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Table 1. Outline of the Guidelines Development Process

Topic	Comment
Goal of the Guidelines	The guidelines provide guidance to HIV care practitioners in the United States on the optimal use of antiretroviral (ARV) agents when treating infants, children, and adolescents in early to mid-puberty (sexual maturity rating [SMR] 1–3) with HIV.
Panel Members	The Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV (the Panel) is composed of approximately 30 voting members who have expertise in the management of HIV infection in infants, children, and adolescents. Members include representatives from the Committee on Pediatric AIDS of the American Academy of Pediatrics and community representatives with knowledge of pediatric HIV infection (e.g., parents and caregivers of children and youth with HIV). The Panel also includes at least one representative from each of the following U.S. Department of Health and Human Services (HHS) agencies: the Centers for Disease Control and Prevention (CDC), the U.S. Food and Drug Administration (FDA), the Health Resources and Services Administration (HRSA), and the National Institutes of Health (NIH). A representative from the Canadian Paediatric and Perinatal HIV/AIDS Research Group and a representative from the Australasian Society for HIV, Viral Hepatitis, and Sexual Health Medicine participate as nonvoting, <i>ex officio</i> members of the Panel. The U.S. government representatives are appointed by their respective agencies; nongovernmental members are selected after an open announcement to call for nominations. Each member serves on the Panel for a 3-year term with an option for reappointment. A list of current members can be found in the Guidelines Panel Members .
Financial Disclosure	All members of the Panel submit an annual financial disclosure statement in writing, reporting any association with manufacturers of ARV drugs or diagnostics used to manage HIV infections. A list of the latest disclosures is available on the ClinicalInfo website.
Users of the Guidelines	Providers of care to infants, children, and adolescents with HIV in the United States
Developer	Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV—a working group of the Office of AIDS Research Advisory Council (OARAC)
Funding Source	NIH Office of AIDS Research and HRSA
Evidence Collection	A standardized review of recent, relevant literature related to each section of the guidelines is performed by a technical assistance consultant (through funding from HRSA) and provided to individual Panel working groups. The recommendations generally are based on studies published in peer-reviewed journals. The Panel may occasionally use unpublished data to revise the guidelines, particularly when the new information relates to dosing or patient safety. These data come from presentations at major conferences or from the FDA and/or drug manufacturers.

Topic	Comment
Recommendation Grading	Described in Table 2
Method of Synthesizing Data	<p>Each section of the guidelines is assigned to a small group of Panel members with expertise in the area of interest. The members synthesize the available data and propose recommendations to the Panel. The Panel discusses all proposals during monthly teleconferences. Proposals are modified based on Panel discussion and then distributed with ballots to all Panel members for concurrence and additional comments. If there are substantive comments or votes against approval, the recommended changes and areas of disagreement are brought back to the full Panel (by email or teleconference) for additional review, discussion, and further modification to reach a final version that is acceptable to all Panel members. The recommendations in these final versions represent endorsement from a consensus of members and are included in the guidelines as official Panel recommendations.</p>
Other Guidelines	<p>These guidelines focus on infants, children, and adolescents in early to mid-puberty (SMR 1–3) with HIV. Guidelines for the treatment of adolescents in late puberty (SMR 4–5) are provided by the Panel on Antiretroviral Guidelines for Adults and Adolescents.</p> <p>Separate guidelines outline the use of antiretroviral therapy (ART) during pregnancy and interventions to reduce perinatal HIV transmission, including interventions to prevent perinatal transmission (the Perinatal Guidelines); ART for adults and postpubertal adolescents with HIV; and ARV prophylaxis for those who experience occupational or nonoccupational exposure to HIV. These and other HIV guidelines are also available on the Clinicalinfo website.</p>
Update Plan	<p>The full Panel meets monthly by teleconference to review data that may warrant modification of the guidelines. Smaller working groups of Panel members hold additional teleconferences to review individual drug sections or other specific topics (e.g., What to Start: Initial Combination Antiretroviral Regimens for People With HIV). Updates may be prompted by new drug approvals (or new indications, formulations, or frequency of dosing), new safety or efficacy data, or other information that may have a significant impact on the clinical care of patients. In the event of significant new data that may affect patient safety, the Panel may issue a warning announcement and post accompanying recommendations on the Clinicalinfo website until the guidelines can be updated with appropriate changes. All sections of the guidelines are reviewed at least once a year, with updates as appropriate.</p>
Public Comments	<p>A 2-week public comment period follows the release of the updated guidelines on the Clinicalinfo website. The Panel reviews these comments to determine whether additional revisions to the guidelines are indicated. The public may also submit comments to the Panel at any time via the Contact Us webpage.</p>

Table 2. Rating Scheme for Recommendations

Strength of Recommendation	Quality of Evidence for Recommendation
A: Strong recommendation for the statement	I: One or more randomized trials in children ^a with clinical outcomes and/or validated laboratory endpoints
B: Moderate recommendation for the statement	I*: One or more randomized trials in adults with clinical outcomes and/or validated laboratory endpoints, plus accompanying data in children ^a from one or more well-designed, nonrandomized trials or observational cohort studies with clinical outcomes
C: Optional recommendation for the statement	II: One or more well-designed, nonrandomized trials or observational cohort studies in children ^a with clinical outcomes II*: One or more well-designed, nonrandomized trials or observational cohort studies in adults with clinical outcomes, plus accompanying data in children ^a from one or more smaller nonrandomized trials or cohort studies with clinical outcome data III: Expert opinion

^a These studies include children or children and adolescents but not studies that are limited to postpubertal adolescents.

Table 3. Recommended Virologic Testing Schedules for Infants With Perinatal and Breastfeeding Exposure to HIV

Infants With Perinatal HIV Exposure ^a	
Risk Category	Age at HIV NAT ^{b,c} Testing
<p>Infants at High Risk of HIV Acquisition</p> <p>Infants with perinatal HIV exposure to—</p> <ul style="list-style-type: none"> • Viremia (HIV RNA \geq50 copies/mL) in the 4 weeks prior to delivery • Early (acute or recent) HIV during pregnancy or HIV diagnosed in labor or postpartum <p>Note: Viremia can be documented by a laboratory or presumed by other clinical factors (e.g., new diagnosis, ART adherence challenges, stopping ART prior to delivery).</p>	<p>Birth</p> <p>14–21 days</p> <p>1–2 months</p> <p>2–3 months (see note below)</p> <p>4–6 months</p> <p>All infants at high risk of perinatal HIV transmission should have specimens obtained for HIV testing at birth before or immediately after initiating an ARV drug regimen; however, presumptive HIV therapy should not be delayed.</p> <p>Note: Additional virologic testing is recommended 2 to 6 weeks after infant ARV drugs are discontinued (i.e., at age 2 to 3 months if the infant receives 6 weeks of ARV drugs).</p> <p>If an infant's NAT test result is positive, a repeat test should be performed as soon as possible and ART should be initiated.</p>
<p>Infants at Low Risk of HIV Acquisition Who Are Not Being Breastfed</p> <p>Infants with perinatal HIV exposure to—</p> <ul style="list-style-type: none"> • Sustained viral suppression (<50 copies/mL) from 20 weeks of gestation through delivery <p>Note: Ideally, sustained viral suppression is documented by HIV RNA testing, including at least two consecutive tests obtained at least 4 weeks apart with HIV RNA <50 copies/mL, but can be based on the clinical judgment of providers.</p>	<p>Birth (see note below)</p> <p>14–21 days</p> <p>1–2 months (see note below)</p> <p>4–6 months</p> <p>Note: A birth test generally should be performed but is not necessary for infants at low risk of HIV acquisition unless there are concerns that the newborn could be lost to follow-up without further testing.</p> <p>Note: For infants at low risk of HIV acquisition, testing may be timed to occur at least 2 weeks after cessation of ZDV prophylaxis.</p>
<p>Infants Not Meeting Criteria for High or Low Risk of HIV Acquisition</p> <ul style="list-style-type: none"> • In these clinical scenarios, some infants may receive presumptive HIV therapy and others may receive only ZDV prophylaxis. 	<p>For all infants in this group, a NAT should be obtained at birth and the NAT testing schedule for infants at high risk of HIV acquisition (shown above) should be followed.</p> <p>The timing of virologic testing 2 to 6 weeks after ARV drugs are discontinued will vary based on the duration of infant ARV drugs.</p>
<p>See Table 11 and Table 11.1 in Antiretroviral Management of Infants With In Utero, Intrapartum, or Breastfeeding Exposure to HIV for information about presumptive HIV therapy and ZDV prophylaxis, including duration of ARV drugs.</p>	

Infants With Perinatal HIV Exposure at Low Risk of HIV Acquisition Who Are Being Breastfed	
Guidance for Virologic Testing During Breastfeeding	Age at HIV NAT ^{b,c} Testing
<p>From Birth to Age 6 Months</p> <p>A NAT test at birth is recommended for infants with perinatal HIV exposure who are at low risk of HIV acquisition and are being breastfed.</p>	<p>Birth</p> <p>14–21 days</p> <p>1–2 months (see note below)</p> <p>4–6 months</p> <p>Note: NAT testing of the infant should be performed at least every 3 months during breastfeeding. An additional virologic test should be performed if the gap between the tests at ages 1 to 2 months and 4 to 6 months is greater than 3 months.</p> <p>In addition to the standard time points after birth, NAT testing also should be performed at 4 to 6 weeks and 4 to 6 months after cessation of breastfeeding, regardless of the age when breastfeeding ends.</p>
<p>If Breastfeeding Continues Beyond 6 Months of Age</p>	<p>NAT testing of the infant should be performed at least every 3 months during breastfeeding and at 4 to 6 weeks and 4 to 6 months after cessation of breastfeeding, regardless of the age when breastfeeding ends.</p>
<p>If Viremia Develops While Breastfeeding (a detectable viral load)</p>	<p>Prompt NAT testing of the infant</p> <p>Additional testing time points are based on the clinical scenario and use of infant ARV prophylaxis or presumptive HIV therapy; see Table 12 in Antiretroviral Management of Infants With In Utero, Intrapartum, or Breastfeeding Exposure to HIV.</p> <p>If there is a detectable maternal viral load and breastfeeding continues, some Panel members would recommend monthly virologic testing of the infant as an approach to early detection of HIV infection during ongoing exposure.</p> <p>Consultation with an expert is recommended to determine the need for infant ARV prophylaxis or presumptive HIV therapy and additional testing time points.</p>
<p>Consultation with an expert and/or the National Perinatal HIV Hotline (888-448-8765) is recommended for questions about HIV diagnostic testing for infants with perinatal HIV exposure who are being breastfed.</p> <p>See Table 12 in Antiretroviral Management of Infants With In Utero, Intrapartum, or Breastfeeding Exposure to HIV for information about extended ARV prophylaxis and presumptive HIV therapy during breastfeeding.</p> <p>See Preventing HIV Transmission During Infant Feeding for additional guidance about breastfeeding.</p>	

^a This table summarizes standard time points for HIV virologic diagnostic testing of infants according to risk of perinatal acquisition.

Table 4. Characteristics and Requirements for In-Person Clinic Visits vs. Telemedicine Visits

	In-Person Visits	Telemedicine Visits
Patient/caregiver convenience		✓
Flexibility (time and locations) of appointments		✓
Confidentiality concerns	✓	✓
Directly observed therapy in home settings		✓
Physical assessment (e.g., skin rashes)	✓	✓
Physical exam, including weight and height	✓	✓ ^a
Adherence support and counseling	✓	✓
Mental health assessment and counseling	✓	✓
Multidisciplinary support (assessment and coordination of nutritional and social services)	✓	✓
Laboratory testing on site	✓	
Travel to clinic	✓	
Technology requirements (internet access, equipment, skills)		✓
Legal and administrative guidelines for visit documentation and billing	✓	✓

^a Cooperative children can be weighed and have their height measured at home if a scale and measuring tape are available, with simple instructions for continuity, or directly observed during a synchronous visit or obtained from a recent pediatric or other specialty in-office visit.

Table 5. CD4 Cell Counts and Percentages in Healthy Children: Distribution by Age

	Age						
	0-3 Months	3-6 Months	6-12 Months	1-2 Years	2-6 Years	6-12 Years	12-18 Years
CD4 cell count ^{a,b}	2,600 (1,600-4,000)	2,850 (1,800-4,000)	2,670 (1,400-4,300)	2,160 (1,300-3,400)	1,380 (700-2,200)	980 (650-1,500)	840 (530-1,300)
CD4 percentage ^{a,c}	52 (35-64)	46 (35-56)	46 (31-56)	41 (32-51)	38 (28-47)	37 (31-47)	41 (31-52)

^a Values presented as median (10th to 90th percentile)

^b n = 699

^c n = 709

Source: Shearer WT, Rosenblatt HM, Gelman RS, et al. Lymphocyte subsets in healthy children from birth through 18 years of age: the Pediatric AIDS Clinical Trials Group P1009 study. *J Allergy Clin Immunol.* 2003;112(5):973-980.

Table 6. Sample Schedule for Clinical and Laboratory Monitoring of Children Before and After Initiation of Antiretroviral Therapy^a

Laboratory Testing	Entry Into Care ^{a,b}	ART Initiation ^c	Weeks 1–2 on Therapy	Weeks 2–4 on Therapy	Every 3–4 Months ^d	Every 6–12 Months ^d	Virologic Failure (Prior to Switching ARV Regimens)
Medical History and Physical Examination ^{e,f}	✓	✓	✓	✓	✓		✓
Adherence Evaluation ^f		✓	✓	✓	✓		✓
CD4 Count ^d	✓	✓			✓	✓	✓
Plasma Viral Load ^g	✓	✓		✓	✓		✓
Resistance Testing	✓						✓
CBC With Differential ^d	✓	✓		✓	✓	✓	✓
Chemistries ^{d,h}	✓	✓		✓	✓	✓	✓
Lipid Panel ⁱ	✓	✓				✓	
Random Plasma Glucose ^j		✓				✓	
Urinalysis	✓	✓				✓	
HBV Screening ^k	✓						✓
Pregnancy Test for Youth and Young Adults of Childbearing Potential ^l	✓	✓					✓
HLA-B*5701 ^m	✓						
HCV Screening ⁿ	✓						
TB Screening ^o	✓					✓	
CMV Antibody Testing ^p	✓					✓	

^a See the texts on immunologic, virologic, general laboratory, and clinical monitoring of children with HIV for details on recommended laboratory tests to perform.

- ^b If a child does not initiate ART after receiving an HIV diagnosis, the child's CD4 count and plasma viral load should be monitored at least every 3 to 4 months.
- ^c If ART is initiated within 30 to 90 days of a pre-therapy laboratory result, repeat testing may not be necessary.
- ^d CD4 count, CBC, and chemistries can be monitored less frequently (every 6–12 months) in children and youth who are adherent to therapy, who have CD4 count values that are well above the threshold for opportunistic infection risk, and who have had sustained virologic suppression and stable clinical status for more than 2 to 3 years. Viral load testing every 3 to 4 months is generally recommended to monitor ARV adherence.
- ^e Pay special attention to changes in weight that might occur after altering an ARV regimen. Weight gain or weight loss may occur when using some ARV drugs (see [Table 17h. Lipodystrophies and Weight Gain](#)).
- ^f Virtual visits may be appropriate at some time points, particularly for adherence assessments and for visits for established patients, see [Table 4](#) above.
- ^g Some experts monitor viral load more often (with each injection) in adolescents initiating long-acting injectable CAB and RPV (LA CAB/RPV). Viral load monitoring should be performed 4 to 8 weeks after a switch to LA CAB/RPV. HIV RNA also should be checked in patients with unplanned missed visits and delayed dosing of LA CAB/RPV. When viremia develops during long-acting therapy, resistance testing, including integrase resistance testing, should be performed. Follow-up dosing in patients with missed doses should not be delayed while waiting for viral load and resistance test results. However, regimen changes should be prompted if resistance to CAB and/or RPV is discovered (see [Optimizing Antiretroviral Therapy in the Setting of Viral Suppression](#) in the [Adult and Adolescent Antiretroviral Guidelines](#)).
- ^h Chemistries refer to a comprehensive metabolic panel. Some experts perform a comprehensive panel at entry and routinely test Cr, ALT, AST, with additional tests tailored to the history of the individual patient.
- ⁱ If lipid levels have been abnormal in the past, more frequent monitoring may be needed. For patients treated with TDF, more frequent urinalysis should be considered.
- ^j Random plasma glucose is collected in a gray-top blood collection tube or other designated tube. Some experts would consider monitoring HgbA1C, rather than routine blood glucose, in children at risk for prediabetes/diabetes.
- ^k Baseline HBV screening is recommended with HBsAb, HBsAg, and HBcAb. HBV screening is also recommended for individuals who have previously demonstrated no immunity to HBV and who are initiating a regimen that contains ARV drugs with activity against HBV, specifically 3TC, FTC, TAF, or TDF.
- ^l See the [Pregpregnancy Counseling and Care](#) in the [Perinatal Guidelines](#).
- ^m Conduct HLA-B*5701 on entry or prior to initiating ABC if not done previously. Choose an alternative ARV drug if the patient is HLA-B*5701 positive (see the [Abacavir](#) section in [Appendix A: Pediatric Antiretroviral Drug Information](#)).
- ⁿ Baseline hepatitis C screening is recommended with HCV nucleic acid (HCV RNA) testing if aged <18 months or hepatitis C antibody if aged ≥18 months. If HCV testing is positive, refer to the [Infectious Diseases Society of America HCV in Children guidelines](#) for management.
- ^o TB screening is recommended at baseline and annually with tuberculin skin test if aged <2 years or interferon gamma release assay if aged ≥2 years (see [Mycobacterium tuberculosis](#) in the [Pediatric Opportunistic Infection Guidelines](#)).
- ^p CMV antibody testing is recommended at age 1 year (or at baseline evaluation if aged >1 year at initial visit) and then annually for CMV-seronegative infants and children with HIV who are immunosuppressed (i.e., CD4 count <100 cells/mm³ or CD4 percentage <10%). Severely immunosuppressed children with HIV who are CMV seropositive should have ophthalmologic screening for CMV retinitis. Some experts consider routine ophthalmologic screening in CMV seropositive children with HIV until they are old enough to report visual symptoms (see [Cytomegalovirus](#) in the [Pediatric Opportunistic Infection Guidelines](#)).
- Key:** 3TC = lamivudine; ABC = abacavir; ALT = alanine aminotransferase; ART = antiretroviral therapy; ARV = antiretroviral; AST = aspartate aminotransferase; CAB = cabotegravir; CBC = complete blood count; CD4 = CD4 T lymphocyte; CMV = cytomegalovirus; Cr = creatinine; FTC = emtricitabine; HBV = hepatitis B virus; HBsAb = HBV surface antibody; HBsAg = HBV surface antigen; HBcAb = HBV core antibody; HCV = hepatitis C virus; HgbA1C = glycosylated hemoglobin; RPV = rilpivirine; TAF = tenofovir alafenamide; TB = tuberculosis; TDF = tenofovir disoproxil fumarate

Table 7. Primary Food and Drug Administration–Approved Assays for Monitoring Viral Load

Assay	Abbott Real Time	NucliSens EasyQ v2.0	COBAS AmpliPrep/ TaqMan v2.0	Versant v1.0	Aptima HIV-1 Quant Assay
Method	Real-time RT-PCR	Real-time NASBA	Real-time RT-PCR	Real-time RT-PCR	Real-time TMA
Dynamic Range	40–10 ⁷ copies/mL	25–10 ⁷ copies/mL	20–10 ⁷ copies/mL	37–11×10 ⁷ copies/mL	30–10 ⁷ copies/mL
Specimen Volume ^a	0.2–1 mL	0.1–1 mL	1 mL	0.5 mL	≥0.4 mL
Manufacturer	Abbott Laboratories	bioMérieux	Roche	Siemens	Hologic, Inc.

^a Laboratories often request large blood volumes for standard viral load testing. Consider contacting the local laboratory to determine minimum blood volume required to run the assay. Smaller volumes for children can be accommodated.

Key: NASBA = nucleic acid sequence–based amplification; RT-PCR = reverse transcription-polymerase chain reaction; TMA = transcription-mediated amplification

Table A. Factors to Consider When Selecting an Antiretroviral Treatment Regimen for Children

Factors to Consider	Key Questions and Comments
Acquired potential drug resistance	Are there any concerns that the child ^a may have HIV virus resistant to certain ARV drugs?
Age and weight	<p>Are dosing, PK, and safety information for an ARV drug available based on the child's weight and age?</p> <p>Are there weight and/or age requirements for ARV drug use per FDA approvals or Panel recommendations, including gestational age and postnatal age requirements?</p> <p>Do efficacy and safety data support the choice of specific ARV drugs as part of an initial ART regimen?</p> <p>Is weight-band dosing information available? Weight-band dosing minimizes the need for frequent dose adjustments.</p>
Available formulations	<p>What drug formulations are available for potential treatment regimens (e.g., liquids, dispersible tablets, film-coated tablets that must be swallowed whole, tablets that can be crushed or split)?</p> <p>If pills are available, what is the pill size?</p> <p>Are multiclass single-tablet regimens available? See Appendix A, Table 1. Antiretrovirals Available in Fixed-Dose Combination Tablets or as a Co-packaged Formulation, by Drug Class and Table 2. Antiretroviral Fixed-Dose Combination Tablets and Co-packaged Formulations: Minimum Body Weights and Considerations for Use in Children and Adolescents.</p>
Frequency of dosing	Is a once-daily regimen possible?
Preparation and administration of medication by caregivers	<p>How complicated is preparing the medication(s) needed for the ART regimen?</p> <p>What can be done to ensure that caregivers can safely and accurately administer the medications?</p> <p>Providers should complete the following:</p> <ul style="list-style-type: none"> • Provide medication counseling with trained medical staff. • Provide correctly sized oral syringes. • For liquids, ensure that bottles include stoppers to minimize spilling and medication wastage. • Provide medication calendars after discussing who will be administering the ART and identifying the most convenient time for administration. • Address any food restrictions or requirements for ARVs to be given with food. • Repeat teaching at each clinic visit.

Factors to Consider	Key Questions and Comments
Palatability and tolerance	How palatable and well-tolerated is the regimen?
Ability to swallow pills	<p>Can this child swallow pills or be taught how to swallow pills?</p> <p>The age that a child can learn the skill of swallowing pills varies. Usually, children aged 4 years and older can be taught to swallow pills.</p>
Drug–drug interactions	Does the child require chronic treatment for any other conditions (e.g., mental health conditions, seizure disorders, tuberculosis)? If so, are there any potential drug interactions? See Drug–Drug Interactions in the Adult and Adolescent Antiretroviral Guidelines and the HIV Drug Interaction Checker .
Contraindications	Are there contraindications to prescribing a specific ARV or ART regimen? For example, a positive HLA-B*5701 allele test result is a contraindication for use of abacavir.
Comorbidities and pregnancy	Are there other factors that can affect ARV choices for the drug regimen? Examples include tuberculosis, hepatitis B virus infection, and, for adolescents, pregnancy.
Toxicity	<p>What are the most common side effects and safety profiles for the ARV(s)? See Appendix A. Pediatric Antiretroviral Drug Information.</p> <p>Are there specific toxicity or side effect considerations for individual children (e.g., weight gain in children or adolescents who are overweight or obese, depression)?</p>
Availability, ^b cost, and insurance coverage	<p>Are the medications and formulations needed readily available? Some new drugs or pediatric formulations may not be available in certain areas, or concerns may exist about maintaining a continuous supply.</p> <p>Does the child have insurance coverage?</p> <p>Can the family afford out-of-pocket costs (e.g., co-pays)?</p> <p>Does the regimen require prior authorization?</p>

^a For the sake of brevity, the term “child” encompasses infants, children, and prepubertal adolescents.

^b Because some ARV medications or pediatric formulations may not be available in certain hospitals or geographic areas, clinicians should check availability and advocate for additions to formularies at local hospitals and/or pharmacies as needed.

Key: ART = antiretroviral therapy; ARV = antiretroviral; FDA = U.S. Food and Drug Administration; HLA = human leukocyte antigen; PK = pharmacokinetic; **the Panel = the Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV**

Table B. Advantages and Disadvantages of Anchor Drugs Recommended for Initial Antiretroviral Therapy Regimens in Infants From Birth to <30 Days of Age

Anchor Drugs ^a	Advantages	Disadvantages
RAL (<i>Preferred</i>)	<ul style="list-style-type: none"> • FDA-approved INSTI for use in term newborns weighing ≥ 2 kg • Produces rapid reduction in viral load • Safe and well tolerated • Avoids use of NVP and exposure to another class of ARVs (NNRTIs) 	<ul style="list-style-type: none"> • First-generation INSTI with lower barrier to resistance than DTG or BIC • Granule formulation requires a multistep preparation before administration. • Caregivers must be taught how to properly prepare granule formulation. Explain that only a small volume of the prepared granule suspension is used; the rest must be discarded and cannot be reused. • Limited to use in term infants (≥ 37 weeks of gestation) or preterm infants with a postmenstrual age ≥ 37 weeks at the time of treatment initiation
NVP (<i>Preferred</i>)	<ul style="list-style-type: none"> • Available in convenient oral solution • Can be used in preterm newborns with a gestational age ≥ 32 weeks 	<ul style="list-style-type: none"> • Not a <i>Preferred</i> ARV outside the neonatal period due to the potential for toxicity and development of viral resistance, although it can be used if clinically indicated • Reduced virologic efficacy in young infants, regardless of exposure to NVP as part of a peripartum preventive regimen • A single mutation can confer resistance to this drug and, in some instances, to all NNRTIs.
LPV/r (<i>Alternative</i>)	<ul style="list-style-type: none"> • Available in convenient oral solution • More durable than RAL or NVP 	<ul style="list-style-type: none"> • Should not be administered to neonates before a postmenstrual age of 42 weeks (calculated as gestational age at birth plus postnatal age) and a postnatal age <14 days • Poor palatability and bitter taste may cause incomplete dosing if infant spits it out. • Not a <i>Preferred</i> ARV outside the neonatal period due to issues with palatability and concerns about toxicity, although it can be used if clinically indicated

^a This table focuses on advantages and disadvantages regarding the selection of anchor drugs for ART regimens used in infants aged <30 days. Additional information is available in Table 9. Advantages and Disadvantages of Antiretroviral Components Recommended for Initial Therapy in Infants and Children.

Key: ART = antiretroviral therapy; ARV = antiretroviral; BIC = bictegravir; DTG = dolutegravir; FDA = U.S. Food and Drug Administration; INSTI = integrase strand transfer inhibitor; LPV/r = lopinavir/ritonavir; NNRTI = non-nucleoside reverse transcriptase inhibitor; NVP = nevirapine; RAL = raltegravir

Table 8. Antiretroviral Treatment Regimens Recommended for Initial Therapy for HIV Infection in Infants and Children: Birth to <12 Years of Age

<i>Preferred</i> Initial Regimens and ARV Drugs Based on Age and Weight at Time of Treatment Initiation			
8A. Infants From Birth to <30 Days of Age			
Panel Recommendation ^{a,b}	Regimen or ARV Drug	Age and/or Weight Restriction ^c	Formulations and Comments ^c
<i>Preferred</i> ART regimens for infants ≥37 weeks of gestation and aged <30 days and preterm infants with a postmenstrual age of ≥37 weeks at treatment initiation	NNRTI (NVP) or INSTI (RAL) plus two NRTIs <ul style="list-style-type: none"> • NVP plus ZDV plus (3TC or FTC) or • RAL plus ZDV plus (3TC or FTC) 	None ≥2 kg (RAL)	All oral solutions RAL granules for oral suspension plus oral solutions for ZDV plus (3TC or FTC)
<i>Preferred</i> ART regimen for preterm infants ≥32 to <37 weeks of gestation	NNRTI (NVP) plus two NRTIs <ul style="list-style-type: none"> • NVP plus ZDV plus (3TC or FTC) 	None	All oral solutions
<i>Preferred</i> ART regimens for preterm infants <32 weeks of gestation	Consultation with a pediatric HIV expert or the National Perinatal HIV/AIDS Hotline (1-888-448-8765) is recommended		
<i>Alternative</i> ART regimens for infants	PI (LPV/r) plus two NRTIs <ul style="list-style-type: none"> • LPV/r plus ZDV plus (3TC or FTC) 	Postmenstrual age ≥42 weeks and a postnatal age of >14 days (LPV/r)	All oral solutions
<i>Alternative</i> NRTI backbone for infants	<ul style="list-style-type: none"> • ABC plus (3TC or FTC) if HLA-B*5701 negative 	≥37 weeks of gestation	All oral solutions Use of ABC ^d requires negative HLA-B*5701 results.

Preferred Initial Regimens and ARV Drugs Based on Age and Weight at Time of Treatment Initiation			
8B. Infants and Children Aged ≥30 Days to <2 Years			
Panel Recommendation ^{a,b}	Regimen or ARV Drug	Age and/or Weight Restriction ^c	Formulations and Comments ^c
Preferred ART regimens for infants and children aged ≥30 days to <2 years	INSTI (DTG) ^{e,f} plus two NRTIs	DTG ≥30 days and ≥3 kg to <25 kg	DTG dispersible tablets plus oral solutions (ABC ^d , ZDV, 3TC, or FTC)
	<ul style="list-style-type: none"> DTG plus ZDV plus (3TC or FTC) or DTG plus ABC plus (3TC or FTC) if HLA-B*5701 negative 	DTG ≥30 days and ≥3 kg to <25 kg	
	<ul style="list-style-type: none"> DTG/ABC/3TC in FDC if HLA-B*5701 negative 	≥3 months and ≥6 kg to <25 kg (Triumeq PD)	DTG/ABC/3TC in FDC dispersible tablets (Triumeq PD)
		≥25 kg (Triumeq)	DTG/ABC/3TC FDC tablets if ≥25 kg (Triumeq). See Dolutegravir for special instructions if a child is unable to swallow pills.
Alternative anchor drugs to replace DTG in an ART regimen with a Preferred NRTI backbone for infants and children aged ≥30 days to <2 years	Boosted PI	Postmenstrual age ≥42 weeks and postnatal age >14 days	LPV/r is available in an oral solution.
	<ul style="list-style-type: none"> LPV/r^f (boosted PI) 		
	<ul style="list-style-type: none"> ATV plus RTV (boosted PI) 	ATV ≥15 kg to <25 kg	ATV is available in powder packets; RTV is available in 100-mg tablets and 100-mg powder packets.
	NNRTI NVP (NNRTI)	<3 years	NVP is available in an oral solution.

Preferred Initial Regimens and ARV Drugs Based on Age and Weight at Time of Treatment Initiation			
8C. Children Aged ≥2 Years to <12 Years			
Panel Recommendation ^{a,b}	Regimen or ARV Drug	Age and/or Weight Restriction ^c	Formulations and Comments ^c
Preferred ART regimens for children aged ≥2 years to <12 years who are unable to swallow pills	INSTI (DTG) plus Two NRTIs		For children who are unable to swallow pills
	<ul style="list-style-type: none"> • DTG/ABC/3TC in FDC if HLA-B*5701 negative 	≥3 months and 3 kg to <25 kg (Triumeq PD)	DTG/ABC/3TC is available in FDC dispersible tablets (Triumeq PD).
	<ul style="list-style-type: none"> • DTG plus ZDV plus (3TC or FTC) 	≥30 days and ≥3 kg (DTG)	DTG is available in dispersible tablets and taken with oral solutions (ZDV, 3TC, or FTC).
	<ul style="list-style-type: none"> • DTG plus FTC/TAF; FTC/TAF in FDC (Descovy) 	≥30 days and ≥3 kg (DTG) ≥14 kg to <25 kg (FTC/TAF)	TAF is available as FTC/TAF in FDC (Descovy) only, not as an individual drug. See Tenofvir Alafenamide for special instructions about administering FTC/TAF to children who are not able to swallow pills. For children who are ≥25 kg and unable to swallow pills, see Dolutegravir and Tenofvir Alafenamide for special instructions about administering DTG 50 mg and FTC/TAF (FTC 200 mg/TAF 25 mg).
Preferred ART regimens for children aged ≥2 years to <12 years who are able to swallow pills	INSTI (BIC or DTG) plus Two NRTIs		For children who are able to swallow pills
	<ul style="list-style-type: none"> • BIC plus FTC plus TAF in FDC^{g,h} 	Aged ≥2 years and ≥14 kg to <25 kg (BIC 30 mg/FTC 120 mg/TAF 15 mg) ≥25 kg (BIC 50 mg/FTC 200 mg/TAF 25 mg)	BIC is available only in the FDC BIC/FTC/TAF. The product label states that for children who are unable to swallow a whole tablet, the BIC/FTC/TAF tablet can be split and each part taken separately, as long as all parts are ingested within approximately 10 minutes; see Bictegravir .

Preferred Initial Regimens and ARV Drugs Based on Age and Weight at Time of Treatment Initiation			
8C. Children Aged ≥2 Years to <12 Years			
Panel Recommendation ^{a,b}	Regimen or ARV Drug	Age and/or Weight Restriction ^c	Formulations and Comments ^c
	• DTG plus ABC plus 3TC in FDC if HLA-B*5701 negative	≥25 kg	DTG/ABC/3TC is available in FDC tablets (Triumeq).
	• DTG plus FTC/TAF ; FTC/TAF in FDC (Descovy) ^d	≥14 kg (DTG tablets [Tivicay] and FTC/TAF tablets)	TAF is available only as FTC/TAF in FDC (Descovy); not available as an individual drug. See Tenofovir Alafenamide .
<i>Alternative anchor drugs in an ART regimen with a Preferred NRTI backbone for children aged ≥2 years to <12 years^d</i>	• ATV powder plus RTV powder (boosted PI)	≥15 kg to ≤ 25 kg	ATV is available in 50-mg powder packets; RTV is available in 100-mg powder packets.
	• ATV capsules plus RTV tablets (boosted PI)	≥15 kg	ATV and RTV powder can be mixed with soft food or liquid.
	• ATV plus COBI in FDC tablet (ATV/c, boosted PI)	≥35 kg	
	• DRV plus RTV (boosted PI)	≥20 kg	DRV is available in an oral solution or tablets to be taken with RTV powder or tablets.
	• DRV plus COBI in FDC tablet (DRV/c, boosted PI)	≥40 kg	
	• NVP	None	NVP is available in an oral solution or immediate-release tablets.
	• NVP XR	Aged ≥6 years	
	• EFV	Aged ≥3 years and ≥10 kg	EFV capsules can be opened and used as a sprinkle formulation for children who are unable to swallow pills.
• DOR	≥35 kg	DOR is available as a single-tablet regimen (DOR/3TC/TDF).	

^a Panel recommendations summarized in this table are for children with HIV-1 infection.

^b Recommendations for ARV drugs or ART regimens to be used in special circumstances are addressed in the text (e.g., ARV resistance, HBV coinfection).

^c Additional information about FDCs is available in [Appendix A. Pediatric Antiretroviral Drug Information, Appendix A, Table 1. Antiretrovirals Available in Fixed-Dose Combination Tablets or as a Co-packaged Formulation, by Drug Class](#), and [Appendix A, Table 2. Antiretroviral Fixed-Dose Combination Tablets and Co-packaged Formulations: Minimum Body Weights and Considerations for Use in Children and Adolescents](#).

^d ABC is not approved by the U.S. Food and Drug Administration (FDA) for use in full-term neonates and infants aged <3 months. Recent data from the IMPAACT P1106 trial and two observational cohorts provide reassuring data on the safety of ABC in infants when initiated at the age of <3 months (see [Abacavir](#)). Before ABC administration, a negative HLA-B*5701 allele

test result should be available. An FDC tablet that contains ABC/3TC (Epzicom and generic) is available for use in children weighing ≥ 25 kg.

^e If DTG dispersible tablets are not available, RAL can be administered using either the oral granules for suspension dispersed in water or the chewable tablets dispersed in juice, formula, or milk.

^f An NRTI backbone of ZDV plus 3TC twice daily or ABC plus 3TC twice daily allows for all medications to be administered at the same time when given in combination with LPV/r or RAL. There is considerable experience with ZDV and 3TC in this age group. ABC is associated with less bone marrow toxicity than ZDV and may be the preferred NRTI for long-term use.

^g BIC/FTC/TAF tablets are available in two different strengths, with the lower-strength tablet for children weighing ≥ 14 kg and < 25 kg.

^h The product label for BIC/FTC/TAF (Biktarvy) states that for children who are unable to swallow a whole tablet, the BIC/FTC/TAF tablet can be split and each part taken separately, as long as all parts are ingested within approximately 10 minutes.

ⁱ FTC plus TAF is recommended as a *Preferred* NRTI combination for children and adolescents weighing ≥ 14 kg when used with an INSTI or NNRTI; an FDC tablet that contains FTC/TAF (Descovy) is available in two strengths, with dosage determined by a child's weight (see [Tenofovir Alafenamide](#)). FTC/TAF is approved by the FDA for children weighing ≥ 14 kg when used in the regimen BIC/FTC/TAF, which is also available in two strengths, with dosage determined by a child's weight. FTC/TAF is a *Preferred* NRTI combination for children and adolescents weighing ≥ 35 kg when used with a boosted PI; FTC/TAF is not approved or recommended for use with a boosted PI in children weighing < 35 kg.

Key: 3TC = lamivudine; ABC = abacavir; ARV = antiretroviral; ART = antiretroviral therapy; ATV = atazanavir; BIC = bictegravir; COBI = cobicistat; DOR = doravirine; DRV = darunavir; DRV/c = darunavir/cobicistat; DTG = dolutegravir; EFV = efavirenz; FDC = fixed-dose combination; FTC = emtricitabine; HLA = human leukocyte antigen; INSTI = integrase strand transfer inhibitor; HBV = hepatitis B virus; LPV/r = lopinavir/ritonavir; NNRTI = non-nucleoside reverse transcriptase inhibitor; NRTI = nucleoside reverse transcriptase inhibitor; NVP = nevirapine; PI = protease inhibitor; RAL = raltegravir; RTV = ritonavir; TAF = tenofovir alafenamide; TDF = tenofovir disoproxil fumarate; ZDV = zidovudine

Table 9. Advantages and Disadvantages of Antiretroviral Components Recommended for Initial Therapy in Infants and Children

See [Appendix A. Pediatric Antiretroviral Drug Information](#) and [Table 7. Antiretroviral Regimen Considerations for Initial Therapy Based on Specific Clinical Scenarios](#) in the [Adult and Adolescent Antiretroviral Guidelines](#) for more information. For detailed information about drug interactions, see [Drug–Drug Interactions](#) and [ARV class-specific tables 24a to 24g and 25a to 25b](#) in [Adult and Adolescent Antiretroviral Guidelines](#), as well as the [HIV Drug Interaction Checker](#) and updated prescribing information.

Note: Drugs within each ARV class are listed in alphabetical order.

ARV Class/ Agent(s)	Advantages	Disadvantages
All INSTIs	<p>INSTI Class Advantages</p> <ul style="list-style-type: none"> Well tolerated 	<p>INSTI Class Disadvantages</p> <ul style="list-style-type: none"> Possible weight gain in adults, especially Black/African American women The potential exists for multiple drug interactions due to metabolism via hepatic enzymes (e.g., CYP3A4, UGT1A1). Information about drug interactions is available in the Adult and Adolescent Antiretroviral Guidelines and the HIV Drug Interaction Checker. Oral absorption can be reduced by simultaneous administration with drugs or supplements containing polyvalent cations.
BIC	<ul style="list-style-type: none"> Once-daily administration No food requirement Coformulated with TAF/FTC (see Appendix A, Table 1. Antiretrovirals Available in Fixed-Dose Combination Tablets or as a Co-packaged Formulation, by Drug Class) Higher barrier to resistance than RAL 	<ul style="list-style-type: none"> The FDC tablet is not recommended for patients with hepatic impairment or an estimated CrCl <30 mL/min. CNS side effects, particularly sleep disturbances. Depression and suicidal ideation (rare; usually in people with preexisting psychiatric conditions) CYP3A4 and UGT1A1 substrate (but not a CYP3A4 inducer or inhibitor); potential for drug–drug interactions Inhibits tubular secretion of creatinine, resulting in an increase in serum creatinine without affecting glomerular function. This increase is generally benign but can be misinterpreted by clinicians not aware of this side effect. Added follow-up may be required in patients with underlying renal disease.

ARV Class/ Agent(s)	Advantages	Disadvantages
DTG	<ul style="list-style-type: none"> • Once-daily administration • No food requirement • Coformulated with ABC/FTC and with 3TC (see Appendix A, Table 1. Antiretrovirals Available in Fixed-Dose Combination Tablets or as a Co-packaged Formulation, by Drug Class) • Single-agent DTG pills are available in several doses and are small in size. • DTG and the FDC ABC/DTG/3TC are available as dispersible tablets for suspension. • Higher barrier to resistance than RAL 	<ul style="list-style-type: none"> • UGT1A1 substrate; potential for drug–drug interactions. • CNS side effects, particularly sleep disturbances. Depression and suicidal ideation (rare; usually in people with preexisting psychiatric conditions) • Inhibits tubular secretion of creatinine, resulting in an increase of serum creatinine without affecting glomerular function. This increase is generally benign but can be misinterpreted by clinicians not aware of this side effect. Added follow-up may be required in people with underlying renal disease.
RAL	<ul style="list-style-type: none"> • No food requirement • Available in tablet, chewable tablet, and oral granules for suspension formulations • Chewable tablets can be crushed and mixed with various liquids for infants aged ≥ 4 weeks who weigh ≥ 3 kg. • Favorable lipid profile 	<ul style="list-style-type: none"> • Lower barrier to resistance than boosted PI-, BIC-, or DTG-based regimens • Oral absorption of RAL can be reduced by simultaneous administration with drugs or supplements containing polyvalent cations. • UGT1A1 substrate; potential for drug interaction • Depression and suicidal ideation (rare; usually in patients with preexisting psychiatric conditions) • Increases in creatine kinase, myopathy, and rhabdomyolysis have been reported. • Potential for rare systemic allergic reaction or hepatitis • Granule formulation requires a multistep preparation before administration; caregiver must be taught how to properly prepare this formulation. • Higher pill burden than other INSTI-based regimens. No FDC formulation.

ARV Class/ Agent(s)	Advantages	Disadvantages
All NNRTIs	<p>NNRTI Class Advantages</p> <ul style="list-style-type: none"> • Longer half-life allows for once-daily dosing of DOR, EFV, and RPV • Lower risk of dyslipidemia and fat maldistribution than PIs • PI-sparing • Lower pill burden than PIs for children taking the solid formulation; easier to use and adhere to than PI-based regimens 	<p>NNRTI Class Disadvantages</p> <ul style="list-style-type: none"> • Prevalence of NNRTI-resistant viral strains in patients who have never used ART drugs and the drugs' low barrier for the development of resistance. A single mutation can confer resistance, with cross-resistance between EFV and NVP. • Rare but serious and potentially life-threatening cases of skin rash (including SJS) and hepatic toxicity are possible. All NNRTIs pose this risk, but the risk is greatest with NVP; these toxic effects have not been reported in neonates. • Potential for multiple drug interactions due to metabolism via hepatic enzymes (e.g., CYP3A4). Information about drug interactions is available in the Drug-Drug Interactions section of the Adult and Adolescent Antiretroviral Guidelines and the HIV Drug Interaction Checker.
DOR	<ul style="list-style-type: none"> • Once-daily administration • Available as a single-drug tablet and coformulated with TDF/FTC (see Appendix A, Table 1. Antiretrovirals Available in Fixed-Dose Combination Tablets or as a Co-packaged Formulation, by Drug Class) • No food requirement • Has continued antiviral activity in the setting of some NNRTI mutations • Favorable lipid profile • Not associated with weight gain compared with boosted DRV or EFV 	<ul style="list-style-type: none"> • Neuropsychiatric AEs, but fewer than reported for EFV • DOR is contraindicated when coadministered with drugs that are strong cytochrome P450 (CYP)3A enzyme inducers (see Doravirine). • Potential for CYP3A4 drug interactions • Treatment-emergent DOR resistance mutations may confer resistance to certain NNRTIs.
EFV	<ul style="list-style-type: none"> • Once-daily administration • Available as a single-drug tablet and coformulated with TDF/FTC and TDF/3TC (see Appendix A, Table 1. Antiretrovirals Available in Fixed-Dose Combination Tablets or as a Co-packaged Formulation, by Drug Class) • Can give with food (but avoid high-fat meals); usually recommended to be taken on an empty stomach • Capsules can be opened and added to food. 	<ul style="list-style-type: none"> • CNS side effects, including dizziness, abnormal dreams, headache, depression, suicidality, insomnia, and somnolence. Bedtime dosing is recommended to reduce CNS effects. • Rash (generally mild); QTc prolongation, dyslipidemia • Potential for CYP3A4 drug interactions • No commercially available liquid formulation • Limited data on dosing for children aged <3 years • No data on dosing for children aged <3 months

ARV Class/ Agent(s)	Advantages	Disadvantages
NVP	<ul style="list-style-type: none"> • Liquid formulation is available. • Dosing information for young infants is available. • No food requirement • Extended-release formulation that allows once-daily dosing in older children is available. 	<ul style="list-style-type: none"> • Reduced virologic efficacy in young infants, regardless of exposure to NVP as part of a peripartum preventive regimen • Higher incidence of rash/HSR than other NNRTIs • Higher rates of serious hepatic toxicity than EFV • Decreased virologic response compared with EFV • Twice-daily dosing necessary in children with body surface area <0.58 m² • Low barrier to resistance
RPV	<ul style="list-style-type: none"> • Once-daily dosing • Available as a single-drug tablet and coformulated with TDF/FTC and TAF/FTC (see Appendix A, Table 1. Antiretrovirals Available in Fixed-Dose Combination Tablets or as a Co-packaged Formulation, by Drug Class) 	<ul style="list-style-type: none"> • Should not use in children with viral loads >100,000 copies/mL • Food requirement. Must be taken with a ≥500 kcal meal at a consistent time each day; this may affect adherence. • Potential for CYP3A4 drug interactions • RPV oral absorption is reduced with increased gastric pH. Use of RPV with PPIs is contraindicated; see Adult Drug-Drug Interactions for dosing recommendations when RPV is coadministered with H2 blocker or antacids. • Low barrier to resistance • Side effects include depression, headache, skin rash, and QTc prolongation.
All PIs	<p>PI Class Advantages</p> <ul style="list-style-type: none"> • NNRTI-sparing • Clinical, virologic, and immunologic efficacy are well documented. • Higher barrier to resistance than NNRTIs and RAL. Resistance to PIs requires multiple mutations. • When combined with a dual-NRTI backbone, a regimen that contains a PI targets HIV at two steps of viral replication by inhibiting the activity of viral reverse transcriptase and protease enzymes 	<p>PI Class Disadvantages</p> <ul style="list-style-type: none"> • Metabolic complications, including dyslipidemia, fat maldistribution, and insulin resistance • Potential for multiple drug interactions because of metabolism via hepatic enzymes (e.g., CYP3A4); information about drug interactions is available in the Adult and Adolescent Antiretroviral Guidelines and the HIV Drug Interaction Checker. • Higher pill burden than NRTI-based or NNRTI-based regimens for people taking solid formulations • Poor palatability of liquid preparations, which may affect adherence • Most PIs require RTV or COBI boosting, resulting in drug-drug interactions that are associated with RTV or COBI.

ARV Class/ Agent(s)	Advantages	Disadvantages
ATV/r and ATV/c Unboosted ATV	<ul style="list-style-type: none"> • Once-daily dosing • Powder formulation is available for young children. • ATV has less effect on TG and total cholesterol levels than other PIs (but RTV boosting may be associated with elevations in these parameters). 	<ul style="list-style-type: none"> • No liquid formulation • Food requirement • Indirect hyperbilirubinemia is common but asymptomatic. Scleral icterus may be distressing to the patient, which may affect adherence. Other side effects include cholelithiasis, nephrolithiasis, and PR interval prolongation. • Must be used with caution in patients with preexisting conduction system defects (can prolong the PR interval of an ECG) • ATV boosted with RTV or COBI is recommended. Both RTV and COBI are associated with a large number of drug–drug interactions. CYP3A4 substrate and inhibitor • ATV absorption is reduced when ATV is given with acid-lowering therapies. • COBI inhibits active tubular secretion of creatinine and can increase serum creatinine without affecting renal glomerular function. This increase is generally benign but can be misinterpreted by clinicians not aware of this side effect. Added follow-up may be required in individuals with underlying renal disease.
DRV/c or DRV/r	<ul style="list-style-type: none"> • Can be used once daily in children aged ≥ 12 years • Liquid formulation is available. • DRV requires a boosting agent. • Available as a single-drug tablet and coformulated as DRV/c and DRV/c/TAF/FTC (see Appendix A, Table 1. Antiretrovirals Available in Fixed-Dose Combination Tablets or as a Co-packaged Formulation, by Drug Class) 	<ul style="list-style-type: none"> • Pediatric pill burden high with current tablet dose formulations • Food requirement • Must be boosted with RTV or COBI to achieve adequate plasma concentrations • Contains sulfa moiety; the potential for cross-sensitivity between DRV and other drugs in sulfonamide class is unknown. Other side effects include hyperlipidemia and increased transaminases. • RTV and COBI are associated with a large number of potential drug–drug interactions. • COBI inhibits active tubular secretion of creatinine and can increase serum creatinine without affecting renal glomerular function. This increase is generally benign but can be misinterpreted by clinicians not aware of this side effect. Added follow-up may be required in patients with underlying renal disease. • Can be used only once daily in the absence of certain PI-associated resistance mutations

ARV Class/ Agent(s)	Advantages	Disadvantages
LPV/r	<ul style="list-style-type: none"> • LPV is available coformulated with RTV in liquid and tablet formulations. • Tablets can be given without food, but they may be better tolerated when taken with a meal or snack. 	<ul style="list-style-type: none"> • Poor palatability of liquid formulation (bitter taste) • Liquid formulation should be administered with food. • RTV is associated with a large number of drug–drug interactions. • Should not be administered to neonates before a postmenstrual age of 42 weeks (the span of time between the first day of the mother’s last menstrual period and birth, plus the time elapsed after birth) and a postnatal age ≥ 14 days • Must be used with caution in patients with preexisting conduction system defects (can prolong PR and QT interval of an ECG)
ABC plus (3TC or FTC)	<ul style="list-style-type: none"> • Palatable liquid formulations • No food requirement • Available in FDC tablets (see Appendix A, Table 1. Antiretrovirals Available in Fixed-Dose Combination Tablets or as a Co-packaged Formulation, by Drug Class) 	<ul style="list-style-type: none"> • Risk of ABC HSR; perform HLA-B*5701 screening before initiating ABC. • ABC use has been associated with CV disease and cardiac events in some, but not all, observational studies conducted in adults.
FTC/TAF for children aged ≥ 6 years	<ul style="list-style-type: none"> • Once-daily dosing • Small tablet size • Lower risk of TFV-associated renal and bone toxicity with TAF than with TDF in adults • Available in FDC tablets (see Appendix A, Table 1. Antiretrovirals Available in Fixed-Dose Combination Tablets or as a Co-packaged Formulation, by Drug Class) • Active against HBV; a recommended dual-NRTI option for individuals with HBV/HIV coinfection 	<ul style="list-style-type: none"> • Limited data on the safety and efficacy of this combination in children • Increased lipid levels

ARV Class/ Agent(s)	Advantages	Disadvantages
TDF plus (3TC or FTC)	<ul style="list-style-type: none"> • Once-daily dosing for TDF • Resistance is slow to develop. • Lower risk of mitochondrial toxicity than other NRTIs • No food requirement • TDF is available as reduced-strength tablets and oral powder for use in younger children. • Available in FDC tablets (see Appendix A, Table 1. Antiretrovirals Available in Fixed-Dose Combination Tablets or as a Co-packaged Formulation, by Drug Class) • Active against HBV; a recommended dual-NRTI option for individuals with HBV/HIV coinfection. 	<ul style="list-style-type: none"> • Limited pediatric experience • Potential bone and renal toxicity
ZDV plus (3TC or FTC)	<ul style="list-style-type: none"> • Extensive pediatric experience • Coformulations of ZDV and 3TC are available for children weighing ≥ 30 kg. • Palatable liquid formulations • No food requirement • FTC is available as a palatable liquid formulation that can be administered once daily. 	<ul style="list-style-type: none"> • Bone marrow suppression and lipotrophy with ZDV • ZDV requires twice-daily dosing.

Key: 3TC = lamivudine; ABC = abacavir; AE = adverse event; ARV = antiretroviral; ART = antiretroviral therapy; ATV = atazanavir; ATV/c = atazanavir/cobicistat; ATV/r = atazanavir/ritonavir; BIC = bictegravir; CNS = central nervous system; COBI = cobicistat; CrCl = creatinine clearance; CV = cardiovascular; CYP = cytochrome P450; DOR = doravirine; DRV = darunavir; DRV/c = darunavir/cobicistat; DRV/r = darunavir/ritonavir; DTG = dolutegravir; ECG = electrocardiogram; EFV = efavirenz; FDC = fixed-dose combination; FTC = emtricitabine; HBV = hepatitis B virus; HSR = hypersensitivity reaction; INSTI = integrase strand transfer inhibitor; LPV = lopinavir; LPV/r = lopinavir/ritonavir; NNRTI = non-nucleoside reverse transcriptase inhibitor; NRTI = nucleoside reverse transcriptase inhibitor; NVP = nevirapine; PI = protease inhibitor; PPI = proton pump inhibitor; PR interval = interval between the onset of atrial depolarization to the onset of ventricular depolarization; QTc interval = duration of ventricular electrical activity, measured as the time between the start of the QRS complex and the end of the T wave, corrected for heart rate; RAL = raltegravir; RPV = rilpivirine; RTV = ritonavir; SJS = Stevens-Johnson Syndrome; TAF = tenofovir alafenamide; TDF = tenofovir disoproxil fumarate; TFV = tenofovir; TG = triglyceride; ZDV = zidovudine

Table 10. Antiretroviral Regimens or Components That Are Not Recommended for Initial Treatment of HIV Infection in Children and Adolescents

ARV Regimen	Rationale
Regimens containing only NRTIs	Inferior virologic efficacy
Regimens containing three drug classes	Potential to induce multiclass resistance Use as an initial regimen in children has not been studied
Regimens containing three NRTIs and one NNRTI	Added cost and complexity outweigh any benefit
Full-dose, dual-PI regimens	Insufficient data to recommend; potential for added toxicities
Oral regimens containing only two ARV drugs	Not FDA approved for pediatric use
ARV Component	Rationale
Unboosted ATV -containing regimens in children	Inadequate drug exposure
CAB	Not FDA approved for use in individuals who are ARV-naïve or in children aged <12 years and weighing <35 kg
DRV/r in children <3 years	Potential for seizures
Once-daily DRV -based regimens in children aged ≥3 years to <12 years	Insufficient data to recommend
EFV -based regimens for children aged <3 years	CYP2B6 genotyping required to determine appropriate dosing
ETR -based regimens	Insufficient data to recommend; unlikely to be used as initial therapy
EVG -based regimens	First-generation INSTIs with lower barriers to resistance than second-generation INSTIs (BIC and DTG) that are now available for initial ARV regimens in children
FTR	Not FDA approved for use in adults who are ARV-naïve or for pediatric use
IBA	Not FDA approved for use in adults who are ARV-naïve or for pediatric use
LEN	Not FDA approved for use in adults who are ARV-naïve or for pediatric use
LPV/r dosed once daily	Inadequate drug exposure
MVC -based regimens	Only effective for CCR5-tropic virus
TDF -containing regimens in children aged <2 years	Potential bone toxicity Appropriate dose has yet to be determined

Key: ARV = antiretroviral; ATV = atazanavir; BIC = bictegravir; CAB = cabotegravir; CYP = cytochrome P450; DRV = darunavir; DRV/r = darunavir/ritonavir; DTG = dolutegravir; EFV = efavirenz; ETR = etravirine; EVG = elvitegravir; FDA = U.S. Food and Drug Administration; FTR = fostemsavir; IBA = ibalizumab; INSTI = integrase strand transfer inhibitor; LEN = lenacapavir; LPV/r = lopinavir/ritonavir; MVC = maraviroc; NNRTI = non-nucleoside reverse transcriptase inhibitor; NRTI = nucleoside reverse transcriptase inhibitor; PI = protease inhibitor; TDF = tenofovir disoproxil fumarate

Table 11. Antiretroviral Regimens or Components That Are Never Recommended for Treating HIV in Children and Adolescents^a

ARV Regimen or Component ^a	Rationale	Exceptions
One ARV Drug Alone (Monotherapy)	Rapid development of resistance Inferior antiviral activity compared with regimens that include ≥ 3 ARV drugs Monotherapy “holding” regimens are associated with more rapid CD4 count declines than nonsuppressive ART.	Infants with perinatal HIV exposure and negative virologic tests who are receiving 4–6 weeks of ZDV prophylaxis to prevent perinatal transmission of HIV
Two NRTIs Alone	Rapid development of resistance Inferior antiviral activity compared with regimens that include ≥ 3 ARV drugs	Not recommended for initial therapy Some clinicians may opt to continue using two NRTIs alone in patients who achieve virologic goals with this regimen.
Any Regimen Containing 3TC Plus FTC	Similar resistance profile and no additive benefit	No exceptions
Any Regimen Containing TDF and TAF	No data to support potential additive efficacy or toxicity	No exceptions
Dual-NNRTI Combinations	Enhanced toxicity	No exceptions
TDF Plus ABC Plus (3TC or FTC) as a Triple-NRTI Regimen	High rate of early viral failure when this triple-NRTI regimen was used as initial therapy in treatment-naive adults	No exceptions
NVP as Component of Initial ARV Therapy Regimen in Adolescent Girls with CD4 Counts >250 cells/mm ³ or Adolescent Boys with CD4 Counts >400 cells/mm ³	Increased incidence of symptomatic (including serious and potentially fatal) hepatic events in these patient groups	Only if benefit clearly outweighs risk

^a Several ARV drugs that are no longer available or that have not been recommended for use in children for several years have been removed from this chapter, including the NRTIs stavudine and didanosine; the protease inhibitors fosamprenavir, indinavir, nelfinavir, saquinavir, and tipranavir; and the fusion inhibitor enfuvirtide (see [Archived Drugs](#)).

Key: 3TC = lamivudine; ABC = abacavir; ART = antiretroviral therapy; ARV = antiretroviral; CD4 = CD4 T lymphocyte; FTC = emtricitabine; NNRTI = non-nucleoside reverse transcriptase inhibitor; NRTI = nucleoside reverse transcriptase inhibitor; NVP = nevirapine; TAF = tenofovir alafenamide; TDF = tenofovir disoproxil fumarate; ZDV = zidovudine

Table 12. Transmission Risk Assessment by HIV RNA Levels and Antenatal Time Period

Antenatal Time Period			Transmission Risk	
HIV RNA at <20 Weeks' Gestation	HIV RNA ≥20 Weeks' Gestation to 4 Weeks Prior to Delivery	HIV RNA at ≤4 Weeks Prior to Delivery	In Utero	Intrapartum
N/A ^a	N/A ^a	≥50 copies/mL ^b	High	High
N/A ^a	≥50 copies/mL ^b	<50 copies/mL	Low to moderate	Low
≥50 copies/mL ^b	<50 copies/mL	<50 copies/mL	Low	Low
<50 copies/mL	<50 copies/mL	<50 copies/mL	Low	Low

^a HIV RNA levels in this time period do not change the transmission risk categorization because transmission risk is determined by viremia later in gestation.

^b HIV RNA values of ≥50 copies/mL can be documented or presumed (e.g., early [acute or recent] HIV, new diagnosis of HIV, or known lapse in adherence).

Table 13. Antiretroviral Management for Infants With *In Utero* or Intrapartum Exposure to HIV

Clinical Setting	Risk of Acquisition		Neonatal ARV Management ^{a,b}	Rationale
	<i>In Utero</i>	Intrapartum		
High Risk of Acquisition				
<p>HIV RNA ≥ 50 copies/mL in the 4 weeks prior to delivery</p> <p>Viremia can be documented by lab or presumed by other clinical factors (e.g., new diagnosis, ART adherence problems, reports of having stopped ART prior to delivery).</p>	High	High	<p>Presumptive HIV therapy using a three-drug regimen of ZDV and 3TC plus either NVP (treatment dose) or RAL</p> <p>Duration is from birth for 2–6 weeks; consensus not reached by members of the Panel.^c</p> <p>If the duration of a three-drug regimen is <6 weeks, and the birth NAT is negative, ZDV should be continued alone to complete a total of 6 weeks of prophylaxis.</p> <p>HIV NAT obtained before or immediately after starting presumptive therapy with three drugs^{d,e}</p>	<p>Viremia in the 4 weeks immediately prior to delivery confers very high risk for <i>in utero</i> and intrapartum transmission.</p> <p>Plasma HIV RNA levels of 50–200 copies/mL could be expected to confer lower risk than those >200 copies/mL but could also be an indicator of poor adherence and raise concern for higher levels of viremia at other times.</p>
Low Risk of Acquisition				
<p>HIV RNA <50 copies/mL from 20 weeks' gestation through delivery</p> <p>Ideally documented by at least two consecutive tests at least four weeks apart with HIV RNA <50 copies/mL, but can be based on clinical judgment of providers.</p>	Low	Low	ZDV for 2 weeks	<p>Sustained virologic suppression from 20 weeks' gestation is associated with extremely low risk of transmission <i>in utero</i> or intrapartum.</p> <p>Although <i>in utero</i> transmission events have been documented prior to 20 weeks, the extremely low frequency of these events does not merit the presumptive HIV therapy approach.</p>
Other Clinical Scenarios				
<p>HIV RNA ≥ 50 copies/mL at >20 weeks' gestation, but HIV RNA <50 copies/mL in the 4 weeks prior to delivery</p>	Low to Moderate	Low	<p>HIV NAT at Birth^{d,e}</p> <p>Two Options for ARV Management</p> <p>1. Presumptive HIV therapy with a three-drug regimen,</p>	<p>Viremia in the late second and third trimester elevates risk of <i>in utero</i> transmission (increasing risk with higher HIV RNA levels and longer duration</p>

Clinical Setting	Risk of Acquisition		Neonatal ARV Management ^{a,b}	Rationale
	In Utero	Intrapartum		
			<p>as described above for infants at high risk. If birth the HIV NAT is negative, de-escalate the prophylaxis regimen to ZDV alone to complete 2–6 weeks total.^c</p> <p>2. ZDV prophylaxis for 2–6 weeks</p>	<p>of viremia).</p> <p><i>Option 1.</i> Some Panel members believe that the potential benefit of early treatment for an infant who acquired the infection <i>in utero</i> merits a presumptive HIV therapy approach.</p> <p><i>Option 2.</i> Other Panel members believe that the marginal potential benefit and anticipated low frequency of <i>in utero</i> infection do not merit the additional complexity of and potential toxicity of presumptive HIV therapy and favor ZDV prophylaxis only.</p> <p>All infants should receive a minimum of 2 weeks ZDV prophylaxis, but up to 6 weeks may be used when indicated based on risk assessment.</p>
Early (acute or recent) HIV at any point during pregnancy	Moderate to High depending on maternal HIV RNA levels and weeks' gestation	High if HIV RNA ≥ 50 copies/mL in the last 4 weeks of pregnancy	HIV NAT at birth ^{d,e} Manage infant ARVs according to the level and timing of the maternal viremia as described in the rows above (just as for an infant exposed to established infection).	<p>Early or recent HIV diagnosed at any time during pregnancy is a unique situation because very high HIV RNA levels place infants at high risk of HIV acquisition.</p> <p>For infants perinatally exposed to known HIV infection, risk of transmission increases when viremia occurs later in pregnancy. Some Panel members would manage all cases with presumptive therapy, whereas others would only use it for viremia after 20 weeks' gestation.</p>

Clinical Setting	Risk of Acquisition		Neonatal ARV Management ^{a,b}	Rationale
	<i>In Utero</i>	Intrapartum		
Unconfirmed maternal HIV status with at least one positive HIV test at delivery or postpartum or Newborn has a positive HIV antibody test	High/ Uncertain	High/ Uncertain	HIV NAT at birth ^{d,e} Presumptive HIV therapy with a three-drug regimen as described above for newborns with a high risk of <i>in utero</i> or intrapartum HIV acquisition If supplemental testing confirms a negative maternal HIV status, discontinue infant ARV drugs immediately.	Supplemental maternal HIV testing and/or NAT testing of the infant is required to determine the level of risk and need to continue infant presumptive HIV therapy or initiate ART. ^e

^a Infant ARVs should be initiated in the first 6 hours after delivery, especially for infants with a high risk of acquisition. See [Table 11.1](#) for ARV dosing.

^b See [HIV-2 Infection and Pregnancy](#) for ARV prophylaxis recommendations for infants perinatally exposed to HIV-2 mono-infection. In the event of maternal HIV-2 infection or HIV-1 and HIV-2 coinfection, the infant ARV regimen should be based on the determination of low or high risk of HIV-1 transmission as described in the above table using ARVs that are active against HIV-2. Because HIV-2 is not susceptible to NVP, RAL should be used in presumptive HIV therapy regimens for infants at high risk of HIV acquisition with exposure to HIV-2 or to both HIV-1 and HIV-2.

^c The optimal duration of three-drug regimen in newborns who are at a high risk for HIV acquisition is unknown. Newborns who are at a high risk for HIV acquisition should receive the ZDV component for 6 weeks. The other two ARVs, (3TC and NVP) or (3TC and RAL), may be administered for 2 to 6 weeks; the recommended duration for treatment with three ARVs varies depending on infant HIV NAT results, maternal viral load at the time of delivery, and the additional risk factors for HIV transmission. Consultation with an expert in pediatric HIV is recommended when selecting a therapy duration because this decision should be based on case-specific risk factors and interim infant HIV NAT results.

^d NAT test at birth should be obtained before or immediately after starting ARVs. See [Diagnosis of HIV Infection in Infants and Children](#) for additional information about HIV testing and NATs.

^e When a newborn HIV NAT is positive, infant ART should be initiated without waiting for the results of confirmatory HIV NAT testing, given the low likelihood of a false-positive HIV NAT (see [When to Initiate Antiretroviral Treatment in Children with HIV Infection](#) and [What to Start in the Pediatric Antiretroviral Guidelines](#)). However, the specimen for confirmatory HIV testing should be obtained prior to ART initiation.

Note: Providers with questions about ARV management of infants should consult an expert in pediatric HIV infection or the [National Perinatal HIV Hotline](#) (1-888-448-8765).

Key: 3TC = lamivudine; ART = antiretroviral therapy; ARV = antiretroviral; NAT = nucleic acid test; NVP = nevirapine; the Panels = the Panel on Treatment of HIV During Pregnancy and Prevention of Perinatal Transmission and the Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV; RAL = raltegravir; ZDV = zidovudin

Table 13.1 Drug Dosing Recommendations for Antiretroviral Prophylaxis and Presumptive HIV Therapy in Infants With *In Utero* or Intrapartum Exposure to HIV^a

This table provides dosing for antiretroviral (ARV) prophylaxis and presumptive HIV therapy in infants with *in utero* or intrapartum exposure to HIV. Dosing for additional ARV prophylaxis during breastfeeding is provided in [Table 12.1. Antiretroviral Prophylaxis Dosing for Infants Who Are Breastfed.](#)

For infants with HIV infection, recommendations for initial ARV therapy regimens and ARV dosing are available in the [Pediatric Antiretroviral Guidelines](#); see [What to Start](#) and [Appendix A. Pediatric Antiretroviral Drug Information.](#)

ARV Drug	Drug Doses by Gestational Age at Birth								
<p>ZDV</p> <p>Note: For newborns who are unable to tolerate oral agents, the IV dose is 75% of the oral dose while maintaining the same dosing interval.</p>	<p>≥35 Weeks of Gestation at Birth</p> <p><i>Birth to Age ≤6 Weeks</i></p> <ul style="list-style-type: none"> • ZDV 4 mg/kg per dose orally twice daily or alternative simplified weight-band dosing (see table below) <p>Simplified Weight-Band Dosing for Newborns Aged ≥35 Weeks of Gestation From Birth to 4 Weeks</p> <table border="1" data-bbox="565 961 1414 1171"> <thead> <tr> <th data-bbox="565 961 829 1031">Weight Band</th> <th data-bbox="829 961 1414 1031">Volume of ZDV 10 mg/mL Oral Syrup Twice Daily</th> </tr> </thead> <tbody> <tr> <td data-bbox="565 1031 829 1077">2 kg to <3 kg</td> <td data-bbox="829 1031 1414 1077">1 mL</td> </tr> <tr> <td data-bbox="565 1077 829 1123">3 kg to <4 kg</td> <td data-bbox="829 1077 1414 1123">1.5 mL</td> </tr> <tr> <td data-bbox="565 1123 829 1171">4 kg to <5 kg</td> <td data-bbox="829 1123 1414 1171">2 mL</td> </tr> </tbody> </table>	Weight Band	Volume of ZDV 10 mg/mL Oral Syrup Twice Daily	2 kg to <3 kg	1 mL	3 kg to <4 kg	1.5 mL	4 kg to <5 kg	2 mL
	Weight Band	Volume of ZDV 10 mg/mL Oral Syrup Twice Daily							
	2 kg to <3 kg	1 mL							
	3 kg to <4 kg	1.5 mL							
4 kg to <5 kg	2 mL								
<p>≥30 Weeks to <35 Weeks of Gestation at Birth</p> <p><i>Birth to Age 2 Weeks</i></p> <ul style="list-style-type: none"> • ZDV 2 mg/kg per dose orally twice daily <p><i>Age 2 Weeks to ≤6 Weeks</i></p> <ul style="list-style-type: none"> • ZDV 3 mg/kg per dose orally twice daily 									
<p><30 Weeks of Gestation at Birth</p> <p><i>Birth to Age 4 Weeks</i></p> <ul style="list-style-type: none"> • ZDV 2 mg/kg per dose orally twice daily <p><i>Age 4 Weeks to ≤6 Weeks</i></p> <ul style="list-style-type: none"> • ZDV 3 mg/kg per dose orally twice daily 									

ARV Drug	Drug Doses by Gestational Age at Birth										
3TC	<p>≥32 Weeks of Gestation at Birth</p> <p><i>Birth to Age <4 Weeks</i></p> <ul style="list-style-type: none"> • 3TC 2 mg/kg per dose orally twice daily <p><i>Age ≥4 Weeks to ≤6 weeks</i></p> <ul style="list-style-type: none"> • 3TC 4 mg/kg per dose orally twice daily 										
<p>NVP^b</p> <p>Note: These are NVP treatment doses for a presumptive HIV therapy regimen. NVP dosing for extended ARV prophylaxis during breastfeeding is provided in Table 12.1.</p> <p>Note: Do not use NVP if HIV-2 infection (or HIV-2 co-infection with HIV-1) is present or suspected; see HIV-2 Infection and Pregnancy.</p>	<p>≥37 Weeks of Gestation at Birth</p> <p><i>Birth to Age ≤6 Weeks</i></p> <ul style="list-style-type: none"> • NVP 6 mg/kg per dose orally twice daily 										
	<p>≥34 Weeks to <37 Weeks of Gestation at Birth</p> <p><i>Birth to Age <1 Week</i></p> <ul style="list-style-type: none"> • NVP 4 mg/kg per dose orally twice daily <p><i>Age ≥1 Week to ≤6 Weeks</i></p> <ul style="list-style-type: none"> • NVP 6 mg/kg per dose orally twice daily 										
	<p>≥32 Weeks to <34 Weeks of Gestation at Birth</p> <p><i>Birth to Age <2 Weeks</i></p> <ul style="list-style-type: none"> • NVP 2 mg/kg per dose orally twice daily <p><i>Age ≥2 Weeks to <4 Weeks</i></p> <ul style="list-style-type: none"> • NVP 4 mg/kg per dose orally twice daily <p><i>Age ≥4 Weeks to ≤6 Weeks</i></p> <ul style="list-style-type: none"> • NVP 6 mg/kg per dose orally twice daily 										
RAL	<p>≥37 Weeks of Gestation at Birth and Weighing ≥2 kg^c</p> <p><i>Birth to Age 6 Weeks</i></p> <table border="1" data-bbox="565 1482 1414 1892"> <thead> <tr> <th data-bbox="565 1482 980 1598">Body Weight</th> <th data-bbox="980 1482 1414 1598">Volume (Dose) of RAL 10 mg/mL Suspension</th> </tr> </thead> <tbody> <tr> <td data-bbox="565 1598 980 1696">Birth to 1 Week: Once-Daily Dosing</td> <td data-bbox="980 1598 1414 1696">Approximately 1.5 mg/kg per dose</td> </tr> <tr> <td data-bbox="565 1696 980 1761">2 kg to <3 kg</td> <td data-bbox="980 1696 1414 1761">0.4 mL (4 mg) once daily</td> </tr> <tr> <td data-bbox="565 1761 980 1827">3 kg to <4 kg</td> <td data-bbox="980 1761 1414 1827">0.5 mL (5 mg) once daily</td> </tr> <tr> <td data-bbox="565 1827 980 1892">4 kg to <5 kg</td> <td data-bbox="980 1827 1414 1892">0.7 mL (7 mg) once daily</td> </tr> </tbody> </table>	Body Weight	Volume (Dose) of RAL 10 mg/mL Suspension	Birth to 1 Week: Once-Daily Dosing	Approximately 1.5 mg/kg per dose	2 kg to <3 kg	0.4 mL (4 mg) once daily	3 kg to <4 kg	0.5 mL (5 mg) once daily	4 kg to <5 kg	0.7 mL (7 mg) once daily
Body Weight	Volume (Dose) of RAL 10 mg/mL Suspension										
Birth to 1 Week: Once-Daily Dosing	Approximately 1.5 mg/kg per dose										
2 kg to <3 kg	0.4 mL (4 mg) once daily										
3 kg to <4 kg	0.5 mL (5 mg) once daily										
4 kg to <5 kg	0.7 mL (7 mg) once daily										

ARV Drug	Drug Doses by Gestational Age at Birth	
	1 to 4 Weeks: Twice-Daily Dosing	Approximately 3 mg/kg per dose
	2 kg to <3 kg	0.8 mL (8 mg) twice daily
	3 kg to <4 kg	1 mL (10 mg) twice daily
	4 kg to <5 kg	1.5 mL (15 mg) twice daily
	4 to 6 Weeks: Twice-Daily Dosing	Approximately 6 mg/kg per dose
	3 kg to <4 kg	2.5 mL (25 mg) twice daily
	4 kg to <6 kg	3 mL (30 mg) twice daily
	6 kg to <8 kg	4 mL (40 mg) twice daily
	ABC^d Note: The Panels do not recommend ABC as part of three-drug regimen for newborns with HIV exposure. However, in situations where ZDV is not available or the infant has ZDV-associated toxicity, ABC could be considered an alternative to ZDV.	≥37 Weeks' Gestation at Birth <i>Birth to <1 Month</i> <ul style="list-style-type: none"> • ABC 2 mg/kg per dose orally twice daily <i>Age ≥1 Month to ≤6 Weeks</i> <ul style="list-style-type: none"> • ABC 4 mg/kg per dose orally twice daily

^a The optimal duration of three-drug regimens for newborns at high risk of HIV acquisition is unknown; all infants should receive the ZDV component of the three-drug regimen for 6 weeks. The other two ARVs, (3TC and NVP) or (3TC and RAL), may be administered for 2 to 6 weeks; the recommended duration for these ARVs varies depending on infant HIV NAT results, maternal viral load at the time of delivery, and additional risk factors for HIV transmission. Consultation with an expert in pediatric HIV is recommended when selecting a therapy duration because this decision should be based on case-specific risk factors and interim infant HIV NAT results.

^b The NVP doses for infants ≥32 to <37 weeks' gestation at birth and infants ≥37 weeks' gestation at birth are not yet approved by the FDA. The FDA also has not approved a dose of NVP for infants aged <1 month. The doses for infants ≥32 to <34 weeks' gestation at birth are based on modeling and might underestimate potential toxicity in infants of 32 to <34 weeks gestational age because the doses used to develop the model were lower than the doses now recommended. See [Nevirapine](#) in [Appendix A: Pediatric Antiretroviral Drug Information](#) in the [Pediatric Antiretroviral Guidelines](#) for additional information about dosing.

^c RAL dosing is increased at 1 week and 4 weeks of age because metabolism by UGT1A1 is low at birth and increases rapidly during the next 4 to 6 weeks of life. No dosing information is available for preterm infants or infants weighing <2 kg at birth. The current dosing regimen with two dose changes in the first month of life may be challenging for some families. To minimize dosing changes, some experts increase to the 3-mg/kg twice-daily dose upon discharge on day 4 or 5 of life.

^d ABC is approved by the FDA for use in children aged ≥3 months when administered as part of an ARV regimen. ABC also has been reported to be safe in infants and children ≥1 month of age. More recently, an ABC dosing recommendation using PK simulation models has been endorsed by the WHO using weight-band dosing for full-term infants from birth to 1 month of age. See [Abacavir](#) in [Appendix A: Pediatric Antiretroviral Drug Information](#) in the [Pediatric Antiretroviral Guidelines](#) for additional

information about the use of ABC between birth and 1 month of age. At this time, the Panels do not recommend ABC as part of a presumptive HIV therapy regimen. However, in situations where ZDV is not available or the infant has ZDV-associated toxicity, ABC could be considered an alternative to ZDV. This substitution should be considered in circumstances where increased risk of ZDV toxicity may exist, such as in infants with anemia or neutropenia. Because of ABC-associated hypersensitivity, negative testing for HLA-B*5701 allele should be confirmed prior to the administration of ABC.

Key: 3TC = lamivudine; ABC = abacavir; ARV = antiretroviral; FDA = U.S. Food and Drug Administration; IV = intravenous; NVP = nevirapine; the Panels = the Panel on Treatment of HIV During Pregnancy and Prevention of Perinatal Transmission and the Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV; PK = pharmacokinetic; RAL = raltegravir; UGT = uridine diphosphate glucotransferase; WHO = World Health Organization; ZDV = zidovudine

Table 14. Antiretroviral Management of Infants With Exposure to HIV During Breastfeeding

Maternal HIV RNA levels should be monitored periodically during breastfeeding because the status of viral suppression can change over time (see [Preventing HIV Transmission During Infant Feeding](#)). Decisions about infant antiretroviral (ARV) management during breastfeeding should be based on clinical assessment and incorporate shared decision-making when indicated.

Providers with questions about ARV management of infants should consult an expert in pediatric HIV infection or the [National Perinatal HIV Hotline](#) (1-888-448-8765).

Level of Transmission Risk During Breastfeeding by Maternal HIV RNA Levels	Description	Infant ARV Management During Breastfeeding ^a
Sustained Viral Suppression (HIV RNA <50 copies/mL)	When sustained maternal virologic suppression during pregnancy (at a minimum during the third trimester has been achieved, documented by at least two HIV RNA measurements below the limits of detection at least 1 month apart) and breastfeeding and there are no concerns about adherence	<ul style="list-style-type: none"> • After completion of 2-week ZDV prophylaxis in infants at low risk of <i>in utero</i> or intrapartum transmission, some Panel members recommend no additional ARV prophylaxis, but others recommend extended prophylaxis with NVP or 3TC during breastfeeding. The Panels did not reach consensus about the use of extended ARV prophylaxis during breastfeeding (see Table 12.1). • Most Panel members recommend that, if used, extended ARV prophylaxis should be continued until 6 weeks after last exposure to breast milk. However, it may be reasonable to discontinue prophylaxis earlier when concern for maternal viremia is low.
Current HIV RNA Levels <50 copies/mL But Concerns About Future Risk	When maternal virologic suppression has been achieved during pregnancy but there is concern about future risk (e.g., ART adherence or loss of virologic suppression for other reasons) during breastfeeding	<ul style="list-style-type: none"> • Consider extended ARV prophylaxis with NVP or 3TC (see Table 12.1). • Recommended duration is until 6 weeks after last exposure to breast milk. Providers and parents may consider cessation earlier if concerns about future risk for viremia have resolved. • Provide added adherence support as indicated.
New Viremia During Breastfeeding (HIV RNA ≥200 copies/mL)	When maternal viremia with HIV RNA ≥200 copies/mL develops or presumed viremia (e.g., nonadherence, interrupted access to ARVs)	<ul style="list-style-type: none"> • Breastfeeding should be stopped temporarily or discontinued and replacement feeding initiated (see Situations to Consider Modifying or Stopping Breastfeeding in Preventing HIV Transmission During Infant Feeding).

Level of Transmission Risk During Breastfeeding by Maternal HIV RNA Levels	Description	Infant ARV Management During Breastfeeding ^a
		<p>Most experts recommend permanent discontinuation of breastfeeding if HIV RNA ≥ 200 copies/mL, but some support resuming breastfeeding once re-suppressed.</p> <ul style="list-style-type: none"> • Perform infant HIV NAT.^a • Initiate presumptive HIV therapy using three-drug regimen of ZDV, 3TC, and DTG.^b For infants aged <4 weeks, ZDV and 3TC plus NVP (treatment dose) or RAL should be used. See Table 12.1 for dosing information. • Duration of 2–6 weeks; consensus was not reached by Panel members. • If the duration of the three-drug regimen is <6 weeks, and the NAT is negative, continue ZDV alone to complete a total of 6 weeks of prophylaxis.
<p>New Viremia During Breastfeeding (HIV RNA <200 copies/mL)</p>	<p>The Panels did not reach consensus about neonatal management when maternal viremia develops that is quantifiable but <200 copies/mL.</p>	<ul style="list-style-type: none"> • Breastfeeding should be stopped temporarily or discontinued and replacement feeding initiated (see Situations to Consider Modifying or Stopping Breastfeeding in Preventing HIV Transmission During Infant Feeding). • Perform infant HIV NAT.^a • Some Panel members recommend initiation of presumptive ARV therapy (as described for new viremia ≥ 200 copies/mL, above); other Panel members recommend initiation of single-drug ARV prophylaxis (see Table 12.1). • Some Panel members recommend management based on repeat HIV RNA testing. • Consultation with an expert is suggested.
<p>New Diagnosis of HIV When Breastfeeding</p>	<p>Newly diagnosed maternal HIV while breastfeeding infant</p>	<ul style="list-style-type: none"> • Stop breastfeeding and initiate replacement feeding. • Perform infant HIV NAT.^a • Initiate presumptive HIV therapy using three-drug regimen of ZDV, 3TC, and DTG.^b For infants aged <4 weeks, ZDV

Level of Transmission Risk During Breastfeeding by Maternal HIV RNA Levels	Description	Infant ARV Management During Breastfeeding ^a
		<p>and 3TC plus NVP (treatment dose) or RAL should be used. See Table 12.1 for dosing information.</p> <ul style="list-style-type: none"> • Duration of 2 to 6 weeks; consensus was not reached by Panel members. • If the duration of three-drug regimen is <6 weeks and the NAT is negative, continue ZDV alone to complete a total of 6 weeks of prophylaxis.

^a An HIV NAT at birth is recommended for all breastfeeding infants. A NAT should be obtained before or immediately after starting ARVs. See [Diagnosis of HIV Infection in Infants and Children](#) for additional information about infant NATs during breastfeeding and follow-up testing after maternal viremia.

^b DTG, a second-generation integrase strand transfer inhibitor with a higher barrier to resistance than RAL, can be used in infants aged ≥4 weeks and weighing ≥3 kg.

Note: Given limited data, decisions about infant ARV prophylaxis during breastfeeding should be based on shared decision-making with the infant's parents.

Key: 3TC = lamivudine; ART = antiretroviral therapy; ARV = antiretroviral; DTG = dolutegravir; NAT = nucleic acid test; NVP = nevirapine; the Panels = Panel on Treatment of HIV During Pregnancy and Prevention of Perinatal Transmission and Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV; RAL = raltegravir; ZDV = zidovudine

Table 14.1. Antiretroviral Prophylaxis Dosing for Infants Who Are Breastfed

ARV Prophylaxis for Infants When Maternal Sustained Viral Suppression is Achieved												
Recommended Regimen	Recommended Duration and Dosing											
ZDV	ZDV administered for 2 weeks after birth (see Table 11.1 for dosing)											
Options for Extended Postnatal Prophylaxis ^a												
Recommended Regimen	Recommended Duration and Dosing											
ZDV	ZDV administration continued for 4–6 weeks after birth (See Table 11.1 for dosing; note that ZDV is not recommended for prophylaxis beyond this initial postnatal period.)											
NVP ^{b,c}	<p>NVP administered starting at birth or after completion of initial prophylaxis ZDV, through 6 weeks after cessation of breastfeeding</p> <p>Simplified Age-Based NVP Dosing for Newborns ≥32 Weeks' Gestation Receiving Extended NVP Prophylaxis During Breastfeeding^{b,c}</p> <table border="1"> <thead> <tr> <th>Age</th> <th>Dose and Volume of NVP 10 mg/mL Oral Syrup Administered Once Daily</th> </tr> </thead> <tbody> <tr> <td rowspan="2">Birth to 6 weeks</td> <td>2.0 to < 3.0 kg: 10 mg (1.0 mL)</td> </tr> <tr> <td>≥ 3.0 kg: 15 mg (1.5 mL)</td> </tr> <tr> <td>6 weeks to 6 months</td> <td>20 mg (2.0 mL)</td> </tr> <tr> <td>6 months to 9 months</td> <td>30 mg (3.0 mL)</td> </tr> <tr> <td>9 months to 18 months</td> <td>40 mg 4.0 mL</td> </tr> </tbody> </table>	Age	Dose and Volume of NVP 10 mg/mL Oral Syrup Administered Once Daily	Birth to 6 weeks	2.0 to < 3.0 kg: 10 mg (1.0 mL)	≥ 3.0 kg: 15 mg (1.5 mL)	6 weeks to 6 months	20 mg (2.0 mL)	6 months to 9 months	30 mg (3.0 mL)	9 months to 18 months	40 mg 4.0 mL
Age	Dose and Volume of NVP 10 mg/mL Oral Syrup Administered Once Daily											
Birth to 6 weeks	2.0 to < 3.0 kg: 10 mg (1.0 mL)											
	≥ 3.0 kg: 15 mg (1.5 mL)											
6 weeks to 6 months	20 mg (2.0 mL)											
6 months to 9 months	30 mg (3.0 mL)											
9 months to 18 months	40 mg 4.0 mL											
3TC	<p>3TC administered starting after completion of initial prophylaxis ZDV, through 6 weeks after cessation of breastfeeding</p> <p>Age 2 Weeks to <4 Weeks</p> <ul style="list-style-type: none"> 3TC 2 mg/kg per dose orally twice daily <p>Age ≥4 Weeks to 12 months</p> <ul style="list-style-type: none"> Use simplified weight-band dosing outlined in the table below. 											

Simplified Weight-Band Dosing for 3TC (10 mg/ml Solution) When Used as Prophylaxis During Breastfeeding ^d	
Weight Band	Dose and Volume of 3TC 10 mg/mL Oral Solution Administered Twice Daily
2 to < 3 kg	10 mg (1 mL)
3 kg to <4 kg	15 mg (1.5 mL)
4 kg to <8 kg	25 mg (2.5 mL)
≥8 kg	50 mg (5 mL)

Recommended Infant ARV Management When Maternal Viremia Develops or HIV is Diagnosed During Breastfeeding ^a	
Presumptive HIV Therapy Regimens	Recommended Duration and Dosing
ZDV plus 3TC plus DTG ^e	<p>Three-drug presumptive HIV therapy regimen. ZDV and 3TC plus NVP or RAL should be used in place of DTG for infants aged <4 weeks and/or weighing <3 kg.^{e,f} See Table 11.1 for dosing of ZDV and 3TC in infants aged <6 weeks. Refer to drug sections in Appendix A: Pediatric Antiretroviral Drug Information for appropriate age-based dosing of DTG and for dosing of ZDV, 3TC, NVP, or RAL in infants aged >6 weeks.</p> <p>Presumptive HIV therapy is recommended for a duration of 2–6 weeks (see Table 12).</p>

^a Consultation and referrals to local or regional Pediatric HIV specialists are available through the [National Perinatal HIV Hotline](#) (1-888-448-8765).

^b NVP dosing is adapted from the [Consolidated Guidelines on HIV Prevention, Testing, Treatment, Service Delivery and Monitoring: Recommendations for a Public Health Approach](#). For infants at low risk of transmission, these doses can be given from birth. (Simplified Age-Based Dosing for Newborns ≥32 Weeks' Gestation Receiving Extended NVP Prophylaxis During Breastfeeding in the World Health Organization's [Consolidated Guidelines on HIV Prevention, Testing, Treatment, Service Delivery and Monitoring: Recommendations for a Public Health Approach](#), July 2021)

^c 3TC should be used as extended ARV prophylaxis during breastfeeding when there is evidence or concern for maternal NVP resistant virus (including HIV-2 infection or HIV-1/HIV-2 co-infection) or when an infant cannot tolerate NVP. Dosing recommendations for 3TC are included in the table.

^d Dosing for extended 3TC prophylaxis during breastfeeding, based on established 3TC dosing for treatment and weight-band dosing used in PROMISE-EPI Source: Mennecler A, Kankasa C, et al. Optimised prevention of postnatal HIV transmission in Zambia and Burkina Faso (PROMISE-EPI): a phase 3, open-label, randomised controlled trial. *Lancet*. 2024;403(10434):1362-1371. <https://pubmed.ncbi.nlm.nih.gov/38484756>.

^e DTG, a second-generation integrase strand transfer inhibitor with a higher barrier to resistance than RAL, is preferred in infants aged ≥4 weeks and weighing ≥3 kg.

^f When maternal HIV infection is diagnosed while breastfeeding, a three-drug presumptive HIV therapy regimen is recommended for the infant, with a duration of 2–6 weeks (see [Table 12.1](#)). The same regimen is recommended for infants at high risk of HIV acquisition after *in utero* or intrapartum exposure (see [Table 11](#) and [Table 11.1](#)). No trials have evaluated the use of multidrug regimens to prevent transmission after cessation of breastfeeding with early (acute or recent) HIV infection. Some Panel members recommend presumptive HIV therapy until the infant's HIV status can be determined. If the infant's initial HIV NAT is negative, the optimal duration of presumptive HIV therapy is unknown. A 28-day course may be reasonable based on current recommendations for nonoccupational HIV exposure.

Key: 3TC = lamivudine; ARV = antiretroviral; NVP = nevirapine; RAL = raltegravir; ZDV = zidovudine

Table 15. Approaches for Monitoring Medication Adherence

Routine Assessment of Medication Adherence in Clinical Care ^a	Description
Monitor viral load.	Viral load monitoring should be done more frequently after initiating or changing medications. ^a
Assess a quantitative self-report of missed doses.	Ask the child/adolescent and/or caregiver about the number of missed doses over a defined period (e.g., the last 1, 3, or 7 days). Alternatively, ask, "How many days did you take your medication during the past week?"
Request a description of the medication regimen.	Ask the child/adolescent and/or caregiver about the name, appearance, and number of medications and how often the medications are taken.
Assess barriers to medication administration.	Engage the child/adolescent and/or caregiver in a dialogue about potential barriers to adherence and strategies to overcome them.
Monitor pharmacy refills.	Approaches include a pharmacy-based or clinic-based assessment of on-time medication refills.
Employ telemedicine to monitor and support medication administration.	Telemedicine visits allow remote and often face-to-face contact and provide new opportunities to support families; to visualize ART preparation, handling, and swallowing; and to conduct DOT in the home setting.
Conduct pill counts.	Approaches include asking people to bring medications to the clinic, conducting home visits, or providing referrals to community health nursing.
Monitor attendance for ART injection appointments among adolescents on LAI regimens.	For individuals on LAI ART, adherence is related to receiving scheduled injections on time. Therefore, reducing barriers to adherence should focus on scheduling convenient appointments, minimizing school and work absences, and ensuring transportation to appointments.
Targeted Approaches to Monitoring Adherence in Special Circumstances	Description
Implement DOT in person and via telemedicine.	Include a brief period of hospitalization if indicated.
Measure drug concentration in plasma or DBS.	Measuring drug concentrations can be considered for particular drugs.
Approaches to Monitoring Medication Adherence in Research Settings	Description
Measure drug concentrations in hair.	Measuring hair drug concentrations can be considered for particular drugs; it provides a good measure of adherence over time. ^{27, 66, 67}
Use electronic monitoring devices.	Approaches include MEMS caps and Wisepill.
Use mobile phone–based technologies.	Approaches include interactive voice response, text messaging, and mobile apps.

^a See [Clinical and Laboratory Monitoring of Pediatric HIV Infection](#) regarding the frequency of adherence assessment after initiating or changing therapy.

Key: app = application; ART = antiretroviral therapy; DBS = dried blood spot; DOT = directly observed therapy; LAI = long-acting injectable; MEMS = Medication Event Monitoring System

Table 16. Strategies to Improve Adherence to Antiretroviral Medications

Initial Intervention Strategies
<ul style="list-style-type: none">• Establish trust and identify mutually acceptable goals for care.• Obtain explicit agreement on the need for treatment and adherence.• Determine whether the child is aware of their HIV status. Consider talking to the child's caregivers about disclosing this information to the child in a developmentally appropriate way.• Identify psychosocial, behavioral, or structural barriers that may affect adherence and help the child and/or family access resources to help eliminate these barriers.• Identify family, friends, health team members, and others who can support adherence.• Educate the child/adolescent and family about the critical role of adherence in therapy outcome, including the relationship between partial adherence and resistance and the potential impact on future drug regimen choices.• With the child/adolescent and family together, develop a treatment plan that they believe is achievable.• Address any concerns child/adolescent and caregivers have about the medications.• Work with the child/adolescent and family to make specific plans for taking medications as prescribed and for supporting adherence. Assist them in arranging administration during day care, school, and in other settings, when needed. Consider home delivery of medications.• Identify barriers—such as co-pays and insurance access—related to medication access to help prevent interruptions in ART.• Schedule a home visit or telemedicine visit to review medications and determine how they will be administered in the home setting.• In certain circumstances, consider a brief period of hospitalization for patient education and to assess the tolerability of the chosen medications.
Medication Strategies
<ul style="list-style-type: none">• Choose the simplest regimen possible; reduce dosing frequency, pill size, and number of pills (see Appendix A, Table 1. Antiretrovirals Available in Fixed-Dose Combination Tablets or as a Co-packaged Formulation, by Drug Class and Appendix A, Table 2. Antiretroviral Fixed-Dose Combination Tablets and Co-packaged Formulations: Minimum Body Weights and Considerations for Use in Children and Adolescents). Consider LAI regimens (e.g., LA CAB/RPV) for eligible children and adolescents.• When choosing a regimen, consider the child/adolescent's routines and potential variations in individual and family activities.• Choose the most palatable medicine possible (pharmacists may be able to add syrups or flavoring agents to improve palatability).• Choose drugs with the fewest AEs; provide anticipatory guidance for managing AEs.• Simplify food requirements for medication administration.• Prescribe drugs carefully to avoid adverse drug–drug interactions.• Assess pill-swallowing capacity and offer pill-swallowing training and aids (e.g., pill-swallowing cup, pill glide). Adjust pill size as needed or check if the pill can be crushed. Consider dispersible formulations if possible. See drug sections in Appendix A: Pediatric Antiretroviral Drug Information for information about available formulations and administration of individual drugs.• Choose ARV regimens with high genetic barriers to resistance, when available, if there are concerns about adherence.

Follow-Up Intervention Strategies

- Members of the multidisciplinary team should monitor adherence at each visit. In between visits, adherence can be monitored and supported by telephone, email, text, and other secure applications; confidentiality of any communication approach must be ensured.
- Provide ongoing support, encouragement, and understanding of the difficulties associated with maintaining adherence to daily medication regimens.
- Provide education and counseling that explain the meaning and significance of viral load results.
- Use education aids, including pictures, calendars, and stickers.
- Encourage the use of pill boxes, reminders, mobile apps, and alarms.
- Provide follow-up clinic visits, telephone calls, text messages, and telemedicine visits to support and assess adherence.
- Provide access to support groups, peer groups, summer camp programs, or one-on-one counseling for caregivers and individuals.
- Provide referrals and support access to counseling and treatment services for individuals with identified mental health problems, including depression and substance abuse.
- Provide pharmacist-based adherence support, such as medication education and counseling, blister packs, refill reminders, automatic refills, and home delivery of medications.
- Consider DOT at home, in the clinic, or, in certain circumstances, during a brief period of inpatient hospitalization.
- Consider gastrostomy tube use in certain circumstances.
- Information on other interventions to consider can be found at the [HIV Compendium of Best Practices](#) on the [CDC's website](#).

Key: AE = adverse effect; app = application; ART = antiretroviral therapy; ARV = antiretroviral; CDC = Centers for Disease Control and Prevention; DOT = directly observed therapy; LA CAB/RPV = long-acting injectable cabotegravir and rilpivirine; LAI = long-acting injectable

Table 17a. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Central Nervous System Toxicity

Updated: September 30, 2025

Reviewed: September 30, 2025

Adverse Effects	Associated ARVs	Onset/ Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/ Monitoring	Management
Global CNS Depression	LPV/r oral solution that contains both ethanol (42.4% v/v) and propylene glycol (15.3% w/v) as excipients	<p>Onset</p> <ul style="list-style-type: none"> 1–6 days after starting LPV/r <p>Presentation</p> <p><i>Neonates/Premature Infants</i></p> <ul style="list-style-type: none"> Global CNS depression (e.g., abnormal EEG, altered state of consciousness, somnolence) 	Unknown; rare case reports have been published.	<p>Prematurity</p> <p>Low birth weight</p> <p>Aged <14 days (whether birth was premature or term)</p>	Avoid use of LPV/r until a postmenstrual age of 42 weeks and a postnatal age of ≥14 days unless no other alternatives are available. See Lopinavir/Ritonavir .	<p>Discontinue LPV/r; symptoms should resolve in 1–5 days.</p> <p>If needed, reintroducing LPV/r can be considered when the child is outside the vulnerable period (i.e., a postmenstrual age of 42 weeks and a postnatal age ≥14 days).</p>
Neuropsychiatric Symptoms and Other CNS Manifestations	EFV	<p>Onset</p> <ul style="list-style-type: none"> For many symptoms, onset is 1–2 days after starting EFV. Many symptoms subside or diminish by 2–4 weeks, but symptoms may persist in a significant proportion of children. 	<p>Variable, depending on age, symptoms, and assessment method</p> <p>Children</p> <ul style="list-style-type: none"> 24% of children experienced any EFV-related CNS manifestation in one case series, with 18% of participants requiring drug discontinuation. 	<p>Insomnia is associated with elevated EFV trough concentration (≥4 mcg/mL).</p> <p>CYP2B6 polymorphisms that decrease EFV metabolism and cause increased EFV serum concentrations (CYP2B6 516 T/T genotype or co-carriage of CYP2B6 516 G/T and 983 T/C variants)</p>	Avoid use of EFV for initial ART in children and adolescents to prevent EFV-associated CNS side effects. See What to Start: Antiretroviral Treatment Regimens Recommended for Initial Therapy in Infants and Children With HIV .	<p>If symptoms are excessive or persistent, obtain EFV trough concentration. If EFV trough concentration is >4 mcg/mL and/or symptoms are severe, strongly consider drug substitution if a suitable alternative exists.^a</p> <p>Alternatively, consider dose reduction with repeat TDM and dose adjustment (with input from an expert pharmacologist).</p>

Adverse Effects	Associated ARVs	Onset/ Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/ Monitoring	Management
		<p>Presentation (May Include One or More of the Following)</p> <p><i>Neuropsychiatric Symptoms</i></p> <ul style="list-style-type: none"> • Abnormal dreams • Psychosis • Suicidal ideation or attempted/completed suicide <p><i>Other CNS Manifestations</i></p> <ul style="list-style-type: none"> • Dizziness • Somnolence • Insomnia or poor sleep quality • Impaired concentration • Seizures (including absence seizures) • Cerebellar dysfunction (e.g., tremor, dysmetria, ataxia) <p>Note: CNS side effects (e.g., impaired concentration, abnormal dreams, sleep disturbances) may be more difficult to assess in children.</p>	<ul style="list-style-type: none"> • Five of 45 participants (11%) experienced new-onset seizures in one study of children aged <36 months; two of these participants had alternative causes for seizures. • Cases of cerebellar dysfunction have been reported in children with very high EFV plasma levels. <p>Adults</p> <ul style="list-style-type: none"> • 30% incidence for any CNS manifestations of any severity • 6% incidence of EFV-related, severe CNS manifestations, including suicidality. However, evidence is conflicting about whether EFV use increases the incidence of suicidality. • Two case series reported late-onset ataxia with or without encephalopathy associated with high EFV levels. 	<p>History of psychiatric illness or use of psychoactive drugs</p>	<p>In situations where EFV treatment may be indicated, consider the following:</p> <ul style="list-style-type: none"> • Administer EFV on an empty stomach, preferably at bedtime. • Prescreen for psychiatric illness; avoid use in the presence of psychiatric illness, including depression or suicidal thoughts. Avoid concomitant use of psychoactive drugs. • Consider using TDM in children with mild or moderate EFV-associated toxicities. 	

Adverse Effects	Associated ARVs	Onset/ Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/ Monitoring	Management
	RPV	<p>Onset</p> <ul style="list-style-type: none"> • Most symptoms occur in the first 4–8 weeks of treatment. <p>Presentation</p> <p><i>Neuropsychiatric Symptoms</i></p> <ul style="list-style-type: none"> • Depressive disorders • Suicidal ideation • Abnormal dreams/nightmares <p><i>Other CNS Manifestations</i></p> <ul style="list-style-type: none"> • Headache • Dizziness • Insomnia • Somnolence 	<p>Children</p> <ul style="list-style-type: none"> • Depressive disorders of all severity grades were reported in 22.2% of children and adolescents aged 12–17 years.. • Somnolence was reported in 5 of 36 children (14%). <p>Adults</p> <ul style="list-style-type: none"> • CNS/neuropsychiatric adverse events of all severity grades were reported in 43% of participants at 96 weeks (most were Grade 1). Depressive disorders of all severity grades were reported in 9% of participants; <1% of participants discontinued RPV because of severe depressive disorders. Higher frequency of depression and dizziness reported when coadministered with DTG. 	History of neuropsychiatric illness	Monitor carefully for depressive disorders and other CNS symptoms.	Consider drug substitution in cases of severe symptoms.

Adverse Effects	Associated ARVs	Onset/ Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/ Monitoring	Management
	RAL	<p>Onset</p> <ul style="list-style-type: none"> As early as 3–4 days after starting RAL <p>Presentation</p> <ul style="list-style-type: none"> Increased psychomotor activity Headaches Insomnia Depression Cerebellar dysfunction (e.g., tremor, dysarthria, ataxia) 	<p>Children</p> <ul style="list-style-type: none"> Increased psychomotor activity was reported in one child. <p>Adults</p> <ul style="list-style-type: none"> Headache Insomnia (<5% in adult trials) Rare case reports of cerebellar dysfunction in adults 	<p>Elevated RAL concentrations</p> <p>Cotreatment with TDF, a PPI, or inhibitors of UGT1A1</p> <p>Prior history of insomnia or depression</p>	<p>Prescreen for psychiatric symptoms.</p> <p>Monitor carefully for CNS symptoms.</p> <p>Use with caution in the presence of drugs that increase RAL concentration.</p>	<p>Consider drug substitution (RAL or coadministered drug) in cases of severe insomnia or other neuropsychiatric symptoms.</p>
	DTG	<p>Onset</p> <ul style="list-style-type: none"> Anytime, but usually 7–30 days after starting DTG <p>Presentation</p> <p><i>Neuropsychiatric Symptoms</i></p> <ul style="list-style-type: none"> Depression or exacerbation of preexisting depression Anxiety Self-harm thoughts, suicidal ideation, or attempted/ completed suicide Drowsiness 	<p>Children</p> <ul style="list-style-type: none"> In a retrospective cohort analysis, neuropsychiatric events that resulted in discontinuation occurred in 2 of 29 (6.8%) children who initiated DTG. Higher frequency of suicidal ideation or behavior reported in children in the ODYSSEY trial receiving DTG (2.3%) than those receiving SOC ARVs (1.4%). Overall neuropsychiatric adverse events were 	<p>Preexisting depression or other psychiatric illness</p> <p>History of ARV-related neuropsychiatric symptoms</p>	<p>Use with caution in the presence of psychiatric illness, especially in children and adolescents with depression or a history of ARV-related neuropsychiatric symptoms.</p> <p>Consider morning dosing of DTG.</p>	<p>For persistent or severe neuropsychiatric symptoms, consider discontinuing DTG if a suitable alternative exists.</p> <p>For mild symptoms, continue DTG and counsel that symptoms likely will resolve with time.</p>

Adverse Effects	Associated ARVs	Onset/ Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/ Monitoring	Management
		<ul style="list-style-type: none"> Neurocognitive deficits (lower total competence and school performance) <p><i>Other CNS Manifestations (Generally Mild)</i></p> <ul style="list-style-type: none"> Sleep disturbances Dizziness Headache 	<p>4.3% in children receiving DTG and 2.2% in children receiving SOC ARVs. Most neuropsychiatric AEs were transient and did not lead to treatment changes.</p> <p>Adults</p> <ul style="list-style-type: none"> 2.7% of the neuropsychiatric AEs reported in a large prospective cohort resulted in treatment discontinuation. Higher frequency of neuropsychiatric symptoms reported with DTG than with other INSTIs. A class effect has been suggested. 	<p>Higher frequency of overall neuropsychiatric symptoms reported when DTG is coadministered with ABC, and of depression and dizziness when DTG is coadministered with RPV. However, evidence is conflicting for ABC association.</p>		
	BIC	<p>Onset</p> <ul style="list-style-type: none"> 1–63 days after starting BIC (as late as 233 days for schizoaffective disorders) <p>Presentation</p> <p><i>Neuropsychiatric Symptoms</i></p> <ul style="list-style-type: none"> Depression or exacerbation of preexisting depression 	<p>Children</p> <ul style="list-style-type: none"> One child (1%) had Grade 2 insomnia and anxiety that led to drug discontinuation in clinical trials. 	<p>Preexisting depression or other psychiatric conditions</p> <p>History of ARV-related neuropsychiatric symptoms</p>	<p>Use with caution in the presence of psychiatric conditions or in children and adolescents with a history of ARV-related neuropsychiatric symptoms.</p>	<p>For persistent or severe neuropsychiatric symptoms, consider discontinuing BIC if a suitable alternative exists.</p> <p>For mild symptoms, continue BIC and counsel that symptoms are likely to resolve with time.</p>

Adverse Effects	Associated ARVs	Onset/ Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/ Monitoring	Management
		<ul style="list-style-type: none"> • Suicidal ideation or attempted suicide • Schizoaffective disorders • Anxiety <p><i>Other CNS Manifestations (Generally Mild)</i></p> <ul style="list-style-type: none"> • Sleep disturbances • Dizziness • Insomnia 	<p>Adults</p> <ul style="list-style-type: none"> • Overall, the frequency of neuropsychiatric events in BIC and DTG comparator arms appeared similar in adult clinical trials. • Abnormal dreams, dizziness, and insomnia occurred in 1–5% of adults. • Suicidal ideation, suicide attempts, schizoaffective disorders, and depression occurred in <1% of adults. • A recent study reported a 3.3% short-term BIC-related discontinuation rate due to neuropsychiatric AEs after ART switch in a large cohort of adults with HIV in routine clinical practice setting. 			

Adverse Effects	Associated ARVs	Onset/ Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/ Monitoring	Management
	CAB	<p>Presentation</p> <p><i>Neuropsychiatric Symptoms (Generally Mild or Moderate, Occasionally Serious)</i></p> <ul style="list-style-type: none"> • Mood disorders, including depression and suicidal ideation or attempt • Anxiety disorders <p><i>Other CNS Manifestations (Generally Mild or Moderate)</i></p> <ul style="list-style-type: none"> • Sleep disorders • Dizziness • Headache • Somnolence 	<p>Children</p> <ul style="list-style-type: none"> • Insomnia was reported in 1 of 8 adolescents in the ongoing MOCHA trial. <p>Adults</p> <ul style="list-style-type: none"> • 2–4% pooled incidence was reported in Phase 3 trials for CNS AEs, including sleep disorders, dizziness, and headache. • 5% pooled incidence for anxiety, 3% for depression and <1% for suicidal ideation in Phase 3 trials at 48 weeks, with comparable incidence in CAB and control groups. 	<p>Preexisting depression or other psychiatric conditions could be contributing factors, but causal links have not clearly been identified.</p> <p>CAB exposure did not differ between study participants with and without CNS or neuropsychiatric manifestations.</p>	<p>Monitor individuals for depressive symptoms or self-injurious thoughts or behavior, especially with prior history of such symptoms.</p>	<p>Promptly evaluate severe depressive symptoms, self-injurious behavior, or other CNS symptoms for a possible relationship with CAB and assess risks and benefits of continued CAB treatment.</p> <p>If CAB is discontinued—</p> <ul style="list-style-type: none"> • Counsel the individual about prolonged residual CAB levels in the blood for 52 weeks or longer and monitor frequently for symptom resolution. • Ensure that a new suppressive regimen is started within 30 days of last injection.

^a Even in cases wherein patients have achieved sustained virologic suppression (i.e., suppression for 6–12 months) on their current regimen, clinicians should consider switching patients to new ARV regimens to permit the use of pills instead of liquids; reduce pill burden; allow the use of once-daily medications; reduce the risk of adverse events; minimize drug interactions; and align a child's regimen with widely used, efficacious adult regimens. See [Modifying Antiretroviral Regimens in Children with Sustained Virologic Suppression on Antiretroviral Therapy for more information](#).

3 **Key:** ABC = abacavir; AE = adverse event; ARV = antiretroviral; BIC = bictegravir; CAB = cabotegravir; CNS = central nervous system; CYP2B6 = cytochrome P450 2B6;
4 DTG = dolutegravir; EEG = electroencephalogram; EFV = efavirenz; INSTI = integrase strand transfer inhibitor; LPV/r = lopinavir/ritonavir; MOCHA = More Options for Children and
5 Adolescents; PPI = proton pump inhibitor; RAL = raltegravir; RPV = rilpivirine; SOC = standard of care; TDF = tenofovir disoproxil fumarate; TDM = therapeutic drug monitoring;
6 UGT1A = uridine diphosphate-glucuronosyltransferase family 1 member A complex; v/v = volume per volume; w/v = weight per volume

Table 17b. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Dyslipidemia

Updated: September 30, 2025

Reviewed: September 30, 2025

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
Dyslipidemia	<p>PIs</p> <ul style="list-style-type: none"> All PIs, especially RTV-boosted PIs; lower incidence reported with DRV/r and ATV, with or without RTV <p>NRTIs</p> <ul style="list-style-type: none"> Lower incidence reported with TDF than with TAF <p>NNRTIs</p> <ul style="list-style-type: none"> Lower incidence reported with NVP, RPV, and ETR than with EFV <p>INSTIs</p> <ul style="list-style-type: none"> EVG/c 	<p>Onset</p> <ul style="list-style-type: none"> As early as 2 weeks to months after beginning therapy <p>Presentation</p> <p><i>PIs</i></p> <ul style="list-style-type: none"> ↑ LDL-C, TC, and TG <p><i>NRTIs</i></p> <ul style="list-style-type: none"> ↑ LDL-C, TC, and TG. Significant increase in plasma lipid values was observed in adults switching from TDF to TAF, regardless of third agent or presence of a boosting agent. <p><i>NNRTIs</i></p> <ul style="list-style-type: none"> ↑ LDL-C, TC, and HDL-C 	<p>Reported frequency varies with specific ARV regimen, duration of ART, and the specific laboratory parameters used to diagnose lipid abnormalities.</p> <p>10% to 20% of young children receiving LPV/r will have lipid abnormalities.</p> <p>40% to 75% of older children and adolescents with prolonged ART history will have lipid abnormalities.</p>	<p>Advanced HIV disease</p> <p>High-fat, high-cholesterol diet</p> <p>Sedentary lifestyle</p> <p>Obesity</p> <p>Hypertension</p> <p>Smoking</p> <p>Family history of dyslipidemia or premature ASCVD</p> <p>Metabolic syndrome</p> <p>Fat maldistribution</p>	<p>Prevention</p> <ul style="list-style-type: none"> Low-fat diet Exercise Smoking-prevention counseling Use of ARV drugs, such as INSTIs, and to a lesser extent, newer PIs (e.g., ATV, DRV), is associated with a lower prevalence of dyslipidemia. When considering a TDF-based or TAF-based regimen, the lipid-lowering beneficial effect of TDF should be weighed against its potential for increased renal and bone toxicities. 	<p>Assess all patients for additional ASCVD risk factors. Patients with HIV are considered to be at moderate risk for ASCVD.^b</p> <p>ARV regimen changes should be considered, especially when the patient is receiving older PIs (e.g., LPV/r) and/or RTV boosting. Switching to a PI-sparing regimen, a PI-based regimen with a more favorable lipid profile, or COBI boosting causes a decline in LDL-C or TG values. The lipid-lowering effect of an ARV regimen switch on LDL-C is less pronounced than with statin therapy but may be enough to re-establish a healthy lipid profile.</p> <p>Refer patients to a lipid specialist early if LDL-C is ≥250 mg/dL or TG is ≥500 mg/dL.</p>

			<p>Pooled dyslipidemia prevalence of 39.5% and an incidence of 32% (191 per 1,000 person-years) reported in a meta-analysis and a review of a large consortium of prospective observational cohorts, respectively.</p>		<p>Monitoring^a</p> <ul style="list-style-type: none"> Obtain fasting (or non-fasting) lipid profile (TC, HDL-C, non-HDL-C, LDL-C, and TG) twice (>2 weeks but ≤3 months apart) and average these results. Monitor every 6 months (for abnormal results) or every 12 months (for normal results). If TG or LDL-C is elevated or if a patient has additional risk factors, obtain FLP. <p><i>Children With Lipid Abnormalities and/or Additional Risk Factors</i></p> <ul style="list-style-type: none"> Obtain 12-hour FLP before initiating or changing therapy and every 6 months thereafter (more often if indicated). <p><i>Children Receiving Lipid-Lowering Therapy With Statins or Fibrates</i></p> <ul style="list-style-type: none"> Obtain 12-hour FLP, LFT, and CK at 4 weeks, 8 weeks, and 3 months after starting lipid therapy. If minimal alterations in AST, ALT, and CK are indicated, monitor every 3–4 months during the first year and every 6 months thereafter (or as clinically indicated). 	<p>If LDL-C is ≥130 mg/dL but <250 mg or TG is ≥100 mg/dL but <500 mg/dL, the following staged treatment approach is recommended by the NHLBI guidelines^b:</p> <ul style="list-style-type: none"> Implement diet, nutrition, and lifestyle management for 6–9 months. Consult with a dietician if one is available. If a 6- to 9-month trial of lifestyle modification fails and the patient is aged ≥10 years, consider implementing lipid-lowering therapy after consulting a lipid specialist. Statin therapy should be considered for patients with elevated LDL-C levels. NHLBI guidelines provide recommendations for statin therapy in patients with specific LDL-C levels and risk factors.^b Concurrent substitution—preferably to ARV drugs with no inhibitory or inducing effect on CYP3A4 or OATP1B1 (e.g., INSTI)—also should be considered as appropriate to limit drug–drug interaction potential. Drug therapy can be considered in cases of severe hypertriglyceridemia (TG ≥500 mg/dL). Fibrates (gemfibrozil and fenofibrate) may be used.
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Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
					<ul style="list-style-type: none"> Repeat FLP 4 weeks after increasing doses of antihyperlipidemic agents. 	<p>Refer to Statin Therapy in People With HIV in the Adult and Adolescent Guidelines for additional recommendations on statin therapy for people with HIV who are aged <40 years.^c</p> <p>The long-term risks of lipid abnormalities in children who are receiving ART are unclear. However, persistent dyslipidemia in children may lead to premature ASCVD.</p>

^a Because of the burden of collecting fasting blood samples, some practitioners routinely measure cholesterol and TG from nonfasting blood samples and follow up abnormal values with a test done in the fasted state.

^b Refer to the NHLBI guidelines: [Expert Panel on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents](#).

^c [Statin Therapy in People With HIV](#) in the Adult and Adolescent Guidelines states the following: "There are insufficient data to inform whether risk enhancers, such as HIV-related factors, would favor statin therapy among people under 40 years of age. However, some younger people with HIV may be at increased ASCVD risk—particularly those with a very long duration of HIV infection (e.g., due to perinatal exposure)."

Key to Symbol:

↑ = increase

Key: ALT = alanine aminotransferase; ART = antiretroviral therapy; ARV = antiretroviral; ASCVD = atherosclerotic cardiovascular disease; AST = aspartate aminotransferase; ATV = atazanavir; CK = creatine kinase; COBI = cobicistat; CYP3A4 = cytochrome P450 3A4; DRV = darunavir; DRV/r = darunavir/ritonavir; EFV = efavirenz; ETR = etravirine; EVG/c = elvitegravir/cobicistat; FLP = fasting lipid profile; HDL-C = high-density lipoprotein cholesterol; INSTI = integrase strand transfer inhibitor; LDL-C = low-density lipoprotein cholesterol; LFT = liver function test; LPV/r = lopinavir/ritonavir; NHLBI = National Heart, Lung, and Blood Institute; NNRTI = non-nucleoside reverse transcriptase inhibitor; NRTI = nucleoside reverse transcriptase inhibitor; NVP = nevirapine; OATP1B1 = organic anion transporter polypeptide 1B1; PI = protease inhibitor; RPV = rilpivirine; RTV = ritonavir; TAF = tenofovir alafenamide; TC = total cholesterol; TDF = tenofovir disoproxil fumarate; TG = triglyceride

**Table 17c. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—
Gastrointestinal Effects**

Updated: June 27, 2024

Reviewed: June 27, 2024

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
Nausea/ Vomiting	All ARV drugs, but most notably RTV-boosted PIs	Onset <ul style="list-style-type: none"> • Early Presentation <ul style="list-style-type: none"> • Nausea and emesis, both of which may be associated with anorexia and/or abdominal pain 	Varies by ARV agent; generally <15%	Unknown	Instruct patient to take PIs with food. Monitor for weight loss and ARV adherence.	Reassure the patient that these adverse effects generally improve over time (usually in 6–8 weeks). Consider switching to ARV drugs with smaller tablet sizes (see Appendix A, Table 2. Antiretroviral Fixed-Dose Combination Tablets and Co-packaged Formulations: Minimum Body Weights and Considerations for Use in Children and Adolescents). Provide supportive care. In extreme or persistent cases, use antiemetics or switch to another ARV regimen.
Diarrhea	All ARV drugs, but most notably RTV-boosted PIs	Onset <ul style="list-style-type: none"> • Early Presentation <ul style="list-style-type: none"> • More frequent bowel movements and 	Varies by ARV agent; generally <15%	Unknown	Monitor for weight loss and dehydration.	In prolonged or severe cases, exclude infectious or noninfectious (e.g., lactose intolerance) causes of diarrhea.

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
		stools that are generally soft				<p>Reassure patient that this adverse effect generally improves over time (usually in 6–8 weeks). Consider switching to another ARV regimen in persistent and severe cases.</p> <p>Treatment data in children are lacking; however, the following strategies may be useful when the ARV regimen cannot be changed:</p> <ul style="list-style-type: none"> • Modifying the diet • Using bulk-forming agents (e.g., psyllium) • Using antimotility agents (e.g., loperamide) • Using crofelemer, which is approved by the FDA to treat ART-associated diarrhea in adults aged ≥18 years; no pediatric data are available.
Pancreatitis	Rare, but may occur with NRTIs or RTV-boosted PIs	Onset <ul style="list-style-type: none"> • Any time, usually after months of therapy 	<2%	Use of concomitant medications that are associated with pancreatitis (e.g., TMP-SMX, pentamidine, ribavirin)	Measure serum amylase and lipase concentrations if persistent abdominal pain develops.	<p>Discontinue offending agent and avoid reintroduction.</p> <p>Manage symptoms of acute episodes.</p>

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
		Presentation <ul style="list-style-type: none"> • Emesis, abdominal pain, and elevated amylase and lipase levels (asymptomatic hyperamylasemia or elevated lipase do not in and of themselves indicate pancreatitis) 		Hypertriglyceridemia Advanced HIV infection Previous episode of pancreatitis Alcohol use		If pancreatitis is associated with hypertriglyceridemia, consider using interventions to lower TG levels.

Key: ART = antiretroviral therapy; ARV = antiretroviral; FDA = U.S. Food and Drug Administration; NRTI = nucleoside reverse transcriptase inhibitor; PI = protease inhibitor; RTV = ritonavir; TG = triglyceride; TMP-SMX = trimethoprim sulfamethoxazole

**Table 17d. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—
Hematologic Effects**

Updated: June 27, 2024
Reviewed: June 27, 2024

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
Anemia ^a	ZDV	<p>Onset</p> <ul style="list-style-type: none"> Variable; weeks to months after starting therapy <p>Presentation</p> <p><i>More Common</i></p> <ul style="list-style-type: none"> Asymptomatic Mild fatigue Pallor Tachypnea <p><i>Rare</i></p> <ul style="list-style-type: none"> Congestive heart failure 	<p>Newborns Exposed to HIV</p> <ul style="list-style-type: none"> Severe anemia is uncommon but might be coincident with physiologic Hgb nadir. <p>Children With HIV Who Are Taking ARV Drugs</p> <ul style="list-style-type: none"> Anemia is two to three times more common with ZDV-containing regimens than with all other regimens. 	<p>Newborns Exposed to HIV</p> <ul style="list-style-type: none"> Premature birth is the most common risk factor. <i>In utero</i> exposure to ZDV-containing regimens Advanced maternal HIV Neonatal blood loss Combination ARV prophylaxis or presumptive HIV therapy, although no particular regimen has been identified as being worse than others. <p>Children With HIV Who Are Taking ARV Drugs</p> <ul style="list-style-type: none"> Underlying hemoglobinopathy (e.g., sickle cell disease, G6PD deficiency) 	<p>Newborns Exposed to HIV</p> <ul style="list-style-type: none"> Obtain CBC at birth. Consider repeating CBC at 4 weeks for neonates who are at higher risk (e.g., those born prematurely or who are known to have low birth Hgb) and for neonates who receive ZDV beyond 4 weeks. <p>Children With HIV Who Are Taking ARV Drugs</p> <ul style="list-style-type: none"> Avoid using ZDV in children with severe anemia when alternative agents are available. Obtain CBC as part of routine care (see Clinical and Laboratory Monitoring of Pediatric HIV Infection). 	<p>Newborns Exposed to HIV</p> <ul style="list-style-type: none"> Anemia rarely requires intervention unless it is symptomatic or Hgb <7.0 g/dL. ZDV administration can be limited to 4 weeks in low-risk neonates (see Antiretroviral Management of Infants With In Utero, Intrapartum, or Breastfeeding Exposure to HIV). <p>Children With HIV Who Are Taking ARV Drugs</p> <ul style="list-style-type: none"> Discontinue non-ARV, marrow-toxic drugs, if feasible. Treat coexisting iron deficiency, OIs, and malignancies. For persistent, severe anemia that is thought to be associated with ARV drugs (typically macrocytic anemia), switch to a regimen that does not contain ZDV.

Table 17d. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Hematologic Effects

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
				<ul style="list-style-type: none"> • Myelosuppressive drugs (e.g., TMP-SMX, rifabutin) • Iron deficiency • Advanced or poorly controlled HIV disease • OIs of the bone marrow • Malnutrition 		
Macrocytosis	ZDV	<p>Onset</p> <ul style="list-style-type: none"> • Within days or weeks of starting therapy <p>Presentation</p> <ul style="list-style-type: none"> • Asymptomatic, but MCV often is >100 fL • Sometimes associated with or may progress to anemia 	>90% to 95% for all ages	None	No monitoring required—macrocytosis can be detected if CBC is obtained as part of routine care (see Clinical and Laboratory Monitoring of Pediatric HIV Infection).	No management required.

Table 17d. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Hematologic Effects

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
Neutropenia ^a	ZDV	<p>Onset</p> <ul style="list-style-type: none"> • Variable <p>Presentation</p> <ul style="list-style-type: none"> • Asymptomatic 	<p>Newborns Exposed to HIV</p> <ul style="list-style-type: none"> • Rare <p>Children With HIV Who Are Taking ARV Drugs</p> <ul style="list-style-type: none"> • 2% to 4% of children on ARV drugs • Highest rates occur in children on ZDV-containing regimens 	<p>Newborns Exposed to HIV</p> <ul style="list-style-type: none"> • <i>In utero</i> exposure to ARV drugs • Combination ARV prophylaxis, particularly ZDV plus 3TC and NVP <p>Children With HIV Who Are Taking ARV Drugs</p> <ul style="list-style-type: none"> • Advanced or poorly controlled HIV infection • Myelosuppressive drugs (e.g., TMP-SMX, ganciclovir, hydroxyurea, rifabutin) 	<p>Children With HIV Who Are Taking ARV Drugs</p> <ul style="list-style-type: none"> • Obtain CBC as part of routine care. 	<p>Newborns Exposed to HIV</p> <ul style="list-style-type: none"> • No established threshold for intervention; some experts would consider using an alternative NRTI for prophylaxis if ANC reaches <500 cells/mm³. ZDV administration can be limited to 4 weeks in low-risk neonates (see Antiretroviral Management of Infants With In Utero, Intrapartum, or Breastfeeding Exposure to HIV). <p>Children With HIV Who Are Taking ARV Drugs</p> <ul style="list-style-type: none"> • Discontinue non-ARV, marrow-toxic drugs, if feasible. • Treat coexisting OIs and malignancies. • In cases of persistent, severe neutropenia that is thought to be associated with ARV drugs, switch to a regimen that does not contain ZDV.

^a HIV infection itself, OIs, and medications that are used to prevent OIs (e.g., TMP-SMX) can all contribute to anemia and neutropenia. Prolonged use of NVP with ZDV in three-drug regimens for the prevention of perinatal HIV transmission has been associated with increased rates of anemia and neutropenia in some, but not all, studies. The effects are of uncertain clinical significance and appear to be transient.

Key: 3TC = lamivudine; ANC = absolute neutrophil count; ARV = antiretroviral; CBC = complete blood count; fL = femtoliter; G6PD = glucose-6-phosphate dehydrogenase; g/dL = grams per deciliter; Hgb = hemoglobin; MCV = mean cell volume; NRTI = nucleoside reverse transcriptase inhibitor; NVP = nevirapine; OI = opportunistic infection; TMP-SMX = trimethoprim-sulfamethoxazole; ZDV = zidovudine

Table 17e. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Hepatic Events

Updated: April 11, 2024

Reviewed: June 27, 2024

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
Hepatitis	<p>Most ARV drugs have been associated with hepatitis, but a strong association exists between hepatitis and the use of NVP and EFV.</p> <p>NVP, EFV, ABC, RAL, DTG, and MVC have been associated with hepatitis in the context of HSRs.</p> <p>NRTIs, especially ZDV, have been associated with lactic acidosis and hepatic steatosis.</p>	<p>Onset</p> <ul style="list-style-type: none"> Acute toxic hepatitis occurs most commonly within the first few months of therapy, but it can occur later. Steatosis presents after months or years of therapy. Patients with HBV coinfection can experience a hepatitis flare with the initiation or withdrawal of 3TC, FTC, TDF, or TAF. A flare also can occur with the emergence of resistance to 3TC or FTC (especially if the patient is receiving only one anti-HBV agent). Note that TDF and TAF have high barriers to resistance when used to treat HBV. 	Uncommon	<p>HBV or HCV coinfection</p> <p>Underlying liver disease</p> <p>Use of other hepatotoxic medications and supplements (e.g., St. John's wort [<i>Hypericum perforatum</i>], chaparral [<i>Larrea tridentata</i>], germander [<i>Teucrium chamaedrys</i>])</p> <p>Alcohol use</p> <p>Pregnancy</p> <p>Obesity</p> <p>Higher drug concentrations of PIs</p> <p>For NVP-Associated Hepatic Events in Adults</p> <ul style="list-style-type: none"> Female sex with pre-NVP CD4 count >250 cells/mm³ Male sex with pre-NVP CD4 count >400 cells/mm³ 	<p>Prevention</p> <ul style="list-style-type: none"> Avoid concomitant use of hepatotoxic medications. In patients with elevated levels of hepatic enzymes (>5 times to 10 times ULN) or chronic liver disease, most clinicians would avoid NVP. <p>Monitoring</p> <p><i>For ARV Drugs Other than NVP</i></p> <ul style="list-style-type: none"> Obtain AST and ALT levels at baseline and at least every 3–4 months thereafter^b; monitor at-risk patients more frequently (e.g., those with HBV or HCV coinfection or elevated baseline AST and ALT levels). 	<p>Evaluate the patient for other infectious and noninfectious causes of hepatitis and monitor the patient closely.</p> <p>Asymptomatic Hepatitis</p> <ul style="list-style-type: none"> Potentially offending ARV drugs should be discontinued if ALT or AST level is >5 times ULN. <p>Symptomatic Hepatitis</p> <ul style="list-style-type: none"> Discontinue all ARV drugs and other potentially hepatotoxic drugs. If a patient experiences hepatitis that is attributed to NVP, NVP should be discontinued permanently.

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
		<ul style="list-style-type: none"> • Hepatitis can be a manifestation of IRIS if it occurs early in therapy, especially in patients with HBV or HCV coinfection. <p>Presentation</p> <ul style="list-style-type: none"> • Asymptomatic elevation of AST and ALT levels • Symptomatic hepatitis with nausea, fatigue, and jaundice • Hepatitis may present in the context of HSR with rash, lactic acidosis, and hepatic steatosis. 		<ul style="list-style-type: none"> • Population-specific HLA types^a 	<p><i>For NVP</i></p> <ul style="list-style-type: none"> • Obtain AST and ALT levels at baseline, at 2 weeks, and at 4 weeks, and then every 3 months. 	<ul style="list-style-type: none"> • Consider viral causes of hepatitis: HAV, HBV, HCV, EBV, and CMV.

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
Indirect Hyperbilirubinemia	ATV	<p>Onset</p> <ul style="list-style-type: none"> • Within the first months of therapy <p>Presentation</p> <ul style="list-style-type: none"> • Can be asymptomatic or associated with jaundice • Levels of direct bilirubin can be normal or slightly elevated when levels of indirect bilirubin are very high. • Normal AST and ALT 	In long-term follow-up, 9% of children who were receiving ATV had at least one total bilirubin level >5 times ULN, and 1.4% of children experienced jaundice.	None established	<p>Monitoring</p> <ul style="list-style-type: none"> • No ongoing monitoring is needed. • After an initial rise over the first few months of therapy, unconjugated bilirubin levels generally stabilize; levels can improve over time. 	<p>Isolated indirect hyperbilirubinemia is not an indication to stop ATV.</p> <p>Psychological impact of jaundice should be evaluated, and alternative agents should be considered.</p> <p>Jaundice can result in nonadherence, particularly in adolescents; this side effect should be discussed with patients.</p>

^a For example, HLA-DRB1*0101 in White people, HLA-DRB1*0102 in South African people, and HLA-B35 in Thai people and White people.

^b Less frequent monitoring can be considered in children whose clinical status has been stable for >2 years to 3 years (see [Clinical and Laboratory Monitoring of Pediatric HIV Infection](#)).

Key: 3TC = lamivudine; ABC = abacavir; ALT = alanine transaminase; ARV = antiretroviral; AST = aspartate aminotransferase; ATV = atazanavir; CD4 = CD4 T lymphocyte; CMV = cytomegalovirus; DTG = dolutegravir; EBV = Epstein-Barr virus; EFV = efavirenz; FTC = emtricitabine; HAV = hepatitis A virus; HBV = hepatitis B virus; HCV = hepatitis C virus; HLA = human leukocyte antigen; HSR = hypersensitivity reaction; IRIS = immune reconstitution inflammatory syndrome; MVC = maraviroc; NRTI = nucleoside reverse transcriptase inhibitor; NVP = nevirapine; PI = protease inhibitor; RAL = raltegravir; TAF = tenofovir alafenamide; TDF = tenofovir disoproxil fumarate; ULN = upper limit of normal; ZDV = zidovudine

Table 17f. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Insulin Resistance, Asymptomatic Hyperglycemia, and Diabetes Mellitus

Updated: April 11, 2023
 Reviewed: June 27, 2024

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
Insulin Resistance, Asymptomatic Hyperglycemia, and Diabetes Mellitus ^a	ZDV, LPV/r, and possibly other PIs and INSTIs	<p>Onset</p> <ul style="list-style-type: none"> Weeks to months after beginning therapy <p>Presentation</p> <ul style="list-style-type: none"> Asymptomatic fasting hyperglycemia (which sometimes occurs in the setting of lipodystrophy), metabolic syndrome, or growth delay Symptomatic DM (rare) 	<p>Children</p> <ul style="list-style-type: none"> IR, 6% to 12% (incidence is higher during puberty, 20% to 30%) IFPG, 0% to 7% IGT, 3% to 4% DM, 0.2 per 100 child-years 	<p>Risk Factors for Type 2 DM</p> <ul style="list-style-type: none"> Lipodystrophy Metabolic syndrome Family history of DM High BMI (obesity) 	<p>Prevention</p> <ul style="list-style-type: none"> Lifestyle modification <p>Monitoring</p> <ul style="list-style-type: none"> Monitor for signs of DM, change in body habitus, and acanthosis nigricans. Obtain RPG levels at initiation of ART, 3–6 months after ART initiation, and yearly thereafter. In patients with an RPG ≥ 140 mg/dL, obtain FPG after an 8-hour fast and consider referring the patient to an endocrinologist. 	<p>Counsel patient on lifestyle modification (e.g., implementing a diet low in saturated fat, cholesterol, trans fat, and refined sugars; increasing physical activity; ceasing smoking).</p> <p>Recommend that the patient consult with a dietician.</p> <p>If the patient is receiving ZDV, switch to TAF, TDF, or ABC.</p> <p>For Patients With Either an RPG ≥ 200 mg/dL Plus Symptoms of DM or an FPG ≥ 126 mg/dL</p> <ul style="list-style-type: none"> These patients meet diagnostic criteria for DM; consult an endocrinologist. <p>For Patients With an FPG of 100–125 mg/dL</p> <ul style="list-style-type: none"> Impaired FPG suggests insulin resistance; consult an endocrinologist.

Table 17f. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Insulin Resistance, Asymptomatic Hyperglycemia, and Diabetes Mellitus

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
						<p>For Patients With an FPG of <100 mg/dL</p> <ul style="list-style-type: none"> This FPG is normal, but a normal FPG does not exclude IR. Recheck FPG in 6–12 months.

^a IR, asymptomatic hyperglycemia, IFPG, IGT, and DM form a spectrum of increasing severity.

IR: Often defined as elevated insulin levels for the level of glucose observed.

IFPG: Often defined as an FPG of 100–125 mg/dL.

IGT: Often defined as an elevated 2-hour plasma glucose (PG) of 140–199 mg/dL in a 75-g oral glucose tolerance test (OGTT) (or, if the patient weighs <43 kg, 1.75 g per kg of glucose up to a maximum of 75 g).

DM: Often defined as either an FPG \geq 126 mg/dL, an RPG \geq 200 mg/dL in a patient with hyperglycemia symptoms, a glycosylated hemoglobin (HgbA1c) of \geq 6.5%, or a 2-hour PG \geq 200 mg/dL in an OGTT.

However, the Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV does not recommend performing routine measurements of insulin levels, HgbA1c, or glucose tolerance without consulting an endocrinologist. These guidelines are instead based on the readily available RPG and FPG levels. The HgbA1c test may underestimate glycemia in people with HIV; it is not recommended for diagnosis and may present challenges for monitoring.

Key: ABC = abacavir; ART = antiretroviral therapy; ARV = antiretroviral; BMI = body mass index; DM = diabetes mellitus; FPG = fasting plasma glucose; IFPG = impaired fasting plasma glucose; IGT = impaired glucose tolerance; INSTI = integrase strand transfer inhibitor; IR = insulin resistance; LPV/r = lopinavir/ritonavir; mg/dL = milligrams per deciliter; PI = protease inhibitor; RPG = random plasma glucose; TAF = tenofovir alafenamide; TDF = tenofovir disoproxil fumarate; ZDV = zidovudine

Table 17g. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Lactic Acidosis

Updated: September 30, 2025

Reviewed: September 30, 2025

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
Lactic Acidosis	<p>NRTIs</p> <ul style="list-style-type: none"> ZDV Less likely with 3TC, FTC, ABC, TAF, and TDF <p>Other Drugs</p> <ul style="list-style-type: none"> See the Risk Factors and Prevention/Monitoring columns for information regarding the toxicity of propylene glycol when LPV/r oral solution is used in neonates. 	<p>Onset</p> <ul style="list-style-type: none"> Generally, after years of exposure A few cases have been reported shortly after initiation in people with underlying liver disease. <p>Presentation</p> <ul style="list-style-type: none"> Lactic acidosis may be clinically asymptomatic. <p><i>Lactic Acidosis May Also Present With Insidious Onset of a Combination of Signs and Symptoms</i></p> <ul style="list-style-type: none"> Generalized fatigue, weakness, and myalgias Vague abdominal pain, weight loss, unexplained nausea, or vomiting 	3TC, FTC, ABC, TAF, and TDF are less likely to induce clinically significant mitochondrial dysfunction than ZDV.	<p>Adults</p> <ul style="list-style-type: none"> Female sex High BMI Chronic HCV infection African American race Coadministration of TDF with metformin Overdose of propylene glycol CD4 count <350 cells/mm³ Acquired riboflavin or thiamine deficiency Possible pregnancy Overdose in setting of renal insufficiency, including a case of ARV-associated new-onset renal insufficiency (TDF/FTC plus DRV/c) 	<p>Prevention</p> <ul style="list-style-type: none"> Due to the presence of propylene glycol as a diluent, LPV/r oral solution should not be used in preterm neonates or any neonate who has not attained a postmenstrual age of 42 weeks and a postnatal age of ≥14 days. Monitor for clinical manifestations of lactic acidosis and promptly adjust therapy. <p>Monitoring</p> <p><i>Asymptomatic Patients</i></p> <ul style="list-style-type: none"> Routine measurement of serum lactate is not recommended. 	<p>For Patients With Lactate 2.1–5.0 mmol/L (Confirmed With a Second Test)</p> <ul style="list-style-type: none"> Consider discontinuing all ARV drugs temporarily while conducting additional diagnostic work-up. <p>For Patients With Lactate >5.0 mmol/L (Confirmed With a Second Test)^b or >10.0 mmol/L (Any One Test)</p> <ul style="list-style-type: none"> Discontinue all ARV drugs. Provide supportive therapy (e.g., IV fluids; some patients may require sedation and respiratory support to reduce oxygen demand and ensure adequate oxygenation of tissues).

Table 17g. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Lactic Acidosis

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
		<ul style="list-style-type: none"> Dyspnea Peripheral neuropathy <p>Note: Patients may present with acute multiorgan failure (e.g., fulminant hepatic failure, pancreatic failure, respiratory failure).</p>		<p>Preterm Infants or Any Neonates Who Have Not Attained a Postmenstrual Age of 42 Weeks and a Postnatal Age of ≥ 14 Days</p> <ul style="list-style-type: none"> Exposure to propylene glycol, which is used as a diluent in LPV/r oral solution, because these newborns have a diminished ability to metabolize propylene glycol, which may lead to accumulation, increasing the risk of adverse events. 	<p><i>Patients With Clinical Signs or Symptoms Consistent With Lactic Acidosis</i></p> <ul style="list-style-type: none"> Obtain blood lactate level.^a Additional diagnostic evaluations should include serum bicarbonate, anion gap, and/or arterial blood gas; amylase and lipase; serum albumin; and hepatic transaminases. 	<p>Anecdotal (Unproven) Supportive Therapies</p> <ul style="list-style-type: none"> Administer bicarbonate infusions, THAM, high doses of thiamine and riboflavin, and oral antioxidants (e.g., L-carnitine, co-enzyme Q10, vitamin C). <p>Following the resolution of clinical and laboratory abnormalities, resume therapy either with an NRTI-sparing regimen or a revised NRTI-containing regimen. Institute a revised NRTI-containing regimen with caution, using NRTIs that are less likely to induce mitochondrial dysfunction (i.e., ABC, TAF, TDF, FTC, or 3TC). Lactate should be monitored monthly for ≥ 3 months.</p>

^a Blood for lactate determination should be collected, without prolonged tourniquet application or fist clenching, into a pre-chilled, gray-top, fluoride-oxalate-containing tube and transported on ice to the laboratory to be processed within 4 hours of collection.

^b Management can be initiated before receiving the results of the confirmatory test.

Key: 3TC = lamivudine; ABC = abacavir; ARV = antiretroviral; BMI = body mass index; CD4 = CD4 T lymphocyte; DRV/c = darunavir/cobicistat; FTC = emtricitabine; HCV = hepatitis C virus; IV = intravenous; LPV/r = lopinavir/ritonavir; NRTI = nucleoside reverse transcriptase inhibitor; TAF = tenofovir alafenamide; TDF = tenofovir disoproxil fumarate; THAM = tris (hydroxymethyl) aminomethane; ZDV = zidovudine

Table 17h. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Lipodystrophies and Weight Gain

Updated: June 27, 2024

Reviewed: June 27, 2024

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
<p>Lipodystrophy (Fat Maldistribution)</p> <p>General Information</p>	See below for specific associations.	<p>Onset</p> <ul style="list-style-type: none"> Increase in trunk and limb fat is the first sign; peripheral fat wasting may not appear for 12–24 months after ART initiation. 	Frequency is low (<5%) with current regimens.	<ul style="list-style-type: none"> Genetic predisposition Puberty HIV-associated inflammation Older age Longer duration of ART Body habitus 	<p>Prevention</p> <ul style="list-style-type: none"> Initiate a calorically appropriate low-fat diet and an exercise regimen. <p>Monitoring</p> <ul style="list-style-type: none"> BMI measurement Waist circumference and waist-hip ratio 	<ul style="list-style-type: none"> Physicians should perform a regimen review and consider changing the regimen when lipodystrophy occurs. Improvement in fat maldistribution can vary following a regimen change. Improvement may occur after several months or years, or it may not occur at all.
<p>Central Lipohypertrophy or Lipo-accumulation</p>	Can occur in the absence of ART, but these conditions most often are associated with the use of PIs and EFV.	<p>Presentation</p> <ul style="list-style-type: none"> Central fat accumulation with increased abdominal girth, which may include a dorsocervical fat pad (buffalo hump). Gynecomastia may occur in males, or breast hypertrophy may occur in females, particularly with the use of EFV. 	Frequency is low (<5%) with current regimens.	<ul style="list-style-type: none"> Obesity before initiation of therapy Sedentary lifestyle 	<p>Prevention</p> <ul style="list-style-type: none"> Initiate a calorically appropriate low-fat diet and an exercise regimen. <p>Monitoring</p> <ul style="list-style-type: none"> BMI measurement Waist circumference and waist-hip ratio measurements 	<ul style="list-style-type: none"> Counsel patient on lifestyle modification and dietary interventions (e.g., maintaining a calorically appropriate diet that is low in saturated fats and simple carbohydrates and starting an exercise regimen, especially strength training). Recommend smoking cessation (if applicable) to decrease future CVD risk.

Table 17h. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Lipodystrophies and Weight Gain

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
						<ul style="list-style-type: none"> • Consider using an INSTI instead of a PI or EFV, although some INSTIs may be associated with generalized weight gain (see below). Data Are Insufficient to Allow the Panel to Safely Recommend Use of Any of the Following Modalities in Children: • Recombinant human growth hormone • Growth hormone–releasing hormone • Metformin • Thiazolidinediones • Recombinant human leptin • Anabolic steroids • Liposuction

Table 17h. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Lipodystrophies and Weight Gain

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
Facial/Peripheral Lipotrophy	Most cases are associated with the use of ZDV, a thymidine analogue NRTI.	<p>Presentation</p> <ul style="list-style-type: none"> • Thinning of subcutaneous fat in the face, buttocks, and extremities, measured as a decrease in trunk/limb fat by DXA or triceps skinfold thickness. Preservation of lean body mass distinguishes lipotrophy from HIV-associated wasting. 	Frequency is low (<5%) with current regimens.	Underweight before ART initiation	<p>Prevention</p> <ul style="list-style-type: none"> • Limit the use of ZDV. <p>Monitoring</p> <ul style="list-style-type: none"> • Patient self-report and physical examination are the most sensitive methods of monitoring lipotrophy. 	<ul style="list-style-type: none"> • Replace ZDV with another NRTI when possible. <p>Data Are Insufficient to Allow the Panel to Safely Recommend Use of Any of the Following Modalities in Children:</p> <ul style="list-style-type: none"> • Injections of poly-L-lactic acid • Recombinant human leptin • Autologous fat transplantation • Thiazolidinediones
Weight Gain	Significant weight gain may occur with all ARV regimens, but it appears to be more pronounced with INSTIs (DTG, BIC, EVG, RAL) and TAF.	<p>Onset</p> <ul style="list-style-type: none"> • Gradual weight gain after initiating ARV drugs is common with all currently used regimens. The mechanism for weight gain is unclear and under investigation. 	Rate of development of obesity is unclear.	<p>In Infants and Children</p> <ul style="list-style-type: none"> • Limited evaluation has demonstrated weight gain, but such observations have not been consistently attributable to specific ARVs <p>In Adolescents</p> <ul style="list-style-type: none"> • Female sex • Pre-treatment obesity 	<p>Prevention</p> <ul style="list-style-type: none"> • Initiate a calorically appropriate low-fat diet and an exercise regimen. <p>Monitoring</p> <ul style="list-style-type: none"> • BMI measurement • Waist circumference and waist-hip ratio measurements 	<p>Counsel patient on lifestyle modifications and dietary interventions (e.g., maintaining a calorically appropriate healthy diet that is low in saturated fats and simple carbohydrates and starting an exercise regimen, especially strength training).</p> <p>Children with HIV and significant weight gain should be managed according to standard AAP recommendations for weight management.</p>

Table 17h. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Lipodystrophies and Weight Gain

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
				<p>In Adults</p> <ul style="list-style-type: none"> • Low pre-treatment BMI • Older age • Female sex • Black race • Possible genetic polymorphisms 		

Key: AAP = American Academy of Pediatrics; ART = antiretroviral therapy; ARV = antiretroviral; BIC = bictegravir; BMI = body mass index; CVD = cardiovascular disease; DTG = dolutegravir; DXA = dual energy X-ray absorptiometry; EFV = efavirenz; EVG = elvitegravir; INSTI = integrase strand transfer inhibitor; NRTI = nucleoside reverse transcriptase inhibitor; the Panel = the Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV; PI = protease inhibitor; RAL = raltegravir; TAF = tenofovir alafenamide; ZDV = zidovudine

See the archived version of [Supplement III, February 23, 2009, Pediatric Guidelines](#) on the [Clinicalinfo website](#) for a more complete discussion and reference list.

**Table 17i. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—
Nephrotoxic Effects**

Updated: September 30, 2025

Reviewed: September 30, 2025

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
Urolithiasis/ Nephrolithiasis	ATV DRV causes crystalluria, but it is not associated with nephrolithiasis.	Onset <ul style="list-style-type: none">Weeks to months after starting therapy Presentation <ul style="list-style-type: none">CrystalluriaHematuriaPyuriaFlank painIncreased creatinine levels in some cases	ATV-related nephrolithiasis occurs in <10% of patients and has been reported after stopping ATV.	In adults, elevated urine pH (>5.7) The risk factors in children are unknown.	Prevention <ul style="list-style-type: none">Maintain adequate hydration. Monitoring <ul style="list-style-type: none">Obtain urinalysis at least every 6–12 months.	Provide adequate hydration and pain control. Consider using another ARV drug in place of ATV.
Renal Dysfunction	TDF	Onset <ul style="list-style-type: none">Variable; in adults, renal dysfunction may occur weeks to months after initiating therapy.Hypophosphatemia appears at a median of 18 months.Glucosuria may occur after 1 year of therapy.Abnormal urine protein/osmolality ratio may be an early indicator.	Adults <ul style="list-style-type: none">Approximately 2% of adults experience increased serum creatinine levels.Approximately 0.5% of adults experience severe renal complications.	Risk May Increase in Children With the Following Characteristics <ul style="list-style-type: none">Aged >6 yearsBlack race, Hispanic/Latino ethnicityAdvanced HIV infection	Monitor urine protein, urine glucose, and serum creatinine at 3- to 6-month intervals. Some Panel members routinely monitor serum phosphate levels in patients who are taking TDF.	If TDF is the likely cause, consider using an alternative ARV drug. TAF has significantly less renal toxicity than TDF. Changing from TDF to TAF may improve renal function and has been shown to be safe.

Table 17i. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Nephrotoxic Effects

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
		<p>Presentation</p> <p><i>More Common</i></p> <ul style="list-style-type: none"> Increased serum creatinine levels, proteinuria, and normoglycemic glucosuria Increased urinary protein/creatinine ratio and albumin/creatinine ratio Hypophosphatemia, usually asymptomatic; may present with bone and muscle pain or muscle weakness <p><i>Less Common</i></p> <ul style="list-style-type: none"> Renal failure, acute tubular necrosis, Fanconi syndrome, proximal renal tubulopathy, interstitial nephritis, and nephrogenic diabetes insipidus with polyuria 	<p>Children</p> <ul style="list-style-type: none"> Approximately 4% of children experience hypophosphatemia or proximal tubulopathy; frequency increases with prolonged TDF therapy and advanced HIV infection. 	<ul style="list-style-type: none"> Hypertension Diabetes Concurrent use of PIs (especially LPV/r) and preexisting renal dysfunction Longer duration of TDF treatment The presence of the apolipoprotein L1 variants G1 and G2 appears to increase the risk of renal abnormality in children with HIV. These alleles are more common in people of Black descent. 	<p>Measure serum phosphate if the patient experiences persistent proteinuria or glucosuria or has symptoms of bone pain, muscle pain, or weakness.</p> <p>Because toxicity risk increases with the duration of TDF treatment, do not decrease the frequency of monitoring over time.</p>	

Table 17i. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Nephrotoxic Effects

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
Elevation in Serum Creatinine	DTG, COBI, RPV, BIC	<p>Onset</p> <ul style="list-style-type: none"> • Within 1 month of starting treatment <p>Presentation</p> <ul style="list-style-type: none"> • Asymptomatic. These drugs decrease renal tubular secretion of creatinine, leading to an increase in serum creatinine levels without a true change in eGFR. • Clinicians need to distinguish between a true change in eGFR and other causes. A true change may be associated with other medical conditions, the continuing rise of serum creatinine levels over time, and albuminuria. 	Common laboratory finding	<p>In adults, baseline serum creatinine, male sex, TDF use, and possibly defined polymorphisms (UGT1A1).</p> <p>The risk factors in children are unknown.</p>	Monitor serum creatinine. Assess for renal dysfunction if serum creatinine increases by >0.4 mg/dL or if increases continue over time.	<p>No need to change therapy</p> <p>Reassure the patient about the benign nature of the laboratory abnormality.</p>

Key: ARV = antiretroviral; ATV = atazanavir; BIC = bictegravir; COBI = cobicistat; DRV = darunavir; DTG = dolutegravir; eGFR = estimated glomerular filtration rate; LPV/r = lopinavir/ritonavir; Panel = the Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV; PI = protease inhibitor; RPV = rilpivirine; TAF = tenofovir alafenamide; TDF = tenofovir disoproxil fumarate; UGT1A1 = uridine diphosphate glucuronosyltransferase 1A1

Table 17j. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Osteopenia and Osteoporosis

Updated: September 30, 2025

Reviewed: September 30, 2025

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
Osteopenia and Osteoporosis	<p>Any ARV regimen</p> <p>Specific Agents of Concern</p> <ul style="list-style-type: none"> TDF, especially when used in a regimen that includes a boosting agent (i.e., RTV, COBI) PIs (LPV, ATV>DRV) EFV 	<p>Onset</p> <ul style="list-style-type: none"> Any age; decrease in BMD is usually seen soon after initiating ART. <p>Presentation</p> <ul style="list-style-type: none"> Usually asymptomatic Rarely presents as osteoporosis, a clinical diagnosis defined by evidence of bone fragility (e.g., a fracture with minimal trauma). 	<p>BMD Z-score Less than -2.0</p> <ul style="list-style-type: none"> <10% in U.S. cohorts Approximately 10% to 20% in international cohorts 	<p>Longer duration and greater severity of HIV disease</p> <p>Detectable viral load</p> <p>Vitamin D insufficiency/deficiency</p> <p>Delayed growth or pubertal delay</p> <p>Low BMI</p> <p>Lipodystrophy</p> <p>Smoking</p> <p>Prolonged systemic corticosteroid use</p> <p>Medroxyprogesterone use</p> <p>Lack of weight-bearing exercise</p>	<p>Prevention</p> <ul style="list-style-type: none"> Ensure that the patient has sufficient intake and levels of both calcium and vitamin D. Encourage weight-bearing exercise. Minimize modifiable risk factors (e.g., smoking, low BMI, use of steroids or medroxyprogesterone). Use TAF instead of TDF whenever possible. Use TDF with RPV or an unboosted INSTI. When using TDF or EFV in a regimen, consider measuring vitamin D levels and supplementing with vitamin D3 if deficiency is identified. 	<p>Same options as for prevention</p> <p>Consider changing the ARV regimen (e.g., switching from TDF to TAF and/or from LPV/r to RPV or an unboosted INSTI whenever possible).</p> <p>Supplement with vitamin D3 to raise serum 25-OH-vitamin D concentrations to >30 ng/mL. There is no clear benefit to administering daily supplemental vitamin D3 doses that are >4,000 IU. If patients are receiving a daily dose of vitamin D3 that is >4,000 IU, consider monitoring levels of 25-OH-vitamin D.</p> <p>While an overall effect was not seen in a large trial of vitamin D supplementation in adolescents with HIV, an increase in BMD was seen in those adolescents with vitamin D deficiency.</p> <p>An increase in BMD was seen in one trial that evaluated the use of alendronate in youth</p>

					<p>Monitoring</p> <ul style="list-style-type: none"> • Assess nutritional intake (i.e., calcium, vitamin D, and total calories). • Consider measuring serum 25-OH-vitamin D levels, particularly in patients who are taking ARV drugs of concern.^a • DXA is rarely indicated.^b 	<p>with HIV and low BMD. However, the role of bisphosphonates in managing osteopenia and osteoporosis in children with HIV has not been established.</p>
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^a Drugs of greatest concern are TDF and EFV. Some experts measure 25-OH-vitamin D in children with HIV with additional risk factors, including living at high latitudes, sun avoidance, low dietary intake, and obesity.

^b DXA scanning is not routinely recommended for children and youth who are being treated with TDF. DXA scanning can be considered for children and youth who are receiving additional medications that also affect bone density or have non-HIV-related conditions for which DXA scans may be indicated (e.g., cerebral palsy).

Key: 25-OH-vitamin D = 25-hydroxy vitamin D; ART = antiretroviral therapy; ARV = antiretroviral; ATV = atazanavir; BMD = bone mineral density; BMI = body mass index; COBI = cobicistat; DRV = darunavir; DXA = dual-energy X-ray absorptiometry; EFV = efavirenz; INSTI = integrase strand transfer inhibitor; IU = international unit; LPV = lopinavir; LPV/r = lopinavir/ritonavir; PI = protease inhibitor; RPV = rilpivirine; RTV = ritonavir; TAF = tenofovir alafenamide; TDF = tenofovir disoproxil fumarate

Table 17k. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Rash and Hypersensitivity Reactions

Updated: September 30, 2025

Reviewed: September 30, 2025

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
Rash	Any ARV drug can cause rash.	<p>Onset</p> <ul style="list-style-type: none"> First few days to weeks after starting new ARV drug(s) <p>Presentation</p> <ul style="list-style-type: none"> Most rashes are mild-to-moderate diffuse maculopapular eruptions. <p>Note: A rash can be the initial manifestation of systemic hypersensitivity (see the SJS/TEN/EM major and HSR sections below).</p>	<p>Common (>10%)</p> <ul style="list-style-type: none"> EFV ETR FTC NVP <p>Less Common (5% to 10%)</p> <ul style="list-style-type: none"> ABC ATV DRV TDF <p>Uncommon (2% to 4%)</p> <ul style="list-style-type: none"> BIC LPV/r MVC RAL RPV 	<ul style="list-style-type: none"> Sulfonamide allergy is a risk factor for rash in patients who are taking PIs that contain a sulfonamide moiety (i.e., DRV). Polymorphisms in CYP2B6 and multiple HLA loci are associated with an increased risk of rash in patients who are taking NVP. 	<p>When Starting NVP or Restarting NVP After Interruptions of >14 Days</p> <ul style="list-style-type: none"> Utilize once-daily lead-in dosing.^a This may not be necessary in children aged <2 years.^b Avoid the use of systemic corticosteroids during NVP dose escalation. Assess the patient for rash severity, mucosal involvement, and other signs of systemic reaction. 	<p>Mild-to-Moderate Maculopapular Rash Without Systemic or Mucosal Involvement</p> <ul style="list-style-type: none"> Most rashes will resolve without intervention; ARV drugs can be continued while monitoring.^a Antihistamines may provide some relief. <p>Severe Rash and/or Rash Accompanied by Systemic Symptoms</p> <ul style="list-style-type: none"> Manage as SJS/TEN/EM major, DRESS, or HSR, as applicable (see below). <p>Rash in Patients Receiving NVP</p> <ul style="list-style-type: none"> Given the elevated risk of HSR, measure hepatic transaminases. If hepatic transaminases are elevated, NVP should be discontinued and not restarted (see the HSR section below).

Table 17k. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Rash and Hypersensitivity Reactions

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
SJS/TEN/EM Major	Many ARV drugs, especially NNRTIs (see the Estimated Frequency column)	<p>Onset</p> <ul style="list-style-type: none"> • First few days to weeks after starting new ARV drug(s) <p>Presentation</p> <ul style="list-style-type: none"> • Initial rash may be mild, but it often becomes painful, evolving to blister/bulla formation with necrosis in severe cases. Usually involves mucous membrane ulceration and/or conjunctivitis. • Systemic symptoms may also include fever, tachycardia, malaise, myalgia, and arthralgia. 	<p>Infrequent</p> <ul style="list-style-type: none"> • NVP (0.3%) • EFV (0.1%) • ETR (<0.1%) <p>Case Reports</p> <ul style="list-style-type: none"> • ABC • ATV • DRV • LPV/r • RAL • ZDV 	<p>Adults</p> <ul style="list-style-type: none"> • Female sex <p>Patients who are Black, Asian, or Hispanic are at higher risk.</p>	<p>When Starting NVP or Restarting NVP After Interruptions of >14 Days</p> <ul style="list-style-type: none"> • Utilize once-daily lead-in dosing.^a This may not be necessary in children aged <2 years.^b • Counsel families to report symptoms as soon as they appear. 	<ul style="list-style-type: none"> • Discontinue all ARV drugs and other possible causative agents (e.g., TMP-SMX). • Provide intensive supportive care, including IV hydration, aggressive wound care, eye care, labial adhesion preventive care, pain management, and antipyretics. Parenteral nutrition and antibiotics may also be necessary. • Corticosteroids and/or IVIG are sometimes used, but the use of these interventions is controversial. • Do not reintroduce the offending medication. • In cases where a patient experiences SJS/TEN/EM major while taking an NNRTI, many experts would avoid using other NNRTIs when restarting ART.
DRESS	DRV, DTG, EFV, ETR, NVP, RAL, RPV, BIC	<p>Onset</p> <ul style="list-style-type: none"> • 1–8 weeks after starting new ARV drug(s) <p>Presentation</p> <ul style="list-style-type: none"> • Fever • Lymphadenopathy 	Rare	<ul style="list-style-type: none"> • Unknown • Potential association with HLA-B*53:01 and RAL-induced DRESS 	Obtain a CBC and AST, ALT, and creatinine levels from patients who present with suggestive symptoms.	<ul style="list-style-type: none"> • Discontinue all ARV drugs and other possible causative agents (e.g., TMP-SMX). • The role of systemic steroids or IVIG in treatment is unclear; consultation with a specialist is recommended.

Table 17k. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Rash and Hypersensitivity Reactions

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
		<ul style="list-style-type: none"> • Facial swelling • Morbilliform to polymorphous rash • Peripheral eosinophilia • Atypical circulating lymphocytes • Internal organ involvement (particularly the liver and/or kidneys) 				<ul style="list-style-type: none"> • Provide supportive care for end-organ disease. • Do not reintroduce the offending medication.
<p>HSR</p> <p>With or without skin involvement and excluding SJS/TEN</p>	ABC	<p>Onset</p> <p><i>With First Use</i></p> <ul style="list-style-type: none"> • Within first 6 weeks of initiating ABC <p><i>With Reintroduction</i></p> <ul style="list-style-type: none"> • Within hours of initiating ABC <p>Presentation</p> <ul style="list-style-type: none"> • Symptoms include high fever, diffuse skin rash, malaise, nausea, headache, myalgia, arthralgia, diarrhea, vomiting, abdominal pain, pharyngitis, and respiratory symptoms (e.g., dyspnea). 	<1% to 9% (varies by ethnicity)	<ul style="list-style-type: none"> • HLA-B*5701 (HSR is very uncommon in people who are HLA-B*5701 negative.) • The prevalence of HLA-B*5701 is generally lower in people from Africa and East Asia. 	<ul style="list-style-type: none"> • Screen for HLA-B*5701. ABC should not be prescribed if HLA-B*5701 is present. The medical record should clearly indicate that ABC is contraindicated in these patients. • When starting ABC, counsel patients and families about the signs and symptoms of HSR to ensure prompt reporting of reactions. 	<ul style="list-style-type: none"> • Discontinue all ARV drugs and investigate other causes of the symptoms (e.g., a concurrent viral illness). • Provide symptomatic treatment. • Most symptoms resolve within 48 hours after discontinuing ABC. • Do not rechallenge with ABC even if the patient is HLA-B*5701 negative.

Table 17k. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Rash and Hypersensitivity Reactions

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
		<ul style="list-style-type: none"> With continuation of ABC, symptoms may progress to hypotension and vascular collapse. With rechallenge, symptoms can mimic anaphylaxis. 				
	NVP	<p>Onset</p> <ul style="list-style-type: none"> Occurs most frequently in the first few weeks of therapy but can occur through 18 weeks. <p>Presentation</p> <ul style="list-style-type: none"> Flu-like symptoms (including nausea, vomiting, myalgia, fatigue, fever, abdominal pain, and jaundice) with or without skin rash that may progress to hepatic failure with encephalopathy 	Occurs in 4% of patients on average, with a range of 2.5% to 11%.	<p>Adults</p> <ul style="list-style-type: none"> ARV-naive with a higher CD4 count (>250 cells/mm³ in women; >400 cells/mm³ in men) Female sex (risk is threefold higher in females than in males) Hepatitis B or hepatitis C infection <p>Children</p> <ul style="list-style-type: none"> NVP hepatotoxicity and HSR are less common in prepubertal children than in adults, and both are uncommon in infants. 	<p>When Starting NVP or Restarting NVP After Interruptions of >14 Days</p> <ul style="list-style-type: none"> A 2-week lead-in period with once-daily dosing, followed by dose escalation to twice daily as recommended, may reduce the risk of reaction.^a This may not be necessary in children aged <2 years.^b Counsel families about signs and symptoms of HSR to ensure prompt reporting of reactions. 	<ul style="list-style-type: none"> Discontinue all ARV drugs. Consider other causes of hepatitis and discontinue all hepatotoxic medications. Provide supportive care as indicated and monitor the patient closely. Do not reintroduce NVP. It is unclear whether it is safe to use other NNRTIs after a patient experiences symptomatic hepatitis due to NVP, and many experts would avoid the NNRTI drug class when restarting treatment.

Table 17k. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Rash and Hypersensitivity Reactions

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
				<ul style="list-style-type: none"> High CD4 percentage is associated with an increased risk of NVP toxicity. In the PREDICT Study, the risk of NVP toxicity (rash, hepatotoxicity, and hypersensitivity) was 2.65 times greater in children who had CD4 percentages $\geq 15\%$ than in children who had CD4 percentages $< 15\%$. 	<ul style="list-style-type: none"> Obtain AST and ALT levels in patients with rash. Obtain AST and ALT levels at baseline, before dose escalation, 2 weeks after dose escalation, and thereafter at 3-month intervals. Avoid NVP use in women with CD4 counts > 250 cells/mm³ and in men with CD4 counts > 400 cells/mm³, unless benefits outweigh risks. Do not use NVP as postexposure prophylaxis outside of the neonatal period. 	
	ETR	<p>Onset</p> <ul style="list-style-type: none"> Any time during therapy <p>Presentation</p> <ul style="list-style-type: none"> Symptoms may include rash, constitutional findings, and sometimes organ dysfunction, including hepatic failure. 	Rare	Unknown	Evaluate for hypersensitivity if the patient is symptomatic.	<ul style="list-style-type: none"> Discontinue all ARV drugs. Rechallenge with ETR is not recommended.

Table 17k. Antiretroviral Therapy–Associated Adverse Effects and Management Recommendations—Rash and Hypersensitivity Reactions

Adverse Effects	Associated ARVs	Onset/Clinical Manifestations	Estimated Frequency	Risk Factors	Prevention/Monitoring	Management
	MVC	Rash preceding hepatotoxicity	Rare	Unknown	Obtain AST and ALT levels from patients with rash or other symptoms of hypersensitivity.	<ul style="list-style-type: none"> Discontinue all ARV drugs. Rechallenge with MVC is not recommended.
	DTG	Rash with hepatic dysfunction	Rare	Unknown	Obtain AST and ALT levels from patients with rash or other symptoms of hypersensitivity.	<ul style="list-style-type: none"> Discontinue all ARV drugs. Rechallenge with DTG is contraindicated.

^a The prescribing information for NVP states that patients who experience rash during the 14-day lead-in period should not have the NVP dose increased until the rash has resolved. However, prolonging the lead-in phase beyond 14 days may increase the risk of NVP resistance because of subtherapeutic drug levels. Children who have persistent mild or moderate rash after the lead-in period should receive individualized care. Consult an expert in HIV care when managing these patients. **NVP should be stopped and not restarted** if the rash is severe or progressing. See the [Nevirapine](#) section of the Drug Appendix.

^b Lead-in dosing is **not recommended** when using NVP for either presumptive or definitive HIV therapy in newborns with perinatal HIV exposure or perinatal HIV infection. See the [Nevirapine](#) section of the Drug Appendix and [Table 13. Antiretroviral Management for Infants With *In Utero* or Intrapartum Exposure to HIV in Antiretroviral Management of Infants With *In Utero*, Intrapartum, or Breastfeeding Exposure to HIV.](#)

Key: ABC = abacavir; ALT = alanine transaminase; ART = antiretroviral therapy; ARV = antiretroviral; AST = aspartate aminotransferase; ATV = atazanavir; BIC = bictegravir; CBC = complete blood count; CD4 = CD4 T lymphocyte; CYP2B6 = cytochrome P450 family 2 subfamily B member 6; DRESS = drug reaction (or rash) with eosinophilia and systemic symptoms; DRV = darunavir; DTG = dolutegravir; EFV = efavirenz; EM = erythema multiforme; ETR = etravirine; FTC = emtricitabine; HLA = human leukocyte antigen; HLA-B*53:01 = human leucocyte antigen gene variant; HLA-B*5701 = human leucocyte antigen gene variant; HSR = hypersensitivity reaction; IV = intravenous; IVIG = intravenous immune globulin; LPV/r = lopinavir/ritonavir; MVC = maraviroc; NNRTI = non-nucleoside reverse transcriptase inhibitor; NVP = nevirapine; PI = protease inhibitor; PREDICT Study = Personalised Responses to Dietary Composition Trial Study; RAL = raltegravir; RPV = rilpivirine; SJS = Stevens-Johnson syndrome; TDF = tenofovir disoproxil fumarate; TEN = toxic epidermal necrolysis; TMP-SMX = trimethoprim-sulfamethoxazole; ZDV = zidovudine

Table 18. Examples of Changes in Antiretroviral Regimen Components for Children With Sustained Virologic Suppression

This list is not exhaustive and does not necessarily contain all potential treatment options. Instead, it provides examples of changes that could be made. The table includes information only about switching between ARV drugs; **it does not include all the information that clinicians should consider before prescribing these drugs, such as [child and caregiver preferences](#), drug cost, and the child’s insurance coverage.** Refer to the individual drug sections; [Appendix A, Table 1. Antiretrovirals Available in Fixed-Dose Combination Tablets or as a Co-Packaged Formulation, by Drug Class](#); and [Appendix A, Table 2. Antiretroviral Fixed-Dose Combination Tablets and Co-packaged Formulations: Minimum Body Weights and Considerations for Use in Children and Adolescents](#) in [Appendix A. Pediatric Antiretroviral Drug Information](#) for further information about the use and administration of specific ARV drugs and FDC formulations.

For images of most of the ARV drugs listed in this table, see the [Antiretroviral Medications](#) section of the National HIV Curriculum. In addition, a resource from the United Kingdom illustrates the relative sizes of individual ARV drug FDC tablets (see the [ARV Chart in HIV i-Base](#)). Although most of the drugs listed in that chart are the same as those in the United States, not all formulations available in the United States are included, and there are differences in a few of the brand names.

Current ARV Drug(s)	Age, Weight, and Sexual Maturity Rating Requirements	Potential ARV Drug Switch ^a	Comment
NRTIs			
ABC Twice Daily	Aged ≥3 months ^b	ABC once daily	See the Abacavir^b section for more information.
3TC Twice Daily	Aged ≥3 years	3TC once daily	See the Lamivudine section for more information.
	Any age (starting at full-term birth) Any weight	FTC once daily	See the Emtricitabine section for more information.
ZDV	Aged ≥1 month ^b	ABC	Less long-term mitochondrial toxicity Children aged ≥3 months can take ABC once daily.
	Weighing 17 kg to <25 kg	TDF	TDF is a reasonable, once-daily option for HLA-B*5701-positive children for whom ABC is not recommended and in whom ZDV is not tolerated. TDF is available as an oral powder and as low-strength tablets alone or in combination with FTC.

Current ARV Drug(s)	Age, Weight, and Sexual Maturity Rating Requirements	Potential ARV Drug Switch ^a	Comment
	Weighing ≥14 kg	TAF ^c	Less long-term mitochondrial toxicity. Once-daily dosing. Only available in coformulation with other ARV drugs; can further reduce pill burden. TAF is preferred over TDF because of the lower risk of bone and renal toxicity, but it may be associated with weight gain and lipid abnormalities.
	Weighing ≥14 kg	FTC/TAF ^c (Descovy)	Once-daily dosing. This combination NRTI medication may be more desirable because of smaller pill size and reduced pill burden. Benefits as described for TAF.
Any NRTI	Aged ≥12 years Weighing ≥35 kg	CAB and RPV co-packaged regimen as Cabenuva	NRTI-sparing regimen. Long-acting injectable, complete ARV regimen requiring two IM injections every 1 to 2 months that together are an alternative to daily oral ARV regimens. Must consider prior history of treatment failure and known or suspected drug resistance to individual drugs. Injection site reactions are common but do not often result in discontinuation of the regimen. See the Cabotegravir section for more information.
	Aged ≥12 years Weighing ≥35 kg	DTG/RPV (Juluca)	NRTI-sparing FDC that is a complete regimen. In addition to age and weight criteria (based on RPV component because DTG was approved for younger ages/lower weights), must be virologically suppressed (HIV RNA <50 copies/mL) on a stable ARV regimen for at least 6 months and without history of treatment failure. Should be taken with food. No pediatric data.
NNRTIs			
NVP or EFV	Any age (starting at full-term birth) Weighing ≥2 kg	RAL ^d	RAL is preferred over NVP in infants from birth to age 4 weeks who weigh ≥2 kg. Both are dosed twice daily in children. Note that DTG and BIC have a higher barrier to resistance than RAL. In a child >1 month of age, DTG is preferred. See DTG below.

Current ARV Drug(s)	Age, Weight, and Sexual Maturity Rating Requirements	Potential ARV Drug Switch ^a	Comment
	Age ≥4 weeks Weighing ≥3 kg	DTG	DTG is available as a single drug in dispersible and film-coated tablet formulations, or as part of an FDC tablet, all of which can be dosed once daily if no documented resistance or history of failure with INSTI agents exists. DTG plus FTC/TAF (Descovy) in children weighing ≥14 kg or the weight-appropriate dose of FTC/TDF (Truvada) can be used in children weighing 20 kg to <25 kg. DTG is available as a component of the FDC ABC/DTG/3TC, which is a complete ARV regimen that can be given to infants and children aged ≥3 months and weighing ≥6 kg to <25 kg in dispersible tablets (Triumeq PD) and to children and adolescents weighing ≥25 kg in a single tablet to be swallowed (Triumeq). Higher barrier to resistance, which makes it a good choice for children who have poor adherence. May improve lipid levels. See the Dolutegravir section for more information.
	Aged ≥3 months Weighing ≥6 kg to <25 kg	ABC/DTG/3TC (Triumeq PD)	Once-daily dosing. Dispersible tablets with dosage for use in children based on weight. Aligns a child's regimen with an efficacious regimen that is used in adults. See the Dolutegravir section for more information.
	Aged ≥3 months Weighing ≥5 kg	ATV/r	ATV/r has a potentially greater barrier to resistance; however, taking ATV/r may be difficult for some children, as ATV oral powder must be mixed with food or a beverage before administration, and the palatability of the RTV oral solution is poor.
	Aged ≥3 years Weighing ≥10 kg Weighing ≥40 kg	DRV/r DRV/c as Symtuza	DRV/r has a potentially greater barrier to resistance. DRV/r is administered twice daily to children aged <12 years but may be administered once daily in children aged ≥12 years who do not have any DRV resistance mutations. DRV/c is available in FDC tablet with FTC/TAF for those weighing ≥40 kg. Must be administered with food. Note that the palatability of the RTV oral solution is poor when considering administering to children not able to swallow tablets.
	Weighing ≥14 kg	BIC as Biktarvy	Once-daily dosing. BIC is available as a component of the FDC tablet BIC/FTC/TAF (Biktarvy) in two weight-based dose formulations—one formulation for those weighing ≥14 kg to <25 kg and another for those

Current ARV Drug(s)	Age, Weight, and Sexual Maturity Rating Requirements	Potential ARV Drug Switch ^a	Comment
			weighing ≥ 25 kg. This is a complete ARV regimen that can be taken with or without food.
	Weighing ≥ 25 kg	EVG as Genvoya	EVG is available as a component of the FDC tablet EVG/c/FTC/TAF (Genvoya), which is a complete ARV regimen that must be taken with food.
	Weighing ≥ 35 kg	DOR	DOR is available in a once-daily FDC tablet DOR/3TC/TDF (Delstrigo). Fewer side effects than reported with EFV. It has continued activity in the setting of some NNRTI mutations.
	Aged ≥ 12 years Weighing ≥ 35 kg	CAB and RPV co-packaged regimen as Cabenuva	Long-acting injectable, complete ARV regimen requiring two IM injections every 1 to 2 months that together are an alternative to daily oral ARV regimens. Must consider prior history of treatment failure and known or suspected drug resistance to individual drugs. Injection site reactions are common but do not often result in discontinuation of the regimen. See the Cabotegravir section for more information.
	Aged ≥ 12 years Weighing ≥ 35 kg	RPV	Lower incidence of adverse lipid effects. May have fewer sleep disturbances and neuropsychiatric symptoms compared to EFV. RPV has continued activity in the setting of some NNRTI mutations.
PIs			
LPV/r Twice Daily	Any age (starting at full-term birth) Weighing ≥ 2 kg	RAL ^d	Better palatability. RAL HD can only be given once daily in those weighing ≥ 40 kg. Unlike LPV/r, the use of RAL is not restricted to infants with a corrected gestational age of ≥ 42 weeks and a postnatal age of ≥ 14 days. RAL granules may be difficult to dose for some caregivers.
	Age ≥ 4 weeks Weighing ≥ 3 kg	DTG	Once-daily dosing if no documented resistance or history of failure with INSTI agents exists. May be better tolerated, and it can be given as a dispersible tablet in young children. DTG is available as a component of the FDC ABC/DTG/3TC, which is a complete ARV regimen that can be given to infants and children aged ≥ 3 months and weighing ≥ 6 kg to < 25 kg in dispersible tablets (Triumeq PD) and to children and adolescents weighing ≥ 25 kg in a single tablet to be swallowed (Triumeq). DTG plus FTC/TAF (Descovy) in those weighing ≥ 14 kg, or the weight-appropriate dose of FTC/TDF (Truvada) can be used in children weighing 20

Current ARV Drug(s)	Age, Weight, and Sexual Maturity Rating Requirements	Potential ARV Drug Switch ^a	Comment
			kg to <25 kg. May improve lipid levels. See the Dolutegravir section for more information.
	Aged ≥3 months Weighing ≥6 kg to <25 kg	ABC/DTG/3TC (Triumeq PD)	Once-daily dosing. Dispersible tablets with dosage for use in children based on weight. Aligns a child's regimen with an efficacious regimen that is used in adults. See the Dolutegravir section for more information.
	Aged ≥3 years Weighing ≥10 kg	EFV	Once-daily dosing. Better palatability. Lower incidence of adverse lipid effects. Review NNRTI mutations before use. See the Efavirenz section for concerns about EFV dosing for children aged <3 years.
	Aged ≥3 months Weighing ≥5 kg	ATV/r	Once-daily dosing. ATV/r may have a lower incidence of adverse lipid effects; however, taking ATV/r may be difficult for some children, as ATV oral powder must be mixed with food or a beverage before administration, and the palatability of the RTV oral solution is poor.
	Aged ≥3 years Weighing ≥10 kg Weighing ≥40 kg	DRV/r DRV/c as Symtuza	DRV/r may have a lower incidence of adverse lipid effects. DRV/r is administered twice daily to children aged <12 years, but it may be administered once daily in children aged ≥12 years who do not have DRV resistance mutations. DRV/c is available in FDC tablet with FTC/TAF for those weighing ≥40 kg. Must be administered with food. Note that palatability of the RTV oral solution is poor when considering administering to children not able to swallow tablets.
	Weighing ≥14 kg	BIC as Biktarvy	Once-daily dosing. BIC is available as a component of the FDC tablet BIC/FTC/TAF (Biktarvy) in two weight-based dose formulations—one for those weighing ≥14 kg to <25 kg and another for those weighing ≥25 kg. This is a complete ARV regimen that can be taken with or without food.
	Weighing ≥25 kg	EVG as Genvoya	EVG is available as a component of the FDC tablet EVG/c/FTC/TAF (Genvoya), which is a complete ARV regimen that must be taken with food.
	Weighing ≥35 kg	DOR	DOR is available in a once-daily FDC tablet DOR/3TC/TDF (Delstrigo). Fewer side effects than reported with EFV. It has continued activity in the setting of some NNRTI mutations.

Current ARV Drug(s)	Age, Weight, and Sexual Maturity Rating Requirements	Potential ARV Drug Switch ^a	Comment
	Aged ≥12 years Weighing ≥35 kg	CAB and RPV co-packaged regimen as Cabenuva	Long-acting injectable, complete ARV regimen requiring two IM injections every 1 to 2 months that together are an alternative to daily oral ARV regimens. Must consider prior history of treatment failure and known or suspected drug resistance to individual drugs. Injection site reactions are common but do not often result in discontinuation of the regimen. See the Cabotegravir section for more information.
	Aged ≥12 years Weighing ≥35 kg	RPV	May be better tolerated. Lower incidence of adverse lipid effects. It has continued activity in the setting of some NNRTI mutations.
INSTIs			
RAL	Age >1 month and weighing <14 kg Weighing ≥14 kg	DTG DTG or BIC	<p>Once-daily dosing. Higher barrier to resistance. DTG is available as a single drug in a dispersible tablet for infants and children weighing ≥3 kg; in a dispersible FDC for children weighing ≥6 kg to 25 kg; in a single-drug film-coated tablet for children weighing ≥14 kg; or as an FDC tablet. All of these can be dosed once daily if no documented resistance or history of failure with INSTI agents exists. DTG plus FTC/TAF (Descovy) in those weighing ≥14 kg or the weight-appropriate dose of FTC/TDF (Truvada) can be used in children weighing 20 kg to <25 kg. DTG is available as a component of the FDC ABC/DTG/3TC, which is a complete ARV regimen that can be given to infants and children aged ≥3 months and weighing ≥6 kg to <25 kg in dispersible tablets (Triumeq PD) and to children and adolescents weighing ≥25 kg in a single tablet to be swallowed (Triumeq). See the Dolutegravir section for more information.</p> <p>BIC has once-daily dosing and a higher barrier to resistance. BIC is available as a component of the FDC tablet BIC/FTC/TAF (Biktarvy) in two weight-based dose formulations—one for those weighing ≥14 kg to <25 kg and another for those weighing ≥25 kg. This is a complete ARV regimen that can be taken with or without food.</p>

Current ARV Drug(s)	Age, Weight, and Sexual Maturity Rating Requirements	Potential ARV Drug Switch ^a	Comment
	Aged ≥12 years Weighing ≥35 kg	CAB and RPV co-packaged regimen as Cabenuva	Long-acting injectable, complete ARV regimen requiring two IM injections every 1 to 2 months that together are an alternative to daily oral ARV regimens. Must consider prior history of treatment failure and known or suspected drug resistance to individual drugs. Injection site reactions are common but do not often result in discontinuation of the regimen. See the Cabotegravir section for more information.
EVG/c	Weighing ≥14 kg	DTG or BIC	<p>Once-daily dosing. Higher barrier to resistance. DTG is available as a single drug in a dispersible tablet for infants and children weighing ≥3 kg; in a dispersible FDC for children weighing ≥6 kg to 25 kg; in a single-drug film-coated tablet for children weighing ≥14 kg; or as an FDC tablet. All of these can be dosed once daily if no documented resistance or history of failure with INSTI agents exists. DTG plus FTC/TAF (Descovy) in those weighing ≥14 kg or the weight-appropriate dose of FTC/TDF (Truvada) can be used in children weighing 20 kg to <25 kg. DTG is available as a component of the FDC ABC/DTG/3TC), which is a complete ARV regimen that can be given to infants and children aged ≥3 months and weighing ≥6 kg to <25 kg in dispersible tablets (Triumeq PD) and to children and adolescents weighing ≥25 kg in a single tablet to be swallowed (Triumeq), See the Dolutegravir section for more information.</p> <p>BIC has once-daily dosing and a higher barrier to resistance. BIC is available as a component of the FDC tablet BIC/FTC/TAF (Biktarvy) in two weight-based dose formulations—one for those weighing ≥14 kg to <25 kg and another for those weighing ≥25 kg. This is a complete ARV regimen that can be taken with or without food.</p>
	Aged ≥12 years Weighing ≥35 kg	CAB and RPV co-packaged regimen as Cabenuva	Long-acting injectable, complete ARV regimen requiring two IM injections every 1 to 2 months that together are an alternative to daily oral ARV regimens. Must consider prior history of treatment failure and known or suspected drug resistance to individual drugs. Injection site reactions are common but do not often result in discontinuation of the regimen. See the Cabotegravir section for more information.
Other			

Current ARV Drug(s)	Age, Weight, and Sexual Maturity Rating Requirements	Potential ARV Drug Switch ^a	Comment
Any Multi-Pill and/or Twice-Daily Regimen	Aged ≥3 months Weighing ≥6 kg to <25 kg	ABC/DTG/3TC (Triumeq PD)	Once-daily dosing. Dispersible tablets with dosage for use in children based on weight. Aligns a child's regimen with an efficacious regimen that is used in adults. See the Dolutegravir section for more information.
	Weighing ≥14 kg	FTC/TAF ^c (Descovy) plus DTG	Once-daily dosing. This regimen may be more desirable because of smaller pill sizes, but it has a higher pill burden (two pills instead of one). Aligns a child's regimen with an efficacious regimen that is used in adults. See the Dolutegravir section for more information.
	Weighing ≥14 kg	BIC/FTC/TAF (Biktarvy)	Once-daily dosing. Single pill that can be taken with or without food. Available in two weight-based dose formulations—one for those weighing ≥14 kg to <25 kg and another for those weighing ≥25 kg.
	Weighing ≥25 kg	ABC/DTG/3TC (Triumeq)	Once-daily dosing. Single pill to be swallowed. Aligns a child's regimen with an efficacious regimen that is used in adults. Large pill size may be a deterrent. See the Dolutegravir section for more information.
	Weighing ≥25 kg	EVG/c/FTC/TAF (Genvoya)	Once-daily dosing. Single pill. Alignment with adult ARV regimens. Must be taken with food.
	Weighing ≥35 kg	DOR/3TC/TDF (Delstrigo)	Once-daily dosing. Single pill. Aligns a child's regimen with an efficacious regimen that is used in adults. Must be taken with food at a consistent time daily. Renal and bone toxicity of TDF limit its use. Review NNRTI mutations and check for drug–drug interactions before use.
	Weighing ≥35 kg SMR 4 or 5	EVG/c/FTC/TDF (Stribild)	Once-daily dosing. Single pill. Aligns a child's regimen with an efficacious regimen that is used in adults. Must be taken with food. Renal and bone toxicity of TDF limit its use.
	Aged ≥12 years Weighing ≥35 kg	CAB and RPV co-packaged regimen as Cabenuva	Long-acting injectable, complete ARV regimen requiring two IM injections every 1 to 2 months that together are an alternative to daily oral ARV regimens. Must consider prior history of treatment failure and known or suspected drug resistance to individual drugs. Injection site reactions are common but do not often result in discontinuation of the regimen. See the Cabotegravir section for more information.

Current ARV Drug(s)	Age, Weight, and Sexual Maturity Rating Requirements	Potential ARV Drug Switch ^a	Comment
	Aged ≥12 years Weighing ≥25 kg	FTC/RPV/TAF (Odefsey)	Once-daily dosing. Single pill. Aligns a child's regimen with an efficacious regimen that is used in adults. Review NNRTI mutations and check for drug–drug interactions before use. Must be taken with food at a consistent time daily.
	Aged ≥12 years Weighing ≥35 kg SMR 4 or 5	FTC/RPV/TDF (Complera)	Once-daily dosing. Single pill. Aligns a child's regimen with an efficacious regimen that is used in adults. Review NNRTI mutations and check for drug–drug interactions before use. Must be taken with food at a consistent time daily. Renal and bone toxicity of TDF limit its use.
	Aged ≥12 years Weighing ≥35 kg	DTG/RPV (Juluca)	NRTI-sparing FDC that is a complete regimen. In addition to age and weight criteria (based on RPV component because DTG is approved for younger ages/lower weights), must be virologically suppressed (HIV RNA <50 copies/mL) on a stable ARV regimen for at least 6 months and without history of treatment failure. Should be taken with food. No pediatric data.
	Weighing ≥40 kg	DRV/c/FTC/TA F (Symtuza)	Once daily FDC tablet that is a complete regimen in children who have been virologically suppressed (HIV RNA <50 copies/mL) for at least 6 months with no known mutations associated with resistance to DRV or tenofovir. Must be taken with food.
	Aged ≥12 years Weighing ≥25 kg	DTG/3TC (Dovato)	Once-daily, two-drug complete regimen approved in adolescents and adults with no known mutations associated with resistance to the individual components who are either ART-naive or who are virologically suppressed on a stable ART regimen with no history of treatment failure. Because adolescents may have difficulties adhering to therapy, close monitoring with viral load testing is recommended.

^a The possibility of planned and unplanned pregnancy should be considered when selecting an ART regimen for an adolescent. When discussing ART options with adolescents and their caregivers, it is important to consider childbearing potential and the benefits and risks of all ARV drugs and to provide the information and counseling needed to support informed decision-making; refer to the Perinatal Guidelines (see [Recommendations for Use of Antiretroviral Drugs During Pregnancy, Table 7. Situation-Specific Recommendations for Use of Antiretroviral Drugs During Pregnancy and When Trying to Conceive](#), and [Appendix C. Antiretroviral Counseling Guide for Health Care Providers](#)).

^b For infants and young children who are being treated with liquid formulations of ABC, initiation with once-daily ABC is not generally recommended. In clinically stable infants and children with undetectable viral loads who have had stable CD4 T lymphocyte cell counts on twice-daily ABC, the dose can be changed from twice daily to once daily in those aged ≥3 months. ABC is not approved by the U.S. Food and Drug Administration for use in neonates and infants aged <3 months. Data from the [IMPAACT P1106 trial](#) and two observational cohorts provide reassuring evidence of the safety of ABC

in infants aged <3 months. Based on these data, clinicians may consider the use of twice daily ABC in infants aged ≥1 month to <3 months, in consultation with a pediatric HIV specialist (see the [Abacavir](#) section for more information).

^c For children and adolescents weighing ≥14 kg to <35 kg, TAF can be used in combination with an INSTI or an NNRTI, but not a boosted PI. For children and adolescents weighing ≥35 kg, TAF can be used in combination with an INSTI, NNRTI, or boosted PI.

^d RAL is recommended for twice-daily use in children. Chewable tablets can be used as dispersible tablets starting at 4 weeks of age. RAL HD once daily is **only** recommended for virologically suppressed children weighing ≥40 kg.

Key: 3TC = lamivudine; ABC = abacavir; ART = antiretroviral therapy; ARV = antiretroviral; ATV = atazanavir; ATV/r = atazanavir/ritonavir; BIC = bictegravir; CAB = cabotegravir; DOR = doravirine; DRV = darunavir; DRV/c = darunavir/cobicistat; DRV/r = darunavir/ritonavir; DTG = dolutegravir; EFV = efavirenz; EVG = elvitegravir; EVG/c = elvitegravir/cobicistat; FDC = fixed-dose combination; FTC = emtricitabine; HD = high dose; HLA = human leukocyte antigen; IM = intramuscular; INSTI = integrase strand transfer inhibitor; LPV/r = lopinavir/ritonavir; NNRTI = non-nucleoside reverse transcriptase inhibitor; NRTI = nucleoside reverse transcriptase inhibitor; NVP = nevirapine; PI = protease inhibitor; RAL = raltegravir; RPV = rilpivirine; RTV = ritonavir; SMR = sexual maturity rating; TAF = tenofovir alafenamide; TDF = tenofovir disoproxil fumarate; ZDV = zidovudine

Table 19. Discordance Among Virologic, Immunologic, and Clinical Responses

Differential Diagnosis of Poor Immunologic Response Despite Virologic Suppression
<p>Poor Immunologic Response Despite Virologic Suppression and Good Clinical Response</p> <ul style="list-style-type: none"> • Laboratory error (in CD4 value or viral load measurement) • Misinterpretation of normal, age-related CD4 count decline (i.e., the immunologic response is not actually poor) (see Table 5. CD4 Cell Counts and Percentages in Healthy Children: Distribution by Age) • Low pre-treatment CD4 count or percentage • AEs that are associated with the use of certain drugs (e.g., ZDV, TMP-SMX, systemic corticosteroids) • Use of systemic corticosteroids or chemotherapeutic agents • Conditions that can cause low CD4 values (e.g., HCV, acute viral infections, TB, malnutrition, Sjogren's syndrome, sarcoidosis, syphilis) <p>Poor Immunologic and Clinical Responses Despite Virologic Suppression</p> <ul style="list-style-type: none"> • Laboratory error (in CD4 value or viral load measurement) • Falsely low viral load result for an HIV strain/type that is not detected by viral load assay (i.e., HIV-1 non-M groups, HIV-1 non-B subtypes, HIV-2 [although this is unusual with newer viral load assays]) • Persistent immunodeficiency that occurs soon after initiating ART, but before ART-related reconstitution • Primary protein-calorie malnutrition • Untreated TB • Malignancy
Differential Diagnosis of Poor Clinical Response Despite Adequate Virologic and Immunologic Responses
<ul style="list-style-type: none"> • IRIS • A previously unrecognized, pre-existing infection or condition (e.g., TB, malignancy) • Malnutrition • Clinical manifestations of previous organ damage: brain (e.g., strokes, vasculopathy, worsening neurodevelopmental delay), lungs (e.g., bronchiectasis), cardiac (e.g., cardiomyopathy), renal (e.g., HIV-related kidney disease) • A new clinical event due to a non-HIV illness or condition • A new, or otherwise unexplained, HIV-related clinical event (e.g., treatment failure)

Key: AE = adverse effect; ART = antiretroviral therapy; CD4 = CD4 T lymphocyte; HCV = hepatitis C virus; IRIS = immune reconstitution inflammatory syndrome; TB = tuberculosis; TMP-SMX = trimethoprim-sulfamethoxazole; ZDV = zidovudine

Table 20. Options for Regimens With at Least Two Fully Active Agents to Achieve Virologic Suppression in Children With Virologic Failure and Evidence of Viral Resistance

To optimize antiretroviral (ARV) drug effectiveness, clinicians should evaluate a child’s treatment history and drug-resistance test results when choosing a new ARV regimen. Doing so is particularly important when selecting the nucleoside reverse transcriptase inhibitor (NRTI) components of a non-nucleoside reverse transcriptase inhibitor (NNRTI)–based regimen, where drug resistance to the NNRTIs can occur rapidly if the virus is not sufficiently sensitive to the NRTIs. Regimens should contain at least two, but preferably three, fully active drugs for durable and potent virologic suppression. If the M184V/I mutation associated with emtricitabine and lamivudine is present, these medications should be continued if the new regimen contains tenofovir disoproxil fumarate, tenofovir alafenamide, or zidovudine. The presence of this mutation may increase susceptibility to these NRTIs.

Please see individual drug profiles for information about weight and age limitations (e.g., do not use darunavir in children aged <3 years), drug interactions, and dose adjustments when devising a regimen for children with multiclass drug resistance (see [Appendix A. Pediatric Antiretroviral Drug Information](#)). When modifying ARV regimens in children with chronic hepatitis B/HIV coinfection, the new regimen must contain agents active against hepatitis B. Collaboration with a pediatric HIV specialist is especially important when choosing regimens for children with multiclass drug resistance. Regimens in this table are provided as examples, but the list is not exhaustive.

Prior Failed Regimen	New Regimen Options ^{a,b}
Two NRTIs Plus an NNRTI	<p>Preferred Regimen</p> <ul style="list-style-type: none"> Two NRTIs plus a second-generation INSTI (BIC or DTG)^c <p>Alternative Regimen</p> <ul style="list-style-type: none"> Two NRTIs plus a boosted PI
Two NRTIs Plus a PI	<p>Preferred Regimen</p> <ul style="list-style-type: none"> Two NRTIs plus a second-generation INSTI (BIC or DTG)^c <p>Alternative Regimen</p> <ul style="list-style-type: none"> DTG plus a different boosted PI and with or without NRTI(s)
Two NRTIs Plus an INSTI	<ul style="list-style-type: none"> Two NRTIs plus a boosted PI Second-generation INSTI (DTG^c or BIC^c if not used in the prior regimen) with a boosted PI with or without NRTI(s). DTG may need to be given twice daily if a child has certain documented INSTI mutations, or if there is concern about certain mutations (see the Dolutegravir section for dosing instructions). Two NRTIs plus an NNRTI^d
Failed Regimen(s) That Included NRTI(s), NNRTI(s), and PI(s)	<p>If NRTIs Are Fully Active</p> <ul style="list-style-type: none"> Second-generation INSTI (DTG or BIC)^c plus two NRTIs <p>If NRTIs Are Not Fully Active^b</p> <ul style="list-style-type: none"> Second-generation INSTI plus TAF/FTC or TDF/XTC if able to take TAF or TDF

	<ul style="list-style-type: none"> • Second-generation INSTI plus two NRTIs with a boosted PI • Second-generation INSTI with a boosted PI (based on resistance results). Consider ETR or RPV based on resistance results, age, and weight. • Consider MVC if additional active drug(s) are needed. • Consider off-label use of approved agents or enrollment in clinical trials for novel antiretroviral treatments.
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^a The possibility of planned and unplanned pregnancy should be considered when selecting an ART regimen for an adolescent. When discussing ART options with adolescents and their caregivers, it is important to consider childbearing potential and the benefits and risks of all ARV drugs and to provide the information and counseling needed to support informed decision-making; refer to the [Perinatal Guidelines](#) (see [Recommendations for Use of Antiretroviral Drugs During Pregnancy, Table 7. Situation-Specific Recommendations for Use of Antiretroviral Drugs During Pregnancy and When Trying to Conceive](#), and [Appendix C. Antiretroviral Counseling Guide for Health Care Providers](#)).

^b When modifying ARV regimens in children with chronic hepatitis B/HIV coinfection, the new regimen must contain agents active against hepatitis B.

^c RAL, a first-generation INSTI, has a low barrier to resistance and requires twice-daily dosing in children and adolescents; the second-generation INSTIs BIC and DTG have a higher barrier to resistance and only require once-daily dosing. Many members of the Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV would use BIC/FTC/TAF (Biktarvy) in children with prior treatment failure who have virus with the M184 mutation (see the [Bictegravir](#) section).

^d NNRTIs could be an option in younger children with no exposure to NNRTIs and with taste aversion to boosted PIs, if NRTIs have preserved activity.

Key: ART = antiretroviral therapy; ARV = antiretroviral; BIC = bictegravir; DTG = dolutegravir; FTC = emtricitabine; ETR = etravirine; INSTI = integrase strand transfer inhibitor; MVC = maraviroc; NNRTI = non-nucleoside reverse transcriptase inhibitor; NRTI = nucleoside reverse transcriptase inhibitor; PI = protease inhibitor; RAL = raltegravir; RPV = rilpivirine; TAF = tenofovir alafenamide; TDF = tenofovir disoproxil fumarate; XTC = 3TC (lamivudine) or FTC

Appendix A, Table 1. Antiretrovirals Available in Fixed-Dose Combination Tablets or as a Co-packaged Formulation, by Drug Class

Updated: September 30, 2025

Reviewed: September 30, 2025

Brand Name	NRTIs						NNRTIs			INSTIs				PIs			PK Enhancers	
	ABC	3TC	ZDV	FTC	TDF	TAF ^a	DOR	EFV	RPV ^b	BIC ^a	CAB ^b	DTG	EVG ^a	ATV	DRV	LPV ^c	COBI	RTV
NRTI																		
Cimduo		X			X													
Combivir ^d		X	X															
Descovy				X		X												
Epzicom ^d	X	X																
Temixys		X			X													
Truvada				X	X													
NRTI/NNRTI																		
Atripla ^d				X	X			X										
Complera				X	X					X								
Delstrigo		X			X		X											
Odefsey				X		X				X								
Symfi or Symfi Lo ^d		X			X			X										
NRTI/INSTI																		
Biktarvy				X		X				X								
Dovato		X										X						
Triumeq	X	X										X						
Triumeq PD	X	X										X						
NNRTI/INSTI																		
Juluca									X			X						
Cabenuva									X		X							
NRTI/INSTI/COBI																		
Genvoya				X		X							X				X	
Stribild				X	X								X				X	
NRTI/PI/COBI																		

Brand Name	NRTIs						NNRTIs			INSTIs				PIs			PK Enhancers	
	ABC	3TC	ZDV	FTC	TDF	TAF ^a	DOR	EFV	RPV ^b	BIC ^a	CAB ^b	DTG	EVG ^a	ATV	DRV	LPV ^c	COBI	RTV
Symtuza				X		X									X		X	
PI/COBI																		
Evotaz														X			X	
Prezcobix															X		X	
PI/RTV																		
Kaletra																X		X

^a TAF, BIC, and EVG are only available in FDC tablets. However, TAF 25 mg tablets (Vemlidy) are FDA approved for treatment of HBV. In select circumstances, TAF might be used as one component of a combination ARV regimen, with dosing recommendations similar to those for Descovy.

^b CAB and RPV for intramuscular injection are available as a co-packaged product (Cabenuva); oral formulations of CAB and RPV for initial lead-in dosing must be prescribed separately; see [Cabotegravir and Rilpivirine](#).

^c LPV is only available in FDC tablets or solution.

^d Brand name product is no longer available.

Key: 3TC = lamivudine; ABC = abacavir; ARV = antiretroviral; ATV = atazanavir; BIC = bictegravir; CAB = cabotegravir; COBI = cobicistat; DOR = doravirine; DRV = darunavir; DTG = dolutegravir; EFV = efavirenz; EVG = elvitegravir; FDA = U.S. Food and Drug Administration; FDC = fixed-dose combination; FTC = emtricitabine; HBV = hepatitis B virus; INSTI = integrase strand transfer inhibitor; LPV = lopinavir; NNRTI = non-nucleoside reverse transcriptase inhibitor; NRTI = nucleoside and nucleotide reverse transcriptase inhibitor; PI = protease inhibitor; PK = pharmacokinetic; RPV = rilpivirine; RTV = ritonavir; TAF = tenofovir alafenamide; TDF = tenofovir disoproxil fumarate; ZDV = zidovudine

Appendix A, Table 2. Antiretroviral Fixed-Dose Combination Tablets and Co-packaged Formulations: Minimum Body Weights and Considerations for Use in Children and Adolescents

Updated: September 30, 2025

Reviewed: September 30, 2025

General Considerations When Using Fixed-Dose Combination Products

Please see the individual drug sections under [Appendix A. Pediatric Antiretroviral Drug Information](#) for the recommended dosing of individual fixed-dose combination (FDC) products.

FDC tablets and individual antiretroviral (ARV) drugs also can be looked up by drug name (brand name and generic) at [DailyMed](#). Size is listed under the Ingredients and Appearance section.

For images of most of the FDC tablets listed in this table, see the [Antiretroviral Medications](#) section of the National HIV Curriculum. In addition, a resource from the United Kingdom illustrates the relative sizes of FDC tablets and individual ARV drugs (see the [ARV Chart](#) at [HIV i-BASE](#)). Although most of the drugs listed in the chart are the same as those in the United States, there are several differences: some formulations available in the United States are not included; a few of the brand names are not the same as those listed in Appendix A, Table 2; and the chart includes a formulation that is not available in the United States.

Integrase Strand Transfer Inhibitors

- Bictegravir (BIC) and dolutegravir (DTG), second-generation integrase strand transfer inhibitors (INSTIs), have a higher barrier to resistance than the first-generation INSTIs, elvitegravir (EVG) and raltegravir.
- For children weighing ≥ 6 kg and aged ≥ 3 months, DTG is available in once-daily FDC formulations of abacavir (ABC)/DTG/lamivudine (3TC). If ABC/DTG/3TC is not an option, then single-entity DTG can be used in combination with other FDC tablets. Refer to the [Dolutegravir](#) section for dosing information.
 - ABC/DTG/3TC is available in two different formulations, with the appropriate formulation depending on weight. For children weighing ≥ 6 kg to < 25 kg and aged ≥ 3 months, ABC/DTG/3TC is available in a dispersible tablet, once-daily regimen (Triumeq PD); the number of tablets per dose depends on the child's weight. For children and adolescents weighing ≥ 25 kg, ABC/DTG/3TC is available as a once-daily single-tablet regimen (Triumeq).
 - Whether considering DTG in FDC or single-entity form, **the film-coated tablets and dispersible tablets are not bioequivalent and, thus, are not interchangeable on a milligram-per-milligram basis.**
- For children weighing ≥ 14 kg, BIC is available as the single-tablet, once-daily regimen BIC/emtricitabine (FTC)/tenofovir alafenamide (TAF) (Biktarvy). There are two dosage strengths for pediatric use: one for use in children weighing ≥ 14 kg to < 25 kg and another for children and adolescents weighing ≥ 25 kg and adults. Refer to the [Bictegravir](#) section for dosing information.

- For children weighing ≥ 25 kg, EVG is available as the single-tablet, once-daily regimen elvitegravir/cobicistat (EVG/c)/FTC/TAF (Genvoya). EVG/c/FTC/TAF (Genvoya) has more drug–drug interactions than ABC/DTG/3TC (Triumeq or Triumeq PD) or BIC/FTC/TAF (Biktarvy). Refer to the [Elvitegravir](#) section for dosing information.
- The two-drug, co-packaged regimen of long-acting injectable cabotegravir (CAB) and rilpivirine (RPV) (Cabenuva) is approved by the U.S. Food and Drug Administration (FDA) for use in children and adolescents aged ≥ 12 years and weighing ≥ 35 kg. CAB and RPV are administered by intramuscular injection on a monthly or every-2-months schedule after an optional oral lead-in. See the [Cabotegravir](#) and [Rilpivirine](#) sections for instructions about dosing and administration.

Nucleoside/Nucleotide Reverse Transcriptase Inhibitors

- ABC or TAF in combination with 3TC or FTC are favored over zidovudine (ZDV)/3TC because of the lower risk of nucleoside/nucleotide reverse transcriptase inhibitor–associated mitochondrial toxicity.
- Tenofovir disoproxil fumarate (TDF) is more potent than ABC at high viral loads ($>100,000$ copies/mL) when used in regimens that do not contain an INSTI.
- TAF is favored over TDF because of the lower risk of TDF-associated bone and renal toxicity. TDF is not recommended for children with sexual maturity ratings of 1 to 3 because of TDF-associated bone toxicity.
- For children weighing ≥ 14 kg who can swallow pills, FTC/TAF (Descovy) offers a once-daily alternative to twice-daily ZDV plus 3TC or ABC plus 3TC.
- For children weighing ≥ 14 kg and ≤ 35 kg, FTC/TAF (Descovy) can be used in combination with an INSTI or non-nucleoside reverse transcriptase inhibitor, but not with a protease inhibitor; this restriction does not apply to regimens containing ZDV or ABC.

Non-nucleoside Reverse Transcriptase Inhibitors

- The FDC tablet doravirine/3TC/TDF is approved by the FDA for children and adolescents weighing ≥ 35 kg who are ARV naive or virologically suppressed on a stable ARV regimen (see the [Doravirine](#) section).
- RPV has low potency at high viral loads ($>100,000$ copies/mL) and requires a high-fat meal for optimal absorption, so INSTIs are favored over RPV.

Fixed-Dose Combinations Available for Children and Adolescents

FDC by Class Brand name and generic ^a products, when available	FDC Components	Minimum Body Weight or Weight Range (kg) or Age ^b	Pill Size (mm × mm) or Largest Dimension (mm) ^c	Food Requirements
NRTI				
Cimduo	3TC 300 mg/TDF 300 mg	35 kg	19	Take with or without food.

FDC by Class Brand name and generic ^a products, when available	FDC Components	Minimum Body Weight or Weight Range (kg) or Age ^b	Pill Size (mm × mm) or Largest Dimension (mm) ^c	Food Requirements
Combivir^d	3TC 150 mg/ZDV 300 mg (scored tablet)	30 kg	18 × 7	Take with or without food.
Descovy	FTC 120 mg/TAF 15 mg	With an INSTI or NNRTI • 14 to <25 kg	N/A	Take with or without food.
	FTC 200 mg/TAF 25 mg	With an INSTI or NNRTI • 25 kg With a Boosted PI • 35 kg	12.5 × 6.4	Take with or without food.
Epzicom^d	ABC 600 mg/3TC 300 mg	25 kg	21 × 9	Take with or without food.
Temixys	3TC 300 mg/TDF 300 mg	35 kg	N/A	Take with or without food.
Truvada	FTC 100 mg/TDF 150 mg	17 to <22 kg	14	Take with or without food.
	FTC 133 mg/TDF 200 mg	22 to <28 kg	16	Take with or without food.
	FTC 167 mg/TDF 250 mg	28 to <35 kg	18	Take with or without food.
	FTC 200 mg/TDF 300 mg	35 kg	19 × 8.5	Take with or without food.
NRTI/NNRTI				
Atripla^d	EFV 600 mg/FTC 200 mg/TDF 300 mg	40 kg	20	Take on an empty stomach.
Complera	FTC 200 mg/RPV 25 mg/TDF 300 mg	35 kg and aged ≥12 years	19	Take with a meal. ^e
Delstrigo	DOR 100 mg/3TC 300 mg/TDF 300 mg	35 kg	19	Take with or without food.
Odefsey	FTC 200 mg/RPV 25 mg/TAF 25 mg	25 kg and aged ≥12 years	15	Take with a meal. ^e

FDC by Class Brand name and generic ^a products, when available	FDC Components	Minimum Body Weight or Weight Range (kg) or Age ^b	Pill Size (mm × mm) or Largest Dimension (mm) ^c	Food Requirements
Symfi	EFV 600 mg/3TC 300 mg/TDF 300 mg (scored tablet)	40 kg	23	Take on an empty stomach.
Symfi Lo ^d	EFV 400 mg/3TC 300 mg/TDF 300 mg	35 kg ^f	21	Take on an empty stomach.
NRTI/INSTI				
Biktarvy	BIC 30 mg/FTC 120 mg/TAF 15 mg	14 to <25 kg	N/A	Take with or without food.
	BIC 50 mg/FTC 200 mg/TAF 25 mg	25 kg	15 × 8	Take with or without food.
Dovato	DTG 50 mg/3TC 300 mg	25 kg	19	Take with or without food.
Triumeq	ABC 600 mg/DTG 50 mg/3TC 300 mg	25 kg	22 × 11	Take with or without food.
Triumeq PD	ABC 60 mg/DTG 5 mg/3TC 30 mg	6 to <25 kg and aged ≥3 months ^g	N/A (dispersible)	Take with or without food.
NNRTI/INSTI				
Cabenuva ^h	Cabenuva 400 mg/600 mg kit contains CAB 400 mg/2 mL vial and RPV 600 mg/2 mL vial	35 kg and aged ≥12 years	N/A	See Cabotegravir for instructions about dosing and administration.
	Cabenuva 600 mg/900 mg kit contains CAB 600 mg/3 mL vial and RPV 900 mg/3 mL vial	35 kg and aged ≥12 years	N/A	See Cabotegravir for instructions about dosing and administration.
Juluca	DTG 50 mg/RPV 25 mg	35 kg and aged ≥12 years ⁱ	14	Take with a meal. ^e
NRTI/INSTI/COBI				
Genvoya	EVG 150 mg/COBI 150 mg/FTC 200 mg/TAF 10 mg	25 kg	19 × 8.5	Take with food.
Stribild	EVG 150 mg/COBI 150 mg/FTC 200 mg/TDF 300 mg	35 kg and SMR of 4 or 5 ^j	20	Take with food.
NRTI/PI/COBI				

FDC by Class Brand name and generic ^a products, when available	FDC Components	Minimum Body Weight or Weight Range (kg) or Age ^b	Pill Size (mm × mm) or Largest Dimension (mm) ^c	Food Requirements
Symtuza	DRV 800 mg/COBI 150 mg/FTC 200 mg/TAF 10 mg	40 kg	22	Take with food.
PI/COBI				
Evotaz	ATV 300 mg/COBI 150 mg	35 kg	19	Take with food.
Prezcobix	DRV 675 mg/COBI 150 mg	25 to <40 kg	21	Take with food.
	DRV 800 mg/COBI 150 mg	40 kg	23	Take with food.
PI/RTV				
Kaletra	LPV/r Oral Solution <ul style="list-style-type: none"> LPV 80 mg/mL and RTV 20 mg/mL 	Postmenstrual Age of 42 Weeks and a Postnatal Age of ≥14 Days <ul style="list-style-type: none"> No minimum weight 	19	Take with or without food.
	Tablets <ul style="list-style-type: none"> LPV 200 mg/RTV 50 mg LPV 100 mg/RTV 25 mg 			

^a The possibility of planned and unplanned pregnancy should be considered when selecting an antiretroviral therapy (ART) regimen for an adolescent. When discussing ART options with adolescents and their caregivers, it is important to consider childbearing potential and the benefits and risks of all ARV drugs and to provide the information and counseling needed to support informed decision-making (see [Table 7. Situation-Specific Recommendations for Use of Antiretroviral Drugs in Pregnant People and Nonpregnant People Who Are Trying to Conceive](#) and [Appendix C: Antiretroviral Counseling Guide for Health Care Providers](#)).

^b Minimum body weight and age are those recommended by the FDA, unless otherwise noted.

^c Sizes or largest dimensions of generic drugs are not listed because they may vary by manufacturer; this information is available by looking up one of the drug components using [DailyMed](#).

^d Brand name product has been discontinued; generic version is still available.

^e Patients must be able to take oral RPV with a meal of at least 500 calories on a regular schedule (a protein drink alone does not constitute a meal).

^f Because of pharmacokinetic concerns, the Panel on Antiretroviral Therapy and Medical Management of Children Living With HIV (the Panel) recommends caution when using Symfi Lo in children and adolescents who have SMRs of 1 to 3 and weigh ≥40 kg (see the [Efavirenz](#) section).

^g ABC/DTG/3TC is available in dispersible tablets (Triumeq PD) for children weighing ≥6 kg to <25 kg and aged ≥3 months with the dosage and number of tablets based on weight. Refer to the [Dolutegravir](#) section for exact dosage and instructions for administration. Dispersible tablets (Triumeq PD) are not recommended for children and adolescents weighing ≥25 kg.

^h Long-acting injectable CAB and RPV for intramuscular administration are available as a co-packaged product (Cabenuva); oral formulations of CAB and RPV for the optional initial lead-in dosing or bridging between injections >7 days from the target injection window must be prescribed separately (see the [Cabotegravir](#) and [Rilpivirine](#) sections).

ⁱ DTG/RPV (Juluca) is not currently approved for use in adolescents with HIV; however, the doses of the component drugs that make up this FDC tablet are approved for use in adolescents. The Panel usually endorses the use of adult formulations in

adolescents, and this product may be appropriate for use in certain adolescents. See [Modifying Antiretroviral Regimens in Children With Sustained Virologic Suppression on Antiretroviral Therapy](#) for additional considerations on using this combination.

J Although Stribild is approved by the FDA for use in children and adolescents weighing ≥ 35 kg and aged ≥ 12 years, the Panel does not recommend its use in children with SMRs of 1 to 3 given the availability of other INSTI-containing FDCs.

Key: 3TC = lamivudine; ABC = abacavir; ATV = atazanavir; BIC = bictegravir; CAB = cabotegravir; COBI = cobicistat; DOR = doravirine; DRV = darunavir; DTG = dolutegravir; EFV = efavirenz; EVG = elvitegravir; FDA = U.S. Food and Drug Administration; FDC = fixed-dose combination; FTC = emtricitabine; INSTI = integrase strand transfer inhibitor; LPV = lopinavir; LPV/r = lopinavir/ritonavir; N/A = information not available or not applicable; NNRTI = non-nucleoside reverse transcriptase inhibitor; NRTI = nucleoside reverse transcriptase inhibitor; PI = protease inhibitor; RPV = rilpivirine; RTV = ritonavir; SMR = sexual maturity rating; TAF = tenofovir alafenamide; TDF = tenofovir disoproxil fumarate; ZDV = zidovudine

Appendix C, Table A. HIV Infection Stage Based on Age-Specific CD4 Count or Percentage

Stage ^a	Aged <1 Year		Aged 1 Year to <6 Years		Aged ≥6 Years	
	Cells/mm ³	%	Cells/mm ³	%	Cells/mm ³	%
1	≥1,500	≥34	≥1,000	≥30	≥500	≥26
2	750–1,499	26–33	500–999	22–29	200–499	14–25
3	<750	<26	<500	<22	<200	<14

^a The stage is based primarily on the CD4 count; the CD4 count takes precedence over the CD4 percentage, and the percentage is considered only when the count is missing. If a Stage 3–defining condition has been diagnosed (see Table 6), then the stage is 3, regardless of CD4 test results.

Key: CD4 = CD4 T lymphocyte

Source: Centers for Disease Control and Prevention. Revised surveillance case definition for HIV infection—United States, 2014. *MMWR* 2014;63(No. RR-3):1-10.

Appendix C, Table B. HIV-Related Symptoms and Conditions

Mildly Symptomatic
<p>Children with two or more of the following conditions, but none of the conditions listed in the Moderately Symptomatic category, are considered mildly symptomatic:</p> <ul style="list-style-type: none"> • Lymphadenopathy (lymph nodes are ≥0.5 cm at more than two sites and/or bilateral at one site) • Hepatomegaly • Splenomegaly • Dermatitis • Parotitis • Recurrent or persistent upper respiratory tract infection, sinusitis, or otitis media
Moderately Symptomatic
<ul style="list-style-type: none"> • Anemia (hemoglobin <8 g/dL [<80 g/L]), neutropenia (white blood cell count <1,000 per μL [$<1.0 \times 10^9$ per L]), and/or thrombocytopenia (platelet count <100 $\times 10^3$ per μL [$<100 \times 10^9$ per L]) persisting for ≥30 days • Bacterial meningitis, pneumonia, or sepsis (single episode) • Candidiasis, oropharyngeal (thrush), persisting for >2 months in children aged >6 months • Cardiomyopathy • CMV infection, with onset before age 1 month • Diarrhea, recurrent or chronic • Hepatitis • HSV stomatitis, recurrent (more than two episodes within 1 year) • HSV bronchitis, pneumonitis, or esophagitis with onset before age 1 month

- Herpes zoster (shingles) involving at least two distinct episodes or more than one dermatome
- Leiomyosarcoma
- Lymphoid interstitial pneumonia or pulmonary lymphoid hyperplasia complex
- Nephropathy
- Nocardiosis
- Persistent fever (lasting >1 month)
- Toxoplasmosis, onset before age 1 month
- Varicella, disseminated (complicated chickenpox)

AIDS-Defining Conditions

- Bacterial infections, multiple or recurrent^a
- Candidiasis of bronchi, trachea, or lungs
- Candidiasis of esophagus
- Cervical cancer, invasive
- Coccidioidomycosis, disseminated or extrapulmonary
- Cryptococcosis, extrapulmonary
- Cryptosporidiosis, chronic intestinal (>1-month duration)
- CMV disease (other than liver, spleen, or lymph nodes), onset at age >1 month
- CMV retinitis (with loss of vision)
- Encephalopathy attributed to HIV^b
- HSV: chronic ulcers (>1-month duration) or bronchitis, pneumonitis, or esophagitis (onset at age >1 month)
- Histoplasmosis, disseminated or extrapulmonary
- Isosporiasis, chronic intestinal (>1-month duration)
- Kaposi sarcoma
- Lymphoma, Burkitt (or equivalent term)
- Lymphoma, immunoblastic (or equivalent term)
- Lymphoma, primary (of brain)
- *Mycobacterium avium* complex or *Mycobacterium kansasii*, disseminated or extrapulmonary
- *Mycobacterium tuberculosis* of any site, pulmonary, disseminated, or extrapulmonary
- *Mycobacterium*, other species or unidentified species, disseminated or extrapulmonary
- Pneumocystis jirovecii (previously known as Pneumocystis carinii) pneumonia
- Pneumonia, recurrent^c
- Progressive multifocal leukoencephalopathy
- Salmonella septicemia, recurrent
- Toxoplasmosis of brain, onset at age >1 month

- Wasting syndrome attributed to HIV^b

^a Only among children aged <6 years.

^b Suggested diagnostic criteria for these illnesses, which might be particularly important for HIV encephalopathy and HIV wasting syndrome, are described in the following references:

Centers for Disease Control and Prevention. 1994 Revised classification system for human immunodeficiency virus infection in children less than 13 years of age. *MMWR*. 1994;43(No. RR-12).

Centers for Disease Control and Prevention. 1993 Revised classification system for HIV infection and expanded surveillance case definition for AIDS among adolescents and adults. *MMWR*. 1992;41(No. RR-17).

^c Only among adults, adolescents, and children aged ≥6 years.

Key: CMV = cytomegalovirus; HSV = herpes simplex virus

Modified from:

Centers for Disease Control and Prevention. 1994 revised classification system for human immunodeficiency virus infection in children less than 13 years of age. *MMWR*. 1994;43(No. RR-12).

Centers for Disease Control and Prevention: Revised Surveillance Case Definition for HIV Infection—United States, 2014. *MMWR*. 2014;63(No. RR-3):1-10.

Appendix D, Table A. Likelihood of Developing AIDS or Death Within 12 Months, by Age and CD4 T-Cell Percentage or Log₁₀ HIV-1 RNA Copy Number in HIV-Infected Children Receiving No Therapy or Zidovudine Monotherapy

CD4 Percentage					Log ₁₀ HIV RNA Copy Number		
Age	10%	20%	25%	30%	6.0	5.0	4.0
Percent Mortality (95% Confidence Interval)							
6 Months	28.7	12.4	8.5	6.4	9.7	4.1	2.7
1 Year	19.5	6.8	4.5	3.3	8.8	3.1	1.7
2 Years	11.7	3.1	2.0	1.5	8.2	2.5	1.1
5 Years	4.9	0.9	0.6	0.5	7.8	2.1	0.7
10 Years	2.1	0.3	0.2	0.2	7.7	2.0	0.6
Percent Developing AIDS (95% Confidence Interval)							
6 Months	51.4	31.2	24.9	20.5	23.7	13.6	10.9
1 Year	40.5	20.9	15.9	12.8	20.9	10.5	7.8
2 Years	28.6	12.0	8.8	7.2	18.8	8.1	5.3
5 Years	14.7	4.7	3.7	3.1	17.0	6.0	3.2
10 Years	7.4	2.2	1.9	1.8	16.2	5.1	2.2

Note: Table modified from: HIV Paediatric Prognostic Markers Collaborative Study Group. *Lancet*. 2003;362:1605-1611.

Appendix D, Table B. Death and AIDS/Death Rate per 100 Person-Years by Current Absolute CD4 Cell Count and Age in HIV-Infected Children Receiving No Therapy or Zidovudine Monotherapy (HIV Paediatric Prognostic Markers Collaborative Study) and Adult Seroconverters (CASCADE Study)

Age (Years)	Absolute CD4 Cell Count (cells/mm ³)					
	<50	50–99	100–199	200–349	350–499	500+
Rate of Death Per 100 Patient-Years						
0–4	59.3	39.6	25.4	11.1	10.0	3.5
5–14	28.9	11.8	4.3	0.89	0.00	0.00
15–24	34.7	6.1	1.1	0.71	0.58	0.65
25–34	47.7	10.8	3.7	1.1	0.38	0.22
35–44	58.8	15.6	4.5	0.92	0.74	0.85
45–54	66.0	18.8	7.7	1.8	1.3	0.86
55+	91.3	21.4	17.6	3.8	2.5	0.91
Rate of AIDS or Death per 100 Patient-Years						
0–4	82.4	83.2	57.3	21.4	20.7	14.5
5–14	64.3	19.6	16.0	6.1	4.4	3.5

15–24	61.7	30.2	5.9	2.6	1.8	1.2
25–34	93.2	57.6	19.3	6.1	2.3	1.1
35–44	88.1	58.7	25.5	6.6	4.0	1.9
45–54	129.1	56.2	24.7	7.7	3.1	2.7
55+	157.9	42.5	30.0	10.0	5.1	1.8

Note: Table modified from: HIV Paediatric Prognostic Markers Collaborative Study and the CASCADE Collaboration. *J Infect Dis.* 2008;197:398-404.

Appendix D, Table C. Association of Baseline Human Immunodeficiency Virus (HIV) RNA Copy Number and CD4T-Cell Percentage with Long-Term Risk of Death in HIV-Infected Children^a

Baseline HIV RNA ^c (Copies/mL) Baseline CD4 Percentage	No. Patients ^d	Deaths ^b	
		Number	Percentage
≤100,000			
≥15%	103	15	(15%)
<15%	24	15	(63%)
>100,000			
≥15%	89	32	(36%)
<15%	36	29	(81%)

^a Data from the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development Intravenous Immunoglobulin Clinical Trial.

^b Mean follow-up: 5.1 years.

^c Tested by NASBA[®] assay (manufactured by Organon Teknika, Durham, North Carolina) on frozen stored serum.

^d Mean age: 3.4 years.

Source: Mofenson LM, Korelitz J, Meyer WA, et al. The relationship between serum human immunodeficiency virus type 1 (HIV-1) RNA level, CD4 lymphocyte percent, and long-term mortality risk in HIV-1-infected children. *J Infect Dis.* 1997;175(5):1029–1038.