
# BEST PRACTICES: LABOR & DELIVERY CARE FOR PREGNANT PEOPLE WITH HIV AND CARE OF INFANTS WITH PERINATAL EXPOSURE TO HIV

INTRAPARTUM AND POSTPARTUM CARE FOR PREGNANT PEOPLE WITH HIV, PEOPLE WITH A PRELIMINARILY POSITIVE RAPID HIV TEST, AND NEWBORNS WITH HIV EXPOSURE

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## PURPOSE

- To establish best practices for the delivery and postpartum care of people with HIV (PWH), including those with a preliminary positive rapid HIV test at L&D and newborns with HIV exposure.
- To establish guidelines for the determination of risk status and antiretroviral prophylaxis for infants with perinatal exposure to HIV.

## I. Considerations for LABOR and DELIVERY

**A.** All pregnant people in Illinois should receive HIV counseling and opt-out testing two times during pregnancy (as early in pregnancy as possible and again in the third trimester). The third trimester test should be done between the 27$^{th}$ week of pregnancy and delivery, preferably before 36 weeks of pregnancy to optimize confirmatory testing and initiation of interventions.

**B.** Any pregnant person who does not have documentation of a negative HIV test result from after 27 weeks of the current pregnancy must be offered a rapid HIV test upon admission, ideally a combination HIV-1/2 antigen/antibody test. A rapid HIV test is a screening test that produces an expedited result. These tests can be rapid point-of-care tests or instrumented, laboratory-based tests, but they must result within 60 minutes. A rapid/expedited HIV test that is positive/reactive is considered "preliminarily positive" because supplemental tests are needed to confirm an HIV diagnosis.

- ***Per Illinois law, the Illinois Perinatal HIV Hotline must be called within 12 hours, but no later than 24 hours, of the test result for all pregnant people and exposed newborns found to be preliminarily positive with rapid HIV testing.***
- ***It is recommended that the Hotline be called as soon as the positive rapid test is resulted. The Hotline can provide care recommendations, advise on supplemental HIV tests to confirm HIV status, and link people to case management services.***

**C.** When a pregnant PWH **arrives** in L&D (or at the time of a positive rapid HIV test result), notify an obstetrician with expertise in HIV perinatology or an infectious disease specialist. The **24/7 Illinois Perinatal HIV Hotline (800-439-4079)** is available to provide consultation if no hospital-based specialist experienced in perinatal HIV is available.


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**D.** The Hotline recommends that for all pregnant PWH, regardless of HIV RNA level (viral load), intravenous (IV) zidovudine (ZDV, also known as AZT) be started as soon as possible after the person presents in labor. Similarly, if a scheduled cesarean delivery is planned, the Hotline recommends that people receive IV ZDV for at least 3 hours prior to surgery regardless of viral load. The IV ZDV infusion provides the infant with pre-exposure ZDV prophylaxis that will continue as post-exposure prophylaxis after birth while the infant receives oral prophylaxis.

- The Hotline views the use of intrapartum IV ZDV regardless of viral load to be consistent with and complementary to the recommendation for postnatal ZDV. The Hotline acknowledges these recommendations differ from but are not inconsistent with the Department of Health and Human Services (DHHS) Perinatal Guidelines. These guidelines state the following: "IV ZDV is **not** required for individuals who meet **ALL** of the following three criteria: (1) are receiving ART (antiretroviral therapy), (2) have HIV RNA <50 copies/mL within 4 weeks of delivery, and (3) are adherent to their ARV regimen. However, a study showing that 6 percent of women with suppressed HIV RNA levels during pregnancy had viral load rebound near delivery highlights the importance of using clinical judgement when making the decision to use intrapartum IV ZDV, regardless of the patient's viral load. The additional benefit of IV ZDV in women who are receiving ART and are virally suppressed (HIV RNA <50 copies/mL) has not been evaluated in randomized clinical trials."
- The Hotline recommends use of intrapartum IV ZDV due to 1) methodological limitations of the current evidence that led to the policy change, 2) the complementary benefit of both pre- and post-exposure prophylaxis for individuals at risk of HIV acquisition, and 3) the public health benefit of simple and consistent messaging across hospital systems that ensures consistent access to ZDV for intrapartum prophylaxis.
- ZDV dosage is based on the person's weight. People admitted in preterm labor with a significant chance of delivery should be started on IV ZDV immediately.
  - IV ZDV dosing is as follows: 2 mg/kg loading dose over 1 hour followed by 1 mg/kg/hour maintenance infusion until the cord is clamped.
- **ZDV is not compatible with all medications.** Please check with pharmacy before running ZDV in the same line with other medications.
- In situations where IV ZDV is not available, the 24/7 Illinois Perinatal HIV Hotline should be consulted as soon as possible.

**E.** Invasive procedures should be avoided if possible (fetal scalp electrodes, fetal scalp blood sampling, and operative vaginal delivery). Artificial rupture of membranes (AROM) may be considered for standard obstetric indications in people with HIV RNA <50 copies/mL who are on ART. AROM should be avoided in people with HIV RNA ≥50 copies/mL, unless there is a clear obstetric indication.

**F.** Route of delivery for a person previously diagnosed with HIV is determined by the person's level of viral suppression.




- Cesarean delivery should be offered to people with clinically significant viral loads (>1000 copies/ml) as cesarean delivery is associated with a reduced risk of transmission when performed prior to active labor and rupture of membranes. People who are scheduled for cesarean delivery should receive IV ZDV for at least 3 hours prior to surgery.
- For people with undetectable or low viral loads (<1000 copies/ml) and receiving ART, the risks of cesarean delivery may outweigh any theoretical benefit of reduced transmission. The 24/7 Illinois Perinatal HIV Hotline is available for consultation regarding mode of delivery.

**G.** Route of delivery should be carefully considered for people who test preliminarily positive in labor by a rapid HIV test and whose confirmed HIV status is unknown.

- If the person is confirmed to have HIV infection and has not received ART, a cesarean delivery performed early in labor with intact membranes may still be beneficial.
- Consultation should be sought with a Maternal-Fetal Medicine or Infectious Disease Specialist experienced in perinatal HIV. The 24/7 Illinois Perinatal HIV Hotline is available for this consultation. For example, in an individual with a preliminarily or known positive HIV test result whose membranes are ruptured and transition to active labor has occurred, there may be little benefit to cesarean delivery for the purpose of prevention of HIV transmission.

**H.** If the pregnant person does not have documentation of a negative HIV test result from 27w0d or later in the current pregnancy and refuses HIV testing for themselves, **then their newborn must be administered a rapid HIV test according to Illinois law**. It is not necessary to do a rapid HIV test on a newborn if the birthing parent was previously diagnosed with HIV or has already been administered a rapid test. When rapid HIV tests are performed on newborns, they may need to be performed "off-label", as the tests are for individuals over age 2 years; this is acceptable and appropriate, as the test is not testing for neonatal infection, but rather is testing for maternal antibodies, which would indicate HIV exposure.

**I.** For infants with preliminarily positive HIV tests, see Considerations for Newborns with HIV Exposure (Section IV).

## II. Considerations for BIRTHING PARENT-BABY RECOVERY

**A.** Infants should be given an early bath.

- They should be suctioned and bathed as soon as possible to remove maternal blood contamination **before** vitamin K and antibiotic eye prophylaxis (erythromycin) administration. This early infant bath should occur in the delivery room if possible and should be documented in the medical record.
- If Narcan or other medications need to be given urgently, cleanse the site with alcohol followed by Betadine prior to injection.

**B.** Infant ZDV syrup should be given **as soon as possible after birth, with the goal of within 1 hour**.




- In order to expedite the process, the pharmacy should be notified of the imminent need for a stat ZDV syrup order when the pregnant PWH is admitted to Labor and Delivery. **Have ZDV syrup available at delivery.**
- Simplified weight-band dosing for ZDV for infants ≥35 weeks gestation given orally twice daily is: 2 to <3kg = 1mL, 3 to <4kg = 1.5mL, 4 to <5kg = 2mL.
- Preterm infants <35 weeks will require a dose reduction (See Section V)
- An infant unable to tolerate oral feedings may be given the oral dose via a feeding tube or intravenous preparation.
- See DOSING TABLES FOR NEWBORN ANTIRETROVIRAL DRUGS (Section V). For more information, call the Hotline at 800-439-4079 or consult the federally approved Perinatal Guidelines.

**C.** Infant risk status should be determined – see CONSIDERATION FOR NEWBORNS WITH HIV EXPOSURE (Section IV).

## III. Considerations for POSTPARTUM CARE AND INFANT FEEDING

**A.** Providers should routinely discuss infant feeding plans, ideally during antenatal care.

- Formula feeding is the only way to eliminate breastmilk transmission of HIV, however, if a PWH expresses interest in breast/chestfeeding, non-judgmental counseling should be provided as outlined in the DHHS Perinatal Guidelines Infant Feeding for Individuals with HIV in the United States | NIH
- **Clinicians should consult experts in pediatric HIV if a PWH chooses to breast/chestfeed.**
- If a person with a preliminarily positive result from a rapid HIV test is awaiting confirmatory testing and desires to breast/chestfeed, they can be offered the option of pumping and storing the breast milk until the confirmatory test results are available. This can be done to optimize development of a milk supply for someone who desires to breast/chestfeed if the confirmatory HIV test result comes back negative. **The person needs clear counseling regarding the importance of not using the breast milk to feed the baby until the confirmatory test result is negative**.
- Engaging Child Protective Services or similar agencies is not an appropriate response if a PWH chooses to breast/chestfeed.
- When lactation suppression is desired, PWH should be instructed in measures to suppress lactation such as supportive/tight bras, ice, or cold compresses and ibuprofen to reduce discomfort.
- Counseling against pre-mastication should be provided.

**B.** Universal precautions should be reviewed prior to discharge with particular attention to vaginal bleeding and disposal of sanitary pads.




**C.** Contraceptive and STI counseling should be performed prior to the person's discharge.

**D.** Social work consultation is advised to address disclosure counseling and partner notification. Disclosure of HIV status is a sensitive issue and should be addressed in a confidential and non-judgmental manner.

**E.** Follow-up appointments for the PWH and newborn must be scheduled prior to discharge. The Hotline is available to provide a list of resources for referral as well as case management for people at risk of loss to follow-up.

**F.** For birthing parents or newborns with a preliminarily positive rapid HIV test, confirmatory HIV testing must be sent prior to discharge. **The positive rapid HIV test result must be reported to the 24/7 Illinois Perinatal HIV Hotline** (**800-439-4079**) **within 12 hours, but no later than 24 hours, of the test result.** Follow-up for this confirmatory testing is essential.

## IV. Considerations for NEWBORNS WITH HIV EXPOSURE

### A. DETERMINATION OF INFANT RISK STATUS

All infants with HIV exposure should be assessed for risk of perinatal HIV acquisition.

- Infants at High Risk for acquisition of HIV infection are born to PWH who meet AT LEAST ONE of the following criteria:
    - did not receive antenatal care
    - did not receive antepartum antiretroviral therapy
    - only received intrapartum antiretroviral therapy
    - had acute or primary HIV infection diagnosed during pregnancy
    - diagnosed with HIV during labor or postpartum, or have unknown (or pending) HIV status
    - received antepartum antiretroviral drugs but did not have viral suppression (defined as at least two consecutive tests with HIV RNA level <50 copies/mL obtained at least 4 weeks apart) within 4 weeks prior to delivery
- Low Risk for HIV infection: All other infants

### B. INFANT TESTING AND FOLLOW-UP

- All infants with HIV exposure should have an HIV DNA PCR or RNA PCR or Total Nucleic Acid (TNA) test performed on peripheral blood. Timing and frequency of infant HIV testing as well as other laboratory monitoring is determined by the infant's risk status.
- A physician experienced in pediatric HIV should evaluate all infants with HIV exposure within 4-10 days of discharge. Referral resources as well as case management resources are available through the 24/7 Illinois Perinatal HIV Hotline at 800-439-4079.
- For newborns of PWH with sustained viral suppression who breast/chestfeed, recommended virologic testing schedules are detailed in Table 13 of the DHHS Perinatal Guidelines. **Clinicians should consult experts in pediatric HIV if a PWH chooses to breast/chestfeed.**




LOW RISK INFANT

1. Perform HIV DNA PCR or RNA PCR or Total Nucleic Acid (TNA)*** at:
    - 2-3 weeks of age
    - 4-8 weeks of age
    - 4-6 months of age
2. **Any infant with a positive PCR or TNA should be immediately referred to a pediatric HIV specialist**
3. Infant may be discharged from HIV specialty care if all of the above PCR tests are negative.
   ***** HIV RNA PCR or TNA is preferred for infants born to people who acquired HIV outside of the US or Europe who may be living with non-clade B viral subtype**

HIGH RISK INFANT

1. Perform HIV DNA PCR or RNA PCR or Total Nucleic Acid (TNA)*** at:
    - **Birth**
    - 2 weeks of age
    - 4 weeks
    - 8 weeks of age (at least 2 weeks after completing antiretrovirals)
    - 4-6 months of age
2. **Consultation with a pediatric HIV specialist is strongly recommended in cases where PWH did not receive ART during pregnancy.**
3. **Any infant with a positive PCR or TNA should be immediately referred to a pediatric HIV specialist.**
4. Obtain CBC with differential at 4 weeks of age if still on three antiretrovirals.
5. Obtain urine or saliva for CMV PCR before 3 weeks of age.
6. Infant may be discharged from HIV specialty care if all of the above PCR tests are negative.
   ***** HIV RNA PCR or TNA is preferred for infants born to people who acquired HIV outside of the US or Europe who may be living with non-clade B viral subtype.**

**C. INFANT ANTIRETROVIRAL PROPHYLAXIS CONSIDERATIONS**

- Newborn antiretroviral prophylaxis is based on infant risk status.
- **Antiretroviral prophylaxis for newborns of PWH with sustained viral suppression who breast/chestfeed, should be discussed with experts in pediatric HIV.**
- Dosing tables for individual drugs are detailed in Section V.


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ZDV=Zidovudine or AZT; 3TC=Lamivudine; NVP=Nevirapine or Viramune; RAL=Raltegravir

<table>
<tr><th colspan="2">Newborns at Low Risk of Perinatal HIV Transmission</th></tr>
<tr><th>Recommended Regimen</th><th>Recommended Duration</th></tr>
<tr><td>• ZDV</td><td>• ZDV administered for 4 weeks[a]<br>Or,<br>• ZDV administered for 2 weeks if the newborn is ≥37 weeks gestation and is born to a person with HIV who:<br>○ Is currently receiving and has received at least 10 consecutive weeks of ART during pregnancy; and<br>○ Has achieved and maintained or maintained viral suppression (defined as at least two consecutive tests with HIV RNA <50 copies/mL obtained at least 4 weeks apart) for the remainder of pregnancy; and<br>○ Has a viral load <50 copies/mL at or after 36 weeks; and<br>○ Did not have acute HIV infection during pregnancy; and<br>○ Has reported good ART adherence, and adherence concerns have not been identified.</td></tr>
<tr><th colspan="2">Extended Postnatal Prophylaxis for Newborns at Low Risk of HIV Transmission During Breastfeeding</th></tr>
<tr><td>• ZDV</td><td>• ZDV administered for 4 to 6 weeks</td></tr>
<tr><td>• NVP</td><td>Simplified Age-Based Dosing for Newborns ≥32 Weeks Gestation Receiving Extended NVP Prophylaxis During Breastfeeding[c]
<table>
<tr><th>Age</th><th>Volume of NVP 10 mg/mL Oral Syrup Daily</th></tr>
<tr><td>Birth to 6 weeks</td><td>1.5 mL</td></tr>
<tr><td>6 weeks to 6 months</td><td>2.0 mL</td></tr>
<tr><td>6 months to 9 months</td><td>3.0 mL</td></tr>
<tr><td>9 months to 1 to 4 weeks post-weaning</td><td>4.0 mL</td></tr>
</table></td></tr>
<tr><th colspan="2">Newborns at Higher Risk of Perinatal HIV Transmission</th></tr>
<tr><th>IL Perinatal HIV Hotline Recommended Regimen</th><th>Recommended Duration[a,b]</th></tr>
<tr><td>• Presumptive HIV therapy with ZDV/3TC/NVP</td><td>• If birth PCR is negative, administer ZDV, 3TC and NVP for 2 weeks, then continue ZDV alone through 6 weeks of age<br>• If birth PCR is positive, continue ZDV, 3TC and NVP and consult a Pediatric HIV specialist</td></tr>
</table>


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| Alternate Regimen | Recommended Duration[a,b] |
|---|---|
| • Presumptive HIV therapy with ZDV/3TC/RAL | • If birth PCR is negative, administer ZDV, 3TC and RAL for 2 weeks, then continue ZDV alone through 6 weeks of age<br>• If birth PCR is positive, continue ZDV, 3TC and RAL and consult a Pediatric HIV specialist |

[a] **All ARV drugs should be initiated as close to the time of birth as possible, preferably within 3 hours of delivery**

[b] The optimal duration of presumptive HIV therapy in newborns who are at a high risk for perinatal HIV acquisition is unknown. Newborns who are at a high risk for HIV acquisition should receive the ZDV component of the three-drug presumptive HIV therapy regimen for 6 weeks. The other two ARVs (3TC and NVP or 3TC plus RAL) may be administered for 2 to 6 weeks; the recommended duration for these ARVs varies depending on infant HIV NAT results, maternal viral load at the time of delivery, additional risk where increased risk of ZDV toxicity may exist such as in infants with anemia or neutropenia, and additional risk factors for HIV transmission including breastfeeding.

[c] Extended NVP prophylaxis during breastfeeding recommendations are adapted from the Consolidated Guidelines on HIV Prevention, Testing, Treatment, Service Delivery and Monitoring: Recommendations for a Public Health Approach. If prescribed, these simplified doses should start following confirmation of a negative infant NAT test and completion of a presumptive HIV therapy regimen in infants at high risk of HIV acquisition. For infants at low risk of transmission, these doses can be given from birth. Geneva: World Health Organization; 2021 Jul. Simplified Age-Based Dosing for Newborns ≥32 Weeks Gestation Receiving Extended NVP Prophylaxis During Breastfeeding in Consolidated Guidelines on HIV Prevention, Testing, Treatment, Service delivery and Monitoring: Recommendations for a Public Health Approach

- **Instruct parent/caregiver on how to draw up and administer HIV medications to infants with HIV exposure.**
  - Nurses should observe and document that the parent/caregiver can draw the correct dosage and administer the medication to the infant successfully prior to discharge (see Section V for dosage information).
  - Newborns should be discharged with a **2- or 4-week supply** of medications, depending on the level of transmission risk. ZDV (zidovudine) syrup and other antiretroviral medications used for infant prophylaxis are not readily available from community pharmacies and parents often have difficulty obtaining them. The 24/7 Illinois Perinatal HIV Hotline is available to assist institutions in successfully discharging infants with this medication. It is **critical** that medication doses are administered at scheduled times**.**

### D. PNEUMOCYSTIS JIROVECII PNEUMONIA (PCP) PROPHYLAXIS

- PCP prophylaxis is recommended beginning at 6 weeks of age ONLY for infants with a positive DNA PCR or RNA PCR or TNA.
- Consult with a pediatric HIV specialist to determine need. PCP prophylaxis is NOT recommended if the DNA PCR or RNA PCR or TNA performed at ≥ 2 weeks and ≥ 6-8 weeks of age are negative, and subsequent tests remain negative.


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## V. DOSING TABLES for NEWBORN ANTIRETROVIRAL DRUGS

<table>
<tr><th>Drug</th><th>ARV Dosing by Age and Weight</th></tr>
<tr><td>ZDV<br>(Zidovudine)<br><br>Note: For newborns unable to tolerate oral agents, the IV dose is 75% of the oral dose while maintaining the same dosing interval.</td><td>
<u>Simplified Weight-Band Dosing for Newborns Aged ≥35 Weeks Gestation from Birth to 4 Weeks</u>:
<table>
<tr><th>Weight Band (kg)</th><th>Volume (mL)<br>ZDV 10 mg/mL Oral Syrup<br>Twice Daily</th></tr>
<tr><td>2 to <3 kg</td><td>1 mL</td></tr>
<tr><td>3 to <4 kg</td><td>1.5 mL</td></tr>
<tr><td>4 to <5 kg</td><td>2 mL</td></tr>
</table>
Age >4 Weeks:<br>• ZDV 12 mg/kg/dose orally twice daily; this dose adjustment is only for infants with confirmed HIV infection<br>
<u>≥30 to <35 Weeks Gestation at Birth</u><br>Birth to Age 2 Weeks:<br>• ZDV 2 mg/kg/dose orally twice daily<br>Age 2 Weeks to 6–8 Weeks:<br>• ZDV 3 mg/kg/dose orally twice daily<br>Age >6–8 Weeks:<br>ZDV 12 mg/kg/dose orally twice daily; this dose adjustment is only for infants with confirmed HIV infection<br>
<u><30 Weeks Gestation at Birth</u><br>Birth to Age 4 Weeks:<br>• ZDV 2 mg/kg/dose orally twice daily<br>Age 4 to 8–10 Weeks:<br>• ZDV 3 mg/kg/dose orally twice daily<br>Aged >8–10 Weeks:<br>• ZDV 12 mg/kg/dose orally twice daily; this dose adjustment is only for infants with confirmed HIV infection
</td></tr>
<tr><td>3TC<br>(Lamivudine)</td><td>
<u>≥32 Weeks Gestation at Birth</u><br>Birth to Age 4 Weeks:<br>• 3TC 2 mg/kg/dose orally twice daily<br>Age >4 Weeks:<br>• 3TC 4 mg/kg/dose orally twice daily<br><br>
<u><32 Weeks Gestation at Birth</u><br>Consult IL Perinatal HIV Hotline
</td></tr>
</table>


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<table>
<tr><th>Drug</th><th>ARV Dosing by Age and Weight</th></tr>
<tr><td>NVP<br>(Nevirapine)</td><td>≥37 Weeks Gestation at Birth<br>Birth to Age 4 Weeks:<br>• NVP 6 mg/kg/dose orally twice daily[a]<br>Age >4 Weeks:<br>• NVP 200 mg/m$^2$ of BSA/dose orally twice daily; only make this dose increase for infants with confirmed HIV infection.<br>---<br>≥34 to <37 Weeks Gestation at Birth<br>Birth to Age 1 Week:<br>• NVP 4 mg/kg/dose orally twice daily<br>Age 1 to 4 Weeks:<br>• NVP 6 mg/kg/dose orally twice daily<br>Age >4 Weeks:<br>• NVP 200 mg/m$^2$ of BSA/dose orally twice daily; only make this dose increase for infants with confirmed HIV infection.<br>---<br>≥32 to <34 Weeks' Gestation at Birth<br>Birth to Age 2 Weeks<br>• NVP 2 mg/kg per dose orally twice daily<br>Age 2 to 4 Weeks<br>• NVP 4 mg/kg per dose orally twice daily<br>Age 4 to 6 Weeks<br>• NVP 6 mg/kg per dose orally twice daily<br>Age >6 Weeks<br>• NVP 200 mg/m$^2$ BSA per dose orally twice daily; only make this dose increase for infants with confirmed HIV infection.<br>Consult IL Perinatal Hotline for infants <32 weeks</td></tr>
<tr><th>Drug</th><th>ARV Dosing by Age and Weight</th></tr>
<tr><td>RAL<br>(Raltegravir)<br><br>Note:<br>If the mother has taken RAL 2–24 hours prior to delivery, the</td><td>≥37 Weeks Gestation at Birth and Weighing ≥2 kg[b]<br><table><tr><th>Body Weight (kg)</th><th>Volume (Dose) of Suspension, RAL 10 mg/mL, to be Administered</th></tr><tr><td>Birth to 1 Week: Once Daily Dosing</td><td>Approximately 1.5 mg/kg/dose</td></tr><tr><td>2 to <3 kg</td><td>0.4 mL (4 mg) once daily</td></tr><tr><td>3 to <4 kg</td><td>0.5 mL (5 mg) once daily</td></tr><tr><td>4 to <5 kg</td><td>0.7 mL (7 mg) once daily</td></tr></table></td></tr>
</table>


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neonate's first dose of RAL should be delayed until 24–48 hours after birth; additional ARVs should be started as soon as possible.

| **1 to 4 Weeks: Twice Daily Dosing** | **Approximately 3 mg/kg/dose** |
|---|---|
| 2 to <3 kg | 0.8 mL (8 mg) twice daily |
| 3 to <4 kg | 1 mL (10 mg) twice daily |
| 4 to <5 kg | 1.5 mL (15 mg) twice daily |
| **4 to 6 Weeks: Twice Daily Dosing** | **Approximately 6 mg/kg/dose** |
| 3 to <4 kg | 2.5 mL (25 mg) twice daily |
| 4 to <6 kg | 3 mL (30 mg) twice daily |
| 6 to <8kg | 4mL (40mg) twice daily |

In cases where RAL will be used, clinicians should carefully review the extensive instruction booklet *Raltegravir (Isentress) Instructions for Use for Babies and Toddlers* (link below) for proper RAL preparation and dosing and weigh the complexity of RAL preparation/dosing with the benefits of its administration. Consultation with an expert in pediatric HIV is **strongly** recommended.
https://www.merck.com/product/usa/pi_circulars/i/isentress/isentress_ifu.pdf

[a] *Investigational NVP treatment dose recommended by the Department of Health and Human Services Perinatal HIV Transmission Panel; FDA has not approved a dose of NVP for infants <1 month of age.*

[b] *RAL dosing is increased at 1 and 4 weeks of age because metabolism by UGT1A1 is low at birth and increases rapidly during the next 4 to 6 weeks of life.* ***No dosing information is available for preterm or low birthweight infants.***

**Approved: 3/24/2023**

*The 24/7 Illinois Perinatal HIV Hotline's BEST PRACTICES: LABOR & DELIVERY CARE FOR PREGNANT PEOPLE WITH HIV AND CARE OF INFANTS WITH PERINATAL EXPOSURE TO HIV were adapted from the U.S. Department of Health and Human Services Recommendations for the Use of Antiretroviral Drugs During Pregnancy and Interventions to Reduce Perinatal HIV Transmission in the United States available at hivinfo.nih.gov. They were developed by Dr. Lynn Yee, Director of the Women's Infectious Disease Program at Northwestern Memorial Hospital and Medical Director of the 24/7 Illinois Perinatal HIV Hotline; Dr. Ellen Chadwick, Director, Section of Pediatric and Maternal HIV Infection and Dr. Jennifer Jao, both at the Northwestern Feinberg School of Medicine and Ann & Robert H. Lurie Children's Hospital of Chicago; and Dr. Julia Rosebush, Director of Pediatric/Adolescent HIV, Comer Children's Hospital at the University of Chicago.*