Centering the Patient in HIV Care with LA CAB + RPV

Suppression and Additional Treatment Goals

We will begin shortly...

Your audio has been muted upon entry.

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Wednesday, September 9, 2026
Virtual Webinar

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Centering the Patient in HIV Care with LA CAB + RPV: Suppression and Additional Treatment Goals

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Selection of references follows principles of evidence-based medicine and, therefore, references may not be all inclusive.

Agenda

September 9 • 7:00 – 8:15 PM ET

Centering the Patient in HIV Care

with CAB+RPV LA

- **Overview of CAB + RPV LA**
- **Beyond Suppression**
- **Bringing it all Together**
- **Q&A**

Please use the Q&A function to submit comments and questions throughout the Webinar

CAB + RPV LA: Highly efficacious with long-term durability in people with HIV, including under-represented populations

ROBUST CLINICAL DEVELOPMENT AND PH III/IV PROGRAM

VOLITION 11M

CROI 2026

High efficacy in early switch, with low rates of CVF with resistance[1]

SOLAR 12M, CARES 96W

Non-inferiority vs oral ART, including BIC/FTC/TAF[2,3]

ATLAS-2M 152W, LATTE-2 256W

Long-term durability up to 5 years, with high rates of virologic suppression[4,5]

IMPALA 96W

AIDS 2026

Non-inferiority vs INSTI-based ART in people with suboptimal HIV control[6]

LATITUDE 48W

Superiority vs oral ART in people with barriers to adherence[7]

MOCHA 96W

CROI 2026

High virologic suppression and strong preference among adolescents with HIV[8]

CONSISTENT EFFECTIVENESS IN REAL-WORLD EVIDENCE

Meta-analysis of published RWE at Month 12*[9]

27 studies, encompassing 7,687 virologically suppressed (VL <50 c/mL) people with HIV receiving CAB + RPV LA for 12 months

93% virologic suppression

maintained after switching to CAB + RPV LA
(N=1,708 people with HIV across six studies; 95% CI: 88.7, 96.9)

0.3% resistance at failure

with overall low virologic failure rate
(N=1,003 people with HIV across five studies; 95% CI: 0.0, 1.2)

*Results presented in the meta-analysis reflect estimates calculated using a random-effects model, and number of studies included for each endpoint varied due to differing timepoints and endpoint definitions. **BIC,** bictegravir; **CAB,** cabotegravir; **CI,** confidence interval; **CVF,** confirmed virologic failure; **FTC,** emtricitabine; **M,** month; **RPV,** rilpivirine; **RWE,** real-world evidence; **TAF,** tenofovir alafenamide; **VL,** viral load; **W,** week

1. Cordova E, et al. Open Forum Infect Dis. 2026; ofag383.; **2.** Ramgopal MN, et al. Lancet HIV 2023;10:e566–77
3. Kityo C, et al. Nat Med 2026;32:168–77; **4.** Overton ET, et al. Clin Infect Dis 2023;76:1646–54
5. Smith G, et al. Open Forum Infect Dis 2021;8:ofab439; **6.** Ruzagira E, et al. AIDS 2026. Poster LB24;
7. Rana AI, et al. N Engl J Med 2026 Feb 26;394(9):858-871; **8.** Gaur A, et al. CROI 2026. Oral 155
9. Orkin C, et al. EACS 2025. Poster eP103

Re-Suppression on INSTI-based Regimens After VF in RCTs and RWE in Studies Evaluating CAB+RPV LA

Systematic literature review (SLR)*

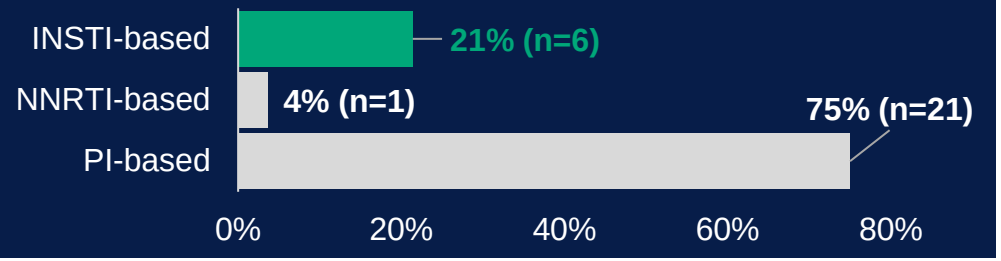
Phase 3/3b trials and **real-world cohorts** (N>10) that reported post-VF regimens and re-suppression outcomes.

Phase 3/3b trials[1,2]

7 trials included

VF: 1% (30/3,073)

93% (26/28) re-suppressed

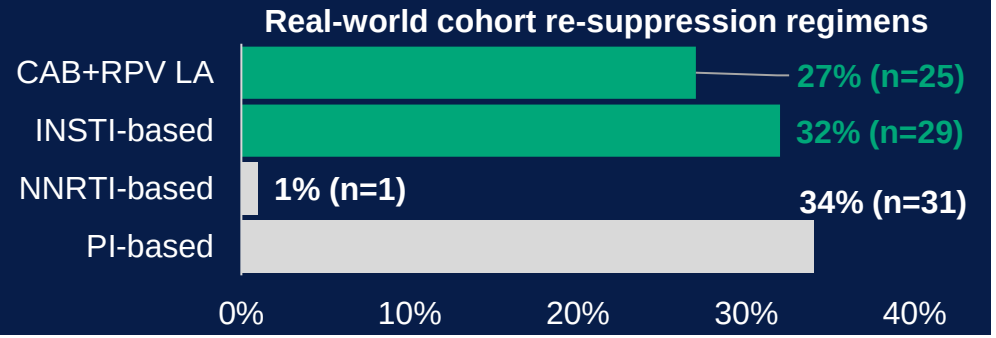


Real-world cohorts[3]

79 studies representing **13,889 people** were included

VF: 1.2% (172/13,899)

88% (65/74) re-suppressed



Additional studies reporting re-suppression post VF on CAB+RPV LA with INSTI-based regimens†

IMPALA
IMPROVING HIV OUTCOMES IN AFRICA WITH LONG ACTING ANTIRETROVIRALS

- Multi-country RCT in Uganda, Kenya, and South Africa[4]
- VF: 2.6% (7/268) at Week 96
- **n=5** resuppressed on **INSTI-based regimen (TLD),** n=1 on LPV/r +TDF/FTC, n=1 on ATZ/r/AZT/3TC

- Single-center case series of 6 patients who experienced VF on CAB + RPV LA in Ontario, Canada[5]
- **n=5** resuppressed on **INSTI-based regimen (BIC/F/TAF)****

INSTI: integrase inhibitor; NNRTI: non-nucleoside reuptake inhibitors; PI: protease inhibitors; VF: virologic failure; TLD: tenofovir alafenamide, lamivudine, dolutegravir

*SLR used Pubmed, Embase, Cochrane and 23 HIV-related conferences through March 2024. Post-VF regimens and re-suppression outcomes among PWH who were virologically suppressed at CAB+RPV LA initiation. Includes 115 participants from CUSTOMIZE with no VF; **6th VF data not available; † studies not included in SLR

1. Elias et al. HIV Glasgow 2024; Glasgow, Scotland. Poster P062. 2. Sinclair et al. IAS 2021; Virtual. Poster PED416; 3. Ring K et al HIV Med 2025; 26(8) 1267-88; 4 Ruzagira E, et al. AIDS 2026. Poster LB24.; 5. Giguere al. IAS 2025; Kigali, Rwanda. Poster LB10

OPERA: High, comparable effectiveness of CAB + RPV LA vs BIC/FTC/TAF

Adults who were virologically suppressed on ART switching to CAB + RPV LA or BIC/FTC/TAF in the US between February 2022 and March 2025

- Prospectively captured, routine clinical data from electronic health records
- BL characteristics, persistence and virologic effectiveness were compared across regimens

OPERA

BL characteristics (N=4,090)

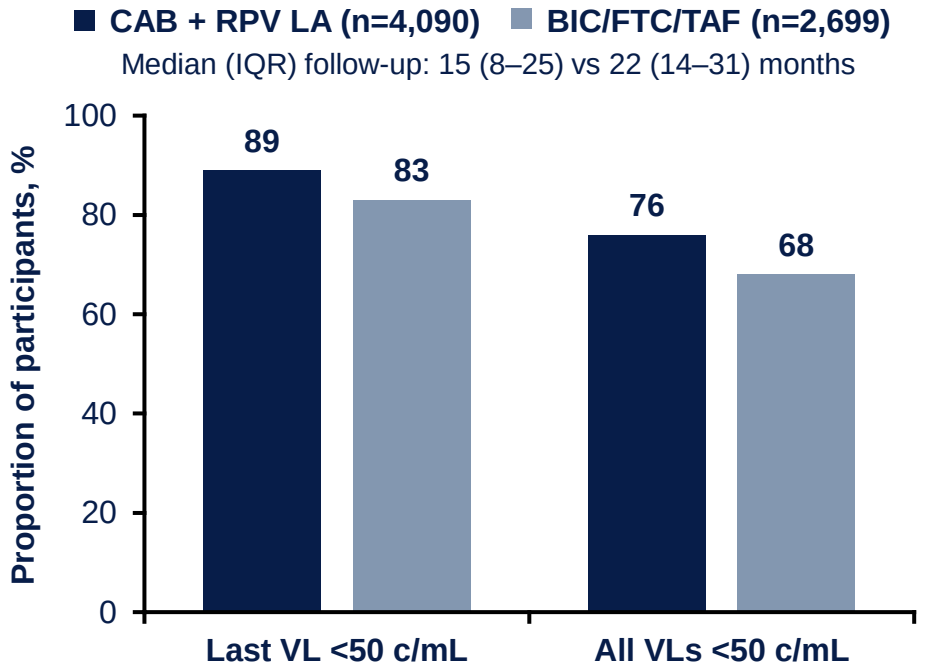
Age
Median: 38 years

Female
14%

Black
42%*

IDU
6%

Virologic outcomes



Proportion of participants with CVF†

1% (n=46/4,090) CAB + RPV LA vs **2% (n=46/2,699) BIC/FTC/TAF**

After experiencing CVF on CAB + RPV LA, **46% (n=21/46) of participants remained on CAB + RPV LA or switched to BIC/FTC/TAF‡**

Resuppression to <50 c/mL following CVF§

68% (n=15/22) CAB + RPV LA
(vs 69% [n=20/29] BIC/FTC/TAF)

*Data missing for 322 individuals; †Two consecutive VLs ≥200 c/mL or one VL ≥200 c/mL followed by discontinuation within 4 months. After adjusting for BL characteristics, difference was not statistically significant; ‡Switched to BIC/FTC/TAF (n=13), remained on CAB + RPV LA (n=8), switched to DRV/c/FTC/TAF (n=8), switched to a regimen with ≥2 core agents, excluding CAB + RPV LA and DTG/RPV (n=8), Other (n=6), Unknown (n=3); §In participants with post-CVF VL available. See slide notes for abbreviations

Hsu R, et al. AIDS 2026. Poster WEPEB099

CAB + RPV LA: Real-world use in broad and diverse populations with unmet needs

Hi-Vis
SHINING A SPOTLIGHT ON REAL-WORLD EVIDENCE
Click for more RWE data

✓ BMI ≥30 kg/m²

Growing evidence, including on the use of 1.5-inch needles

N=3,819

✓ Transgender

Unique challenges, impacted by social disadvantages and less accessibility

N=285

✓ No BL genotype

Inequities in access to care due to incomplete treatment history

N=2,256

✓ Racial and ethnic minorities

Disproportionally affected by HIV, as well as social and structural issues

N=7,738

✓ Migrants

Highly mobile and vulnerable group, who often lack a complete treatment history

N=1,049

✓ Older (≥50 years old)

High prevalence of comorbidities, and long-standing HIV infection

N=6,856

✓ Adherence struggles

Reasons may vary and impact the maintenance of virologic suppression

N=368

>45,000

people with HIV received CAB + RPV LA and were included in real-world studies*†[1–213]

✓ Women

Underrepresented in clinical trials despite the high burden of HIV

N=8,076

✓ Adolescents

Complex population impacted by stigma, discrimination and treatment fatigue

N=503

N=1,749 **Detectable viremia (off-label use)‡**

*N=45,596. Supporting references for subgroup population N numbers can be found in the slide notes; †Potential overlap between real-world cohorts cannot be ruled out; ‡Use of CAB + RPV LA in people with detectable viremia is outside of the labelled indication

BMI, body mass index

References available upon request

CAB + RPV LA: Additional benefits beyond virologic suppression are consistently reported in RCTs and RWE

PREFERENCE / CHOICE

OBSERVED ADHERENCE

QUALITY OF LIFE / STIGMA

ENGAGEMENT IN CARE

OVERALL HEALTH

*RCTs: ATLAS-2M Week 48 HCP-reported adherence: 98% (n=3,719);[1] SOLAR Month 12 HCP-reported adherence: 93% (n=2,527);[2] CARISEL Month 12 HCP-reported adherence: 93% (n=2,376);[3] CARES Week 96 HCP-reported adherence: 96% (n=1,039);[4] RWE: CARLOS Month 24 HCP-reported adherence: 94% (n=3,676);[5] BEYOND Month 24 HCP-reported adherence: 89% (n=2,509).[6] †BL vs 7 months: CrCl (Cockcroft-Gault) [90.9 mL/min (IQR: 78.2–101.6) vs 99.1 mL/min (IQR: 85.1–110.3); p=0.0001, respectively;[25] ‡HIV-specific PozQoL [score range 13–65], and EQ-5D-5L-US [score range 0–1][26]: perception of own quality of life changes (greater or better) at Month 6 vs BL after switching to CAB + RPV LA; HIVDQoL score 88% vs 33% (p=0.01), respectively;[3] HIVTSQs: Increased scores in all items, with therapy satisfaction reaching 5.9/6.0 at Month 13[27] §Switching to CAB + RPV LA helps reduce efforts to keep HIV status disclosed: HSS score at BL vs Month 6: 87.5% vs 33% (p=0.009), respectively[28]

CrCl, creatinine clearance; DDI, drug–drug interaction; HIVDQoL, HIV-dependent quality of life; HIVTSQs, HIV treatment satisfaction survey status version; HSS, HIV stigma scale; IQR, interquartile range

See slide notes for references

CAB + RPV LA: High interest and preference reinforces the importance of choice and partnered treatment decisions

Are people with HIV interested in switching to LA ART?[1–3]

83% Expressed interest in receiving **LA ART**

17% Expressed interest in maintaining **oral ART**

CoRIS
Real-world cohort
271 people on ART receiving HIV care*

Expections of switching to LA ART included comfort, sense of calmness, reduced pill burden and improved adherence

78% Willing to switch to **LA ART**

20% Reluctant to switch to **LA ART**

CARES
Phase IIIb study
64 people on SoC ART who were interviewed

Perceptions of switching to LA ART included reduced pill burden, increased privacy and convenience

85% Chose to switch to **CAB + RPV LA**

15% Chose to continue **DTG/3TC**

VOLITION
Phase IIIb study
145 eligible people on first-line oral ART

Reasons for switching to CAB + RPV LA included not having to worry about missing a dose each day and not having to carry medication around

People with HIV showed high preference for CAB + RPV LA vs oral ART in RCTs and RWE[4–14]

≥90% people with HIV preferred CAB + RPV LA†

- **Convenience**
- **Not worrying about remembering to take HIV medication every day**
- **Pill fatigue**
- **Not having to carry their HIV medication around**
- **Not thinking about their HIV status every day**

See slide notes for footnotes and abbreviations

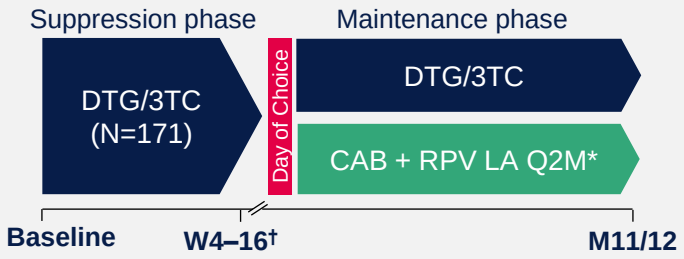
References available upon request

VOLITION: High efficacy in early switch to CAB + RPV LA, empowering ART-naïve people with HIV to choose their preferred treatment

CROI 2026

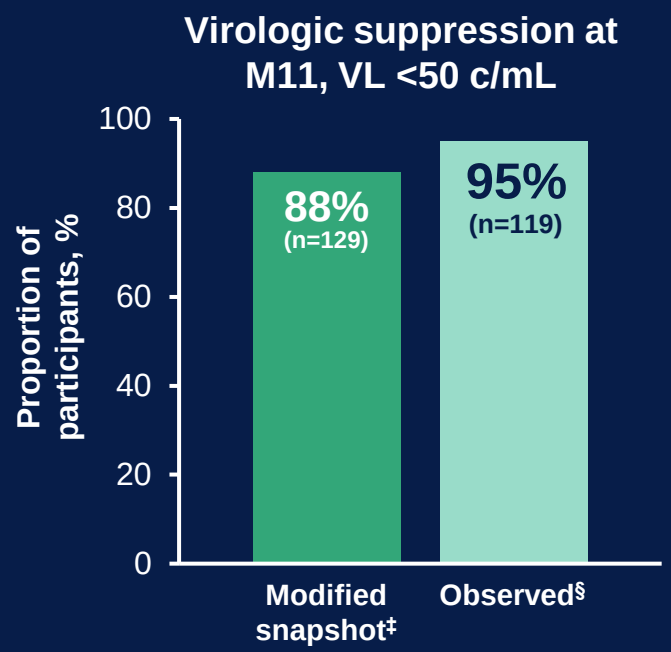
Importance of choice

Phase IIIb, multicenter, non-randomized, parallel-group, open-label study



At Day of Choice,
85% (n=129/151)
of eligible participants **chose to switch to CAB + RPV LA** vs continuing daily oral ART

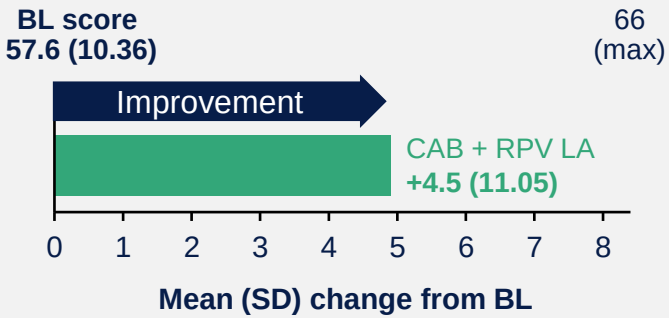
High efficacy and rare CVF with resistance

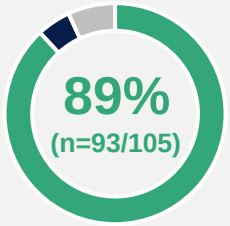


participants experienced CVF with resistance‖

High treatment satisfaction

Treatment satisfaction¶
HIVTSQs





of participants preferred to continue on CAB + RPV LA vs daily oral ART (5%)#

CAB + RPV LA DTG/3TC Unsure

CAB + RPV LA was well tolerated through Month 11, with most DRAEs being ISRs. No new safety signals were identified and no AEs led to withdrawal

*A diverse population of participants was represented (n=129): 26% women, 33% Black or African American, 51% Hispanic/Latine, 21% with BMI ≥30 kg/m^2, 22% with CD4$^+$ <350 cells/mm^3; †Median time to virologic suppression (<50 c/mL) on DTG/3TC: 4.1 weeks (95% CI: 4.1, 4.3); ‡Modified snapshot: RealTime HIV-1 RNA results were prioritised over the cobas® 6800 assay when available and within the Snapshot window; §Includes only participants with available virologic data in-window; ‖Three additional participants met CVF criteria and were withdrawn, however retrospective retesting did not confirm CVF, and no RAMs were detected; ¶Mean (SD) BL HIVTSQs total score (n=127), mean (SD) change from BL to Month 11 HIVTSQs total score (n=114); #Includes 105 participants who responded to the preference questionnaire, with remaining 7% unsure. After rounding proportions total 101%
3TC, lamivudine; **BL,** baseline; **BMI,** body mass index; **DRAE,** drug-related adverse event; **DTG,** dolutegravir; **HIVTSQs,** HIV Treatment Satisfaction Questionnaire status version; **M,** Month; **Q2M,** every 2 months
RAM, resistance-associated mutation; **SD,** standard deviation; **W,** Week

Cordova E, et al. Open Forum Infect Dis. 2026; ofag383

VOLITION Now Published -Open Access

https://doi.org/10.1093/ofid/ofag383

Open Forum Infectious Diseases

MAJOR ARTICLE

Rapid Virologic Suppression With DTG/3TC Facilitates Early Switch to CAB+RPV LA for Treatment-Naive People With HIV-1: Month 11/12 Outcomes From the Phase 3b VOLITION Study

Ezequiel Córdova[1], Charlotte-Paige Rolle[2], Kai Hove[3], Franco Felizarta[4], Marc Johnson[5], Guillermo Cuevas Tascón[6], Jean-Michel Molina[7,8], Joaquin Bravo Urbieta[9,10,11], Laurent Hocqueloux[12], Sergio Lupo[13], Carlos M. Perez[14], Björn-Erik Ole Jensen[15], Celia Jonsson-Oldenbüttel[16], Francisco Xavier Zamora Vargas[17], Jason Szabo[18], Pedro Cahn[19], Andrea Antinori[20], Juan Carlos López Bernaldo de Quirós[21], Antonella Castagna[22], Monika Bui[23], Richard Grove[23], Kehui Wang[24], Marty St. Clair[25], Riya Moodley[3], Jacob Radford[3], Julie Priest[25], Cassidy A. Gutner[25], Ian Jacob[3], Avishek Chatterjee[26], Suryakant Somvanshi[27], Irina Kolobova[25], Rekha Trehan[3], Christopher Polk[25], Parul Patel[25], Patricia de los Rios[25], Paul DiMondi[28], Lori A. Gordon[25], Kimberley Brown[25], Harmony P. Garges[25], Bryn Jones[3], Jean van Wyk[3]

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DOI: 10.1093/ofid/ofag383

CAB + RPV LA: People with HIV report strong preference, improved treatment satisfaction

Preference

≥90%
People with HIV preferred CAB + RPV LA*

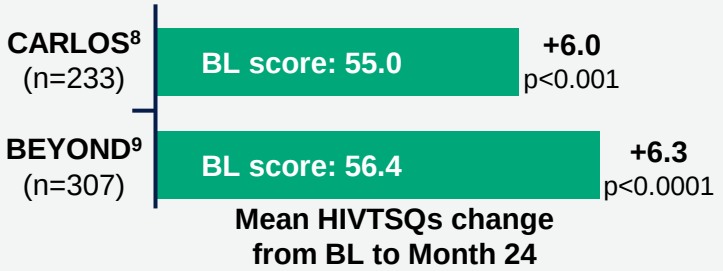
across **RCTs**[1–7] and **RWE**[8–11]

Treatment satisfaction

Switching to CAB + RPV LA was associated with **significant improvement in treatment satisfaction** versus previous oral ART[1,8,9]

In SOLAR, treatment satisfaction significantly improved in people switching to CAB + RPV LA versus continuing **BIC/FTC/TAF**, through Month 12 (Mean change in adjusted HIVTSQ score from BL: +3.4 vs –1.6, p<0.001)†[1]

Statistically significant improvement in treatment satisfaction after switching to CAB + RPV LA in **real-world clinical practice**



*Outcomes reported at Month 12 in SOLAR (90%, n=425), CARISEL (99%, n=277), CUSTOMIZE (92%, n=102), CARLOS (99%, n=257), BEYOND (97%, n=229) and ILANA (97%, n=95). Outcomes reported at Week 48 in ATLAS-2M (98%, n=306), ATLAS + FLAIR pooled data (98%, n=532) and MOCHA (100%, n=140). Outcomes reported at Week 96 in CARES (>99%, n=244). Outcomes reported at median (IQR) CAB + RPV LA duration of 1.0 (0.5, 1.7) years in ADELPHI (93%, n=28)

†Adjusted mean difference between study arms for the mean change in total HIVTSQs scores from BL to Month 12. CAB + RPV LA BL score: 57.88; BIC/FTC/TAF BL score: 58.38; Adjusted treatment difference 95% CI 4.95 (3.59, 6.31, p<0.0001)

HIVTSQs, HIV Treatment Satisfaction Questionnaire status version

References available upon request

CAB + RPV LA: Additional benefits beyond virologic suppression are consistently reported in RCTs and RWE

PREFERENCE / CHOICE | **OBSERVED ADHERENCE** | QUALITY OF LIFE / STIGMA | ENGAGEMENT IN CARE | OVERALL HEALTH

- ✓ **High preference** vs. daily oral ART and switching to CAB + RPV LA associated with **significant improvement in treatment satisfaction** vs oral ART[1,2, 20, 21, 24]
- ✓ **CAB+RPV consistently chosen** when given the opportunity to select preferred treatment option[1,2,21,24,25]

*****RCTs: ATLAS-2M Week 48 HCP-reported adherence: 98% (n=3,719);[1] SOLAR Month 12 HCP-reported adherence: 93% (n=2,527);[2] CARISEL Month 12 HCP-reported adherence: 93% (n=2,376);[3] CARES Week 96 HCP-reported adherence: 96% (n=1,039);[4] RWE: CARLOS Month 24 HCP-reported adherence: 94% (n=3,676);[5] BEYOND Month 24 HCP-reported adherence: 89% (n=2,509);[6] †BL vs 7 months: CrCl (Cockcroft-Gault) [90.9 mL/min (IQR: 78.2–101.6) vs 99.1 mL/min (IQR: 85.1–110.3); p=0.0001, respectively;[7] ‡HIV-specific PozQoL [score range 13–65], and EQ-5D-5L-US [score range 0–1])[8]; perception of own quality of life changes (greater or better) at Month 6 vs BL after switching to CAB + RPV LA; HIVDQoL score 88% vs 33% (p=0.01), respectively; HIVTSQs: Increased scores in all items, with therapy satisfaction reaching 5.9/6.0 at Month 13 §Switching to CAB + RPV LA helps reduce efforts to keep HIV status disclosed; HSS score at BL vs Month 6: 87.5% vs 33% (p=0.009), respectively;
HIVDQoL, HIV dependent quality of life; **HIVTSQs,** HIV treatment satisfaction survey status version; **HSS,** HIV stigma scale; **IQR,** interquartile range

References available upon request

Suboptimal adherence can lead to an increased risk of viral transmission and resistance

It is estimated that **38% of people with HIV** have **suboptimal adherence** to oral ART due to factors including:[1–3]

- Pill fatigue
- Stigma
- Complexity of dosing schedule
- Emotional challenges
- Busy lifestyle

DHHS guidelines emphasize the importance of **regular assessment** of **barriers** faced by people with HIV to ensure **tailored care** to meet their needs and preferences[4]

1. Ortego C et al AIDS Behav. 2011 Oct;15(7):1381-96.
2. Nachega JB, et al. Lancet HIV 2023;10:e332–42
3. Akinwunmi B, et al. Eur J Public Health 2021;31:567–75; **4.** DHHS. Guidelines for the use of antiretroviral agents in adults and adolescents with HIV, Sep 2025

High, long-term efficacy observed with CAB + RPV LA vs INSTI-based daily oral ART among key populations who may face challenges with adherence to oral ART and retention in care

AIDS 2026

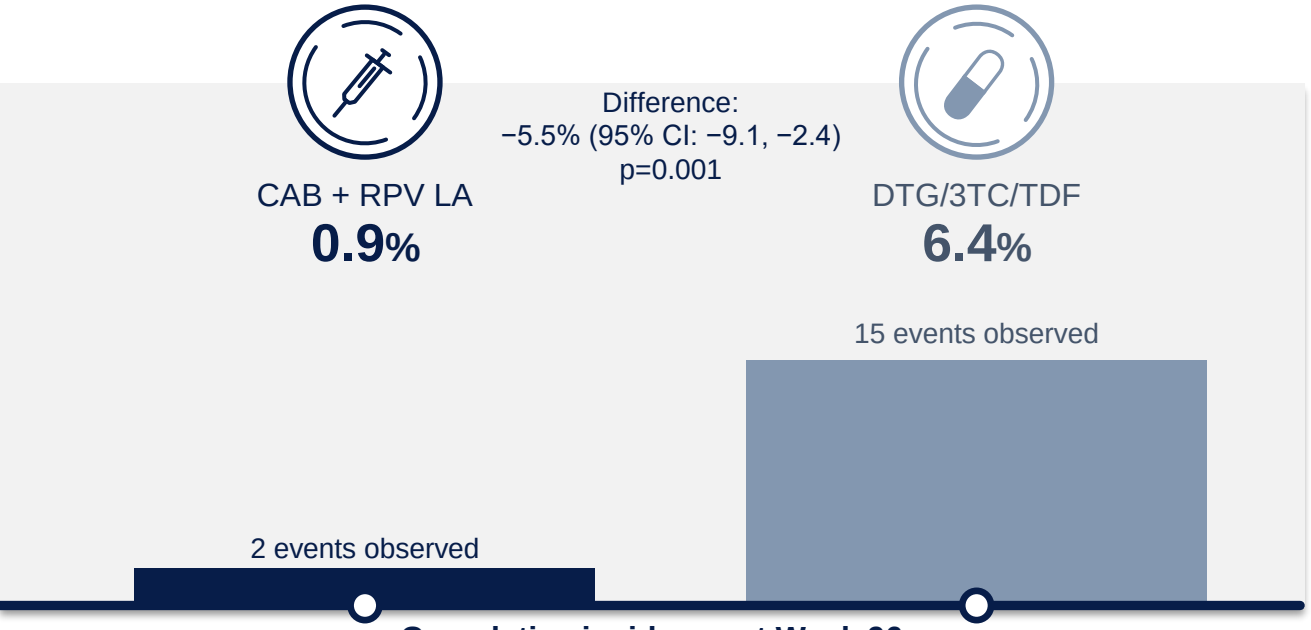
LATA: Superior efficacy vs DTG-based ART at Week 96

Adolescents (12–19 years) suppressed on ART for ≥12 months with no prior treatment failure (N=235)

LATA

Primary endpoint

Confirmed viral rebound (≥50 c/mL) by Week 96
(ITT-adjusted Kaplan-Meier estimated proportion)



Cumulative incidence at Week 96

Low emergent resistance by Week 96*
INSTI/NNRTI RAMs were present in **1 participant on CAB + RPV LA**
NNRTI RAMs were present in **2 participants on DTG/3TC/TDF**

Viral suppression (VL <50 c/mL)
94.9% (n=223/235) CAB + RPV LA
(vs 93.8% [n=226/241] DTG/3TC/TDF)

Discontinuations due to drug-related AEs†
0.9% (n=2/235) CAB + RPV LA (vs 0% [n=0/241] DTG/3TC/TDF)
There were no discontinuations due to ISRs

94%
N=235‡

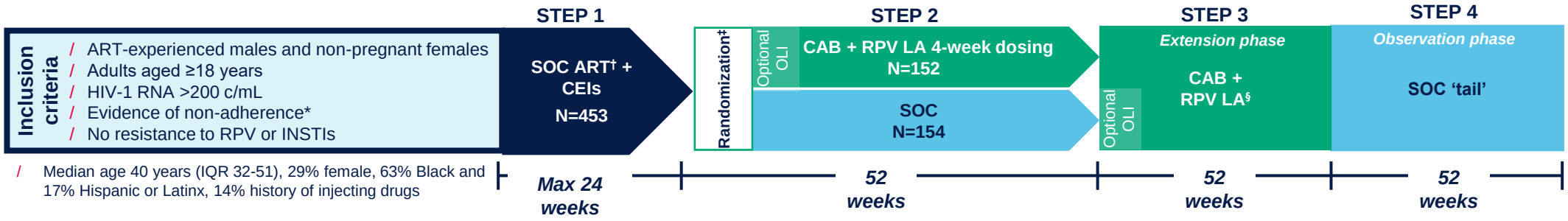
of participants receiving CAB + RPV LA reported that **taking LAIs was a lot easier** than taking daily treatment

*At confirmed viral rebound (n=2 events with CAB + RPV LA; n=15 events with DTG/3TC/TDF [data missing for n=7]). No INSTI RAMs were observed with DTG/3TC/TDF
†No discontinuations due to ISRs were reported; ‡It was assumed data were for all participants receiving CAB + RPV LA as it was not reported otherwise.
It was not possible to calculate the exact number (n) of participants who reported that taking LAIs was a lot easier than taking daily treatment due to rounding

Dangarembizi M, et al. AIDS 2026. Oral OAX1105LB

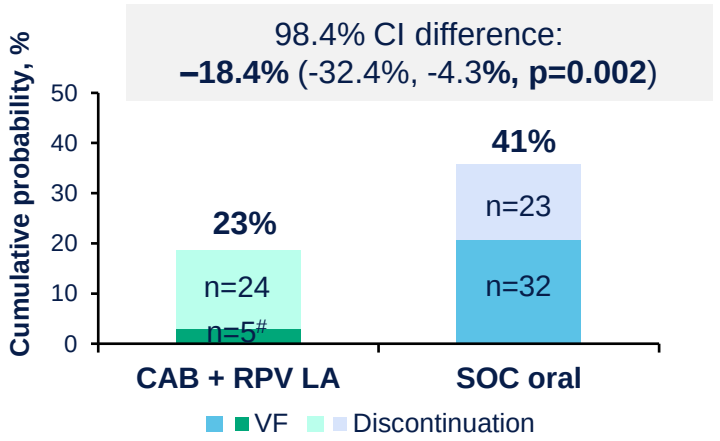
LATITUDE: Superior efficacy of CAB + RPV LA compared to daily oral SOC in PWH with adherence challenges

A Phase III prospective, randomized, open-label study to evaluate LA ART in PWH with adherence challenges in ACTG US sites (including Puerto Rico)

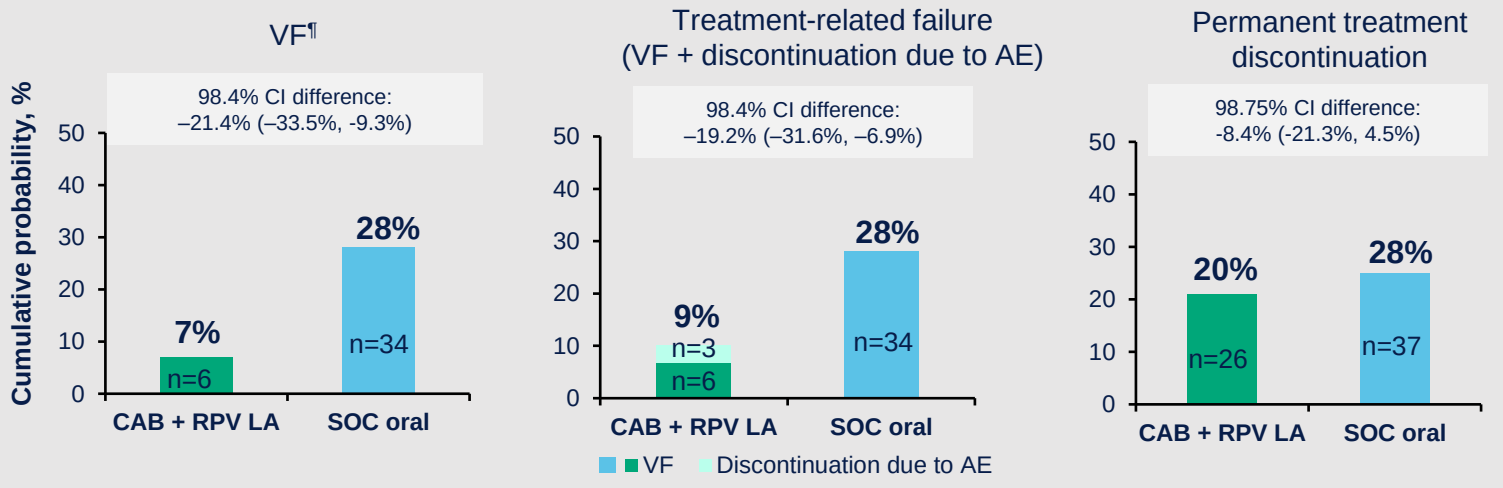


Primary endpoint‖

Regimen Failure: (VF¶ and discontinuation)



Secondary Endpoints‖



/ Week 48, cumulative incidence of a serious AE was 19.3% in CAB+RPV LA group and 14.5% in SOC group (between group difference, -4.8%, 95% CI, -5.6 to 15.2)

CAB + RPV LA superior to oral ART in reducing the risk of regimen failure among PWH with adherence challenges

*Poor viral response despite oral ART for ≥6 months or loss to clinical follow-up with ART non-adherence for ≥6 months; †Consisting of a ≥3-drug ART regimen with ≥2 drugs predicted to be fully active including a boosted protease inhibitor (PI/cobi) and/or an integrase strand transfer inhibitor for up to 24 weeks; ‡Participants who achieve viral suppression criteria at or after Step 1, Week 4, defined as: a) HIV-1 RNA ≤200 c/mL or b) HIV-1 RNA 201-399 c/mL followed by HIV-1 RNA ≤200 c/mL by Step 1 Week 24 will be eligible to enter Step 2. Participants with confirmed VF in Step 2; CAB + RPV LA (n=6), 2 with emergent RAMS (i) Week 18 E138EK; G140GS; Q148K; K103R (ii) Week 49 E138K; Q148K; K20KR; M230M; Oral SOC ART (n=28), 2 with emergent RAMs (i) Week 37, A71V; V77I; V106I (ii) Week 48, M184I; §There is an optional oral lead-in for SOC arm moving to step 3; ‖Pre-planned interim review by an independent DSMB; ¶VF, confirmed HIV-1 RNA >200 c/mL; #One participant assigned to LAI had treatment discontinuation as the primary endpoint but subsequently experienced VF, contributing to the total number of VFs; **ACTG**, AIDS Clinical Trial Group; **AE**, adverse event **CEIs**, conditional economic incentives; **cobi,** cobicistat; **DSMB**, data safety monitoring board; **LAI,** long-acting injectable; **PI,** protease inhibitor; **RAM,** resistance-associated mutation; **SOC**, standard of care; **US,** United States

Rana A, et al. NEJM 2026, 394(9): 858-871

UCSD

Evaluating CAB + RPV LA in people with adherence challenges to oral ART

Study design:

Retrospective observational study at the UCSD Owen Clinic

Study participants

- **People with HIV-1 with adherence challenges to oral ART** defined as having HIV-1 viral load ≥200 c/mL in the prior 12 months and either
  - Poor response to oral therapy*
  - Lost to follow-up†

Initiated CAB + RPV LA

Primary Outcome:

Discontinuation or virologic failure (VF)¶

48 weeks — 96 weeks

Demographics and characteristics:

	Parameter, n (%)‡	N=62
Key demographics	White race	28 (45.2)
	Hispanic ethnicity	22 (35.5)
	Male gender identity	44 (71.0)
Clinical characteristics	Any active substance use	25 (40.3)
	Any neuropsychiatric disorder	35 (56.5)
	Years since HIV diagnosis, median	13.3
	Viral load ≥50 c/mL at LAI initiation	27 (43.5)
	Viral load >10,000 c/mL at LAI initiation	7 (11.3)
	Q2M dosing at initiation	59 (95.2)
	Q1M then Q2M	3 (4.8)
	Other ART‡ at initiation	13 (21)

Results:

Proportion of participants who were virally suppressed (<200 c/mL)

48 weeks	96 weeks
86% (53/62)	77.4% (48/62)
Primary outcome: 17.7% (n=11)[2]	**Primary outcome:** 22.6% (n=14)[1]

Discontinuation reasons

- ✓ **VF with resistance (n=3)[2]**
- ✓ Preference (n=2), lost to follow up (n=3), death (n=1), VF**(n=2)[2]
- ✓ **No additional VFs between week 48 and 96[1]**
- ✓ Adverse events (n=3)[1]

Methamphetamine use significantly associated with VF or loss to follow up (OR=12.5, p=0.026) in univariate analysis

A high proportion of PWH with adherence challenges maintained viral suppression with CAB + RPV LA through week 96 with no failures occurring beyond week 48

UCSD, University of California San Diego; PWH, people with HIV; VL, viral load.

*HIV VLs ≥200 copies/mL separated by ≥4 weeks in the prior 18 months despite being prescribed oral ART. †No contact with an HIV provider for ≥6 months and non-adherence to ART for ≥7 days. ‡Unless otherwise indicated. ‡Other ART at the 96-week analysis included: TAF/FTC (n=3), Lenacapavir SQ injection (n=9), Fostemsavir (n=1); **VF then resuppressed without ART change; ¶At week 48 VF defined as VL ≥200 c/mL > 30 days after CAB+RPV LA initiation. [2]At week 96, VF defined as 2 consecutive VLs ≥200 c/mL, one VL ≥1000 c/mL or one VL ≥200 c/mL with evidence of resistance associated mutations to CAB or RPV.

1. Ostrer et al. AIDS 2026; Rio de Janeiro, Brazil. Poster TUPEB106.
2. Hastie et al. IAS 2025; Kigali, Rwanda. Poster EP0180.

Treatment guidelines: CAB + RPV LA can achieve virologic suppression in people with detectable viremia (off-label use)

Data for CAB + RPV LA in people with viremia are emerging (off-label use), and the IAS–USA and DHHS guidelines have been updated to reflect growing interest in its use in this population[1,2]

IAS–USA guidelines[1]

May be considered for people with viremia who are **unable to take oral ART consistently**, are at **high risk of HIV disease progression** and have **no resistance to CAB or RPV**

DHHS guidelines[2]

On a **case-by-case basis** in select individuals with **persistent VF** despite intensive adherence support on oral ART, who have **no evidence of resistance to RPV or CAB**, and with **shared decision-making** between providers and people with HIV

Local guideline example: New York State DOH

VL, viral load

1. Gandhi RT, et al. JAMA 2025;333:609–28
2. DHHS. Guidelines for the use of antiretroviral agents in adults and adolescents with HIV, Sep 2025
3. BHIVA. Guidelines on antiretroviral treatment for adults living with HIV-1, 2022 (2025 interim update)
4. WHO. Overview of WHO recommendations on HIV and sexually transmitted infection testing, prevention, treatment, care and service delivery. 2025
5. WHO. WHO recommends injectable lenacapavir for HIV prevention. Available at: https://www.who.int/news/item/14-07-2025-who-recommends-injectable-lenacapavir-for-hiv-prevention. Accessed Feb 2026

CROWN: Study design

CROWN Protocol 221611

Phase IIIb, open-label, randomised, multicenter superiority study of CAB + RPV LA in viremic participants

Inclusion criteria

- ≥12 years of age
- ≥35 kg
- HIV-1 RNA >1,000 c/mL at screening
- Evidence of insufficient virologic response to oral ART*

Randomisation 3:1

Estimated enrollment N~332

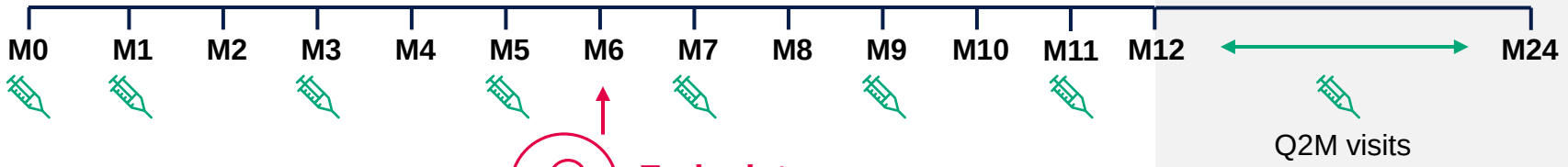
CAB + RPV LA IM Q2M → **Long-term treatment**

ART oral QD

Optional switch to CAB + RPV LA from oral ART if VL <400 c/mL at Month 6

Exclusion criteria

- HBV coinfection
- HIV subtype A6
- Evidence of INSTI or clinically significant NNRTI resistance



Endpoint

Primary endpoint: HIV-1 RNA <50 c/mL on CAB + RPV LA versus oral ART at Month 6

*At least one of the following: a) <1 log_{10} decrease in HIV-1 RNA or HIV-1 RNA >200 c/mL at two time points at least 4 weeks apart in individuals who have been prescribed oral ART for at least 3 consecutive months, b) a documented lapse in current oral ART regimen usage expected to result in HIV-1 viraemia (defined as at least a 30-day consecutive period of non-use of oral ART), c) a documented need for change from oral ART regimen that the investigator attributes as the primary reason for insufficient virologic response (e.g. safety findings and/or limited tolerability, clinically relevant DDIs)

DDI, drug–drug interaction; **IM,** intramuscular; **M,** Month

CROWN (NCT06694805). Available at: https://clinicaltrials.gov/study/NCT06694805 (accessed Mar 2026)

Adherence sufficient to achieve and maintain viral suppression

Adherence required for optimal long-term health outcomes

Suboptimal adherence can lead to an increased risk of viral transmission and resistance

It is estimated that **38% of people with HIV** have **suboptimal adherence** to oral ART due to factors including:[1–3]

- Pill fatigue
- Emotional challenges
- Stigma
- Busy lifestyle
- Complexity of dosing schedule

DHHS guidelines emphasize the importance of **regular assessment** of **barriers** faced by people with HIV to ensure **tailored care** to meet their needs and preferences[4]

HCP, healthcare professional

Non-adherence to oral ART is associated with:[1,5–8]

- A lower CD4 count
- AIDS-related mortality
- Increased risk of transmission
- Higher healthcare costs
- Emerging resistance
- Comorbidities
- Inflammation

LAIs like CAB + RPV LA could help to overcome some of these adherence challenges, and this directly-observed therapy removes the need for adherence to daily dosing while allowing HCPs to track doses received[9]

1. Ortego C et al AIDS Behav. 2011 Oct;15(7):1381-96.
2. Nachega JB, et al. Lancet HIV 2023;10:e332–42
3. Akinwunmi B, et al. Eur J Public Health 2021;31:567–75; **4.** DHHS. Guidelines for the use of antiretroviral agents in adults and adolescents with HIV, Sep 2025
5. Byrd KK, et al. J Acquir Immune Defic Syndr 2019;82:245–51
6. van Rensburg R, et al. CROI 2026. Poster 657; **7.** Castillo-Mancilla JR, et al. Open Forum Infect Dis 2023;10:ofad230
8. Castillo-Mancilla JR, et al. J Int AIDS Soc 2019;22:e25297; **9.** Davis JM, et al. Clin Infect Dis 2024:ciae557

Virally suppressed individuals with suboptimal adherence at increased risk of negative clinical outcomes

Open Forum Infectious Diseases

MAJOR ARTICLE

Association of Incomplete Adherence to Antiretroviral Therapy With Cardiovascular Events and Mortality in Virologically Suppressed Persons With HIV: The Swiss HIV Cohort Study

Jose R. Castillo-Mancilla,[1] Matthias Cavassini,[2,3] Marie Paule Schneider,[3] Hansjakob Furrer,[4] Alexandra Calmy,[5] Manuel Battegay,[6,7] Giulia Scanferla,[8] Enos Bernasconi,[9] Huldrych F. Günthard,[10,11] and Tracy R. Glass[6,12]; for the Swiss HIV Cohort Study

[1]University of Colorado-AMC, Aurora, Colorado, USA, [2]Infectious Diseases Service, Lausanne University Hospital, Lausanne, Switzerland, [3]School of Pharmaceutical Sciences and Institute of Pharmaceutical Sciences of Western Switzerland, University of Geneva, Geneva, Switzerland, [4]Department of Infectious Diseases, Bern University Hospital, Inselspital, University of Bern, Bern, Switzerland, [5]Division of Infectious Diseases, HIV/AIDS Unit, Geneva University Hospitals, Geneva, Switzerland, [6]University of Basel, Basel, Switzerland, [7]Division of Infectious Diseases, University Hospital Basel, Basel, Switzerland, [8]Division of Infectious Diseases, Kantonsspital St. Gallen, St. Gallen, Switzerland, [9]Division of Infectious Diseases, Ospedale Regionale di Lugano, Lugano, Switzerland, [10]Division of Infectious Diseases and Hospital Epidemiology, University Hospital Zurich, Zurich, Switzerland, [11]Institute of Medical Virology, University of Zurich, Zurich, Switzerland, and [12]Department of Medicine, Swiss Tropical and Public Health Institute, Basel, Switzerland

Background. Incomplete antiretroviral therapy (ART) adherence, even if sufficient to maintain viral suppression, is associated with enhanced inflammation in persons with HIV (PWH). However, its clinical implications remain unknown.

Methods. PWH enrolled in the Swiss HIV Cohort Study without a history of cardiovascular disease (CVD) who initiated ART between 2003 and 2018 and had viral suppression (<50 copies/mL) for ≥6 months were evaluated. The association between incomplete self-reported ART adherence (≥1 or ≥2 missed doses in the last month) and (1) any CVD event (myocardial infarction, revascularization, cerebral hemorrhage, stroke, and/or death due to CVD event) or (2) non-CVD-related death was evaluated using adjusted Cox proportional hazards models.

Results. A total of 6971 PWH (74% male) were included in the analysis (median age [interquartile range [IQR]], 39 [32–47] years). The median (IQR) follow-up was 8 (4–11) years, with 14 (8–23) adherence questionnaires collected per participant. In total, 205 (3%) participants experienced a CVD event, and 186 (3%) died a non-CVD-related death. In an adjusted competing risk model where missing data were imputed, missing ≥1 ART dose showed an increased, but not statistically significant, risk for CVD events (hazard ratio [HR], 1.23; 95% CI, 0.85–1.79; $P = .28$). Non-CVD-related mortality showed a statistically significantly increased risk with missing ≥1 ART dose (HR, 1.44; 95% CI, 1.00–2.07; $P = .05$) and missing ≥2 ART doses (HR, 2.21; 95% CI, 1.37–3.57; $P = .001$).

Conclusions. Incomplete ART adherence was significantly associated with an increased risk for non-CVD-related mortality in PWH with virologic suppression. This highlights the potential role of nonadherence to ART as a driver of non-AIDS clinical outcomes.

Keywords. adherence; antiretroviral therapy; cardiovascular disease; viral suppression.

Despite achieving suppressed viral replication by conventional assays, persons with HIV (PWH) taking antiretroviral therapy (ART) have residual systemic inflammation that has been associated with the development of serious non-AIDS events and increased all-cause mortality [1, 2]. While the underlying causes of this residual inflammation and immune activation are not completely understood, they are likely to be multifactorial, requiring a multitargeted approach to reduce the inflammation [3]. Recently, ART nonadherence has been evaluated as a potential driver of the chronic inflammation observed in this population. Recent data have demonstrated that incomplete ART adherence is associated with increased levels of systemic inflammation, immune activation, and coagulopathy in virologically suppressed individuals [4–8] and that optimal adherence may lead to levels of inflammation similar to those observed in persons without HIV [9]. Several potential mechanisms to explain this association have been proposed, in particular that incomplete adherence could result in intermittent low-level HIV replication (ie, below the limit of detection by clinically available assays) [10–12], resulting in enhanced inflammation and immune activation [13, 14]. However, despite being identified in several studies, the association of incomplete adherence with

Received 29 October 2020; editorial decision 15 January 2021; accepted 18 January 2021.

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Open Forum Infectious Diseases®2021

DOI: 10.1093/ofid/ofab032

- 6971 PWH (74% male) from the Swiss HIV Cohort were included in the analysis (median age [interquartile range [IQR]], 39 [32–47]years).
- The median (IQR) follow-up was 8 (4–11) years, with 14 (8–23) adherence questionnaires collected per participant

Independent associations between incomplete adherence with non-CVD-related mortality in virally suppressed inividuals[14]

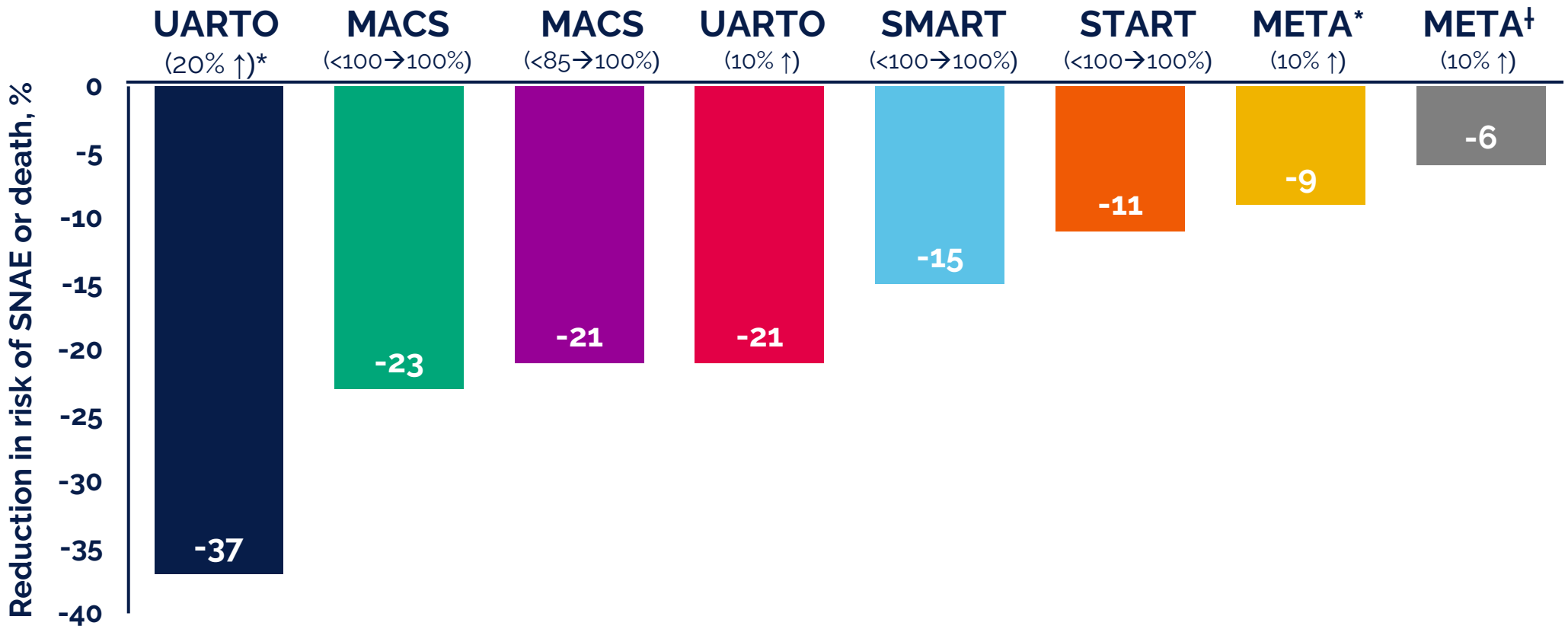
Characteristic	Non-CVD-Related Mortality[b] Univariate/Multivariate	*P* Value
Incomplete ART adherence[c]		
Missed ≥2 doses of ART in the last 4 wk		
Model 2b: Competing risk models with non-CVD-related death as a competing event with missing data imputed	186/186	
Univariate, n = 6971	2.21 (1.38–3.56)	.001
Multivariate, n = 6971	2.21 (1.37–3.57)	.001

- Missing ≥1 ART dose showed an increased, but not statistically significant, risk for CVD events (hazard ratio [HR], 1.23; 95% CI, 0.85–1.79; $P = .28$)

Castillo-Mancilla JR, et al. Open Forum Infect Dis 2021;8:ofab032.

Estimating the reduction in risk of serious non-AIDS events (SNAEs) or death associated with increasing ART adherence

Modelled reduction in the risk of SNAE and/or death based on changes in IL-6 and D-dimer for virally suppressed PWH who increase their ART adherence



*Modeled increases in ART adherence

*Early stage; ‡Late stage.

Castillo-Mancilla JR, et al. Open Forum Infect Dis 2023;10:ofad230.

CAB + RPV LA: Additional benefits beyond virologic suppression are consistently reported in RCTs and RWE

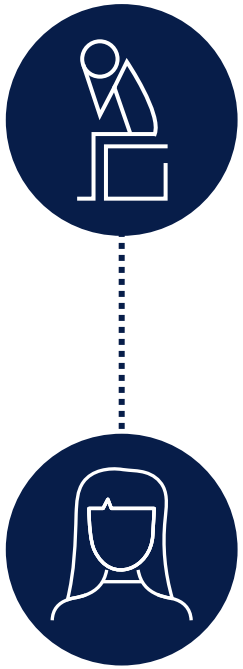
PREFERENCE / CHOICE | **OBSERVED ADHERENCE** | **QUALITY OF LIFE / STIGMA** | ENGAGEMENT IN CARE | OVERALL HEALTH

- ✓ **High preference** vs. daily oral ART and switching to CAB + RPV LA associated with **significant improvement in treatment satisfaction** vs oral ART[1,2, 20, 21, 24]
- ✓ **CAB+RPV consistently chosen** when given the opportunity to select preferred treatment option[1,2,21,24,25]
- ✓ **High, directly observed adherence*[1-7]** with greater adherence and **persistence vs daily oral ART** (including BIC/FTC/TAF)[8,9]
- ✓ **Superior virologic outcomes** in **people with adherence challenges**[22,23]

***RCTs:** ATLAS-2M Week 48 HCP-reported adherence: 98% (n=3,719);[1] SOLAR Month 12 HCP-reported adherence: 93% (n=2,527);[2] CARISEL Month 12 HCP-reported adherence: 93% (n=2,376);[3] CARES Week 96 HCP-reported adherence: 96% (n=1,039);[4] RWE: CARLOS Month 24 HCP-reported adherence: 94% (n=3,676);[5] BEYOND Month 24 HCP-reported adherence: 89% (n=2,509);[6] †BL vs 7 months: CrCl (Cockcroft-Gault) [90.9 mL/min (IQR: 78.2–101.6) vs 99.1 mL/min (IQR: 85.1–110.3); p=0.0001, respectively;[7] ‡HIV-specific PozQoL [score range 13–65], and EQ-5D-5L-US [score range 0–1])[8]; perception of own quality of life changes (greater or better) at Month 6 vs BL after switching to CAB + RPV LA; HIVDQoL score 88% vs 33% (p=0.01), respectively; HIVTSQs: Increased scores in all items, with therapy satisfaction reaching 5.9/6.0 at Month 13 §Switching to CAB + RPV LA helps reduce efforts to keep HIV status disclosed; HSS score at BL vs Month 6: 87.5% vs 33% (p=0.009), respectively;
HIVDQoL, HIV dependent quality of life; **HIVTSQs,** HIV treatment satisfaction survey status version; **HSS,** HIV stigma scale; **IQR,** interquartile range

References available upon request

A high proportion of people with HIV experience poor QoL



Despite the availability of highly effective, well tolerated daily oral ART, **many people with HIV experience poorer QoL than the general population**[1,2]

Factors negatively affecting HRQoL of people with HIV include **stigma, difficulties disclosing HIV status and multimorbidity**[3]

In addition to the UNAIDS targets for people with HIV in 2025, there is a proposed "fourth 90":[3–5]

Ensure the long-term wellbeing of people living with HIV

by addressing multimorbidity, HRQoL, stigma and discrimination

Addressing key unmet needs and improving HRQoL supports UNAIDS overall targets

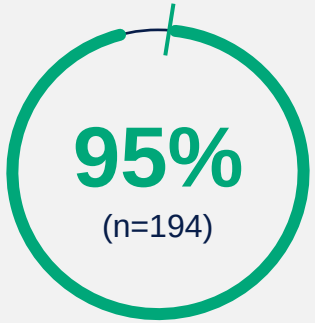
An integrated, person-centred approach is likely to enhance the HRQoL of people with HIV, reinforcing the importance of involving them in treatment discussions and shared decision making[3,5,6]

HRQoL, health-related quality of life; **UNAIDS,** Joint United Nations Programme on HIV/AIDS

1. Miners A, et al. Lancet HIV 2014;1:e32–40; **2.** Engelhard EAN, et al. AIDS 2018;32:103–12; **3.** Lazarus JV, et al. Nat Commun 2021;12:4450
4. UNAIDS. 2025 AIDS targets. Available at: https://aidstargets2025.unaids.org/ (accessed Jan 2025)
5. Okoli C, et al. AIDS Behav 2021;25:1384–95; **6.** Kall M, et al. Lancet HIV 2020;7:e59–68

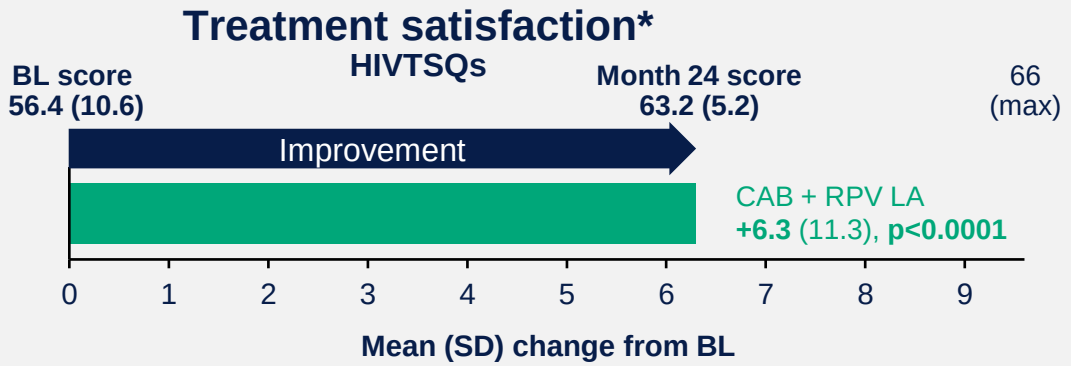
BEYOND: Improved PROs with CAB + RPV LA vs prior daily oral ART continues to be demonstrated after 2 years

Preference and treatment satisfaction



preferred CAB + RPV LA vs daily oral ART

mainly due to not worrying about remembering to take HIV-1 medication every day (85%) and being more convenient (84%)

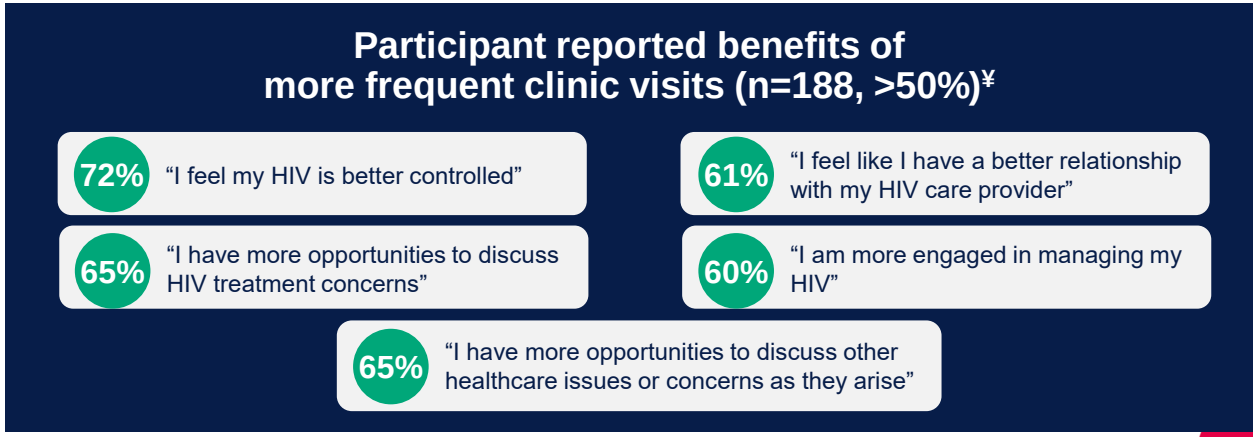


Psychological challenges, concerns, and benefits of more frequent clinic visits

Proportion of people with HIV reporting psychological challenges and feeling stigmatized by HIV-1 treatment decreased from BL (40%, n=308) to Month 24 (7%, n=192)

Concerns about CAB + RPV LA, e.g. effectiveness, tolerability, and administration logistics, decreased from BL to Month 24†

People with HIV found more frequent clinic visits to be beneficial to their care after 24 months on CAB + RPV LA‡



Footnotes available upon request
SD, standard deviation

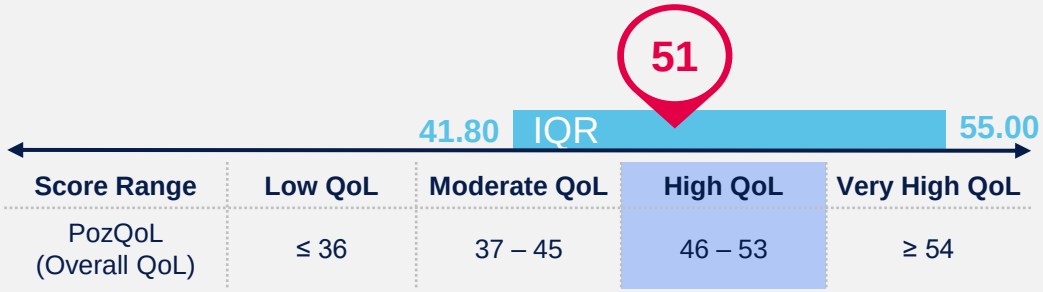
Felizarta et al. IAS 2025; Kigali, Rwanda. Poster THPEB036

CAB + RPV LA: High and improved QoL in people switching from oral ART

ADELPHI study showed high health-related quality of life (HRQoL) and EQ-5D-5L-US* scores in a cross-sectional survey of those switching to CAB + RPV LA[1]

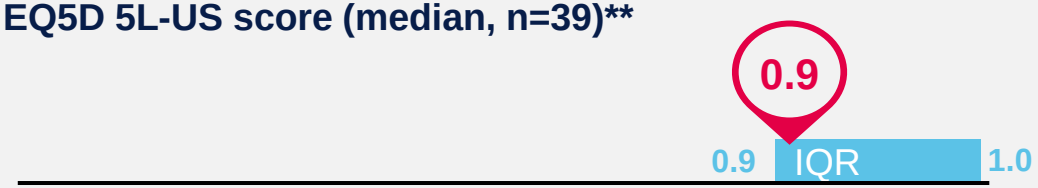
PWH-Reported HRQoL Summary Scores

Overall PozQoL score (median, n=38)*



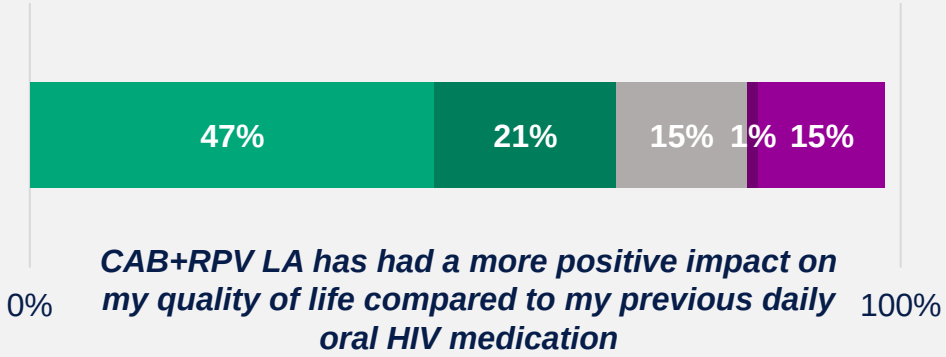
Score Range	Low QoL	Moderate QoL	High QoL	Very High QoL
PozQoL (Overall QoL)	≤ 36	37 – 45	46 – 53	≥ 54

EQ5D 5L-US score (median, n=39)**



PREFER-LA study showed self-reported improvement in quality of life in participants who switched from daily oral ART to CAB+RPV LA[2]

Quality of Life Impact (n=159)



*HIV-specific PozQoL score range 13-65; **EQ-5D-5L-US score range 0-1 where 1.0 represents best possible health state
PWH, people with HIV

1. Brogan et al. IDWeek 2024 Poster P-538;
2. Henry Z, et al. IDWeek 2025. Poster P-396

CAB + RPV LA: Additional benefits beyond virologic suppression are consistently reported in RCTs and RWE

PREFERENCE / CHOICE

- ✓ **High preference** vs. daily oral ART and switching to CAB + RPV LA associated with **significant improvement in treatment satisfaction** vs oral ART[1,2, 20, 21, 24]
- ✓ **CAB+RPV consistently chosen** when given the opportunity to select preferred treatment option[1,2,21,24,25]

OBSERVED ADHERENCE

- ✓ **High, directly observed adherence*[1-7]** with greater adherence and **persistence vs daily oral ART** (including BIC/FTC/TAF)[8,9]
- ✓ **Superior virologic outcomes** in **people with adherence challenges**[22,23]

QUALITY OF LIFE / STIGMA

- ✓ **High and improved quality of life,‡**[8,13-19] including **alleviation** of **psychological challenges** and **reduced stigma**[§13,16,20]

ENGAGEMENT IN CARE

OVERALL HEALTH

*RCTs: ATLAS-2M Week 48 HCP-reported adherence: 98% (n=3,719);[1] SOLAR Month 12 HCP-reported adherence: 93% (n=2,527);[2] CARISEL Month 12 HCP-reported adherence: 93% (n=2,376);[3] CARES Week 96 HCP-reported adherence: 96% (n=1,039);[4] RWE: CARLOS Month 24 HCP-reported adherence: 94% (n=3,676);[5] BEYOND Month 24 HCP-reported adherence: 89% (n=2,509);[6] †BL vs 7 months: CrCl (Cockcroft-Gault) [90.9 mL/min (IQR: 78.2–101.6) vs 99.1 mL/min (IQR: 85.1–110.3); p=0.0001, respectively;[7] ‡HIV-specific PozQoL [score range 13–65], and EQ-5D-5L-US [score range 0–1])[8]; perception of own quality of life changes (greater or better) at Month 6 vs BL after switching to CAB + RPV LA; HIVDQoL score 88% vs 33% (p=0.01), respectively; HIVTSQs: Increased scores in all items, with therapy satisfaction reaching 5.9/6.0 at Month 13 §Switching to CAB + RPV LA helps reduce efforts to keep HIV status disclosed; HSS score at BL vs Month 6: 87.5% vs 33% (p=0.009), respectively;
HIVDQoL, HIV dependent quality of life; **HIVTSQs,** HIV treatment satisfaction survey status version; **HSS,** HIV stigma scale; **IQR,** interquartile range

References available upon request

CAB + RPV LA: Strong interest and willingness to switch to LA reinforces the importance of choice and shared decision making

Importance of choice

VOLITION[1]

When asked how it felt to be **given a choice about their future** HIV treatment (n=155):

72% felt happy to know there are options that **match their lifestyle**,

55% said it provides them with an option to **suit their needs** and daily life, and

53% felt **hope**

Interest in CAB+RPV LA

VOLITION[1]

85% (129/151) Of ART-naïve people rapidly suppressed on DTG+3TC, **chose to switch to CAB+RPV LA on DoC**

CARES[2]

78% (50/64) Of people on first-line oral ART **expressed a willingness to switch to CAB+RPV LA**

Shared decision making

Positive Perspectives 3

People involved in their care and **making joint treatment decisions** more commonly reported **optimal self-rated mental, sexual, physical and overall health**[3]

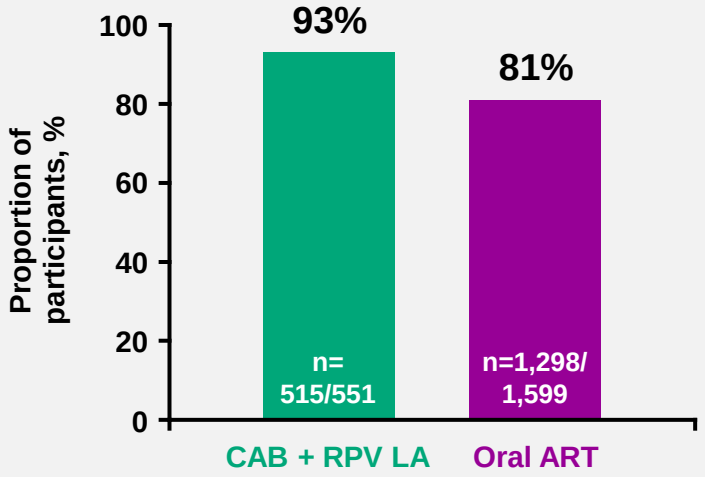
Those **satisfied** with their treatment reported **higher** rates of **self-rated health** and **adherence**[4]

VOLITION: Participant-experience data at BL and DoC using questionnaires; CARES: In-depth interviews conducted with 69 participants on CAB+RPV LA and 64 on oral ART (only data for oral ART shown); PP3: Cross-sectional survey of people living with HIV on ART (n=698)

1. Cordova E, et al. Open Forum Infect Dis. 2026; ofag383;
2. Durden E, et al. IAS 2025. Kigali, Rwanda. Poster LB38;
3. Patel et al. IAS 2025. Kigali, Rwanda. Poster EP0608
4. Patel et al. IAS 2025. Kigali, Rwanda. Poster WEPED080

CAB + RPV LA: Greater engagement and retention in care compared with daily oral ART

The real-world OPERA study found that a **higher proportion** of people with HIV who switched to CAB + RPV LA were **retained in care** versus oral ART after ≥12 months of follow up*[1]



The real-world BEYOND study found people with HIV who switched to CAB + RPV LA **reported greater engagement in care, more chances to discuss treatment, stronger relationships with providers, and increased involvement** in managing their HIV.[2]

Participant-reported benefits of more frequent clinic visits (n=227, >50%)[1]**

- 71% "I feel my HIV is better controlled"
- 57% "I feel like I have a better relationship with my HIV care provider"
- 64% "I have more opportunities to discuss HIV treatment concerns"
- 55% "I am more engaged in managing my HIV"

*CDC's definition of retention in care: two or more VL or CD4 tests per year, ≥3 months apart[4]

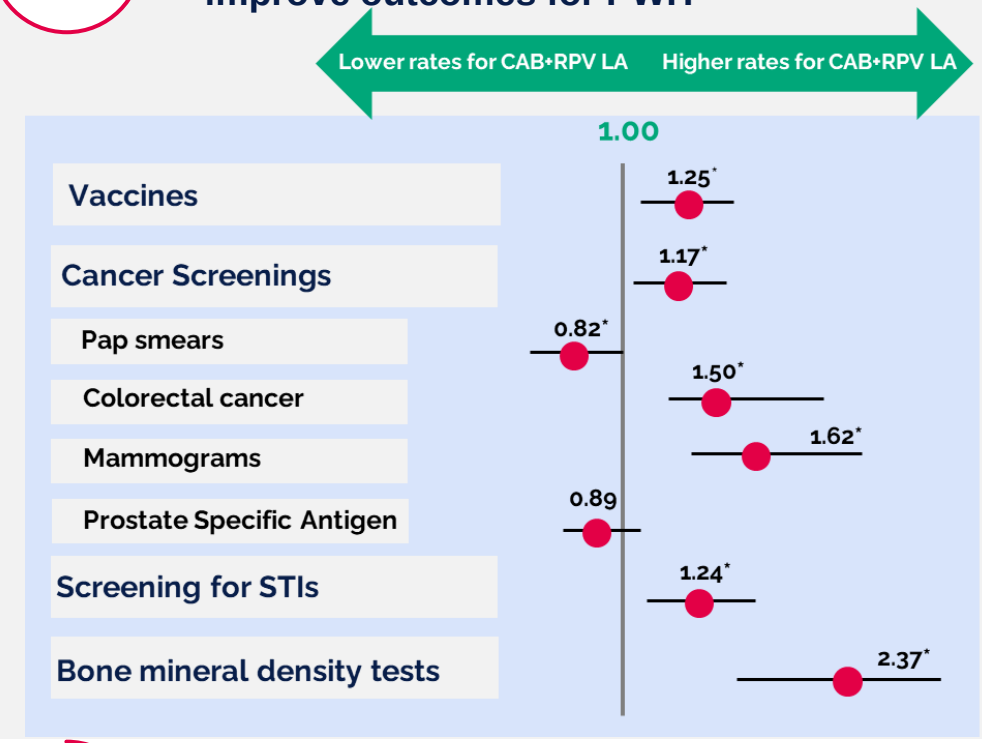
**Responses were not mutually exclusive.

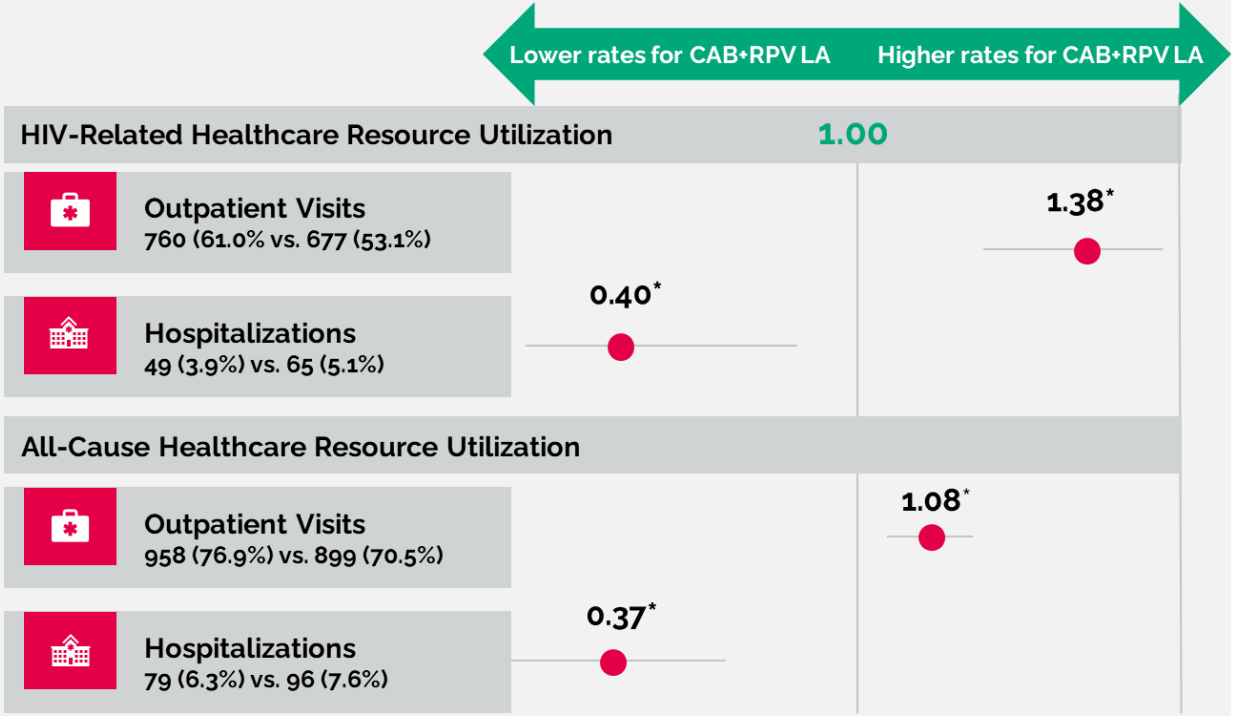
CDC, Centers for Disease Control and Prevention; **STI,** sexually transmitted infections

1. Lackey PC, et al. AIDS 2024. Poster WEPEC319
2. Valenti W, et al. AIDS 2024. Poster TUPEB116

CAB + RPV LA: Provides the opportunity for additional healthcare touchpoints and potential ancillary benefits

ABOVE showed that those switching to CAB + RPV LA had higher rates of vaccinations, cancer screenings, and bone density testing. In the CAB+RPV LA cohort, hospitalization rates were lower, suggesting that **more healthcare interactions could improve outcomes for PWH**[3]





OPERA also showed that an **increase in HCP touchpoints** gave additional opportunities for more STI testing and vaccine administration.[1,2]

*CDC's definition of retention in care: two or more VL or CD4 tests per year, ≥3 months apart[4]
CDC, Centers for Disease Control and Prevention; **STI,** sexually transmitted infections

1. Lackey PC, et al. AIDS 2024. Poster WEPEC319
2. Lackey PC, et al. IDWeek 2024. Poster 577; **3.** Garris et a; AMCP 2025, Houston, TX. Poster B6

Sana Clinic
CAB+RPV LA use in people who inject drugs at a harm reduction clinic

Setting

Sana Clinic, a harm-reduction clinic at Prevention Point in Philadelphia, PA

Study and population

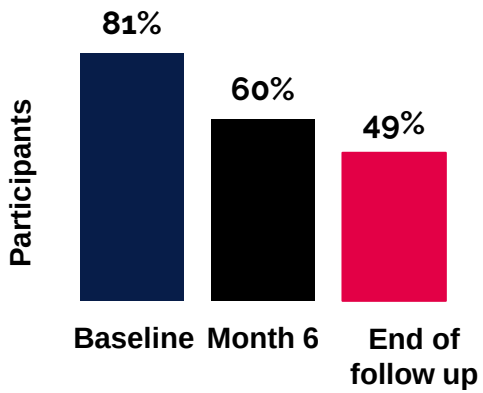
Retrospective cohort of **40 PWH with history of IDU** who initiated CAB+RPV LA between Feb 2022 and June 2025 with at least 6 months of follow up

Patient Characteristics

- 65% male; 95% cisgender;
- 57.5% White; 25% Black; 17.5% Latinx
- 57.5% Unstably housed
- 92.5% reported history of OUD

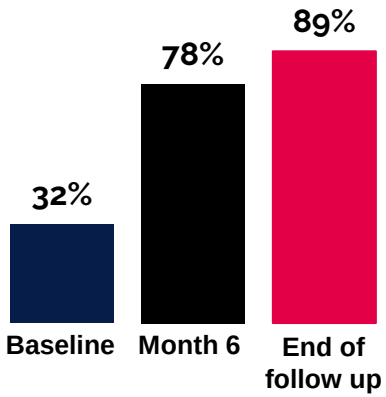
Opioid Use Disorder Outcomes

Self-reported opioid use



Opioid use declined over study period

MOUD uptake and retention

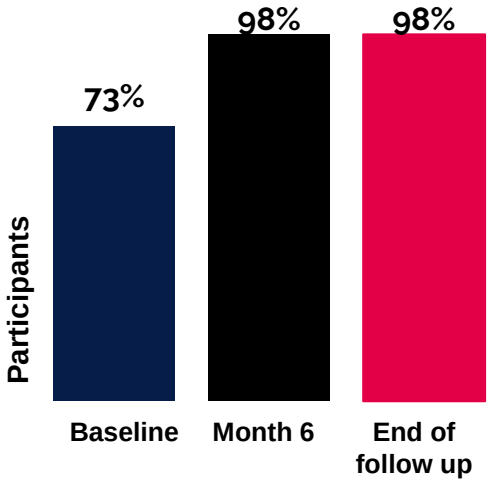


MOUD uptake increased over study period

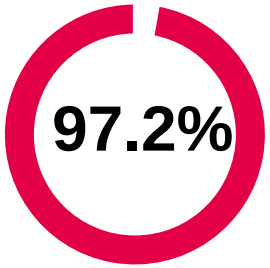
✓ 40% of MOUD initiations were within first 2 months of switch and 91% remained on treatment

HIV Outcomes

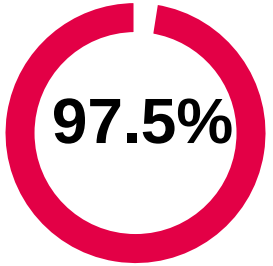
HIV-1 RNA <200 copies/mL



Retention among survivors



Participants with no missed doses



✓ **32.5%** received doses at alternative sites

✓ **22.5%** received doses incarcerated

Switching to CAB+RPV LA was associated with improved viral suppression and engagement in Opioid Use Disorder Treatment among

MOUD, medication for opioid use disorder; OUD, opioid use disorder; IDU, injection drug use.

Whidden et al AIDS 2026; Rio de Janeiro, Brazil. Poster TUPEE558.

CAB + RPV LA evidence spans a broad spectrum of PLWH—from newly suppressed people to adherence challenges, with or without viremia

NEWLY SUPPRESSED → **AT RISK OF NON-ADHERENCE** → **DOCUMENTED ADHERENCE CHALLENGES WITH OR WITHOUT VIREMIA**

VOLITION[1]	LATA[2]	IMPALA[3]	LATITUDE[4]	UCSD[5]	SUPLA[6]	CROWN[7]
Switch immediately after achieving suppression	Suppressed adolescents; no prior failure	Suppressed adults on DTG-based ART	Adherence challenges; ≤200 c/mL before switch	Recent viremia / poor oral response / lost to follow-up	Suboptimal suppression on oral ART; ≥200 c/mL at switch	Viremic; insufficient response to oral ART
DoC:85% chose CAB+RPV LA	**Superior efficacy at W96**	**Non-inferior at W96; 93% preferred LA**	**Superior virologic outcomes vs oral SOC**	**81% / 77% <200 c/mL at W48 / W96**	**88% vs 55% <200 c/mL at W24**	**Ongoing Phase IIIb; N~332; M6 endpoint**

✓**Most common Grades 1 to 4 AEs** in ≥2% participants in label: ISRs, pyrexia, fatigue, headache, musculoskeletal pain, nausea, sleep disorders, dizziness, and rash

✓**ISRs through Week 48**: FLAIR and ATLAS, 83% reported ISR, 1% discontinued due to ISRs; ATLAS-2M, 75% reported any ISR, <1% discontinued due to ISRs

Together, the program evaluates CAB + RPV LA from choice-led early switch through increasingly complex adherence challenges—with and without viremia.

CAB, cabotegravir; **DoC**: Day of Choice; **ISR**, injection site reactions; **LA,** long-acting; **PLWH**, people living with HIV; **RPV**, rilpivirine; **SOC**, standard of care

1. Cordova E, et al. Open Forum Infect Dis. 2026; ofag383. 2. Dangarembizi M, et al. AIDS 2026. Abstract OAX1105LB. 3. Ruzagira E, et al. AIDS 2026. Poster LB24. 4. Rana A, et al. NEJM 2026, 394(9): 858-871. 5. Ostrer L et al AIDS 2026. Poster TUPEB106. 6. Chen NY, et al. CROI 2026. Poster 530. 7. CROWN (NCT06694805). Available at: https://clinicaltrials.gov/study/NCT06694805 (accessed Mar 2026)

CAB + RPV LA: Additional benefits beyond virologic suppression are consistently reported in RCTs and RWE

PREFERENCE / CHOICE

- ✓ **High preference** vs. daily oral ART and switching to CAB + RPV LA associated with **significant improvement in treatment satisfaction** vs oral ART[1,2, 20, 21, 24]
- ✓ **CAB+RPV consistently chosen** when given the opportunity to select preferred treatment option[1,2,21,24,25]

OBSERVED ADHERENCE

- ✓ **High, directly observed adherence*[1-7]** with greater adherence and **persistence vs daily oral ART** (including BIC/FTC/TAF)[8,9]
- ✓ **Superior virologic outcomes** in **people with adherence challenges**[22,23]

QUALITY OF LIFE / STIGMA

- ✓ **High and improved quality of life,‡**[8,13-19] including **alleviation** of **psychological challenges** and **reduced stigma**[§13,16,20]

ENGAGEMENT IN CARE

- ✓ **High retention** in care[10]
- ✓ **Regular HCP interactions** support sustained **engagement in HIV management** and **improved relationships with HCPs**[8,10-12,26]

OVERALL HEALTH

- ✓ **High** rates of **preventative health screenings** and **vaccinations**[10-12]
- ✓ **Lower** observed rates of **hospitalization (all cause and HIV-related)**[12]
- ✓ **Reduced opioid use** following switch to CAB+RPV LA[27]

*****RCTs: ATLAS-2M Week 48 HCP-reported adherence: 98% (n=3,719);[1] SOLAR Month 12 HCP-reported adherence: 93% (n=2,527);[2] CARISEL Month 12 HCP-reported adherence: 93% (n=2,376);[3] CARES Week 96 HCP-reported adherence: 96% (n=1,039);[4] RWE: CARLOS Month 24 HCP-reported adherence: 94% (n=3,676);[5] BEYOND Month 24 HCP-reported adherence: 89% (n=2,509);[6] **†**BL vs 7 months: CrCl (Cockcroft-Gault) [90.9 mL/min (IQR: 78.2–101.6) vs 99.1 mL/min (IQR: 85.1–110.3); p=0.0001, respectively;[7] **‡**HIV-specific PozQoL [score range 13–65], and EQ-5D-5L-US [score range 0–1])[8]; perception of own quality of life changes (greater or better) at Month 6 vs BL after switching to CAB + RPV LA; HIVDQoL score 88% vs 33% (p=0.01), respectively; HIVTSQs: Increased scores in all items, with therapy satisfaction reaching 5.9/6.0 at Month 13
§Switching to CAB + RPV LA helps reduce efforts to keep HIV status disclosed; HSS score at BL vs Month 6: 87.5% vs 33% (p=0.009), respectively;
HIVDQoL, HIV dependent quality of life; **HIVTSQs,** HIV treatment satisfaction survey status version; **HSS,** HIV stigma scale; **IQR,** interquartile range

References available upon request

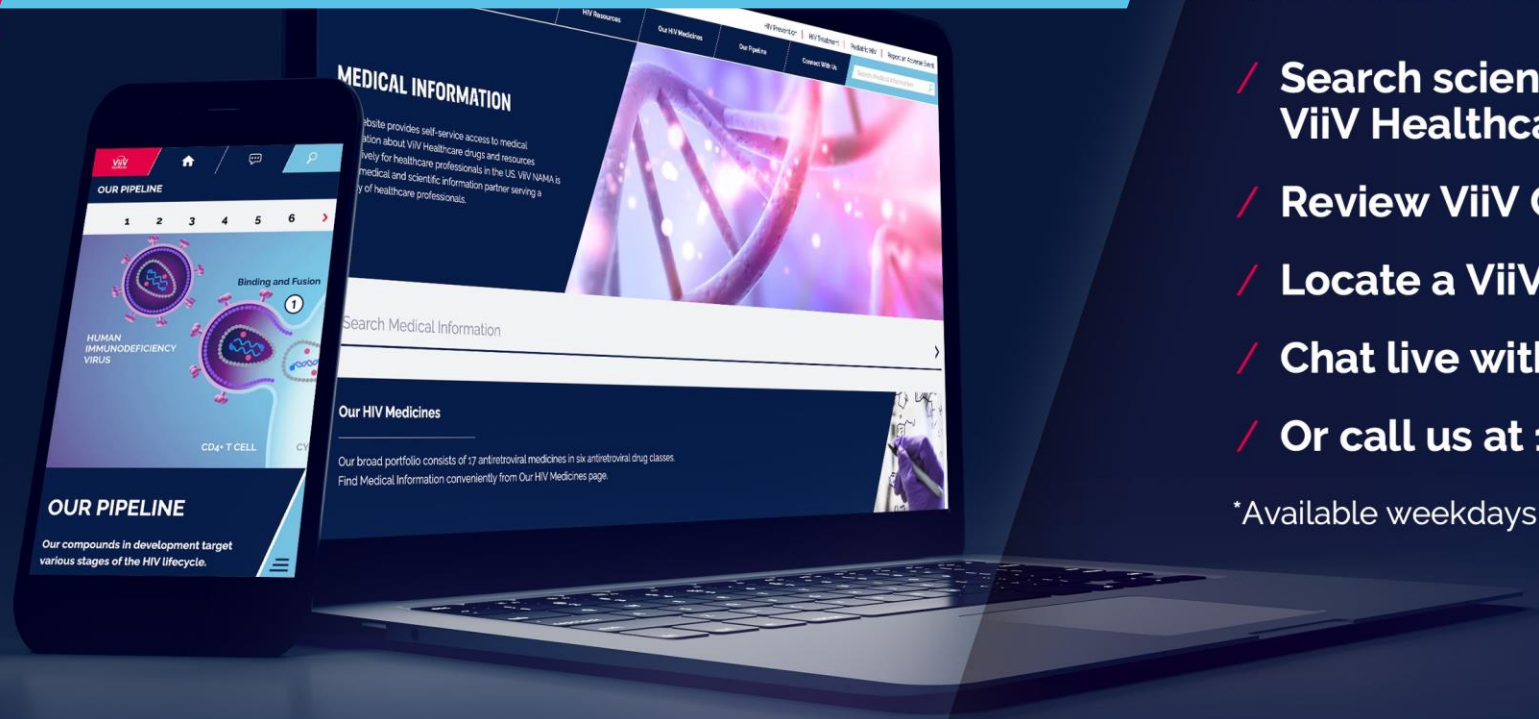
Q & A

- **Please use the Q&A function to submit comments and questions**
- **If we are unable to get to your question, we will ensure to follow up with you!**

FEEDBACK

Tell us what you think of today's program

Thank You!



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