Starting HIV treatment? Information for patients in London

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When you and your doctor discuss starting HIV treatment, a range of factors will be taken into account in deciding the best anti-HIV drugs for you. These will include your health and your lifestyle. An additional factor now is cost. HIV treatment is very cost-effective but is also costly. The way HIV treatment is prescribed in London changed in April 2011 in order to make savings; reducing the drugs budget will protect services from being cut. This factsheet sets out the changed prescribing guidelines for people starting treatment ('first-line treatment'), and explains some of the issues to consider.

Who will the prescribing changes affect?

The new prescribing guidelines will apply to people starting treatment for the first time and to people who need to change from their current treatment to a protease inhibitor (PI)-based regimen.

If you are already on treatment, especially if you are on the single combination pill *Atripla*, the new prescribing guidance is unlikely to affect you unless you and your doctor feel you would benefit from changing. See also NAM's factsheet *Already taking HIV treatment: Information for patients in London*.

Which anti-HIV drugs will people in London be offered if they are starting treatment?

The first option for people new to HIV treatment will be the drug efavirenz (*Sustiva*) in combination with *Kivexa*.

Efavirenz is a drug in the non-nucleoside reverse transcriptase inhibitor (NNRTI, or 'non-nuke') class of anti-HIV drugs. *Kivexa* is one tablet combining the anti-HIV drugs abacavir and 3TC (lamivudine). These drugs are in the nucleoside reverse transcriptase inhibitor (NRTI, or 'nuke') class.

Previously, people were likely to start treatment on a combination of efavirenz and the drugs tenofovir and FTC (emtricitabine) combined as *Truvada*; these three drugs are also in a single pill *Atripla*, which people could change to once stable on treatment. The new guidance means people on first-line treatment will still take two pills a day rather than one, but taken together, once a day.

Where *Kivexa* is not appropriate, *Truvada* is the recommended alternative. *Truvada* could be prescribed if you:

- have a viral load over 100,000 copies/ml
- have a high heart attack risk score based on your medical history
- have chronic hepatitis B infection or you are about to start hepatitis C treatment
- are shown to be at risk of hypersensitivity reaction to abacavir on a pre-treatment test.

If efavirenz is not suitable, the next option would be nevirapine (*Viramune*), another NNRTI, or treatment with a PI rather than an NNRTI. Patients starting with a PI will start with the drug atazanavir (*Reyataz)*, 'boosted' with another PI, ritonavir (*Norvir*). 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.

The integrase inhibitor raltegravir (*Isentress*) will only be used in very specific circumstances: short-term use in first-line treatment for patients with very complex drug interactions, or for pregnant women diagnosed with HIV late in pregnancy, where there is a need for very rapid viral load reduction. As soon as the clinical need has passed, the patient will be switched to another, less expensive drug, which is not expected to affect the outcomes of their treatment.

How were the new first-line drugs 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 changes were in line with the British HIV Association (BHIVA) treatment guidelines current at the time. New treatment guidelines were published in August 2012; these list abacavir/ 3TC (*Kivexa*) as acceptable alternative NRTIs for people starting HIV treatment.

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 that some 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 are the side-effects of the drugs in the new guidelines?

There are some concerns around the potential side-effects of abacavir, contained in *Kivexa*. Studies have come up with contradictory findings as to whether it increases the risk of heart attack. Because of this concern, *Truvada*, instead of *Kivexa*, will be prescribed to patients with a high heart attack risk score.

Atazanavir does not raise blood lipids (fats) as much as other PIs and is taken as one capsule, once a day, so for some people it will mean a reduction in the number of pills. It has been linked to kidney stones in a few patients and can cause a harmless but sometimes marked form of jaundice.

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.

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