



COUNTY OF SANTA CLARA PUBLIC HEALTH DEPARTMENT



HIV/STI CLINICAL PROVIDER TOOLKIT

**GETTING
TO ZERO**
SILICON VALLEY
SANTA CLARA COUNTY

Santa Clara County
**PUBLIC
HEALTH**

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The SCC HIV/STI Clinical Provider Toolkit includes this folder and a full online toolkit available at www.sccphd.org/rxprep. For more information, please email GettingToZeroSCC@phd.sccgov.org or call (408) 792-3250.

FOR PROVIDERS

- A Guide to Taking a Sexual History
- STI and HIV Screening Guidelines
- Introduction to PrEP for HIV Prevention
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- Post-Exposure Prophylaxis (PEP)
- Rapid ART (Antiretroviral Therapy)
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 - Bacterial Vaginosis vs. Trichomoniasis
- Sexually Transmitted Infection Treatment Guidelines

FOR PATIENTS

- What You Need to Know About PrEP/PEP for HIV Prevention

Additional electronic resources from the California Department of Public Health, Office of AIDS, PrEP clinical guidelines, PrEP candidate screening tools, billing and insurance, and educational materials for patients and providers are available at: www.sccphd.org/rxprep.

A GUIDE TO TAKING SEXUAL HISTORY

Take a comprehensive sexual history that includes the gender of sexual partners and anatomic sites of sexual exposure during the past year.

A Thorough Sexual History is Necessary to Identify Patients Who May Need:

- STI screening
- Empiric STI treatment
- Contraceptive or other reproductive resources
- HIV pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis (PEP)
- Remind patients that a sexual history is part of routine healthcare for every patient and is confidential.
- If limited to one question, an option during brief or returning visit is to ask: “What is/are the gender(s) of your sex partners?” in order to assess potential risks for STIs and determine appropriate screening.

Talk to Your Patient About the 6 P’s of Sexual Health:

- 1. Partners:** What are the genders of your sex partners? How many sex partners have you had in the last 12 months?
- 2. Practices:** In the past 12 months, have you had vaginal sex? Oral sex (giving, receiving, or both)? Anal sex (receptive, insertive, or both)?
- 3. Protection from STIs:** How often do you use condoms or other barrier protection during sex?
- 4. Past history of STIs:** Have you ever had an STI? Have any of your partners told you they have an STI?
- 5. Pregnancy Intention:** Do you think you would like to have (more) children at some point? How important is it to you to prevent pregnancy (until then)? If you are having sex that can result in pregnancy, are you using contraception or practicing any form of birth control?
- 6. Plus:** How is your sex life going? What concerns do you have about your sex life? Are you having any difficulties when you have sex? What support, if any, do you have from your family and friends about your gender identity? What support, if any, do you have from your family and friends about your sexual orientation?

Patients may be given sexual history questions in advance to speed up the visit and encourage comfort with disclosing information

COUNTY OF SANTA CLARA PUBLIC HEALTH DEPARTMENT

STI AND HIV SCREENING GUIDELINES

STIs Can Have Severe Consequences if Left Untreated.

Below is a brief overview of STI screening recommendations:

Adults and adolescents ages 13-64	<ul style="list-style-type: none"> Should be tested at least once for HIV
All sexually active women	<ul style="list-style-type: none"> Under 25 years should be tested for chlamydia and gonorrhea every year 25 years and older and with risk factors such as new and multiple sex partners, or a sex partner who has an STI should be tested for chlamydia and gonorrhea every year
All pregnant patients	<p>Should be tested for:</p> <ul style="list-style-type: none"> Syphilis: <i>at least TWICE</i> during pregnancy <ol style="list-style-type: none"> 1) Tested once at either confirmation of pregnancy or at first prenatal encounter (ideally during the 1st trimester) AND 2) By law, patients must be tested during the 3rd trimester (ideally between 28-32 weeks' gestation) regardless of whether such testing was performed or offered during the first two trimesters HIV, Hep B, and Hep C starting early in pregnancy <p>*If risk factors, STI diagnosis, Chlamydia and gonorrhea starting early in pregnancy</p>
Anyone who has sex without condoms or shares injection drug equipment	<ul style="list-style-type: none"> Should be tested at least once yearly for HIV
People who have had oral or anal sex	<ul style="list-style-type: none"> Should include throat and rectal testing options for all STIs Should be tested for HIV quarterly or as needed Consider HIV PrEP
Cis men who have sex with men —OR— Trans women and trans men who have sex with men	<ul style="list-style-type: none"> Tested at least once a year for syphilis, chlamydia, and gonorrhea (those who have multiple or anonymous partners should be tested more frequently, every 3 to 6 months) Tested at least once a year for HIV and may benefit from more frequent testing (e.g., every 3 to 6 months) Tested at least once a year for Hep C, if living with HIV
<p>**Transgender and gender diverse persons: providers should remain aware symptoms consistent with common STIs and screen for asymptomatic infections on the basis of the patient's sexual practices and anatomy.</p>	

PrEP: EFFECTIVE METHODS FOR HIV PREVENTION

PrEP is safe and can reduce the risk of HIV by **more than 90%**

Who is Indicated for PrEP?

Sexually active adults and adolescents who are HIV-negative and have had anal or vaginal sex in the past 6 months, and:

- Have not consistently used a condom, OR
- Have had a bacterial STI in the past 6 months OR
- Have a sexual partner with HIV (especially if the partner has an unknown detectable viral load), OR

People who inject drugs, shares injection equipment, or has an HIV positive injecting partner

Who May Benefit:

Patients often do not disclose stigmatized sexual or substance use behaviors to their provider, especially when not asked about a specific behavior.

- All sexually active adults and adolescents should be informed about PrEP
- Anyone who asks for PrEP
- Patients who report one or more sex partner of unknown HIV status
- People who use drugs or alcohol
- Trans women and men
- Heterosexual men and women with multiple partners
- Men who have sex with men (MSM)

Truvada (Generic TDF/FTC) and Descovy

- Truvada/ generic TDF/FTC and Descovy are all oral medications approved by the FDA for PrEP, and according to the CDC, when taken consistently, have shown to reduce the risk of acquiring HIV in people who are at high risk by more than 90%.
- Some people have early side effects, such as upset stomach or appetite loss, but these are usually mild and resolve within the first month *without* stopping PrEP.
- While Truvada/ generic TDF/FTC and Descovy have been found to cause renal toxicity and decreased bone density in people living with HIV, they have not caused serious short-term safety concerns to date when used for PrEP and are tolerated well by most clients.

Descovy® 200/25 mg

emtricitabine 200 mg/tenofovir alafenamide fumarate 25 mg

1 tablet PO daily, 30-day supply with 2 refills

****Shown to be effective for MSM & trans women**

Truvada® 200/300 mg

Available as generic

emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg

1 tablet PO daily, 30-day supply with 2 refills

Apretude: New PrEP Injectable:

- Apretude (long acting Cabotegravir 600mg (3mL)) is a gluteal only intramuscular injection indicated for in at-risk adults and adolescents weighing at least 35 kg (77 pounds) for PrEP to reduce the risk of sexually acquired HIV
- Approved by the FDA on December 20, 2021
- Safe and highly effective HIV prevention method
- **Dosing schedule:** An IM (gluteal) initiation injection (Apretude 600 mg (3mL)) for month 2 and 3; and an IM (gluteal) continuation injection on month 5 and every two months thereafter

Optional: According to the CDC, an oral lead-in may be acquired for patients who are worried about side effects, to relieve anxiety, about using the long-acting Cabotegravir injection. However, continued daily oral Cabotegravir is not recommended, or FDA approved for PrEP

- Should not be used with other HIV medicine

2-1-1 Pre-Exposure Prophylaxis:

Another Effective Method of PrEP with Truvada or generic TDF/FTC in MSM

How Does PrEP 2-1-1 Dosing Work?	Why PrEP 2-1-1 Dosing?
<ul style="list-style-type: none"> • 2-24 hours before sex: <ul style="list-style-type: none"> ○ Take 2 tablets of Truvada • 24 hours after first dose: <ul style="list-style-type: none"> ○ Take 1 tablet of Truvada • 48 hours after first dose: <ul style="list-style-type: none"> ○ Take 1 tablet of Truvada <p><i>*PrEP 2-1-1 dosing changes if you are going to have sex within 7 days of your last PrEP dose. Start by taking just ONE pill between 2-24 hours before sex. You still take ONE pill 24 hours after the first pill, and ONE pill again 24 hours after that.</i></p>	<ul style="list-style-type: none"> • Barrier of PrEP daily dosing adherence • PrEP discontinuation rates continue to be high • Shown to be highly effective for gay and bisexual men in the French <i>IPERGAY</i> study <p><i>*2-1-1 has not been studied in ciswomen, cismen who have sex with women, transmen, transwomen, or people who inject drugs</i></p> <p><i>*2-1-1 is not FDA-approved; however, it is endorsed by the International AIDS Society USA and is in use at the Lenzen STI Clinic in San Jose</i></p>

Prescribing and Supporting PrEP:

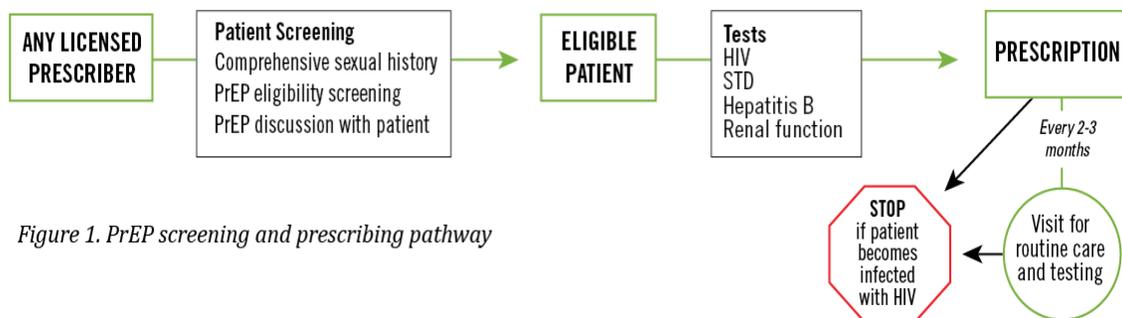


Figure 1. PrEP screening and prescribing pathway

PrEP BILLING AND PAYMENT ASSISTANCE

PrEP-Related Billing Codes

There are no official billing codes specifically for PrEP. Below are lists of ICD-9/10 codes that can be used to cover PrEP- and post-exposure prophylaxis (PEP) -related services. The highlighted codes may be preferred by clients as potentially less stigmatizing and/or more protective of their privacy.

ICD-10	Description
Z20.82	Contact with and (suspected) exposure to other viral communicable diseases
Z20	Contact with and (suspected) exposure to communicable diseases
Z20.6	Contact with and (suspected) exposure to HIV
Z20.8	Contact with and (suspected) exposure to other communicable diseases

Payment Assistance for PrEP

There are several options for helping patients pay for PrEP. For patients on Medicaid, all PrEP-related medical costs should be covered. **Gilead's Advancing Access Medication Assistance** can provide financial assistance to individuals earning less than 500% of the federal poverty level, if they are uninsured or have basic insurance without pharmacy benefits. PrEP payment options for other insured patients are described in the table below.

Gilead Advancing Access Co-Pay Card	Patient Advocate Foundation (PAF)	Ready Set PrEP
<ul style="list-style-type: none"> ▪ \$7,200 max/calendar year ▪ No income restrictions ▪ Covers co-pays, deductibles and co-insurance ▪ 12-month enrollment, reapply ▪ Not used with state/federal plans, such as Medicare 	<ul style="list-style-type: none"> ▪ \$7,500 max/year, re-apply ▪ Income <400% FPL (\$51,040) ▪ Must be insured ▪ Covers co-pays, deductibles and co-insurance ▪ Proof of US residence (utility bill) ▪ Case managers available to help resolve medical cost issues (800-532-5274) 	<ul style="list-style-type: none"> ▪ No max coverage limits ▪ No income restrictions ▪ Covers the full cost of brand-name Truvada and Descovy ▪ 12-month enrollment, reapply through online portal
For more information: Visit: www.gileadcopay.com Call: 877-505-6986	For more information: Visit: https://www.patientadvocate.org/ Call: 800-532-5274	For more information: Visit: https://readyssetprep.hiv.gov/ Call: 855-447-8410

PRESCRIBING PEP (POST-EXPOSURE PROHYLAXIS)

PEP is Taken After Possible Exposure to HIV

- Exposure to HIV is a medical emergency, and PEP should be taken as soon as possible, but no later than within 72 hours of potential exposure.
- HIV testing should be carried out 4 to 6 weeks post-exposure.

What's the Difference Between PrEP and PEP?

	PrEP	PEP
Who can receive it?	HIV-negative individuals at high risk for HIV exposure	HIV-negative individuals who may have been recently exposed to HIV
When is it indicated?	For those who are at risk for acquiring HIV, including people who have a sexual partner who lives with HIV, multiple sex partners, a history of inconsistent or no condom use, those who engage in commercial sex work, and those who share injection equipment.	Following potential exposure to HIV through sexual contact, sharing needles, or injury with blood or bodily fluid exposure from someone living with HIV or of unknown HIV-status.
What is it?	Once-daily Truvada®, Descovy® or generic TDF/FTC, and intramuscular Cabotegravir (CAB) injection	Truvada® plus Raltegravir or dolutegravir (preferred regimen, alternatives may be used)
When should treatment begin?	Pre-exposure, at any time	As soon as possible, but no later than 72 hours after potential exposure
How long is the course of treatment?	Indefinite; varies by patient	28 days
Who can prescribe it?	Any licensed prescriber	Any licensed prescriber, often emergency department clinicians
How effective is it?	Reduces risk by up to 92%	Up to 81% reduction in HIV infection

Prescribing Post-exposure Prophylaxis (PEP)

Tenofovir DF (300 mg)/ Emtricitabine (200 mg) daily + Raltegravir 400 mg BID
OR Tenofovir DF/ Emtricitabine daily + Dolutegravir 50 mg daily for 28 days.

Did you know?
Biktarvy is also used off-label for PEP

RAPID START OF ANTI-RETROVIRAL THERAPY (ART) GUIDELINES

- The goal of rapid start is to initiate immediate, within 24-72 hours, anti-retroviral therapy to all patients newly diagnosed with HIV
- Initiating ART during acute/early infection may improve CD4+ T cell recovery, decrease the overall size of the HIV reservoir, and significantly prevent transmission to sexual partners
- Immediate initiation of ART has also been shown to improve linkage to and retention in long-term HIV care

County of Santa Clara Rapid ART Guidelines

Eligibility For Rapid Start

1. Newly diagnosed HIV patients (inclusive of acute and chronic infection)
2. Patient re-engaging in HIV care with low CD4 cell counts (<200 and/or significant co-morbidities)

Exclusion Criteria

1. Patients with signs of serious CNS infection suspicious for meningitis
2. Patients on phenytoin, phenobarbital, oxcarbazepine, carbamazepine, rifampin, rifabutin, enzalutamide, St. John's wort or any strong inducer of CYP3A4
3. Patients with a history of allergic reaction or intolerance to Bicitgravir or emtricitabine or tenofovir alafenamide or the combination product Biktarvy®.
4. Patients who are pregnant or breast feeding or are planning pregnancy
5. Patients without documented positive HIV test result of any kind

Recommended Regimen for Rapid ART

Bicitgravir/Tenofovir Alafenamide/Emtricitabine (Biktarvy®) 50/25/200 mg tablet

Take one tablet by mouth once daily.

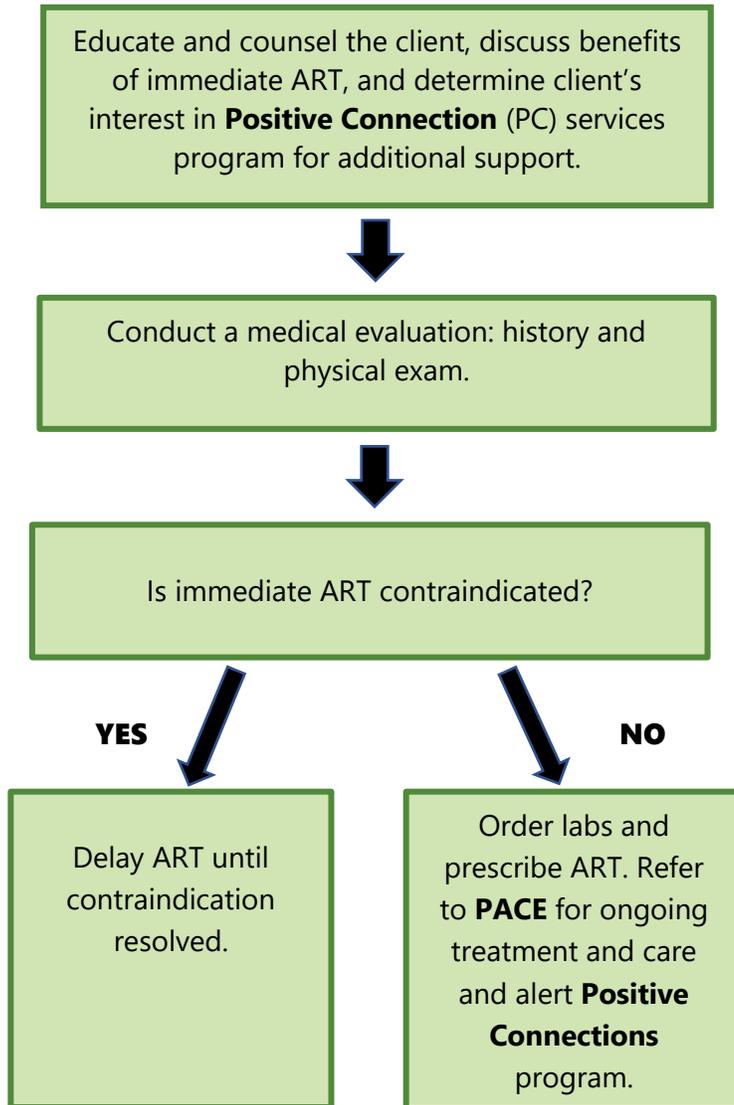
Side Effects of Biktarvy

- Diarrhea
- Nausea
- Headache
- Fatigue
- Abnormal dreams
- Dizziness

Serious but uncommon side effects: signs of kidney problems, signs of liver problems, loss of appetite, stomach/abdominal pain, slow/irregular heartbeat, blue/cold skin, muscle pain

SAMPLE RAPID ART WORKFLOW AND CONFIRMATORY LAB TESTS FOR PATIENTS TESTING HIV POSITIVE

Confirmatory Laboratory Tests



Rapid ART Workflow

<i>To Be Ordered on the Day of Therapy Initiation</i>
HIV-1 and HIV-2 antibodies, P24 Antigen
HIV-1 RNA, quantitative PCR
HIV1 Genotype
CD4 (aka CD4)
HLA-B*5701 Typing
Syphilis (FOR INITIAL DIAGNOSIS)
GC and Chlamydia Triple Screen ** (Order Panel) **
Hepatitis C antibody (aka ANTI-HCV)
Hepatitis B surface antigen (aka HBSAG)
Hepatitis B core antibody... (aka ANTI HBC)
Hepatitis B surface antibody (aka ANTI-HBS)
QuantiFERON
Toxoplasma gondii antibody, IgG
Glucose 6 phosphate dehydrogenase... (aka G6PD)
Anti-HAV, IgG
Liver function test (aka LFT)
Panel 7 (aka P7)
Hemogram with differential (aka CBC)
Urinalysis
**Testing for Gonorrhea and Chlamydia at three sites (oral, anal, urine) is recommended for sexually active MSM; Rectal and Oral swabs are ordered as clinic collect

Positive Connections Program:

The Positive Connections Program provides comprehensive case planning and coordination for those individuals who have been newly diagnosed with HIV or are not currently in care in Santa Clara County ([Positive Connections](#)).
Phone: [\(408\) 792-5080](tel:4087925080)

Partners in Aids Care and Education (PACE) Clinic:

PACE offers a multi-disciplinary approach to care in all stages of HIV infection ([PACE](#)).
Phone: [\(408\) 885-5935](tel:4088855935)

ART CONTRAINDICATIONS

Immediate ART is **Not** Appropriate For:

- Patients for whom immediate ART might be medically dangerous (e.g., untreated central nervous system opportunistic infections such as cryptococcal meningitis)
- Patients likely to have multiple ARV mutations (e.g., treatment experienced with known or suspected resistance) for whom it would be difficult to design an ART regimen without current resistance test results

Pregnancy and RAPID ART:

- **For those who may become pregnant while taking ART:**
 - Discuss possible risks/benefits of specific ARVs at conception and early pregnancy; choose ART through shared decision making.
- **For pregnant individuals:**
 - Dolutegravir 50 mg once daily + (TDF/FTC or TDF/3TC) once daily
 - Raltegravir 400mg twice daily + (TDF/FTC or TDF/3TC) once daily

Patients with positive HIV test while on PrEP:

- Take a thorough medication history to determine the last time that they took PrEP, and their PrEP-taking pattern.
- If the patient took any PrEP in the weeks after date of suspected infection, consider starting an enhanced regimen consisting of an INSTI (dolutegravir or bictegravir) + boosted darunavir + TAF/FTC (or TDF/FTC, TDF/3TC) while awaiting results of the genotype.

Antiretrovirals (ARVs) to Avoid Until Results of Genotype, HIV RNA, and HLA B*5107 Are Known:

- **NNRTIs (efavirenz, etravirine, rilpivirine, doravirine, nevirapine)**
 - Transmitted drug resistance to NNRTI class is most common.
 - Rilpivirine is less potent if baseline viral load >100,000 c/mL.
- **Abacavir-containing regimens, including co-formulations (Epzicom[®], Triumeq[®])**
 - High risk of abacavir hypersensitivity reaction if HLA B*5701(+)
- **2-drug regimens: dolutegravir/3TC (Dovato[®]), dolutegravir/rilpivirine (Juluca[®]), cabotegravir + rilpivirine (Cabenuva[®]), boosted darunavir + 3TC, and others**
 - Risk of transmitted drug resistance and virologic failure; not well studied as RAPID regimens

SYPHILIS

- A sexually transmitted infection that is spread through vaginal, anal, and oral sex or direct contact to infection lesion, blood-borne, mother-to child.
- Syphilis causes sores on the genitals (called chancres). Though the sores are usually painless, they can be easily spread to other people.

Syphilis is Divided into Stages:

- **Primary:** single, painless, clean-based lesion or sore called a "chancre"
- **Secondary:** There are multiple symptoms of syphilis, some examples are, skin rash, condyloma lata, palmar/plantar (P/P) mucous patches, lymphadenopathy, alopecia, hepatitis, and mucocutaneous lesions on one more area of your body (including in mouth, palms of hands, soles of feet, vagina, or anus)
- **Latent:** period when there are no visible signs or symptoms of syphilis
- **Tertiary:** can affect the heart, blood vessels, and the brain and nervous system

Neurosyphilis, Ocular syphilis, and Ootosyphilis Can Occur at Any Stage

Without treatment, Syphilis can spread to the brain and nervous system or eyes

Symptoms of Neurosyphilis

- Severe headaches
- Ataxia
- Paralysis
- Numbness
- Dementia

Symptoms of Ocular Syphilis

- Changes in vision and even blindness

Symptoms of Ootosyphilis

- Sensorineural hearing loss, tinnitus, or vertigo
- Hearing loss can be unilateral or bilateral

Lumbar puncture (LP) is no longer required for evaluation of ocular syphilis. Patient must receive treatment regardless of findings in serology and no longer monitor LP as long as serologies respond to treatment

COMMON MYTH: SYPHILIS ≠ HERPES

Syphilis presents differently in different stages of disease and can be easily misdiagnosed

Congenital Syphilis is on the Rise

Congenital Syphilis is the manifestation of *Treponema pallidum* infection in a fetus or infant acquired via vertical transplacental transmission.

If left untreated, early syphilis in pregnancy results in fatal infection for approximately 80% of cases, with more than 1/3 of which will lead to fetal or neonatal mortality.

However, treatment with antibiotics can prevent 98% of cases. Diagnosis of syphilis in a pregnant patient is urgent and should be treated or referred for treatment immediately and the health department notified by submission of a Confidential Morbidity Report ([CMR](#)).

How Do I Assess if my Patient Is at Risk of Contracting Syphilis?

Ensure the following patients are tested:

- Testing in pregnant women
 - All pregnant women under 25 years of age
 - Pregnant women, 25 years and older if at increased risk (those who have new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has an STI)
 - Retest during the 3rd trimester for women under 25 years of age or at risk
 - Pregnant women with chlamydial infection should have a test of cure 4 weeks after treatment and be retested within 3 months
- Get tested for syphilis if patients are sexually active *and*
 - A man who has sex with men
 - Living with HIV; or
 - Have a partner(s) who have tested positive for syphilis
- Anyone diagnosed with gonorrhea or chlamydia should be tested for syphilis
- Screen asymptomatic adults at increased risk: history of incarceration or commercial sex work, geography, and race/ethnicity
- Transgender and gender diverse people

Diagnosing Syphilis

Serology and Stage: Need Both a Treponemal *AND* Non-treponemal Tests

Non-treponemal Tests

- Examples: RPR and VDRL
- **Quantitative** tests, allowing for assessment of disease burden, treatment adequacy, and re-infection
- Non-specific (can be positive in patients with other conditions)

Treponemal Tests

- Examples: **TPPA, TPHA, FTA-ABS, EIA, CIA, "Syphilis antibody"**
- Detect antibodies specific to *T. pallidum*
- Antibodies usually stay positive for life after initial infection
- Qualitative tests (yes/no); cannot be used to assess for reinfection or response to treatment

Tests Required to Make a Diagnosis of Syphilis

At least TWO serologic tests are needed to make a diagnosis of syphilis

Primary labs: Treponemal (Trep) **OR** nontreponemal test (NTT) labs needed

Secondary: Trep **AND** NTT are both required

Early Non-Primary/Non-Secondary, and Unknown Duration or Late: Trep **AND** NTT, unless patient has history of syphilis, provider must assess if any epidemiologic criteria of infection have been met in the past 12 months

Provider Follow up and Monitoring of Syphilis

Serologic Follow-up

- Patients with enzyme immunoassay (EIA)/chemiluminescence immunoassay (CIA)-positive, RPR/VDRL-positive serology diagnosed with a new syphilis infection should be treated and receive follow-up titers according to national guidelines.
- For asymptomatic patients with discordant serology (EIA/CIA-positive, RPR/VDRL negative) who are treated for syphilis, consider repeating serologic screening in 12 months or sooner if indicated by risk.

Pregnant Women with Syphilis

- Follow-up serologic tests should be performed using the same test type (RPR or VDRL). RPR titer results cannot be compared to VDRL titer results as RPR titers are frequently slightly higher.
- All women should have repeat serologic titers at 28-32 weeks' gestation and at delivery.
- It is acceptable to repeat serologic titers monthly for women at high risk for reinfection or if in geographic region with high syphilis prevalence.
- **Follow-up intervals for primary or secondary syphilis:**
 - Clinical exam at approximately 1 week to confirm symptom improvement.
 - Serologic titer at 6 and 12 months. Expect a fourfold drop in titers at 6-12 months.
- **Follow-up intervals for latent infection:**
 - Serologic titer at 6, 12 and 24 months. Expect a fourfold drop in titer by 12-24 months (if initially high > 1:16).

HIV-infected patients need closer follow-up intervals

CHLAMYDIA

Chlamydia is a common sexually transmitted infection (STI) that can be easily cured but often has no symptoms. If left untreated, chlamydia can make it difficult for women to get pregnant.

What is Chlamydia?	<ul style="list-style-type: none"> • Common STI that can infect both men and women • Can cause serious, permanent, damage to a women’s reproductive system
How is Chlamydia Spread?	<ul style="list-style-type: none"> • Chlamydia can be spread through vaginal, anal, or sex with someone who already has chlamydia • Re-infection can occur even if treated in the past after having unprotected sex with someone who has chlamydia
Signs and Symptoms of Chlamydia	<ul style="list-style-type: none"> • Women with symptoms may notice: <ul style="list-style-type: none"> ○ an abnormal vaginal discharge ○ a burning sensation when urinating • Men with symptoms may notice: <ul style="list-style-type: none"> ○ a discharge from their penis ○ a burning sensation when urinating ○ pain and swelling in one or both testicles
How is Chlamydia Diagnosed?	<ul style="list-style-type: none"> • Urine test • Physical exam or throat, urine, vaginal/cervical, and rectal swabs
Risk Factors for Chlamydia	<ul style="list-style-type: none"> • Anyone who has unprotected vaginal, anal or oral sex can get chlamydia • Gay, bisexual, and other men who have sex with men
How Can Chlamydia Infection be Avoided?	<ul style="list-style-type: none"> • Abstinence • Use condoms (male and female condoms are available) • Plan ahead: Think about protecting yourself. Talk with your sex partner(s) about STIs and the need to protect yourself.
Importance of Early Identification and Treatment	<ul style="list-style-type: none"> • Reduces pelvic inflammatory disease (PID) • Reduces infertility, ectopic pregnancy, and chronic pelvic pain • Prevents complications in newborns

GONORRHEA

Gonorrhea is a common sexually transmitted infection (STI) caused by the *bacterium Neisseria gonorrhoeae*.

What is Gonorrhea?	<ul style="list-style-type: none"> • Common infection among both men and women ages 15-24 years • Cause infections in the genitals, rectum, and throat
How is Gonorrhea Spread?	<ul style="list-style-type: none"> • Gonorrhea can be spread through vaginal, anal, or sex with someone who already has gonorrhea • Gonorrhea can be passed from pregnant mother to baby during childbirth
Signs and Symptoms of Gonorrhea	<ul style="list-style-type: none"> • Women with symptoms may notice: <ul style="list-style-type: none"> ○ increased vaginal discharge ○ a painful or burning sensation when urinating ○ vaginal bleeding between periods • Men with symptoms may notice: <ul style="list-style-type: none"> ○ a discharge from their penis ○ a burning sensation when urinating ○ pain and swelling in one or both testicles • Rectal infections in both men and women may or may not cause symptoms: <ul style="list-style-type: none"> ○ discharge, anal itching, soreness ○ bleeding or painful bowel movements
How is Gonorrhea Diagnosed?	<ul style="list-style-type: none"> • Urine test • Throat and/or rectal swabs
Risk Factors for Gonorrhea	<ul style="list-style-type: none"> • Anyone who has unprotected vaginal, anal or oral sex can get Gonorrhea • Gay, bisexual, and other men who have sex with men
What Happens if Gonorrhea is Not Treated?	<ul style="list-style-type: none"> • Infertility • Ectopic Pregnancy • Long-term pelvic/abdominal pain • Scar tissue formation that blocks fallopian tubes
How Can Gonorrhea Infection be Avoided?	<ul style="list-style-type: none"> • Abstinence • Use condoms (male and female condoms are available)

DISSEMINATED GONOCOCCAL INFECTION (DGI)

DGI is a *severe complication of untreated gonorrhea* and occurs when *Neisseria gonorrhoeae* invades the bloodstream. DGI can cause joint pain, redness or swelling; Fevers, rash that may become filled with fluid, and may cause infections of the blood or heart valves.

Neisseria gonorrhoeae invades the bloodstream and spreads to different sites of the body, which can lead to:

- Septic arthritis
- Polyarthralgia
- Tenosynovitis
- Petechial/pustular skin lesion
- Bacteremia
- re occasions: endocarditis or meningitis

CDC Guidelines for Diagnosing, Testing, and Managing DGI Cases

Diagnosing	<ul style="list-style-type: none">▪ Confirmation of DGI done by isolating <i>Neisseria gonorrhoeae</i> from culture of disseminated sites such as blood, skin/abscess(es), cerebrospinal fluid (CSF), and/or synovial fluid
Testing	<ul style="list-style-type: none">▪ Nucleic acid amplification testing (NAAT)/culture of the sites listed above
Managing	<ul style="list-style-type: none">▪ Treatment updates of DGI listed in Treatment Guidelines document in this toolkit

DGI Missed Opportunities/Best Practices

- Offer PrEP referral if HIV negative
- Initiate partner services while patient is still hospitalized
- Leading change: Creating a sense of urgency (e.g., disease complications, reinfection, etc.)

BACTERIAL VAGINOSIS VS. TRICHOMONIASIS

What's the Difference?

Bacterial Vaginosis (BV)	Trichomoniasis ("Trich")
<ul style="list-style-type: none"> • Occurs when there is too much of a certain bacterium in the vagina, increasing your chance of getting an STI • Any woman can get BV • Having a new or multiple sexual partners, and douching, can cause vaginal imbalance and exposure to BV • Treatment with antibiotics may or may not be necessary for BV • Many women with BV do not have symptoms; however, those with symptoms may notice: <ul style="list-style-type: none"> • A thin, white, or gray vaginal discharge • Vaginal pain, burning, or itching • A strong fish-like odor, especially after sex • Burning when urinating • Itching around the outside of the vagina 	<ul style="list-style-type: none"> • sexually transmitted infection (STI) caused by infection with protozoan parasite called <i>trichomonas vaginalis</i> • More common in women than in men • Parasite passes from an infected person to an uninfected person during sex • Treatment with medication is prescribed by a doctor • Many infected people with trich do not have symptoms; however, those with symptoms may notice: <ul style="list-style-type: none"> ○ Vaginal: Itching, burning, redness, or soreness of genitals ○ Discomfort with urination ○ Change in vaginal discharge (clear, white with fishy smell) ○ Penile: itching or irritation inside penis ○ Burning after urination or ejaculation ○ Discharge from penis

SEXUALLY TRANSMITTED INFECTION TREATMENT GUIDELINES

Comprehensive and updated STI treatment guidelines released by the CDC in July 2021 can be found here: [Sexually Transmitted Infections Treatment Guidelines, 2021 \(cdc.gov\)](https://www.cdc.gov/std/treatment-guidelines). Recommended regimens for infants and children not listed in this chart.

Chlamydia	<ul style="list-style-type: none"> 1st line treatment is now Doxycycline 100 mg PO BID x 7 days for uncomplicated infection Azithromycin 1 g PO x 1 is now an alternative, 2nd line treatment, though remains 1st line if pregnancy cannot be ruled out
Gonorrhea	<ul style="list-style-type: none"> 1st line treatment is now ceftriaxone monotherapy: 500 mg IM x 1 in persons weighing <150 kg, or 1 g IM x 1 in persons 150 kg Doxycycline 100 mg PO BID x 7 days should be added in cases where chlamydial co-infection has not been ruled out
Mycoplasma genitalium (M.gen)	<ul style="list-style-type: none"> NAAT testing for M. gen is indicated in patients with recurrent/persistent urethritis Recommended treatment: Doxycycline 100 mg PO BID x 7 days followed by moxifloxacin 400 mg PO daily x 7 days
Pelvic Inflammatory Disease (PID)	<ul style="list-style-type: none"> First line treatment now includes anaerobic coverage for all patients, regardless of whether BV infection is detected: For outpatient therapy: Ceftriaxone IM x 1 (dosed per weight-based GC guidance above) PLUS Doxycycline 100 mg PO BID AND Metronidazole 500 mg PO BID (both x 14 days)
Nongonococcal Urethritis (NGU)	<ul style="list-style-type: none"> Doxycycline 100 mg PO BID x 7 days has replaced azithromycin 1 g PO once as the preferred initial therapy for NGU.
Trichomonas	<ul style="list-style-type: none"> Treatment no longer varies by HIV status Vaginal infection: Metronidazole 500 mg PO BID x 7 days Penile/urethral infection: Metronidazole or tinidazole, both dosed at 2 gm PO x 1
Syphilis Screening	<ul style="list-style-type: none"> Test all pregnant people at least twice during pregnancy: At the first clinical encounter (ideally during first trimester) AND During third trimester (ideally at 28-32 weeks) Repeat at delivery if high risk OR missed either prior screens
HIV Testing	<ul style="list-style-type: none"> For any patient with gonorrhea or syphilis, test for HIV and offer HIV Pre-Exposure Prophylaxis (PrEP)
Expedited Partner Therapy	<ul style="list-style-type: none"> California health and safety code (§ 120582) authorizes providers to prescribe or dispense expedited partner therapy (EPT) to patients with chlamydia, gonorrhea and trichomoniasis to give to their sex partners, along with instructions for their use.

PrEP/PEP FOR HIV PREVENTION

PrEP Fact Sheet

What is PrEP?

PrEP (pre-exposure prophylaxis) is an additional prevention option for HIV-negative people.

PrEP	➔	before
Exposure	➔	coming into contact with HIV
Prophylaxis	➔	a medicine to prevent infection

PrEP is a safe and effective prevention method for HIV-negative people to reduce the risk of becoming infected. PrEP pills need to be taken daily to help prevent HIV. Cabotegravir (CAB) injection is a new PrEP medication which was approved by the FDA in late 2021. When used consistently and as prescribed, PrEP has been shown to reduce the risk of HIV infection by more than 90% among people at high risk for HIV infection.

Starting PrEP

- Talk to your doctor if you think you may be at high risk for acquiring HIV. If you both agree that PrEP is right for you, you will need to come in for health physicals and testing (HIV, STIs, kidney function, and Hepatitis B and C).
- If tests show that PrEP is likely to be safe, your doctor may give you a prescription for PrEP sold under the name Truvada®, Descovy®, generic TDF/FTC, or Cabotegravir (CAB) injection.
- You will also get tested for HIV and STIs every 3 months and renal function test every 12 months.

Possible Side Effects

- Some people experience gas, nausea, or headache. However, these symptoms go away within the 1st month.
- PrEP can cause small changes in kidney function and bone mineral density, which will return to normal once PrEP is stopped.

Missed a Dose?

- Take it when you remember, but **DON'T** take a double dose to make up for a missed one.

PrEP is another option for prevention. Prevention options include:

- Condoms
- PrEP
- PEP
- Counseling
- ART for partners living with HIV

STAY HEALTHY

- PrEP is highly effective but doesn't protect against other STIs – it's best to use with condoms and get tested for STIs regularly
- Get vaccinated for Hepatitis A & B

PEP Fact Sheet

What is PEP?

- Taken daily for 28 days, PEP (post-exposure prophylaxis) is the use of antiretroviral medication after possible exposure to HIV to reduce the risk of transmission among HIV-negative individuals.
- Exposure is a medical emergency, and PEP should be taken as soon as possible after potential exposure.
- Unlike PrEP (pre-exposure prophylaxis), which is an ongoing HIV protection measure, PEP is intended as an emergency response.

PEP	➔	after (post)
Exposure	➔	possible exposure to HIV
Prophylaxis	➔	a medicine to prevent HIV

When is PEP Indicated?

- Following potential exposure to HIV through unprotected intercourse or needle sharing with someone living with HIV or unknown HIV-status partners; injuries with blood or fluid exposure from someone living with HIV or a source of unknown HIV status.

What is it?

- Truvada® plus Raltegravir or Dolutegravir (preferred regimen, alternatives may be used).

When Should Treatment Begin?

- Within **72 hours** of potential exposure
- Course of Treatment: 28 days

Who Can Prescribe PEP?

- Any licensed prescriber, often Emergency department clinicians

PEP is safe and appropriate for most patients.

- There are few contraindications to the recommended PRP regimen, which is generally well-tolerated.
- Generally, PEP is indicated at any time during pregnancy, but expert consultation should be sought if a pregnant person *has had an exposure*.
- **Follow-up HIV testing should be carried out at 30- and 90-days post-exposure**

FOR ADMINISTRATORS: PrEP BILLING AND PAYMENT ASSISTANCE RESOURCES

PrEP Assistance Program (PrEP- AP)

- [PrEP-AP Formulary](#)

Enrollment Workers

- [Federal Poverty Guidelines Chart](#)
- [FAQ: For Enrollment Workers \(PDF\)](#)
- [Gilead's Advancing Access Program Application](#)
- [Acceptable PrEP-AP Eligibility Documents \(PDF\)](#)

Clinical Providers

- [Allowable PrEP Related Medical Services](#)
- [FAQ: For PrEP-AP Network Providers \(PDF\)](#)

Clients

- [FAQ: For Insured Clients \(PDF\)](#)
- [FAQ: For Uninsured Clients \(PDF\)](#)
- [Client Brochure \(uninsured\) \(PDF\)](#)
- [Client Brochure \(uninsured\) Spanish \(PDF\)](#)
- [Client Brochure \(Medicare\) \(PDF\)](#)
- [Client Brochure \(Medicare\) Spanish \(PDF\)](#)