CLINICAL GUIDELINES PROGRAM
NEW YORK STATE DEPARTMENT OF HEALTH AIDS INSTITUTE | HIV • HCV • STIs • SUBSTANCE USE • LGBTQ+ HEALTH

Virologic and Immunologic Monitoring in HIV Care

Updates, Authorship, and Related Resources

Date of current publication	October 31, 2025
Highlights of changes, additions, and updates in the October 31, 2025 edition	• Updated discussion and references throughout the guideline. • Table 1: Recommended Viral Load and CD4 Count Monitoring in Nonpregnant Patients With HIV: Updated recommended monitoring for patients taking ART with documented viral suppression.
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Author and writing group conflict of interest disclosures	There are no author or writing group conflict of interest disclosures.
Date of original publication	June 1, 2016
Committee	Medical Care Criteria Committee
Developer and funder	New York State Department of Health AIDS Institute (NYSDOH AI)
Development process	See Supplement: Guideline Development and Recommendation Ratings
Related NYSDOH AI resources	**Guidelines** • Rapid ART Initiation • Diagnosis and Management of HIV-2 in Adults **Guidance** • U=U Guidance for Implementation in Clinical Settings **Podcast** • Viremic—Cases in HIV

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Contents

Purpose of This Guideline

Periodic laboratory tests are necessary to evaluate a patient's response to antiretroviral therapy (ART). Monitoring HIV-1 RNA levels (viral load) to confirm appropriate response to treatment and durable viral suppression is the most accurate and meaningful measure of the effectiveness of ART [Gale, et al. 2013]. HIV suppression is essential to the health of the individual with HIV and to preventing HIV transmission through sex.

Regular immunologic monitoring in patients with consistently undetectable HIV viral loads and CD4 counts >200 cells/mm^3 offers little utility in clinical practice today. Clinicians rarely use this information to guide decision-making for clinically stable, virologically suppressed patients.

The New York State Department of Health AIDS Institute has developed these evidence-based recommendations for ambulatory care of patients with HIV to accomplish the following:

- Guide clinicians in the use of HIV viral load testing at appropriate times and intervals to assess initial and ongoing ART responses.
- Clarify the appropriate use of immunologic (CD4 count) monitoring in the care of patients with HIV.

Note on "experienced" HIV care providers: The NYSDOH AI Clinical Guidelines Program defines an "experienced HIV care provider" as a practitioner who has been accorded HIV Specialist status by the American Academy of HIV Medicine. Nurse practitioners (NPs) and licensed midwives who provide clinical care to individuals with HIV in collaboration with a physician may be considered experienced HIV care providers if all other practice agreements are met; NPs with more than 3,600 hours of qualifying experience do not require collaboration with a physician (8 NYCRR 79-5:1; 10 NYCRR 85.36; 8 NYCRR 139-6900). Physician assistants who provide clinical care to individuals with HIV under the supervision of an HIV Specialist physician may also be considered experienced HIV care providers (10 NYCRR 94.2).

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Viral Load and CD4 Count Monitoring Intervals

☑ RECOMMENDATIONS

Monitoring Intervals

- To assess a patient's response to ART and immunologic status and to identify when a change in ART regimen is needed, clinicians should perform plasma HIV-1 RNA level (viral load) and CD4 count testing as detailed in Table 1: Recommended Viral Load and CD4 Count Monitoring in Nonpregnant Patients With HIV. (A1)
- Clinicians should address modifiable barriers to adherence and engagement in care to help ensure optimal virologic suppression. Modifiable barriers may include, but are not limited to, substance use, mental illness, other chronic medical conditions, ART-associated adverse medication effects, unstable housing, or low health literacy. (A2)
- Quarterly CD4 count monitoring is *no longer recommended* for nonpregnant patients [a] receiving ART who have consistently undetectable viral load levels and CD4 counts >200 cells/mm^3 (see Table 1 for recommended intervals). (A2)

Abbreviations: ART, antiretroviral therapy; DHHS, U.S. Department of Health and Human Services.

Note:

a. For pregnant patients, see DHHS Recommendations for the Use of Antiretroviral Drugs During Pregnancy and Interventions to Reduce Perinatal HIV Transmission in the United States > Table 3. Laboratory Testing Schedule Before and After Antiretroviral Therapy Initiation.

Laboratory monitoring can provide a consistent and objective measure of a successful and appropriate antiretroviral regimen. The optimal frequency of HIV-1 viral load and immunologic monitoring has been debated, but appropriate viral load monitoring can be useful for detecting virologic failure early, helping to reduce transmission by ensuring an undetectable viral load, and assessing adherence challenges. Too frequent laboratory monitoring can contribute to treatment fatigue, over-medicalization, and false positive results. Because viral load monitoring remains the most important method of ensuring continued viral load suppression, patients who are monitored at longer intervals should be carefully selected.

The decision to increase a patient's monitoring interval should be based on length of viral suppression, CD4 count, use of ART for transmission prevention, and adherence to medical care, including visit attendance and retention in care. For select patients with an initial CD4 count ≥300 cells/mm^3 and sustained viral suppression for ≥3 years the frequency of HIV viral load monitoring may be reduced to once annually [Benator, et al. 2015]. The reduction in viral load monitoring frequency does not necessarily correspond to a reduction in visit frequency and regular clinical encounters remain beneficial, offering opportunities for early identification of new health concerns and providing ongoing patient support and reassurance. Patients should continue to be evaluated by a clinician at least twice yearly for discussion of adherence challenges, evaluation for sexually transmitted infection (STI) screening, and management of comorbidities.

→ KEY POINTS

- Quarterly HIV RNA monitoring remains appropriate for patients with a recent history of nonadherence, mental health disorders, substance use, homelessness, poor social support system, or other major medical conditions.
- Semiannual monitoring may be appropriate for patients with persistently undetectable HIV RNA and none of the above characteristics.
- Patients who are monitored at longer intervals should be carefully selected based on length of viral suppression, CD4 count, use of ART for transmission prevention, and adherence to medical care, including visit attendance and retention in care.

A retrospective study noted that the strongest predictor of virologic failure at 12 months was a missed or canceled appointment rather than the interval of follow-up [Buscher, et al. 2013]. HIV viral load testing once, twice, and ≥3 times within the first year of starting ART produced similar results [Shen, et al. 2016]. However, this and other similar studies [Romih, et al. 2010; Reekie, et al. 2008] have significant limitations, including their retrospective nature and short follow-up periods. Until more definitive data are available, the decision to lengthen monitoring intervals for HIV RNA levels should be individualized based on length of viral suppression, CD4 count, use of ART for transmission prevention, and adherence to medical care, including visit attendance and retention in care.

Studies do not indicate the appropriate interval for viral suppression monitoring for ongoing transmission prevention. Data indicate that the linked sexual transmission of HIV in serodiscordant couples in which the partner with HIV maintains sustained viral suppression is negligible [Rodger, et al. 2016]. Based on this information, those with HIV may rely on ART as a strategy to prevent viral transmission to an uninfected partner.

Table 1, below, provides a guide for monitoring HIV RNA levels and CD4 counts.

Table 1: Recommended Viral Load and CD4 Count Monitoring in Nonpregnant Patients With HIV [a]

Event	HIV RNA Viral Load	CD4 Count	Comments
Entry into care	Baseline viral load (A1)	Baseline CD4 count (A1)	• If a patient is not taking ART, recommend initiation [b]. (A1) • Monitor as below.
Patients Taking ART			
ART initiation or change to address virologic failure	• Within 4 weeks after ART start or change (A3) • At least every 8 weeks until complete virologic suppression is documented (A3)	• 12 weeks after ART initiation (A3) • Every 4 months until CD4 count >200 cells/mm^3 is obtained on 2 measurements at least 4 months apart (A2), then monitor as below once virologic suppression is achieved	• Virologic failure occurs when a viral load <200 copies/mL is either not achieved or not maintained • Virologic suppression is defined as a viral load <20 to <50 copies/mL obtained with a highly sensitive assay
ART change for simplification or due to adverse effects	Within 4 weeks after ART change, then as below (A3)	Monitor as below for documented virologic suppression	—
Documented viral suppression	• At least every 4 months (A3) • May extend interval to 6 months in patients stable on ART with CD4 count >200 cells/mm^3 and complete viral suppression for 1 year (B2) • May extend interval to 12 months in select patients stable on ART with initial CD4 count ≥300 cells/mm^3 and sustained viral suppression for ≥3 years	• During first 2 years of suppressive ART [DHHS(a) 2025] (B2): – Every 3 months if CD4 count is <300 cells/mm^3 – Every 6 months if CD4 count is ≥300 cell/mm^3 • Consider annual monitoring if CD4 count is >300 cells/mm^3 [Nicolás, et al. 2016] • After 2 years of suppressive ART: Optional if CD4 count is >350 cells/mm^3 (B2)	—
New HIV RNA ≥500 copies/mL after previous viral suppression	Repeat viral load test 2 weeks after first result (A2)	Obtain CD4 count if previous result is >6 months old (B3)	• Assess for adherence and drug-drug interactions (A3) • Obtain resistance testing (A1)

Table 1: Recommended Viral Load and CD4 Count Monitoring in Nonpregnant Patients With HIV [a]			
Event	**HIV RNA Viral Load**	**CD4 Count**	**Comments**
New HIV RNA level over the limit of detection of sensitive assays, 20 to 50 copies/mL, but <500 copies/mL after previous viral suppression	Repeat viral load test within 4 weeks to differentiate low-level transient viremia ("blip") from virologic failure [c] (A2)	If repeat viral load is detectable, obtain CD4 count if previous result is >6 months old (B3)	• Assess for adherence and drug-drug interactions (A3) • If repeat viral load is detectable, consider resistance testing [d] (B3) • Patients with low-level viremia ≤200 copies/mL over a period of 12 months without demonstrated failure may continue routine testing intervals of at least every 4 months [e]
Patients Not Taking ART			
CD4 count ≤500 cells/mm^3 (A2)	At least every 4 months	At least every 4 months	At every visit, recommend ART initiation [b]
CD4 count >500 cells/mm^3 (A2)	At least every 6 months	At least every 6 months	At every visit, recommend ART initiation [b]

Abbreviation: ART, antiretroviral therapy.

Notes:

a. For recommendations on virologic monitoring in pregnancy, see DHHS Recommendations for the Use of Antiretroviral Drugs During Pregnancy and Interventions to Reduce Perinatal HIV Transmission in the United States.
b. See NYSDOH AI guideline Rapid ART Initiation.
c. An ART regimen should not be changed based on a single viral load elevation. The risk of virologic rebound (breakthrough) increases when values are ≥500 copies/mL [Grennan, et al. 2012].
d. Standard genotypic tests may not provide resistance results when viral load is low. For repeated low-level viremia, an assay that detects resistance mutations in archived proviral DNA is available; however, clinical data are insufficient to recommend for or against its use in the patient care setting.
e. In patients with low-level viremia, clinicians should consult with an experienced HIV care provider; low-level viremia can be due to multiple causes, and its clinical effect is not clear.

Virologic Monitoring (HIV Viral Load)

Plasma HIV-1 RNA level (viral load): Plasma levels of viral RNA have been shown to correlate with clinical outcomes, including overall mortality, and measurement of HIV RNA levels provides the most precise means of establishing whether a response to antiretroviral therapy (ART) has occurred [HIV Surrogate Marker Collaborative Group 2000; Thiebaut, et al. 2000; Murray, et al. 1999; Marschner, et al. 1998; Mellors, et al. 1997].

HIV RNA levels should be obtained from all patients at baseline [Porter, et al. 2015; Behrens, et al. 2014; Molina, et al. 2013; Tarwater, et al. 2004; Gulick, et al. 2003; Wu, et al. 2003].

For patients beginning ART, or those changing therapy as a result of virologic failure, HIV RNA should be measured at 4 weeks after initiation of ART and should decrease by at least 1 log (10-fold) in the presence of effective therapy [Haubrich, et al. 2011] (see Appendix: Interpretation of HIV Viral Load). For patients who do not have background antiretroviral resistance, an undetectable viral load (<50 copies/mL) is usually achieved within 3 months. Patients with a baseline HIV viral load >100,000 copies/mL can be expected to achieve an undetectable viral load within 6 months of effective treatment.

An absent or incomplete viral load response to ART should raise concerns about poor adherence to ART and viral resistance [Townsend, et al. 2009; Baxter, et al. 2000]. If a patient has less than a 1.0 $\log_{10}$ reduction in viral load after 4 weeks, or if the viral load remains >200 copies/mL after 12 weeks, evaluate for potential issues such as drug resistance, adherence

challenges, drug-drug interactions, or drug absorption problems [DHHS(b) 2025; Pyngottu, et al. 2021]. The reduction in viral load will be more rapid with INSTI-containing regimens than with other regimens. At 4 weeks, INSTI-containing regimens should reduce viral load by 2 to 3 logs. If the reduction is slower (e.g., 1.5- to 2-log drop within 6 weeks), check the patient's genotype test results and discuss adherence or other possible causes for the less robust response, such as drug-drug interactions [Venter, et al. 2019; Stephan, et al. 2014].

Blips: Patients on previously suppressive ART with newly detectable HIV RNA levels of 50 to 500 copies/mL may be experiencing low-level transient viremia ("blip") and not virologic failure. A blip by definition means that the viral load is again below the level of quantification on repeat testing performed promptly after a detectable result in someone previously suppressed. Persistent elevation, even at low levels, warrants further investigation. Acute concurrent illness and/or recent vaccination may cause this transient rise; however, studies have suggested that low-level transient viremia represents random biologic and statistical variation or false elevations of viral load resulting from laboratory processing [Lee, et al. 2006; Nettles, et al. 2005]. Isolated blips may not be indicative of risk of virologic failure; however, consecutive blips have been associated with an elevated risk of treatment failure [Pernas, et al. 2016]. Retesting should be performed within 4 weeks to differentiate low-level transient viremia (a blip) from sustained viremia and possible virologic failure.

The risk of virologic rebound (breakthrough) increases when values are >500 copies/mL [Grennan, et al. 2012]. However, ART should not be changed based on a single viral load elevation. Both low-level viremia (LLV; 50 to 999 copies/mL) and transient viral blips are associated with an increased risk of subsequent virologic failure. A European multicenter cohort study found that individuals experiencing blips had a 70% higher risk virologic failure and those with LLV had a 120% higher risk of virologic failure than participants with sustained viral suppression [Elvstam, et al. 2023]. Persistent LLV may lead to the development of drug resistance mutations. In the aforementioned study, 35% of individuals with LLV had at least 1 resistance mutation detected within 90 days [Elvstam, et al. 2023].

Intermittent viremia, including blips, has also been linked to increased levels of inflammatory markers such as sCD14 and D-dimer. These markers are associated with monocyte activation and pathway coagulation, suggesting that even transient increases in viral load may contribute to systemic inflammation [Funderburg, et al. 2024]. LLV has also been associated with higher all-cause mortality. A study reported that individuals with LLV had more than double the risk of death than those with sustained suppression. Additionally, LLV in the range of 200 to 999 copies/mL was linked to an increased risk of serious non-AIDS events [Elvstam, et al. 2021].

Advances in molecular detection technology have led to the development of HIV nucleic acid tests that are highly sensitive and more reliable than earlier versions. Real-time polymerase chain reaction (PCR) technology has been widely adopted for HIV-1 RNA quantification, but new technologies are continually emerging and being adapted to viral detection and quantification. The currently available U.S. Food and Drug Administration (FDA)-approved HIV-1 viral load tests that use real-time PCR technology offer a larger dynamic range of quantification than early-version viral load tests. The lower and upper limits of quantification of the currently available U.S. Food and Drug Administration (FDA)-approved HIV-1 viral load tests are shown in Table 3, below. Several different HIV viral load tests have been developed, and 4 are currently approved for use in the United States. Dried blood sampling is a newer technology that may provide a rapid and efficient method for sample collection as it becomes more available for point-of-care evaluation and medication adjustment and for settings without phlebotomy access. Comparative studies have demonstrated consistent results between plasma samples collected by staff and dried blood samples obtained by patients despite potential variability in collection techniques [Sahu, et al. 2024]. This technology continues to evolve and is not widely available.

HIV testing is conducted using assays from multiple manufacturers, each with a specific lower limit of quantification. The upper limit of quantification typically ranges up to 10,000,000 copies/mL, depending on the assay used. All currently available viral load assays quantify the level of cell-free virus in plasma and are approved by the FDA for monitoring response to ART, tracking viral suppression, and detecting treatment failure. As mentioned above, successful ART with first-line, INSTI-containing regimens should decrease the viral load by at least 2 logs (>100-fold) within 4 weeks, with the viral load decreasing below the limit of detection within 6 months [DHHS(a) 2025], and reductions in viral load may be slower for patients taking non–INSTI-containing regimens. Cohort studies strongly suggest that patients with viral loads <50 copies/mL have more sustained viral suppression than patients with viral loads between 50 and 400 copies/mL [Elvstam, et al. 2023; Fleming, et al. 2019; Joya, et al. 2019]. Assays that can detect <50 copies/mL are recommended for determining prolonged viral suppression and for monitoring patients who are on ART.

→ KEY POINT

- Achieving and maintaining an undetectable viral load is always the goal of ART.

Immunologic Monitoring (CD4 Count)

Lymphocyte subsets (CD4 count): CD4 lymphocyte count is used to evaluate immunologic staging, predict the risk of clinical progression, and make decisions regarding opportunistic infection prophylaxis [Lopez Bernaldo de Quiros, et al. 2001; El-Sadr, et al. 2000]. Low CD4 counts can be seen in other disease processes and should therefore not be used to diagnose HIV infection. Although CD4 count was used historically to establish a threshold for initiating ART, current guidelines in New York State recommend ART for all patients with HIV regardless of CD4 count. For patients who may not be ready to initiate ART, CD4 count can be used to guide discussions between patient and care provider regarding the urgency of initiating ART.

Although a CD4 count should be obtained at baseline [Moore and Keruly 2007; Oldfield, et al. 1998; Havlir, et al. 1996; Schneider, et al. 1992; Fischl, et al. 1988], clinicians are unlikely to use it to guide clinical decision-making in practice for virologically suppressed patients once their CD4 count remains above 200 cells/mm^3. However, for those infected with HIV-2 or HIV-1 variants that cannot be accurately quantified, such as group O isolates [Berger, et al. 2020], using viral load assays, CD4 count remains the most effective tool for monitoring disease progression.

Although a significant CD4 count increase often occurs among patients treated with effective ART, the absence of such an increase should not be interpreted as treatment failure if the viral load declines appropriately. ART regimens are generally not changed in patients with undetectable viral loads who experience immunologic failure, although patients should remain on appropriate prophylaxis for opportunistic infections based on CD4 count. One study of a cohort of more than 62,000 individuals in New York City over 1.9 years of observation reported that in those who entered the cohort with a CD4 count ≥350 cells/mm^3, there was a >90% likelihood of sustaining a CD4 count >200 cells/mm^3 during that period of time [Myers, et al. 2016]. Reassuringly, other data suggest that in patients with sustained viral suppression and CD4 counts between 100 and 200 cells/mm^3, the risk of pneumocystis pneumonia is very low even in the absence of prophylaxis [Chaiwarith, et al. 2013; Mocroft, et al. 2010; D'Egidio, et al. 2007].

Lack of correlation between viral load and CD4 count response is particularly common among patients aged ≥50 years [Sabin, et al. 2008; Gras, et al. 2007] and patients with low initial CD4 counts (<100 cells/mm^3) [Kelley, et al. 2009; Moore and Keruly 2007; Garcia, et al. 2004].

Absolute CD4 counts are calculated values that may fluctuate widely. The calculation is made by multiplying the total white blood cell count (in thousands) by the percentage of total lymphocytes and then by the percentage of CD4 lymphocytes. Therefore, any change in one of these three parameters will cause the absolute CD4 count to vary. CD4 percentage is a direct measurement and more reliable than the calculated absolute CD4 value, especially over time. A stable CD4 percentage, even when fluctuations occur in the absolute CD4 count, can reassure both the patient and the clinician that immunologic stability is present.

Some factors that can cause these fluctuations include sex, age, race, drugs (zidovudine, cephalosporins, cancer chemotherapy, nicotine, interferon, and corticosteroids), anti-lymphocyte antibodies, and splenectomy. Differences in reagents and equipment both within a laboratory and between laboratories may further contribute to variations in CD4 counts. There is also interlaboratory variation of normal range.

Appendix: Interpretation of HIV Viral Load

Table A1: Interpretation of HIV Viral Load			
HIV-1 RNA Copy Number			
Copies/mL	**Log^{10}**		
1,000,000 100,000 10,000 1,000 100	6.0 5.0 4.0 3.0 2.0		
Reduction With ART If Patient Has 100,000 copies/mL			
Log Change	**Percent Decrease**	**Fold Reduction**	**Resultant Copy Number**
0.5	68.38	3	33,000
1.0	90.00	10	10,000
2.0	99.00	100	1,000
3.0	99.90	1,000	100
Abbreviation: ART, antiretroviral therapy.			

All Recommendations

☑ ALL RECOMMENDATIONS: VIROLOGIC AND IMMUNOLOGIC MONITORING IN HIV CARE

Monitoring Intervals

- To assess a patient's response to ART and immunologic status and to identify when a change in ART regimen is needed, clinicians should perform plasma HIV-1 RNA level (viral load) and CD4 count testing as detailed in Table 1: Recommended Viral Load and CD4 Count Monitoring in Nonpregnant Patients With HIV. (A1)
- Clinicians should address modifiable barriers to adherence and engagement in care to help ensure optimal virologic suppression. Modifiable barriers may include, but are not limited to, substance use, mental illness, other chronic medical conditions, ART-associated adverse medication effects, unstable housing, or low health literacy. (A2)
- Quarterly CD4 count monitoring is *no longer recommended* for nonpregnant patients [a] receiving ART who have consistently undetectable viral load levels and CD4 counts >200 cells/mm^3 (see Table 1 for recommended intervals). (A2)

Abbreviations: ART, antiretroviral therapy; DHHS, U.S. Department of Health and Human Services.

Note:

a. For pregnant patients, see DHHS Recommendations for the Use of Antiretroviral Drugs During Pregnancy and Interventions to Reduce Perinatal HIV Transmission in the United States > Table 3. Laboratory Testing Schedule Before and After Antiretroviral Therapy Initiation.

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Supplement: Guideline Development and Recommendation Ratings

Table S1: Guideline Development: New York State Department of Health AIDS Institute Clinical Guidelines Program	
Developer	New York State Department of Health AIDS Institute (NYSDOH AI) Clinical Guidelines Program
Funding source	NYSDOH AI
Program manager	Clinical Guidelines Program, Johns Hopkins University School of Medicine, Division of Infectious Diseases. See Program Leadership and Staff.
Mission	To produce and disseminate evidence-based, state-of-the-art clinical practice guidelines that establish uniform standards of care for practitioners who provide prevention or treatment of HIV, viral hepatitis, other sexually transmitted infections, and substance use disorders for adults throughout New York State in the wide array of settings in which those services are delivered.
Expert committees	The NYSDOH AI Medical Director invites and appoints committees of clinical and public health experts from throughout New York State to ensure that the guidelines are practical, immediately applicable, and meet the needs of care providers and stakeholders in all major regions of New York State, all relevant clinical practice settings, key New York State agencies, and community service organizations.
Committee structure	• Leadership: AI-appointed chair, vice chair(s), chair emeritus, clinical specialist(s), JHU Guidelines Program Director, AI Medical Director, AI Clinical Consultant, AVAC community advisor • Contributing members • Guideline writing groups: Lead author, coauthors if applicable, and all committee leaders
Disclosure and management of conflicts of interest	• Annual disclosure of financial relationships with commercial entities for the 12 months prior and upcoming is required of all individuals who work with the guidelines program, and includes disclosure for partners or spouses and primary professional affiliation. • The NYSDOH AI assesses all reported financial relationships to determine the potential for undue influence on guideline recommendations and, when indicated, denies participation in the program or formulates a plan to manage potential conflicts. Disclosures are listed for each committee member.
Evidence collection and review	• Literature search and review strategy is defined by the guideline lead author based on the defined scope of a new guideline or update. • A comprehensive literature search and review is conducted for a new guideline or an extensive update using PubMed, other pertinent databases of peer-reviewed literature, and relevant conference abstracts to establish the evidence base for guideline recommendations. • A targeted search and review to identify recently published evidence is conducted for guidelines published within the previous 3 years. • Title, abstract, and article reviews are performed by the lead author. The JHU editorial team collates evidence and creates and maintains an evidence table for each guideline.
Recommendation development	• The lead author drafts recommendations to address the defined scope of the guideline based on available published data. • Writing group members review the draft recommendations and evidence and deliberate to revise, refine, and reach consensus on all recommendations. • When published data are not available, support for a recommendation may be based on the committee's expert opinion. • The writing group assigns a 2-part rating to each recommendation to indicate the strength of the recommendation and quality of the supporting evidence. The group reviews the evidence, deliberates, and may revise recommendations when required to reach consensus.

Table S1: Guideline Development: New York State Department of Health AIDS Institute Clinical Guidelines Program	
Review and approval process	• Following writing group approval, draft guidelines are reviewed by all contributors, program liaisons, and a volunteer reviewer from the AI Community Advisory Committee. • Recommendations must be approved by two-thirds of the full committee. If necessary to achieve consensus, the full committee is invited to deliberate, review the evidence, and revise recommendations. • Final approval by the committee chair and the NYSDOH AI Medical Director is required for publication.
External reviews	• External review of each guideline is invited at the developer's discretion. • External reviewers recognized for their experience and expertise review guidelines for accuracy, balance, clarity, and practicality and provide feedback.
Update process	• JHU editorial staff ensure that each guideline is reviewed and determined to be current upon the 3-year anniversary of publication; guidelines that provide clinical recommendations in rapidly changing areas of practice may be reviewed annually. Published literature is surveilled to identify new evidence that may prompt changes to existing recommendations or development of new recommendations. • If changes in the standard of care, newly published studies, new drug approval, new drug-related warning, or a public health emergency indicate the need for immediate change to published guidelines, committee leadership will make recommendations and immediate updates and will invite full committee review as indicated.

Table S2: Recommendation Ratings and Definitions		
Strength	**Quality of Evidence**	
A: Strong B: Moderate C: Optional	1	Based on published results of at least 1 randomized clinical trial with clinical outcomes or validated laboratory endpoints.
	*	Based on either a self-evident conclusion; conclusive, published, in vitro data; or well-established practice that cannot be tested because ethics would preclude a clinical trial.
	2	Based on published results of at least 1 well-designed, nonrandomized clinical trial or observational cohort study with long-term clinical outcomes.
	2†	Extrapolated from published results of well-designed studies (including nonrandomized clinical trials) conducted in populations other than those specifically addressed by a recommendation. The source(s) of the extrapolated evidence and the rationale for the extrapolation are provided in the guideline text. One example would be results of studies conducted predominantly in a subpopulation (e.g., one gender) that the committee determines to be generalizable to the population under consideration in the guideline.
	3	Based on committee expert opinion, with rationale provided in the guideline text.