West of Scotland: Protocol for HIV Pre-exposure Prophylaxis (PrEP)

(October 2025)

BASHH/BHIVA guidelines on the use of HIV pre-exposure prophylaxis (PREP) 2025:
https://www.bashh.org/_userfiles/pages/files/prep_2025.pdf

Section 1: Introduction

What is HIV PrEP?

PrEP is one of several ways of reducing sexual transmission of HIV (others include condom use or changes in behaviour). **PrEP medication should therefore be considered as just one component of wider interventions to prevent HIV transmission in those at highest risk.** Most individuals will be prescribed oral Tenofovir Disoproxil/Emtricitabine (PrEP-TD/FTC) as PrEP. A small number of patients will be prescribed Tenofovir Alafenamide/Emtricitabine (PrEP-TAF/FTC) or Injectable Cabotegravir (see section 9).

PrEP reduces the risk of getting HIV **from sex** by about 99% when taken as prescribed.

People who get PrEP from non-NHS sources

- Some people choose to buy PrEP online. Information on how to do this is in the i-base guide (*may need to copy and paste following link)*: https://i-base.info/guides/prep/buying-prep-online
- The website www.iwantprepnow.co.uk also provides information about PrEP
- **Can still access routine monitoring from sexual health clinics**

Referring individuals to be seen

If an individual is considering NHS funded PrEP (or is already taking self-purchased PrEP) they should be booked into the appropriate clinic in your board for their initial assessment. If booking a client into clinic then **baseline investigations** as detailed on page 4 can be completed ahead of their appointment to help allow prescriptions to be completed at their first PrEP clinic appointment.

Section 2: PrEP Equity and Suitability

Reduction in HIV incidence and access to HIV prevention, treatment and care are not equally experienced amongst all communities.

Scottish services are moving away from using specific eligibility criteria. PrEP is suitable for most people who request it, except where HIV risk is very low and therefore the risk of PrEP outweighs the benefit.

PrEP should be offered to people, regardless of their gender or sexual orientation, who would benefit from a risk in HIV risk. These will include

particular populations eg: GBMSM; those with particular behaviours and those with reduced sexual health autonomy.
Consider:

1. GBMSM
2. Individuals having condomless sex with HIV-positive partners who are taking antiretroviral therapy (ART) but whose plasma viral load is not <200 copies/ml or those who are not taking any anti-retroviral therapy
3. Transgender and non-binary people at greater risk of HIV
4. Heterosexual men and women at greater risk of HIV acquisition, such as women who have bisexual male partner(s)
5. Individuals themselves who travel or who have partners that travel, who tend to have partners from high prevalence countries
6. Individuals who regardless of gender or sexual orientation are likely to have condomless anal sex in the future with people at risk of HIV
7. Individuals who inject drugs or whose partner(s) inject drugs and who might share injecting equipment
8. Individuals from higher HIV prevalence countries (eg: Sub-Saharan Africa)
9. Individuals who have transactional sex

Exclusion criteria

PrEP should **not** be used:

- If the individual is already HIV-positive or currently suspected of seroconverting to HIV
- In monogamous sero-discordant couples where the person living with HIV is on treatment and has an undetectable viral load for more than 6 months

Section 3: Pre-PrEP work-up

Initial PrEP consultation

- Create a new episode in NASH
- Record “STI-PrEP” as the Main Reason for attending on episode page
- Record full history, including medical and drug history in addition to sexual history
- Complete the ‘***HIV PrEP ASSESSMENT’*** form on nash
- STISS code the episode – code all relevant options (Appendix 2)
- Where indicated offer vaccination for Hepatitis A, B, HPV, Mpox and Gonorrhoea
- Consider PEPSE if risk in last 72 hours

- Contraception as appropriate
- 'Doxypep' as appropriate

Baseline Investigations required:

- 4th generation HIV test
    - *Where a high-risk exposure has occurred in the previous 3 weeks, a HIV viral load could be considered to exclude acute HIV infection. This should be discussed with a senior clinician and is in addition to the 4th generation HIV test; Ensure that the correct bottle is used for HIV viral load*
    - *For those with seroconversion symptoms it is recommended that a 4th generation HIV test and HIV viral load should be performed and PrEP initiation be deferred until HIV infection has been excluded. Atypical testing results should be discussed with a regional expert*
- Hepatitis B cAb/ sAntigen (and/or sAb to ensure vaccination response)
- Hepatitis C Ab/ PCR
- Syphilis serology
- Chlamydia and GC NAAT from all relevant sites
- Pregnancy test as appropriate
- Consider Blood Pressure if other concerns or clinically indicated
- U+E
- Calculation of Creatinine clearance using the local recommended equation for measuring renal function such as CKD-EPI. It is important to use the same equation consistently to allow for comparison and assess any changes that should occur. This is recorded on the HIV '*HIV prep assessment'* nash form. See Appendix 1 for advice on managing eGFR and Creatinine clearance results

- If >50yrs or risk factors for reduced BMD, QFracture or FRAX tool should be undertaken to assess need for DEXA scan

Specific situations- Considerations prior to prep initiation

HIV window period

- Symptoms of Primary HIV Infection (PHI) – PrEP must not be provided until PHI excluded.

- PrEP can be initiated whilst awaiting HIV result unless signs of seroconversion

Starting PrEP after PEP

- PrEP can be started straight away after finishing a course of PEP. A 4th generation HIV test should be done on day 28 of PEP (as PEP is finished and PrEP is started, followed by a test six weeks after starting PrEP

Gastro-Intestinal conditions and Weight-loss medications

- PrEP TD/FTC is thought to be absorbed in the duodenum therefore absorption may be decreased in gastrectomy/ bariatric surgery and inflammatory gastro-intestinal disorders. In these situations it may be that Cabotegravir PrEP may be preferred. If this isn't suitable daily PrEP rather than event-based should be recommended and PrEP-TAF/FTC may be more forgiving in this situation because of higher levels of tenofovir in tissues
- Dosing PrEP-TD/FTC with a high fat meal may be helpful where there is concern about absorption or drug levels
- Colonic surgery and colectomy are thought unlikely to affect absorption
- Weight loss medications such as semaglutide and tirzepatide delay gastric emptying. Theoretically the absorption of PrEP could be delayed. Advice would be to avoid Event based dosing or TTSS dosing if possible. In addition, if someone is starting PrEP then if starting with an initial double dose, this should be taken well before risk (4 hours+). Note this is pragmatic advice and currently we lack evidence so more information on management will be forthcoming

Hepatitis B surface antigen positive/recent history of Hepatitis B infection

- Ensure you have up to date Hepatitis B results before starting PrEP
- If Hepatitis B sAg is positive, refer to local hepatology team
- Communicate with hepatology team when stopping PrEP (LFTS and Hepatitis serology will need regular monitoring)
- If PrEP is initiated then daily dosing regimen is preferable

Risk of renal toxicity is increased if:

- Pre-existing renal dysfunction
- Nephrotoxic drugs – including NSAIDS (such as ibuprofen and diclofenac), and recreational drugs

- Hypertension
- Other co-morbidities including cardiac disease, diabetes
- Baseline renal dysfunction or proteinuria
- Age >40

Risk of reduction in bone mineral density is increased if:

- Risk factors for osteoporosis exist eg: smoking, steroid use, low body weight, menopausal, increased alcohol intake, previous fragility fracture
- In those over 50 years, risk factors for reduced bone mineral density should be assessed at baseline, the Qfracture or FRAX tool should be undertaken to assess risk and clarify the need for referral for a DEXA scan. Refer if risk is >10%

Drug interactions

- These should be checked on www.hiv-druginteractions.org

Pregnancy risk

- PrEP TD/FTC can be provided if risk of acquiring HIV in pregnancy is greater than risks associated with PrEP
- PrEP TD/FTC is not known to be teratogenic or harmful in pregnancy in PrEP trials
- The risks and benefits of alternatives to PrEP should be discussed with pregnant or breastfeeding woman
- PrEP TD/FTC is not known to alter efficacy of hormonal contraceptive method

Section 4: Counselling to support PrEP prescription

a) Establish patient's understanding of, motivation for and expectations of PrEP

- Clarify limitations of PrEP e.g. it is only effective against risk of HIV transmission, it does not protect against other STIs, and must be taken as prescribed to be effective
- Establish patient's commitment to follow-up and adherence

b) Discuss adherence and how to take medication

- Clarify that adherence is important in all to ensure efficacy. Taking PrEP as event based can be more complicated to understand so it is important to discuss this regularly

c) Management of side-effects

- Supportive advice for mild side effects: headache, nausea, diarrhoea, bloating. Usually improves after approximately 1 month. Seek urgent medical advice if develops worsening rash or symptoms of allergy
- Persisting GI side-effects: Taking PrEP with food can reduce GI side effects. For those experiencing GI side effects following the double dose (used in event based dosing), can advise that the double dose can be split as long as both tablets taken within the 2-24 hour window prior to sex. Take the first tablet then the second can be taken 6-12 hours after the first as long as still 2 hours before sex
- Incremental dosing can be suggested to try to help with side-effects such as GI. Individuals should be counselled to use other HIV prevention methods during the micro-dosing period and until 7 days of full dosing:
    - Days 1-3: Quarter tablet
    - Days 4-7: Half tablet
    - Days 7-11: One tablet alternate days
    - Days 12 onwards: One tablet daily

d) Nephrotoxicity

- Renal toxicity is uncommon
- Advise against regular NSAID use
- Advise to check drug-drug interactions for all prescribed/OTC and herbal remedies
- Counsel around avoiding dehydration with recreational drug/alcohol use
- Note that the use of creatine supplements may affect the creatinine clearance result but are not contraindicated with PrEP. The recommendation is to stop for 2-4 weeks before kidney function is tested, but this is a pragmatic approach rather than being evidence based

- Flowchart 1 (page 18) gives information on management dependant on renal function at baseline

e) Bone health

- 1.5-2% reduction bone mineral density at hip and spine at 48 weeks
- No increased risk of fracture whilst taking
- Bone density recovers completely if short term use of PrEP (<48 weeks)
- If >50 or risk factors for osteoporosis do QFracture/ FRAX and if risk >10% refer for dexa scan; If <10% check annually whilst taking PREP
- Consider recommending vitamin D and calcium supplementation in addition to lifestyle advice if risk factors for low bone mineral density
- Individuals identified as having intermediate/high risk for fracture should be referred to their GP for further management

f) Counsel around risk of HIV infection and symptoms of primary HIV infection (PHI)

- Re-enforce importance of adherence
- Discuss PHI symptoms and need to test urgently for HIV if symptoms develop; Discuss small risk of anti-retroviral resistance if acquires HIV
- Discuss combination prevention strategies – condom use

g) Counsel around management of missed doses (see section 7)

h) Counsel around plans to discontinue (see section 8)

i) Arrange follow-up (see section 6)

j) Offer to send link to HIV PrEP leaflet via SMS sender (leaflet link accessed through link on '*HIV PrEP assessment*' form. Altenatively the NHS inform link on PrEP could be sent: https://www.nhsinform.scot/hiv-prep-pre-exposure-prophylaxis/what-is-hiv-prep

k) Communication with GP

Encourage communication with GP, important for avoiding possible drug interactions and for holistic care

Section 5: PrEP prescribing and dosing options

PREP can be dosed in several different options.

1. **DAILY PrEP** – one tablet is taken every day
2. **EVENT-BASED DOSING (EBD)** – PrEP is taken when sex happens. This is described on pages 8 and 9
3. **TTSS** – PrEP is taken four days a week, one on **T**uesday, **T**hursday, **S**aturday and **S**unday

The number of tablets prescribed at the first visit should usually be 90 or **120 tablets** (3 months plus one month buffer if concerns around getting appointment).

Medication must be prescribed on NASH. Daily and event based PrEP are differentiated on the prescription page of NaSH.

Subsequent supplies will depend on how much the individual has:

- Ensure those coming for 3 month clinical review have enough to allow for appointment changes (usually 4 months)
- Six or seven month supplies can be given to those who have been on PrEP for a minimum of 3 months, are stable and are categorised as green/ amber (see page 10). They should still have 3 monthly sexual health testing **(**HIV, Syphilis, Chlamydia and Gonorrhoea**)**

DAILY DOSING

- One tablet is taken every day, ideally at the same time every day, regardless of sexual activity
- Most evidence exists for daily dosing
- Can be used by any patient regardless of gender or risk group
- **Preferred** option for people with Hepatitis B infection
- Does not require forward planning
- Ideal for individuals who have frequent sex (weekly)
- More forgiving of missed doses once steady state achieved

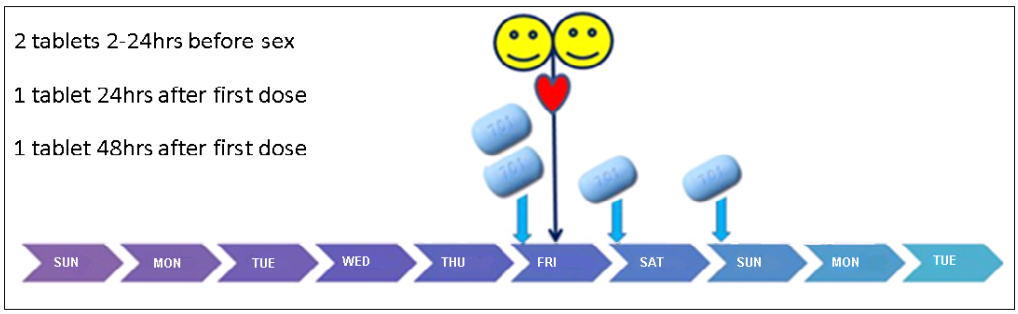
- Disadvantages include higher exposure to possible toxicity and higher drug costs
- Consider starting with a double dose if imminent risk
- The time to clinical protection is estimated as 2-24 hours to be effective **after taking a double dose OR 7 days if no double dose**

EVENT BASED DOSING (EBD)

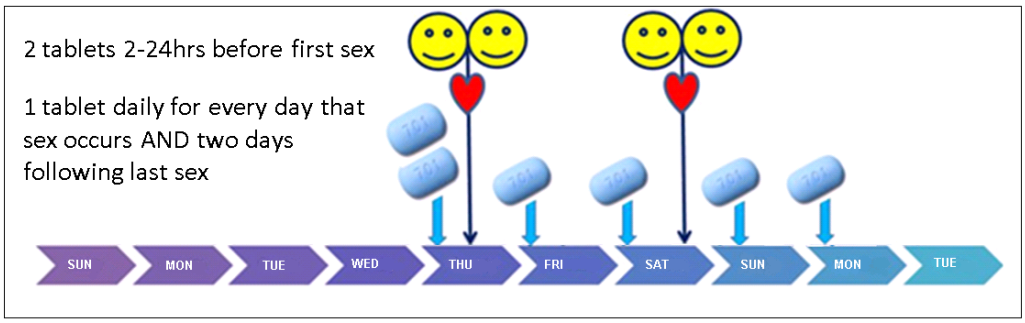
- Note there are two different dosing regimes depending on the type of sex, these are described further on the next page:
    1. **2:1:1** This is for insertive and receptive anal sex, insertive vaginal/neovaginal sex
        i. Take 2 tablets 2-24hours before sex, then
        ii. Take 1 tablet daily for 2 days after the last risk
    2. **2:7** This is for receptive vaginal/neovaginal sex or if risk is from injecting drug use
        i. Take 2 tablets 2-24hours before sex, then
        ii. Take 1 tablet daily for 7 days after the last risk

- Not the preferred option for those with active Hepatitis B infection
- Not the preferred option for those taking medication that delays gastric emptying
- Requires forward planning
- Ideal for people who have less frequent sex (less frequently than weekly) as more than 7 doses per week is not recommended
- Less forgiving if missed doses
- Advantages include lower exposure to possible toxicity and lower drug costs

Diagramatic example: PrEP dosing if single sexual risk exposure – anal sex:



Multi-risk PrEP dosing – anal sex:



TTSS dosing

- Take one tablet on Tuesday, Thursday, Saturday, Sunday
- Less forgiving if missed doses
- Not the preferred option for those with Hepatitis B infection
- Not the preferred option for those on medication that delays gastric emptying
- Advantages include lower exposure to possible toxicity and lower drug costs

Section 6: First Follow-up after starting PrEP

Timing of initial follow-up depends on the need for HIV testing if they are within the window period when they commence PrEP.
Those who were in the window period when they started PrEP should have an HIV test 45 days after the possible exposure.

Those outwith the window period when they start PrEP should attend at 3/12 for initial follow up.

Subsequent follow-up for those on PrEP-TD/FTC

Depends on the categorisation of patient, as **Green, Amber** or **Red**, as follows:

GREEN:
Aged 18-40 years
No medical conditions which increase bone/renal risk
No co-prescribed medicines which interact or associated with renal impairment
No significant social complexity
GFR>90

Follow-up

- 6 monthly PrEP reviews
- 3 monthly HIV/STI screens
- Annual renal function

AMBER:
Aged >40 years and <70 years
GFR >60 < 90
Comorbidity which can impact kidneys/co-prescribed medication which can affect kidneys
No significant social complexity

Follow-up

- 6 monthly PrEP reviews
- 3 monthly HIV/STI screens
- **Six monthly** renal function

RED:
Aged over 70 years
Aged under 18 years
eGFR < 60
Significant drop in eGFR (confirmed reduction of 15ml/min or 25% reduction in CrCl in the last 12 months)
Individuals with signficant renal comorbidities (eg transplant)
Individuals with Hep B or C coinfection
Individuals with possible adverse reactions to PrEP
Individuals with reduced bone density (osteopenia/osteoporosis) or significant risk factors (previous fractures/alcohol/steroid)
Concerning drug interactions
Pregnant individuals
Significant social complexity

Follow-up

- 3 monthly PrEP reviews
- **3 monthly** renal function/urinalysis if renal concerns – Senior clinician will determine this

ONGOING investigations required whilst taking PrEP#

Test	GREEN	AMBER	RED
Syphilis	Every 3m	Every 3m	Every 3m
HIV 4th generation	Every 3m	Every 3m	Every 3m
CT/GC NAAT at appropriate sites	Every 3m	Every 3m	Every 3m
Pregnancy test	As indicated	As indicated	As indicated
HCV Ab/PCR*	Annual	Annual	Annual
HBV cAb/ HBV sAg	Annually if not vaccinated or non-responder	Annually if not vaccinated or non-responder	Annually if not vaccinated or non-responder
U+E	Annual	Every 6 months	As per clinician
Urinalysis		If renal concern	If renal concern
uPCR		If urinalysis protein 1+ or more	If urinalysis protein 1+ or more
BP		As indicated	As indicated

 # In those with infrequent risk, SHS and HIV testing may be done less frequently after discussion
If history of chems/ group sex consider 3 monthly Hepatitis C testing

What else needs to be done at the 3 or 6 monthly PrEP review appointments:

- Open a new NASH episode and new '*HIV PrEP assessment'* form for each review
- Adherence check and support
- Enquire about any new medications/ supplements and check for new interactions
- Prescribe further PrEP
- Arrange follow-up appointment

Annual 12 monthly review:

- Open a new episode and new '*HIV PrEP assessment'* form
- Ensure GP communication if consent
- Assess bone risk if >50yrs/risk factors for reduced BMD
- Review ongoing HIV risk factors and need for PrEP
  - Patient no longer requires PrEP - proceed to **section 8**

Section 7: Atypical and Indeterminate HIV test results

Atypical HIV test results include:

1. Unchanging antibody reactivity in 2 or more consecutive samples that do not fit with a pattern usually associated with confirmed positivity
2. Discrepant reactivity that changes over time, whilst remaining on PrEP or for a period of time after stopping PrEP

PrEP can cause blunting of antibody response with non-reactive or atypical and non-progressive Fiebig profiles seen where viral load is likely to be undetectable.
Atypical cases should be discussed with a regional expert and investigated further for possible seroconversion.
If seroconversion is suspected on PrEP, recommendation would be to intensify ART whilst investigations are ongoing.
Laboratory request forms for atypical cases should contain information on whether the individual is on/off PEP/PrEP to allow for better interpretation of results.

Section 8: Starting and stopping PrEP advice and when PEP may be required

A clinician should only recommend stopping PrEP when the risks outweigh the benefits:

- If patient has significant bone/renal disease or has had toxicity from standard PrEP, TAF/FTC PrEP (Descovy) or cabotegravir should be considered
- Patients with Hepatitis B should only discontinue PrEP after discussion with senior GUM clinician and hepatology team.
- PrEP should continue for 48h following most recent anal sex or for 7 daily doses if receptive vaginal sex/ injecting drug use risk

The following table summarises advice to be given when starting, stopping and restarting PrEP.

	TD-FTC 200/245 mg or TAF-FTC 200/25 mg fixed-dose combinations		
	Time to start of protection	**Safely stopping**	**Restarting**
Receptive anal sex	Double dose (2 pills) 2–24 hours before risk	Continue single dose daily for 2 days after last risk	Restart with a single dose if less than 7 days since last dose*
Insertive vaginal/ neovaginal/anal sex	Double dose (2 pills) 2–24 hours before risk	Continue single dose daily for 2 days after last risk	Restart with a single dose if less than 7 days since last dose*
Receptive vaginal/ neovaginal sex	Double dose (2 pills) 2–24 hours before risk	Continue single dose daily for 7 days after last risk	Restart with a single dose if less than 3 days since last dose*
Injection drug use	Double dose (2 pills) 2–24 hours before risk	Continue single dose daily for 7 days after last risk	Restart with a single dose if less than 4 days since last dose*

*Last dose of a complete course (i.e. time to start of protection + time to safely stop) according to exposure, or daily dosing. If doses have been missed, see section 8.2 and Table 3 below.

It may be that PEP is required in some situations, the following table summarises this advice:

Sexual risk (no condom, partner not on ART or PrEP)	**Time between last PrEP dose before exposure and resumption of PrEP**	**Recommendation after exposure**	**Level of evidence**
Insertive/receptive anal sex or insertive vaginal sex	≤7 days	Resume PrEP with a double dose as prescribed	1B: PK/PD; RCT
	>7 days	Take a double dose of PrEP as soon as possible in the 24 hours after exposure, continue daily and seek urgent advice from clinical services for intensification to PEP	1B: animal challenge; PK/PD
Receptive vaginal sex	≤3 days	Resume PrEP with a double dose as prescribed	1B: PK/PD
	>3 days	Take a double dose of PrEP as soon as possible in the 24 hours after exposure, continue daily and seek urgent advice from clinical services for intensification to PEP	1B: animal challenge; PK/PD
Receptive neovaginal sex	≤3 days	Resume PrEP with a double dose as prescribed	2C
	>3 days	Take a double dose of PrEP as soon as possible in the 24 hours after exposure, continue daily and seek urgent advice from clinical services for intensification to PEP	2C
Injecting drug use	≤4 days	Resume PrEP with a double dose as prescribed	2C
	>4 days	Take a double dose of PrEP as soon as possible in the 24 hours after exposure, continue daily and seek urgent advice from clinical services for intensification to PEP	2C

Section 9: Eligibility criteria for PrEP TAF/FTC (Descovy®) for pre-exposure prophylaxis for HIV (PrEP) in Scotland

PrEP-TAF/FTC (Descovy®) has been shown to be non-inferior to PrEP-TDF/FTC) in reducing incident HIV infections in a large, randomised clinical trial involving gay, bisexual and other men who have sex with men (GBMSM) and transgender women (TGW). Adverse effects on markers of bone mineral density and renal function were significantly reduced in the Descovy® arm.

There is a significant cost implication in prescribing this regimen in place of generic PrEP-TD/FTC, although the original cost benefit analysis supporting
PrEP in Scotland was made using a list price for TDF/FTC PrEP (Truvada®) equivalent to the current list price for Descovy®.

For patients where Descovy® is being considered as PrEP, the case should be discussed at a local or regional HIV/GUM MDT.
In cases where indications are not clear, referral for discussion at the Scottish national complex PrEP MDT should be made and the decision documented and recorded.

The following scenarios may warrant consideration of starting or switching to PrEP-TAF/FTC:

1. **Those aged less than 18 years of age**
   PrEP-TAF/FTC should be continued till age 20 years to ensure bone optimisation as described below

2. **RENAL**
   a. **High risk renal factors for TD/FTC:**
   Moderate or severe reduction in glomerular filtration (estimated glomerular filtration rate [eGFR] ≤ 59 ml/min/1.73m2 at baseline or during follow-up) and clinical assessment suggests that TAF/FTC would have a lower risk profile than TD/FTC
   OR
   - Individuals with proven renal toxicity[i] with TD/FTC (acute or chronic)

   b. **Medium risk renal factors for TD/FTC:**
   Individuals with an eGFR ≥ 60 ml/min/1.73m2 in which:

- a progressive reduction in estimated glomerular filtration rate on TD/FTC is seen

AND

- significant concurrent medical issues or monitoring/prescribing concerns that suggest TAF/FTC would have a lower risk profile to TD/FTC

3. BONE:

a. High risk bone factors for TD/FTC:

Individuals with confirmed osteoporosis on DEXA or a high risk of a major fracture as determined by an appropriate fragility risk score.
Note: high fracture probability defined as > 10% (major osteoporotic or hip fracture absolute risk), with NICE recommending QFracture or FRAX scores

- **Medium risk bone factors for PrEP-TD/FTC:**
  Note: markers of increased absolute fracture risk include previous vertebral fracture(s), previous fragility fracture, smoking, high alcohol intake, menopausal status; high-dose oral or high-dose systemic glucocorticoids (more than 7.5 mg prednisolone or equivalent per day for 3 months or longer) or other causes of secondary osteoporosis

4. Gastrointestinal intolerance/swallowing difficulties:

There is no evidence base for changes made for GI intolerance, nor any evidence that PrEP-TAF/FTC has better GI tolerability than PrEP-TD/FTC. Any changes should be based on clinical experience and with MDT input. A list of excipients for all available TD/FTC formulations is available.

When not to use Descovy®

Descovy® should not be used in following circumstances:

- Individuals < 35 kg
- In those currently prescribed/taking: adefovir disoproxil, carbamazepine, oxcarbazepine, phenobarbital, phenytoin, primidone or St John's Wort

Caution should be used with patients with or at risk of metabolic and lipid disorders due to potential increase in lipid profile. Individuals can increase

weight when changing from TD to TAF due to the suppressive effect of TD on weight.

Section 10: Eligibility criteria for Injectable Cabotegravir for pre-exposure prophylaxis for HIV (PrEP) in Scotland

SMC restriction is for adults and adolescents (weighing at least 35kg) at high risk of sexually acquired HIV who require PrEP but for whom oral PrEP is not appropriate to meet their HIV prevention needs.
Cabotegravir was superior to daily PrEP-TD/FTC in the reduction of incident HIV acquisitions in a phase IIb/III study in men who have sex with men and transgender women (HPTN 083) and in a phase III study in cisgender women (HPTN 084) at high risk of acquiring human immunodeficiency virus (HIV).

Cabotegravir tablets may be used as an oral lead in to assess tolerability of cabotegravir prior to administration of long acting cabotegravir injection.

Cabotegravir is protective 7 days after the first injection.

For patients where cabotegravir is being considered as PrEP the case should be discussed at a local or regional MDT. In cases where indications are not clear, referral for discussion at the Scottish national complex PrEP MDT should be made and the decision documented and recorded.
The cabotegravir-la tail is approximately one year (12-23% have detectable levels at 52-60 weeks after injection but around 80% have no detectable levels at 24 weeks). This should be discussed with the individual and a plan arranged for when cabotegravir is stopped.

Patient monitoring whilst on Cabotegravir PrEP
Patients who are on 2 monthly injectable cabotegravir should have a 4th generation HIV test in addition to HIV viral load testing at every 2 month visit for PrEP.
It is important that appointments for cabotegravir PrEP are clearly organised with the individual and the clinic has a system in place to ensure attendance and follow-up.
Individuals should have STI testing done regularly as agreed with senior clinician.
Injections can be given 7 days prior to or after the arranged date.

Appendix 1 Flowcharts for renal assessment at baseline and once established on PrEP

Flowchart 1: Managing renal function at baseline