

Table 6. What to Start: Initial Antiretroviral Regimens During Pregnancy

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In general, the Panel on Treatment of HIV During Pregnancy and Prevention of Perinatal Transmission (the Panel) recommends that **prepregnancy regimens should be continued when pregnancy occurs on fully suppressive antiretroviral (ARV) regimens**, unless these regimens include an ARV drug or ARV regimen that is not recommended for use in nonpregnant adults or concerns exist about safety and inferior efficacy during pregnancy (see [Table 7](#) and [When Antiretroviral Therapy is Being Taken When Pregnancy Occurs](#)). Recommendations for initial antiretroviral therapy (ART) during pregnancy when there has never been receipt of ART or ARV prophylaxis are located in Table 6, with additional comments on circumstances when clinicians may need to consider additional factors when initiating ART in patients who previously received ART or ARV drugs for prophylaxis (see [Previous Experience With Antiretroviral Medications but Not on Antiretroviral Therapy During Current Pregnancy](#) and [Table 7](#)).

Whenever possible, changes in ARV regimens should be timed so that viral suppression can be achieved before attempts at becoming pregnant begin (see [Table 7](#)).

Regimens are listed alphabetically within each drug class and recommendation category for initial therapy, so the order does not indicate a ranking of preference. In addition, except where noted below, the Panel makes no recommendation for one agent or regimen over another within each category (e.g., among *Preferred* or *Alternative* medications). The table also indicates ARV drugs or regimens that are available in fixed-dose combination tablets. Patients and providers should make shared decisions about which ARV drugs to use during pregnancy after discussing the benefits of ART and the known and potential health risks during pregnancy and risks to fetuses and infants (see [Appendix C: Antiretroviral Counseling Guide for Health Care Providers](#) and [Recommendations for Use of Antiretroviral Drugs During Pregnancy: Overview](#)).

Note: For more information about the use of specific drugs and dosing in pregnancy, see [Table 7](#), the individual drug sections in [Appendix B: Safety and Toxicity of Individual Antiretroviral Agents in Pregnancy](#), and [Table 14. Antiretroviral Drug Use in Pregnancy: Pharmacokinetic and Toxicity Data in Human Pregnancy and Recommendations for Use in Pregnancy](#).

Table 6. What to Start: Initial Antiretroviral Regimens During Pregnancy

Preferred Initial Regimens in Pregnancy		
<p>Drugs or drug combinations are designated as <i>Preferred</i> for therapy during pregnancy when clinical trial data in adults have demonstrated efficacy and durability with acceptable toxicity and ease of use and when pregnancy-specific PK data are available to guide dosing. In addition, the available data must suggest a favorable risk-benefit balance for the drug or drug combination compared with other ARV drug options; the assessment of risks and benefits should incorporate outcomes for health during pregnancy, as well as the health of the fetus and infant. Some <i>Preferred</i> drugs or regimens may have minimal toxicity or teratogenicity risks that are offset by other advantages during pregnancy or when trying to conceive. Therefore, it is important to read all the information on each drug in the Perinatal Guidelines before administering any of these medications to patients (see Appendix B: Safety and Toxicity of Individual Antiretroviral Agents in Pregnancy).</p>		
Preferred Dual-NRTI Backbones	Advantages	Disadvantages
TAF/FTC or TAF Plus 3TC	<ul style="list-style-type: none"> • Once-daily dosing • Available as an FDC • Reassuring PK data and extensive use during pregnancy; no dose adjustment required in pregnancy • Both NRTI combinations active against HBV • Minimal toxicity compared with ZDV/3TC • When combined with DTG, the efficacy and toxicity of TAF/FTC and TDF/FTC in pregnancy are similar, but TAF/FTC is associated with fewer adverse birth outcomes and less risk of insufficient weight gain in pregnancy. 	<ul style="list-style-type: none"> • When combined with DTG, TAF/FTC is associated with more treatment-emergent obesity in nonpregnant adult women compared with TDF/FTC. (Notably, the impact on weight gain in pregnancy may be beneficial, as noted in the Advantages column.)
TDF/FTC or TDF/3TC	<ul style="list-style-type: none"> • Once-daily dosing • Available as an FDC • Reassuring PK data and extensive use during pregnancy; no dose adjustment required in pregnancy • Both NRTI combinations active against HBV • When combined with DTG, the efficacy and toxicity of TAF/FTC and TDF/FTC in pregnancy are similar. 	<ul style="list-style-type: none"> • Potential concerns about fetal bone and early-life growth abnormalities exist with TDF, although clinical findings are reassuring to date. • TDF has potential renal toxicity; thus, TDF-based, dual-NRTI combinations should be used with caution in patients with renal insufficiency.

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Preferred INSTI Regimens	Advantages	Disadvantages
BIC/TAF/FTC (FDC)	<ul style="list-style-type: none"> • Co-formulated as a single, once-daily pill; for this reason, may be preferred over DTG to support adherence • High barrier to resistance • No food requirement • No dose adjustment required in pregnancy • No safety concerns observed • High rates of viral suppression • Covers HBV • BIC/TAF/FTC is a <i>Preferred</i> regimen for initial treatment in people HIV infection without a history of CAB exposure for PrEP; see Early (Acute or Recent) HIV Infection and the Adult and Adolescent Antiretroviral Guidelines. 	<ul style="list-style-type: none"> • PK and safety data in pregnancy suggest sufficient efficacy and safety of BIC for its use as a <i>Preferred</i> initial agent in pregnancy when there has not been prior ARV or ART experience (ARV-naïve). Drug levels are lower in the second and third trimesters of pregnancy than in nonpregnant or postpartum patients and are reduced in later pregnancy to a greater degree for BIC than for DTG, but BIC levels remained above the protein-adjusted EC₉₅ during pregnancy; therefore, despite lower levels, high rates of viral suppression are seen. • Potential concerns about excess weight gain • Specific timing and/or fasting recommendations apply if BIC is taken with calcium or iron (e.g., in prenatal vitamins; see Table 14 and Bictegravir for details). • BIC/TAF/FTC is not <i>Preferred</i> for initial treatment in people with a history of CAB-LA exposure for PrEP due to concerns about INSTI resistance mutations, unless genotype testing has demonstrated an absence of INSTI resistance mutations; DRV/r is <i>Preferred</i> in this situation; see the Adult and Adolescent Antiretroviral Guidelines.
DTG Plus a Preferred Dual-NRTI Backbone (see Alternative INSTI Regimens below for comments about specific FDCs)	<ul style="list-style-type: none"> • Once-daily dosing • Sufficient data about PK, efficacy, and safety of DTG in pregnancy • High rates of viral suppression • Dose adjustments during pregnancy are not needed. • May be particularly useful when drug interactions or the potential for preterm birth with a PI-based regimen are a concern. 	<ul style="list-style-type: none"> • Potential concerns about excess weight gain • Do not use DTG/3TC in the setting of HBV coinfection without another drug active against HBV. • Specific timing and/or fasting recommendations apply if DTG is taken with calcium or iron (e.g., in prenatal vitamins; see Table 14).

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	<ul style="list-style-type: none"> DTG has been shown to rapidly decrease viral load in pregnancy when presentation to care is late in pregnancy and there is no prior experience with ART or ARVs (ARV-naïve). In nonpregnant adults, DTG is associated with lower rates of INSTI resistance than RAL, and DTG allows for once-daily dosing; for these reasons, DTG is particularly useful in scenarios of presentation to care late in pregnancy. DTG with an NRTI backbone of TAF or TDF with 3TC or FTC is a <i>Preferred</i> regimen for initial treatment in people with HIV infection without a history of CAB exposure for PrEP; see Early (Acute or Recent) HIV Infection and the Adult and Adolescent Antiretroviral Guidelines. 	<ul style="list-style-type: none"> DTG is not <i>Preferred</i> for initial treatment in people with a history of CAB-LA exposure for PrEP due to concerns about INSTI resistance mutations, unless genotype testing has demonstrated an absence of INSTI resistance mutations; DRV/r is <i>Preferred</i> in this situation; see the Adult and Adolescent Antiretroviral Guidelines. In the United States, not available as an FDC except as a two-drug regimen (see DTG/3TC under <i>Alternative INSTI Regimens</i> below)
Preferred PI Regimens	Advantages	Disadvantages
DRV/r Plus a Preferred Dual-NRTI Backbone	<ul style="list-style-type: none"> DRV/r is a <i>Preferred</i> PI for initial therapy only in certain circumstances (e.g., exposure to CAB-LA when genotype testing is unavailable or demonstrates INSTI resistance mutations). See DRV/r under <i>Alternative PI Regimens</i> below for full details. 	<ul style="list-style-type: none"> See DRV/r under <i>Alternative PI Regimens</i> below.

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Alternative Initial Regimens in Pregnancy		
<p>Drugs or drug combinations are designated as <i>Alternative</i> options for therapy during pregnancy when clinical trial data in adults show efficacy and the data in pregnancy are generally favorable but limited. Most <i>Alternative</i> drugs or regimens are associated with more PK, dosing, tolerability, formulation, administration, or interaction concerns than those in the <i>Preferred</i> category, but they are acceptable for use in pregnancy. Some <i>Alternative</i> drugs or regimens may have known toxicity or teratogenicity risks that are offset by other advantages for during pregnancy or when trying to conceive. Therefore, it is important to read all the information on each drug in the Perinatal Guidelines before administering any of these medications to patients (see Appendix B: Safety and Toxicity of Individual Antiretroviral Agents in Pregnancy).</p>		
Alternative INSTI Regimens	Advantages	Disadvantages
DTG/3TC (FDC)	<ul style="list-style-type: none"> • Once-daily dosing • DTG/3TC is available as an FDC. • Component drugs have well-described PK that are adequate in pregnancy and no safety concerns. See <i>Preferred</i> INSTI Regimens above for other details about DTG and 3TC. 	<ul style="list-style-type: none"> • Not recommended for initial therapy before the availability of HBV serology, HIV RNA level, and HIV genotype test. Therefore, DTG/3TC is classified as <i>Alternative</i> for new ART initiation in pregnancy to avoid delay while waiting for these results. • DTG/3TC is not recommended in the setting of early (acute or recent) HIV infection in pregnancy, as prompt initiation is critical and HIV RNA levels are often >500,000 copies/mL in these settings (see Table 7. Antiretroviral Regimen Considerations for Initial Therapy Based on Specific Clinical Scenarios in the Adult and Adolescent Antiretroviral Guidelines). • Viral decay and viral suppression rates are similar to standard three-drug regimens in nonpregnant adults, although data in pregnancy are limited. Consider close viral load monitoring for all individuals. DTG/3TC is not recommended if there are adherence concerns. • Do not use DTG/3TC in the setting of HBV coinfection without another drug active against HBV. • See above DTG section regarding prior CAB-LA use.
DTG/ABC/3TC (FDC)	<ul style="list-style-type: none"> • Once-daily dosing • DTG/ABC/3TC is available as an FDC. • See above section about DTG for other details. 	<ul style="list-style-type: none"> • DTG/ABC/3TC requires HLA-B*5701 testing before use (see ABC/3TC below). • Do not use DTG/ABC/3TC or DTG/3TC in the setting of HBV coinfection without another drug active against HBV. • Potential concerns about excess weight gain • See above section about DTG for other details.

Table 6. What to Start: Initial Antiretroviral Regimens During Pregnancy

RAL Plus a Preferred Dual-NRTI Backbone	<ul style="list-style-type: none"> • No safety concerns observed. • Like DTG, RAL may be particularly useful when drug interactions or the potential for preterm birth with PI-based regimens are a concern. • PK data are available for RAL in pregnancy when using the twice-daily formulation (400 mg twice daily). • Like DTG, RAL has been shown to rapidly decrease viral load in pregnancy when presentation to care is late in pregnancy and there is no prior experience with ART or ARVs (ARV-naïve). In nonpregnant adults, DTG is associated with lower rates of INSTI resistance than RAL, and DTG permits once-daily dosing; for these reasons, DTG is <i>Preferred</i> and RAL is <i>Alternative</i> for use during pregnancy. 	<ul style="list-style-type: none"> • Twice-daily dosing in pregnancy is recommended due to low drug level with once-daily dosing during pregnancy. • Not available as an FDC • Lower barrier to resistance than DTG; for this reason, RAL is <i>Alternative</i> for use during pregnancy • Population PK data do not support using the once-daily 1,200 mg (2 × 600 mg) extended-release formulation (raltegravir HD) in pregnancy. • Specific timing and/or fasting recommendations apply if RAL is taken with calcium or iron (e.g., in prenatal vitamins; see Table 14 and Raltegravir for details).
Alternative PI Regimens	Advantages	Disadvantages
ATV/r Plus a Preferred Dual-NRTI Backbone	<ul style="list-style-type: none"> • Once-daily dosing • Extensive experience during pregnancy 	<ul style="list-style-type: none"> • Not available as an FDC • Associated with increased maternal indirect bilirubin levels, which theoretically may increase the risk of neonatal hyperbilirubinemia. No clinically significant neonatal hyperbilirubinemia or kernicterus reported, but neonatal bilirubin monitoring is recommended. • Requires increased dosing in the second or third trimester • Has been associated with small but significant reductions in language and social-emotional scores and late language • PIs may increase the risk of preterm birth. • Cannot be used with PPIs • Requires consideration of timing when dosed with H2 blockers, which are commonly used during pregnancy (see Table 14).

Table 6. What to Start: Initial Antiretroviral Regimens During Pregnancy

DRV/r Plus a Preferred Dual-NRTI Backbone	<ul style="list-style-type: none"> When a PI-based regimen is indicated, DRV/r is recommended over ATV. However, DRV/r requires twice-daily dosing in pregnancy, and dosing frequency affects adherence. For that reason, when use of a PI-based regimen is indicated during pregnancy, some Panel members would use ATV/r rather than DRV/r for ART. DRV/r with a NRTI backbone of TAF or TDF with 3TC or FTC is the <i>Preferred</i> regimen for initial treatment in people with early (acute or recent) HIV infection <i>and</i> a history of CAB-LA exposure for PrEP, see Early (Acute or Recent) HIV Infection and the Adult and Adolescent Antiretroviral Guidelines. 	<ul style="list-style-type: none"> Not available as an FDC Requires twice-daily dosing during pregnancy Requires administration with food PIs may increase the risk of preterm birth.
Alternative Dual-NRTI Backbone	Advantages	Disadvantages
ABC/3TC	<ul style="list-style-type: none"> Once-daily dosing Available as an FDC Well-tolerated during pregnancy Reassuring PK data during pregnancy 	<ul style="list-style-type: none"> Requires HLA-B*5701 testing before use. ABC should not be used in patients who test positive for HLA-B*5701 because of the risk of developing a hypersensitivity reaction. Requires education about hypersensitivity reactions. Now classified as an <i>Alternative</i> ARV drug because of the inability to start without HLA-B*5701 testing and concerns over cardiac safety. ABC is not active against HBV; see Hepatitis B Virus/HIV Coinfection for recommended dual NRTI backbones. ABC/3TC administered with ATV/r or EFV is not recommended if pretreatment HIV RNA is >100,000 copies/mL. ABC is not recommended as part of regimens for initial treatment of acute HIV infection unless the patient previously tested negative for the HLA-B*5701 gene variant; using TDF or TAF rather than ABC will avoid delays in ART initiation while awaiting HLA-B*5701 test results.

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ZDV/3TC	<ul style="list-style-type: none"> Available as an FDC Significant experience during pregnancy 	<ul style="list-style-type: none"> Requires twice-daily dosing Associated with higher rates of side effects, including nausea, headache, and reversible maternal and neonatal anemia and neutropenia Other regimens have demonstrated similar or greater efficacy and fewer side effects.
Alternative NNRTI Regimens	Advantages	Disadvantages
EFV/TDF/FTC (FDC) or EFV/TDF/3TC (FDC) or EFV Plus a <i>Preferred</i> Dual-NRTI Backbone	<ul style="list-style-type: none"> Once-daily dosing Available as an FDC Extensive experience in pregnancy Not associated with increased risk of NTDs or other congenital anomalies in human studies (although cautionary text based on animal studies remains in the package insert); see Efavirenz and Table 14. No dose changes required during pregnancy Useful for patients who require treatment with drugs that have significant interactions with <i>Preferred</i> agents or who need the convenience of a co-formulated, single-tablet, once-daily regimen and are not eligible for DTG 	<ul style="list-style-type: none"> Overall higher rates of adverse events than some <i>Preferred</i> drugs Requires enhanced surveillance for depression and suicidality Increased risk of adverse birth outcomes has been observed with EFV/TDF/FTC versus DTG/TAF/FTC started during pregnancy. Increased risk of toxicity, including dizziness, fatigue, hepatotoxicity, vivid dreams/nightmares
RPV/TDF/FTC (FDC) or RPV/TAF/FTC (FDC) or RPV (Oral) Plus a <i>Preferred</i> Dual-NRTI Backbone	<ul style="list-style-type: none"> Once-daily dosing Available as an FDC Useful for patients who require treatment with drugs that have significant interactions with <i>Preferred</i> agents or who need the convenience of a co-formulated, single-tablet, once-daily regimen and are not eligible for DTG 	<ul style="list-style-type: none"> Limited use for individuals with high pretreatment HIV RNA. RPV is not recommended in patients with pretreatment HIV RNA >100,000 copies/mL or CD4 counts <200 cells/mm³. Requires close viral monitoring in second and third trimesters because PK data suggest lower drug levels. Insufficient data to suggest dosing changes. Requires consideration of timing when dosed with H2 blockers, which are commonly used during pregnancy (see Table 14) Requires administration with food

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<i>Insufficient Data for Use as Initial Regimens in Pregnancy</i>		
These drugs and drug combinations are approved for use in adults, but pregnancy-specific PK or safety data are too limited to make recommendations for use in pregnancy. When virologic suppression on one of these drugs or drug combinations is present when pregnancy occurs, providers and patients should consider whether to continue the current regimen or switch to a <i>Preferred</i> ARV regimen (see When Antiretroviral Therapy is Being Taken When Pregnancy Occurs and Table 7). It is critical that providers report exposures to these medications in pregnancy to the Antiretroviral Pregnancy Registry .		
<i>Insufficient Data</i>	Advantages	Disadvantages
DOR or DOR/TDF/FTC	<ul style="list-style-type: none">• Co-formulated with TDF/FTC• No food requirement	<ul style="list-style-type: none">• Limited PK, toxicity, and efficacy data in pregnancy• Initial studies suggest potentially lower drug levels in third trimester.

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Not Recommended for Use as Initial Regimens in Pregnancy		
<p>Drugs and drug combinations listed in this category are <i>Not Recommended</i> for initial use in pregnancy because of inferior virologic efficacy or potentially serious safety concerns for during pregnancy or for the fetus or because they are not recommended for initial therapy in nonpregnant adults. This category includes drugs or drug combinations for which PK data demonstrate low drug levels and risk of viral rebound during pregnancy. Levels of these drugs are often low in late pregnancy (during the second and third trimesters), when risk for perinatal transmission is high if viremia occurs (see Table 7 and Table 14).</p> <p>Note: When virologic suppression on one of these drugs or drug combinations is present when pregnancy occurs, providers and patients should consider whether to continue the current regimen or switch to a <i>Preferred</i> ARV regimen (see When Antiretroviral Therapy is Being Taken When Pregnancy Occurs and Table 7).</p>		
Not Recommended	Advantages	Disadvantages
ATV/c		<ul style="list-style-type: none"> Limited existing data suggest insufficient levels of both COBI and ATV in second and third trimesters. Changing the COBI component to RTV is likely to improve efficacy but will increase pill burden.
Long-Acting Injectable CAB Plus RPV (Co-packaged Formulation)	<ul style="list-style-type: none"> Injectable delivery may be more effective and/or more convenient than oral ART for some patients. Approved for nonpregnant adults who have RNA levels <50 copies/mL for at least 3 months on a stable oral ARV regimen, with no history of treatment failure and no known or suspected resistance 	<ul style="list-style-type: none"> Limited PK, toxicity, and efficacy data during pregnancy Not recommended as initial treatment for adults or adolescents (pregnant or nonpregnant) who have never received ARV drugs Due to the long half-life of injectable CAB and RPV, drug levels may persist up to 12 months after the last dose. Optimal timing of switch to an oral regimen is not known (see Management of People With HIV and Antiretroviral Therapy Experience in the Adult and Adolescent Antiretroviral Guidelines).
DRV/c (FDC) or DRV/c/FTC/TAF (FDC)	<ul style="list-style-type: none"> DRV/c/FTC/TAF is co-formulated as a single-tablet, once-daily regimen. 	<ul style="list-style-type: none"> Limited existing data suggest insufficient levels of COBI in second and third trimesters; viral breakthroughs have been reported. Changing COBI component to RTV is likely to improve efficacy but will increase pill burden; in addition to adding RTV as separate pill, both DRV and RTV should be dosed twice daily.

Table 6. What to Start: Initial Antiretroviral Regimens During Pregnancy

<p>EVG/c/FTC/TAF (FDC) or EVG/c/FTC/TDF (FDC)</p>	<ul style="list-style-type: none"> • Co-formulated as single-tablet, once-daily regimen 	<ul style="list-style-type: none"> • Limited existing data suggest insufficient levels of both COBI and EVG in second and third trimesters. • Viral breakthrough at birth was identified in 26% of previously suppressed individuals in IMPAACT P1026. Data are insufficient to suggest dosing changes. • Unlike for DRV/c and ATV/c, there is no option to replace COBI with RTV boosting. • Specific timing and/or fasting recommendations apply, especially if taken with calcium or iron (e.g., in prenatal vitamins; see Table 14 and Elvitegravir for details).
<p>LPV/r Plus a Preferred Dual-NRTI Backbone</p>	<ul style="list-style-type: none"> • Extensive experience during pregnancy 	<ul style="list-style-type: none"> • Not recommended in nonpregnant individuals who are ART-naïve • Requires twice-daily dosing; data suggest that once-daily LPV/r will not achieve sufficient plasma concentrations. • Some experts recommend increased dosing in the second and third trimesters (see Table 14 and Lopinavir/Ritonavir). • Associated with nausea and diarrhea • Associated with increased risk of preterm birth and small-for-gestational-age neonatal status (see Antiretroviral Drug Regimens and Pregnancy Outcomes) • Available as a liquid formulation, but the LPV/r solution contains approximately 42% (v/v) ethanol and 15% (w/v) propylene glycol. Other ARV liquid formulations (DRV and RTV) are available if a liquid formulation is required.

Table 6. What to Start: Initial Antiretroviral Regimens During Pregnancy

<i>Not Recommended</i> for Initial Use in Pregnancy, but May Be Used in Special Circumstances of Substantial Prior ART Experience		
<p>These drugs are <i>Not Recommended</i> for initial use in pregnancy when there has never been prior receipt of ART or ARV drugs for prophylaxis (i.e., ARV-naïve). Except for NVP and LPV/r, data on the PK, safety, and efficacy of these drugs during pregnancy are limited.</p> <p>These drugs also are categorized as <i>Not Recommended</i> during pregnancy, except in special circumstances, because the Panel recognizes that circumstances may exist in which patients who are ART-experienced may need to initiate or continue these drugs during pregnancy to reach or maintain viral suppression (see Table 7).</p>		
<i>Not Recommended</i> Except in Special Circumstances of Substantial Prior ART Experience	Advantages	Disadvantages
ETR	<ul style="list-style-type: none"> Standard adult dose is appropriate during pregnancy in the special circumstance where ETR is used. 	<ul style="list-style-type: none"> Not recommended in nonpregnant individuals who are ART-naïve Limited PK, toxicity, and efficacy data during pregnancy
FTR		<ul style="list-style-type: none"> Not recommended in nonpregnant individuals who are ART-naïve Limited PK, toxicity, and efficacy data during pregnancy
IBA		<ul style="list-style-type: none"> Not recommended in nonpregnant individuals who are ART-naïve Limited PK, toxicity, and efficacy data during pregnancy Requires IV administration
LEN	<ul style="list-style-type: none"> Early data suggest limited toxicity and appropriate PK data 	<ul style="list-style-type: none"> Not recommended in nonpregnant individuals who are ART-naïve Limited efficacy data during pregnancy Use is limited to multidrug-resistant HIV
MVC	<ul style="list-style-type: none"> Limited data suggest a standard adult dose is appropriate during pregnancy in the special circumstance where MVC is used. 	<ul style="list-style-type: none"> Not recommended in nonpregnant individuals who are ART-naïve Limited PK, toxicity, and efficacy data during pregnancy Requires tropism testing before use

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<p>NVP</p>	<ul style="list-style-type: none"> • Standard adult dosing is appropriate during pregnancy in the special circumstance where NVP is used. 	<ul style="list-style-type: none"> • Not recommended in nonpregnant individuals who are ART-naïve • Greater potential for adverse effects • Low barrier to resistance • Requires complex lead-in dosing • NVP should be used with caution when initiating ART in pregnancy when CD4 counts are >250 cells/mm³. • Use NVP and ABC together with caution; both can cause hypersensitivity reactions in the first few weeks after initiation.
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Note: The following drugs and drug combinations (not listed above) should not be used during pregnancy; if pregnancy occurs while taking any of these medications, medications should be switched to a recommended regimen: d4T, ddI, NFV, RTV (as the sole PI), two-drug ARV regimens (except for DTG/3TC or CAB/RPV), or a three-NRTI ARV regimen (e.g., ABC/ZDV/3TC). See [Archived Drugs](#) in the Perinatal Guidelines and the [Adult and Adolescent Antiretroviral Guidelines](#) for individual ARV drugs, ARV combinations, and ARV regimens that are not recommended or that should not be used in adults.

Key: 3TC = lamivudine; ABC = abacavir; ART = antiretroviral therapy; ARV = antiretroviral; ATV = atazanavir; ATV/c = atazanavir/cobicistat; ATV/r = atazanavir/ritonavir; BIC = bictegravir; CD4 = CD4 T lymphocyte; CAB = cabotegravir; CAB-LA = long-acting cabotegravir; COBI = cobicistat; d4T = stavudine; ddI = didanosine; DOR = doravirine; DRV = darunavir; DRV/c = darunavir/cobicistat; DRV/r = darunavir/ritonavir; DTG = dolutegravir; EC₉₅ = 95% maximal effective concentration; EFV = efavirenz; ETR = etravirine; EVG = elvitegravir; EVG/c = elvitegravir/cobicistat; FDC = fixed-dose combination; FTC = emtricitabine; FTR = fostemsavir; H2 blocker = histamine H2-receptor antagonist; HBV = hepatitis B virus; HD = high dose; IBA = ibalizumab; IMPAACT = International Maternal Pediatric Adolescent AIDS Clinical Trials; INSTI = integrase strand transfer inhibitor; IV = intravenous; LEN = lenacapavir; LPV/r = lopinavir/ritonavir; MVC = maraviroc; NFV = nelfinavir; NNRTI = non-nucleoside reverse transcriptase inhibitor; NRTI = nucleoside reverse transcriptase inhibitor; NTD = neural tube defect; NVP = nevirapine; the Panel = the Panel on Treatment of HIV During Pregnancy and Prevention of Perinatal Transmission; PI = protease inhibitor; PK = pharmacokinetic; PPI = proton pump inhibitor; PrEP = pre-exposure prophylaxis; RAL = raltegravir; RPV = rilpivirine; RTV = ritonavir; TAF = tenofovir alafenamide; TDF = tenofovir disoproxil fumarate; ZDV = zidovudine; v/v = volume/volume; w/v = weight/volume