Regimens/Components **Not** Recommended for Initial Tx of HIV in Children and Adolescents[1]

regimen/ARV component	rationale
Dual (full-dose) PI regimens	Insufficient data; potential added toxicities
Regimens containing only NRTIs	Inferior virologic efficacy
Regimens containing 3 drug classes	Potential to induce multiclass resistance; use as an initial regimen in children not studied
Regimens containing 3 NRTIs and 1 NNRTI	Added cost/complexity outweighs benefit
Regimens containing only 2 ARVs	Not FDA approved for use in peds
Unboosted ATV-containing regimens	Inadequate drug exposure
Once-daily DRV regimens in children ≥3 yo to <12 yo	Insufficient data
EFV-based regimens for children <3 yo	CYP2B6 genotyping required to determine appropriate dosing
ETR-based regimens	Insufficient data
LPV/r dosed once daily	Inadequate drug exposure
DRV/r in children <3 yo	Potential for seizures
MVC-based regimens	Only effective for CCR5-tropic virus
TDF-containing regimens in children <2 yo	Potential bone toxicity; appropriate dose not yet determined
EVG-based regimens	1st-generation INSTI w/ low barrier to resistance compared w/ BIC and DTG, which are now avail. for children
FTR	Not FDA approved for use in pediatric pts or for ARV-naïve adults/adolescents
IBA	Not FDA approved for use in pediatric pts or for ARV-naïve adults/adolescents

Regimens/Components **Not** Recommended for Initial Tx of HIV in Children and Adolescents[1,2]

LEN	Not FDA approved for use in pediatric pts or for ARV-naïve adults/adolescents
CAB	Not FDA approved for use in children <12 yo or for ARV-naïve adults/ adolescents

ART Regimens **Never** Recommended in Children and Adolescents[1,2]

regimen	rationale	exceptions
1 ARV drug alone (Monotherapy)	• Rapid development of resistance • Inferior antiviral activity vs. ≥3 drugs • Monotherapy "holding" regimens assoc w/ more-rapid CD4 decline vs. nonsuppressive ART regimens	Infants w/ perinatal HIV exposure and negative virologic tests who are receiving 4-6wk of ZDV ppx to prevent perinatal HIV transmission
2 NRTIs alone	• Rapid development of resistance • Inferior antiviral activity vs. ≥3 drugs	**Not recommended** for initial tx Some clinicians may opt to continue this tx in pts on 2 NRTIs and achieving virologic goals
TDF + ABC + (3TC or FTC) as triple-NRTI regimen	• High rate of early viral failure when this regimen used as initial tx in tx- naïve adults	**No exceptions**

ARV Components **Never** Recommended as Part of an ART Regimen in Children and Adolescents[1,2]

component	rationale	exceptions
Dual-NNRTI combos	Enhanced toxicity	**No exceptions**
Any regimen containing both 3TC + FTC	Similar resistance profile; no added benefit	**No exceptions**
Any regimen containing both TDF + TAF	No data to support potential additive efficacy or toxicity	**No exceptions**
NVP as component of initial tx in adolescent girls w/ CD4 counts >250 or adolescent boys w/ CD4 counts >400	Increased incidence of symptomatic (incl. serious and potentially fatal) hepatic events	Only if clear benefit

[1] Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV. Table 9. Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection. Department of Health and Human Services. 2024. Available at https://clinicalinfo.hiv.gov/en/guidelines/pediatric-arv/regimens-recommended-initial-therapy-antiretroviral-naive-children. Accessed July 31, 2024.

[2] Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV. Table 10. Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection. Department of Health and Human Services. 2024. Available at https://clinicalinfo.hiv.gov/en/guidelines/pediatric-arv/regimens-not-recommended-initial-therapy-antiretroviral-naive-children. Accessed July 31, 2024.