

STRATEGIES FOR WHEN TO START ANTI-HIV THERAPY



issues to think about when going on therapy for the first time

Deciding when to start anti-HIV therapy and what treatments to use can leave many people feeling overwhelmed. While therapy can greatly slow the course of HIV disease, extend life and improve quality of life, it may also cause side effects. None will likely work indefinitely for most people.



A PUBLICATION FROM

PROJECT
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Information,
Inspiration and
Advocacy for People
Living With HIV/AIDS

MARCH 2004

Some people choose to put off therapy for as long as it's safely possible. Others decide to begin therapy earlier in the course of their disease. Both strategies have merit and both are supported by some research. Thinking about all the information and options will help you achieve the best outcome in either strategy.

When a person sees starting anti-HIV therapy as part of a larger picture, it may be easier to make changes as new information becomes available. For instance, you may decide to start with a certain regimen of drugs, but

then find that they do not work as well as you hoped. It can be extremely helpful if you've already explored your options up front and charted out what your next regimen will be. You can then proceed to it with confidence rather than being overwhelmed by the fact that your first choice didn't work out as you had expected.

One way to start making decisions about therapy is by making a list of questions to consider, like those on the next page. Your answers can help you figure out the next steps in devising your own treatment strategy.

Some questions to answer before starting therapy ...



What is your current CD4+ cell count?

- › Is it stable and above 350, or is it below 200?
- › Are you aware of the health risks related to a count below 200?
- › Overall, what is the trend? Increasing? Decreasing? Stable?

What is your current viral load?

- › Is it below 10,000 or even undetectable?
- › Is it above 55,000 or steadily climbing on two or more tests?
- › Overall, what is the trend? Increasing? Decreasing? Stable?

Are you ready and willing to commit to therapy?

- › Have you ever taken a medicine that you had to take on time every day? Was that easy or difficult?
- › What kinds of situations might make you miss a dose?
- › Can you keep your medicine with you throughout the day? Where is best place to store it so you can get to it and you don't forget to take it?
- › Does your doctor's office or local AIDS service organization offer an adherence support program to help you take your meds as prescribed?



Are you aware of the possible side effects?

- › Are you aware of the side effects that may give you the most problems, like nausea or diarrhea?
- › Do you know which are most likely to happen only in the first week or so after starting therapy and are likely to get better over time?
- › Are you aware of the signs of more dangerous or long-term side effects that may occur? Do you have a back-up regimen to switch to?
- › Are you aware of the things you can do to help avoid or lessen them? (For more information, read Project Inform's publication, *Dealing with Drug Side Effects*.)



Do you know which therapies may preserve more options for later?

- › Have you thought about what your second, and possibly third, regimen will be if your first doesn't work?
- › Have you read about the drugs currently being studied and how they may be used if others stop working?
- › Do you want to start with the strongest (most potent) possible combination, or would you rather save those drugs for later?

How do you feel about therapy?

- › Do you feel confident that starting now is the right thing to do? What makes you feel this way?
- › Do you feel anxious or worried? Have you talked with your doctor about your concerns?
- › What feelings do you have about a specific drug? Where do they come from? What might help address your concerns?

Are you aware of how therapy may impact your life?

- › How do you feel about taking pills every day, perhaps for the rest of your life? What support do you have to help you through the difficult times?
- › In the first days after you start therapy, what support and flexibility do you have with commitments like work, taking care of children or volunteering?
- › Will starting treatment limit you taking part in activities that you enjoy?
- › How do you plan to carry your meds with you if you're away from home overnight, on vacation or in places that are awkward for taking medicines?

When to start therapy

It is possible and reasonable to start taking anti-HIV drugs at any point in the course of your HIV disease. However, there's no consensus on the *best* time to start.

A group of people—including researchers, doctors, people living with HIV and their advocates—regularly meet to discuss the results of studies and their experiences treating and living with HIV. This group is called the Federal Guidelines Committee.

Every year or so, they update a set of guidelines for doctors and patients to help them make decisions about using anti-HIV drugs. Often referred to as the “Federal Guidelines” or “Guidelines,” the excerpts below are for adults and adolescents.

These Guidelines are meant to help *guide* people through the issues that may arise while using therapy. They are not rules to be followed precisely. When enough information is known about some aspect of treating HIV disease, the Guidelines will then recommend or suggest a preference. When the data are less clear, they will state just that.

Some people do not find out they're HIV-positive until after they've already become sick

from an AIDS-related infection. Knowing

your HIV status earlier allows you more time to deal with it before you face anti-HIV treatment decisions. However, it's still possible to make informed choices even when dealing with health challenges.

Although the following chart recommends that all people with CD4+ cell counts below 200 be on treatment, it is never truly too late to start. People who find out they're positive when their CD4+ cell counts are below 200 can still benefit from starting therapy.



basic federal guidelines

IF YOU HAVE THESE THREE ...			THEN ...
symptoms	cd4+ cell count	hiv level	the guidelines recommend
Severe symptoms, AIDS-defining illnesses	any number	any number	Strong recommendation to start therapy.
Severe symptoms or no symptoms at all	below 200	any number	Strong recommendation to start therapy.
No symptoms	200–350	any number	Treatment should be offered, though some disagreement exists.
No symptoms	350 or more	55,000 or higher	Although up to 30% of people in this category may have disease progression if left untreated, there are no data yet to prove conclusively that treating now is beneficial in the long-term.
No symptoms	350 or more	Below 55,000	Most would not recommend therapy, as the risk of progression is low (15%).
No symptoms or primary HIV infection (acute retroviral syndrome)	Over 200	Any number—to as high as millions of copies	Detectable HIV level, but antibody tests are negative or indeterminate. Treatment may be offered, but benefits of treating now are still theoretical. No data exist to prove long-term clinical benefit.

things to think about

If anti-HIV drugs were easy to take, were free from side effects, and never stopped working in spite of resistance, then making decisions about when to start would be easy. However, with the medications currently available the trick is to balance the benefits of reducing HIV levels and increasing CD4+ cell counts along with the risks of side effects and treatment failure. The following examples help make dealing with this struggle clearer. Each has its own possible benefits and disadvantages. These pros and cons are explained, but the only “right” answer is the one that comes from carefully considering both sides.

E X A M P L E

1

Acute or primary infection

A man knows that he was exposed to HIV several weeks ago. Tests show that his HIV level is 600,000, but he continues to test negative on antibody tests. This indicates that he’s in the *acute* or *primary* stage of HIV infection. His doctor says that he should start treatment immediately and only has days to decide. Should he start now?

the pros



No data conclusively proves that starting now results in a longer more healthy life. However, some researchers suggest that early treatment may:

- › decrease the severity of the acute syndrome;
- › alter the initial *viral set point* (believed by some to affect the rate of disease progression over time);
- › keep HIV from changing (*mutating*) around the body’s defenses; and
- › preserve immune functions.

the cons



These are less theoretical and include the possibility that a person will:

- › have to take therapy indefinitely;
- › go through his or her treatment options too quickly and run out of viable combinations; and
- › develop long-term side effects.

EXAMPLE

2

CD4+ cell count
between 200 and 350

A woman, who has probably been HIV-positive for ten years, is watching her CD4+ cell count decline. It has dropped from 450 to 375 to 320 over the last 6 months. Her HIV level, however, is relatively stable around 15,000. She is frightened about side effects and hesitant about starting therapy. Should she start now or wait to see what happens with these two markers?

the pros



If she starts now, she may reduce her risk of getting sick in the next three years than if she waits.

- › She may have a stronger and more durable response to therapy.
- › Starting therapy with a lower viral load allows more drug combinations to be considered.

the cons



If her fears of side effects are strong enough, she may find it difficult to stay on her regimen.

- › Starting now may reduce the risk of disease progression in the short term, but it may not hold up over time. This is because the risk for treatment failure from drug resistance and/or side effects increases with each year on therapy.

EXAMPLE

3

CD4+ cells over 350
with low HIV level

A man finds out that he is HIV-positive. He reads a lot of literature on the Internet about treating HIV. He gets excited about some of the new and more experimental strategies. His CD4+ cell count is 450 and his HIV level has never been above 4,000 on 3 tests over the last 6 months. He wants to fight the virus aggressively and would like to try therapy. Should he start treatment?

the pros



Starting this early may theoretically lead to longer-term benefits in immune function and *viral diversity*. As with taking treatment during primary infection, however, the possible benefits have not been proven conclusively.

the cons



Starting treatment this early could lead to running out of options sooner.

- › Treatment started at this point may have to be taken indefinitely. The risks for treatment failure from drug resistance and/or side effects increases with each year on therapy.

EXAMPLE

4

Having both HIV
and hepatitis C

A woman has been living with HIV for more than ten years. She has also lived with hepatitis C virus (HCV) for twenty or more years. Recently she finds out that she has significant liver damage. The tests that measure the functioning of her liver and a liver biopsy show that the HCV is causing this damage. She has never been on anti-HIV or HCV therapy. Her CD4+ cell count is 300 and her HIV level is 80,000. Should she start anti-HIV treatment now or wait until after she has tried to treat the hepatitis?

the pros



- › Starting anti-HIV therapy now will reduce the risk that her CD4+ cell count will drop and lead to the development of an AIDS-related infection.
- › Anti-HIV therapy works as well in people with HCV as in those not infected with HCV.
- › Anti-HIV therapy can be well tolerated by people with HCV.

the cons



- › HCV therapy can have very unpleasant side effects that may be worse in people who also use anti-HIV therapy.

the best starting combination

What is the best combination for people starting therapy?

The question of what combination of anti-HIV drugs a person should use as first line therapy can appear confusing. There are, however, only a few factors to consider. These narrow the range of choices for first line therapy. They include:

- its potency;
- its ease of use and number of pills; and
- its potential for short- and long-term side effects.



Remember the goals of therapy

An effective combination of anti-HIV drugs should lower your HIV level as low as possible (preferably to undetectable) and increase your CD4+ cell count. This should happen without causing debilitating side effects or harming your quality of life. Given your schedule, it should also be easy enough to take so you can take every dose as prescribed (adhere well).

The issue of adherence to medicines cannot be stressed enough. Several studies have found that the most common reason for treatment failure is missed doses. So, adherence must play a significant role in any decision you make about treatment. Project Inform's publication, *Adherence: Keeping up with Your Meds*, can help you prepare for and maintain good adherence.

Four different classes of anti-HIV drugs are approved for use in different combinations. They are:

- › NRTIs (*nucleoside* analogue reverse transcriptase inhibitors)

and NtRTIs (*nucleotide* analogue reverse transcriptase inhibitors);

- › NNRTIs (non-nucleoside reverse transcriptase inhibitors);
- › PIs (protease inhibitors); and,
- › Entry Inhibitors.

Each of these four classes works differently to stop HIV from making more of itself (*replicating*). Currently in the US, three or more anti-HIV drugs are used together to form effective regimens. For first line therapy this usually includes two NRTIs and one from another class, like an NNRTI or PI. A list of these drugs can be found in the Drug ID Chart on page 9.

The Federal Guidelines list the following two combinations as "preferred" first line regimens. This is because they're believed to have good anti-HIV potency and are easy to take. The Guidelines also list more than a dozen other regimens that may

be less potent, have somewhat more side effects, have to be taken more often, or require taking more pills than those listed below.

- › Combivir* + efavirenz; and
- › Combivir* + Kaletra.

* *Combivir is a combination pill of AZT + 3TC. d4T + 3TC may be used in place of Combivir in either of the above combinations. Tenofovir + 3TC may also be used in place of Combivir with efavirenz.*

In fact, several other combinations may be just as effective and have a legitimate role in first line therapy. These include using:

- › nevirapine instead of efavirenz,
- › FTC instead of 3TC,
- › atazanavir + ritonavir instead of Kaletra, and
- › another ritonavir-boosted protease inhibitor regimen instead of Kaletra.

NRTIs and NtRTIs

NRTIs (nucleoside) and NtRTIs (nucleotide analogue reverse transcriptase inhibitors) are almost always used as part of anti-HIV regimens. Usually two are combined with another class of drugs. Sometimes three NRTIs are used as a complete first line regimen. Although there are several drugs in this class, few combinations are considered for first line treatment. This is either because a drug like ddC is generally considered inferior, or that two of the drugs, such as d4T + ddI, have high risks for side effects when combined. AZT and d4T also should not be used together as they decrease each other's effectiveness and increase risks of side effects.

The Federal Guidelines recommend that 3TC + AZT or 3TC + d4T be used as part of first line regimens. The Guidelines also indicate that 3TC + tenofovir may also be used. This is mainly because 3TC does not add significant toxicities to AZT, d4T or tenofovir and can slow the development of resistance to these drugs. All three drugs can be dosed at once or twice a day. Also, AZT and 3TC are combined into a single pill called Combivir, which simplifies dosing.

Abacavir and 3TC can also be used together. This is not often recommended for first line therapy because abacavir can cause a life-threatening allergic reaction in up to 5% of people who take it. Abacavir is often saved for later use, when perhaps fewer options exist—making the potential benefits of using abacavir outweigh this concern.

A newer drug, FTC, may be used in place of 3TC. FTC was approved for once-a-day dosing and is a sister drug to 3TC. FTC is expected to have similar side effects and level of effectiveness to 3TC. FTC actually breaks down in the body less quickly than 3TC, and further studies may actually prove it to be superior. However, HIV resistance to one of them causes resistance to the other.

There are growing concerns that side effects attributed to d4T should limit its use. Some studies show that d4T significantly weakens *mitochondria*, the energy source in cells. This can lead to *lactic acidosis*, a dangerous buildup of lactic acid in blood and other tissues. Both side effects are thought to play a primary role in the loss of fat in the face, arms and legs. These problems have been seen most often in people taking d4T with ddI.

The drug ddI is not often used as part of a first line regimen because it must be taken on an empty stomach and cannot be taken at the same time as many other meds. This can make it very difficult to use, especially if it's used with other drugs, like certain protease inhibitors that are taken with food.

Tenofovir, an NtRTI, is a relatively new drug from a class very similar to NRTIs. It offers once-a-day dosing, and so far appears to have few short-term side effects. There's also some evidence that it may work even when HIV has developed resistance to other NRTIs. For this reason, there's still some debate about whether tenofovir is best used as first line therapy or saved for second or third line regimens. No studies have been done that can help guide decisions on this matter. However, tenofovir's ease of use, potency and relatively few side effects make it an attractive first line option.

Recent studies have found that tenofovir and abacavir used together may lead to early failure of an anti-HIV regimen for reasons that are not entirely understood. Also, tenofovir does interact to some degree with atazanavir, a protease inhibitor.

Lastly, Trizivir (AZT + 3TC + abacavir) is the only currently approved three-drug NRTI combination available in one pill. It can be taken alone, without taking it with drugs of any other class. However, Trizivir may not be as potent for first line therapy as other combinations, mainly in people whose HIV levels are very high (above 100,000). Also, Trizivir contains abacavir, which is not a preferred first line drug in the Guidelines due to its side effects (noted above).

Some controversy exists when using Trizivir on its own. It's not considered a particularly potent combination. Where other combinations are able to reduce HIV levels to below 500 in 80% or more of study participants, Trizivir was only able to do so in 60% of people in one study.

Also, future regimens may depend on at least one or two of these three drugs in order to work effectively. So starting off with Trizivir may lower a person's chances of creating a good second or third line regimen. For these reasons, Trizivir may only be a proper first line option for people who need a very simple regimen or cannot tolerate NNRTIs or PIs.

NRTIs that should not be used together in a regimen

AZT + d4T	ddl + ddC
d4T + ddC	ddC + 3TC
abacavir + tenofovir	

NNRTIs

NNRTIs (non-nucleoside reverse transcriptase inhibitors) work differently than NRTIs, but act against HIV at the same point in its replication cycle. As part of first line therapy, NNRTIs are regularly used with two NRTIs. Regimens with efavirenz have been compared to several other combinations in studies and have consistently proven both potent and long-lasting. Efavirenz was selected by the Guidelines panel as a preferred drug in first line therapy.

Even though the Guidelines recommend efavirenz over nevirapine, there are times when nevirapine may be preferred. This is mainly true for people who wish to save protease inhibitors for later, but who are con-

cerned about the brain-related (neurological) side effects of efavirenz. These may include vivid and disturbing dreams, difficulty concentrating, insomnia and mood changes. In studies, 14–53% of people who have taken efavirenz reported these side effects.

Pregnant women and women trying to conceive should avoid efavirenz. They may consider nevirapine a better option when not starting a regimen with a protease inhibitor. The risk for rashes from using nevirapine appears to be slightly higher in women than men. Among women who develop the rash, it's more likely to be severe. So women, in general, shouldn't feel a particular benefit to choosing

nevirapine over efavirenz. But women who are pregnant or trying to conceive need to be aware of the risks of using efavirenz during pregnancy and should avoid it.

One important point to keep in mind is that all of the currently approved NNRTIs are highly cross resistant with one another. This means that when HIV becomes resistant to one of them, it will likely be resistant to the other two NNRTIs, making them less useful. Therefore, most people only get one shot at using this class of drugs. Of the three drugs in this class, delavirdine is used least often. This is mostly because it must be taken three times a day and interacts with many other meds.

Entry inhibitors

Enfuvirtide is part of a completely new class of drugs called entry inhibitors. It stops HIV from fusing with CD4+ cells, thus blocking the virus from entering the cell. Although enfuvirtide has many positive features, it must be injected under the skin twice a day. For this reason, it's unlikely that enfuvirtide will ever be a desirable first line therapy. It's currently approved only for people whose other regimens have already failed.

Protease inhibitors

This class of drugs contains some of the most potent anti-HIV drugs available, though some are more potent than others. Other factors to consider when using PIs for first line therapy include ease of use and the potential for serious long-term side effects. In this regard, Kaletra is a potent drug that is simple to take, and atazanavir has some of the lowest potential for side effects and is easy to use. Kaletra was deemed a preferred regimen for first line therapy by the Guidelines panel for these reasons. Atazanavir, although the Guidelines suggest it as part of an alternative regimen, may in fact be a reasonable first line choice, especially if boosted with ritonavir.

Although other PI combinations may be used as first line therapy, most require a low dose of ritonavir be added as a booster. This way, they become more potent and can be taken less often and at lower doses. None of the PIs boosted with ritonavir (besides Kaletra) have been studied intensively as first line therapy. When

they're not boosted with ritonavir, the other PIs have problems that may make them more appropriate as part of an *alternative* rather than *preferred* regimen. These problems include reduced anti-HIV activity, inconvenient dosing, and increased risk of side effects.

Most protease inhibitors are highly potent. Some doctors prefer to save them if or when other less complicated regimens—perhaps those with fewer side effects—have failed. Although this may theoretically be an excellent strategy, not enough studies have yet been conducted that prove this is the best one.

There are also other data suggesting that when HIV becomes resistant to atazanavir, it may still be sensitive to other PIs. If this proves to be true, atazanavir may become a preferred first line therapy. However, the studies so far are conflicting. Those who use atazanavir in first line therapy at this time may still develop a significant level of resistance to other PIs.

Starting therapy in women

The Guidelines for when to start therapy for HIV-positive women who are pregnant or plan to conceive in the near future are largely the same as for other adults. If a pregnant woman has a low CD4+ cell count and high HIV level, she must decide how to protect her health as well as her developing baby.



Some doctors recommend that HIV-positive women wait to begin treatment until the second trimester (starts the 13th week of pregnancy). Since the first trimester is when the baby's major organs develop, this is when birth defects from taking medicines are most likely to occur. Some anti-HIV drugs should NOT be taken during pregnancy, which are discussed in the next section. (For more information, read Project Inform's publication, *Pregnancy and HIV*.)

For women using oral contraceptives or other female hormone replacement therapies, it's important to note that some anti-HIV drugs interact with oral contraceptives. It may be necessary to adjust the dose of the oral contraceptives, use other methods of birth control or change your anti-HIV drugs. (For more information, read Project Inform's publication, *Drug Interactions*.)

HIV drug resistance testing

Data show that up to 20% of all newly infected people in the United States may have drug-resistant strains of HIV. More than 5% of these strains are resistant to more than one class of drugs. For this reason, some doctors recommend that people infected since 2001 or so have resistance testing done *before* choosing their first regimen. This can help ensure that the regimen has the best chance for working well. For more information on resistance testing, read Project Inform's publication, *HIV Drug Resistance Tests*.

drug i.d. chart

GENERIC NAME	TRADE NAME
Protease inhibitor	
amprenavir	Agenerase
atazanavir	Reyataz
fosamprenavir	Lexiva
indinavir	Crixivan
lopinavir+ritonavir	Kaletra
nelfinavir	Viracept
ritonavir	Norvir
saquinavir	Fortovase
saquinavir	Invirase
NRTI (nucleoside) and NtRTI (nucleotide analogue reverse transcriptase inhibitor)	
3TC (lamivudine)	Epivir
abacavir	Ziagen
AZT (zidovudine)	Retrovir
AZT/3TC	Combivir
AZT/3TC/abacavir	Trizivir
d4T (stavudine)	Zerit
ddC (zalcitabine)	Hivid
ddI (didanosine)	Videx
ddI-EC (didanosine)	Videx-EC
FTC (emtricitabine)	Emtriva
tenofovir	Viread
NNRTI (non-nucleoside reverse transcriptase inhibitor)	
delavirdine	Rescriptor
efavirenz	Sustiva
nevirapine	Viramune
Fusion inhibitor	
T20 (enfuvirtide)	Fuzeon

take charge of your healthcare

Project Inform has several publications that can help you create and manage your own personal treatment plan. Along with this strategy publication, we have five others that may be useful to you. They include: *Strategies for Maintaining Your General Health*; *Strategies for Managing Opportunistic Infections*; *Strategies for Third Line Therapy*; *Strategies for Structured Treatment Interruptions*; and *Strategies for Switching Therapy*. These and many other publications are all available free from Project Inform at 1-800-822-7422 or www.projectinform.org.



What to start first: NNRTIs, PIs, or neither?

Although doctors and researchers have now reported on dozens of first line regimens, no large study has yet been completed that shows which is the best to start with. So far, we know that when a person's HIV level remains under 50 for at least one year on therapy, it will usually remain that way for at least another two years, assuming good adherence. This is true for almost any combination that is used. However, certain regimens like those with efavirenz or Kaletra have been more likely to achieve this result in studies.

Even less clear is how much the choice of a first regimen impacts how well a second one will work. Some data show that when a person starts therapy with a protease inhibitor, they will likely be able to use efavirenz successfully as second line therapy. However, there are less data so far on the other way around. There are even less data that show the long-term implications of starting a regimen with three NRTIs, like Trizivir, although recent data suggest that a triple NRTI regimen is much more likely to fail. Therefore, forming a longer-term treatment strategy requires weighing the theoretical and real risks and benefits.

Perhaps the most limiting factor of all the drugs is cross resistance. When a person's virus develops a high level of resistance to one drug in a specific class, it will generally have at least some resistance to the other drugs in that class. When HIV develops even low levels of resistance, it causes the drug to be less potent. Thus, even with more than 20 approved drugs, it's only possible to come up with two or possibly three highly potent regimens in a row.

Some people currently believe that the best first line strategy is to take whatever is the *most* potent. Studies so far show that the most powerful and long-lasting effects come from a person's first regimen. The longer a person stays on it without major side effects or resistance, the better. The longer it continues working, the more likely that other new drugs may be approved in the meantime,

I wonder how my first regimen will impact my second regimen.



allowing for more second and third line options. As a rule, ritonavir-boosted PIs like Kaletra are considered the most potent and long-lasting.

Others feel that saving potent and longer lasting medications for second line therapy is the better strategy. They feel that starting treatment with an NNRTI or only NRTIs is best. This would likely work for most people for some period of time and it keeps PIs for later. It is also hoped that the NNRTIs and NRTIs will have fewer long-term effects on cholesterol and triglycerides. Again, the theory has merit, but there are no studies to prove that this is the superior long-term strategy. Also, the potency of these regimens has been shown to be less among people who start therapy when their HIV levels are above 100,000.

Whichever choice you and your doctor make, it's probably wisest to have a good fall back strategy if your first regimen doesn't work as well as you hoped. Decide ahead of time what your definition of *treatment failure* means and what your next regimen will be.

What kinds of side effects would you tolerate and which would cause you to switch treatments? Many people living with HIV are aware of the fat redistribution problems linked to at least some degree with anti-HIV drugs. They wish to avoid these effects and don't want to take the meds that are blamed for causing them. This is a reasonable desire.

However, the emerging picture of these problems points to many factors that may lead to fat redistribution. These include age, length of time being HIV-positive, length of time on therapy, and the lowest ever CD4+ cell count as well as some specific drugs. All of this must be considered before ruling out what might be a potent and easy to use drug as part of a regimen.

You may be so concerned about adherence that you're willing to try less potent combinations that are simpler to take as first line therapy. Or, you may prefer to try one that's a little more complicated as your first regimen and save the simpler ones in case you have problems with adherence.

Lastly, it's important to be specific and reasonable about your goals in terms of drops in HIV levels and gains in CD4+ cell counts. It can be very helpful to have already decided what you'll switch to if you don't achieve them. Some people will only consider their first regimen successful if it reduces their HIV levels to below 50 in the first few weeks of therapy. Others may hope for such a rapid response but are willing to give it up to six months to lower their HIV levels to below 50 before switching. The higher your HIV level upon starting therapy, the longer it may take to reach full viral suppression. Some regimens, like ones with PIs, are generally better than others in quickly reducing HIV levels when a person's viral load is very high before starting therapy.

In conclusion

Your doctor may have strong opinions about when to start therapy or which regimen is best for you. Your opinion and your concerns count too, and the best relationship between you and your doctor is usually a collaborative one. Share your concerns with your doctor(s) so they can help you build the best treatment strategy for you. Project Inform's publication, *Building a*

Cooperative Doctor/Patient Relationship, offers tips for building this kind of relationship.

Only you can decide when it is the best time for you to start therapy. Because it's your life and your body, only you can ultimately decide how you wish to balance the need to keep your HIV in control with any risks for disease progression and side effects. Remember to ask a lot of questions:

of yourself, your doctor, other people living with HIV and information sources like Project Inform. Plot out your strategy so it includes other aspects of general health maintenance and possible second or third line options. Take your time, be prepared and then enjoy your life to the fullest degree possible, knowing you've made the best decision you possibly could have.

Filling this out before your next doctor's appointment can improve your discussions about starting anti-HIV therapy.

What factors do you consider most important in selecting your first regimen?

	MOST IMPORTANT	VERY IMPORTANT	LESS IMPORTANT	NOT IMPORTANT
Can reduce a high HIV level	4	3	2	1
Long lasting	4	3	2	1
Fewer pills in each dose	4	3	2	1
Dosing only once or twice a day	4	3	2	1
Low chance of stomach side effects	4	3	2	1
Low chance of brain-related side effects	4	3	2	1

After looking over the available information on anti-HIV therapies, what are two possible combinations that appear to meet the most of your concerns?

Regimen #1:

Regimen #2:

My reasons for considering these regimens:

Concerns I have about these regimens:

Side effects to discuss with my doctor and plan for:

Adherence strategies I will use include:

Questions to ask my doctor: