FAQs for TAF-LD and DRV/r 400/50 (FDC) -HCW Sensitization, Sep 2025

(a) Expanded TAF-LD Guidance		
	Question	**Response**
1	Does the transition also include clients on the 2nd Line who are within the criteria?	The WHO recommends that TDF/TAF can be used as NRTI backbone in both initial and subsequent regimens. ● Clients on TLD as subsequent regimen (after being transitioned from ATV/r) can be switched to TAF-LD if they are within the transition criteria contained in the circular. ● TAF/3TC backbone separate/combined is not available in-country hence clients on PI as part of their subsequent regimens will not benefit from transition.
2	Should clients on the other regimens who are within the criteria be transitioned ie (a) ABC/3TC + DTG (b) AZT/3TC + DTG	● Clients on ABC/3TC or AZT/3TC and are within the transition criteria contained in the circular should be switched to TAF-LD if there are no contra-indications to use of TAF such as on-going hemodialysis
3	Clients within the criteria on Anti-TBs and ABC-based regimen; Can they switch back to TAF-LD after completion of Anti-TBs?	● Yes ● Clients who are within the transition criteria and have completed anti-TBs should be switched to TAF-LD (2 weeks after completion of RIF containing anti-TBs) if there are no contra-indications to use of TAF such as need for rifapentine based TPT (3HP) after TB treatment is completed or on hemodialysis
4	Is Isoniazid for 6 months (6H) an alternative for clients on TAF-LD who require TP Preventive Therapy (TPT)?	6H is an option for clients: ● Who cannot tolerate 3HP ● Where TLD or ABC cannot be used due to various clinical/pharmacological reasons In all other scenarios, 3HP is preferred (while using TLD for the 12-week duration) due to the reduced pill count/duration of use hence better adherence.

5	Can TAF-LD be used with the MDR TB regimen of Beadquiline/Pretomanid/Linezolid/Moxifloxacin (BPaLM) in MDR TB cases or should we switch to TLD?	● TAF-LD can be used with BPaLM MDR TB regimen with no drug-drug interactions anticipated ● The regimen does contain Rifampicin (which the decreases the TAF concentrations when co-administered)
6	Can a client currently on ABC/3TC/DTG with CrCl above 30 ml/min be switched to TAF-LD?	● Yes ● Clients with a CrCl above 30ml/min can be transitioned to TAF-LD ● Close clinical and laboratory follow up is critical after switch
7	What are the options for clients with a CrCl of < 30 ml/min?	● Clients with CrCl <30 ml/min, ABC + 3TC should be used with appropriate renal dose adjustments (the program has made arrangements to continue availing these single molecules. ● In scenarios where TAF-LD is the only option available, use with caution after initial discussion, review and with close monitoring by a physician/renal specialist ● Alternative future options for these clients will include TAF/FTC or dual ART (these are not yet available in country)
8	What ART regimen should be provided to clients newly initiating on ART?	● As per the guidance, the only clients new on ART who should be initiated on TAF-LD regime are PLHIV; : ○ ≥ 60 years of age ○ With chronic comorbidities outlined in guidance ● Note: only CALHIV currently on ART attaining weight of ≥ 30kg should be transitioned to TAF-LD (from ABC regimens)
9	Is a Creatinine test a pre-requisite for TAF-LD initiation/transition?	● All clients should be monitored as recommended in the guidelines including a Creatinine test at baseline and then annually. ● Where a creatinine test cannot be accessed, a transition to TAF-LD (for eligible clients) should be initiated as efforts are made to attain a creatinine test at earliest.

		• A transition for clients who present with renal failure clinical symptoms should be delayed until after requisite assessment including relevant laboratory tests
10	Is a suppressed viral load (VL) mandatory before transition? What is the recommended cut-off?	• As per the guidelines, a VL result obtained in the last 6 months is pre-requisite before a single drug substitution. • However, where a VL result is not available in the last 6 months, the last VL can be utilised (if suppressed) as efforts are made to obtain a recent test. • Clients with HVL should continue to have appropriate interventions before switch • The cut-off VL for transition is 1,000 copies/mL
11	Can TAF-LD Be used for PEP?	• There is no current evidence to support use TAF-LD for PEP • TLD remains the preferred drug of choice for PEP
12	Does TAF reverse the TDF effects?	• TAF does not reverse the damage already caused by TDF. • However, switching from TDF to TAF can stop further renal/bone toxicity effects and may allow some recovery but not full reversal of TDF's long-term effects.
13	Will the transition result in excess/expiry of stocks of TLD at the facilities?	• Transition to TAF should be passive. • All clients will be transitioned in the next drug refill/clinical appointment and should NOT be actively recalled. • We do not anticipate TLD overstocks as clients targeted for this transition are less than 170,000 of those on TLD (total 1.23M)
(b) DRV/r 400/50mg FDC Guidance		
14	Patients on TB treatment are to be switched back to DTG for the duration of TB treatment; What of those who were switched to DRV/r due to DTG intolerance?	• Patients with DTG intolerance on DRV/r who develop TB would have to be provided LPV/r 800/200mg twice daily or Efavirenz together with NRTIs for the duration of TB treatment and until 2 weeks after successfully completing TB

		treatment. After this, they should be switched back to DRV/r. ● All efforts must be made to consistently screen for TB and provide appropriate TPT to avoid the development of TB disease, as this complicates the treatment of individuals who are on DRV/r Since this is to be used as a second line regimen for first line DTG, we anticipate most, if not all, clients should have received TPT already
15	Children weighing <40 Kg failing DTG-based and requiring subsequent PI based ART: what are the options? Are there other formulations of DRV/r available for them?	● Children ≥ 3kg and ≥10kg can use DRV 75mg or 150mg boosted with ritonavir after treatment failure with DTG-based ART and in the presence of evidence of DTG resistance, as guided by your RTWG or ULIZA NASCOP
16	In the context of DRV/r, 400/50 mg, what is the guidance to the facilities/HCWs where DRT is not available?	● DRV/r 400/50 FDC should not be used in PLHIV with drug-resistant mutations to PIs or DRV. Find out if your client can be enrolled for studies performing DRT, such as the NDOVU study, through your RTWG. ● In the absence of a DRT, escalate the case for discussion with your RTWG or ULIZA NASCOP for switch decisions to a 3rd-line regimen. In this case, a higher dose of DRV 600mg + RTV 100mg administered twice daily may be required