Expanding Access

Optimizing Use of Long-Acting Injectable PrEP

This program has been supported by an independent educational grant from Gilead Sciences, Inc.

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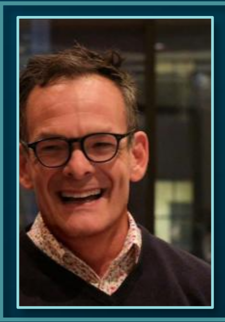

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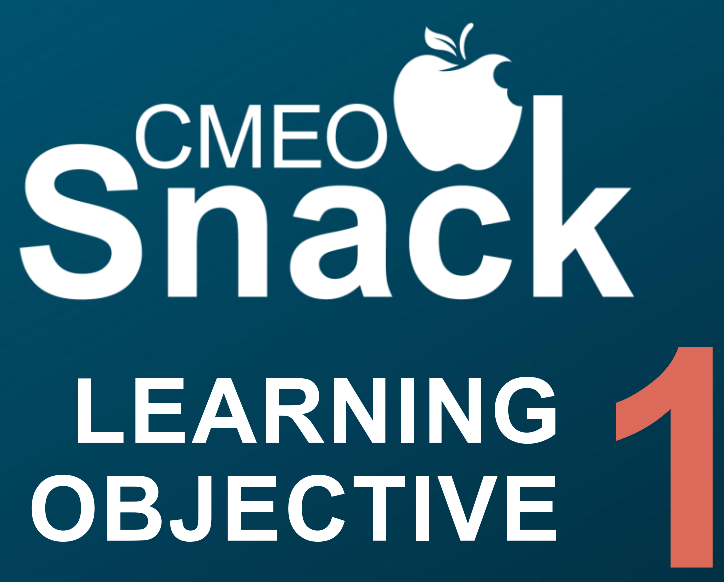


Differentiate between LAI PrEP options including optimal patient selection criteria, transitioning strategies, and monitoring considerations

Deep Dive into PrEP Options: Expanding the HIV Prevention Toolkit with LAI

The cornerstone of HIV prevention is **informed, patient-centered choice**—**made through** shared decision-making between the patient and the clinical care team.

Key Questions

- Which patients are most likely to benefit from LAI PrEP versus oral PrEP?
- When and how should clinicians transition patients from oral to LAI PrEP?
- What monitoring and implementation strategies are needed to ensure safe and effective use across diverse practice settings?

LAI = long-acting injectable; PrEP = pre-exposure prophylaxis.
Sewlll, WC, et al. *Curr HIV/AIDS Rep.* 2021; 18(1):48-56.

Who Benefits Most from Long-Acting Injectable PrEP?

People with ongoing HIV exposure risk

Individuals seeking discretion or reduced stigma

STIGMA

Individuals with challenges to daily oral adherence

Pregnant and post-partum women

Discussion:
What drove preference differences between regions?
Are LAIs substantially more effective than oral PrEP in preventing HIV acquisition in PBW and vertical transmission?
Was there a modest reduction in HIV incidence at a population level?

Baker D, et al. *J Gen Intern Med.* 2026 ;41(1):43-52. Centers for Disease Control and Prevention [CDC]. CDC Website. 2025. https://www.cdc.gov/hivnexus/hcp/prep/index.html. Johnson LF, et al. *AIDS*. 2024;38(4):589-594. Khan T, et al. 5th HIV Research for Prevention Conference. 2024. Abstract No. OA0502. https://www.natap.org/2024/HIVR4P/HIVR4P_29.htm. Wara NJ, et al. *J Int AIDS Soc*. 2023;26(5):e26088. World Health Organization [WHO]. WHO Website. 2025. https://www.who.int/news/item/14-07-2025-who-recommends-injectable-lenacapavir-for-hiv-prevention?.

PrEP Options: Routes, Dosing, and Key Considerations

Agent	Route	Schedule	Indications	Key Efficacy and Safety Considerations	Regulatory Status
Emtricitabine/ tenofovir disoproxil fumarate (TDF/FTC)	Oral	Daily	Indicated for PrEP in at-risk adults and adolescents ≥35 kg to reduce risk of sexually acquired HIV-1 infection; confirm HIV-1 negative status prior to initiation.	High efficacy with consistent daily adherence; renal function monitoring recommended; small decreases in bone mineral density observed; assess hepatitis B virus (HBV) status prior to initiation and monitor if discontinued.	FDA- and EMA-approved; recommended in WHO guidelines
Emtricitabine/ tenofovir alafenamide (TAF/FTC)	Oral	Daily	Indicated for PrEP in at-risk adults and adolescents ≥35 kg, excluding individuals at risk from receptive vaginal sex; confirm HIV-1 negative status.	High efficacy with daily adherence (noninferior to TDF/FTC in studied populations); smaller changes in renal and bone biomarkers vs TDF; assess HBV status prior to initiation.	FDA (U.S. only; excludes receptive vaginal sex)
Cabotegravir long-acting (CAB-LAI)	Intramuscular clinic-based administration	Every 2 months, (after 2 initiation injections 1 month apart)	Indicated for PrEP in at-risk adults and adolescents ≥35 kg.	High efficacy independent of daily oral adherence; injection every 2 months; confirm HIV-1 status prior to each dose; resistance risk if infection occurs during dosing delays or PK tail.	FDA- and EMA-approved for prevention
Lenacapavir long-acting	Subcutaneous injection by practitioner	Every 6 months after loading dose	Indicated for PrEP in at-risk adults and adolescents ≥35 kg.	High efficacy independent of daily adherence (clinical trial data); 6-month dosing interval following initiation regimen; clinician-administered injection; confirm HIV-1 negative status prior to dosing.	FDA-approved (U.S.) and European Commission–authorized (EU/EEA).
Dapivirine (DVR)	Vaginal ring (self-inserted)	Monthly	Indicated in select countries for use by cisgender women at high risk of HIV-1 infection.	Modest efficacy observed in clinical trials; locally administered; generally well tolerated; no significant systemic safety concerns identified in studies.	Approved by EMA and WHO; not FDA-approved

Indications and availability vary by country and regulatory authority (FDA, EMA, WHO, national ministries). Clinicians should consult local guidance to confirm approved PrEP options in their region. Cabotegravir [package insert]. https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/215499Orig1s004lbl.pdf. Emtricitabine and tenofovir alafenamide [package insert]. https://rsc.niaid.nih.gov/sites/default/files/emtricitabine-tenofovir-alafenamide-descovy-pi_june-2025.pdf. Emtricitabine and tenofovir disoproxil fumarate [package insert]. https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/021356s058%2C022577s014lbl.pdf. Lenacapavir [package insert]. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/220020s000lbl.pdf. Mayer KH, et al. *Lancet*. 2020;396(10246):239-254.

CME OUTFITTERS

Cabotegravir: Long-Acting Injectable (LAI) PrEP

LAI PrEP CAB-LA:

- FDA-approved December 2021 for PrEP in adults and adolescents ≥35 kg
- **MOA:** INSTI: blocks HIV DNA integration
- **Route of administration: Gluteal IM injection:** 600 mg at month 1, month 2, then every 2 months (with optional oral lead-in)
- **Efficacy, Effectiveness, and Implementation:**
  - Opera and Trio Health real-world cohorts demonstrated **> 99% effectiveness** (n = 1,300); 85% initiation, 69% on-time injection adherence; stigma reduction reported (PILLAR implementation study); Emerging data suggest CAB-LA was generally well tolerated when exposure occurred before or during pregnancy; data remain limited
- **Safety:** Safe, tolerable, and acceptable in clinical studies, supporting further implementation research in adolescent populations

EACS = European AIDS Clinical Society; IM = intramuscular; INSTI = integrase strand transfer inhibitor; MOA = mechanism of action.

Ambrosioni J, et al. *HIV Med*. 2026;27(1):18-32. Cairns G. aidsmap Website. 2022. https://www.aidsmap.com/news/feb-2022/injected-prep-cabotegravir-maintains-its-advantage-over-four-years. Fonner VA, et al. *AIDS*. 2023;37(6):957-966. İnan A, et al. *Infect Dis Clin Microbiol*. 2026;1:14-25. Landovitz RJ, et al. *Lancet HIV*. 2023;10(12):e767-e778. Mussini C, et al. *AIDS Behav*. 2025;29(1):64-76. National Institutes of Health [NIH]. NIH Website. 2024. https://www.nih.gov/news-events/news-releases/long-acting-injectable-cabotegravir-hiv-prevention-safe-pregnancy. Stranix-Chibanda L, et al. *Lancet HIV*. 2025;12(4):e252-e260.

Cabotegravir Summary: PrEP Efficacy and Safety Data

	HPTN 083 (N=4,566)	HPTN 084 (N=3,223)
Study Design	**Phase 2b-3, randomized, double-blind, double-dummy, noninferiority, active-controlled trial**	**Phase 3, randomized, double-dummy, active-controlled, superiority trial**
Methodology	• Participants were randomized 1:1 to receive either Q2M IM CAB 600 mg at Weeks 5, 9, and every 2 months thereafter + daily oral TDF/FTC placebo or oral daily TDF/FTC + Q2M IM CAB placebo at Weeks 5, 9, and every 2 months thereafter	• Participants were randomized 1:1 to receive either Q2M IM CAB 600 mg at Weeks 5, 9, and every 2 months thereafter + daily placebo or Oral daily TDF/FTC + Q2M IM CAB placebo at Weeks 5, 9, and every 2 months thereafter
Primary Endpoint	Incident HIV infection	
Study Population	**Cisgender men who have sex with men and transgender women at substantial risk for HIV acquisition** • **Argentina, Brazil, Peru, South Africa, Vietnam, Thailand, US**	**Cisgender women at substantial risk for HIV acquisition in high-incidence sub-Saharan African settings** • **Botswana, Eswatini, Kenya, Malawi, South Africa, Uganda, Zimbabwe**
Efficacy Outcomes	• Q2M IM CAB reduced HIV incidence **by 66%** compared with daily TDF/FTC (HR 0.34; 95% CI [0.18-0.62]; P<0.001) meeting criteria for superiority and consistent across prespecified subgroups • Following primary analysis, extended retrospective virologic testing was done to better characterize timing of HIV-1 cases; 1/13 incident cases in CAB group was reclassified as a baseline case • Adherence to CAB Q2M: Advantage over daily oral pill was observed	• Q2M IM CAB reduced HIV incidence **by 88%** compared with daily TDF/FTC (HR 0.12; 95% CI [0.05–0.31]; P<0.0001), after adjusting for site and the group-sequential design • Following primary analysis, extended retrospective virologic testing was done to better characterize timing of HIV-1 cases; 1/4 incident cases in CAB group was reclassified as a baseline case • Adherence to CAB Q2M: Advantage over daily oral pill was observed
Safety Data	Common non-ISR AEs (≥1%; across trial safety reporting) included diarrhea, headache, pyrexia, fatigue, nausea, dizziness The percentage of participants with non-ISR adverse events was similar between treatment and comparator groups in both studies CAB-LA was discontinued due to injection-site reactions in ~2% of participants in the CAB arm in HPTN 083	
Pregnancy Data	• N/A	• OLE showed CAB maternal and pregnancy outcomes to be consistent across CAB and TDF/FTC exposure groups with the expected background rates
Hypersensitivity Reactions[1]*	• Hypersensitivity reactions have been reported in association with integrase inhibitors including cabotegravir	

Q2M for PrEP* Identified during postmarketing use of CAB or CAB-containing regimens. Since these reactions are voluntarily reported from a population of unknown size, reliably estimating their frequency or confirming a causal link to drug exposure is not always feasible.

Availability and indications may vary by country. Confirm local regulatory guidance.

AE= adverse event; CI = confidence interval; HPTN = HIV Prevention Trials Network; HR = hazard ratio; ISR = injection-site reaction; OLE = open label extension; Q2M: every 2 months.

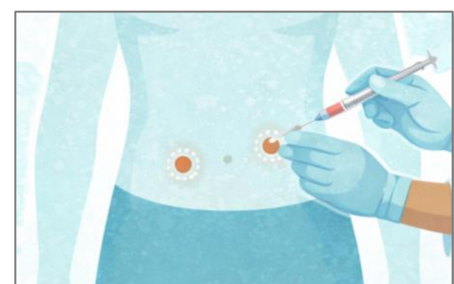
Cabotegravir [Package insert]. https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/215499s000lbl.pdf. Landovitz RJ, et al. *N Engl J Med*. 2021;385(7):595-608. Delany-Moretlwe S, et al. *Lancet*. 2022;399(10337):1779-1789. Delany-Moretlwe et al. International AIDS Conference; 2024. https://www.natap.org/2024/IAS/IAS_50.htm.

CME OUTFITTERS

Lenacapavir: LAI PrEP

LAI PrEP Lenacapavir

- FDA-approved June 2025 for HIV PrEP in adults and adolescents ≥35 kg
- **MOA:** Interferes with capsid-mediated processes including uncoating, nuclear import, and virion assembly
- **Route of administration: SC injection** every 6 months following oral and injectable loading doses
- **Efficacy:**
  - **PURPOSE 1** (cisgender women, Africa): no incident HIV infections in the lenacapavir arm; superior to oral TDF/FTC, with limited pregnancy exposure data; no safety signals identified to date
  - **PURPOSE 2** (cisgender men, gender-nonbinary & transgender populations): **met primary endpoint,** with superior reduction in HIV incidence compared with daily oral PrEP
- **Safety:** most common adverse events included injection-site reactions and nausea (≥3%, all grades); discontinuations due to adverse events were uncommon (1.2%)



AI-generated visuals

SC = subcutaneous; TDF/FTC = tenofovir/emtricitabine.

Availability and indications may vary by country. Confirm local regulatory guidance.

Bekker LG, et al. *N Engl J Med.* 2024;391(13):1179-1192. Jogiraju V, et al. *Lancet.* 2025;405(10485):1147-1154. Kelley CF, et al. *N Engl J Med.* 2025;392(13):1261-1276. Lenacapavir [package insert]. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/220020s000lbl.pdf. Mansoor LE, et al. Conference on Retroviruses and Opportunistic Infections [CROI]; 2025. Abstract No. 1230. https://www.croiconference.org/abstract/1160-2025/.

Lenacapavir Summary: Efficacy and Safety Data

	PURPOSE 1 (N=5,338)	PURPOSE 2 (N=3,265)
Study Design	Phase 3, double-blind, active-controlled, multicenter, randomized studies	
Methodology	• Background HIV-1 (bHIV) incidence – i.e., the HIV incidence expected without PrEP (same as placebo group), calculated in the screened population • Participants randomly assigned (2:2:1) to twice-yearly lenacapavir (LEN), once-daily F/TAF (emtricitabine/tenofovir alafenamide), or once-daily TDF/FTC (emtricitabine/tenofovir disoproxil fumarate) + corresponding oral tablet placebo or placebo injection[3]	• Background HIV-1 incidence calculated in the screened population • Participants randomized to twice-yearly LEN or once-daily TDF/FTC in a 2:1 ratio[4]
Primary Endpoint	Incident HIV infection	
Study Population	**Cisgender women at substantial risk for HIV acquisition in high-incidence settings** • **South Africa, Uganda**	**Cisgender men, transgender women, transgender men, and gender-diverse persons at substantial risk for HIV acquisition** • **United States, Mexico, Peru, Argentina, Brazil, South Africa, Thailand**
Efficacy Outcomes	• Twice-yearly LEN = **no incident HIV infections**, with a statistically significant reduction compared with background HIV incidence (P<0.001) and daily F/TDF (P<0.0001) • Adherence to LEN: Most injections were delivered on time	• Twice-yearly LEN reduced HIV incidence **by 96%** compared with bHIV incidence (P<0.001) and by 89% compared with daily TDF/FTC (*p*=0.002) • Adherence to LEN: Most injections were delivered on time
Safety Data	• Most common (≥1%) AEs reported in both PURPOSE 1 and PURPOSE 2 were ISRs; no hypersensitivity reactions reported • Percentage of participants with non-ISR AEs was similar in all groups in PURPOSE 1 (headache, UTI, genitourinary chlamydia) and PURPOSE 2 (rectal chlamydia, oropharyngeal and rectal gonococcal infection) • LEN was discontinued due to ISRs in 4 (0.2%) participants in PURPOSE 1 and 26 (1.2%) participants in PURPOSE 2	
Pregnancy Data	• Available pregnancy outcomes were consistent with expected background rates for the population.	N/A - participants assigned female at birth who had the ability to become pregnant were required to use contraception. None became pregnant.

AE = adverse event; CYP3A = Cytochrome P450, family 3, subfamily A; ISR = injection-site reaction; P-gp = P-glucoprotein; SmPc = Summary of Product Characteristics; USPI = United States prescribing information; UTI = urinary tract infection.

Availability and indications may vary by country. Confirm local regulatory guidance.

Bekker LG, et al. *N Engl J Med*. 2024;391(13):1179-1192. Kelley C, et al. *N Engl J Med*. 2025;392(13):1261-1276. Lenacapavir [package insert]. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/220020s000lbl.pdf.

Benefits and Differences in LAI PrEP

CAB-LA

IM injection: 1 dose → 1 month → every 2 months

Twice-Yearly Lenacapavir*

SC injection every 6 months: initiation requires oral tablets + injection

Dosing and administration routes affect initiation, patient education, and preferences

*Lenacapavir is not FDA-approved for IM injection of HIV PrEP.
Availability and indications may vary by country. Confirm local regulatory guidance.

Cabotegravir [package insert]. https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/215499Orig1s004lbl.pdf.
Lenacapavir [package insert]. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/220020s000lbl.pdf.

What's on the Horizon for PrEP?

Key Considerations for Initiating PrEP Following Results

Before Initiation → HIV-Negative Required

- Confirm HIV-negative with 4th-gen Ag/Ab test
  - Offering same day PrEP service increases uptake and retention
- If recent high-risk exposure or acute symptoms → add HIV NAAT or RNA PCR
- Prevents resistance

Testing Cadence by PrEP Type

- Daily oral PrEP (TDF/FTC, TAF/FTC) → q3M
- CAB-LA (q2M injection) → before each injection
- Lenacapavir (q6M injection) → HIV testing is recommended before each injection, but protocols may allow more flexibility in timing and methods (e.g., NAAT or antigen/antibody test), compared to stricter CAB-LA requirements

NAAT = nucleic acid amplification test; PCR = polymerase chain reaction; q = every; M = month.

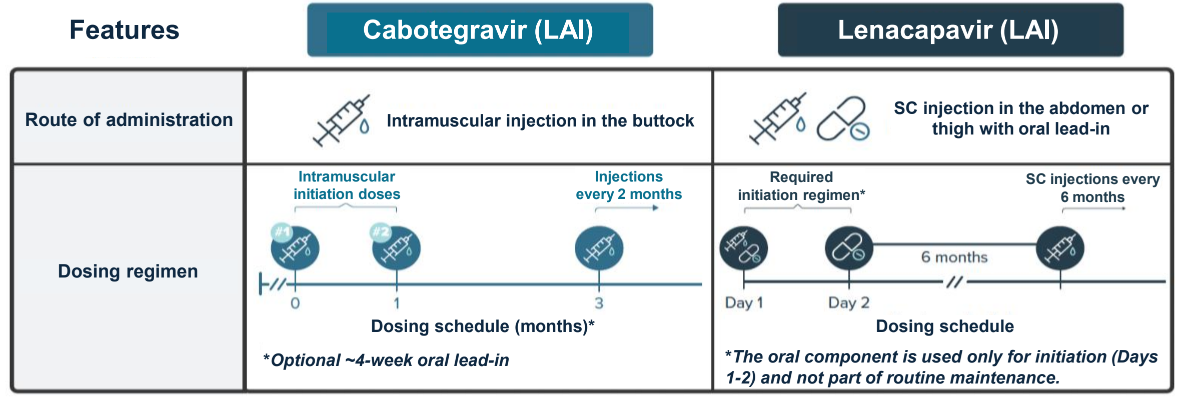
Centers for Disease Control and Prevention [CDC]. CDC Website. 2025. https://www.cdc.gov/hivnexus/hcp/prep/index.html. Wiser AL. Cleve Clin J Med. 2024;91(6):361-371.

Switching Considerations: Transitioning from Oral to LAI PrEP

Clinical tips:

- **Do not delay LAI initiation if the patient is ready and testing is appropriate**
- **Keep in mind, switching should be planned carefully to avoid gaps in HIV protection**

- Patients may transition from oral PrEP to LAI PrEP for clinical, behavioral, or preference-based reasons.
- Considerations when switching from oral PrEP to LAI PrEP:
  - Confirm HIV-negative status immediately before initiation
  - Oral lead-in with cabotegravir is optional and based on patient preference
  - Lenacapavir requires oral initiation dosing and should not be skipped
  - Schedule follow-up visits at the time of the first injection



Landovitz RJ, et al; *JAMA.* 2025;334(7):638-639. Mills A, et al. *AIDS*. 2022 Feb 1;36(2):195-203. Vail R, et al. New York State Department of Health AIDS Institute Website. 2025. https://www.hivguidelines.org/guideline/hiv-prep/#toc_7v7e7xuq. Vail R, et al. New York State Department of Health AIDS Institute Website. 2025. https://www.hivguidelines.org/guideline/hiv-prep-len.

Monitoring Protocols, STI Screening, and SDoH Considerations

Monitoring for LAI differs from oral PrEP

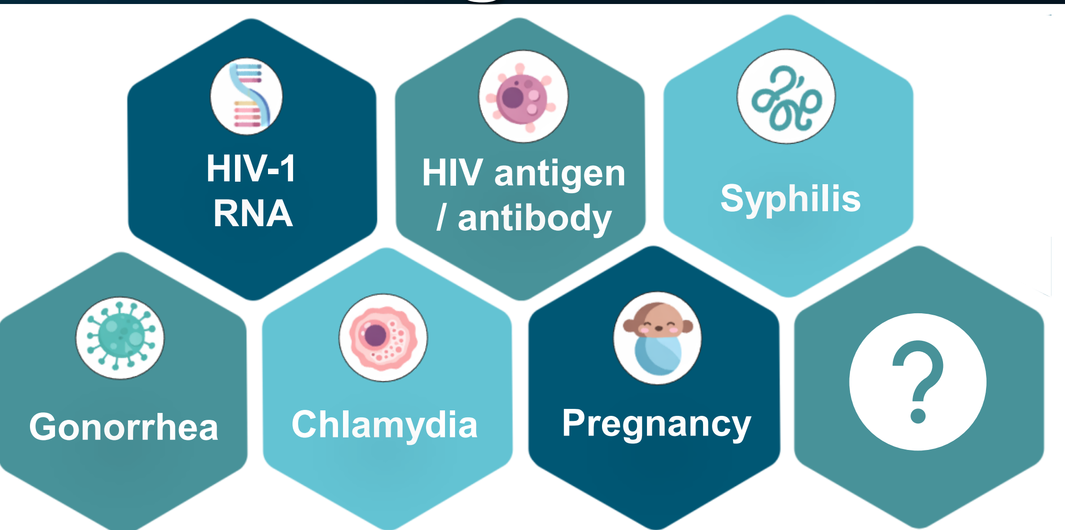
- LAI requires visits every 2-6 months
  - More visits necessary with CAB-LA vs lenacapavir
  - Re: CAB-LA, instead of the q3M visits for oral PrEP, patients would come in q2M
  - Opportunity to ↓ clinic burden and ↑ access through providing sites for injection administration
- Timely injections are crucial
  - Missed doses may negatively impact protection; what to do for missed or delayed dose
    - *Discussion on next slide*
- Clinics need to incorporate organizational systems:
  - Track injection schedules and follow up on missed visits

Patient-centered SDoH must be considered (e.g., work leave, transportation, housing, insurance, and socioeconomic barriers)

SDoH = social drivers of health; STI = sexually transmitted infection.

Miller AS, et al. *J Urban Health.* 2023;100(1):212-214. Parikh UM, et al. *Open Forum Infect Dis.* 2025;12(6):ofaf285. Patel RR, et al. *MMWR Morb Mortal Wkly Rep*. 2025;74(35):541-549. PrEPWatch. PrEPWatch Website. 2024. https://www.prepwatch.org/wp-content/uploads/2024/07/The-Lens-on-LEN.AVAC-primer.July-2024.pdf.

Considerations while on treatment: ongoing monitoring



Expert Discussion: How should STI screening cadence be operationalized when injection intervals extend (e.g., 2- or 6-month dosing), while maintaining risk-based testing per guidelines?

- Align STI screening cadence with injection scheduling while maintaining guideline-recommended risk-based intervals (e.g., q3-6 months)
- Build workflows to prevent missed STI testing when injection intervals extend (e.g., future agents)
  - Site-specific, relation to injection intervals

Miller AS, et al. *J Urban Health.* 2023;100(1):212-214. Parikh UM, et al. *Open Forum Infect Dis.* 2025;12(6):ofaf285. Patel RR, et al. *MMWR Morb Mortal Wkly Rep*. 2025;74(35):541-549. PrEPWatch. PrEPWatch Website. 2024. https://www.prepwatch.org/wp-content/uploads/2024/07/The-Lens-on-LEN.AVAC-primer.July-2024.pdf.

Clinical Tips: Missed or Delayed Injection Management

Scenario	Cabotegravir LA	Lenacapavir
Planned Delayed Injection	If a patient plans to miss a scheduled every-2-month continuation injection visit by >7 days, oral cabotegravir 30 mg once daily may be taken for up to 2 months to replace 1 missed injection. The first oral dose should be taken approximately 2 months after the last injection. Restart injection on the day oral dosing completes or within 3 days thereafter. For oral PrEP durations >2 months, an alternative oral regimen is recommended.	If a scheduled 6-month injection is anticipated to be delayed by >2 weeks, lenacapavir tablets 300 mg orally once every 7 days may be used on an interim basis (for up to 6 months if needed) until injections resume. Resume injection within 7 days after the last oral dose.
Unplanned Missed Injection	If a scheduled injection visit is missed or delayed by >7 days and oral dosing has not been taken in the interim, clinically reassess to determine if resumption remains appropriate. If second injection is missed and time since first injection is: • ≤2 months: Administer 600 mg IM as soon as possible, then continue every 2 months. • >2 months: Restart with 600 mg IM, followed by 600 mg IM 1 month later, then continue every 2 months. If third or subsequent injection is missed and time since prior injection is: • ≤3 months: Administer 600 mg IM as soon as possible, then continue every 2 months. • >3 months: Restart with 600 mg IM, followed by 600 mg IM 1 month later, then continue every 2 months.	Individuals who miss a scheduled injection visit should be clinically reassessed to ensure resumption remains appropriate and that the individual remains HIV-1 negative. During continuation dosing, if >28 weeks have elapsed since the last injection and tablets have not been taken, reinitiate with the initiation dosing schedule from Day 1 and then continue continuation dosing.
Key Practical Distinction	Shorter dosing interval with defined 2- and 3-month restart thresholds.	Longer dosing interval (26 weeks) with weekly oral option during anticipated delays; restart required if >28 weeks without oral dosing.

Individuals who miss a scheduled injection visit should be clinically reassessed to ensure resumption remains appropriate.
Test for HIV-1 infection prior to initiating CAB LA or Lenacapavir and prior to each injection, in accordance with the respective prescribing Information.
Cabotegravir [package insert]. https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/215499Orig1s004lbl.pdf. Centers for Disease Control and Prevention [CDC]. CDC Website. 2025. https://www.cdc.gov/hivnexus/hcp/prep/index.html. Landovitz RJ, et al. *Lancet HIV*. 2020;7(7):e472-e481. Landovitz RJ et al. *NEJM*. 2021;385(7):595–608. Lenacapavir [package insert]. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/220020s000lbl.pdf. Marzinke MA, et al. *J Infect Dis*. 2021;224(9):1581-1592.

Addressing Barriers to Care Social Drivers of Health

SDOH

Food Insecurity
→ Screen respectfully, connect to community food programs

Housing
→ Acknowledge instability, refer to social work/community resources

Pharmacy Access
→ Assess for insurance, work schedules, cost barriers; advocate

Literacy & Language Barriers
→ Use teach-back, plain language, interpreters, education

Transportation
→ Help arrange rideshares, vouchers, or mobile clinics

Bailey K, et al. *Pediatrics*. 2024;153(1):e2023062275. Bussell JK, et al. *Clin Diabetes*. 2017;35(3):171-177. Ebeywa E, et al. *J Nurse Pract*. 2021;17(10):1292-1296. Lathrop B. *Nurs Womens Health*. 2020;24(1):36-44. National Academies of Sciences, Engineering, and Medicine. *The Future of Nursing 2020–2030: Charting a Path to Achieve Health Equity.* 2021. https://www.ncbi.nlm.nih.gov/books/NBK573914/. Centers for Disease Control and Prevention [CDC]. CDC Website. 2025. https://www.cdc.gov/hivnexus/hcp/prep/index.html. Harrison SE, et al. *AIDS Care*. 2022;34(11):1435-1442.

Wrap Up: Important Considerations for LAI PrEP

- **Optimal patient selection:**
  - Individual preference, adherence challenges, stigma concerns, high-risk populations
- **Transitioning patients from oral → LAI PrEP:**
  - Requires careful timing and overlap
- **Monitoring:**
  - Confirm HIV-negative status at each injection, track injection adherence
- **Implementation challenges:**
  - Staffing for injection visits and follow-up
  - Prior authorizations, insurance approvals, and billing work; global considerations
  - Logistics: storage, ordering, and drug availability on site

Dedicated personnel or teams improve success of LAI PrEP programs

Baker D, et al. *J Gen Intern Med.* 2026; 41(1):43-52. Khan T, et al. 5th HIV Research for Prevention Conference. 2024. Abstract No. OA0502. https://www.natap.org/2024/HIVR4P/HIVR4P_29.htm.

AI-generated visuals
Tools available at https://www.cmeoutfitters.com/infectious-disease-hub/.

Using patient education tools in practice to discuss options, and weigh switching, in supportive not prescriptive ways

"My job is to provide you with information… "

- Start with patient goals + preferences
- Match option to routine + access realities
- Confirm understanding + plan for follow-up/testing

“Taking time by **personal contact** or consultation is the best option I have received. It could be by **phone, in-person or online meeting**, but it needs to make a feeling of **carefulness and empathy** rather than just giving information.”

- A patient who is receiving PrEP

SMART Goals

Specific, Measurable, Attainable, Relevant, Timely, Inclusive and Equitable

Put information into action! Consider the following goals; then *set a time frame* that fits with your work environment and *a reasonable improvement target* that aligns with your patient population.

- Incorporate a structured, patient-centered PrEP options discussion into initiation visits that clearly explains the available oral and LAI PrEP options by dosing schedule, administration route, visit frequency, and monitoring requirements, and document how the selected option aligns with the patient's risk profile, preferences, and anticipated adherence patterns, **within 30 days.**
- Implement a standardized transition protocol **for all patients** initiating or switching to LAI PrEP that includes confirmation of HIV-negative status (with appropriate RNA testing when indicated), counseling on oral lead-in requirements and missed-dose management, and scheduling of follow-up injections to prevent gaps in protection **in the next 60 days**.
- Integrate a structured patient selection framework into clinical workflow that assesses ongoing HIV exposure risk, prior oral PrEP experience, adherence challenges, stigma or privacy concerns, pregnancy considerations, and logistical feasibility to guide optimal LAI PrEP selection **in the next 60–90 days**.
- Develop and apply a monitoring plan for patients receiving LAI PrEP that aligns injection intervals with HIV testing and STI screening recommendations, incorporates reminder systems to support on-time injections, and establishes a protocol for managing delayed or missed doses **in the next 90 days.**

CME OUTFITTERS

Additional Resources

Visit www.cmeoutfitters.com
for clinical information and
certified educational activities

Visit the

Infectious Disease Hub

Free resources and education for health care professionals and patients

https://www.cmeoutfitters.com/infectious-disease-hub/

HCP: Motivational Approaches and SDM to Improve PrEP Uptake and Adherence

Patients: Let's Talk PrEP: How to Work with Your Team to Stick with Your Plan

Other programs in this series include:

1 Breaking Barriers – Implementing Status-Neutral HIV Screening and Prevention for All

Oni Blackstock, MD, MHS (Moderator)
Cristina Mussini, MD
Sunil Suhas Solomon, MBBS, PhD, MPH
Boghuma K. Titanji, MD, MSc., DTM&H, PhD

2 Staying Current – Navigating the Latest Advances in PrEP Options

Christina Madison, PharmD(Moderator)
Chloe Orkin, MBE
Sunil Suhas Solomon, MBBS, PhD, MPH
Boghuma K. Titanji, MD, MSc., DTM&H, PhD

4 Partnering for Success – Patient Engagement and PrEP Adherence Strategies

Florence Momplaisir, MD, MSHP (Moderator)
Tristan J. Barber, MA, MD, FRCP
Linda-Gail Bekker, MBChB, DTMH, DCH, FCP, PhD
Sunil Suhas Solomon, MBBS, PhD, MPH

To Receive Credit

To receive CME/CE credit for this activity, participants must complete the post-test and evaluation online.

Participants will be able to download and print their certificate immediately upon completion.