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CE Information

PROGRAM OVERVIEW

Long-acting injectable pre-exposure prophylaxis (LAI PrEP) represents an evolving approach to HIV prevention by offering an alternative to daily oral medication that may improve adherence, privacy, and the patient experience. Agents such as injectable cabotegravir and lenacapavir have demonstrated strong efficacy and are being incorporated into evolving PrEP care models, with additional long-acting options under investigation. However, implementation in primary care remains inconsistent because of barriers such as limited awareness, insurance and access challenges, clinic workflow demands, appointment logistics, injection-related concerns, and challenges with patient follow-up. This program is designed to provide healthcare professionals who manage sexually active adolescents and adult patients at risk for HIV with actionable strategies to optimize the use of LAI HIV agents for prevention.

Using the *Bright Spots* learning model, the program highlights real-world successes where LAI implementation has achieved measurable results. Expert faculty share practical approaches to overcoming barriers and leveraging facilitators for LAI adoption, emphasizing strategies that are adaptable to a variety of practice environments. Throughout this presentation, participants will learn how to integrate shared decision-making, interprofessional collaboration, and patient-centered care into their workflows to improve initiation and persistence with LAI PrEP.

By the end of this activity, learners will be better able to identify key factors that influence implementation of LAI PrEP within primary care workflows and evaluate the selection of appropriate LAI agents by integrating patient preferences with the latest clinical evidence. Ultimately, this initiative aims to empower clinicians to replicate successful models, address gaps in HIV prevention and care, and enhance patient outcomes through the optimal delivery of LAI PrEP.

TARGET AUDIENCE

The intended audience for this activity is advanced practice providers who specialize in primary care and are involved in the management of sexually active adolescents and adults.

LEARNING OBJECTIVES

Upon successful completion of this activity, participants should be better able to:

- Identify key facilitators and barriers to implementing LAI PrEP within primary care workflows.
- Select appropriate LAI PrEP by incorporating patient preferences and the latest clinical evidence.

CE Information (continued)

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CE Information (continued)

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Speaker Contracted by Ineligible Company: AbbVie, Gilead, Merck, ViiV
Independent Research Contractor: Gilead, Merck, ViiV
Individual Stocks (publicly traded): Gilead

Rachel K. Scott, MD, MPH, FACOG
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CE QUESTIONS?

Contact us at CME@VindicoCME.com

HIV PREVENTION: Practical Strategies for LONG-ACTING INJECTABLES

Featuring BRIGHT SPOTS

Moti Ramgopal, MD, FACP, FIDSA
Rachel K. Scott, MD, MPH, FACOG
William R. Short, MD, MPH, FIDSA



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Consultant: Gilead, ViiV
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Agenda

Introduction and Pretest

LAI PrEP in the Primary Care Setting: Practice Pearls for the APP

Introduction to BRIGHT SPOTS

Bright Ideas for Success: Actionable Takeaways

Posttest and Question & Answer

- Participate in Pretest & Posttest
- Submit questions



PRETEST



Please scan the QR code
to participate in the pretest.

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Question 1 of 3:

A 21-year-old man on daily TDF/FTC for PrEP reports occasional missed doses. He has recent gonorrhea, a CrCl of 56 mL/minute, and a negative HIV test. He wants to switch regimens but is unsure about injections.

What is the most appropriate next step?

A. Continue daily oral TDF/FTC with adherence counseling, despite his borderline renal function.

B. Switch to daily oral tenofovir alafenamide (TAF)/FTC, as it has a better renal safety profile.

C. Offer LAI PrEP while discussing his preferences and potential adherence challenges.

D. Discontinue PrEP due to his sexually transmitted infection (STI) history and risk of further drug resistance.

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Question 2 of 3:

A 42-year-old cisgender woman who recently began dating again reports inconsistent condom use and believes HIV prevention is mainly for younger people. Which clinician response best reflects the recommended communication approach?

A. "HIV prevention is mostly prioritized for younger adults, so we can revisit PrEP if your risk changes later."

B. "PrEP is generally used when a partner has HIV, so we should wait until you have that specific risk."

C. "HIV exposure can occur across the lifespan, so let's discuss PrEP routinely to see if it fits your goals."

D. "STI screening should come first, and PrEP can be considered later if a bacterial infection is found."

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Question 3 of 3:

A primary care health clinic wants to improve PrEP initiation and retention among sexually active adults. Which clinic workflow best reflects a patient-centered approach?



A. Offer PrEP only after patients describe high-risk behavior, then standardize 1 regimen for follow-up.

B. Use risk scoring to determine eligibility, then refer patients to HIV specialists for PrEP initiation.

C. Choose the most effective formulation first, then address adherence barriers during later visits.

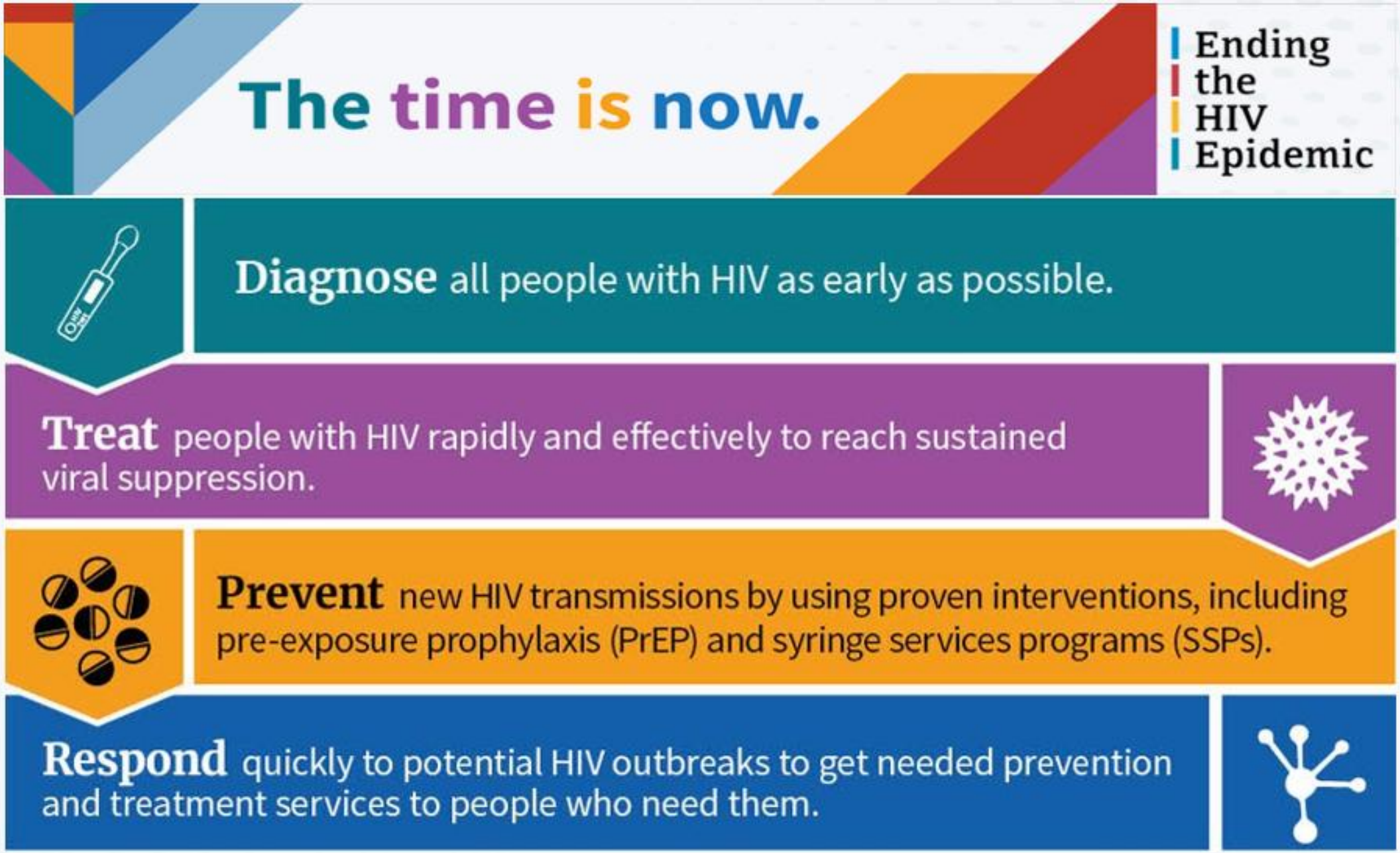
D. Assess needs routinely, elicit preferences, address barriers, individualize PrEP choice, and plan flexible follow-up.

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LAI PrEP in the Primary Care Setting: Practice Pearls for the APP

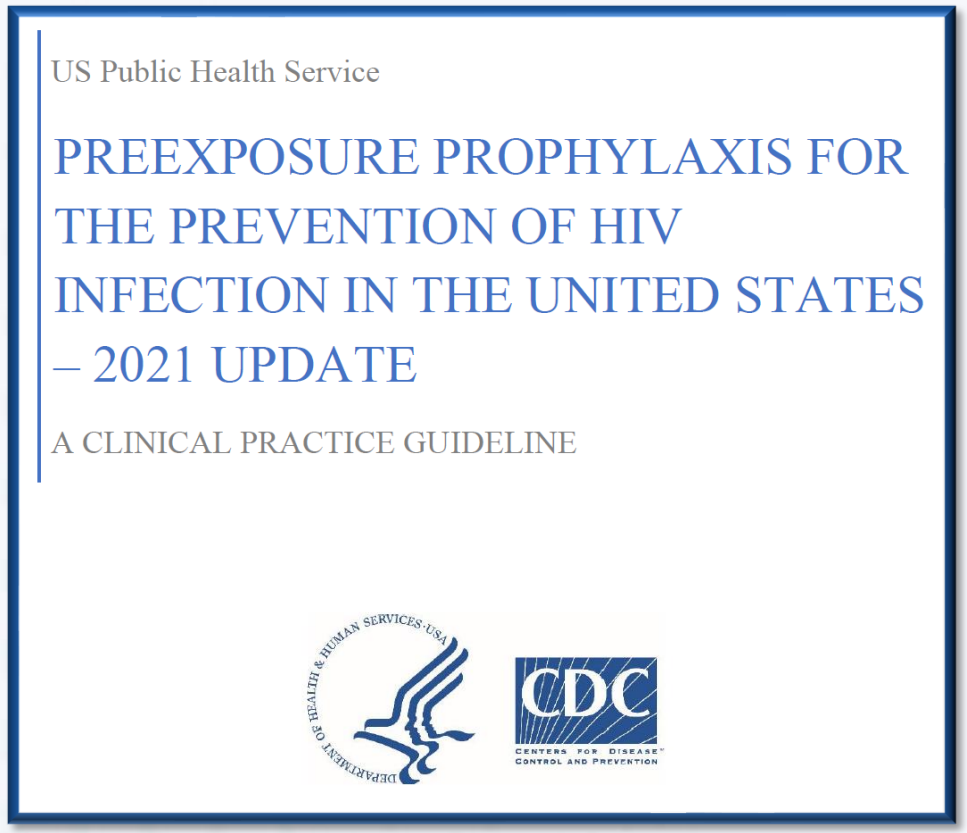
Prepared by Rachel K. Scott, MD, MPH, FACOG

Scientific Director of Women's Health Research
MedStar Health Research Institute
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Washington, DC



HIV = human immunodeficiency virus. Health Resources & Services Administration (HRSA). Ending the HIV Epidemic in the U.S. Reviewed January 2025. Accessed June 24, 2026. https://www.hrsa.gov/ending-hiv-epidemic

Who Would Benefit From PrEP?



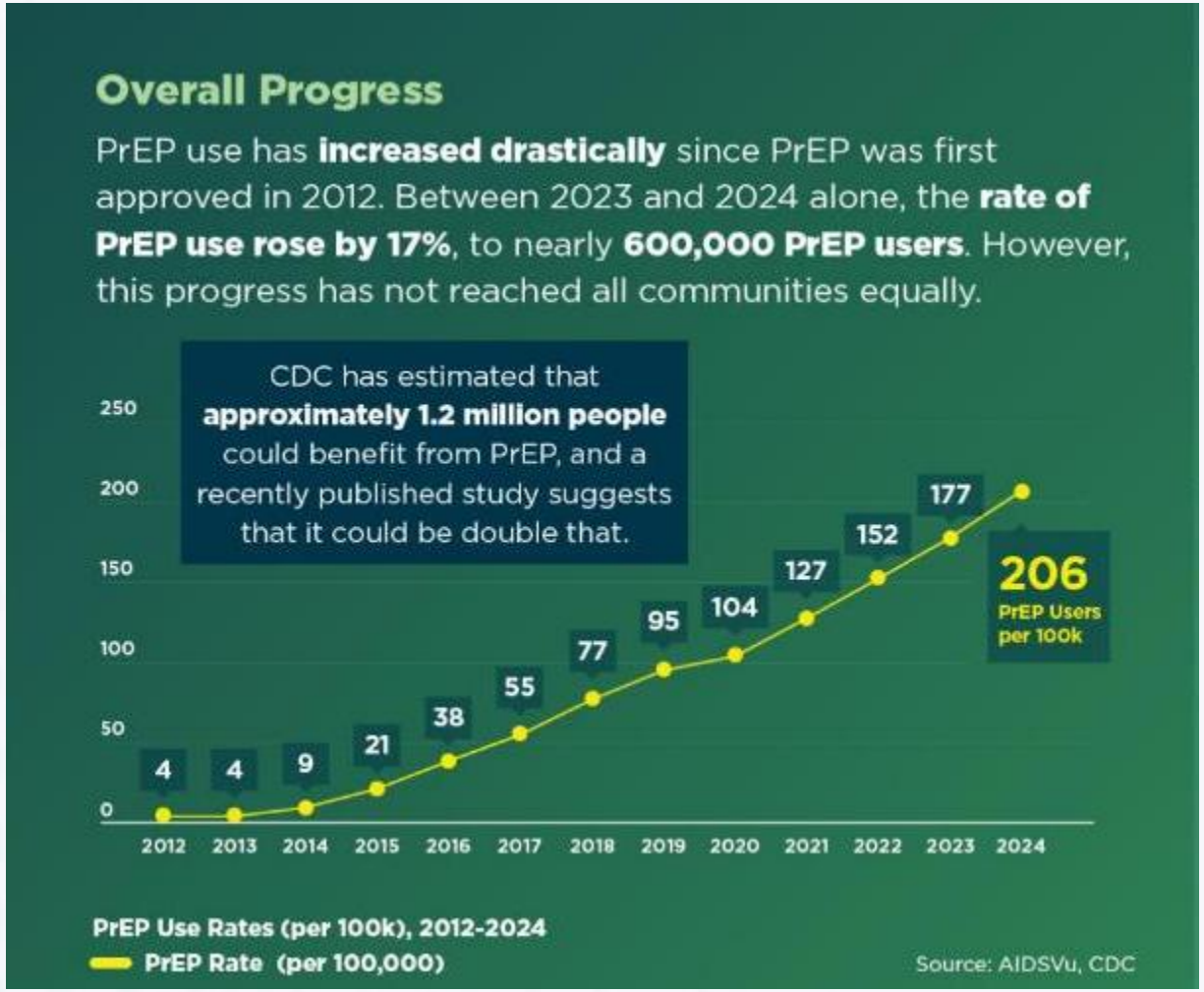
- Sexually active adults and adolescents who had anal or vaginal sex in the past 6 months **AND** any of the following:
  - Sexually active partner with HIV (especially if partner has an unknown or detectable viral load)
  - Bacterial STI in past 6 months
  - History of inconsistent or no condom use with sexual partner(s)
- PWID
  - Partner with HIV **OR** sharing injection equipment

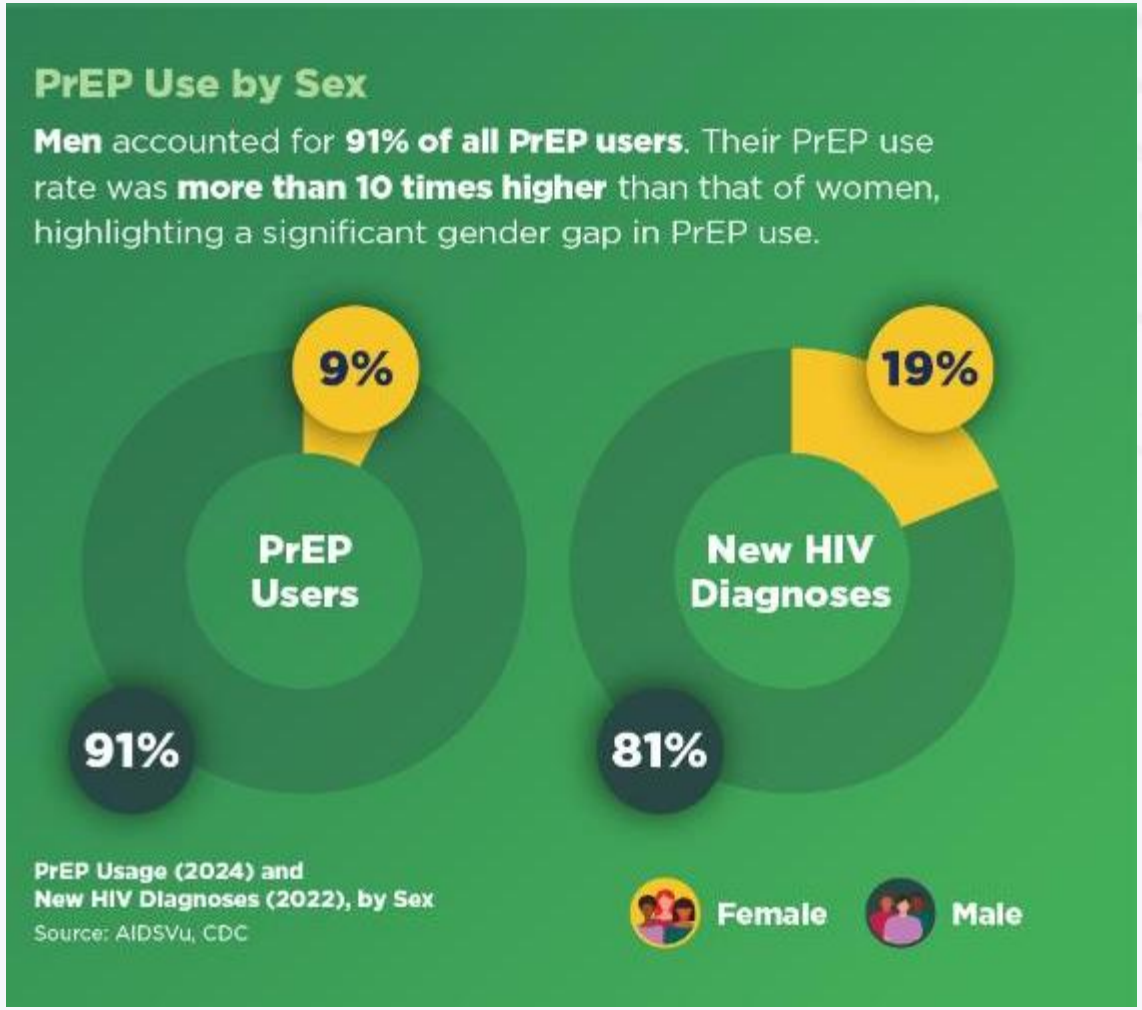
And anyone who requests PrEP

PWID = persons who inject drugs; STI = sexually transmitted infection.

Centers for Disease Control and Prevention (CDC). Updated 2021. Accessed July 6, 2026. https://stacks.cdc.gov/view/cdc/112360;
Gandhi RT, et al. *JAMA.* 2025;333(7):609-628.

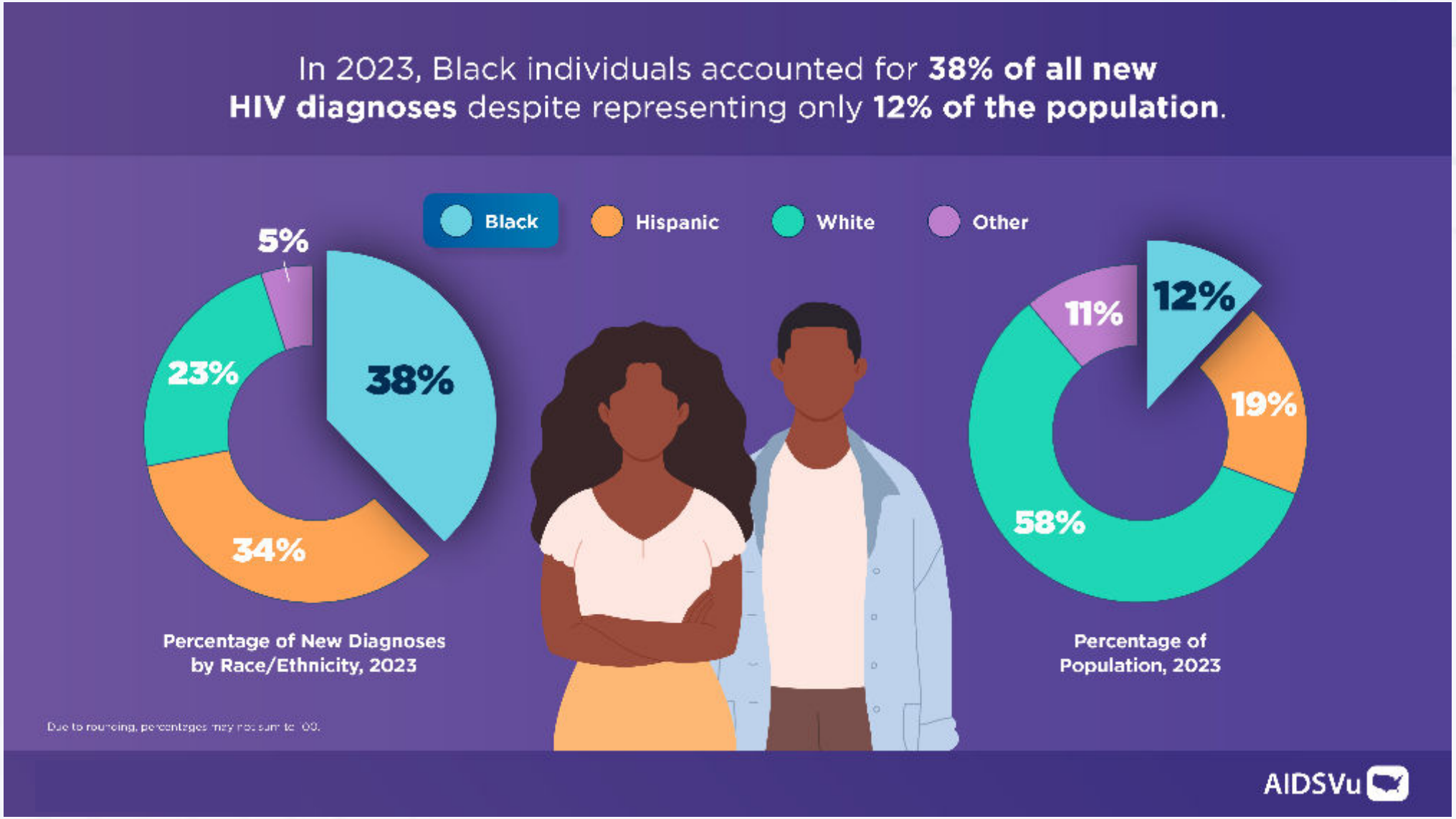
PrEP Use & Disparities by Sex





AIDSVu = AIDS Visualizing and Understanding.
PrEPVu.org. PrEP Use in 2024. June 26, 2025. Accessed June 24, 2026. https://prepvu.org/resources/prep-use-in-2024/

Racial Disparities in PrEP Use



AIDSVu. 2026. Accessed June 24, 2026. https://aidsvu.org/resources/toolkits/national-black-hiv-aids-awareness-day-toolkit-2026/

Universal PrEP Counseling

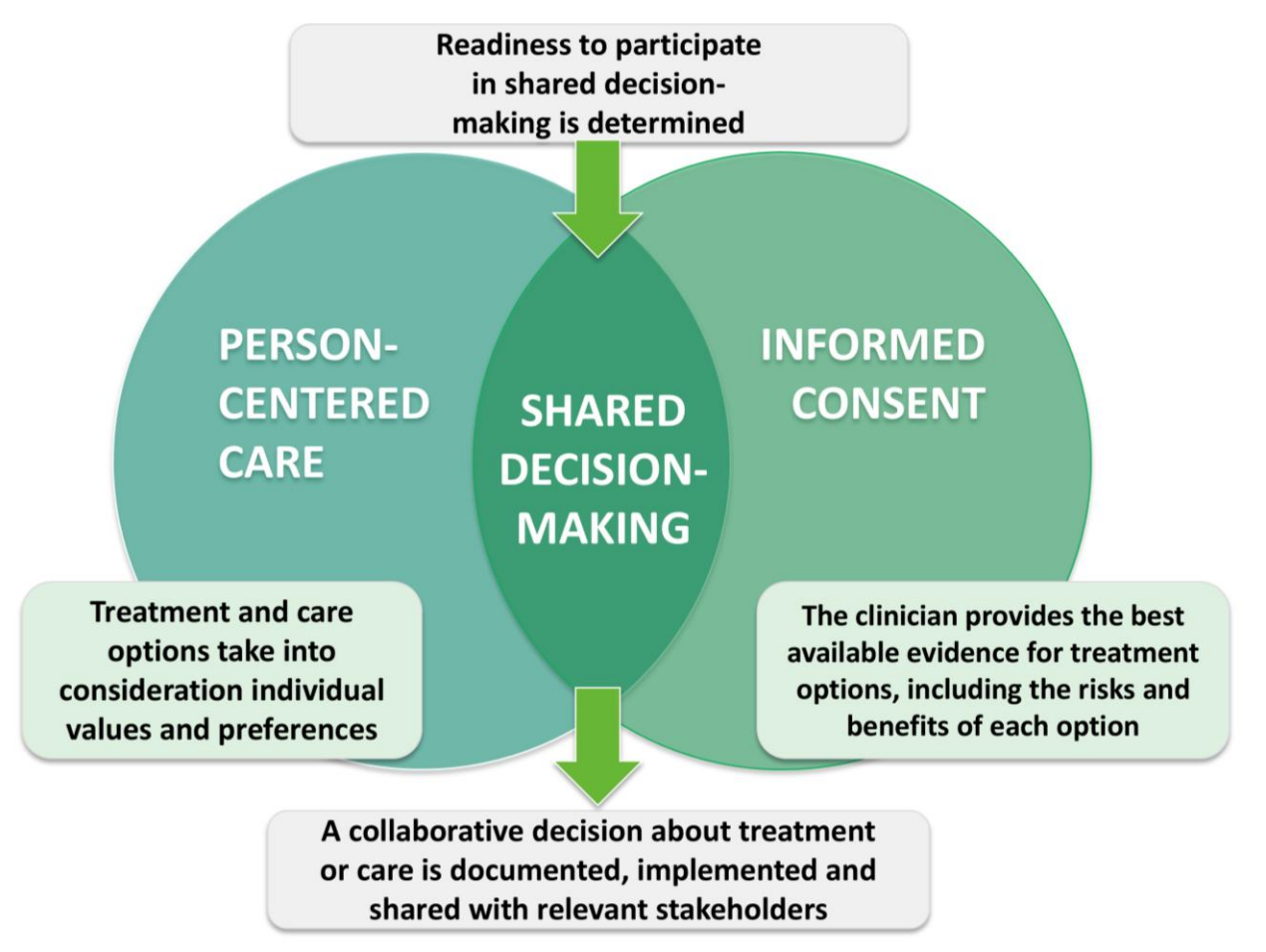
Discuss PrEP with all sexually active adults/adolescents and offer PrEP to anyone who desires it.

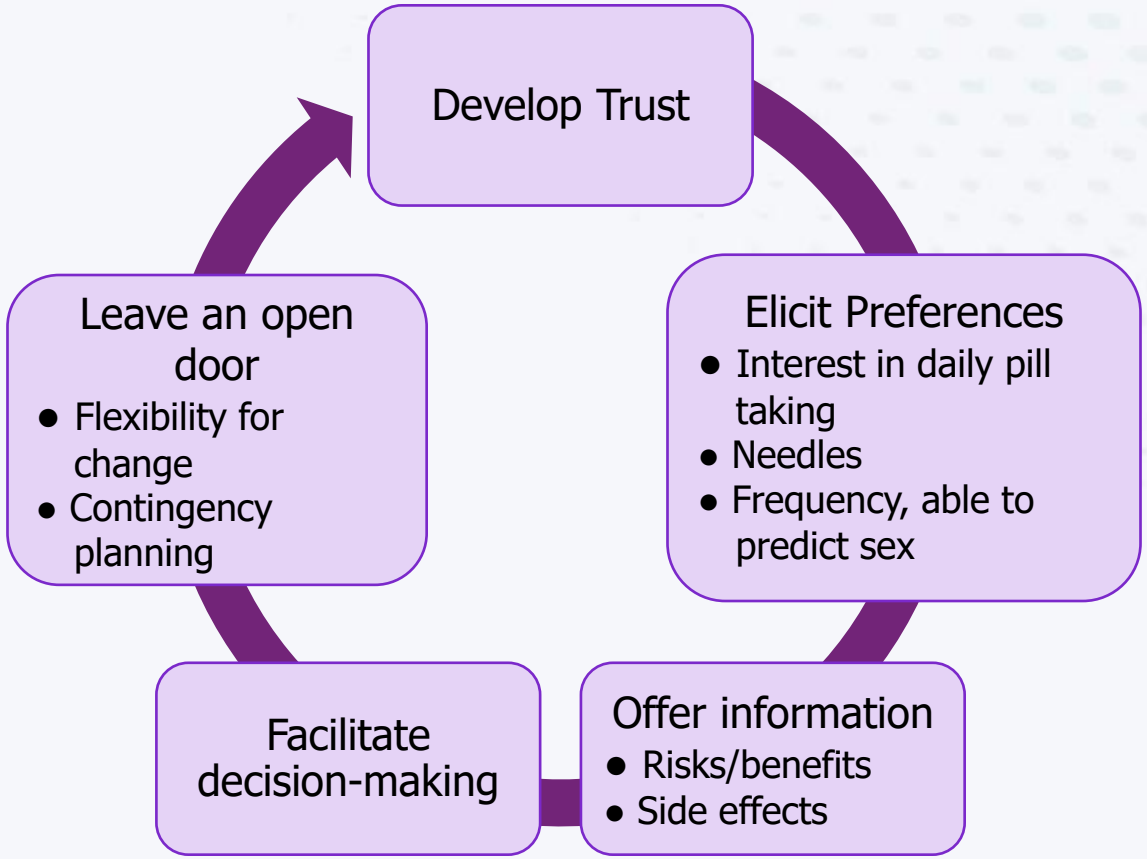
- Normalize talking about PrEP and HIV prevention by starting with the disclaimer that we talk to *all* patients about PrEP
- Initiate the PrEP conversation:
  - Do not wait for patients to ask
- Nonjudgemental approach:
  - Emphasis on benefits of PrEP
  - Avoid risk-based counseling or stigmatizing language



Ervin K, et al. *Nurse Care Open Access J.* 2017;3(1):204-210.
Seidman D. Presented at: Conference on Retroviruses and Opportunistic Injections (CROI) 2022; February 12-16, 2022; Virtual.

Shared Decision-Making





Ervin K, Blackberry I, Haines H. *Nurse Care Open Access J.* 2017;3(1):204-210.
Seidman D. Presented at: Conference on Retroviruses and Opportunistic Injections (CROI) 2022; February 12-16, 2022; Virtual.

Currently Available PrEP Options in the United States

Oral PrEP



TDF/FTC

(once daily)
(on demand*)



TAF/FTC
(once daily)

Injectable PrEP



Cabotegravir
(every 2 months)



Lenacapavir
(every 6 months)

When taken as prescribed, both oral and injectable PrEP reduce the risk of getting HIV from sex by about 99%. PrEP prevents HIV, but not other STIs.

*On-demand use is not approved by the FDA.

FDA = US Food and Drug Administration; FTC = emtricitabine; TAF = tenofovir alafenamide; TDF = tenofovir disoproxil fumarate.

CDC. Published December 2021. Accessed June 24, 2026. https://stacks.cdc.gov/view/cdc/112360; Gandhi RT, et al. *JAMA.* 2025;333(7):609-628; World Health Organization (WHO). Guidelines on lenacapavir for HIV prevention and testing strategies for long-acting injectable pre-exposure prophylaxis. July 14, 2025. Accessed June 24, 2026. https://www.who.int/publications/i/item/9789240111608; Emtricitabine/tenofovir disoproxil fumarate. Prescribing Information. Revised June 2013. Accessed June 24, 2026. https://www.accessdata.fda.gov/drugsatfda_docs/label/2013/021752s035lbl.pdf; Emtricitabine/tenofovir alafenamide. Prescribing Information. Revised October 2019. Accessed June 24, 2026. https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/208215s012lbl.pdf; Cabotegravir. Prescribing Information. Revised December 2021. Accessed June 24, 2026. https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/215499s000lbl.pdf; Lenacapavir. Prescribing Information. Revised June 2025. Accessed June 24, 2026. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/220020s000lbl.pdf

Clinical Recommendations for HIV PrEP

Type of Exposure	Daily TDF/FTC	On-Demand ("2-1-1") TDF/FTC	Daily TAF/FTC	CAB-LA IM Every 2 months	Lenacapavir SC Every 6 months
Insertive anal/vaginal sex	✓	✓	✓	✓	✓
Receptive anal sex	✓	✓	✓	✓	✓
Receptive vaginal sex	✓		✓*	✓	✓
Receptive neovaginal sex	✓			✓	✓
Injection drug use	✓				✓
Pregnant and breastfeeding people	✓			✓	✓
Initiate with a double dose	✓	✓			✓
Individuals with reduced CrCl (30-60 mL/min) or who have osteopenia or osteoporosis			✓	✓	✓

✓* = not studied in this population.

CAB-LA = long-acting cabotegravir.; CrCl = creatinine clearance; IM = intramuscular.

CDC. Published December 2021. Accessed June 24, 2026. https://stacks.cdc.gov/view/cdc/112360;
Gandhi RT, et al. *JAMA*. 2025;333(7):609-628; Patel RR, et al. *MMWR Morb Mortal Wkly Rep*. 2025;74(35):541-549.

From CDC and International Antiviral Society-USA Panel

Injectable PrEP: Clinical Eligibility for LEN and CAB

Injectable PrEP

Cabotegravir

Every 2 Months



Lenacapavir

Every 6 Months



Injectable PrEP Eligible (all conditions must be met)

- Adults and adolescents (≥35 kg)
- HIV screening:
  - Prior to initiating: negative HIV Ag/Ab test should be confirmed using RNA-specific assay
  - With each injection: negative HIV Ag/Ab test should be confirmed using RNA-specific assay
- STI testing every 3-6 months*
- No signs/symptoms of acute HIV infection
- No allergy to PrEP medication or contraindicated medications

Ag/Ab = antigen/antibody; CAB = cabotegravir; LEN = lenacapavir.
*See CDC Guidelines for further details on STI testing.

Gandhi RT, et al. *JAMA.* 2025;333:609-628;
Patel RR, et al. *MMWR Morb Mortal Wkly Rep*. 2025;74(35):541-549;
CDC. STI Guidelines. 2021. https://www.cdc.gov/std/treatment-guidelines/toc.htm
CDC. Clinical Guidance for PrEP. Published April 30, 2026. https://www.cdc.gov/hivnexus/hcp/prep/index.html

Long-Acting Injectable Cabotegravir for PrEP

- Every 2-month IM injection (after initial 2 doses)
- Up to 99% effective
- Time to 8× protein-adjusted IC_{90} (target concentration):
  - Median: 2 days (95% within 1 week)

Dose Schedule	
Oral lead-in (optional)	30 mg/day for up to a month
Gluteal IM injection	
Initial dose →	600 mg (single 3 mL vial)
Second dose →	4 weeks after initial dose
Thereafter →	Every 8 weeks*

*If ≥7 days late for an every-2-month continuation injection: Take daily oral cabotegravir 30 mg/day up to 2 months. Discontinue oral bridging on the day of the restart injection.

IC_{90} = inhibitory concentration 90.

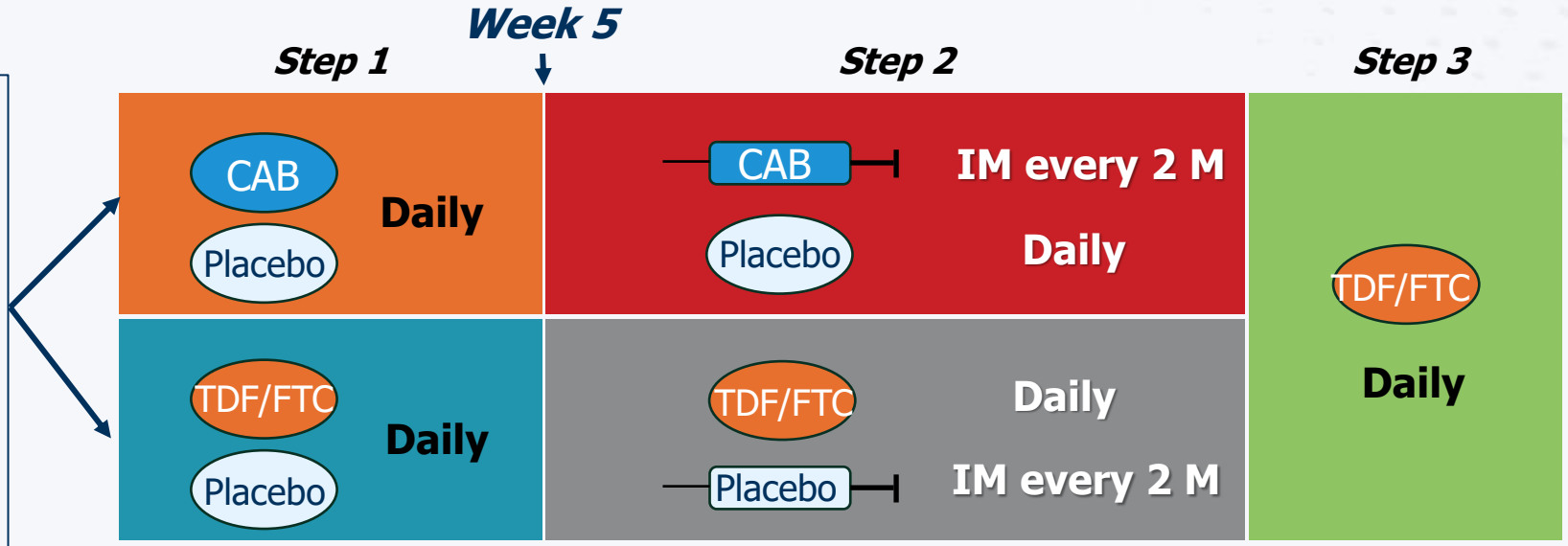
CDC. Published December 2021. Accessed June 24, 2026. https://stacks.cdc.gov/view/cdc/112360;
Cabotegravir extended-release injectable suspension. Prescribing information. Updated December 2021. Accessed June 24, 2026. https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/215499s000lbl.pdf

Injectable PrEP With Cabotegravir: HPTN 083 and 084 Trials—Injectable CAB vs Daily Oral TDF/FTC for PrEP

- International, randomized, double-blind phase 2b/3 (083) and phase 3 (084) trials

083: MSM and TGW aged ≥18 at high risk of HIV infection* (N=4566)[1]

084: cisgender women, aged 18-45, at high risk of HIV infection (N=3224)[2]



*Any noncondom receptive anal intercourse, >5 partners, stimulant drug use, incident rectal or urethral STI or incident syphilis in past 6 months, or SexPro Score ≤16 (US only)

First 2 doses given in Week 5 and 9, then every 2 months thereafter.

M = month; MSM = men who have sex with men; SexPro = Personalized Sexual Health Promotion; TGW = transgender women.

1. Landovitz RJ, et al. *Lancet HIV*. 2023 Dec;10(12):e767-e778.
2. Delany-Moretlwe S, et al. *Lancet*. 2022 May 7;399(10337):1779-1789.

HPTN 083 and 084: HIV Incidence

- LA CAB met criteria for superiority vs TDF/FTC in both 083 and 084[1,2]

The rate of incident HIV infection was more than 88% lower with CAB-LA than with oral TDF/FTC in cisgender women

Primary Efficacy Endpoint	HPTN 083[1] (MSM, TGW)		HPTN 084[2] (Cisgender Women)	
	CAB (n=2244)	TDF/FTC (n=2247)	CAB (n=1614)	TDF/FTC (n=1610)
HIV infections, n	13*	39	4	36
PYFU	3205	3187	1956	1942
HIV incidence per 100 PY	0.41	1.22	0.20	1.85
Hazard Ratio for CAB vs TDF/FTC (95% CI)	**0.34 (0.18-0.62)**		**0.12 (0.05-0.31)**	

*Includes 1 case readjudicated post hoc as a baseline infection; revised HIV incidence based on readjudication: 0.37 (95% CI: 0.19-0.65), revised hazard ratio (HR): 0.32 (95% CI: 0.16-0.58). 50 (2.4%) CAB participants permanently discontinued the injections owing to an injection-related adverse event. Discontinuation was strongly associated with increased severity of the injection-site reactions.

LA = long acting; PY = person-years; PYFU = person-years of follow-up.

1. Landovitz RJ. *N Engl J Med*. 2021;385(7):595-608; 2. Delany-Moretlwe S, et al. *Lancet*. 2022;399(10337):1779-1789.

Long-Acting Injectable Lenacapavir for PrEP

- Every 6-month SC injection
- Up to 99% effective
- Time to protection: Unknown; Limited data suggest 2 hours after the day 2 loading-dose (without the oral loading doses 21-28 days)

Dose Schedule	
SC injection	
Initial dose →	**Day 1: 927 mg (2 × 1.5 mL injections) + 600 mg orally (2 × 300 mg tablets)** **Day 2: 600 mg orally (2 × 300 mg tablets)**
Thereafter →	**Every 6 months***

*If ≥7 days late for an every-6-month continuation injection: Prescribe another form of PrEP until injections resume. Discontinue other PrEP on the day of the restart injection.

† Subcutaneous (SC) administration into the abdomen (anterior thigh can be used as an alternative injection site if preferred). Do NOT administer intradermally due to risk of serious injection site reactions.

Lenacapavir. Package insert. Revised June 2025. Accessed June 24, 2026. https://www.gilead.com/-/media/files/pdfs/medicines/hiv/yeztugo/yeztugo_pi.pdf
Patel RR, et al. *MMWR Morb Mortal Wkly Rep*. 2025;74(35):541-549; Jogiraju V, et al. Paper presented at: AIDS 2022; 29 July-2 August, 2022; Montreal, Quebec, Canada.

Lenacapavir: PURPOSE 1 and 2 Efficacy

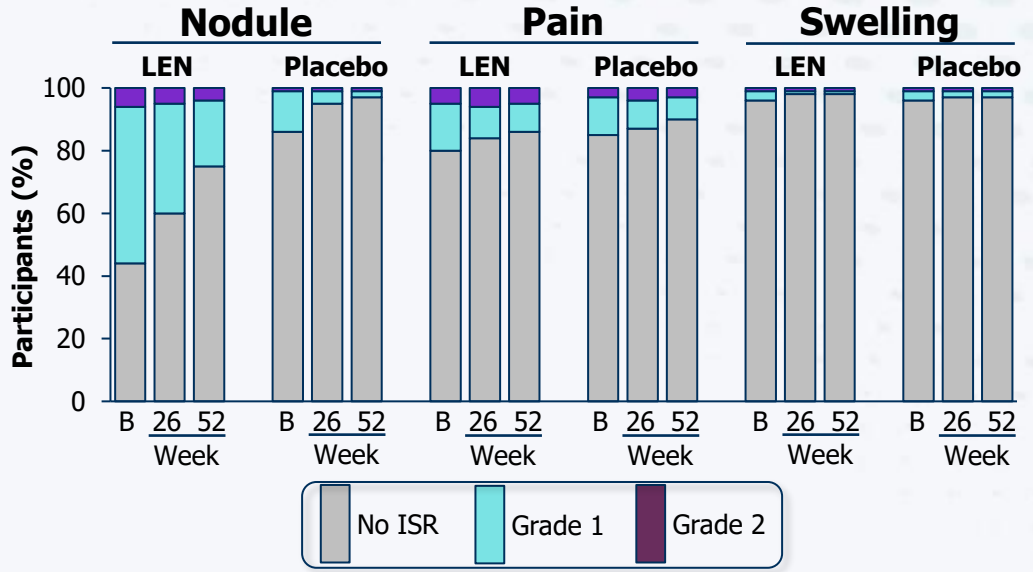
	HIV Incidence Per 100 Person Years (95% CI)					
	PURPOSE-1			PURPOSE-2		
	Incidence per 100 PY	# Infections	Person Years	Incidence per 100 PY	# Infections	Person Years
Background HIV Incidence	2.41			2.37		
LEN	**0**	**0**	**1939**	**0.10**	**2**	**1938**
TAF/FTC	2.02	39	1932	–	–	–
TDF/FTC	1.96	16	949	0.93	9	967

Gill K, et al. Efficacy, safety, and pharmacokinetics of twice-yearly subcutaneous lenacapavir (LEN) for PrEP among adolescents and young people in the phase 3 trials PURPOSE 1 and PURPOSE 2. Presented at: International AIDS Society; July 13-17, 2025; Kigali, Rwanda;
Bekker LG, et al. *N Engl J Med*. 2024;391(13):1179-1192; Kelley CF, et al. *N Engl J Med*. 2025392(13):1261-1276.

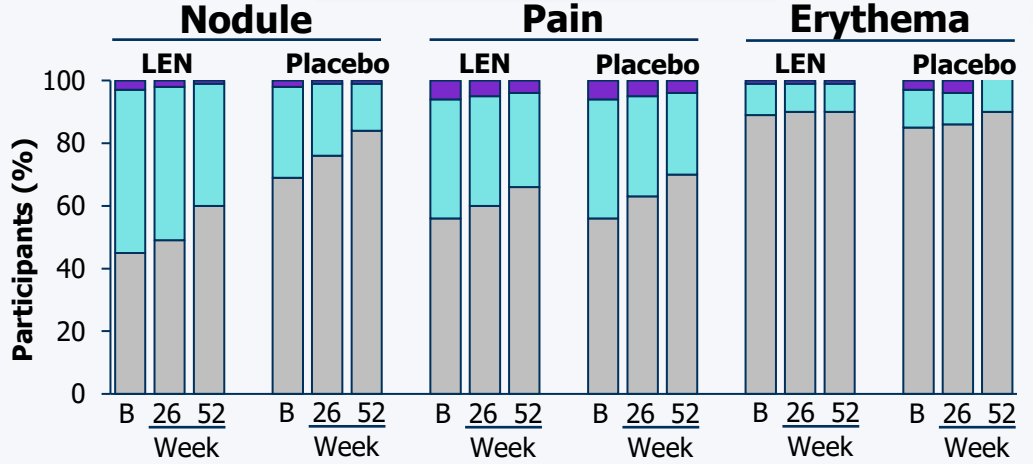
PURPOSE 1 and 2: Injection-Site Reactions

- Injected into subcutaneous space
- Injection-site reactions were the most common side effect (including pain, erythema, nodules)
- Nodules:
  - May be palpable under skin but usually invisible
  - As drug elutes over time, the depot get smaller, and nodules resolve or reduce in size substantially prior to next injection
- Frequency of injection site reactions, including nodules, decreased with subsequent doses

PURPOSE 1



PURPOSE 2

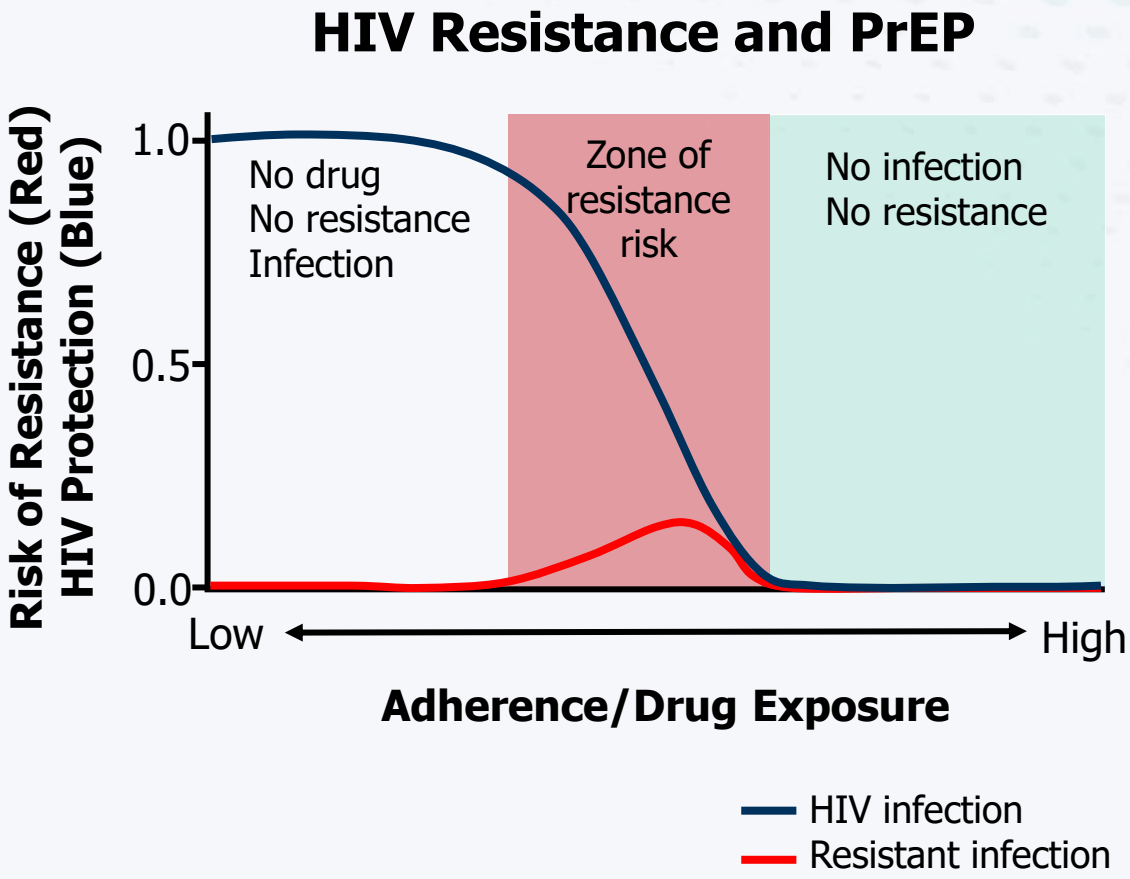


B = baseline; ISR = injection site reaction.

Bekker LG, et al. *N Engl J Med.* 2024;391:1179-1192; Kelley CF, et al. *N Engl J Med.* 2025;392:1261-1276.

Discontinuation of LAI PrEP: the Tail

- Without a follow-up dose, there is a long duration of declining levels of CAB or LEN
- HIV acquisition can occur when drug levels are too low to be protective. There is a risk of resistance when the virus replicates in the presence of CAB or LEN alone
- Assess PrEP discontinuation on a case-by-case basis:
  - Assess continued potential HIV exposure(s)
  - Offer switch to a different LAI PrEP or oral PrEP (TDF/FTC or TAF/FTC can begin within 8 weeks after last CAB injection)
  - When LEN is discontinued, medication levels in the body decline over 18 months, starting 6 months after the last injection, and do not offer HIV protection after 6 months
  - Continue follow-up quarterly for 12 months (or as indicated) to assess PrEP needs and HIV testing



CDC. PrEP Clinical Practice Guidelines. Updated 2021. Accessed July 6, 2026. https://stacks.cdc.gov/view/cdc/112360
Patel RR, et al. *MMWR Morb Mortal Wkly Rep*. 2025;74(35):541-549.

Key Takeaways

- PrEP education should be offered universally to sexually active adults and adolescents, including to women across all life stages
- Multiple PrEP options now exist, and selection should be individualized
- Long-acting injectables (cabotegravir and lenacapavir) offer significant advantages but require specific management
- Shared decision-making and adherence support are essential


BRIGHT
SPOTS

Background and Introduction: LAIs for HIV Prevention

Clinical Infectious Diseases
IDSA FEATURES

Policy Recommendations to Support Equitable Access to Long-Acting Injectables for Human Immunodeficiency Virus Prevention and Treatment: A Policy Paper of the Infectious Diseases Society of America and the HIV Medicine Association

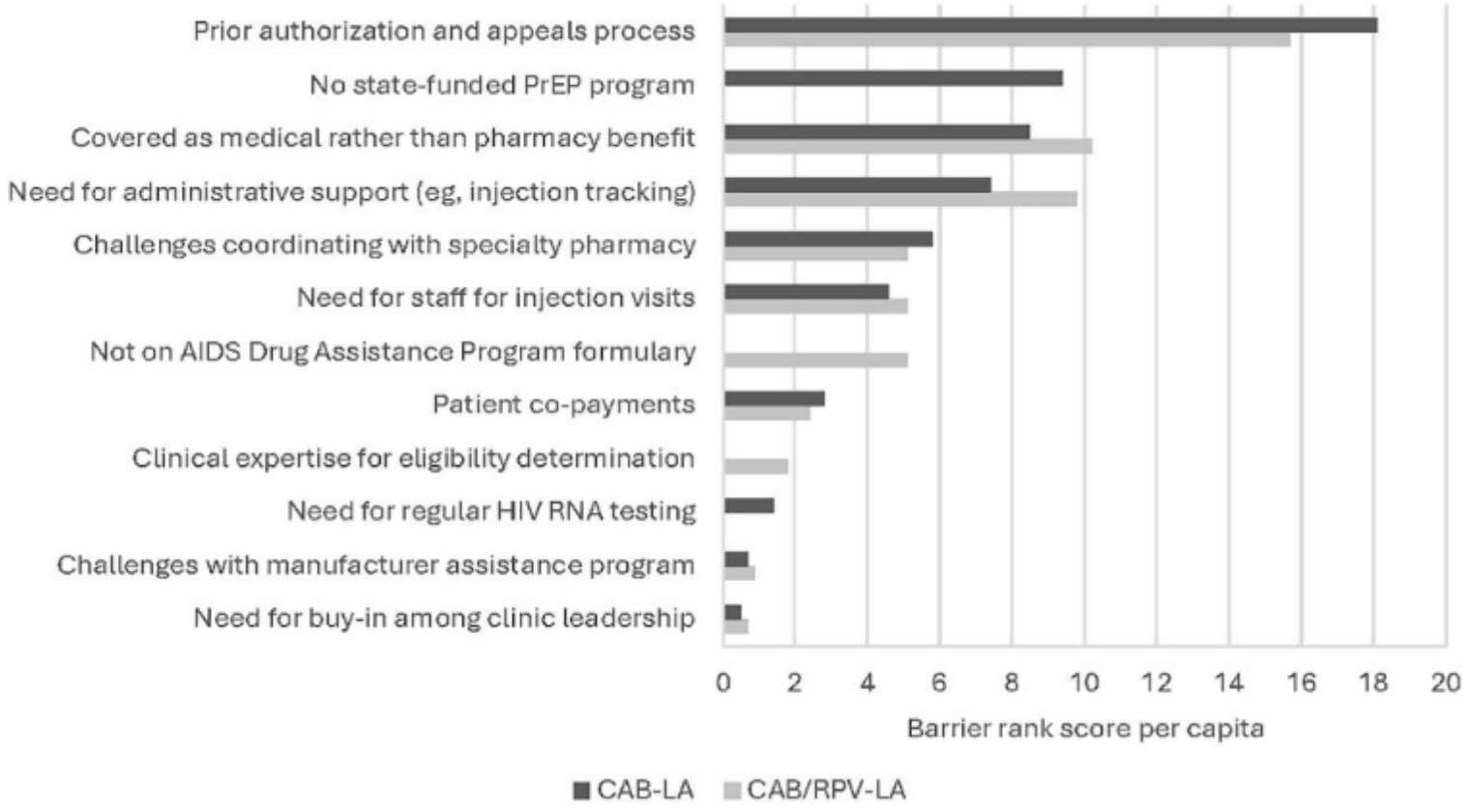
Julia L. Marcus,[1] Andrea Weddle,[2,3] Colleen F. Kelley,[2,3] Allison Agwu,[2,4] Sheila Montalvo,[5] Elizabeth Sherman,[2,6] Tara Vijayan,[2,6] Jose Gutierrez,[7] Matthew D. Hickey,[8] Samantha E. Dilworth,[9] Douglas Krakower,[3] Teaniese L. Davis,[10] Lauren F. Collins,[2,3] Moira C. McNulty,[11] Jonathan A. Colasanti and Katerina A. Christopoulos[2,4]

"LAIs for HIV prevention and treatment could dramatically improve health outcomes and health equity for people with HIV and those who could benefit from PrEP. Despite widespread acceptability and demand by providers and potential users of LAIs, implementation has been extremely limited…"

RPV = rilpivirine.

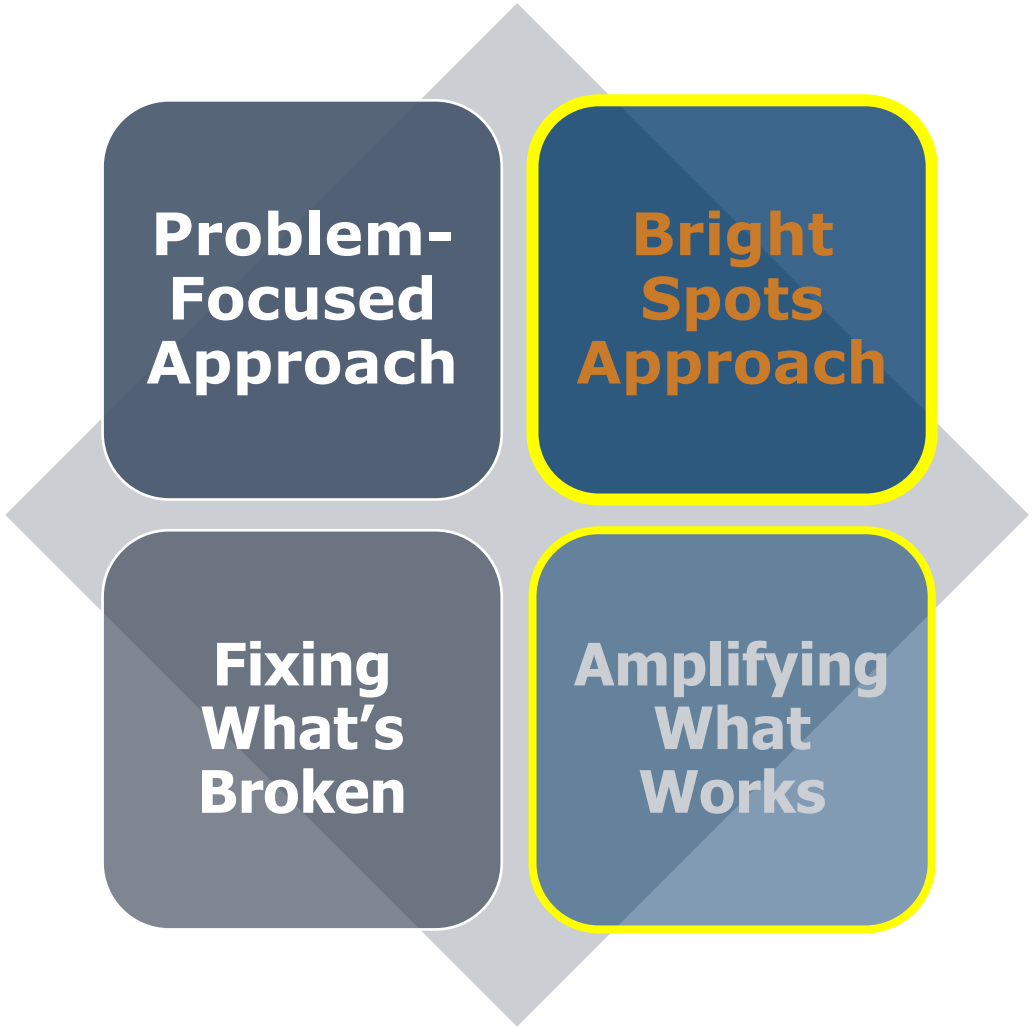
Marcus JL, et al. *Clin Infect Dis.* 2025;82(2):206-211.

Ranked barriers to implementation of LAIs for HIV treatment and prevention among HIV providers.



BRIGHT SPOTS

Introducing the "Bright Spots" Learning Model



Bright Spots Approach

- Focus on a **success story**, not failures
- Identify **"Bright Spots"** — where success is already happening
- Replicate **effective strategies and systems** to drive broader change
- Build **solution-oriented** principles that emphasizes what works

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Bright Ideas for Success:
A Bright Spot

Prepared by Moti Ramgopal, MD, FACP, FIDSA

Founder and Chairman
Midway Specialty Care Centers, Florida and International
Clinical Professor of Medicine
FSU College of Medicine
Medical Director
Midway Immunology and Research Center
Fort Pierce, FL

Florida's Infectious Disease Specialists: The Scale of Operations



Our physicians are leaders in HIV care, prevention research, and global PrEP initiatives.

18 Clinics across Florida with International outreach and a Clinic in Guyana

Florida Macro Data (2024)

4,463
New HIV Diagnoses

132,444
PWH in Florida
(Source: Flheaithcarts.gov)

Fort Pierce Main Clinic (2025)

Low-middle income area serving a diverse underprivileged population.

Specialty Pharmacy with Copay Assistance & Buy-and-Bill Solutions

Over 6,000 +
PWH in Care

1,300
Patients with at least 1 PrEP Rx (2024-2025)

2,000+
Total Number of Patients on LAIs

LAI = long-acting injectable; PCP = primary care provider; PrEP = pre-exposure prophylaxis; PWH = people with HIV; Rx = prescription.

Flhealthcharts.gov; Midway Specialty Care Center (MSCC) internal data by Moti Ramgopal, MD. Some portions of slide images were generated with the use of Notebook LM.

LAI for HIV PrEP

It works. People prefer it. Real-World evidence supports it.

1. IT WORKS

PURPOSE 2
(NEJM 2025)

Twice-yearly lenacapavir for HIV prevention in men and gender-diverse persons

- Phase 3 randomized trial
- Twice-yearly dosing
- Nearly complete protection against HIV

2. PEOPLE PREFER IT

HPTN 084, HPTN 076, HPTN 077

Cabotegravir Long-Acting (CAB-LA) for PrEP

Across multiple studies, participants who used injectable PrEP reported:

- Strong preference for injections over daily oral pills (56–96%)
- Less pill burden and greater privacy/discretion
- Greater convenience and confidence in protection
- Interest in switching increased over time with experience

3. REAL-WORLD EVIDENCE

Real-World Use of CAB-LA for PrEP (OFID 2025)

- Evaluated >3,000 individuals receiving CAB-LA for PrEP in routine clinical care
- High adherence to injection schedule
- Good persistence on CAB-LA
- No HIV infections observed during follow-up
- Demonstrates successful implementation in real-world practice

LAI PrEP delivers what matters most: | **Highly effective protection** | **Preferred by patients** | **Successfully used in real-world practice**

SOURCES

1. Bekker L-G, et al. Twice-Yearly Lenacapavir for HIV Prevention in Men and Gender-Diverse Persons. *N Engl J Med*. 2025. doi:10.1056/NEJMoa2411858
2. Delany-Moretlwe S, et al. Cabotegravir for the Prevention of HIV-1 in Women (HPTN 084). *N Engl J Med*. 2022.
3. Landovitz RJ, et al. HPTN 083/HPTN 077: Acceptability and preference for long-acting injectable PrEP. *Clin Infect Dis*. 2021;73(5):e1200–e1208.
4. Ramgopal M, et al. Real-World Use of Cabotegravir Long-Acting for Pre-Exposure Prophylaxis: Data from Trio Health Cohort. *Open Forum Infect Dis*. 2025;12(Suppl 1):ofae631.157. doi:10.1093/ofid/ofae631.157

The MDT Approach – LAI for PrEP Implementation

A collaborative, patient-centered team driving access, adherence, and outcomes.



Pharmacists
Medication expertise, counseling, and safety monitoring

Medical Assistants
Rooming, patient preparation, and follow-up support

Pharmacy Care Coordinators
Benefits support, prior authorizations, and medication access

Nurses
Patient education, injections, monitoring, and ongoing care

Case Managers
Care coordination, resources, and addressing barriers

HIV Specialists/ PCP/APPs
Clinical evaluation, PrEP eligibility, and prescribing

Other Support Staff
Patient navigators handling outreach, education, and clinic scheduling

MDTs are formed from various specialities and may include:

- Specialists/ PCP/APPs
- Nurses
- Pharmacists
- Case Managers
- Social Workers
- Many More

MDT = Multidisciplinary/Interprofessional Team. Midway Specialty Care Centers (MSCC) Clinic Approach. ChatGPT creation. Courtesy of Moti Ramgopal, MD. July 2026.

Shared Decision-Making Is a Structured Bidirectional Process

CLINICAL ELIGIBILITY

Sexual risk: Condomless anal/vaginal sex, recent STI increase risk for HIV by 2-3 folds, multiple partners, partner with HIV (unknown/unsuppressed VL)

IDU risk: Sharing needles/equipment

Patient-driven: ANY PERSON that requests PrEP regardless of disclosed risk



PATIENT PREFERENCE & GOALS

Lifestyle fit (work/travel schedules), injection acceptance vs. pill burden, and overcoming stigma.

Explicit discussions around how important is it to avoid daily pills.
How easy is it to attend appointments? Every 2 months vs every 6 months?

REAL-WORLD FEASIBILITY

Patient consistency for scheduled visits, EMR tracking capabilities, and reliable pharmacy drug availability.

EMR = electronic medical record; IDU = injection drug use.

Vail RM, et al. Updated October 16, 2025. Accessed July 6, 2026. https://www.hivguidelines.org/guideline/hiv-prep/?mycollection=pep-prep

LAI PrEP
Case Studies

Case 1: 28-year-old Cisgender Latina Female

Case Summary:

- 28-year-old cisgender Latina female, G3A1P2
- No reported medical history; Denies medications and allergies.
- Recently discharged post-miscarriage (~12 weeks) with recent *Chlamydia trachomatis* (CT) infection
- Now presents with persistent dysuria, abnormal discharge, and lower abdominal pain
- PCP referral: Short note and only a repeat urine. CT/GC NAAT negative
- One sexual partner (father of her children); partner accuses her of infidelity

Assessment:

- Urgent gynecologic assessment, with persistent genitourinary symptoms post-chlamydia → consider *Mycoplasma genitalium*
- Relationship stress; potential psychosocial distress
- **Candidate for HIV PrEP**

Plan:

- Order *M. genitalium*, *T. vaginalis*, RPR, HIV 4th-generation, HBV, and HCV tests
- Provide psychosocial support and confidentiality assurance
- Schedule follow-up in 2 weeks

G3A1P2 = 3 pregnancies, 1 spontaneous or induced abortion, 2 deliveries;
GC = *Neisseria* gonorrhoeae; HBV/HCV = hepatitis B/C virus;
NAAT = nucleic acid amplification test; RPR = rapid plasma reagin.

Case 1 (cont'd): 28-year-old Cisgender Female

Language Approach:

- Nonjudgmental, trauma-informed, inclusive communication
  - ✓ *"Sometimes infections occur even in long-term relationships; our goal is to ensure your full recovery."*
  - ✗ Avoid assumptions about infidelity or blame ✗
- Reassure confidentiality and normalize STI discussion
- Emphasize empowerment and autonomy—not blame

PrEP Counseling:

Discuss HIV prevention options:

- Oral PrEP vs. injectable PrEP (LAIs)
  - (Injectable PrEP may reduce stigma and barriers in culturally sensitive context)
- Offer choice, respecting patient confidentiality and lifestyle

Key Teaching Moments:

- Women are underrepresented in PrEP uptake but remain vulnerable
- Women in "monogamous" relationships remain at risk for STIs due to partner non-disclosure or asymptomatic infections
- Persistent symptoms with negative CT/GC → test for *Mycoplasma genitalium* per CDC (2021)

Case 2: HIV Prevention in an Older Adult With Ongoing Sexual Exposure

Case Summary:

- 76-year-old cisgender male, married to a cisgender female
- Hx: well-controlled HTN (valsartan/HCTZ), hyperlipidemia (rosuvastatin), ED (tadalafil), normal kidney function
- Reports an active sexual relationship with his wife and regular encounters with male sex workers
- Presents every 2–3 months for non-occupational post-exposure prophylaxis (nPEP), paying out of pocket
- Currently obtains doxycycline PEP from online service

Assessment:

- Denies previous STIs and reports no condom use during sexual activity.
- Refuses oral or injectable PrEP due to privacy concerns ("*I don't want my insurance to know.*")

Plan:

- Screen for HIV, syphilis, GC/CT, and hepatitis B/C
- Assess renal function before offering PrEP options
- Continue to encourage regular follow-ups for sexual practices associated with HIV exposure

ED = erectile dysfunction;
HCTZ = hydrochlorothiazide;
HTN = hypertension;
Hx = history.

Case 2 (cont'd): 76-year-old Cisgender Male

Language Approach:

- Maintain a nonjudgmental and affirming tone; avoid assumptions about orientation or risk behavior
  - ✓ Example*: "Tell me more about what strategies you currently use to stay healthy and protected."*

PrEP Counseling:

- Clarify the difference between PrEP and nPEP, emphasizing efficacy, safety, and privacy protections
- Discuss confidential medication access options (e.g., cash-pay pharmacy programs)

Key Teaching Moments:

- Address misconceptions – insurance use does not automatically disclose diagnosis
- Discuss doxy-PEP limitations (not protective against HIV; risk of resistance)

Case 3: PrEP Re-Initiation
Managing Injection Site Pain and Access Barriers

Case Summary:

- 45-year-old transgender woman
- Hx: Patient on gender-affirming hormones (estradiol 2 mg, 3 tablets PO QD; spironolactone 100 mg, 1 tablet PO BID) for 7 months
- Presented to the clinic 1 year ago to re-initiate PrEP
- Previously on generic TDF/FTC oral PrEP through an online service, but discontinued approximately 4 months prior because she had not been sexually active at the time
- Expressed interest in PEP for STI prevention as well

Assessment:

- Sexual practices associated with HIV exposure due to receptive anal sex practices – reports new trans-woman relationship
- Reports always using condoms during sexual activities

Plan:

- Candidate for PrEP (oral vs. injectable options)
- Screen for HIV, syphilis, GC/CT, and hepatitis B/C, creatinine
- Assess renal function before offering PrEP options

BID = twice daily; PO = by mouth.

Case 3 (cont'd): 45-year-old Transgender Woman

Language Approach:

- Empower shared decision-making
  - ✓ Example: *"Let's decide together what prevention plan fits your life right now. We can adjust as your needs change."*
- Instead of asking yes/no questions, encourage a conversation
  - ✓ Example: *"What has your experience been with using condoms and other prevention methods?*

PrEP Counseling:

Patient started on CAB-LA for PrEP

- Follow-up visit, patient admitted that injection site pain did not lessen with subsequent injection (4 total)
  - Significant discomfort for several days after which interfered with daily activities.
  - Patient expressed a desire to discontinue PrEP, as she was not currently sexually active.
- *Alternatives were discussed:* return to PO TDF/FTC vs TAF/FTC or switch to subcutaneous lenacapavir.
  - Patient expressed returning to a daily pill was an unnecessary burden given currently low risk, but was amenable to different LAI modality.
- Insurance denied coverage – prior authorization submitted and pending at the time of next due injection. Options reviewed, including oral bridging. Patient consented to receive an additional dose of IM cabotegravir.

Key Teaching Moments:

- Reinforce the importance of follow-up
- Self-pay options; Make aware of appeal process and submission with supporting clinical documentation.

The Replicable Blueprint

1. LAIs represent a clinical paradigm shift, but they require the operational engine of Shared Decision-Making to succeed.



2. True SDM must rigidly balance clinical eligibility, patient preference, and real-world system capacity.

3. Operationalizing this requires EMR documentation, proactive pharmacy coordination, and a dedicated multidisciplinary team.

The Bottom Line: Structured conversations plus supportive clinic workflows equal equitable, successful access to LAIs.

Courtesy of Moti Ramgopal, MD. July 2026.

BRIGHT SPOTS

Practical, Actionable Strategies

Clinic Setting

- Tailored outreach and education
- Training for staff on LAI workflows and patient communication
- Insurance navigation and support
- Partnering with community-based organizations and trusted messengers
- Flexible appointment scheduling
- Use of data to drive equity

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POSTTEST



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Question 1 of 3:

A 21-year-old man on daily TDF/FTC for PrEP reports occasional missed doses. He has recent gonorrhea, a CrCl of 56 mL/minute, and a negative HIV test. He wants to switch regimens but is unsure about injections.

What is the most appropriate next step?

A. Continue daily oral TDF/FTC with adherence counseling, despite his borderline renal function.

B. Switch to daily oral tenofovir alafenamide (TAF)/FTC, as it has a better renal safety profile.

C. Offer LAI PrEP while discussing his preferences and potential adherence challenges.

D. Discontinue PrEP due to his sexually transmitted infection (STI) history and risk of further drug resistance.

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Question 2 of 3:

A 42-year-old cisgender woman who recently began dating again reports inconsistent condom use and believes HIV prevention is mainly for younger people. Which clinician response best reflects the recommended communication approach?

A. "HIV prevention is mostly prioritized for younger adults, so we can revisit PrEP if your risk changes later."

B. "PrEP is generally used when a partner has HIV, so we should wait until you have that specific risk."

C. "HIV exposure can occur across the lifespan, so let's discuss PrEP routinely to see if it fits your goals."

D. "STI screening should come first, and PrEP can be considered later if a bacterial infection is found."

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Question 3 of 3:

A primary care health clinic wants to improve PrEP initiation and retention among sexually active adults. Which clinic workflow best reflects a patient-centered approach?



A. Offer PrEP only after patients describe high-risk behavior, then standardize 1 regimen for follow-up.

B. Use risk scoring to determine eligibility, then refer patients to HIV specialists for PrEP initiation.

C. Choose the most effective formulation first, then address adherence barriers during later visits.

D. Assess needs routinely, elicit preferences, address barriers, individualize PrEP choice, and plan flexible follow-up.

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