

What to Start: Initial Combination Regimens for the Antiretroviral-Naïve Patient

(Updated January 10, 2011)

Panel's Recommendations:

- *The Panel recommends the following as preferred regimens for antiretroviral (ARV)-naïve patients:*
 - *efavirenz/tenofovir/emtricitabine (EFV/TDF/FTC) (AI)*
 - *ritonavir-boosted atazanavir + tenofovir/emtricitabine (ATV/r + TDF/FTC) (AI)*
 - *ritonavir-boosted darunavir + tenofovir/emtricitabine (DRV/r + TDF/FTC) (AI)*
 - *raltegravir + tenofovir/emtricitabine (RAL + TDF/FTC) (AI)*
- *A list of Panel-recommended alternative and acceptable regimens can be found in [Table 5a](#) and [Table 5b](#).*
- *Selection of a regimen should be individualized based on virologic efficacy, toxicity, pill burden, dosing frequency, drug-drug interaction potential, resistance-testing results, and comorbid conditions.*
- *Based on individual patient characteristics and needs, in some instances, an alternative regimen may actually be a preferred regimen for a patient.*

Rating of Recommendations: A = Strong; B = Moderate; C = Optional

Rating of Evidence: I = data from randomized controlled trials; II = data from well-designed nonrandomized trials or observational cohort studies with long-term clinical outcomes; III = expert opinion

There are more than 20 approved ARV drugs in 6 mechanistic classes with which to design combination regimens. These 6 classes include the nucleoside/nucleotide reverse transcriptase inhibitors (NRTIs), non-nucleoside reverse transcriptase inhibitors (NNRTIs), protease inhibitors (PIs), fusion inhibitors (FIs), CCR5 antagonists, and integrase strand transfer inhibitors (INSTIs).

The Panel provides recommendations for preferred, alternative, and acceptable regimens; regimens that may be acceptable but more definitive data are needed; and regimens that may be acceptable but should be used with caution ([Tables 5a and 5b](#)). Potential advantages and disadvantages of the components recommended as initial therapy for ARV-naïve patients are listed in [Table 6](#) to guide prescribers in choosing the regimen best suited for an individual patient. A list of agents or components not recommended for initial treatment can be found in [Table 7](#).

CONSIDERATIONS WHEN SELECTING A FIRST ANTIRETROVIRAL REGIMEN FOR ANTIRETROVIRAL THERAPY-NAÏVE PATIENTS

Data Used for Making Recommendations

The Panel reviews clinical trial data published in peer-reviewed journals and data prepared by manufacturers for Food and Drug Administration (FDA) review. In selected cases, data presented in abstract format in major scientific meetings also are reviewed. The first criterion for selection is published information from a randomized, prospective clinical trial with an adequate sample size that demonstrates durable viral suppression and immunologic enhancement (as evidenced by increase in CD4 count). Few of these trials include clinical endpoints, such as development of AIDS-defining illness or death. Thus, assessment of regimen efficacy and potency is primarily based on surrogate marker endpoints (HIV RNA and CD4 responses). The Panel reviewed data from randomized clinical trials to arrive at preferred, alternative, or acceptable ratings in [Tables 5a and 5b](#). “Preferred regimens” are those studied in randomized controlled trials and shown to have optimal and durable virologic efficacy, favorable tolerability and toxicity profiles, and ease of use. “Alternative regimens” are those regimens that are effective but have potential disadvantages when compared to preferred regimens. On the basis of individual patient characteristics and needs, a regimen listed as an alternative may actually be the preferred regimen in certain situations. Some regimens are classified as “Acceptable Regimens” because of reduced virologic activity, lack of efficacy data from large clinical trials, or other factors (such as greater toxicities, **requiring additional testing, pill burden, or drug interaction potential**) compared with preferred or alternative regimens.