Neonatal HIV Exposure Clinical Guideline

This guideline is intended to ensure appropriate and timely management of newborns at risk for HIV infection, following current recommendations from AAP, CDC, ACOG and NIH at the time of publication. Please refer to the link below for the most up to date treatment options. For questions, please contact Pediatric Infectious Disease.

HIV Positive

- Notify PCP immediately
- ID consultation (do not delay treatment)
- Delay Vitamin K/Hepatitis B vaccine until bath/site well cleansed
- Give erythromycin after eyes are cleansed
- Initiate treatment as soon as possible (within 6 hours of delivery)
- Formula feed (No Breastfeeding)
- Obtain CBC with Diff, AST, ALT, HIV DNA PCR (whole blood purple top 1ml minimum)

Mother treated with ART

Maternal Viral load <50

Yes

No

Higher Risk Infant

Infant Treatment:
- Contact Pediatric Infectious Disease
- Start 3 Drug Treatment Regimen:
  - EITHER:
    - Zidovudine (ZDV), Lamivudine (3TC), Nevirapine (NVP) - treatment dose
    - OR ZDV, 3TC, Raltegravir (RAL)

Infant Antiviral Dosing Regimen

Lower Risk Infants
1 Zidovudine (ZDV) 10mg/mL oral
- 35 weeks and over:
  - 2-3kg: 1ml Q12
  - 3-4kg: 1.5ml Q12
  - 4-5kg: 2ml Q12
- 30 - 35 weeks gestation:
  - 2mg/kg/dose Q12
  - IV: 1.5mg/kg/dose q12 if unable to take PO
- < 30 weeks: www.aidsinfo.nih.gov

Higher Risk Infants
- Contact Infectious Disease
- ABC- ≥ 37 weeks 2 mg/kg BID
- 3TC- ≥ 32 weeks-2 mg/kg BID
- NVP- ≥37 weeks 6 mg/kg BID
- 34-37 weeks 4 mg/kg BID
- 32-34 weeks 2 mg/kg BID
- Raltegravir:
  - 2 to < 3 kg 0.4 mL once daily
  - 3 to < 4 kg 0.5 mL once daily
  - 4 to < 5 kg 0.7 mL once daily

Algorithms are not intended to replace providers’ clinical judgment establish a single protocol. Some clinical situations may not be adequately addressed in this guideline. Clinicians should document management variations or plans of care as indicated. Last updated April 2023


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