Antiretroviral Therapy When 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) **(AIII).** • Use of contraception, regardless of type, should never be a requirement to initiate or continue ARV regimens, even if data are limited on use of 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. Information about the benefits and risks of initiating specific antiretroviral (ARV) regimens when trying to conceive should be provided so that informed decisions about care can be made (see Appendix C: Antiretroviral Counseling Guide for Health Care Providers). Prevention of perinatal HIV transmission is maximized when fully suppressive ART is being used prior to conception and suppression remains consistent during pregnancy and through delivery.[1] For more information, see Prepregnancy Counseling and Care.

In general, the Panel on Treatment of HIV During Pregnancy and Prevention of Perinatal Transmission's recommendations for *Preferred* and *Alternative* ARV medications are the same both during pregnancy and when trying to conceive and initiating treatment (see Table 7. Situation-Specific Recommendations for Use of Antiretroviral Drugs During Pregnancy and When 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. When long-acting (LA) injectable ARVs are being used and switching regimens prior to conceiving is being considered to prevent fetal exposure, it is important to recognize that these medications may be detectable in serum for up to 1 year after the last injection.[2] Additionally, when LA injectable cabotegravir (CAB) and rilpivirine (RPV) are being used and there is a history of poor adherence to oral medications, switching from LA CAB/RPV to oral ART to prepare for conception may be associated with increased risk of viral rebound and non-nucleoside reverse transcriptase inhibitor resistance.[3]

Importantly, when pregnancy is not desired but there is childbearing potential, ARV regimens that are not designated as *Preferred* when trying to conceive may be chosen. Use of contraception, regardless of type, should never be a requirement to initiate or continue ARVs, even if data on these ARVs (e.g., LA CAB/RPV) in pregnancy are limited. Clinicians should engage in shared decision-making, counsel patients on the potential risks and benefits, and be aware of the potential for reproductive coercion.[4]

References

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