational Studies*. Lancet Infect Dis 9: 118-29, 2009. Jin F, et al, *Per-Contact Probability of HIV Transmission in Homosexual Men in Sydney in the Era of HAART*. AIDS, 2010.