

Already taking HIV treatment? Information for patients in London

Last updated November 2012/ Due for review October 2013

The way anti-HIV drugs (antiretrovirals) will be prescribed for patients getting care in London changed in April 2011. This factsheet sets out the way prescribing guidelines may affect people already taking HIV treatment, and explains some of the issues you might want to consider if you, or your service users, are in this situation.

Who will the prescribing guidelines affect?

The prescribing guidelines apply to people starting treatment for the first time and to people who need to change from their current treatment to second-line therapy to include a protease inhibitor (PI). See NAM's factsheet *Starting HIV treatment: Information for patients in London*.

The prescribing practice will only affect patients on treatment who need to change regimen due to viral load rebound or side-effects, and those patients already taking a PI. Patients already taking a PI other than atazanavir (*Reyataz*) will be reviewed to see whether they can be switched to atazanavir and it is possible that people on older treatments may have their regimens reviewed.

Will people in London be asked to change the anti-HIV drugs they are on?

According to the guidelines, people who are currently on effective treatment based on a drug from the non-nucleoside reverse transcriptase inhibitor (NNRTI, or 'non-nuke') class, such as efavirenz (*Sustiva*), will not be asked to change. For example, people taking *Atripla* (efavirenz, tenofovir and FTC [emtricitabine]), or those who take *Truvada* (tenofovir/FTC) will not be asked to change to taking *Kivexa* (abacavir and 3TC [lamivudine]), although this is now the first option for people starting HIV treatment.

People taking a PI other than atazanavir will be reviewed, and recommended to switch to atazanavir unless there are clinical reasons not to. Normally, only the PI element of someone's regimen would change.

People who need to switch from first-line treatment to a second-line PI-based regimen will generally be prescribed atazanavir unless there is a clinical reason not to. Darunavir (*Prezista*) is recommended as the alternative PI for patients who have resistance to atazanavir or cannot tolerate it. The latter group might include people on a group of drugs called PPIs (used to treat acid reflux and ulcers) because of the risk of interaction, and people with a history of kidney stones.

Use of the integrase inhibitor raltegravir (*Isentress*) will be permitted in patients with extensive drug resistance, and in those with drug interaction issues which preclude the use of a boosted PI or an NNRTI.

It is possible that people on older treatments, that are not recognised as first-line treatments in the British HIV Association (BHIVA) treatment guidelines, will have their regimen reviewed and be switched to the new recommended first-line treatments if clinically appropriate.

How have the preferred drugs been chosen?

The clinical outcomes of a number of drugs are now broadly similar. The London HIV Consortium (see below) has decided that cost can be taken into account without compromising quality of care. The new guidelines were produced by the LHC in consultation with lead London clinicians.

The prescribing guidelines are in line with the latest British HIV Association (BHIVA) *treatment guidelines*, published in August 2012.

The LHC plans to audit the clinical effect, if any, of these changes in prescribing practice in order to determine what effect they have on patient outcomes.

Does this mean some anti-HIV drugs will no longer be available?

No. If there are reasons to use different treatments, all the currently available anti-HIV drugs are still an option. Reasons could be:

- the side-effects of a particular drug and their impact on a patient's health and day-to-day quality of life
- the way in which a drug or drugs need to be taken and how well this fits in with someone's lifestyle
- resistance to the preferred first- and second-line treatments
- having another condition or interactions with any other medications a patient is taking.

The LHC has undertaken that: "HIV doctors will continue to ensure treatment is tailored to the needs of the individual patient and, where it is clinically appropriate to do so, will use the least expensive treatment option available. If the least expensive drugs are not clinically appropriate for a patient, then HIV doctors will select a different treatment that will keep the patient well and reduce their viral load to undetectable levels."

What do I need to know about atazanavir?

Atazanavir does not raise blood lipids (fats) as much as other protease inhibitors and is taken as one capsule, once a day, so for some people it will mean a reduction in the number of pills they have to take.

It has been linked to kidney stones in a few patients and can cause a harmless but sometimes marked form of jaundice.

What happens if I don't want to switch?

If there is a clinical reason not to switch, such as drug resistance or side-effects, you will not be expected to change treatment.

If there is not a clear clinical case to stay on your current treatment, and you do not want to switch, discuss your concerns in detail with your doctor. Your treatment should not be changed without your agreement.

Questions to ask your doctor about a potential switch

- Is there any risk that I could have resistance to atazanavir?
- What side-effects can I expect in the first months of treatment?
- If I develop jaundice as a result of a switch to atazanavir, how will that be dealt with?

Make sure your doctor and HIV pharmacist know about **all** the medicines you are taking, including any from your GP, when discussing a switch.

Why have these changes been made?

The changes in prescribing are due to a new two-year drug purchasing agreement made between the LHC and the drug companies.

The LHC represents the majority of London's hospital and primary care trusts (PCTs) and has considerable negotiating power. It has managed over the years to pay about 25% below list price for antiretrovirals.

The prescribing changes were determined by the LHC after PCTs in London told HIV prescribers that their budget would not grow this year. Hospitals need to save £9 million on drugs in order to accommodate other HIV patient and clinic costs: 19% of the entire 2009 London NHS drugs budget was spent on anti-HIV drugs.

It was initially thought that clinics that did not abide by the new prescribing guidelines could be sanctioned by having their drugs budget cut or withheld, but it has now been confirmed that this is not the case.