Antiretroviral Therapy for People with HIV Who Are Trying to Conceive

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Panel's Recommendations
• Reproductive intentions should be reviewed at each health care encounter. The time before a planned attempt to conceive is an important opportunity to review current and alternative antiretroviral (ARV) regimens and underscore the goal of reaching viral suppression (i.e., undetectable HIV RNA) before and throughout pregnancy, along with many other aspects of preconception planning (see Prepregnancy Counseling and Care for Persons of Childbearing Age with HIV) (AIII). • Use of contraception, regardless of type, should never be a requirement to initiate or continue ARV regimens, even if there are limited data on these ARV regimens in pregnancy (e.g., long-acting injectable cabotegravir and rilpivirine) (AIII). Clinicians should engage in shared decision-making, counsel patients on the potential benefits and risks, and be aware of the potential for reproductive coercion (AIII). • Whenever possible, regimen initiation or changes should be made with sufficient time to achieve viral suppression before attempting to conceive or becoming pregnant (AII).
Rating of Recommendations: A = Strong; B = Moderate; C = Optional *Rating of Evidence: I = One or more randomized trials with clinical outcomes and/or validated laboratory endpoints; II = One or more well-designed, nonrandomized trials or observational cohort studies with long-term clinical outcomes; III = Expert opinion*

Antiretroviral therapy (ART) should be initiated and viral suppression (i.e., undetectable HIV RNA) should be achieved prior to pregnancy whenever possible. People should be given information about the benefits and risks of initiating specific antiretroviral (ARV) regimens when trying to conceive so they can make informed decisions about their care (see Appendix C: Antiretroviral Counseling Guide for Health Care Providers). Prevention of perinatal HIV transmission is maximized in individuals who are on fully suppressive ART prior to conception and remain suppressed during pregnancy and through delivery.[1] For more information, see Prepregnancy Counseling and Care for Persons of Childbearing Age with HIV.

In general, the Panel on Treatment of HIV During Pregnancy and Prevention of Perinatal Transmission recommendations for *Preferred* and *Alternative* ARV medications are the same for both pregnant people and people who are trying to conceive and are initiating treatment (see Table 7. Situation-Specific Recommendations for the Use of Antiretroviral Drugs in Pregnant People and Nonpregnant People Who Are Trying to Conceive). However, the time before a planned attempt at conception is an important opportunity to review current ARV regimens and other ARV options, if indicated. This is especially important for regimens that lack pharmacokinetic or safety data and those with possible risk of viral rebound later in pregnancy when medication changes may be more difficult. For people on long-acting injectable ARVs who are considering switching regimens prior to conceiving to prevent fetal exposure, it is important to recognize that these injections must be stopped at least 1 year before conceiving to ensure that the long-acting drugs are fully eliminated. Additionally, among those on long-acting injectable ART who have a history of poor adherence to oral medications, switching from long-acting injectable cabotegravir (CAB) and rilpivirine (RPV) to

oral ART to prepare for conception may be associated with increased risk of viral rebound and non-nucleoside reverse transcriptase inhibitor resistance.[2]

Importantly, many people who are not trying to conceive, but who are of childbearing potential, may choose ARV regimens that are not designated as *Preferred* for people trying to conceive. Use of contraception, regardless of type, should never be a requirement to initiate or continue ARVs, even if there are limited data on these ARVs in pregnancy (e.g., long-acting injectable CAB and RPV). Clinicians should engage in shared decision-making, counsel patients on the potential risks and benefits, and be aware of the potential for reproductive coercion.[3]

References

1. Sibiude J, Le Chenadec J, Mandelbrot L, et al. Update of perinatal human immunodeficiency virus type 1 transmission in France: zero transmission for 5,482 mothers on continuous antiretroviral therapy from conception and with undetectable viral load at delivery. *Clin Infect Dis*. 2023;76(3):e590-e598. Available at: https://pubmed.ncbi.nlm.nih.gov/36037040.

2. Coleman H, Fox J, Chilton D. The risks associated with stopping injectable antiretroviral treatment in women who are trying to conceive: a case series. *AIDS*. 2022;36(8):1205-1206. Available at: https://pubmed.ncbi.nlm.nih.gov/35796738.

3. Lazenby GB, Sundstrom BL, Momplaisir FM, et al. Perception of coercion during contraceptive counseling among individuals with HIV. *Sex Reprod Healthc*. 2022;34:100791. Available at: https://pubmed.ncbi.nlm.nih.gov/36334506.