HIV Test and Treat (T&T) and Re-Engage in Care Guidance

PREPARED BY:
THE HIV/AIDS SECTION—MEDICAL TEAM
BUREAU OF COMMUNICABLE DISEASES
DIVISION OF DISEASE CONTROL AND HEALTH PROTECTION
FLORIDA DEPARTMENT OF HEALTH

October 2023
6th Edition

Florida Department of Health
HIV Test and Treat (T&T) and Re-Engage in Care Guidance
for County Health Departments

INTRODUCTION 2

GETTING STARTED 2
- INDICATIONS 2
- COMPONENTS OF A TEST & TREAT INTERVENTION 2
- TEST & TREAT CODING 2
- SERVICES TIMELINE 3
- BASELINE LABS 4

RECOMMENDED REGIMENS FOR ANTIRETROVIRAL INITIATION 5
- PREFERRED REGIMENS 5
- REGIMENS FOR PREGNANCY OR WOMEN TRYING TO CONCEIVE 5

DRUG INTERACTIONS 6

OPPORTUNISTIC INFECTIONS 6

FREQUENTLY ASKED QUESTIONS 7
- GENERAL 7
- INSURANCE 8
- LABS 8
- MEDICATIONS 9
- RYAN WHITE 10
- SPECIAL POPULATIONS 11

TELEHEALTH RESOURCES 12

ADDITIONAL GUIDANCE 12

LABORATORY TEST QUICK REFERENCE 13

INTRODUCTION

One goal of the Florida Department of Health (Department) is to ensure persons with HIV are started on antiretroviral therapy (ART) within 24 hours of diagnosis and that persons living with HIV stay on ART consistently to obtain and sustain a suppressed viral load. This approach is based on a model first published in the British medical journal in 2007 and is now known as Test and Treat (T&T). T&T is also known as "rapid start". In addition to benefitting an individual patient's health, viral suppression serves public health by preventing HIV transmission, an outcome commonly referred to as "Undetectable equals Untransmittable," or "U=U."

This guidance presents an overview of relevant information for clinicians, including physicians, physician assistants, nurse practitioners and registered nurses, who are providing T&T in clinical settings. Important considerations for starting and monitoring a patient on ART are presented below. Information in this Guidance document has been adapted from the Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services (DHHS). Available at https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv.

GETTING STARTED

T&T Is Indicated for the Following Individuals:

- Patients newly diagnosed with HIV (positive-screening test via rapid point of care test or confirmed-positive test via blood-based lab testing)
- Patients returning to HIV care after a gap in treatment (even one missed day is a gap!)
- Patients who have run out or will run out of ART before they can obtain a refill.
- Patients who have lost insurance coverage or access to ART
- Note: T&T can be repeated on a monthly basis as needed until access to medication is secured

Components of a T&T Intervention:

- Patient to be seen by provider within 24 hours using flexible scheduling options such as onsite or telehealth appointments (maximum 72 hours to accommodate for weekends/holiday closures)
- Availability of onsite or same-day access to ART through issuance program or samples
- ART to be started on day of initial appointment (pending lab results do not delay the start)
- Process to link clients to a health care provider for both primary care and HIV-specific health care needs
- Process to refer clients for assistance with HIV patient care program eligibility, health insurance coverage and case management services

T&T Coding:

- Test and Treatment Initiation 5707
- Test and Treatment Reestablished HIV Care 5708

For further coding information: DHP50-20 DOH Personal Health Coding

T&T Services Timeline:

Day one:

- If clinic provider cannot see the patient in person or via telehealth within 24 hours, contact the HIV/AIDS Section Telehealth Team (see Page 12) to provide the service.
- The clinician meets with the patient for brief medical history, medication review, targeted exam, psychosocial needs assessment, risk reduction discussion, ART education, and regimen selection.
- Dispense (issuance or samples) a 30-day supply of medication.
- Obtain baseline labs (see below for list of labs required) on same day that ART is started. Lack of labs should not delay the visit. ***If labs cannot be drawn, staff should follow up with patient daily to be sure baseline labs have been completed.***
- Expedite HIV patient care program eligibility and case management, ideally on same day or within seven days of T&T visit. Refer to Ryan White program services as needed (e.g., ADAP, housing assistance).
- Schedule follow-up appointment prior to patient discharge
    - If patient will receive care in the community, call community provider to schedule appointment (providing a list of options is not sufficient).
        - Document in Health Management System (HMS) the provider assuming care, and appointment date and time (have patient sign release form to send record to outside provider).
    - If patient will be receiving HIV primary care at current county health department (CHD) location:
        - Request records from all prior HIV care providers
        - Request records from recent hospitalization (if applicable)
        - Assess insurance status to determine plan for access ART ongoing.

Days 3–4 (follow-up):

- Call, or email through Department approved patient portal, to check on patient (recommended at three–four days post-ART start).

Day 14-21 (follow-up):

- Review baseline labs with patient; may be completed in person, via telehealth or over the phone with patient consent.
- If patient is scheduled to see their ongoing HIV care provider during this timeframe, ensure provider office has access to lab results.
- Order opportunistic infection (OI) prevention medication as indicated (see Frequently Asked Questions for details).
- Adjust ART as needed/indicated based on lab results.

Day > 30 (follow-up):

- Monitor/ensure adherence with follow-up labs and appointments.
- If patient to remain in care at CHD, CHD staff should monitor ongoing.
- If patient to receive care at outside provider office, linkage team member or case manager to monitor to be sure patient is successfully linked to care.
    - Notify linkage team or case manager about scheduled appointment.

Minimum Baseline Laboratory Tests for Initial T&T Services (if not already collected):

- HIV 1/2 antigen/antibody (Ag/Ab) immunoassay blood-based test
- Absolute CD4 count with the percentage of CD4 cells
- Viral load HIV-1 ribonucleic acid polymerase chain reaction (HIV-1 RNA PCR) quantitative
- HIV-1 genotype resistance test for protease (PR) and reverse transcriptase (RT)
    - include integrase inhibitor (INSTI) testing if history of INSTI use for nPEP or PrEP or if INSTI resistance is suspected
- Hepatitis panel (chronic) to include:
    - Hepatitis A antibody (total, not IgM)
    - Hepatitis B surface antigen (HBsAg), hepatitis B surface antibody (HBsAb), hepatitis B core antibody total (HBcAb)
    - Hepatitis C virus antibody (HCV Ab) with reflex to HCV RNA
- Comprehensive metabolic panel (CMP)
- CBC with differential
- Urinalysis macro or point-of-care (POC) urine dipstick for protein
- Rapid plasma reagin (RPR monitor with reflex to confirmation)
- Site-specific sexually transmitted infection screening
- Pregnancy test (all people of child-bearing potential). May be POC testing.

Please refer to the chart on page 13 for additional information on tubes and coding for above lab tests.

T&T RECOMMENDED REGIMENS, regimens in alphabetical order
(Except for Pregnant Women or Women Trying to Conceive-see table below)

Regimen	Availability
Bictegravir/emtricitabine/tenofovir alafenamide 50/200/25 mg (Biktarvy), one tablet daily **with or without food**	Issuance, samples
OR	
Darunavir/cobicistat/emtricitabine/tenofovir alafenamide 800/150/200/10 mg (Symtuza), one tablet daily **with food**	Issuance, samples, vouchers
OR	
Dolutegravir 50 mg (Tivicay), one tablet daily **plus** tenofovir alafenamide 25 mg/emtricitabine 200 mg (Descovy), one tablet daily, **both taken with or without food**	Issuance (samples for Descovy portion only)
OR	
Dolutegravir 50 mg (Tivicay), one tablet daily **plus** tenofovir disoproxil fumarate 300 mg/emtricitabine 200 mg (Truvada), one tablet daily, **both taken with or without food**	Issuance

T&T RECOMMENDED REGIMENS (Pregnant Women or Women Trying to Conceive)

Regimen	Availability
Dolutegravir 50 mg (Tivicay), one tablet daily **plus** tenofovir alafenamide 25 mg/emtricitabine 200 mg (Descovy), one tablet daily, **both taken with or without food**	Issuance (samples for Descovy portion only)
OR	
Dolutegravir 50 mg (Tivicay), one tablet daily **plus** tenofovir disoproxil fumarate 300 mg/emtricitabine 200 mg (Truvada), one tablet daily, **both taken with or without food**	Issuance

NOTE: In cases of known resistance, at the provider's discretion, combinations of (protease inhibitor (PI)/ integrase strand transfer inhibitor (INSTI) plus or minus nucleoside reverse transcriptase inhibitor (NRTI) may be dispensed.

NOTE: Dolutegravir/lamivudine is a recommended regimen option for initial treatment of HIV infection ***except*** if HIV RNA is > 500,000 copies/mL, patient has hepatitis B virus (HBV) coinfection or ART is initiated before resistance test results are available. Providers may prescribe this medication and provide through samples or vouchers if deemed clinically appropriate. Please see Frequently Asked Questions, "Medications," for full discussion.

DRUG INTERACTIONS

- Integrase inhibitors can interact with medications containing polyvalent cations (e.g, Al Mg, Ca, Fe, Zn, including prenatal vitamins (see table below)
- Tenofovir alafenamide can interact with medications that induce P-glycoprotein (e.g. rifamycins, carbamazepine)
- Darunavir/cobicistat can interact with medications that inhibit or induce cytochrome P450 3A (CYP 3A)
- Review the Guidelines, prescribing information and the University of Liverpool HIV Drug Interactions resource at www.hiv-druginteractions.org for potential drug interactions.

INSTI Interactions with Polyvalent Cations		
	Bictegravir (BIC)	**Dolutegravir (DTG)**
Antacids (e.g., Al, Mg, Ca)	Take BIC ≥ two hours before or ≥ six hours after antacids containing Al or Mg. Take BIC with antacids containing Ca **with food**.	Take DTG ≥ two hours before or ≥ six hours after antacids containing Al, Mg, Ca.
Polyvalent cation-containing (e.g., Al, Ca, Fe, Mg, Zn) medications, including multivitamins, supplements, laxatives, sucralfate and buffered medications	**Supplements containing Ca or Fe:** Take simultaneously **with food** or, if fasting, take BIC ≥ two hours before. **Other polyvalent cations:** Take BIC ≥ two hours before or ≥ six hours after.	**Supplements containing Ca or Fe:** Take simultaneously **with food** or, if fasting, take DTG ≥ two hours before or ≥ six hours after. **Other polyvalent cations:** Take DTG ≥ two hours before or ≥ six hours after.

Source: Clinical info INSTI drug interactions

MEDICATIONS TO PREVENT OR TREAT OPPORTUNISTIC INFECTIONS

- Sulfamethoxazole/trimethoprim DS 800/160 mg tablets (Bactrim DS or Septra DS) and fluconazole 100 mg tablets are available to keep in stock for issuance for the following scenarios:
  - Sulfamethoxazole/trimethoprim for patients with a CD4 count < 200 cells/mm^3, history of *pneumocystis jirovecii* pneumonia (PJP), or suspected /documented active PJP pneumonia.
  - Fluconazole for patients with oropharyngeal candidiasis or suspected/documented esophageal candidiasis. Note that oropharyngeal candidiasis is a class B symptom and not AIDS-defining, while esophageal candidiasis is considered AIDS-defining.
- For patients requiring access to any other medications, providers and staff should utilize local resources and work with eligibility staff in their region to expedite eligibility to obtain medications through the local Ryan White program or the Florida AIDS Drug Assistance Program (ADAP).
- See the OI Guidelines for additional information including when to start/stop primary and secondary prevention for PJP.

FREQUENTLY ASKED QUESTIONS

General

Q: In what situations is it advisable to hold off on immediate ART initiation?

A: Using shared decision making, one may hold off on immediate initiation for persons who appear extremely ill. There are two OIs (cryptococcal meningitis and tuberculosis of the central nervous system) for which guidelines recommend delaying initiation of ART. These presentations are usually seen in hospital settings.

Persons brought to T&T with a preliminarily positive rapid HIV test who, on risk-factor assessment, are deemed to be at low risk of HIV infection and thus have a higher likelihood of false-positive HIV antibody testing might best be served by delaying T&T until confirmatory HIV test results are available.

Q: What if the patient does not want to start ART?

A: This is the choice of the patient. In these situations, it is important to discuss and assess why the patient is not interested in starting treatment. In the event they still decide not to start ART despite a shared-decision making approach, then it is important to verify you have accurate contact information (and preferably more than one way to contact the patient) to follow up after a few days to assess how the patient is doing. It is very important to follow up to confirm linkage to care is successful.

Q: Can our CHD participate in T&T if we don't have an onsite HIV clinic?

A. Yes. Providers in sexually transmitted disease, adult health and family planning clinics can be trained to initiate HIV medications. The HIV/AIDS Section Telehealth Team is available to provide training.

Q: If our CHD does not have an onsite clinician available or the clinician has not provided HIV medications before, are we able to participate in T&T for our communities?

A: Yes, your CHD can access the telehealth T&T clinicians and your patient can be seen at your local CHD or in the privacy of their home over a face-to-face Health Insurance Portability and Accountability Act (HIPAA) compliant computer connection (See Telehealth T&T process). Patients will need to have an HMS electronic health record opened and vital signs completed or reported when possible if accessing telehealth services from home. The telehealth clinician will document the care in your CHD's HMS record, including completing the issuance program medication documentation. A member of your CHD team will then need to arrange for the draw of initial laboratory specimens, provide issuance program medication and link to ongoing HIV care within your community. The telehealth clinicians will assess the laboratories drawn at the baseline visit and discuss with a member of your CHD onsite team.

Q: What ICD10 code should be used for a T&T visit?

A: For a patient presenting with history of an AIDS diagnosis (CD4 count less than 200 cells/mm^3 or having an AIDS defining condition including opportunistic infection(s) (OI) and cancers), use B20. Otherwise, at these initial visits, use Z21 to denote a diagnosis of asymptomatic HIV infection when you have a confirmed HIV-1/2 Ag/Ab immunoassay test result and R75 when you have a positive rapid test not yet confirmed.

Q : What OIs should I be concerned about?
A: Please see the Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV available at https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-opportunistic-infection for an introduction to OIs and treatments. Practitioners need to review the baseline laboratory drawn at the T&T visit in a timely fashion and should prescribe OI prophylaxis as indicated by lab results.

Insurance

Q: If my patient has insurance, are we able to provide T&T medications?
A: For an insured patient, the best practice is to e-prescribe the medication to the pharmacy of the patient's choice and then call and speak with the staff at the pharmacy. Ask the staff to run the medication to see if prior authorization is required. If prior authorization is required or it will take more than a day to get the medication into the pharmacy, provide T&T issuance program or pharmaceutical samples of antiretroviral (ARV) medications to support the patient's initial therapy. Please note that T&T can provide ARVs to any patient at risk of running out of medication, experiencing a gap in medication (even one day), or if a patient does not have a secured manner to obtain ARVs on a regular basis. T&T can be repeated on a monthly basis if needed.

Q: What if the patient has an insurance plan for which our provider is not eligible for reimbursement?
A: This is decided at the local CHD level. Your CHD may support treatment initiation for out-of-network insured patients. In some instances, if the patient agrees, you can discuss their case with an in-network provider and collaborate to initiate lab and medication needs for the patient. In some instances, the insurance may not reimburse at as high of a level when the provider is out of network, but the reimbursement may be adequate to cover the costs of the T&T evaluation (CHD provider time and lab cost). If your CHD is not able to see the patient for reasons related to payer source, assist with immediate linkage to a provider in their network.

Labs

Q: Is a confirmed HIV test required before patients can present for T&T evaluations?
A: No, a patient should be offered a T&T evaluation based upon an initial HIV-positive screening test. The T&T clinician will determine the likelihood of a potential false-positive test and may wait to initiate T&T until there is a confirmatory HIV-1/2 Ag/Ab immunoassay blood-based test result. When the history or at-risk behaviors support the likelihood the screening HIV test will be confirmed positive, the patient should proceed through the T&T evaluation process and initiate ART.

Q: What if the patient's lab returns a positive HBsAg test result?
A: Your patient has hepatitis B infection. All the recommended T&T issuance program regimens contains two drugs active against hepatitis B: tenofovir alafenamide/emtricitabine or tenofovir disoproxil fumarate/emtricitabine. The patient should be informed they need further evaluation with their primary care provider. Once the HBsAg is known to be positive, the patient should be contacted, and test results should be sent to the patient's primary care provider with consent of

the patient. It should be stressed not to stop taking their ARV medication, as serious flares of hepatitis B have occurred when treatment was abruptly stopped.

Guidelines do not recommend starting T&T with dolutegravir/lamivudine (Dovato) if hepatitis B testing results are not available. Dolutegravir/lamivudine (Dovato) does not provide adequate coverage for treatment of hepatitis B. Patents who do not have hepatitis B coinfection can be switched to dolutegravir/lamivudine, if clinically appropriate, by their HIV care provider at a subsequent visit. If the patient is on dolutegravir/lamivudine and positive HBsAg results, the regimen should be modified to include a second drug active against hepatitis B, such as tenofovir disoproxil fumarate or tenofovir alafenamide.

Medications

Q: How do I obtain issuance medication?
A: Issuance medication is obtained from the online Pharmacy Forms System through the Bureau of Public Health Pharmacy. If you do not have access to the online ordering system, refer to your CHD nursing director for guidance.

Q: How do I obtain pharmaceutical samples?
A: As a cost-savings measure for the Department, we encourage CHD practitioners to use manufacturer samples and vouchers for T&T clients in accordance with the Bureau of Public Health Pharmacy's policy DOHP 395-1, which states CHD practitioners are allowed to obtain manufacturer samples. Contact your local representative or see the pharmaceutical master contact list to obtain samples or vouchers. Reach out to the HIV Medical team at HIVMedicalTeam@flhealth.gov if you experience any barriers in obtaining samples.

Q: How do I know if the patient is taking concomitant drugs that may interact with one or more of the T&T medications?
A: Obtain a thorough medication history, including over-the-counter medications. Drugs that may impair renal function (such as nonsteroidal anti-inflammatory drugs) may interact with tenofovir disoproxil fumarate or tenofovir alafenamide (lesser extent) containing regimens. Drugs that induce p-glycoprotein and/or CYP3A4 (such as carbamazepine, oxcarbazepine, phenytoin, rifabutin, rifampin) may interact with tenofovir alafenamide and protease-inhibitor containing regimens. Polyvalent cations may interact with INSTI-containing regimens. Cobicistat (component of Symtuza) is a boosting agent and can interact with many drugs, primarily through inhibition of CYP3A4, CYP2D6 and P-glycoprotein.

Use University of Liverpool's HIV Drug Interaction Checker to check for possible drug-drug interactions.

Q: How do you counsel the patient on the use of their ARV medications?
A: Provide the patient instructions on how to take their medications, including whether the medications need to be taken with food. Instruct the patient on the importance of taking the medications at about the same time each day. **However, a patient does not need to stick with the time they took the first dose of medication at the T&T visit if that time is not the best time for them to remember to take the medication**. The patient can change to their

preferred dosing time on the next day and stick with that time from then on. Counsel the patient on the importance of not missing doses and the relationship of missing doses to the development of resistance, which could make the virus more difficult to treat and require the use of more medications. Counsel the patient on the importance of not running out of their medications, contacting the pharmacy in advance for refills and available resources to assist them in obtaining their medications should they lack insurance or have copays, deductibles or premiums that they cannot afford. Use the North Florida AIDS Education and Training Center Medication Information Sheets to assist in educating patients about their ARV regimen.

Q: What if a patient returns to us and states they cannot obtain their medication?
A: No patient should be turned away without medication if it is at all preventable. Provide the patient with samples or issuance program medication (can be provided monthly) while the issue is addressed. Florida ADAP can assist eligible uninsured clients or clients with insurance who need premium and/or copay assistance. Individual drug manufacturers provide medications without charge for some low-income uninsured or underinsured patients through patient assistance programs. Patients with private insurance can use pharmaceutical company copay cards for copays. For further information on patient assistance and copay programs go to the manufacturer websites or needymeds.org.

Patients with high copays may require alternative copay assistance, such as through ADAP, if the pharmaceutical company copay card cannot be used or does not provide coverage for the entire year. Other copay programs (e.g., My Good Days or Patient Advocate Foundation) are available to assist patients with federally-funded insurance (i.e., Medicare, Medicaid, Tricare). Consider use of a local or mail-order specialty pharmacy to assist you in making sure patients with insurance can maintain access to their ARVs. Referral to a Ryan White case management agency is recommended.

Q: Am I restricted in the T&T program to the drugs on the T&T formulary?
A: No, any licensed practitioner may prescribe the regimen they deem clinically appropriate, in consultation with their patient, for initiation of therapy. Patients can still be seen and obtain labs through the T&T program even if they are not issued medication at the visit.

Ryan White Program

Q: If eligibility for Ryan White is not completed before the patient runs out of ART, can the T&T program use the issuance program to provide additional ART to prevent a lapse in medication?
A: Yes, the goal is to ensure no patient in need of ARV medication goes without.

Q. If my CHD does not have a relationship with a Ryan White lead agency, how are services reimbursed?
A: Services can be paid through several options, depending on the client's situation:

- CHD bills client's insurance
- Client self-pays per CHD sliding fee schedule
- CHD establishes a purchase order/contract with the local Ryan White lead agency to be reimbursed (for Ryan White-eligible clients only)

For a T&T visit, most expenses are related to clinician time, medication and lab tests. Where a client does not have the means to self-pay or the CHD cannot bill the client's insurance, services will have to be covered with local funds.

- Medication can be provided without charge to the client through the Department Issuance Program or providers can use samples or vouchers.
- Clinician time provided through the HIV Telehealth Program bears no cost to the CHD. Local clinician time will have to be covered with local fees.
- Lab costs are typically where there is a challenge in finding funding.

Special Populations

Q: How do we address the high-risk patient who presents with acute viral syndrome symptoms with a high-risk exposure within the last 15 days (potential window of fourth generation Ag/Ab testing)?

A: Take a thorough health and sexual history, evaluating high-risk activity of the patient and their partner(s). Perform a rapid HIV test and draw blood for an HIV-1/2 Ag/Ab immunoassay test. If the patient has symptoms of acute HIV infection, draw an HIV-1 PCR RNA quantitative viral load. Initiate post-exposure prophylaxis (PEP) HMS Code 5705 with one of the T&T regimens and **follow up per PEP guidance**. Discuss safe sex practices while awaiting test results and follow up. See also: PEP to Prevent HIV Infection (Clinical Guidelines Program).

Q: What if the patient is pregnant, planning to become pregnant or not on adequate birth control?

A: Always refer to the latest update of the DHHS recommendations for use of ARVs during pregnancy. Symtuza and Biktarvy are not recommended for use during pregnancy. Dolutegravir (Tivicay) with [tenofovir alafenamide/emtricitabine (Descovy) or tenofovir disoproxil fumarate/emtricitabine (Truvada)] are preferred ARV regimen options throughout pregnancy and for those who are trying to conceive.

Q: How do you evaluate a patient who presents with a positive HIV-1/2 Ag/Ab immunoassay test result whose HIV-1 viral load returns an undetectable result?

A: In the case of an individual presenting with a positive HIV Ag/Ab combination assay who is then found to have an undetectable HIV viral load, one must consider the possibility of a false-positive HIV test. The HIV-1/2 Ag/Ab immunoassay test specificity is greater than 99.6 percent. For every 10,000 tests performed, as many as 40 may be false positive. False-positive test results have been reported during pregnancy. Of note, there is a very small subset of HIV patients (approximately 0.5%) termed elite controllers. An elite controller is a person living with HIV who is able to maintain undetectable viral loads for at least 12 months despite not having started antiretroviral therapy (ART). Hence, he/she would have a repeated positive HIV-1/2 Ag/Ab and an HIV-1 viral load undetectable.

When the HIV viral load returns as undetectable, repeat the test to confirm and assess the patient's history to determine if they would be considered at low risk for HIV infection. Consider whether the patient may have been on ART at the time of the viral load draw. Inquire as to any memory of signs and symptoms consistent with acute HIV seroconversion. Note this scenario could warrant obtaining a *qualitative viral load* (not the quantitative ones used in clinical management) test.

TELEHEALTH RESOURCES

Telehealth services for T&T are available. Equipment costs are minimal and include a CHD computer with video camera and speakers. HIPAA-compliant Doximity or Microsoft Teams is used and provided to the CHD at no cost. When anticipating a telehealth T&T patient, please contact one of the following staff members (start with the first person on the list and progress downward):

- HIV/AIDS Section Statewide Practitioner —239-339-3899
- Telehealth PA—904-254-0258
- If none of the above are available, please contact the Medical Director of Disease Control and Health Protection, Dr. Andréa Sciberras – 850-756-2283

One of these staff members will accept the telehealth session and will establish a connection. A calendar invite will be sent to the contact person at the originating site with the date and time of the visit and the name of the provider seeing the patient. Before each telehealth encounter, test the system and problem-solve any connection issues.

ADDITIONAL GUIDANCE

- HIV/AIDS Clinical Practice Guidelines
- Clinician Consultation Center
- Antiretroviral Drug Interactions
- Antiretroviral Patient Medication Information Sheets

LABORATORY TEST QUICK REFERENCE

TEST NAME	TUBE	TEST CODE QUEST	TEST CODE STATE	TEST CODE LABCORP
HIV 1/2 Ag/Ab Immunoassay (if no record of confirmed HIV)	SST	**91431**	**0500**	**083935**
HIV-1 RNA, Quantitative Real Time PCR Viral Load	White top (S/T/F)*	**40085**	**0560**	**550430**
HIV-1 Genotype (RT, PR)	3 White tops (S/T/F)*	**34949**	**0570**	**551697**
HIV-1 Genotype (RT, PR, INSTI)	3 White tops (S/T/F)*	**91692**	**N/A**	**551700**
Comprehensive Metabolic Panel (14)	SST	**10231**	**N/A**	**322000**
Chronic Hepatitis Panel (HAV, HBV, HCV)	SST	**6462**	**0380**	**144445**
CBC (Includes Diff/PLT)	Lavender top	**6399**	**N/A**	**005009**
Lymphocyte Subset Panel 5 (Absolute CD4 & CD4% Panel 5)	Lavender top*	**8360 (CBC requires additional lavender)**	**0540** (CD4 and CD8 only)	**505008 *Lavender AND yellow top tube**
Urinalysis Macroscopic Urinalysis (POC dipstick)	Yellow top CHD	**6448** **N/A**	**N/A** **N/A**	**003038** **N/A**
Pregnancy test (POC dipstick) If child-bearing potential	CHD	**N/A**	**N/A**	**N/A**
RPR (monitor) with confirmation	SST	**799**	**0250**	**012005**
CT/GC (site specific)	Urine Rectal swab Oral swab	**Urogenital/ vaginal 11363** **Rectal 16506** **Oral 70051** **Urine 36341**	**0430 indicate site: Urine, Rectal, Oral or Vaginal. MUST indicate "-SC" if self-collected**	**Urine 183194** **Rectal 188672** **Oral 188698** **Urogenital/Vaginal 183160**

***S/T/F: separate plasma, transfer to screw-cap tube, and freeze prior to transporting, when possible**

See the following websites for complete details regarding specimen collection instructions:

- Quest Diagnostics
- Florida Department of Health Bureau of Public Health Laboratories
- Labcorp