

Midlands and East Region: Antiretroviral Therapy (ART) Prescribing Implementation Guidance for Adult and Adolescent Patients Starting and Switching Treatment 2017



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1 Introduction

Midlands and East Region: Antiretroviral Therapy (ART) Prescribing Implementation Guidance for Adult and Adolescent Patients Starting and Switching Treatment 2017

This prescribing implementation guidance has been developed following a request from NHS England to the HIV CRG members from the Midlands and East Regions.

The prescribing implementation guidance has been developed using:

- HIV CRG best prescribing guidance 2015
- HIV CRG guidance on MDT arrangements 2015
- BHIVA Treatment Guidelines 2015 Available online at:- <http://www.bhiva.org/HIV-1-treatment-guidelines.aspx>
- NHS England Clinical Commissioning statements relating to antiretroviral prescribing
- Commissioning for Value Scheme

Included in this document are:

- Recommendations for starting and switching ART regimens
- Starting regimens flow chart
- Examples of starting regimens using the price banding approach
- Starting ARTs Banding Graphic
- ART Audit and MDT approval form for starting ART regimens (double sided)
- Switching regimens flow chart
- ART Audit and MDT approval form for switching ART regimens (double sided)
- Switching ARTs Bands Graphic

2 Methods and Rationale

A group was convened consisting of representation from the three areas comprising the West Midlands, East Midlands and the East of England. The group consisted of HIV consultants from the HIV CRG, clinical HIV pharmacists, procurement pharmacists, specialised service commissioners and NHSE pharmacists as well as representatives from NHIVNA, HIVPA, BHIVA, BASHH and patient representatives.

Draft guidance was provided to HIV prescribing clinicians and pharmacists from the three areas for comment (February 2016). Comments received before 21st February 2016 were considered and discussed before final recommendations were issued on 20th April 2016. These recommendations were approved by NHSE Midlands and East HIV Specialised Commissioners in May 2016. This formed the basis for commissioning ART therapy in the Midlands and East regions as of August 2016. Since then the national commissioning for value scheme was introduced. The guidelines have been updated to include these switches within the graph bandings and the switching audit forms to produce the updated NHSE Midlands and East 2017 ART Guidelines. As new agents/generics or fixed dose combinations become available and approved for use by NHS England this guidance may be periodically updated.

In November 2015 pharmaceutical companies tendered their pricing offers to the Midlands and East areas for the period April 2016 – March 2018. The prices offered were considered by the ART group; pricing had a significant bearing on the selection of recommended starting regimens. It has been recognised that at this time a balance between commissioning for value and prescribing as per National clinical guidelines (BHIVA prescribing guidelines 2015) is required. This implementation guidance aims to realise significant cost savings for NHS England whilst maintaining high quality patient care.

This implementation guidance specifically recognises:

- The greater need for peer review in the prescribing of ARTs
- That HIV networks using recognised local and regional HIV MDTs will be responsible for approving ART use in accordance with this guidance
- There will be an increase in the use of generic ARVs as they become available
- Cost efficiencies will facilitate access to new ART products and treatment strategies as they become available and make ARTs available to a growing number of new patients requiring treatment
- Both patients and clinicians have a responsibility to use and prescribe ARTs which provide value to the NHS

We have adopted an approach of using “ART Price Bands” based upon the prices offered to the Midlands and East Region. Within these bands are different ART regimen options which allow for individualised prescribing according to need. The principle is that regimens in lower price bands are used in preference to those in higher bands (*if clinically appropriate*). Similarly use of regimens in higher bands will require greater justification at peer reviewed HIV MDTs.

3 Members of the Midlands and East ART Prescribing Implementation Group

WEST MIDLANDS	EAST MIDLANDS	EAST of ENGLAND
HIV Commissioner Philippa Turner NHSE Pharmacist Suzy Heafield/Mandy Mathews/Rabia Gowa	HIV Commissioner Barry O'Neill NHSE Pharmacist Susanna Taylor	HIV Commissioner Daniel Eve NHSE Pharmacist Joe Kerin
Procurement Pharmacist Diptyka Hart (UHB)	Procurement Pharmacist Jane Page (Derby)	Procurement Pharmacist Kevan Wind
Clinical HIV Pharmacist Justine Barnes (HEFT)	Clinical HIV Pharmacist Alison Darley <i>Nottingham*</i>	Clinical HIV Pharmacist Portia Jackson (Norwich)
HIV CRG ARV Sub-group representative Steve Taylor (Birmingham)	BHIVA Representative) Adrian Palfreman (Leicester)	HIV CRG representative Dush Mital Milton kynes
Patient Representative Tom Hayes (UK CAB)	Patient Representative Dano Wheals (UK CAB)	Patient Representative Longret Kwardem (UK CAB)
NHIVNA Representative: Cathy Ormiston (Burton), CHIVA Representative: Kate Ghandi (Birmingham), Midlands and East CMU Pharmacist: Linda Carpenter BASHH Representative Kaveh Manavi (UHB), Public Health Clinical Virologist Erasmus Smit		

*on maternity leave February 2016-January 2017

4 Recommendations for starting and switching ART Regimens Midlands and East Region 2017

Using the Prescribing Implementation Guidance:

We have developed ART audit and MDT approval forms to be used within the Midlands and East region to provide a consistent and transparent approach to prescribing. The forms should be completed before or shortly after starting or switching ART regimens. These forms will be used to audit ART usage as required by NHS England.

The grouping of several different regimens into “cost bands” allows the opportunity for clinicians to make choices of commissioned treatments which meet the needs of individual patients whilst being able to maintain an effective overall approach to cost management.

The ability to have a choice of regimens within bands of a broadly similar cost acknowledges the widely differing needs of patients and recognises that one regimen is not suitable for all patients.

It also encourages pharmaceutical companies to price their products competitively so that new drugs can be made available at an earlier stage to the greatest number of people.

In addition, it allows clinics to create a baseline picture in terms of the proportion of people in each ART band within their own patient cohort. Subsequently they can measure how prescribing initiatives agreed within their own centres can impact the banding mix moving forwards

It also recognises that each clinic has a unique mixture of patients in terms of demographics, comorbidities, and previous ART use which will impact the proportion of people on different ARTs.

Providing the number of combinations within each band is appropriately diverse, efficiency savings can be achieved in a relatively straightforward step-wise manner over time without requiring a detailed knowledge of individual drug prices.

In addition the banding graphics provided can provide clinicians with an immediate visual indication of the costs of particular regimens and therefore the relative cost of therapies under consideration.

Starting ART Regimens

Band 0 & 1 Regimens

- These regimens can be prescribed without MDT approval
- “Starting ART” audit forms need to be completed and retained for on-going ART audits
- Clinicians should aim to start patients on **Band 0** regimens unless there are clear and significant clinical reasons not to do so
- Clinicians and patients together may agree a time limited trial of a **Band 0** regimen to establish efficacy and tolerability on an individual level
- Patients should be counselled that the majority of people can tolerate these regimens without significant problems
- However patients should also be counselled that alternative regimens will be made available to those patients experiencing significant and ongoing side effects

Band 2 Regimens

- **Band 2** regimens should be used when there are sound clinical reasons for not starting with a **Band 0 or 1** regimen
- Reasons for not starting on a **Band 0 or 1** regimen need to be documented on the “Starting ART” form and MDT audit form
- If two experienced HIV Health Care professionals are in agreement that a **Band 2** regimen is required, obtaining “retrospective” peer review approval at a recognised MDT is acceptable practice
- Two healthcare professionals can be defined as one HIV consultant and an experienced HIV healthcare professional.
- “Starting ART” audit forms should still be completed and submitted to a recognised MDT for retrospective peer review approval within 4 weeks of starting the regimen
- Several larger HIV centres have agreed to receive ART audit forms for remote approval to support functioning of local HIV networks. Centres offering this service should agree to turn around approval requests within 8 working days.

Band 3 Regimens

- Patients requiring **Band 3** or **more complex regimens** should be discussed prospectively at a recognised MDT prior to initiation of the regimen
- Supporting information to facilitate MDT discussions and approval should be provided in addition to completing and submitting the “Starting ART and MDT audit form

6 Starting ART Regimens Midlands and East Region 2017 Prescribing Implementation Guidance Algorithm for Adult and Adolescent Patients Starting ARV Treatment.

Recommended Starting Regimen

Abacavir + Lamivudine (Generic), Efavirenz

Abacavir
Not recommended
VL >100,000
HLA*B5701 +ve
Hepatitis B Sag +ve
CV risk >10%

Efavirenz
Not recommended
Mental Health
Shift Work
Drug interactions

Alternative regimen from **BAND 1** selected
Complete ART Audit Form – Internal use

Alternative **BAND 1** regimen not clinically appropriate. **BAND 2** regimen proposed
Complete ART Audit/MDT Form and submit to MDT. Preference is to approve prospectively. Retrospective approval may be sought for urgent cases.

BAND 1 and 2 regimens not clinically appropriate.
BAND 3 regimen proposed
Preference is to discuss prospectively at MDT
Complete ART Audit/MDT Form,
Provide clinical case summary to MDT for discussion.

Complex Cases

These cases should be discussed prospectively at recognised HIV MDT

- ✓ Advice Required
- ✓ > than 2 class ARV resistance
- ✓ > than 4 ARV proposed in the regimen
- ✓ Significant co-morbidities
- ✓ Complex drug-drug Interactions
- ✓ Significant ARV toxicities
- ✓ Predicted issues with ARV intolerance
- ✓ Predicted significant adherence Issues
- ✓ Co infections
- ✓ Opportunistic Infections
- ✓ Pregnancy
- ✓ Child and Adolescent cases

Supporting clinical information needs to be provided to allow for informed MDT discussion. This includes ARV history, VL and CD4 responses to treatment, resistance reports and co medications. ART Audit /MDT Form should be provided to MDT if ART approval required.

7 Regional MDTs

Regional MDT meetings should prioritise discussing complex patients as described below to make optimum use of specialist expertise assembled. By using a standardised ART audit form it is anticipated that most peer review prescribing decisions and approvals can be made at smaller local recognised MDTs either directly or via remote arrangements within networks.

It is also recognised that the exact composition of HIV MDTs will vary across regions and clinical networks. The exact composition arrangements should be agreed with regional commissioners with the aim is working towards CRG MDT recommendations but should not be punitive to existing good practice.

Cases that should be routinely discussed at a recognised MDT meeting include:

- Those cases where prescribing advice is required
- Patients requiring Band 3 or more complex regimens
- Those cases with greater than 2 class resistance
- Regimens requiring 4 or more drugs
- Regimens require banding
- Cases where there are significant co-morbidities
- Complex clinically significant drug interactions
- Significant toxicities or side effects
- Significant or predicted issues with intolerance
- Significant or predicted adherence issues
- Severe opportunistic infections
- Pregnancy
- Child and adolescent cases

Supporting information to allow informed discussion of these cases should be provided in advance of the MDT.

8 Notes on this guidance regarding the use of specific antiretroviral agents

As in the 2014-2016 Midlands and East guidance **abacavir + lamivudine** remains the nucleoside backbone of choice when clinically appropriate.

This guidance will be subject to change as commissioning statements from NHS England are released. This includes products where part of a fixed dose drug combination is a drug not yet commissioned.

Abacavir use is dependent upon:

- Viral load <100,000 copies/ml (unless given with dolutegravir)
- HLA-B*5701 negative
- The Hepatitis B status of the patient
- CVD risk <10% by recognised calculator (e.g., Framingham or QRISK2)

Efavirenz may be considered unsuitable if there are:

- Significant current or past mental health illness
- Lifestyle or occupational issues, such as working late evening or night shifts

In this guidance the starting regimen of choice remains **abacavir + lamivudine plus generic efavirenz**

- It is recognised that this combination in BHIVA guidelines 2015 is listed as “*an alternative*” rather than a preferred option and that more tolerable regimens are now available with less CNS side effects.
- This guidance acknowledges that for certain patient groups this regimen is not clinically appropriate or not tolerated. However, it is also appreciated that a significant proportion of individuals starting this combination tolerate it without significant side effects.
- It is acknowledged that patients experiencing significant side effects should be switched to a different combination based on the recommendations of a recognised HIV MDT.

Tenofovir disoproxil fumarate (DF) based backbone use is dependent on:

- Abacavir being contraindicated or not tolerated
- Baseline VL >100,000 c/ml
- Treatment to be commenced before HLAB*5701 is available
- CV risk >10%
- The Hepatitis B status of the patient

Rilpivirine use is dependent upon:

- Efavirenz being contraindicated or not tolerated
- Baseline VL <100,000 copies/ml
- Dietary considerations or antacid use do not preclude use

Protease Inhibitors use is dependent upon:

- Primary/suspected resistance with single NRTI or NNRTI mutations
- Significant concern over the patient's adherence
- Treatment to be commenced before a resistance test is available

Nevirapine, Kaletra® and Etravarine have not been included in the final draft of this guidance. This is because they are not currently classified as either a preferred or alternative regimens within the BHIVA 2015 treatment guidelines.

However, clinicians may still wish to start patients on these agents, for example BHIVA Pregnancy guidelines still recommend the use of Nevirapine and Kaletra in pregnancy; these cases should be discussed prospectively at a recognised MDT

Regimens commenced prior to the availability of baseline resistance assay and/or HLA B*5701 result should be considered as a “*holding regimen*” and ART choices should be reviewed within 4-12 weeks once baseline results are available.

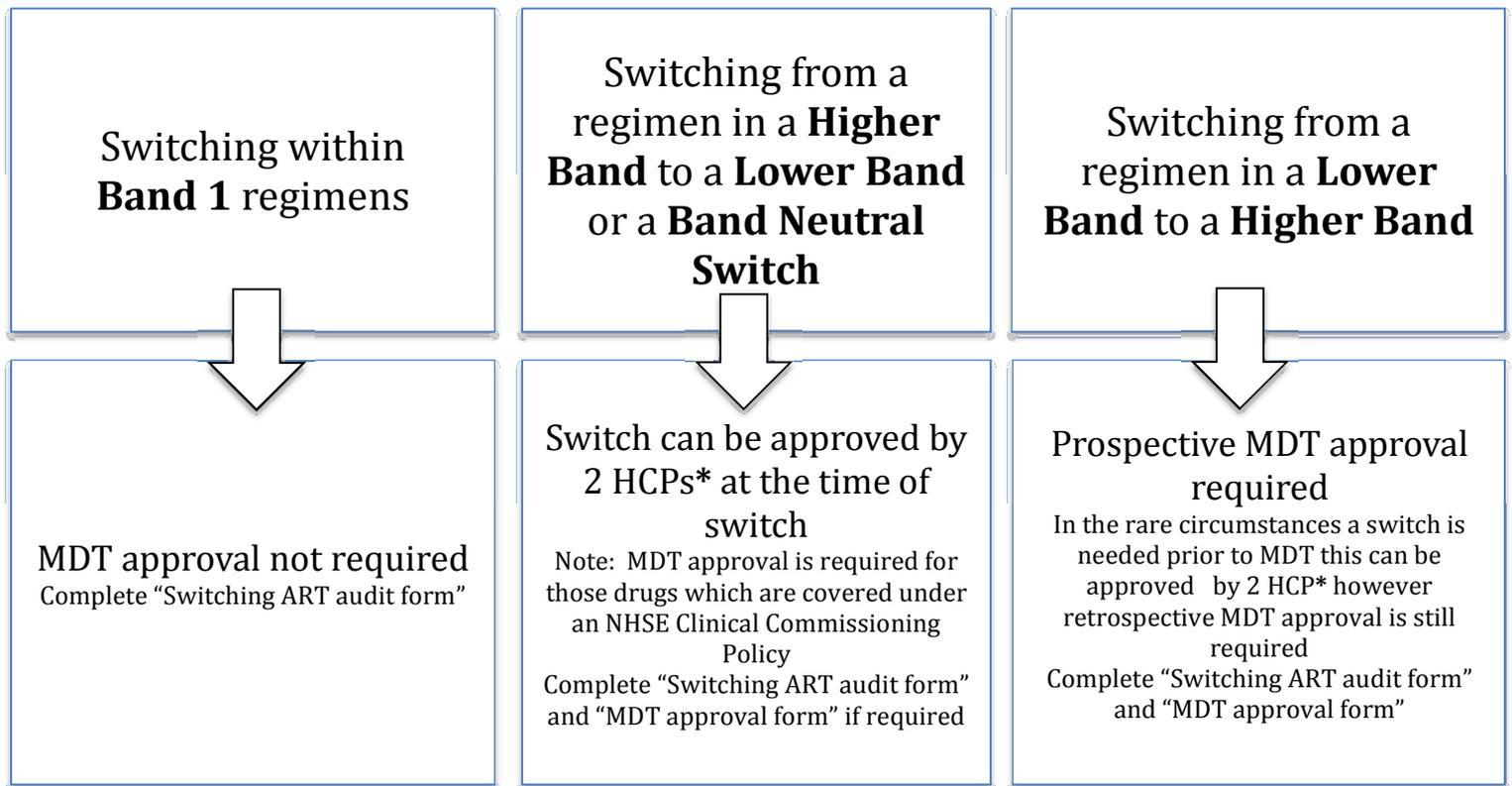
NHS England has published four commissioning policies which need to be adhered to alongside this guidance. The commissioning policies can be found via the following links:

1. Elvitegravir/cobicistat/emtricitabine/tenofovir for treatment of HIV in adults.
Reference: NHS England F03/P/a
<https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/10/f03pa-elvitegravir-hiv-oct15.pdf>
2. Use of cobicistat as a booster in treatment of HIV positive adults and adolescents
Reference: NHS England F03/P/b
<https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/10/f03pb-cobicistat-oct15.pdf>
3. Dolutegravir for treatment of HIV-1 in adults and adolescents
Reference: NHS England B06/P/a
<https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/05/b06-p-a-dolutegravir.pdf>
4. Tenofovir Alafenamide for treatment of HIV 1 in adults and adolescents
Reference: NHS England: 16043/P
https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2013/05/16043_FINAL.pdf
5. Treatment as Prevention (TasP) in HIV infected adults
Reference: NHS England F03/P/c
<https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/10/f03pc-tasp-oct15.pdf>

9 Recommendations for switching ART regimens (Midlands and East Region 2017)

- Antiretrovirals should be prescribed in line with NHS England Clinical Commissioning Policies in addition to agreed regional prescribing initiatives. Antiretrovirals and treatment strategies currently under review by NHS England should not be prescribed /implemented without an individual funding request (IFR).
- With **generic formulations**, new drug treatments and new fixed dose combinations, we anticipate that changing or switching treatments will become much more common. For this reason a switching algorithm for the Midlands and East region has been developed. It is recognised that clinical benefit can be achieved whilst using more cost effective regimens.
- **Switching from fixed dose formulations** to individual generic components can realise significant cost savings to the NHS. Where costs are not prohibitive, fixed dose combinations (including single tablet regimens) are still commissioned within current NHS England funding pathways.
- **Future directives may advocate switching strategies.** Switching of ART regimens for the purpose of cost savings alone, currently, should be individualised taking into account the patients' clinical needs and understanding. Changes must be prospectively discussed with the patient and associated costs of switching regimens taken into account.
- Switching to a regimen which will provide clinical benefit to the patient which also results in switching to a regimen in a **lower band** will generally be approved. However the Switching ART audit form must still be completed for audit purposes.
- Switching to a regimen in a higher band should generally only be considered where a regimen within the same, or lower, band would not provide the desired clinical response. These cases should be prospectively discussed at a recognised MDT (see flow diagram switching ART)

10 Algorithm for Switching ART regimens (Midlands and East Region 2017)



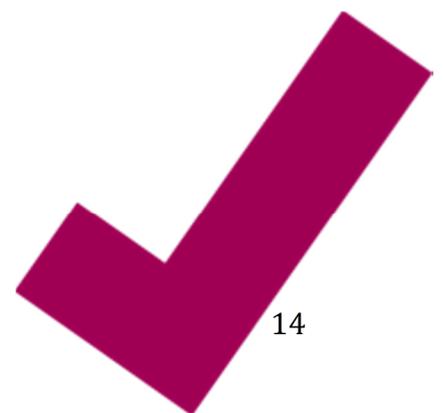
**Two healthcare professionals can be defined as one HIV consultant and an experienced HIV healthcare professional.*

- Reasons for switching ART regimens should not be at the detriment of patient care.
- It is recognised that clinical benefit can be achieved whilst still using more cost effective regimens
- Switching of ART regimens for the purpose of cost savings alone must be individualised taking into account patients clinical needs and understanding of the reasons for switch.
- Changes must be prospectively discussed with the patient, taking into account the associated costs of switching regimens.

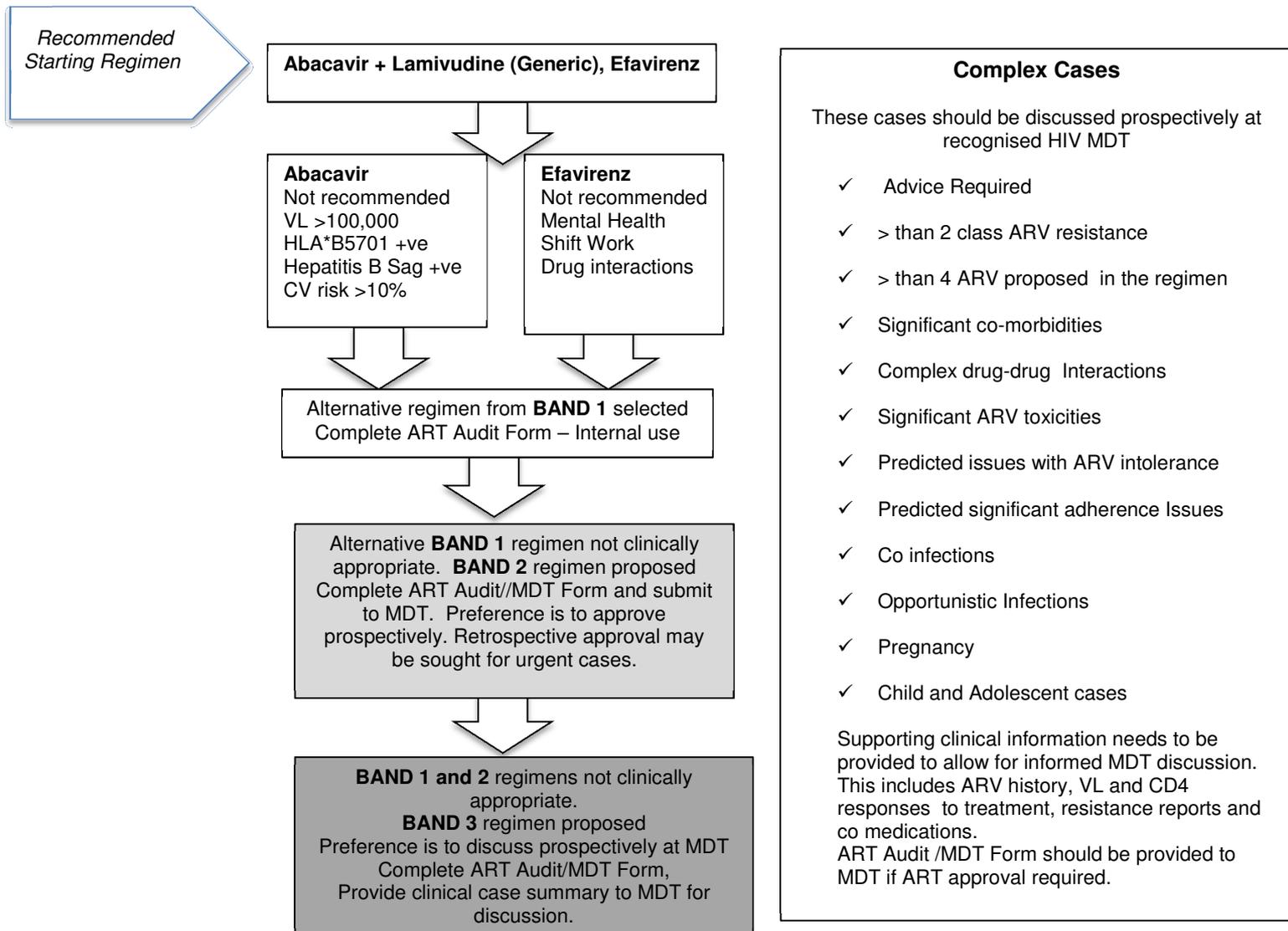
**11 Appendix 1 – Midlands and East Region ART Prescribing
Implementation Guidance for Adult and Adolescent Patients
Starting and Switching Treatment 2017**

**Visual Aid Graphs and Starting & Switching Formal Audit
Forms and MDT Approval Forms**

**Midlands and East Region:
Antiretroviral Therapy (ART)
Prescribing Implementation
Guidance for Adult and
Adolescent Patients Starting
and Switching Treatment
2017**

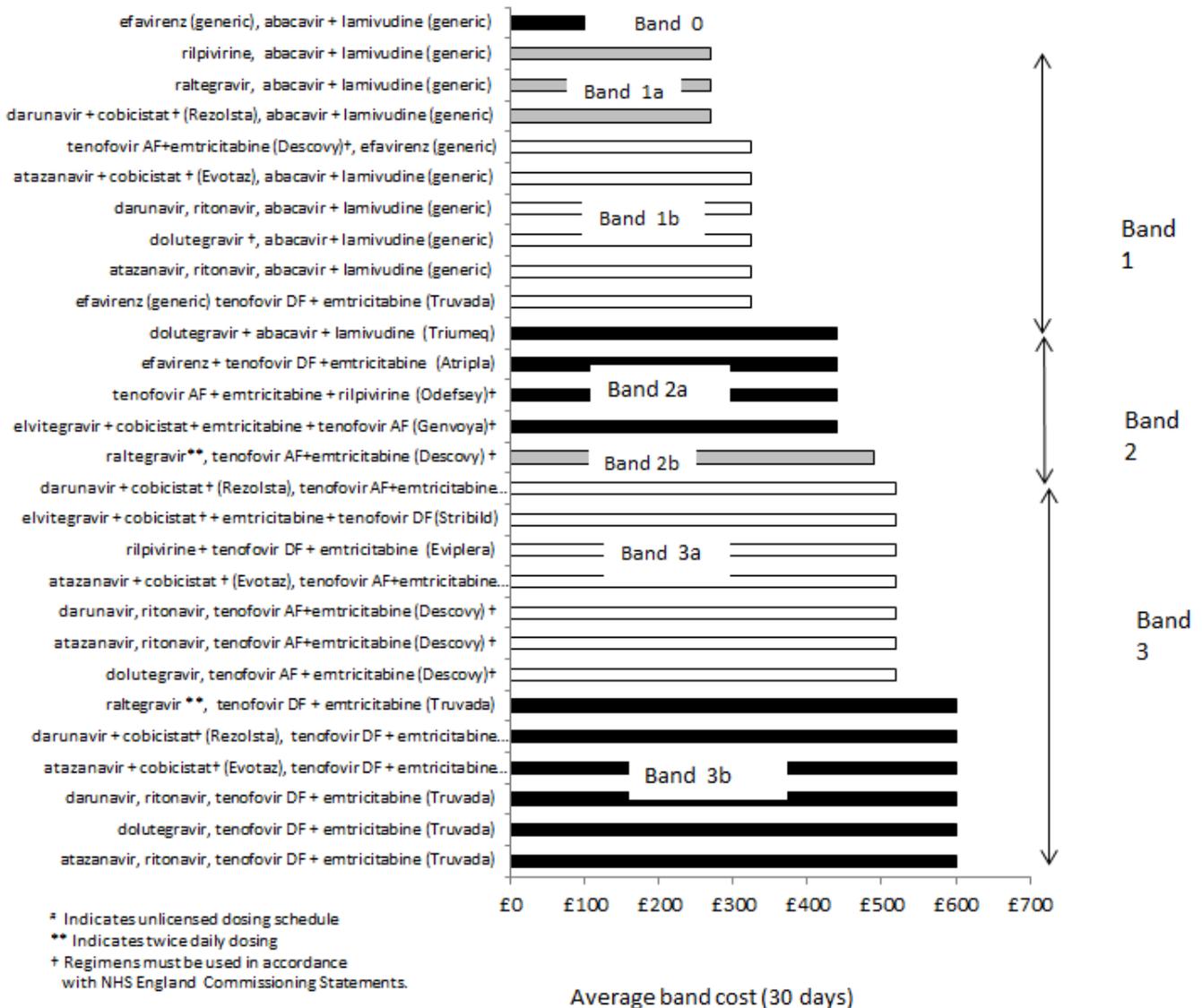


Midlands and East Region 2017: Prescribing Implementation Guidance Algorithm for Adult and Adolescent Patients Starting ART Treatment



Visual aid to assist in starting ART regimens using an ART banding approach (Midlands and East Region 2017)

Visual Aid: Starting ARV Regimens using an ARV Banding Approach



This is not an exhaustive list and only includes some of the more commonly used drug regimens.

Examples of Starting Regimens Linked to Midlands and East Region Banding Approach Prescribing Implementation Guidance 2017

Efavirenz (generic), abacavir + lamivudine (generic) is the first choice starting regimen. It is acknowledged that this regimen will not be suitable for all patients. In such cases patients should use or switch to a **Band 1** regimen if available.

If this is not clinically appropriate a **Band 2** regimen should be selected if it is deemed appropriate by at least two HIV Health Care professionals. Starting ART audit forms should still be completed and submitted to a recognised MDT for retrospective peer review approval.

STARTING TREATMENT: AUDIT FORM 2017

Patient Initials: **PID:** **Centre:** **Date:**

Sex M/F/Trans: **Age:** **Latest CD4:** **Latest VLM:**

Proposed Regimen (please include formulation and dose).

Drug / Preparation	Dose	Frequency	Formulation

Proposed Regimen Band

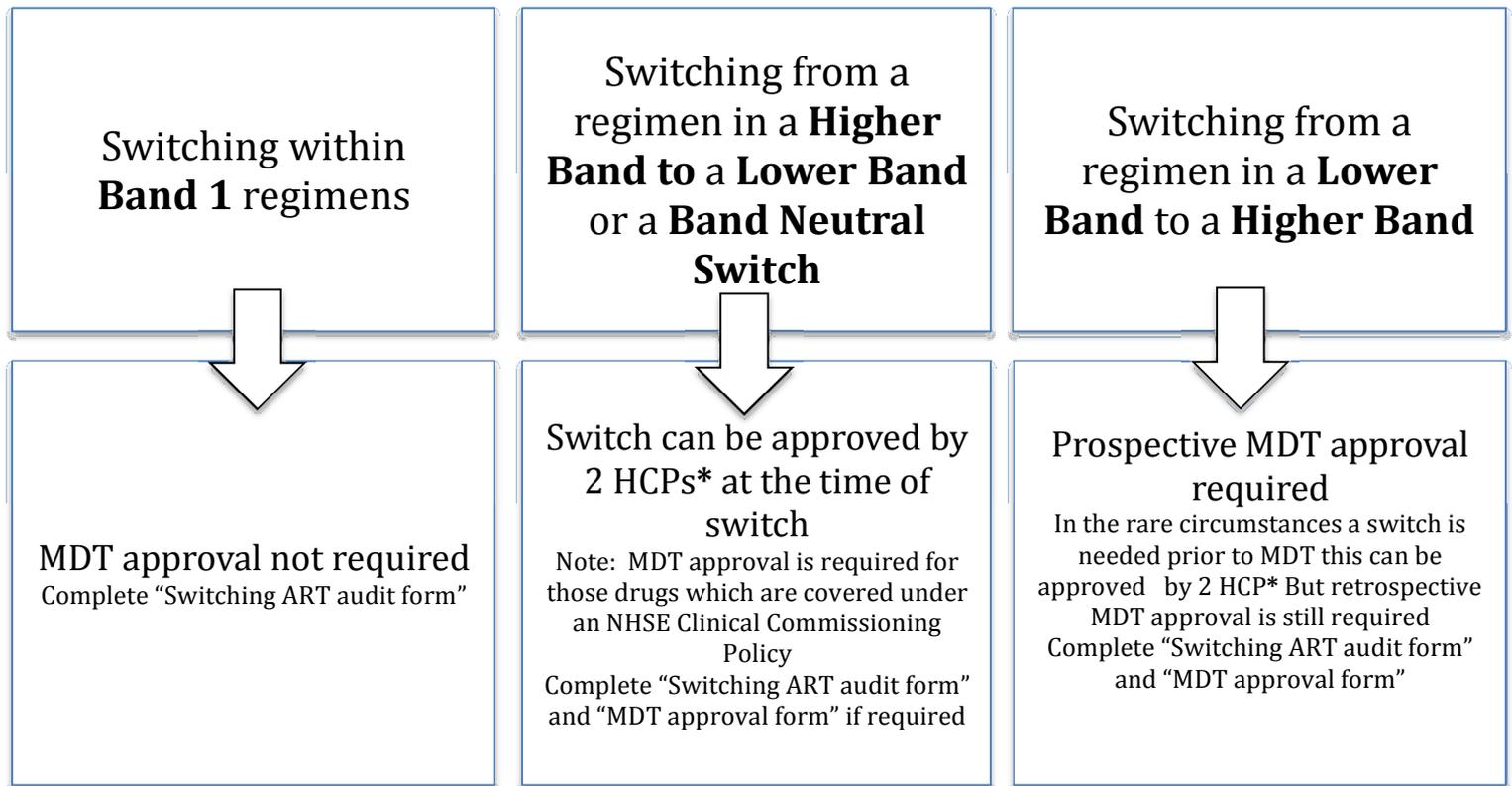
- Band 0 & 1** MDT peer review not required. This form is complete (retain for Audit)
- Band 2** Retrospective MDT peer review acceptable,
IF the original decision is supported by at least 2 HCPs and audit form
submitted to MDT for peer review within 4 weeks.
- Band 3 or above** Prospective MDT discussion required.
Submit this form to MDT prior to prescribing unless urgent circumstances

Select reason(s) for not starting with Band 1 or Band 2 regimen (please select all that apply)

Baseline Resistance	VL>100,000	HLA B*5701 positive
C/V risk > 10%	Hepatitis co-infection	Temporary regimen
Adherence concerns	Significant renal impairment	TB Co-infection
Pregnancy	SPC exclusion criteria (i.e. NVP)	Food requirements
Significant Mental Illness (please state)	Drug Interactions	Significant Hepatic impairment
Neurocognitive impairment	Clinical Trial	Significant recreational drug use
Infant <4	Paediatric patient <12	Adolescent Patient (13 -18)
Malignancy (please state)	Other co-morbidity (please state)	Social circumstances impacting adherence
Patient Request	Occupational issues	Other..... (please state)

Please attach supporting information if a Band 3 regimen is proposed

Algorithm for Switching ART regimens (Midlands and East Region 2017)



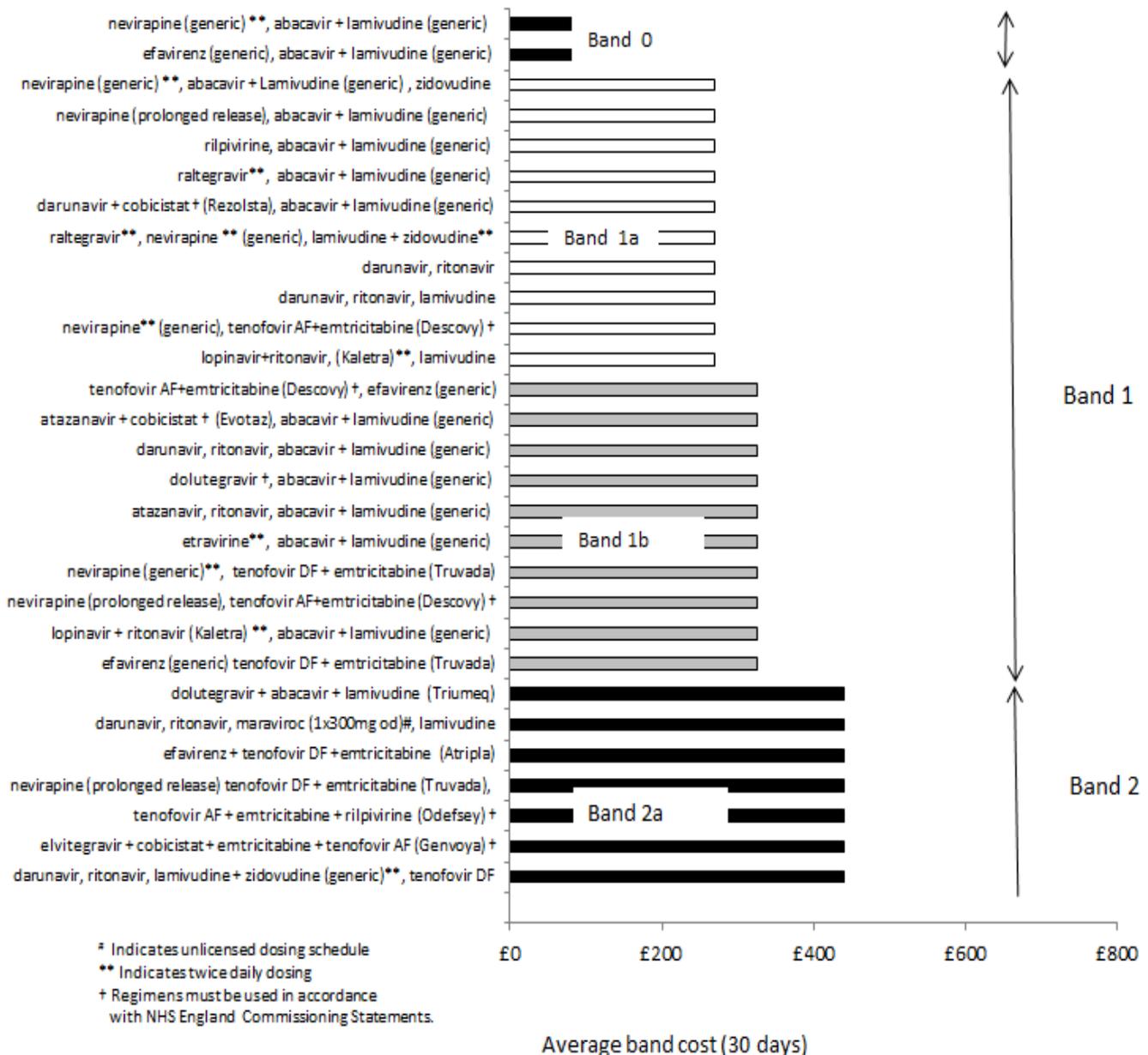
**Two healthcare professionals can be defined as one HIV consultant and an experienced HIV healthcare professional.*

- Reasons for switching ART regimens should not be at the detriment of patient care.
- It is recognised that clinical benefit can be achieved whilst still using more cost effective regimens.
- Switching of ART regimens for the purpose of cost savings alone must be individualised taking into account patients clinical needs and understanding of the reasons for switch.
- Changes must be prospectively discussed with the patient and associated costs of switching regimens taken into account.

Visual Aid: Switching between ARV Regimens using an ARV Banding Approach 2017

(Band 0-Band 2a)

Visual Aid: Switching between ARV Regimens using an ARV Banding Approach

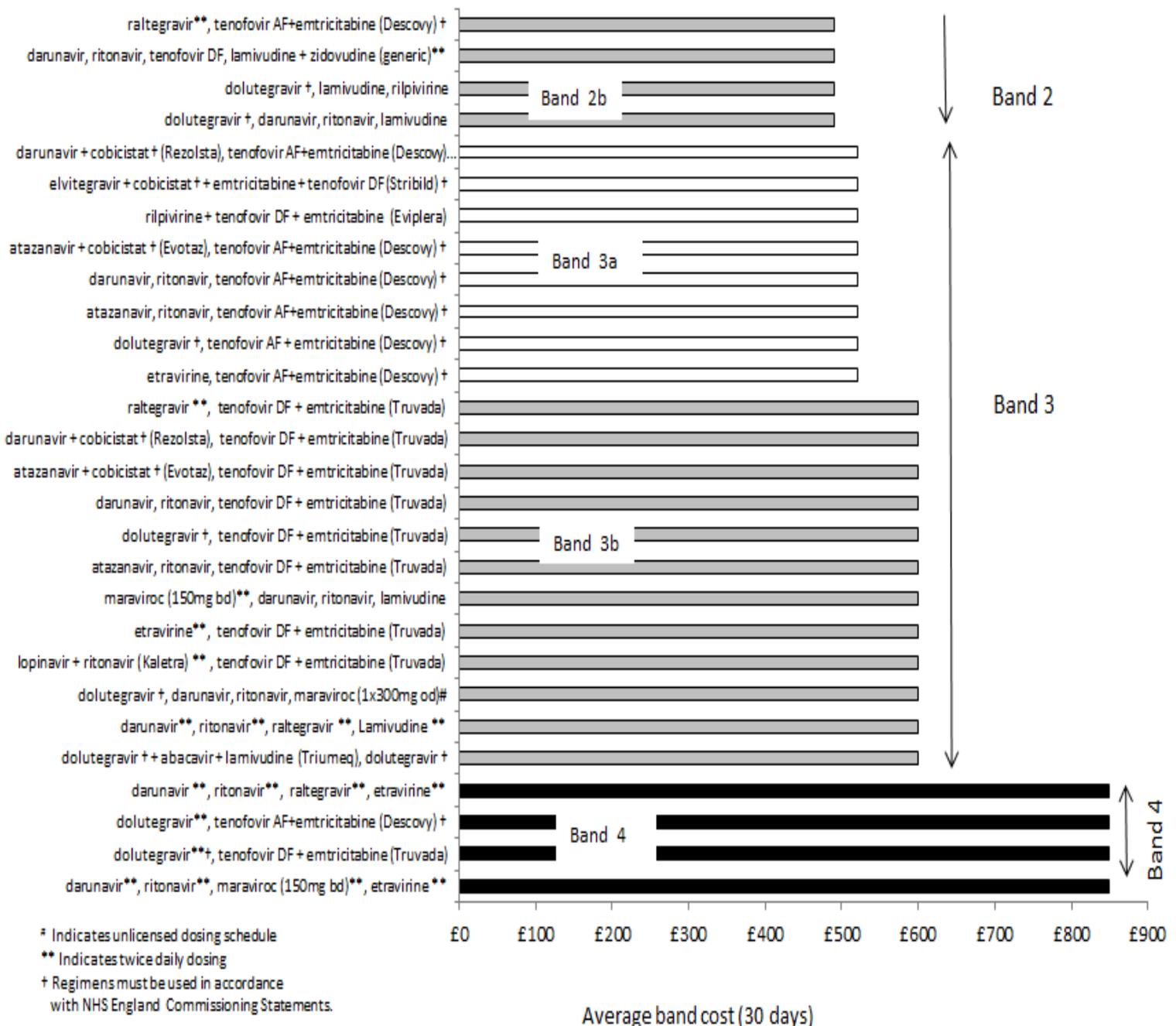


This is not an exhaustive list and only includes some of the more commonly used drug regimens.

Visual Aid: Switching between ARV Regimens using an ARV Banding Approach 2017

(Band 2b – Band 4)

Visual Aid: Switching between ARV Regimens using an ARV Banding Approach. Bands 2b-4



This is not an exhaustive list and only includes some of the more commonly used drug regimens.

SWITCHING ARV TREATMENT: AUDIT FORM 2017

Patient Initials: **PID:** **Centre:** **Date form complete:**

Current Regimen (please include formulation and dose)

Drug / Preparation	Dose	Frequency	Formulation

Current Regimen Band: Zero 1a 1b 2a 2b 3a 3b 4 Other

Proposed New Regimen (please include formulation and dose) Or recommendation requested from MDT

Drug / Preparation	Dose	Frequency	Formulation

Proposed Band: Zero 1a 1b 2a 2b 3a 3b 4a 4b Other

Select reason(s) for switch (select all that apply)

Intolerance	Simplification	Low level viraemia	
Cost effectiveness (switching to regimen in a lower price band)	Generic formulation available	Adverse Drug Reaction (Please state)	
New Resistance	Virological Failure	HLA B*5701 positive	
C/V risk > 10%	Hepatitis co-infection	Temporary regimen	
Adherence concerns	Significant renal impairment	TB Co-infection	
Pregnancy	Drug Interactions	Food requirements	
Significant Mental Illness (please state)	Repatriation	Sig Hepatic impairment	
Neurocognitive impairment	Clinical Trial	Sig recreational drug use	
Infant <4	Paediatric patient <12	Adolescent Patient (13 -18)	
Malignancy (please state)	Other co-morbidity (please state)	Occupational issues	
Patient Request	Social circumstances impacting adherence	Commissioning for Value Scheme	

If switching to a higher band, complex patient or advice required please provide supporting information

SWITCHING ART TREATMENT: MDT APPROVAL FORM 2017

Patient Initials:

PID:

Centre:

Will switching regimen improve patient care AND result in moving to cheaper regimen band?

YES ⇒ Regimen switch approved remotely. Please retain this form for Audit purposes

NO ⇒ **Send this form for peer review approval at recognised MDT**

If switching to a higher band, complex patient or advice required attach supporting information

MDT Discussion: (To be completed at MDT meeting) MDT Location:

In attendance (please state)

HIV Consultants	ID /Virology Consultants	Other Consultants

Other Members present:

SPRs , Pharmacist , Clinical Nurse Specialist , Nurse , Dietician , Occupational Therapist , Health Adviser , Psychologist Other

Regarding the proposed switch

Is there adequate clinically appropriate rationale YES /NO NHSE Criteria Met YES /NO

Notes (to include regimen(s) approved if different to the regimen proposed):

Switch Approved: Yes / No **Remote approval**

Final Switch: **Band Reduced** **Band Neutral** **Band increased** **Banding for new regimen**.....

12 Appendix 2 – HIV Medication options in your area

HIV medication options in your area

This leaflet was written by and for local HIV positive people. It explains how decisions about prescribing HIV medications are made in the West Midlands, East Midlands and East of England NHS region. On the back page there are contact details for further information on HIV treatment, and for your local clinic and support services. Remember, you are not alone!

What is HIV treatment?

- HIV treatment is usually a combination of three or more different drugs – called a 'regimen'.
- There are many regimen options that are easy to take and with very few side-effects.
- Your medication may come in a single pill (called a fixed dose combination or FDC) or a small number of pills.
- They have strange names but it is useful to memorise or make a note of them in-case you need to tell someone, like another doctor or your GP.
- Since the mid-1990s these drugs have allowed people with HIV to lead a normal life like anyone else with a long-term managed health condition.



- HIV treatment only works if you take the medication as prescribed – this is called 'adherence'.

How are decisions about my HIV treatment made?

- Your HIV team (nurse, doctor and pharmacist) has access to a range of HIV medications and different regimens. They will give you all the advice, support and guidance you need to help you decide on a treatment option that is right for you.
- Deciding on the best treatment option is based on what suits you in terms of lifestyle, possible side effects, other health issues and other medications.
- Sometimes you may need to change your HIV medication. Your HIV team will explain why this might be beneficial and what the alternatives are.
- Your doctor has access to a range of HIV medications. They fall within bands relating to their cost (see chart on page 3).

- Band 0 drugs cost the least and Band 3 are the most expensive.
- Your doctor may decide that a Band 2 drug suits you better, in terms of possible side effects or effectiveness, than a Band 1 drug.
- It is harder for your doctor to prescribe the more expensive Band 3 drugs. They have to hold a team meeting to do this. This process keeps NHS spending accountable when drugs from all bands are effective and money is limited.

What does my HIV team need to know?

- **How you are feeling:** An HIV diagnosis can trigger difficult feelings and you may benefit from extra support. Some HIV drugs can also affect the way you feel. If you have suffered from anxiety or depression in the past, tell your HIV team.
- **Working life:** Shift work or irregular working times may affect your treatment options. For example,

some drugs can make you dizzy, others you have to take with a meal.

- **Family life:** Tell your team what is going on in your life, for example, childcare, domestic violence, or living alone with no family. You may benefit from extra support.
- **Other medications and recreational drugs:** Tell your doctor what other medications, vitamins and herbal supplements you are taking, for example, for menopause, anti-depressants, statins, hormone treatment, methadone. These can affect how well HIV treatment works. Recreational drugs can also interact with some HIV drugs so it is best to be up front with your doctor.
- **Sharing health information:** Your HIV clinic can not legally share your health information without your permission. However, your healthcare will be easier to manage if your GP knows, for example, when prescribing for other conditions. Tell your team if you want your health information shared.

What is a 'generic' drug?

When a drug company makes a new drug, it is controlled under a patent for 20 years. Once the patent runs out, other drug companies can make the drug at a lower cost. These are called 'generic' drugs.

The NHS always tries to use generic drugs. This is normal for many health conditions. If your medication changes to a generic form it is nothing to worry about – the drug is the same, even if the pill and the packaging look different.



What are side effects?

When you start taking HIV medication, your body can take a while to adjust. Some changes may not seem important, but always report anything unusual to your HIV team.

Talk to your doctor about switching to another regimen if the side effects do not go away or interfere in your day-to-day life. Do not suffer in silence.

Cost bands for HIV treatment

These bands apply to your drugs if you are starting HIV treatment in West Midlands, East Midlands and East of England NHS region, 2017. The average cost for a month's supply of a regimen in Band 1 is about £300, while some in Band 3 are £600.

Band 0	<ul style="list-style-type: none"> efavirenz (generic), abacavir + lamivudine (generic)
Band 1	<ul style="list-style-type: none"> rilpivirine, abacavir + lamivudine (generic) raltegravir, abacavir + lamivudine (generic) darunavir + cobicistat (Rezolsta), abacavir + lamivudine (generic) tenofovir AF + emtricitabine (Descovy®), efavirenz (generic) atazanavir + cobicistat (Evotaz®), abacavir + lamivudine (generic) darunavir, ritonavir, abacavir + lamivudine (generic) dolutegravir, abacavir + lamivudine (generic) atazanavir, ritonavir, abacavir + lamivudine (generic) efavirenz (generic) tenofovir DF + emtricitabine (Truvada®)
Band 2	<ul style="list-style-type: none"> dolutegravir + abacavir + lamivudine (Triumeq®) efavirenz + tenofovir DF + emtricitabine (Atripla®) tenofovir AF + emtricitabine + rilpivirine (Odefsey®) elvitegravir + cobicistat + emtricitabine + tenofovir AF (Genvoya®) raltegravir, tenofovir AF + emtricitabine (Descovy®)
Band 3	<ul style="list-style-type: none"> darunavir + cobicistat (Rezolsta®), tenofovir AF + emtricitabine (Descovy®) elvitegravir + cobicistat + emtricitabine + tenofovir DF (Stribild®) rilpivirine + tenofovir DF + emtricitabine (Eviplera®) atazanavir + cobicistat (Evotaz®), tenofovir AF + emtricitabine (Descovy®) darunavir, ritonavir, tenofovir AF + emtricitabine (Descovy®) atazanavir, ritonavir, tenofovir AF + emtricitabine (Descovy®) dolutegravir, tenofovir AF + emtricitabine (Descovy®) raltegravir, tenofovir DF + emtricitabine (Truvada®) darunavir + cobicistat (Rezolsta®), tenofovir DF + emtricitabine (Truvada®) atazanavir + cobicistat (Evotaz), tenofovir DF + emtricitabine (Truvada®) darunavir, ritonavir, tenofovir DF + emtricitabine (Truvada®) dolutegravir, tenofovir DF + emtricitabine (Truvada®) atazanavir, ritonavir, tenofovir DF + emtricitabine (Truvada®)

Where can I get advice and support?

- You can get free online advice through community forums like myHIV or helplines (see below). All these services are confidential and helplines are anonymous.
- Find out if there are any local support services where you can get one-to-one support and advice or go to a support group and meet with other people living with HIV. This is called 'peer' support. It is comforting to meet with or speak to someone who knows what you're going through.
- Speak to your HIV team – they can also refer you to local services.

Further information

HIV i-base

Information on HIV treatment, online questions and answers, free patient guides (ask your clinic or local support group to order them).

www.ibase.info

questions@i-base.org.uk

Confidential free helpline:

0808 800 6013

Terrence Higgins Trust myHIV

Online counselling and advice, live chat with online community forum, peer support.

www.tht.org.uk/myhiv

Confidential free helpline:

0808 802 1221

NAM Aidsmap

HIV-related information, including patient guides – *Taking your HIV treatment* and *Your Next Steps* are especially useful.

www.aidsmap.com

Positively UK

Training, advocacy, advice and support by and for people living with HIV. They run the national peer mentoring programme.

www.positivelyuk.org

Tel: 020 7713 0444

UK-CAB

HIV treatment advocacy network, free to join, online community forum, training and meetings on HIV topics.

www.ukcab.net

In my area

My clinic:

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Who I can contact at the clinic:

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Tel:

Local support services:

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