HIV — Post-Exposure Prophylaxis (PEP)

Non-occupational exposure — act within 72 hours

CLINICAL PATHWAY

PEP should start as soon as possible and ideally within hours — ASHM recommends **within 72 hours** of exposure; efficacy falls sharply beyond this. PEP is risk-based, not blanket: most everyday or oral exposures, and exposure to a source with an undetectable viral load (U=U), do not need it.

WHEN PEP IS INDICATED

• **Generally recommended:** receptive/insertive anal or vaginal sex, or shared injecting equipment, where the source has HIV with a detectable or unknown viral load (3-drug), or is of unknown status from a high-prevalence population — MSM, TGD or a high-prevalence country (2-drug).

• **Not recommended:** a source with an undetectable (U=U) viral load; fellatio or cunnilingus (narrow exceptions apply); community needlestick injury; unknown-status source from a low-prevalence setting.

• Full exposure-type stratification (circumcision status, ejaculation, bite criteria) is detailed in ASHM PEP Guidelines Table 2 — check the live source rather than relying on memory for borderline cases.

SEXUAL ASSAULT

PEP is always recommended after male-to-male sexual assault. After other sexual assault it is generally not routinely recommended on exposure grounds alone, but is often still prescribed at the person's request — arrange early follow-up and a low threshold for specialist/psychological referral.

REGIMEN — 28 DAYS

Provide the full course at first presentation, not a short starter pack

2-drug	Tenofovir disoproxil 300mg/emtricitabine 200mg, once daily for 28 days.
3-drug	As above PLUS dolutegravir 50mg once daily for 28 days — the recommended third agent.

IF DOLUTEGRAVIR IS UNSUITABLE

Use raltegravir 1200mg once daily (current dosing — superseded the older 400mg twice-daily regimen) where rifampicin, anticonvulsants or St John's Wort interact with dolutegravir.

FOLLOW-UP TESTING

Baseline, week 2, week 6 and week 12. HIV serology is best performed at **week 6** (2 weeks after PEP cessation); test at **week 4** instead only if transitioning directly onto PrEP. Week 12 is an additional check.

■ SAFETY

• Raltegravir carries a small rhabdomyolysis risk — warn about myalgia, especially with heavy gym work or anabolic steroid use, and advise against statins while on a raltegravir-containing regimen.

• Dolutegravir levels fall with rifampicin, anticonvulsants and St John's Wort — switch to raltegravir if these can't be stopped; separate iron/calcium/antacids by 2–6 hours from the dose.

• Starter packs (5–7 days) reduce completion rates — prescribe the full 28-day course where possible.

■ RED FLAGS / REFER

• Presentation beyond 72 hours — discuss with a specialist rather than declining PEP outright.

• Known/suspected antiretroviral resistance in the source, pregnancy, breastfeeding, or chronic HBV/HCV.

• Sexual assault presentations, or any case where future risk suggests PrEP should follow PEP.

Companion sheet: ID-05A (PrEP). See also ID-01/02 (diagnosis & ART). PEP phonelines are state-based — confirm the current number for your jurisdiction. Verify against the ASHM National PEP Guidelines, 4th edition (Oct 2025) at ashm.org.au before prescribing.