

HIV Screening Guidelines & PrEP in Adolescents

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Pediatric Infectious Diseases

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Objectives

- Why screen?
- When to screen?
- What to send to screen?
- What to do after you screen?
- PrEP options, adherence, and barriers in adolescents

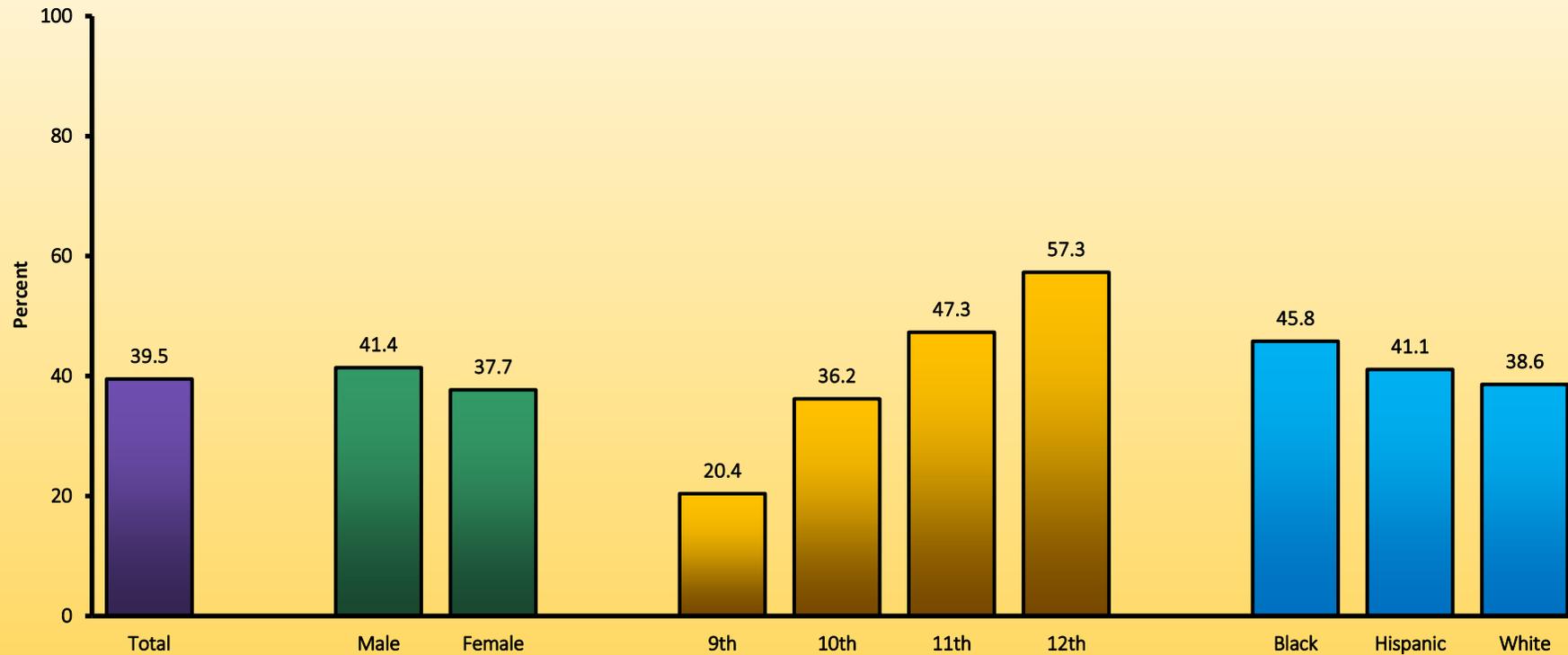
Case #1

- 19 yo male went to PCP for a routine check up and sought out HIV testing because he knew he was at high risk, having had 3 lifetime male partners with no condom use. ROS also with rectal pain.
 - PMH- previously healthy
 - Social- in college, MSM, has receptive anal sex
 - HIV tested +
- 4 months prior during the winter, he had SOB. He developed cold sores, sore throat, subjective fevers, chills all x 2 weeks. He also had rectal pain and bright blood on the toilet paper and went to UC, dx'd with hemorrhoids. Symptomatic care did not help.

Why screen for HIV?

- Teenagers are having sex
- We're trying to end the epidemic
- We have a lot of HIV in South Carolina

Percentage of High School Students Who Ever Had Sexual Intercourse, by Sex,* Grade,* and Race/Ethnicity,* 2017



*M > F; 10th > 9th, 11th > 9th, 11th > 10th, 12th > 9th, 12th > 10th, 12th > 11th; B > W (Based on t-test analysis, $p < 0.05$.)

All Hispanic students are included in the Hispanic category. All other races are non-Hispanic.

Note: This graph contains weighted results.



South Carolina Teens

South Carolina 2017 Results	Total %		Women %		Men %	
	Freshman	Senior	Freshman	Senior	Freshman	Senior
Ever had sex	26	54	22	53	30	-
Had sex before age 13	4	2	7	2	9	-
4+ lifetime partners	5	14	4	12	7	14
Currently having sex	15	35	13	40	17	36
Did <i>not</i> use a condom the last time	10	27	10	32	11	26
Alcohol or drugs with sex the last time	5	10	5	9	6	13
Never tested, or not sure of testing, for HIV (outside of blood donation)	90	82	90	76	91	88
	n=337-340	n=183-208	n= 182-194	n=104-115	n= 157-197	n=78-90



**Ending
the
HIV
Epidemic**

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Ending the HIV Epidemic

- President Trump announced in his state of the union address in Feb 2019 a campaign to End the HIV Epidemic
- *What does this mean, and why is it important?*
- An initiative to reduce the number of new HIV infections in the US by 75% within five years, and 90% by 2030
 - for an estimated 250,000 total HIV infections averted
- Why is it important?
 - > 700,000 Americans have died from HIV since 1981
 - > 1.1 million Americans are currently living with HIV, and more are at risk of HIV infection
 - New HIV diagnoses have plateaued, with ~ 35,000 new diagnoses each year
 - US government spends \$20 billion in annual direct health expenditures for HIV prevention and care
 - Opioid epidemics and HIV complacency among healthcare providers threatens an HIV resurgence

End the Epidemic: Data Driven Target Areas

The Initiative will target our resources to the 48 highest burden counties, Washington, D.C., San Juan, Puerto Rico, and 7 states with a substantial rural HIV burden.



Geographical Selection:

Data on burden of HIV in the US shows areas where HIV transmission occurs more frequently. More than 50% of new HIV diagnoses* occurred in only 48 counties, Washington, D.C., and San Juan, Puerto Rico. In addition, 7 states have a substantial rural burden – with over 75 cases and 10% or more of their diagnoses in rural areas.

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Epidemic

www.HIV.gov

*2016-2017 data

End the Epidemic Plan: Four Key Strategies



Diagnose all people with HIV as early as possible.

Treat people with HIV rapidly and effectively to reach sustained viral suppression.



Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs).

Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.



Location	HIV Diagnoses
1. District of Columbia	34.6
2. Georgia	29.2
3. Florida	25.6
4. Louisiana	25.5
5. Nevada	20.0
6. Maryland	19.3
6. Mississippi	19.3
8. Texas	19.2
9. South Carolina	16.8
10. Puerto Rico	15.7
11. New York	14.9
12. Alabama	13.9
12. New Jersey	13.9
14. North Carolina	13.7
United States ¹	13.6
15. Arizona	13.4
16. California	13.3
16. Tennessee	13.3
18. Illinois	12.6
19. Virginia	12.1
20. Arkansas	11.2
21. Delaware	11.1
22. Massachusetts	11.0
23. U.S. Virgin Islands	10.2
24. Ohio	10.0
25. Kentucky	9.6

HIV diagnosis rate in SC in ages 13-24 years is 20.6 in 2018

Notes

Rates are per 100,000 population.

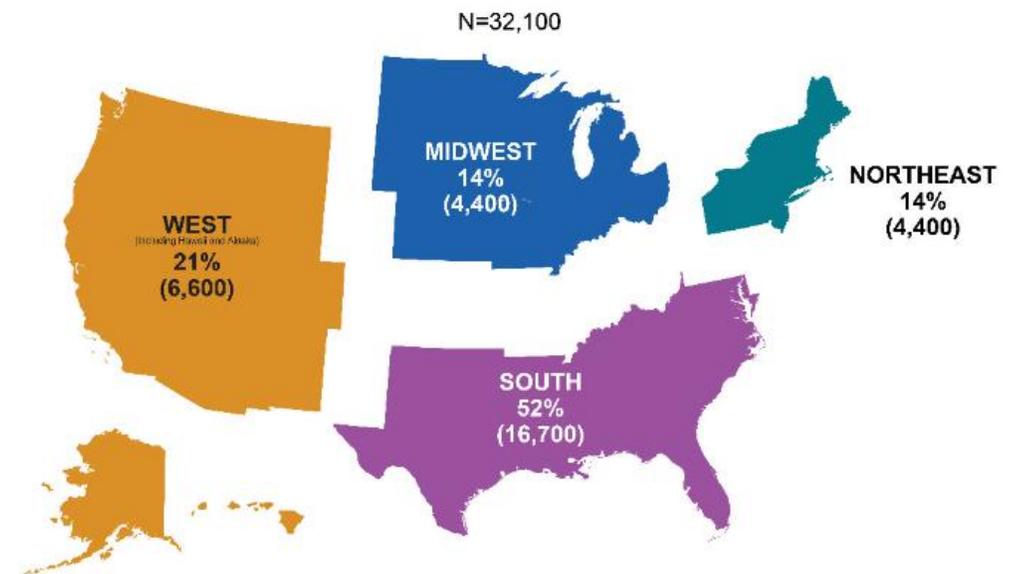
Centers for Disease Control and Prevention, [National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention \(NCHHSTP\) AtlasPlus](#) 2018 Data



HIV+ Adolescents

- In 2021, 32k-36,000 new HIV diagnoses: teens and young adults (ages 13-24) made up 19% of those
 - The highest rates continue to be in the South
- Sexual transmission is the main route
- Adherence with ART may be more difficult in adolescence
 - Just like adults: busy schedules, substance use, mental health
 - Neurodevelopmental stage
 - Psychosocial developmental stage
 - Different levels of caregiver support and navigating new found medical autonomy
 - Transitioning to adult care
 - Changes in insurance status
 - HIV stigma, to include at college

Estimated HIV Infections in the US by Region, 2021*



Source: CDC. Estimated HIV incidence and prevalence in the United States 2017–2021. *HIV Surveillance Supplemental Report 2023*;28(3)

Barriers to screening for HIV

- Many teenagers feel they are not at risk for HIV
- Concerned about confidentiality
- Access to testing
- Blood draw
- Missed opportunities by doctors
 - In a study of 253 teens seen by 49 doctors, 1/3 of teen patients do not receive any talk about sexual health during annual visits
 - When it is discussed, it lasts an average of 36 seconds
 - Patient engagement varied, only 4% had prolonged conversation
 - Adolescent girls, older teens, and explicitly confidential visits were more than 4x as likely to discuss sexual health¹

When to screen for HIV: Routine

- CDC recommends universal, routine screening for all people at least once as part of routine health care, starting at age 13
 - Screen at least yearly
 - PWID and their sex partners
 - People who exchange sex for drugs or money
 - Sex partners of people with HIV
 - Sexually active MSM (consider testing every 3-6 months)
 - Heterosexuals who have had ≥ 1 sex partner since most recent HIV test
 - People receiving treatment for hepatitis, TB, or an STD
- AAP recommends screening on all sexually active teens regardless of age, for all teens at least once by age 16-18 if community prevalence is $>0.1\%$, and annually for high-risk youth
 - Teens tested for other STDs should be tested for HIV at the same visit
 - ED and UC facilities in high-prevalence areas should start routine testing

Case #2

- 16 yo presents to PCP in the summer with fever, vomiting, diarrhea
 - *PCP diagnosis: viral illness, symptomatic care*
- Symptoms worsen, develops muscle aches, arthralgia, HA, presents to ED
 - *ED diagnosis: viral illness, admit for IVF*
- Hospital admission shows leukopenia, thrombocytopenia, elevated CPK, mild transaminitis. RMSF, flu, EBV normal. Improves after 24 hours of IVF
 - *Hospital diagnosis: viral illness, symptomatic care*
- Presents 2 months later to PCP with anal warts...HIV tested +

When to screen for HIV: Acute HIV

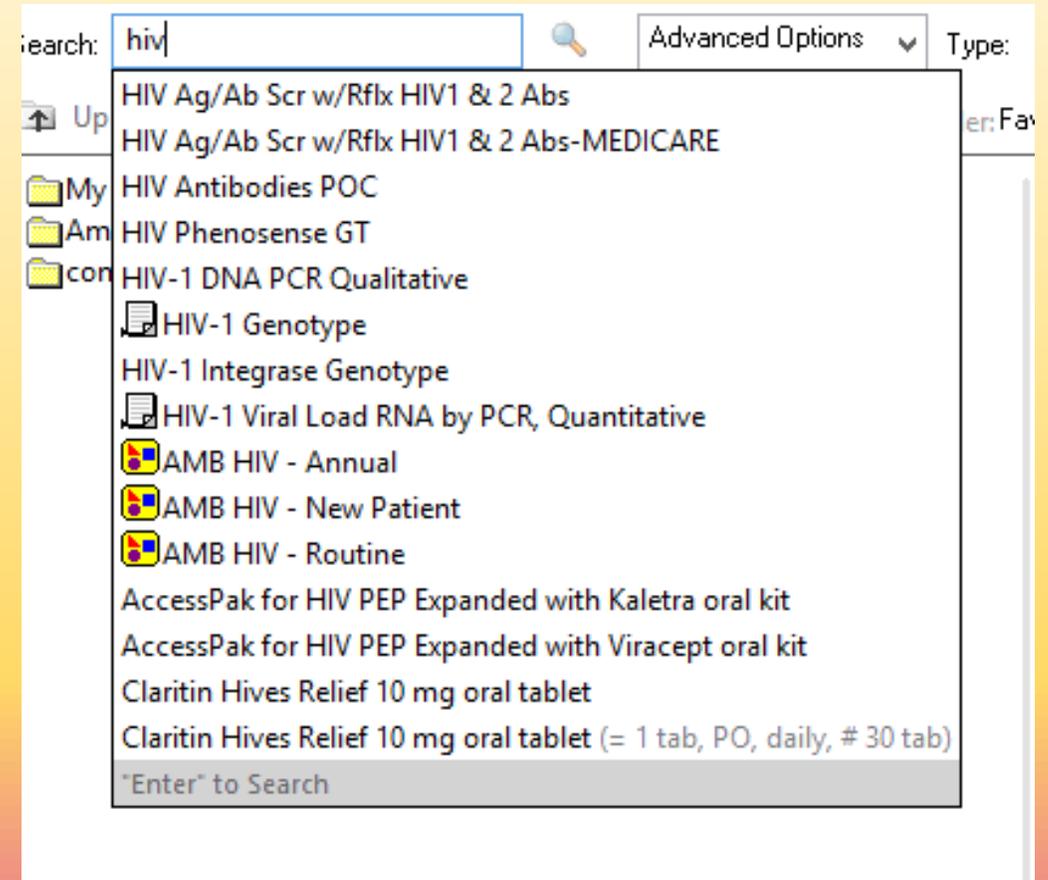
- 50% of people acutely infected with HIV will present to providers with symptoms, few are tested¹
- Symptoms of acute retroviral syndrome
 - Flu-like illness
 - GI-like illness
 - Fever, LAD, rash, HA, oral ulcers
 - Leucopenia, thrombocytopenia, transaminitis, aseptic meningitis, pancreatitis
- Diagnosis and treatment during acute phase can have short-term and long-term benefits and decrease transmission (26 times higher in acute phase²)

Case #3

- 17 yo male presents to ED in winter with complaint of flu symptoms. Patient states that he has had back pain, headache, myalgias and throat pain for the past week. He developed fevers of 102-103 at home over the past several days. He has also had 3 episodes of nonbilious, nonbloody vomiting once daily for the past 3 days.
 - PCP strep and flu negative
 - UC repeat strep and flu negative
 - ED diagnosis: viral illness
- Presents back to PCP eight months later with weight loss ongoing since this winter... HIV tested +

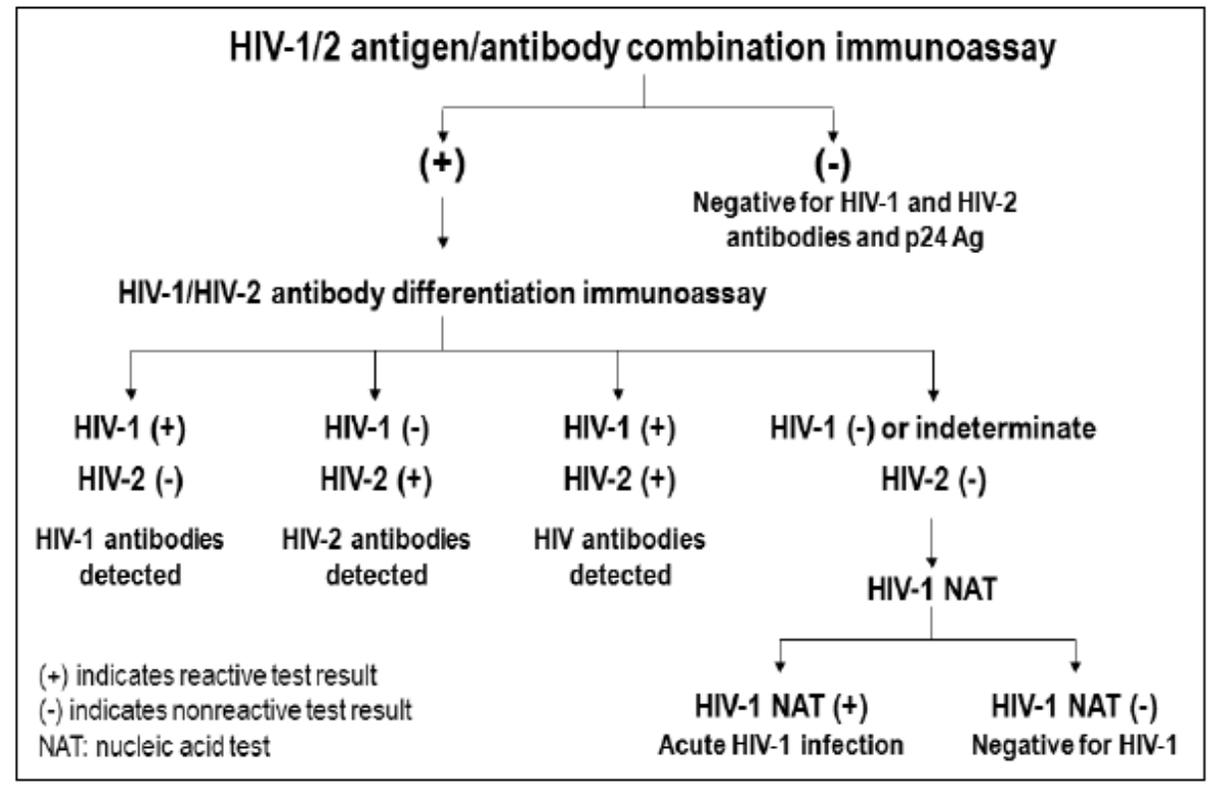
What to send to screen

- Rapid HIV test, or POC
- HIV 4th generation, *aka* HIV-1/2 antigen/antibody immunoassay, *aka* HIV Ag/Ab screen with reflex
 - Detects HIV-1 Ab (most common), HIV-2 Ab (West Africa), and HIV-1 p24 Ag
 - Does not discern Ag reactivity from Ab reactivity
- For acute retroviral syndrome, also send HIV RNA PCR (“viral load”)



Indeterminate test result

- Is your patient high risk? → this could be acute HIV, send HIV NAT (RNA PCR)
- Is your patient low risk? → most likely false positive, but send HIV NAT (RNA PCR)



What to do after your screen?

- If your rapid or POC is positive, send a 4th generation test
 - Trep/RPR, GC/Chlamydia NAAT (urine and/or rectal), consider hepatitis panel
- If your 4th generation test is positive
 - You can hold on other labs and refer to Peds or Adult ID
 - Or...send HIV viral load, CD4
- Counsel your patient
 - HIV is a chronic illness that can be controlled with easy, effective treatment and with good control, you can stay healthy
 - Nothing needs to change in the house (no new silverware or dishes, soap, towels, etc)
 - Transmission is through sex, blood, and mom to baby: it is ok to interact as normal with family, babies, people on chemo
 - RW Clinics help with all barriers to care (cost, transportation, mental health, etc.)
 - SC law states you must disclose your status to your sex or needle-sharing partner
 - DHEC will be in touch with them for anonymous public health reporting
 - Primary care provider is still needed
- Refer to your local Peds or Adult ID for rapid ART (appointment within 48 hours)
 - The goal = offer ART on the same day of appointment if ready

Prisma
Greenville
(864) 454-5130

Age 18 and
above at time of
diagnosis, call
the adult clinic
at
(864) 455-9033,
or for uninsured,
call New
Horizons
(864) 729-8330

Prisma Midlands
(803) 434-7995

For age 21 and
above at time of
diagnosis, call
Immunology
Center
(803) 545-5350

HopeHealth
(843) 664-3655
for all ages

MUSC
(843) 792-7485
for all ages

Alternative sites for screening

- Free, confidential site list for screening
 - <https://gettested.cdc.gov/>
- Drug store OTC test kits ~\$40
- Blood donation

Summary

- Screen because HIV is prevalent in our teens and young adults
 - HIV is high in SC, and is targeted for End the HIV Epidemic campaign goals for our rural populations
- Screen on all sexually active teens and once by age 16
- Screen with HIV 4th generation
 - Add HIV viral load if acute symptoms or indeterminate result
- Screen positive → Counsel and refer to ID specialist for rapid start
- Questions?

PrEP and Adolescents

PrEP: A History

- 2012: TDF-FTC approved for adults
- 2018: approved for youth weighing at least 35 kg
- 2021: CAB-LA approved
- 2025: Lenacapavir approved



Clinical Trial	Participants	Success Rate
iPREX Study	MSM subjects and transgender women in sexual relationships with men	44% reduction in new HIV infections compared to placebo [5]
TDF2 Study	High-risk individuals in Botswana	62.2% efficacy in preventing HIV infections [23]
Partners Study	Serodiscordant heterosexual couples in Kenya and Uganda	TDF: 67% efficacy; FTC/TDF: 75% efficacy in preventing HIV transmission [24]
PROUD Study	MSM populations	Daily TDF/FTC: Effective in reducing the risk of HIV infection [20]
IPERGAY Study	MSM populations	On-demand TDF/FTC: Effective in reducing the risk of HIV infection [25]
DISCOVER Trial	Cisgender men and transgender women	TAF/FTC: Non-inferior to TDF/FTC, providing another option for HIV prevention [26]
CAPRISA 004	Cisgender heterosexual women	Reduction in the risk of HIV infection demonstrated with optimal adherence [27]
FACTS-001 with Tenofovir	Cisgender heterosexual women	Reduction in the risk of HIV infection demonstrated with optimal adherence [28]
ASPIRE	Ring Study Team with Dapivirine	Cisgender heterosexual women [29]
FEM-Prep Study	HIV-negative women in Kenya, South Africa, and Tanzania	No statistically significant reduction in HIV infections observed [30]
Voice Study	HIV-negative women in South Africa, Zimbabwe, and Uganda	No significant reduction in HIV infections observed [31]
Maraviroc (MVC) Trial	Various populations	Did not demonstrate efficacy [32]
éclair	HIV-uninfected individuals at low risk of infection	Safety of CAB-LA [33]
HPTN077	HIV-uninfected individuals at low risk of infection	Safety of CAB-LA [34]
HPTN 083	MSM subjects and transgender women in sexual relationships with men	CAB-LA: 66% lower risk of HIV infection compared to the TDF-FTC group [35].
HPTN084	Cisgender heterosexual women	CAB-LA: 88% lower risk of infection compared to the TDF/FTC group [36]

PrEP Options

Daily oral HIV PrEP



On demand 2-1-1



Long-acting injectable

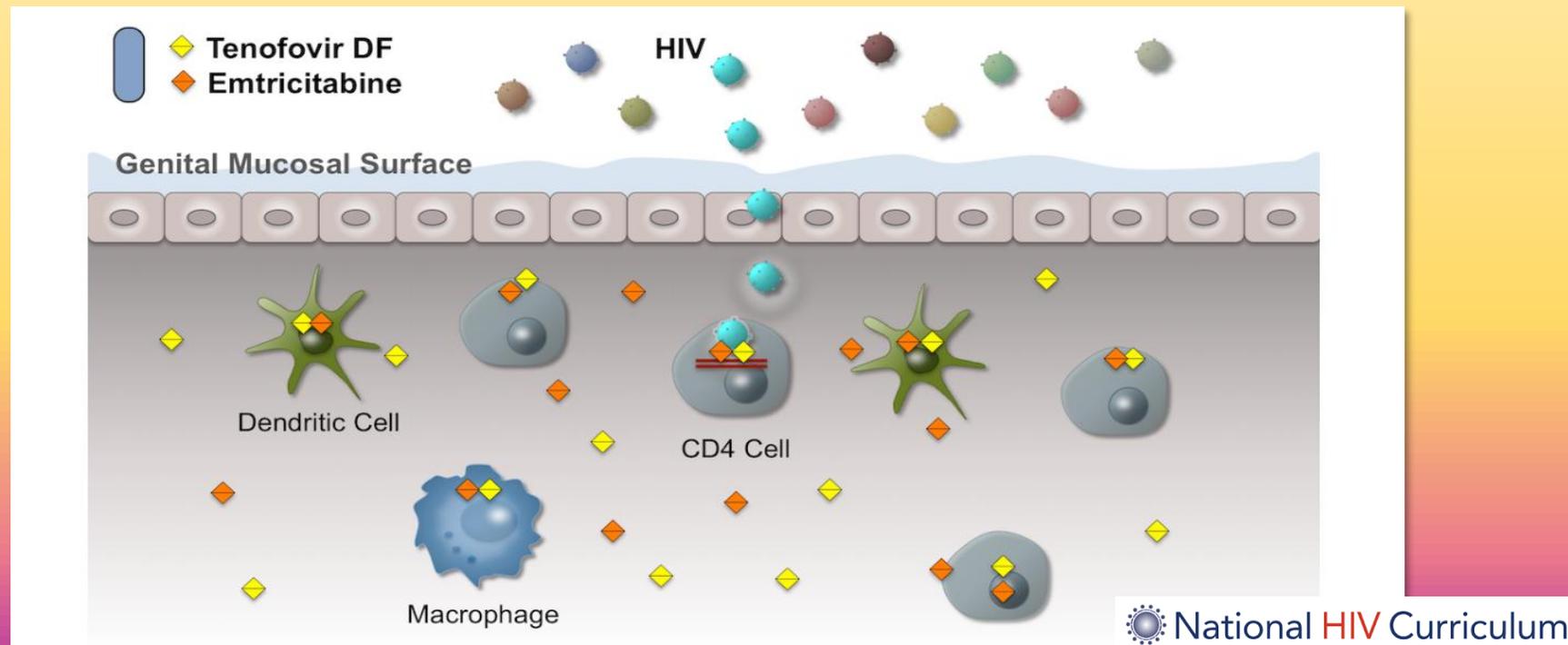


Options for PrEP: Adolescents weighing at least 35 kg

- Risk factor: any sex
 - TDF-FTC (Truvada®) daily
 - CAB-LA every other month, not approved during pregnancy
 - Lenacapavir twice a year
- Risk factor: not receptive vaginal sex
 - TAF-FTC (Descovy®) daily
 - TDF-FTC on demand for age 18 and up
- Risk factor: injection drug use
 - TDF-FTC daily

Mechanism of Action of PrEP

- PrEP achieves high intracellular concentration within the cells of the genital and rectal mucosa, blocking core intracellular viral replication processes

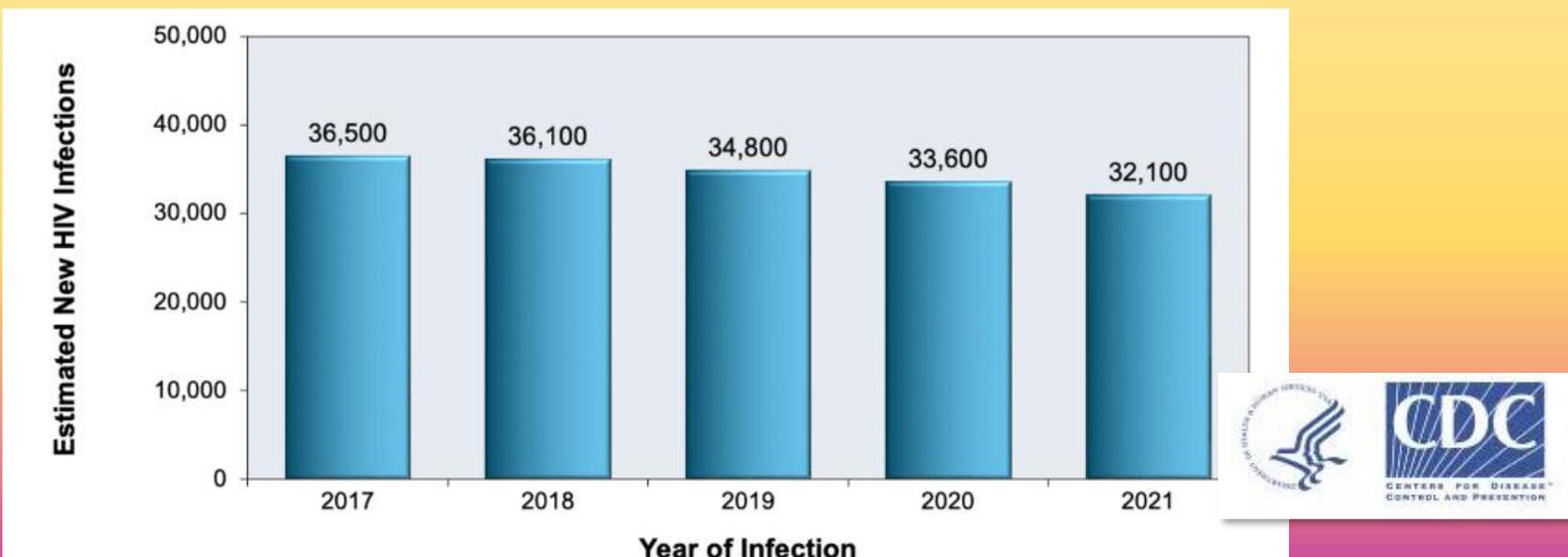


Mechanism of Action of PrEP

- After taking tenofovir DF, drug levels peak in blood cells and rectal tissue in ~ 7 days and cervical tissue in ~20 days
- There is no data for TAF or cabotegravir
- There is no consensus for therapeutic levels
- IAS-USA HIV 2022 Guidelines suggests:
 - 7 day lead-in time with daily PrEP
 - 7 day lead-in with cabotegravir injection (more research needed)
 - No lead-in time if a double-dose is taken on Day 1 for daily PrEP for cis gender men (extrapolated from 2-1-1 data)

The Need for PrEP

- Preventive and risk-reduction measures have helped decrease new infections, albeit slowly
- 2022 saw a decrease: ~32,000 new HIV infections, driven mostly by a 34% decrease in new infections among 13-24 year olds



HIV TREATMENT AND PREVENTION ARE IMPROVING AMONG YOUNG GAY AND BISEXUAL MALES

KNOWLEDGE OF HIV STATUS, VIRAL SUPPRESSION, AND PREP COVERAGE
AMONG YOUNG PEOPLE IN THE U.S., 2017-2021

AMONG YOUNG GAY AND BISEXUAL MALES AGES 13-24

Knowledge of HIV status

increased from about



Viral suppression percentages

increased from about

*Among those with diagnosed HIV in
47 states and the District of Columbia



AMONG ALL 16- TO 24-YEAR-OLDS WHO COULD BENEFIT FROM PREP

PrEP prescriptions increased from about



Source: Centers for Disease Control and Prevention



Increased knowledge of their status



Increased viral suppression



Increased PrEP prescriptions



More than half of all new HIV infections are in the South



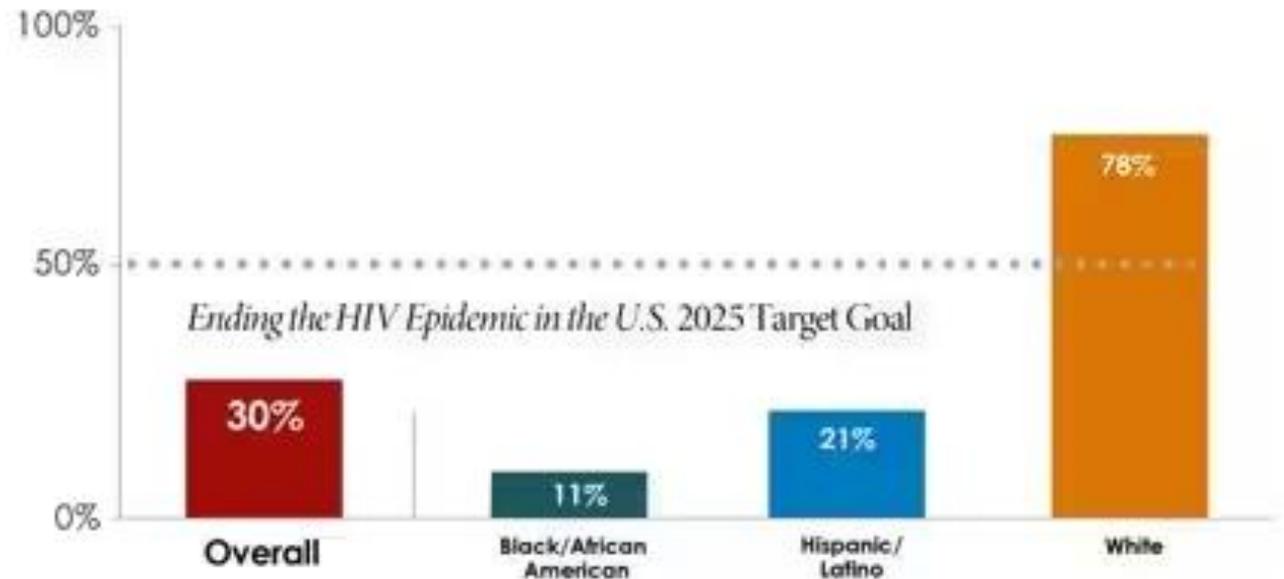
19% of new HIV diagnosis in 2021 were among young people ages 13-24



The majority of people who could benefit from PrEP are Black and Hispanic/Latino, but the majority prescribed PrEP are White

WHILE NEARLY ONE-THIRD OF PEOPLE ELIGIBLE FOR PREP WERE PRESCRIBED IT IN 2021, **STARK DISPARITIES REMAIN**

ESTIMATED PREP COVERAGE IN THE U.S., BY RACE/ETHNICITY, 2021*



*Data unavailable for other races/ethnicities.

Source: Centers for Disease Control and Prevention

Screening for PrEP: Risk Assessment

- Adolescents weighing >35 kg with the following risk factors
- Have had anal or vaginal sex in the past 6 months and any of the following:
 - Partner with HIV
 - Bacterial STI within the past 6 months
 - History of inconsistent or no condom use with partners
- Persons who inject drugs and
 - Has an injecting partner who has HIV
 - Shares injection equipment
 - Has sexual risk factors for acquiring HIV

PrEP in Teens: Efficacy and Adherence

- FDA approved for teens 35 kg and above in 2018
- ATN082¹: US study, 68 MSM participants ages 18-22 years for 24 weeks daily TDF/FTC
 - No seroconversion
 - 62% had protective drug level at week 4, 20% at week 24
- ATN113²: US study, 78 MSM participants ages 15-17 years for 48 weeks daily TDF/FTC
 - Seroconversion rate 6%
 - 54% had protective drug levels at week 4, 28% at week 24, and 22% at week 48
 - Safe and well tolerated
 - 15-19 yo had larger, more persistent decline in bone mineral compared to older participants³
- CHAMPS PlusPills⁴: South African study, enrolled 148 people ages 15-19 years for 52 weeks daily TDF/FTC
 - 1 seroconversion in an opt-out female
 - 92% had protective drugs levels at week 12, 52% at week 52
 - Safe and well tolerated

1 Hosek SG et al. J Acquir ImmuneDefic Syndr. 2013 Apr 1; 62(4))

2 Hosek SG et al. JAMA Pediatr. 2017 Nov; 171(11)

3 Havens PL et al. AIDS Res Hum Retroviruses. 2019 Feb 1: 35(2)

4 Gill K et al. Lancet Child Adolesc Health. 2020 Dec; 4(12)

Daily PrEP Adherence in Teens

- Daily PrEP has shown lower adherence rates in teens and young adults, consistent with lower adherence rates in teens and young adults with other daily medication needs¹
- 2022 meta-analysis of 29 studies with 8600 adolescents and young adults showed 64% adherence²
 - Adherence was reported as self-reported, biological, or pharmacologic
 - Definition of adherence varied from 4-7 x a week of daily PrEP
 - Interventions to promote adherence did not make an impact: free PrEP, counseling, transportation, insurance and pharmaceutical company assistance, phone call, apps
 - Lowest adherence among cis-gender women (46%) compared to MSM (65%)
 - Discordant couples have highest adherence at 95%

1 <https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf>

2 Allison BA, et al. J Adolesc Health 2022 Jan; 70(1)

PrEP Adherence in Teens

- Of 197 young MSM (16-29 years) on PrEP, 33% had stopped by 6 months time
 - Most common reasons for discontinuing: difficulty getting to appointments, lapse in insurance coverage, and perception of no longer being at risk
- Regular screening for the continued need or desire to stop PrEP is essential, screening for barriers and counseling on ways you may help

Will PrEP make teens have more sex?

- Meta-analysis showed increased bacterial STI in MSM on PrEP
- Systematic review was not conclusive
- Clinical trials have been mixed

Who's prescribing PrEP to teens?

- 2021 Prescribers
 - Of 4500 providers who prescribed PrEP for adolescents
 - 54% were MDs, 45% were NPs or PAs
 - Largely generalists: pediatricians, family doctors, followed by adolescent and internal medicine doctors

TABLE 2 Characteristics of Providers who Prescribed PrEP to Adolescents in 2021

	Total	Providers of Adolescents Aged 13–17 Years ^a	Providers of Adolescents Aged 18–19 Years ^a	Providers of Male Adolescents ^a	Providers of Female Adolescents ^a
	<i>N</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)
Total number of providers	4576 (100.0)	783 (100.0)	4048 (100.0)	3966 (100.0)	904 (100.0)
Provider type ^b					
Physician	2455 (53.7)	456 (58.2)	2105 (52.0)	2094 (52.8)	467 (51.7)
NP or PA	2077 (45.4)	316 (40.4)	1908 (47.1)	1839 (46.4)	424 (47.0)
Physician specialty ^c					
Pediatrics	727 (29.6)	217 (47.6)	567 (26.9)	623 (29.8)	148 (31.7)
General peds	520 (21.2)	147 (32.2)	398 (18.9)	437 (20.9)	102 (21.8)
Adolescent medicine	136 (5.5)	47 (10.3)	115 (5.5)	125 (6.0)	31 (6.6)
Pediatric infectious disease	55 (2.2)	20 (4.4)	40 (1.9)	47 (2.2)	13 (2.8)
Other pediatric subspecialty	16 (0.7)	3 (0.7)	14 (0.7)	14 (0.7)	2 (0.4)
General practice, family medicine, or preventive medicine	1007 (41.0)	128 (28.1)	912 (43.3)	909 (43.4)	134 (28.7)
Internal medicine	548 (22.3)	55 (12.1)	506 (24.0)	499 (23.8)	70 (15.0)
General internal medicine	332 (13.5)	33 (7.2)	304 (14.4)	304 (14.5)	38 (8.1)
Adult infectious disease	189 (7.7)	19 (4.2)	177 (8.4)	172 (8.2)	24 (5.1)
Other medicine subspecialty	27 (1.1)	3 (0.7)	25 (1.2)	23 (1.1)	8 (1.7)
Obstetrics and gynecology	41 (1.7)	11 (2.4)	30 (1.4)	13 (0.6)	31 (6.6)
Emergency medicine	94 (3.8)	29 (6.4)	68 (3.2)	25 (1.2)	71 (15.2)
Other specialty	38 (1.5)	16 (3.5)	22 (1.0)	25 (1.2)	13 (2.8)

TABLE 1 Characteristics of Adolescents Aged 13 to 19 y Prescribed PrEP in 2021

	Total	Age 13–17 Years	Age 18–19 Years		Male Sex	Female Sex	
	<i>N</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>P</i>	<i>n</i> (%)	<i>n</i> (%)	<i>P</i>
Total	6444 (100.0)	784 (100.0)	5660 (100.0)	—	5325 (100.0)	1116 (100.0)	—
Sex ^a							
Male	5325 (82.6)	528 (67.3)	4797 (84.8)	<i>P</i> < .001	—	—	—
Female	1116 (17.3)	256 (32.7)	860 (15.2)		—	—	—
Region ^b							
Northeast	1340 (20.8)	185 (23.6)	1155 (20.4)	<i>P</i> = .03	1125 (21.1)	214 (19.2)	<i>P</i> < .001
Midwest	1087 (16.9)	109 (13.9)	978 (17.3)		952 (17.9)	135 (12.1)	
South	2638 (40.9)	315 (40.2)	2323 (40.0)		2021 (38.0)	616 (55.2)	
West	1342 (20.8)	172 (21.9)	1170 (20.7)		1201 (22.6)	141 (12.6)	
Urbanicity							
Rural	334 (5.2)	41 (5.2)	293 (5.2)	<i>P</i> = .95	303 (5.7)	31 (2.8)	<i>P</i> < .001
Urban	6110 (94.8)	743 (94.8)	5367 (94.8)		5022 (94.3)	1085 (97.2)	
Prescription payer type							
Public insurance	2146 (33.3)	399 (50.9%)	1747 (30.9)	<i>P</i> < .001	1644 (30.9)	502 (45.0)	<i>P</i> < .001
Private insurance	2232 (34.6)	202 (25.8)	2030 (35.9)		2020 (37.9)	211 (18.9)	
Pharmaceutical Medication Assistance Program	657 (10.2)	45 (5.7)	612 (10.8)		510 (9.6)	146 (13.1)	
Other assistance program ^c	79 (1.2)	11 (1.4)	68 (1.2)		63 (1.2)	16 (1.4)	
Cash	188 (2.9)	30 (3.8)	158 (2.8)		153 (2.9)	35 (3.1)	
Unknown	1142 (17.7)	97 (12.4)	1045 (18.5)		935 (17.6)	206 (18.5)	

PrEP, HIV preexposure prophylaxis; —, not applicable.

^a There were 3 adolescents with PrEP prescriptions with unknown sex.

^b There were 37 adolescents with unknown region of residence.

^c Other assistance programs include federal and state assistance programs, vouchers, discount cards, and other programs.

Who's covering PrEP for teens?

- 2021 Payers
 - Overall, 35% private insurance, 33% public insurance
 - Among younger adolescents (13 to 17 years) half had public insurance coverage for PrEP, compared with 30% of older adolescents (18 to 19 years)
 - 10% used pharmaceutical assistance programs

Overcoming Obstacles to Providing PrEP to Teens

Parent

- Parental monitoring (parental soliciting of information and adolescent disclosure of information, and parental control/boundaries) and parental recognition of autonomy is associated with reduced risk behavior and increased protective behavior
- Parental recognition of autonomy is associated with medication adherence in chronic illness¹
- Parent/child conversations about HIV are associated with adolescent PrEP knowledge, as seen by an earlier study in adolescent MSMs²
 - Parents who communicated more openly, honestly, with knowledge and were trustworthy had children who reported more positive attitude about PrEP
 - Parents play an important part in influencing the risk behaviors and PrEP knowledge, engagement, and adherence of their children

1 MMWR. 2020. April 24, Vol 69 (3)

2 Thoma BC, et al. J Acquir Immune Defic Syndr. 2018 Dec

Provider

- “Purview Paradox”: Who’s best suited to provide PrEP, the PCP or the specialist?¹
- Cultivate good community relationships
- National hotline
- CME and other educational resources
 - National HIV Curriculum
- Familiarize yourself with your state’s laws and regulations around consent of a minor and providing HIV services
- Familiarize yourself with your EMR’s notification system and patient portal, and be cognizant of what you include in your notes

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PrEP: Pre-Exposure Prophylaxis



Clinically supported advice on PrEP for healthcare providers

Up-to-date clinical consultation for PrEP decision-making, from determining when PrEP is an appropriate part of a prevention program to understanding laboratory protocols and follow-up tests.

See our [PrEP Quick Guide](#) for answers to the most frequently asked questions.

[Submit a Case for Consultation](#)

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[SUBMIT](#)

[Call for a Phone Consultation](#)

844-ASK-NCCC or 844-275-6222

Monday through Friday, 8 a.m. to 4 p.m.

PT, excluding holidays

[CALL](#)

Provider

- Time without the parent in the room is recommended to start at age 11 years
- HEEADDSS assessment (Home, education, employment, activity, drugs, depression, sexuality, safety)
- Familiarize yourself with and discuss up front with your patient...
 - Your state's laws and regulations around consent of a minor and providing HIV services
 - Your EMR's notification system and patient portal, and be cognizant of what you include in your notes
 - HIV + results: flipping to treatment, HIV care services, partner notification by local public health officials

Age of Medical Consent

- Know your state laws for general care for consent, confidentiality, parental disclosure, procedures, services, and reporting to local agencies and discuss these limits with your patient
- Know the regulations specifically for STD and HIV testing, treatment, prevention
- 2022: minors can consent to receive STD services¹
 - Jurisdictions differ for age of “minor”
 - PrEP may not be explicitly listed, and can be considered under broader HIV and/or STD services
- AAP State Advocacy team (email stgov@aap.org) can help further with laws and legislation surrounding minors in your state²

¹ <https://www.cdc.gov/hiv/policies/law/states/minors.html>

² Hsu KK et al. Pediatrics. 2022. Jan 1; 149(1): e2021055207

Jurisdiction	Age of Majority	STD Diagnosis & Treatment (n=50)	STD Prevention (n=14)	HIV Testing (n=18)	HIV Treatment (n=6)	HIV Prophylaxis (n=4)	General Health Care Services or Procedures, Not Specific to a Disease or Condition (n=12)	Physician may but is not required to inform parent or guardian ²
Alabama	19	✓ (12 or older)					✓ (14 or older)	Yes
Florida	18	✓		✓				No
Georgia	18	✓		✓	✓			Yes
Kentucky	18	✓						Yes
Mississippi	21	✓					✓ * (18 or older)	No
North Carolina	18	✓	✓	✓ *				No
South Carolina	18						✓ (16 or older)	No
Tennessee	18	✓						No

n= Represents the number of states with a specific provision

Age of majority is the age at which a person is legally considered an adult with the full rights and responsibilities of an adult

✓ State has provision

*If parents/guardians are not immediately available, cannot be contacted, or unwilling/refuse to consent

If no age is listed for a provision, then there is no minimum age requirement for minors to access service

The information presented here does not constitute legal advice and does not represent the legal views of the CDC, nor is it a comprehensive analysis of all legal provisions relevant to HIV¹

Payment Help

- Most insurances, including Medicaid, are covering PrEP
- ~~Free medication program (Ready, Set, PrEP): No longer taking new enrollees as of July 30~~
 - ~~<https://www.getyourprep.com/>~~
- Co-pay assistance or no-cost program with HIV testing
 - <https://www.gileadadvancingaccess.com>
 - [1-855-330-5479](https://www.gileadadvancingaccess.com)
- State PrEP assistance for clinic visit and/or lab costs ~~(Florida)~~
 - <https://nastad.org/prepcost-resources/prep-assistance-programs>

How Can I Pay for PrEP?

This resource can help you find programs to assist in paying for HIV PrEP medication and services, like lab tests and clinic visits.



Need a provider?

Any health care provider licensed to write a prescription can prescribe PrEP. Specialization in infectious diseases or HIV medicine is not required.

YES



[Find Resources Here](#)



Do you have insurance?

No

Yes, but I still can't afford PrEP.

Yes

If you do not have health insurance, you may be eligible to receive PrEP medicine for free from:

- Drug Manufacturers Patient Assistance Programs
- Patient Assistance Programs for Accessing PrEP via Telemedicine
- Health Center Programs

If you have health insurance but need help paying for your PrEP medication, you may be eligible to receive co-pay assistance from:

- Drug Manufacturers Co-payment Assistance Programs
- Co-payment Assistance Programs for Accessing PrEP via Telemedicine
- Patient Advocate Foundation
- Health Center Programs

If you have insurance, in most cases, the cost of PrEP medicine, lab tests, and clinic visits will be covered. To find out which PrEP medicine your plan covers without charge:

Do you have health insurance through your employer or have purchased it yourself?

YES



Check with your insurance company about PrEP coverage, or look on their drug formulary (drug list) online.

Have you bought your health plan through HealthCare.gov or a state-based Marketplace?

YES



Learn how to verify which PrEP medicine your plan covers without charge.

Are you on Medicaid?

YES



Check with your benefits counselor about PrEP coverage or look on your plan's drug formulary (drug list) online.

Are you on Medicare?

YES



Find which plans cover your drugs.



Do you live in CA, CO, FL, IN, MA, NM, OK, VA, or WA?

YES



Apply to participate in your State PrEP Assistance Program.



Are you eligible to receive care through the Indian Health Service (IHS)?

YES



Find PrEP services available at IHS health centers and most tribal health clinics.

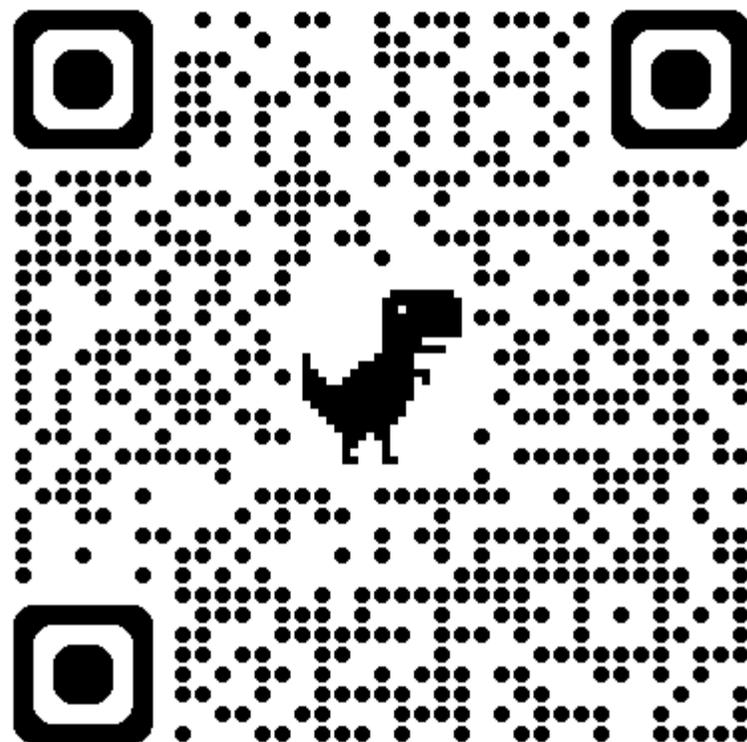


Are you eligible to receive care from Veterans Programs?

YES



Find PrEP services available for Veterans who use VA for their health care.



PrEP In the Office

Screening for PrEP

- Baseline HIV Ag/Ab with reflex or POC fingerstick
 - Before starting CAB, need HIV Ag/Ab AND HIV RNA test
- Cr
- Syphilis, chlamydia, gonorrhea testing
- Before starting TAF/FTC, need baseline lipid panel
- Immunizations: HepB, HPV
- Other STI prevention
- Pregnancy prevention
- Adherence needs

Monitoring during PrEP

- Oral PrEP: follow-up every 3 months
- Injectable PrEP: follow-up every 2 months (after the initial 1 month lead-in injection)
- HIV Ag/Ab with HIV RNA each visit
- Cr every 6-12 months on oral PrEP
- Lipid panel yearly if on TAF/FTC
- Hep C serology yearly for MSM, transgender women who have sex with men, and people who inject drugs
- Bacterial STI testing
 - MSM and transgender women who have sex with men: every 3-4 months
 - Heterosexually active men and women: every 6 months and chlamydia yearly
- Pregnancy tests at least every 3 months

Monitoring during PrEP

- Adherence
 - Studies show if you take it as directed, it works
 - Counsel that PrEP is not treatment dose
 - To decrease resistance potential, it is recommended to screen for HIV (HIV Ag/AB + HIV RNA) every 3 months on oral PrEP or at each injection visit if on CAB and prescribe no more than 90 day supply at a time of daily PrEP and 30 day supply of on-demand PrEP
- Side effects
- Signs/symptoms of acute HIV infection
- Is the form of PrEP working for their lifestyle?
- Pregnancy prevention
- STI prevention and screening

Stopping PrEP

- Repeat HIV testing
- Protection from oral PrEP wanes within several days
- Protection from injectable PrEP wanes 2 months after the last dose
 - *Levels of CAB can be detected for a year or more; to prevent resistance, oral PrEP should be used during this time if there are ongoing risk factors and quarterly screening of HIV should continue for at least 12 months after the last injection*

Newly Acquired HIV while on PrEP

- With newly acquired HIV, PrEP can alter HIV lab results: delayed seroconversion, indeterminate screen, low-level or undetectable HIV RNA
- Avoid POC HIV tests
- HIV RNA
- Genotype testing (with integrase genotype if on CAB)
- CD4
- Link into care, partner notification
- Initiate treatment regimen
 - Dolutegravir + tenofovir/FTC
 - Bictegravir/TAF/FTC
 - Boosted darunavir + tenofovir/FTC

Resistance while on PrEP

- Many studies have shown a low rate of developing resistance on PrEP
- iPrEX showed 2/48 people taking TDF/FTC developed mutations
- HPTN 083 showed 4/9 integrase mutations
- To decrease resistance potential, it is recommended to screen for HIV (HIV Ag/AB + HIV RNA) every 3 months on oral PrEP or at each injection visit if on CAB and prescribe no more than 90 day supply at a time of daily PrEP and 30 day supply of on-demand PrEP

nPEP to PrEP

- Anyone who has been on nPEP and has ongoing or anticipated risk factors should be offered PrEP
- Generally, testing for HIV during nPEP occurs at baseline, 6 weeks, and 3 months post-event
- Should PrEP be desired, begin immediately after completing the 28 day course of nPEP
 - Repeat HIV testing just prior to completing nPEP course (now your turnaround time)
 - Screen on signs/symptoms of acute HIV