



# **LONG-ACTING HIV TREATMENT FREQUENTLY ASKED QUESTIONS**



This fact sheet provides basic information for, and perspectives from communities on long-acting HIV treatment medicines



The most important thing that a person living with HIV can do to stay healthy is to take their HIV antiretrovirals

(ARVs) every day. This is known as adherence. But, this is not easy. HIV treatment is lifelong, people may have concerns about privacy and stigma, they may be fed up with or hate taking pills, or have trouble remembering to take them.

To make HIV treatment adherence easier, researchers developed **long-acting injectable versions of some ARVs**. These are slowly released into the body over weeks to months, replacing the need for daily oral treatment.

## In this fact sheet

How many long-acting injectable ARVs are there?	2
How well does long-acting CAB/RPV treatment work?	3
What is HIV drug resistance?	4
Who is eligible for long-acting CAB/RPV?	5
Who cannot use long-acting CAB/RPV?	6
How is long-acting CAB/RPV given and where?	7
What are common long-acting CAB/RPV side effects?	8
The future of long-acting HIV treatment	8
What communities can do	9



# HOW MANY LONG-ACTING INJECTABLE ARVS ARE THERE?

CAB-LA by itself is also used to prevent HIV.



Currently, there are three long-acting injectable ARVs to treat HIV.

**1** **Long-acting cabotegravir (CAB-LA)** from the integrase inhibitor family, used in combination with;



**2** **Long-acting rilpivirine (RPV-LA)**, from the non-nucleoside family.



For short, this combination is called **CAB/RPV-LA**



**3** **Lenacapavir (LEN)** from a new ARV family, used as part of treatment for people with limited treatment options who need new types of ARVs to suppress the virus.



# HOW WELL DOES LONG-ACTING CAB/RPV TREATMENT WORK?

In two clinical trials, injections of long-acting CAB/RPV worked as well as oral ARVs after 48 weeks and during two years of follow-up. Overall, HIV treatment failed among 1% to 2% of people who were taking oral ARVs and 2% of people taking CAB/RPV-LA.

Although the number of people whose CAB/RPV-LA treatment failed was small (23 out of 1,651), they developed resistance to both ARVs – meaning that these drugs, and others in the same ARV families, would no longer work.

## Known risk factors for CAB/RPV-LA treatment failure

- Having a body mass index above 30kg
- Already having resistance to rilpivirine (which is common among people in whom treatment with efavirenz or nevirapine has failed since these are from the same ARV family)
- People who have certain types of HIV called A6 and A1.

In some low- and middle-income countries, resistance to nevirapine and efavirenz is common.

There is risk of resistance to other drugs in the same ARV family



Cabotegravir belongs to the integrase inhibitor family, which includes raltegravir, dolutegravir and bictegravir.

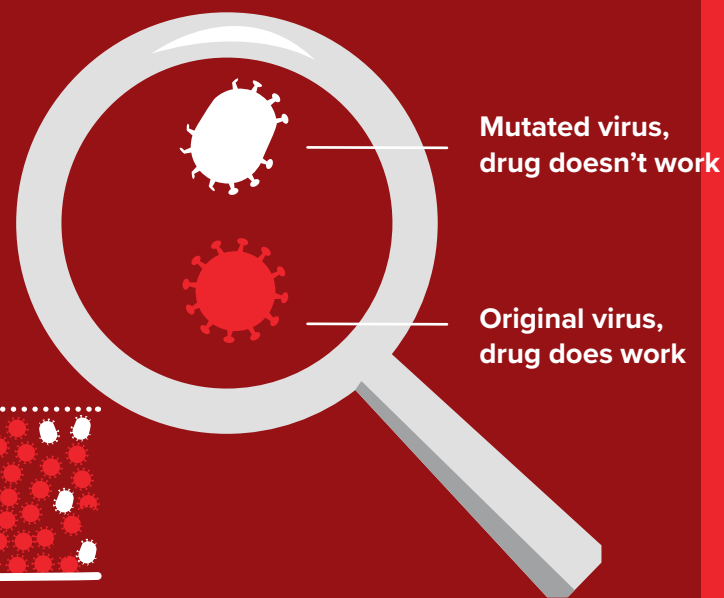
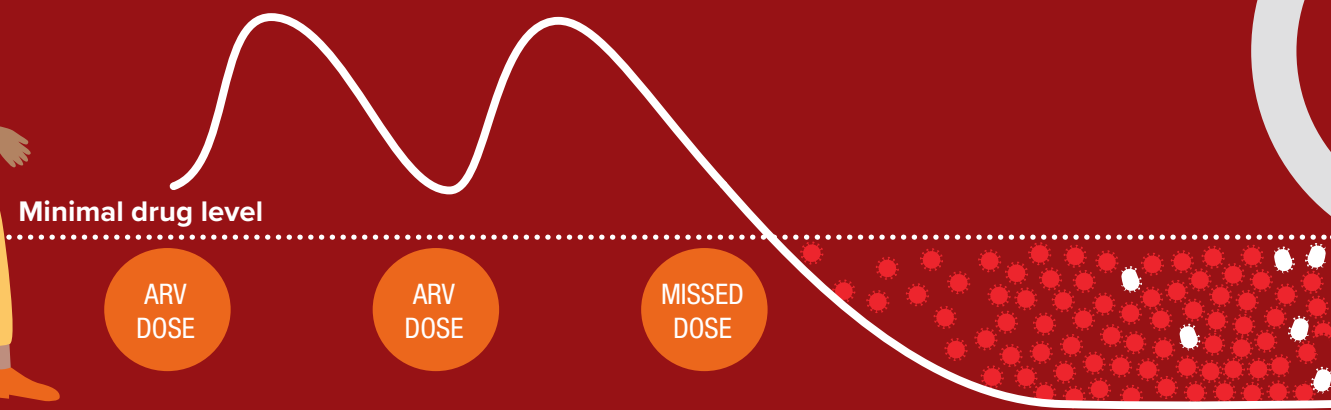


Rilpivirine belongs to the non-nucleoside family, which includes efavirenz and nevirapine.

## What is HIV drug resistance?

- Without treatment, HIV makes billions of copies each day. Some copies have changes (called **mutations**). Certain mutations can prevent a single ARV – or an entire family of ARVs – from working. This is called HIV drug resistance. People with HIV drug resistance are at risk for treatment failure, serious illness, and death.
- Some people acquire HIV that is already resistant to ARVs, or they can develop it. This can happen when people miss doses of their HIV treatment. ARV levels become too low to do their job, giving HIV a chance to multiply. Some of these copies could have mutations that stop their ARVs from working when they re-start treatment.

For more information on ARV drug resistance, see ITPC's [A guide to HIV for community education and advocacy](#).





# WHO IS ELIGIBLE FOR LONG-ACTING CAB/RPV?

Long-acting CAB/RPV is approved in high-income countries but is currently not recommended by the World Health Organization.

## Eligible for long-acting CAB/RPV

- ✓ Adolescents (age 12 years and above), weighing at least 35kg
- ✓ Adults who have a suppressed HIV viral load
- ✓ People with no history of ARV treatment failure
- ✓ People with no evidence of HIV drug resistance

## Eligible for lenacapavir

- ✓ People who have already used many different ARVs and need new medicines to suppress HIV (also known as 'heavily treatment-experienced' people).

Lenacapavir is also being studied for HIV prevention and as part of first-line treatment – results are expected in late-2024 into 2025.



# WHO CANNOT USE LONG-ACTING CAB/RPV?

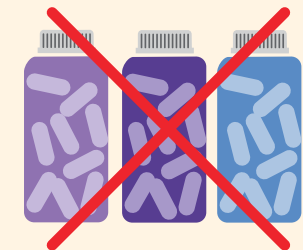
- ✗ People with a detectable viral load
- ✗ People who have a history of HIV treatment failure
- ✗ People with evidence of resistance to drugs from the same families as **cabotegravir** and **rilpivirine**. Drug resistance testing is usually not available in low- and middle-income countries, because it is expensive and results can take weeks, which complicates and delays starting ARVs
- ✗ Women who are pregnant or breast feeding. There is not enough information to recommend CAB/RPV-LA, but ongoing research is collecting this information
- ✗ People taking other certain medicines (including rifampicin, which is used to treat tuberculosis)
- ✗ This long-acting treatment needs to be kept at a stable, cold temperature during delivery and storage, so people who live in areas where this is not possible will be unable to access it.



People taking medicines like rifampicin for tuberculosis



People with resistance to drugs in the same family as cabotegravir; i.e. raltegravir, dolutegravir

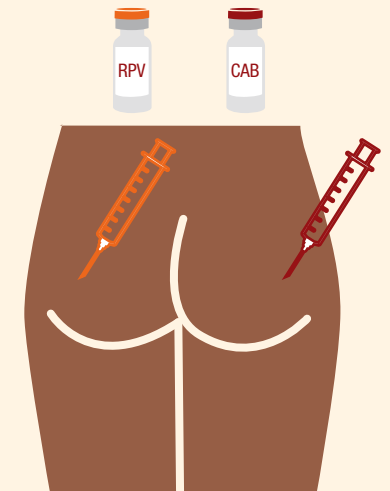
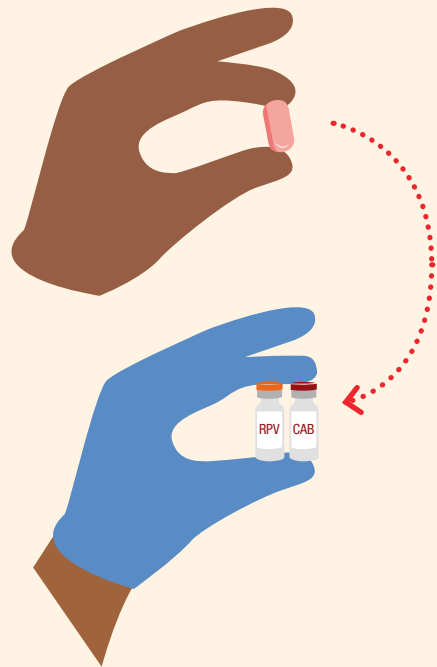


People with resistance to drugs in the same family as rilpivirine: i.e. efavirenz, nevirapine



# HOW IS LONG-ACTING CAB/RPV GIVEN AND WHERE?

- A person can switch directly from oral ARVs to CAB/RPV-LA injections, or they can take cabotegravir and rilpivirine tablets for 30 days before starting CAB/RPV-LA.
- CAB/RPV-LA is given as two intramuscular injections (one for each drug) in the buttocks. These injections need to be given by trained healthcare providers in a private space. Researchers are studying whether it can be injected in the thigh muscle instead, which could enable people to do it themselves.
- After the first injections of CAB-LA, the second injections are given 30 days later; thereafter, injections are given every two months.
- It is important not to miss scheduled injections. CAB-LA and RPV-LA linger in the bloodstream for months to over a year after an injection at levels that are too low to be effective. If someone misses their injections and does not begin to take other ARVs, they could develop drug resistance to both ARVs.





# WHAT ARE COMMON LONG-ACTING CAB/RPV SIDE EFFECTS?

- In clinical trials, the most common side effect was injection site reactions – pain, swelling, and small lumps under the skin or areas of thick, hardened skin.
- These reactions were mild-to-moderate and usually lasted for three days and happened less often over time.
- Other side effects reported by least 2% of people in clinical trials were: fever, feeling tired, headache, muscle pain, nausea, trouble sleeping or abnormal dreams, dizziness, and rash; most were mild-to-moderate.



## The future of long-acting HIV treatment

With ARVs, the first medicines to reach the market are not always the best. Although the first long-acting ARVs have drawbacks, several others are in clinical trials, including a once-weekly combination of oral LEN plus an oral ARV called islatravir.

Better long-acting ARVs are coming – although it may take some time for them to arrive. The world needs to be prepared to deliver them.

# WHAT COMMUNITIES CAN DO

Communities have an important role in preparing for roll-out of long-acting ARVs, including:

- **Sharing information about long-acting HIV treatment.** This ensures that people living with HIV are aware of new treatment options, and it builds demand for them. People living with HIV have concerns about the lack of treatment education on long-acting HIV treatment. For example; they want information on how well it works, how safe it is and what its side effects are, how often they will need injections, whether other people will be able to tell they are using a long-acting ARV, if healthcare systems will be prepared to deliver it, and whether they will experience stigma from healthcare providers who administer it.

- **Advocating for access to long-acting ARVs.** Communities should be involved with decisions and design of policy and programmes for long-acting injectable ARVs. Communities can advocate for widespread access to affordable, long-acting HIV treatment, especially as better options become available.
- **Working with health systems to prepare them for long-acting HIV treatment.** Communities can sensitize healthcare workers about stigma-free care.
- **Monitoring roll-out and delivery of long-acting HIV treatment.** Communities can assess and report on access to and quality of care.

## Other key resources

**HIV i-base** for HIV treatment information, conference reports, updates and reports on the HIV treatment pipeline:

[i-base.info](http://i-base.info)

**Treatment Action Group** for annual reports on ARVs in development:

[www.treatmentactiongroup.org/wp-content/uploads/2023/07/pipeline\\_ARV\\_2023\\_final.pdf](http://www.treatmentactiongroup.org/wp-content/uploads/2023/07/pipeline_ARV_2023_final.pdf)

**AIDSMAP** for HIV treatment information:

[www.aidsmap.com](http://www.aidsmap.com)

**National AIDS Treatment Advocacy Project** for conference reports and updates on HIV treatment:

[www.natap.org](http://www.natap.org)

**ITPC:** A guide to HIV for community education and advocacy:

<https://itpcglobal.org/resource/a-guide-to-hiv-community-education-and-advocacy/>

