



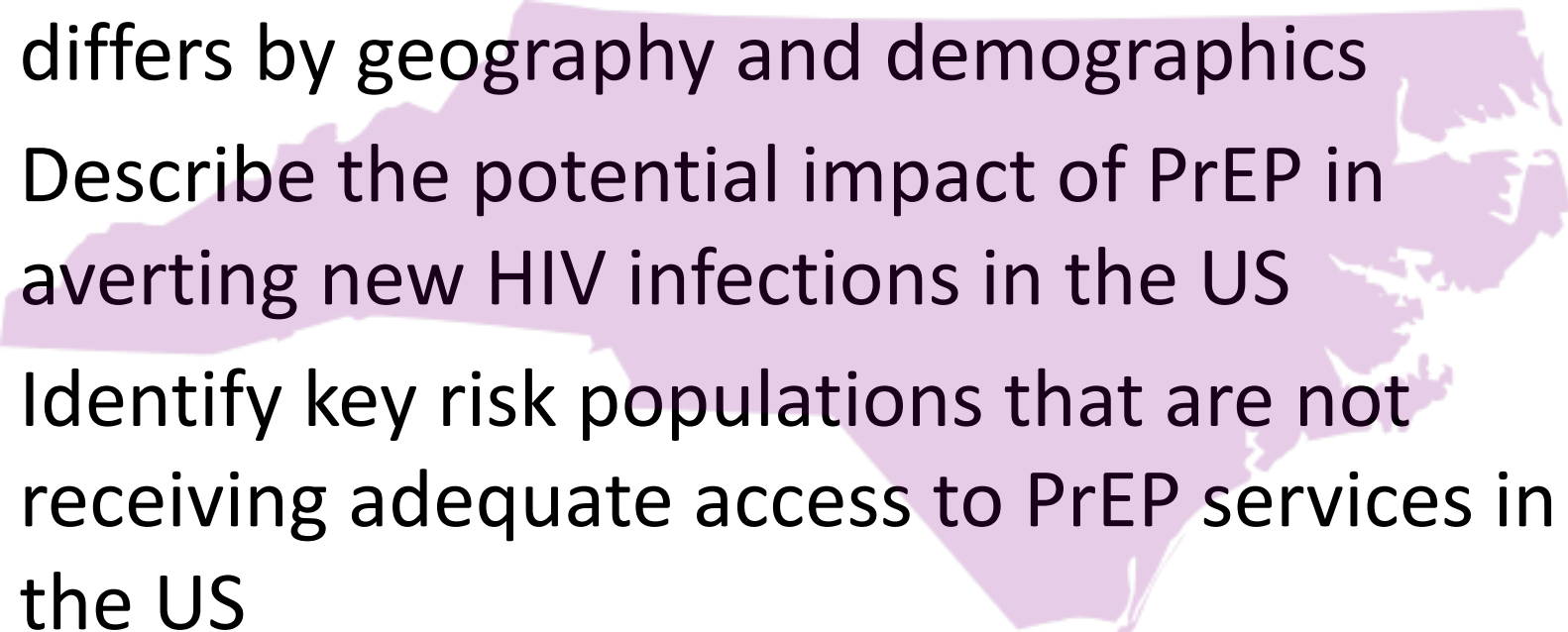
Creating a PrEP Network: Making HIV Prevention Happen

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Objectives

- Outline how the lifetime risk of HIV acquisition differs by geography and demographics
 - Describe the potential impact of PrEP in averting new HIV infections in the US
 - Identify key risk populations that are not receiving adequate access to PrEP services in the US
- 

Greg

26 year old Black MSM presents to primary care for skin rash

- Waiting tables and going to night school for accounting
- Not in a stable relationship currently
 - Uses condoms with some partners, but not all
 - Versatile for anal sex
- Rectal gonorrhoea 2014, NGU 2011
 - Currently on no daily medications
- Uninsured
- Exam reveals lesions c/w secondary syphilis

Karen

35-year-old woman who presents for a routine annual visit

- Treated for Chlamydial infection 4 months ago after presenting to an STD clinic with dysuria
- Struggling to pay bills and sometimes exchanges sex for money/food with 2 of her previous boyfriends

Question to Discuss

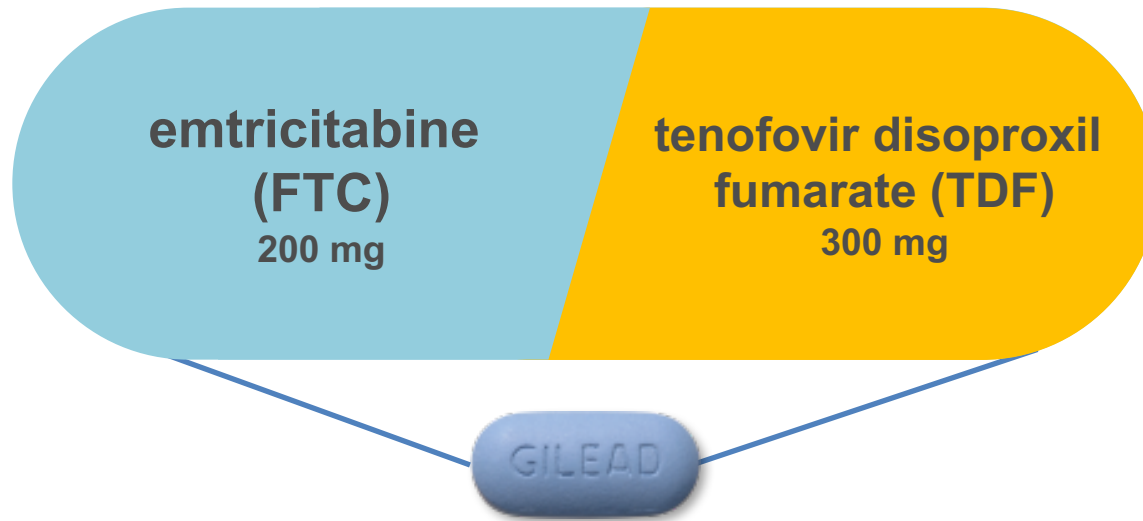
What can we offer Greg and Karen to help prevent them from acquiring HIV?

Multiple, proven prevention strategies



TDF/FTC FOR PrEP

- PrEP is Pre-Exposure Prophylaxis for HIV
 - Use of an anti-HIV medication before an exposure
- TDF/FTC (Truvada) once daily is indicated in combination with safer sex practices for PrEP to reduce the risk of sexually acquired HIV-1 in adults at high risk
- This indication is based on clinical trials in MSM at high risk for HIV-1 infection and in heterosexual serodiscordant couples



Does Greg Meet the Criteria for PrEP?

US Public Health Service

PREEXPOSURE PROPHYLAXIS FOR THE PREVENTION OF HIV INFECTION IN THE UNITED STATES - 2014

A CLINICAL PRACTICE GUIDELINE



Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2014 Clinical Practice Guideline Page 1 of 67

HIV uninfected, plus:

- Any HIV-positive partner(s)
- Condomless sex in past 6 months
 - Any STI in past 6 months
- High number of sex partners
 - In high-prevalence area or sexual network
 - Commercial sex work
- Shared injection equipment
 - Recent drug treatment and current relapse

Does Greg Meet the Criteria for PrEP?

Clinical Infectious Diseases
MAJOR ARTICLE

HIV/AIDS

Willingness to Take, Use of, and Indications for Pre-exposure Prophylaxis Among Men Who Have Sex With Men—20 US Cities, 2014

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¹Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention, Atlanta, Georgia; and ²Department of Sciences, Karolinska Institute, Stockholm, Sweden

Background. Pre-exposure prophylaxis (PrEP) is an effective prevention tool for people at substantial risk of acquiring immunodeficiency virus (HIV). To monitor the current state of PrEP use among men who have sex with men (MSM), we assessed willingness to use PrEP and PrEP utilization. To assess whether the MSM subpopulations at highest risk for infection had indications for PrEP according to the 2014 clinical guidelines, we estimated indications for PrEP by demographic characteristics among MSM.

Methods. We analyzed data from the 2014 cycle of the National HIV Behavioral Surveillance (NHBS) system among MSM who tested HIV negative in NHBS and were currently sexually active. Adjusted prevalence ratios and 95% confidence intervals were estimated from log-linked Poisson regression with generalized estimating equations to explore differences in willingness to take PrEP use, and indications for PrEP.

Results. Whereas over half of MSM said they were willing to take PrEP, only about 4% reported using PrEP. PrEP use was higher among white compared with black and young MSM of other races/ethnicities.

Conclusions. Young, black MSM, despite being at high risk of HIV acquisition, may not have indications for PrEP according to current guidelines. Clinicians may need to consider other factors besides risk behaviors such as HIV incidence and sexual network characteristics when considering prescribing PrEP.

Keywords. HIV; pre-exposure prophylaxis; PrEP; MSM; United States.

Men who have sex with men (MSM) are at increased risk of human immunodeficiency virus (HIV) infection. Despite representing only 2% of the US population, MSM accounted for 65% of estimated HIV diagnoses in the United States in 2013 [1]. Among MSM, blacks are disproportionately affected by HIV. In 2010, black MSM accounted for 42% of estimated incident HIV infections attributed to male-to-male sexual contact, whereas blacks accounted for only about 12% of the US population [2, 3]. The largest number of new infections among black MSM (45%) occurred in those aged 13–24 years, and new infections increased 20% in this age group from 2008 to 2010 [2]. These data indicate a need for increased HIV prevention efforts to further reduce new HIV infections, especially among young black MSM.

Pre-exposure prophylaxis, or PrEP, is an effective prevention tool for people at substantial risk of HIV infection [4]. When

IDSA
Infectious Diseases Society of America

hivma
by medicine association

CEPPH

Young, Black MSM were less likely to have an indication for PrEP
≥ 2 sex partners plus either:
bacterial STI or UAI in past 12 months
1 main HIV-positive partner in past 12 months

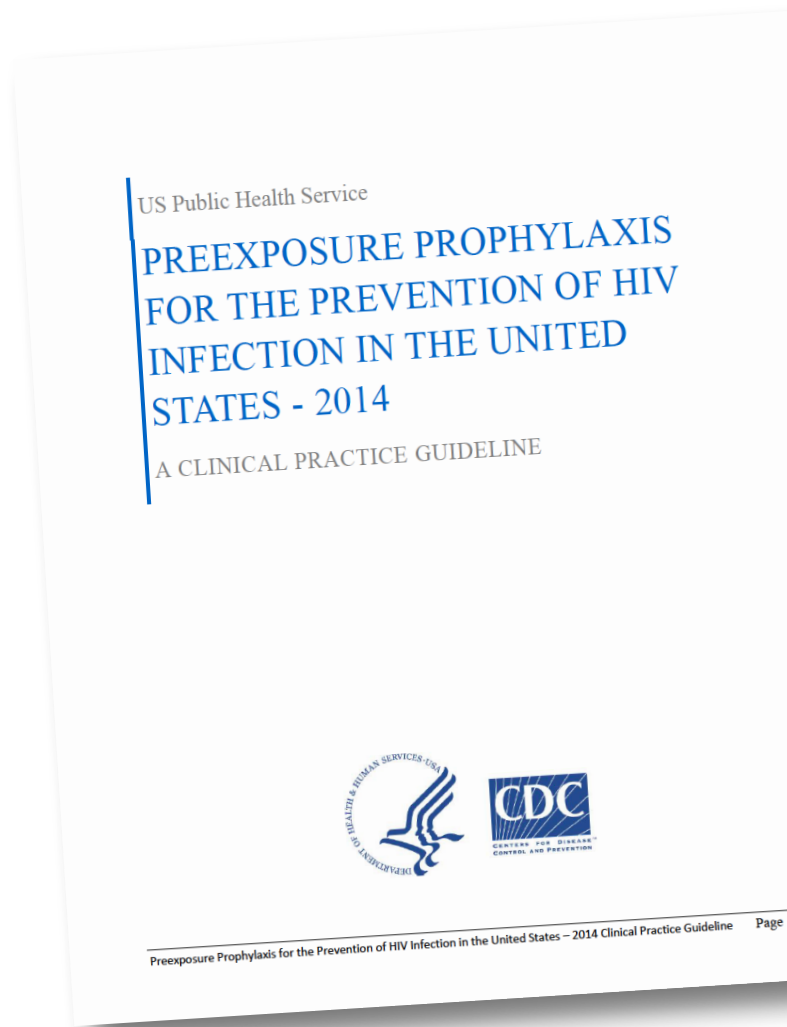
Sexual behavior alone is insufficient to explain higher incidence among Black MSM
In high-prevalence networks, fewer missteps needed to acquire HIV

taken consistently, PrEP has been shown to reduce HIV risk by up to 92% among MSM in randomized trials [5]. The US Food and Drug Administration approved tenofovir disoproxil fumarate as daily oral PrEP in 2012, and PrEP is now covered by many health insurance plans [6]. In 2014, the Centers for Disease Control and Prevention (CDC) published clinical guidelines for PrEP use in populations at high risk for HIV, including MSM on sexual or injection drug use behaviors [7]. PrEP is recommended for HIV-uninfected adults who are in a sexual partnership with an HIV-uninfected man, and for those who are in a sexual partnership with an HIV-uninfected man, and for those who meet one of the following criteria: condomless anal sex in the past 6 months, a sexually transmitted infection in the past 6 months, or an ongoing sexual relationship with an HIV-infected male partner.

MSM = men who have sex with men; UAI = unprotected anal intercourse.

Hoots BE, et al. *Clin Infect Dis*. 2016;63(5):672-677; Maulsby C, et al. *AIDS Behav*. 2014;18(1):10-25.

Does Karen Meet the Criteria for PrEP?



- HIV uninfected, plus:
- Any HIV-positive partner(s)
 - **Condomless sex in past 6 months**
 - **Any STI in past 6 months**
 - High number of sex partners
 - In high-prevalence area or sexual network
 - Commercial sex work
 - Shared injection equipment
 - Recent drug treatment and current relapse

CDC: Numbers of Persons at Risk for HIV Remain High, but Percentages Vary by Population

Estimated percentages and numbers of adults with indications for PrEP, by transmission risk group, United States, 2015

| Transmission risk group | % with PrEP indication* | Estimated number | (95% CI) |
|---|-------------------------|------------------|-------------------|
| Men who have sex with men, aged 18-59 yrs [†] | 24.7 | 492,000 | 212,000-772,000 |
| Adults who inject drugs, aged ≥18yrs [§] | 18.5 | 115,000 | 45,000-185,000 |
| Heterosexually active adults, aged 18-59 yrs [¶] | 0.4 | 624,000 | 404,000-846,000 |
| Men** | 0.2 | 157,000 | 62,000-252,000 |
| Women | 0.6 | 468,000 | 274,000-662,000 |
| Total | | 1,232,000 | 661,000-1,803,000 |

CI = confidence interval.

*Percentage of all estimated persons in each transmission risk group and demographic subset with PrEP indications.

[†]Based on 2007–2012 National Health and Nutrition Examination Survey (NHANES) data, weighted as recommended using current population estimates. Risk factors used to define PrEP indications included two or more male sex partners and at least one of the following: any condomless sex or sexually transmitted infection diagnosis in past 12 months.

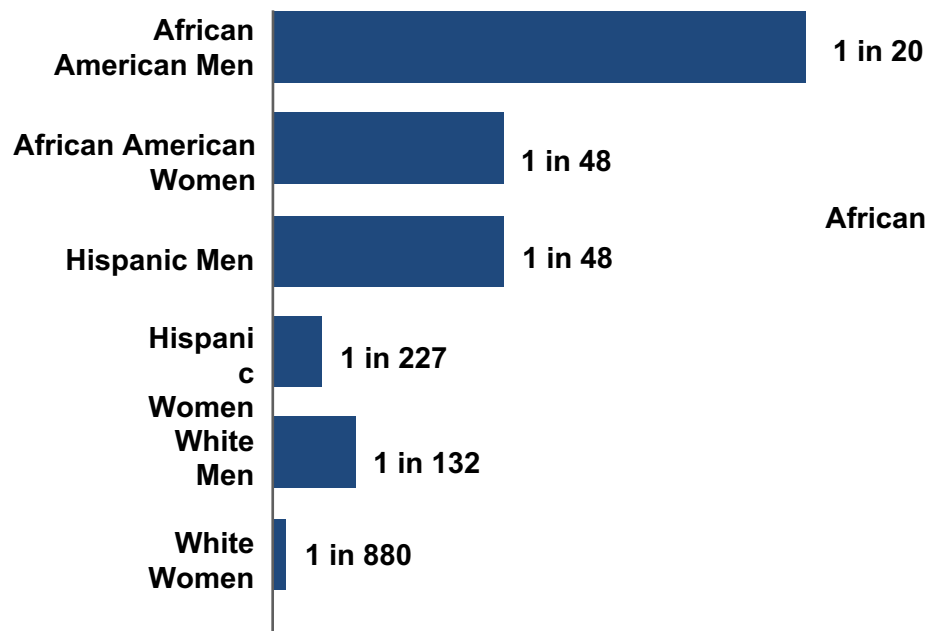
[§]Based on 2013 National Survey on Drug Use and Health. Risk factors used to define PrEP indications included injection of heroin, methamphetamine, stimulants, or cocaine, and injecting with a needle used by someone else before them.

[¶]Based on 2011–2013 National Survey of Family Growth and 2007–2012 NHANES data, weighted as recommended using current population estimates. Risk factors used to define PrEP indications included two or more opposite sex partners and at least one of the following: sex with an HIV positive partner; or any condomless sex in the last 4 weeks and sex with a male who injects drugs or bisexual male (females only) in last 12 months.

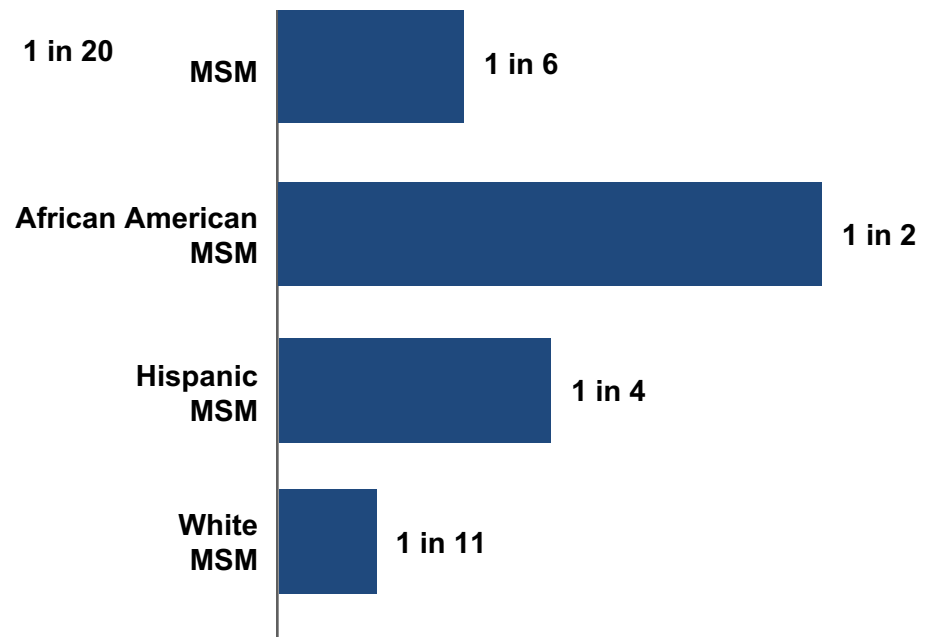
**The relative standard error for males was 30.09%.

African Americans Have the Highest Lifetime Risk of HIV Diagnosis

Lifetime Risk of HIV Diagnosis by Ethnicity¹

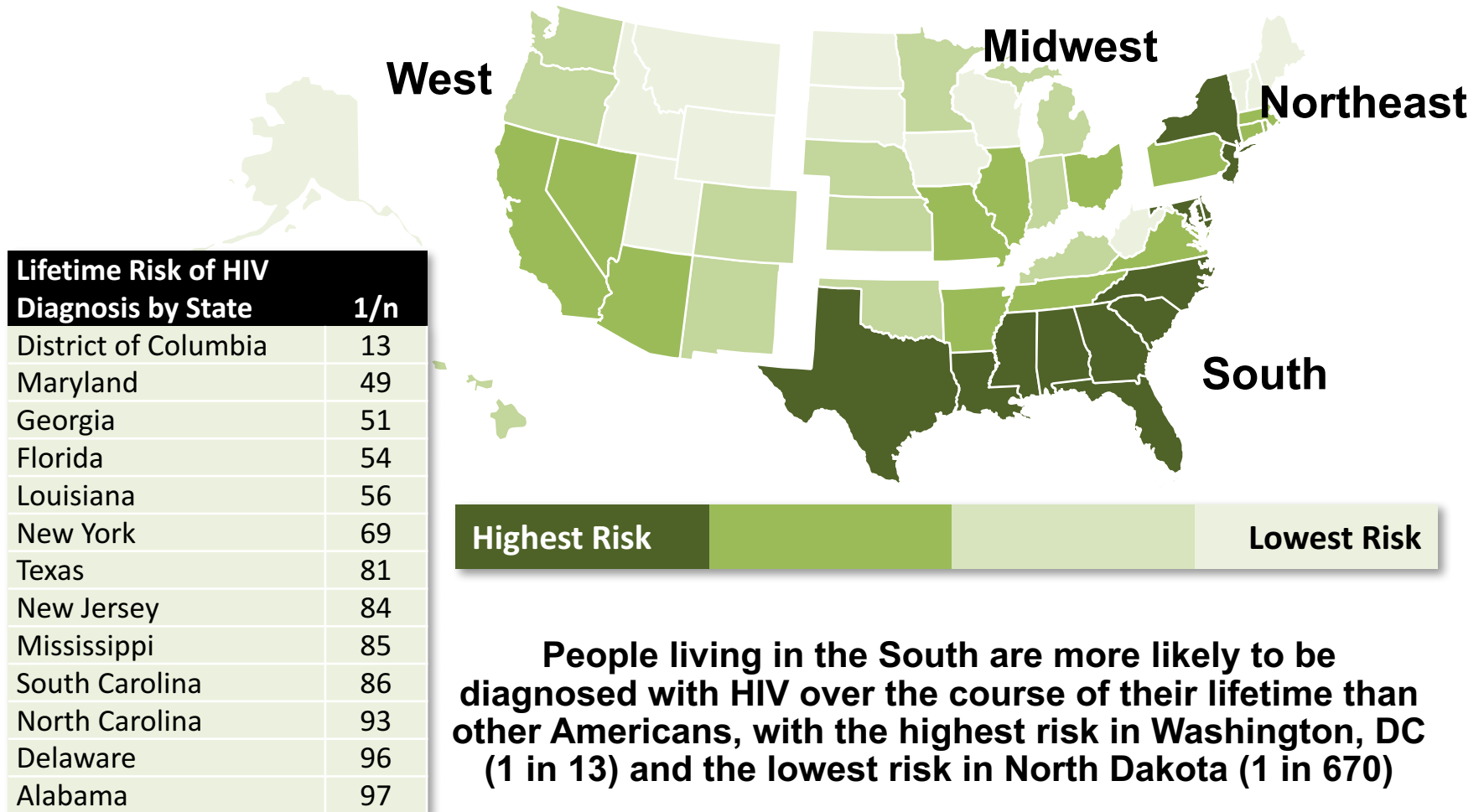


Lifetime Risk of HIV Diagnosis Among MSM, Overall and by Race/Ethnicity¹

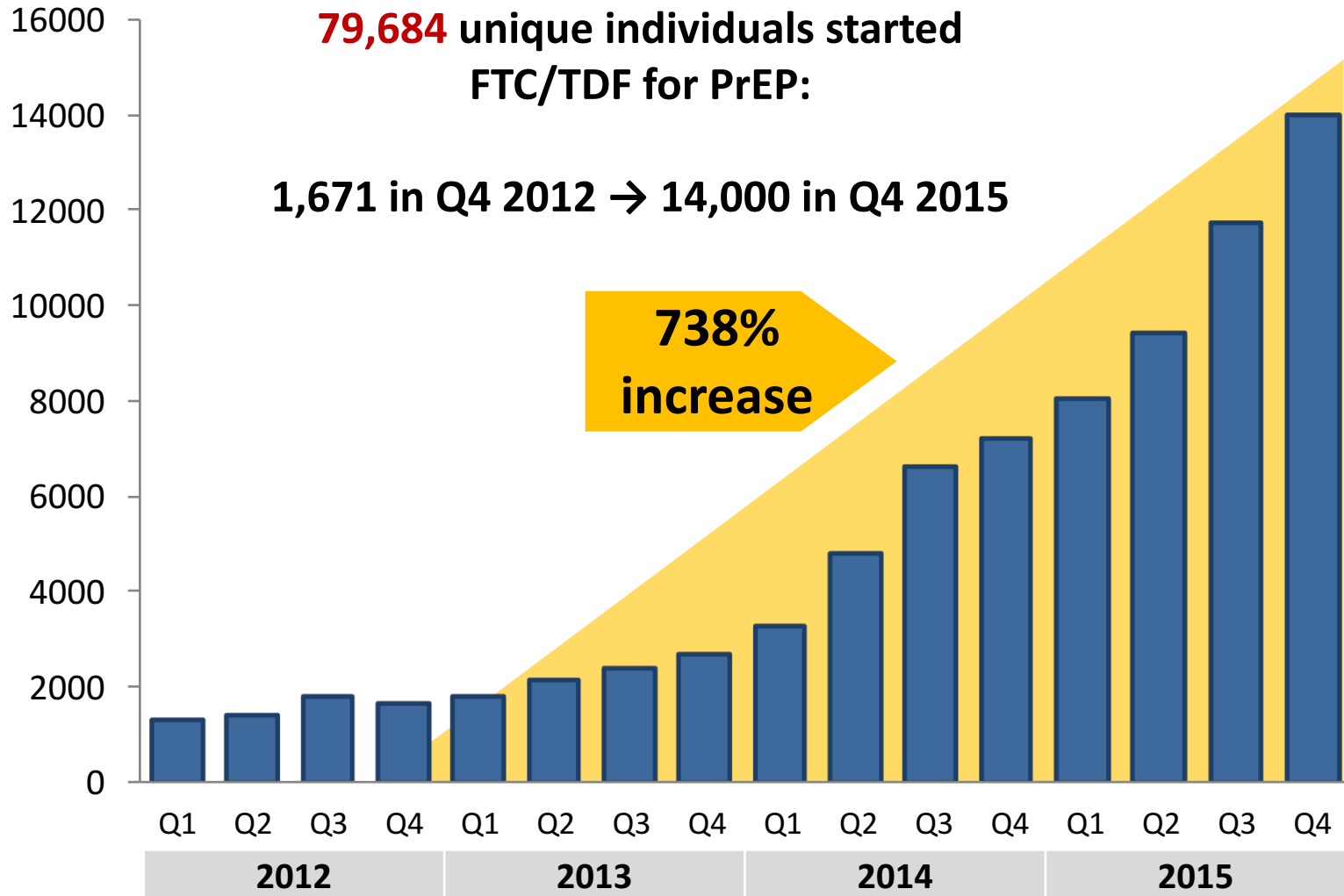


- African Americans are the most affected ethnic group with a lifetime HIV risk of 1 in 20 for men (compared to 1 in 132 for whites) and 1 in 48 for women (compared to 1 in 880 for whites)¹
- African American MSM and Hispanic MSM have a 1 in 2 and 1 in 4 lifetime risk of HIV infection, respectively

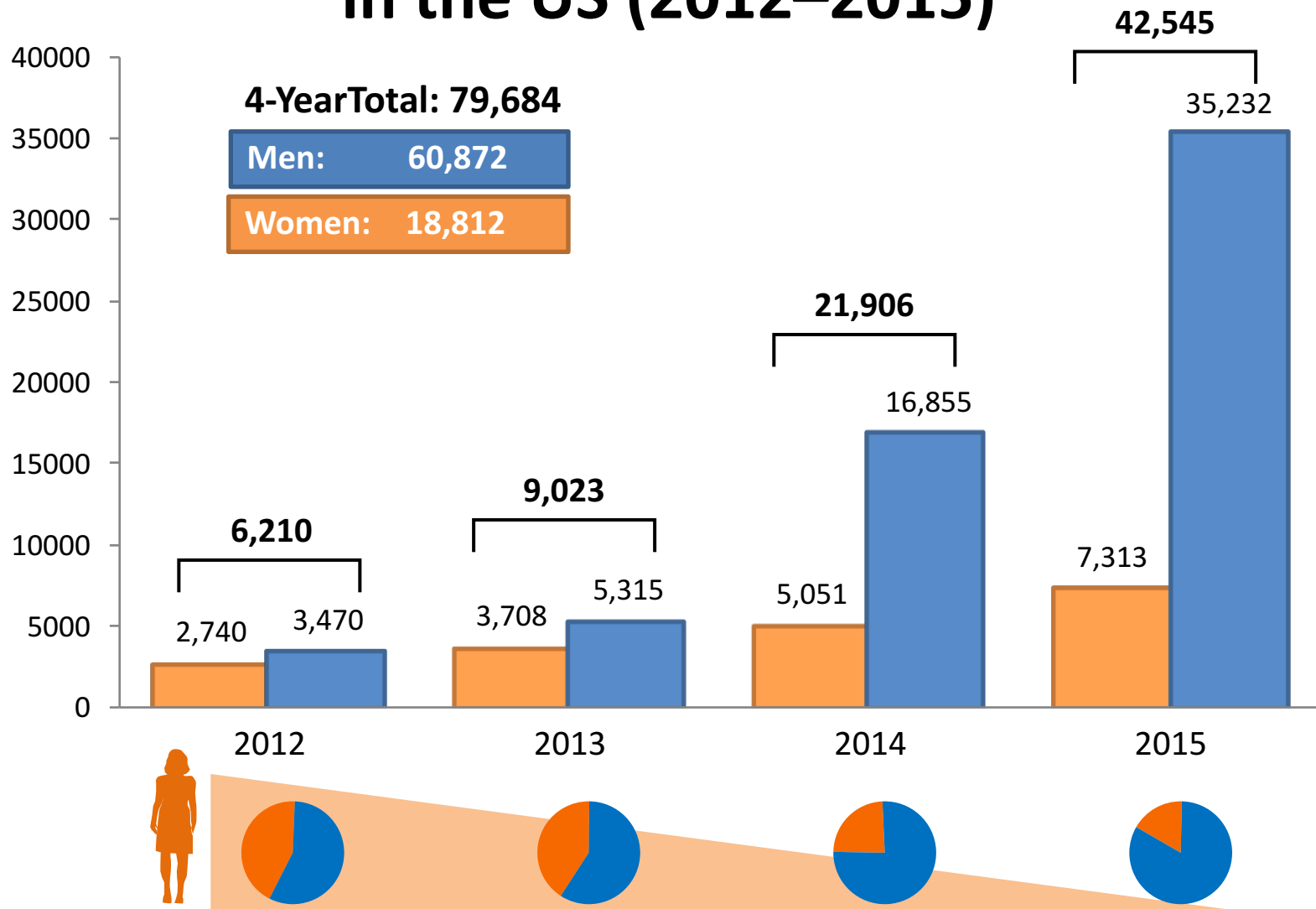
Lifetime Risk of HIV Diagnosis in the US



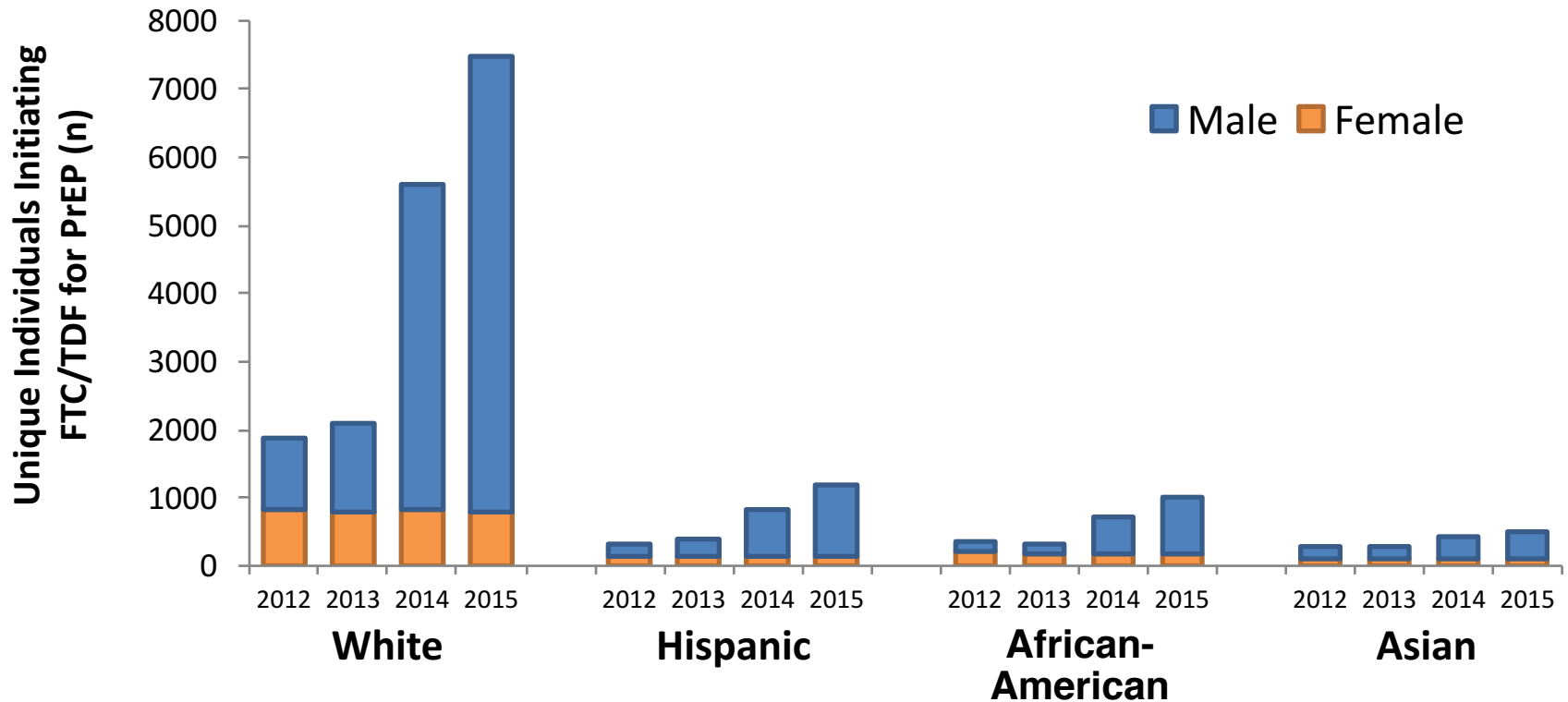
Increase in New PrEP Starts in the US (2012–2015)



Gender/Sex Differences in New PrEP Starts in the US (2012–2015)



Differences in PrEP Starts by Race/Ethnicity and Sex/Gender*

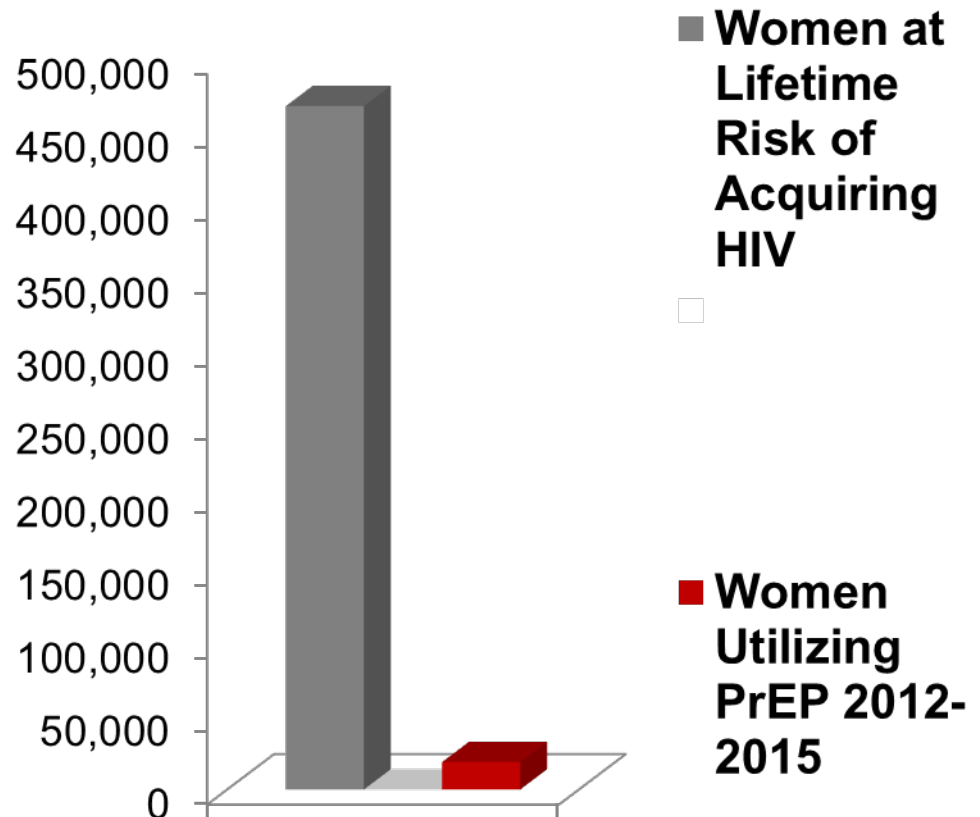


While the number of women who initiate FTC/TDF for PrEP is low across all races/ethnicities, the rate of FTC/TDF for PrEP initiation among African-American and Hispanic women is significantly less than that of White women

* These data represent 43.7% (n = 21,463) of unique individuals who have started FTC/TDF for PrEP from 2012 – Q3 2015. Bush S, et al. ASM Microbe / ICAAC 2016; Boston, MA. Abstract 2651.

Women and PrEP

- An estimated 468,000 women 15-49 years of age have indications for PrEP use
- An unknown number of uninfected women in HIV discordant couples become pregnant each year
- Only 18,812 women have initiated PrEP, with 7,313 of those new starts being in 2015



**Only 4% of women at risk have started Truvada for PrEP
There is a discrepancy between the HIV epidemic in women and
number of women using PrEP.**

Drug Utilization in the United States: 2012–2015

Top 20 US Cities with FTC/TDF for PrEP Use in 2015 (January to December)

Total Number of Individuals Prescribed FTC/TDF for PrEP in 2015

West

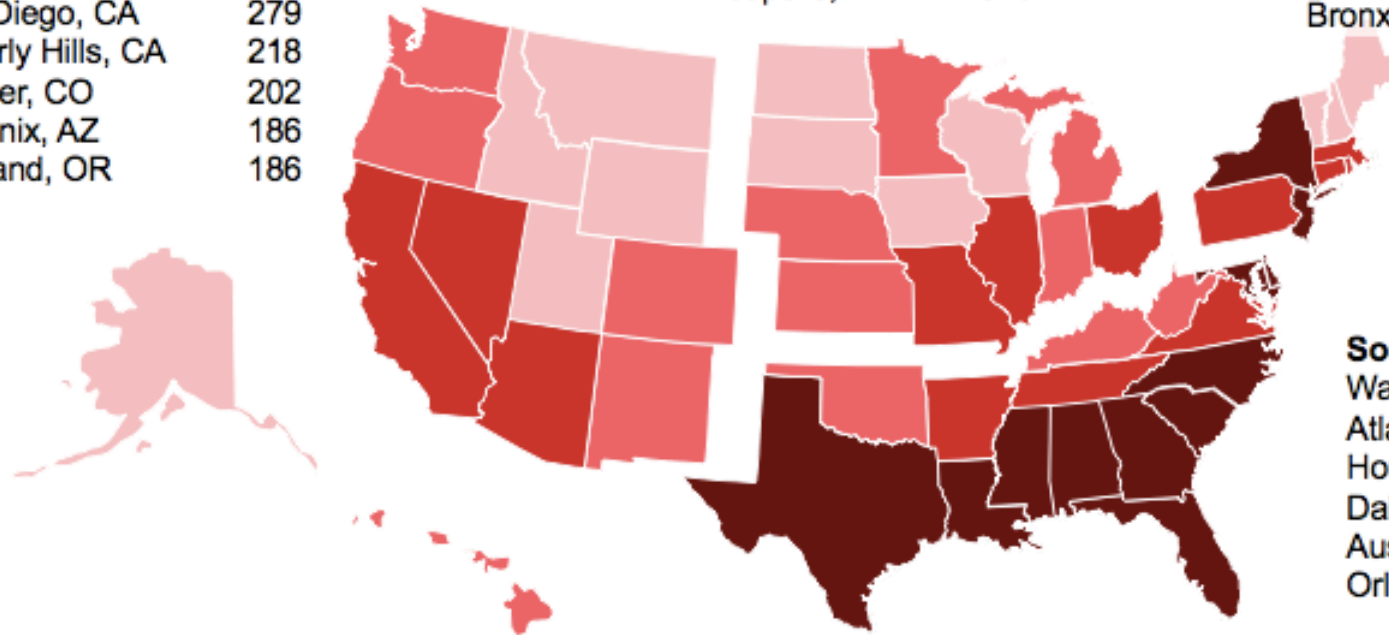
| | |
|-------------------|------|
| San Francisco, CA | 1094 |
| Los Angeles, CA | 660 |
| Seattle, WA | 574 |
| San Diego, CA | 279 |
| Beverly Hills, CA | 218 |
| Denver, CO | 202 |
| Phoenix, AZ | 186 |
| Portland, OR | 186 |

Midwest

| | |
|-----------------|------|
| Chicago, IL | 1001 |
| Minneapolis, MN | 378 |

Northeast

| | |
|------------------|------|
| New York, NY | 2936 |
| Boston, MA | 548 |
| Philadelphia, PA | 500 |
| Bronx, NY | 169 |

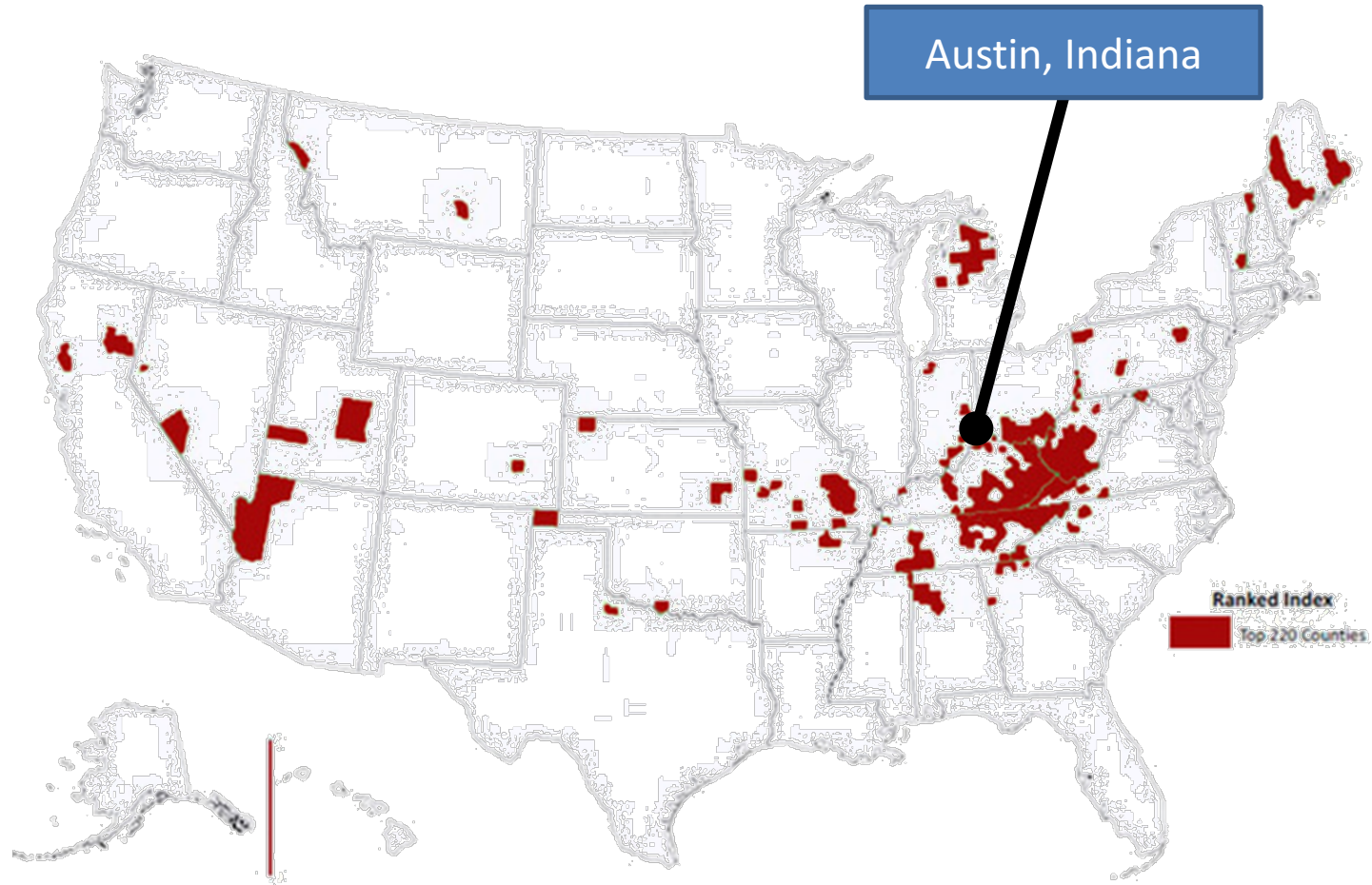


South

| | |
|----------------|-----|
| Washington, DC | 840 |
| Atlanta, GA | 524 |
| Houston, TX | 388 |
| Dallas, TX | 400 |
| Austin, TX | 286 |
| Orlando, FL | 168 |

2015 accounts for 39-55% of starts in each city

Counties Vulnerable to HIV/HCV Outbreaks



Major reasons for slow uptake of PrEP

- Lack of awareness among potential users
- Lack of awareness among providers
- Discomfort of providers
- Community push back
- Associated costs
- Absence of marketing

Two Recent PrEP Studies: A Comparison of IPERGAY and PROUD

PROUD Study (UK)

- High-risk MSM and transgender women (N = 545)
- Randomized; deferred arm
 - Immediate vs deferred PrEP*
- Daily dosing schedule
- Whether or not they were sexually active
- All participants received full preventive services
- 86% reduced risk of HIV

IPERGAY Study (Fr & Canada)

- High-risk MSM and transgender women (N = 400)
- Randomized; placebo arm
- Flexible dosing schedule*
 - “On demand”
 - 2 tabs taken 2-24 hrs before sex
 - 1 tab day after sex and another 1 tab day after that
- All participants received full preventive services
- 86% reduced risk of HIV

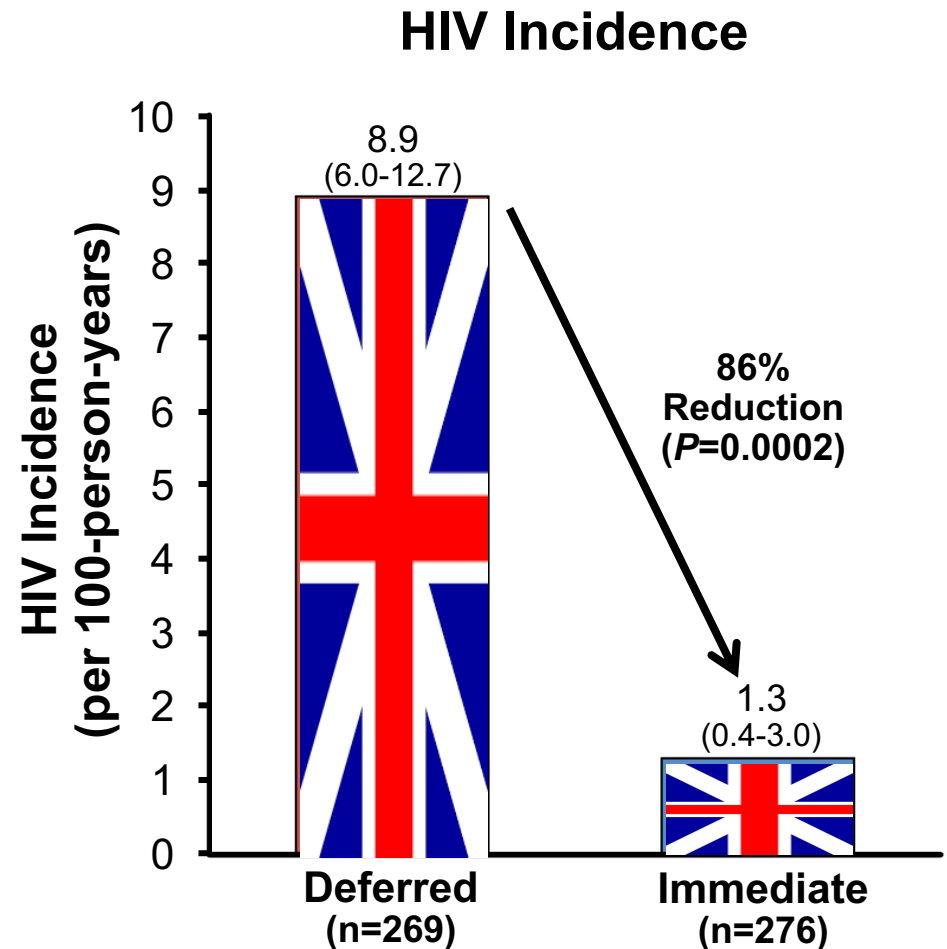
*adherence assessed by face-to-face interviews, pill counts, TDF/FTC plasma and hair concentrations

†PrEP given 1 year after enrolling.

McCormack S, et al. CROI 2015. February 23-24, 2015, Abstract 22LB; Molina JM, et al. CROI 2015. February 23-24, 2015, Abstract 23LB; Fonsart J, et al. AIDS 2014. July 20-25, 2014. Melbourne. Abstract TUAC0103; Antonucci S, et al. AIDS 2014. July 20-25, 2014. Melbourne. Abstract THPE197.

PROUD Study: Results

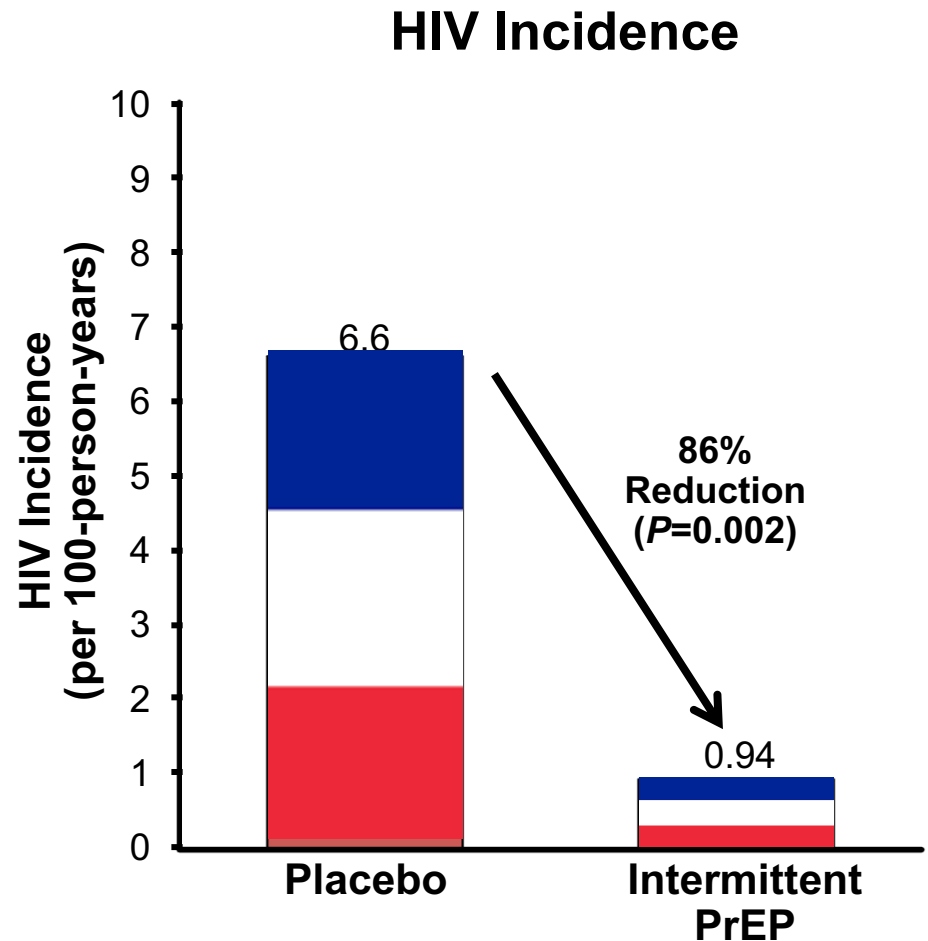
- Significantly fewer new HIV infections with immediate versus deferred PrEP (3 versus 19 cases)
 - 86% reduction ($P=0.0002$)
 - Number needed to treat to prevent 1 infection: 13
- PEP used by 31% in deferred arm
- Preliminary analysis found that risk behaviors were similar between the 2 arms



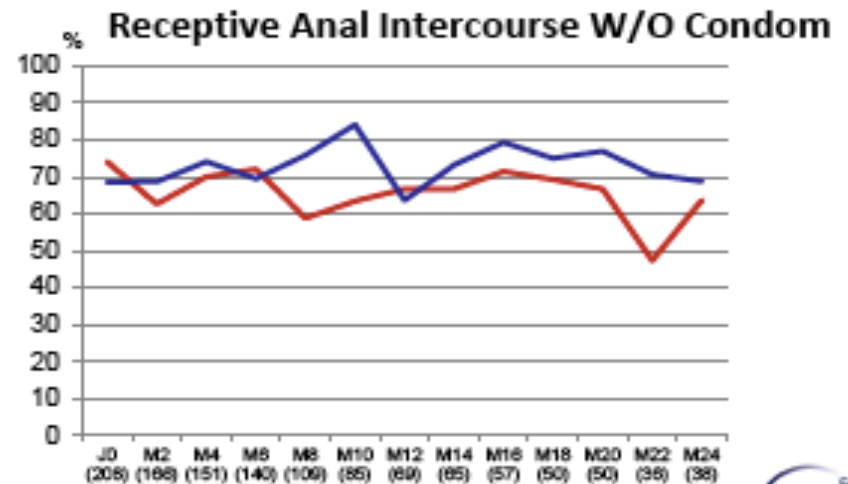
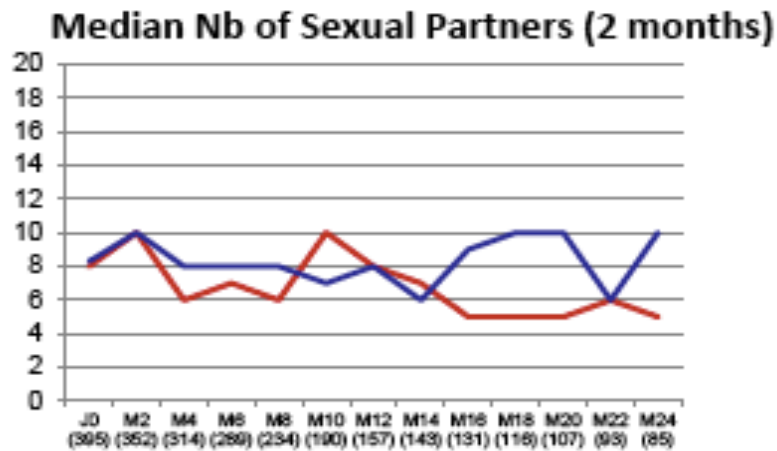
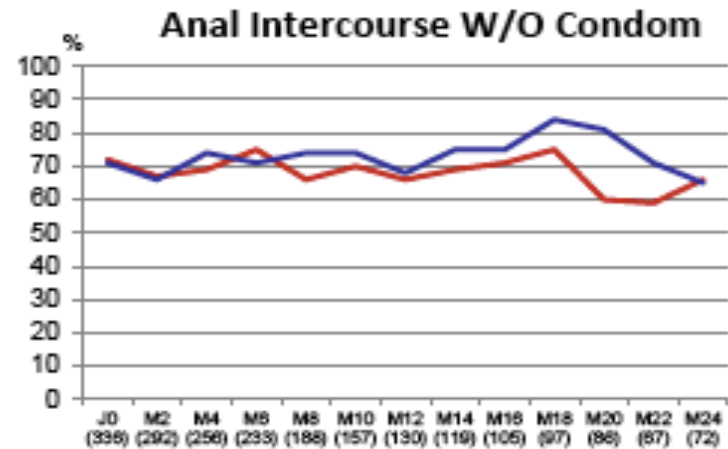
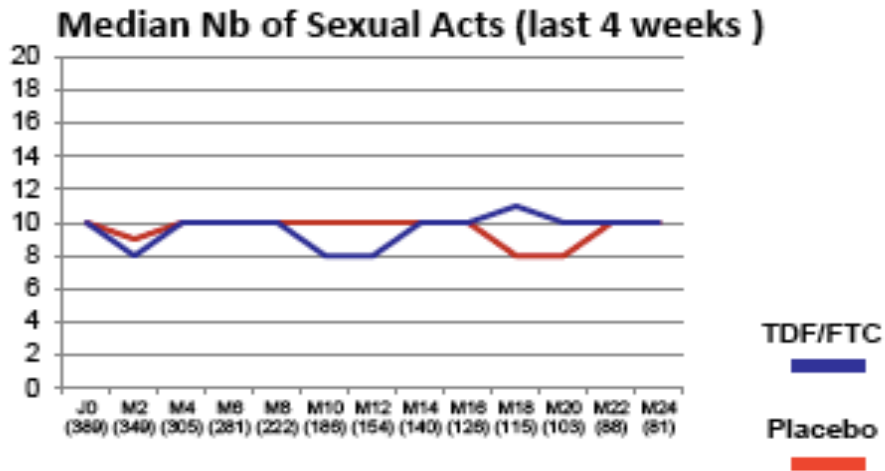
PEP: post-exposure prophylaxis.

IPEGAY Trial: Results

- Significantly fewer new HIV infections with intermittent PrEP versus placebo (2 versus 14 cases)
 - 86% reduction after a mean follow-up of 13 months ($P=0.002$)
- Safety of on-demand PrEP was similar to placebo except for GI adverse events
- Adherence to PrEP was good, supporting the acceptability of on-demand PrEP



Risk Behavior during IPERGAY



No New HIV Infections With Increasing Use of HIV Preexposure Prophylaxis in a Clinical Practice Setting

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¹Department of Adult and Family Medicine, Kaiser Permanente San Francisco Medical Center, and ²Division of Research, Kaiser Permanente Northern California, Oakland, California

(See the Editorial Commentary by Koester and Grant on pages 1604-5.)

Referrals for and initiation of preexposure prophylaxis (PrEP) for human immunodeficiency virus (HIV) infection increased dramatically in a large clinical practice setting since 2012. Despite high rates of sexually transmitted infections among PrEP users and reported decreases in condom use in a subset, there were no new HIV infections in this population.

Keywords. preexposure prophylaxis; men who have sex with men; HIV; sexually transmitted infections; behavioral disinhibition.

The effectiveness of once-daily oral preexposure prophylaxis (PrEP) using tenofovir/emtricitabine for prevention of sexually acquired human immunodeficiency virus (HIV) infection has been demonstrated in trials and open-label studies [1, 2]; however, data on PrEP use outside of the research context are limited. Interest in PrEP was high among men who have sex with men (MSM) in a demonstration project in the United States [3], yet initial pharmacy data indicated that many at-risk individuals were not accessing PrEP [4]. In addition, despite reassuring data suggesting that sexual risk behavior and the incidence of sexually transmitted infections (STIs) did not increase in PrEP trials [5, 6], few data on sexual behavior or STIs have been reported among PrEP users outside of research settings.

We aimed to characterize patterns of PrEP use among members of the Kaiser Permanente Medical Center in San Francisco (KPSF). We describe characteristics of individuals evaluated for and initiating PrEP, trends in PrEP referrals and initiation, incidence of HIV and other STIs among PrEP users, and self-reported changes in condom use and number of sexual partners after PrEP initiation.

METHODS

Kaiser Permanente is a large integrated healthcare system that provides comprehensive medical services to >170 000 adult residents in San Francisco. Our study population included all adult KPSF members evaluated for PrEP from July 2012 (the date of approval by the US Food and Drug Administration) through February 2015. At KPSF, primary care or other providers refer patients to a specialized PrEP program after assessment of risk or patient-initiated request. This program, created to meet the growing demand for PrEP, provides adherence support and clinical monitoring by infectious disease physicians, pharmacists, nurses, and administrative staff.

As part of the PrEP program, patients were screened for medical contraindications to the use of tenofovir/emtricitabine and for HIV antibody and viral load. Demographic data and reasons for starting or not starting PrEP were assessed during an in-person intake visit. Similar to PrEP trials [1], safety assessments and HIV/STI screening were repeated every 1-3 months after PrEP initiation. Testing for chlamydia and gonorrhea was done using nucleic acid amplification tests of urine and self-collected swabs of the throat and rectum. Beginning in July 2014, patients were surveyed by secure email after 6 months of PrEP use about changes in sexual behavior since starting PrEP.

We used descriptive statistics to compare PrEP initiators and noninitiators and those who did and did not report increases in risk behavior, with χ^2 tests for categorical variables and *t* tests for continuous variables. We used Kaplan-Meier analysis to compute the cumulative incidence of STIs and HIV after 6 and 12 months of PrEP use. Concurrent diagnosis of an STI at multiple anatomic sites (ie, pharyngeal, urethral, and/or rectal) was considered 1 infection, whereas diagnoses of gonorrhea and chlamydia in 1 anatomic site were considered multiple infections. Analyses were conducted using SAS software version 9.1 (SAS Institute, Cary, North Carolina). Statistical tests were 2-sided except where otherwise indicated, and statistical significance was defined as $P < .05$.

July 2012- February 2015: 1,045 referrals for PrEP

Of the 801 participants with at least 1 intake visit, 657 (82%) opted to start PrEP

No new HIV diagnoses occurred among PrEP users during 388 person-years of follow-up.

After 6m **30% of diagnosed with any STI**, 18% rectal STI, 17% chlamydia, 15% gonorrhea, and 3.3% syphilis; After 12 months, the corresponding percentages were 50%, 33%, 33%, 28%, and 5.5%, respectively.

Among the 143 PrEP users after 6m on PrEP, **56% said condom use unchanged**, **41% reported a decrease**, and **3% reported an increase**; 74% said their number of sexual partners stayed the same, 15% reported a decrease, and 11% reported an increase

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Clinical Infectious Diseases® 2015;61(10):1601-3

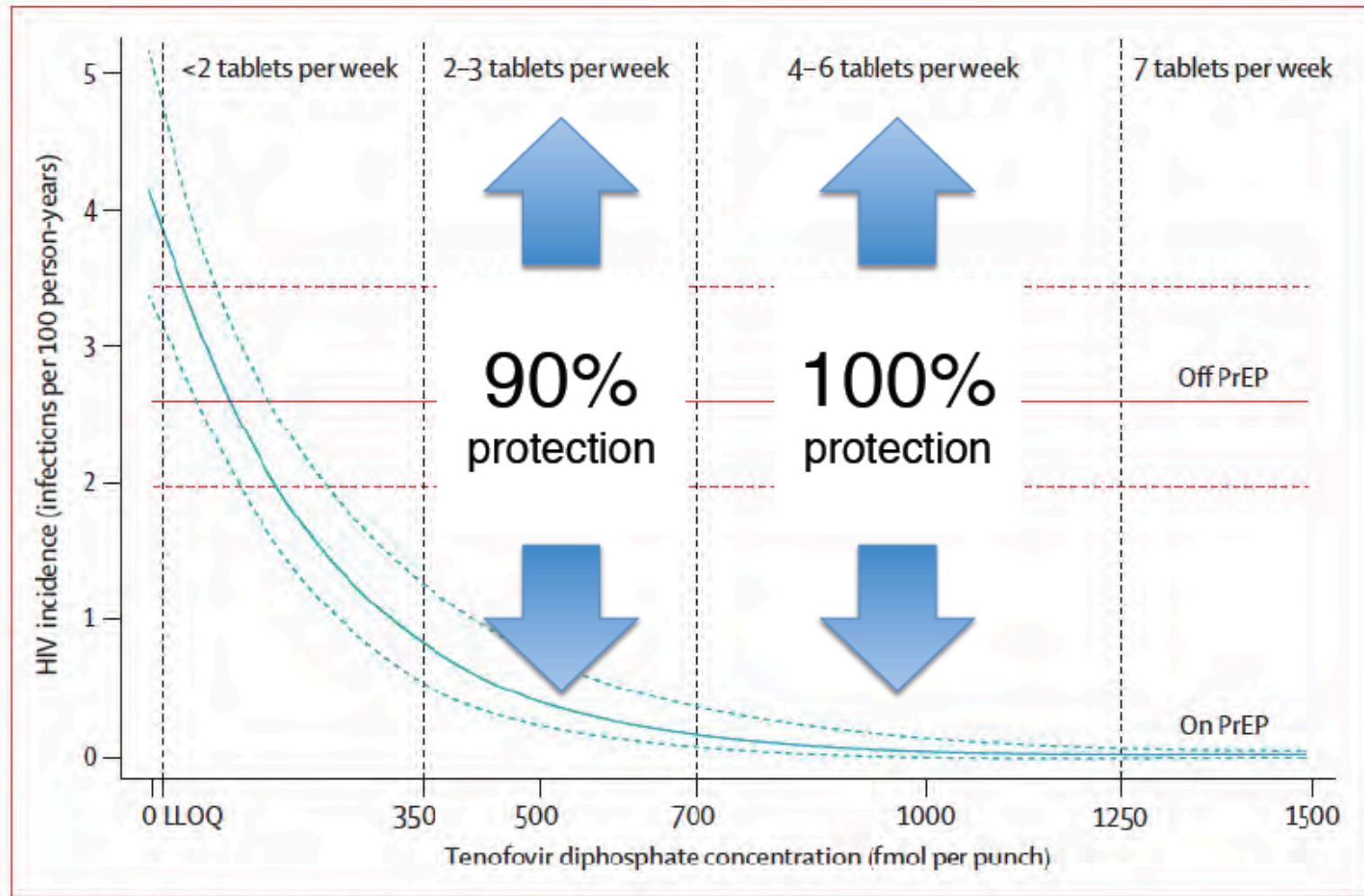
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DOI: 10.1093/cid/civ778

Adherence to PrEP Is Critical

| Study | Overall Efficacy, % | Blood Samples with TFV Detected, % | Efficacy by Blood Detection of TFV, % |
|---------------|--------------------------|------------------------------------|---------------------------------------|
| iPrEx | 44 | 51 | 92 |
| iPrEx OLE | 49 | 71 | NR |
| Partners PrEP | 67 (TDF) 75 (TDF/FTC) | 81 | 86 (TDF) 90 (TDF/FTC) |
| TDF2 | 62 | 80 | 85 |
| Bangkok TFV | 49 | 67 | 74 |
| Fem-PrEP | No efficacy | < 30 | NR |
| VOICE | No efficacy | < 30 | NR |

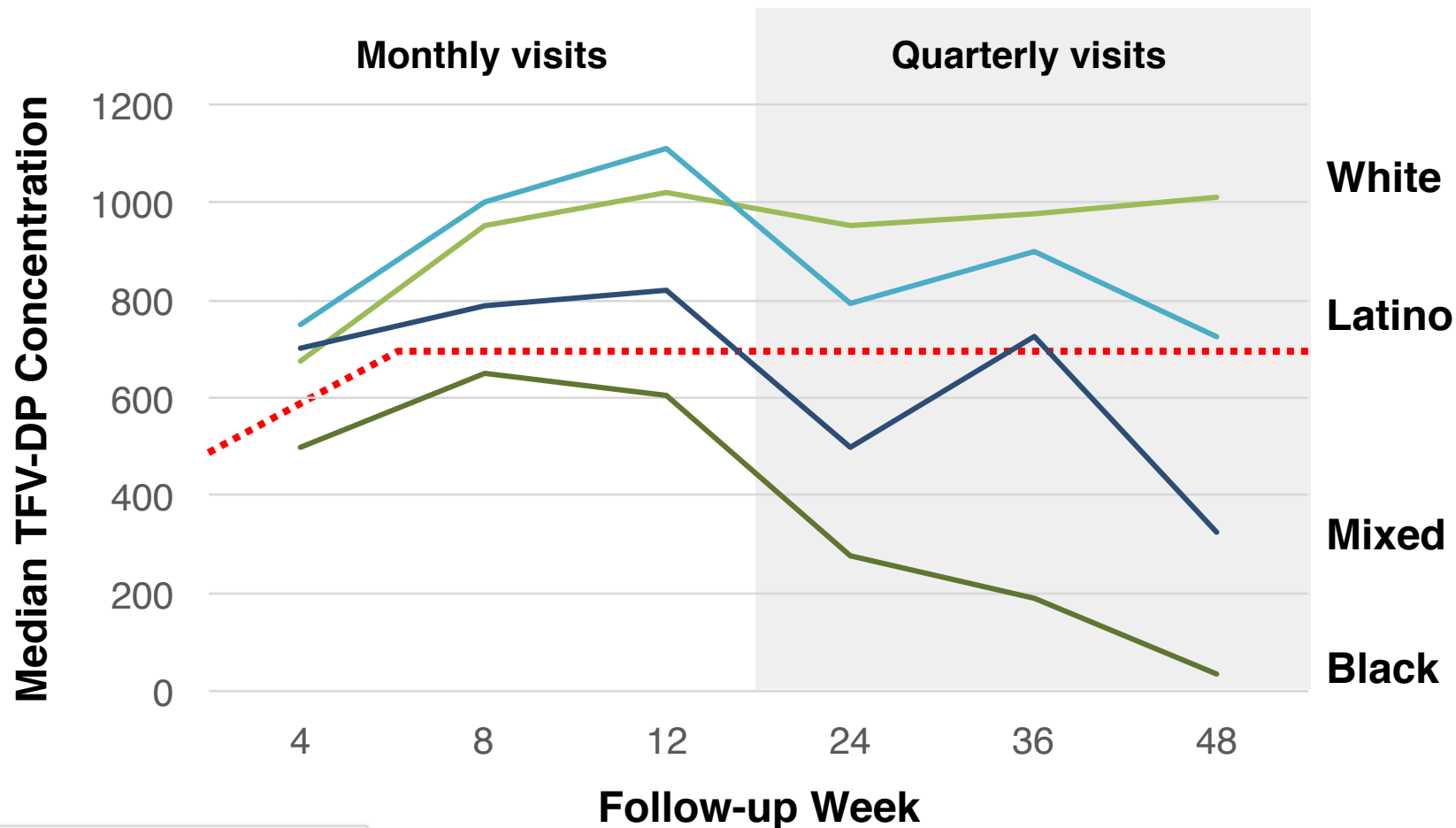
Grant RM, et al. *N Engl J Med*. 2010;363(27):2587-2599; Grant RM, et al. *Lancet Infect Dis*. 2014;14:820-829; Baeten JM, et al. *J Acq Defic Syndr*. 2013;63(Suppl 2):S122; Baeten JM, et al. *N Engl J Med*. 2012;367(5):399-410; Thigpen MC, et al. *N Engl J Med*. 2012;367(5):423-434; Choopanya K, et al. *Lancet*. 2013;381(9883):2083-2090; van Damme L, et al. *N Engl J Med*. 2012;367(5):411-422; Marrazzo J, et al. CROI 2013. Abstract 26LB; CDC. Pre-exposure Prophylaxis for the Prevention of HIV Infection in the United States: A Clinical Practice Guideline. May 2014. www.cdc.gov/hiv/pdf/guidelines/PrEPguidelines2014.pdf. Accessed 2/26/15.

iPrEx OLE confirmed prior estimates



What about adherence in young adults?

Project PrEPare 2 (ATN 110), Oct 2012 - Feb 2015



..... ≥ 4 doses per week

Moving PrEP into practice



Consumer Health Information
www.fda.gov/consumer

FDA Approves First Medication to Reduce HIV Risk

People diagnosed with HIV—the human immunodeficiency virus that without treatment develops into AIDS—take antiviral medications to control the infection that attacks their immune system.

Now, for the first time, adults who do not have HIV but are at risk of becoming infected can take a medication to reduce the risk of sexual transmission of the virus.

The Food and Drug Administration (FDA) has approved the new use of Truvada—to be taken once daily and used in combination with safer sex practices—to reduce the risk of sexually acquired HIV-1 infection in adults who do not have HIV but are at high risk of becoming infected. (HIV-1 is the most common form of HIV.)

In two large clinical trials, daily use of Truvada was shown to significantly reduce the risk of HIV infection.

- by 42 percent in a study sponsored by the National Institutes of Health (NIH) of about 2,500 HIV-negative gay and bisexual men and transgender women, and
- by 75 percent in a study sponsored by the University of Washington of about 4,800 heterosexual couples in which one partner was HIV positive and the other was not.

Debra Birnkranz, M.D., director of the Division of Antiviral Products at FDA, explains that Truvada works to prevent HIV from establishing itself and multiplying in the body. She notes that while this is a new approved use, Truvada is not a new product. It was first approved by FDA in 2004 for use in

combination with other medications to treat HIV-infected adults and children over 12 years old.

"In the 80s and early 90s, HIV was viewed as a life-threatening disease; in some parts of the world it still is. Medical advances, along with the availability of close to 30 approved individual HIV drugs, have enabled us to treat it as a chronic disease most of the time," Birnkranz says.

"But it is still better to prevent HIV than to treat a life-long infection of HIV," she says.

Birnkranz stresses that Truvada is meant to be used as part of a comprehensive HIV prevention plan that includes consistent and correct condom use, risk reduction counseling, regular HIV testing, and treatment of any other sexually-transmitted infections. Truvada is not a substitute for safer sex practices, she says.

Person Must Be HIV Negative

Truvada, produced by Gilead Sciences Inc., is a combination of two antiretroviral medications used to treat HIV—tenofovir disoproxil fumarate and emtricitabine. When Truvada is used as a treatment for HIV rather than a preventive, the patient also takes a third drug, Birnkranz says. Which of the other approved HIV drugs is added depends on the needs of the patient.

Before this medicine is prescribed, Birnkranz says there are several factors



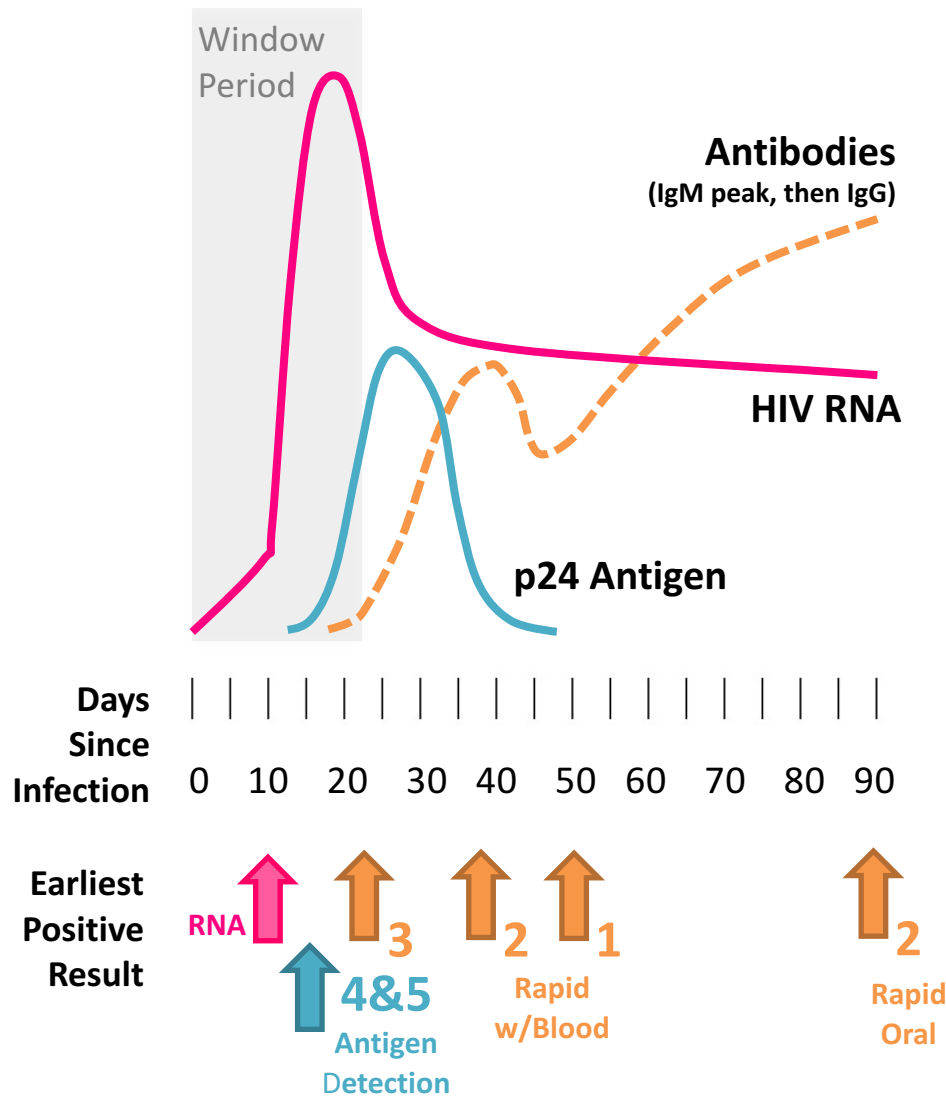
US Public Health Service

PREEXPOSURE PROPHYLAXIS FOR THE PREVENTION OF HIV INFECTION IN THE UNITED STATES - 2014

A CLINICAL PRACTICE GUIDELINE



Starting PrEP: Make sure pt not HIV+

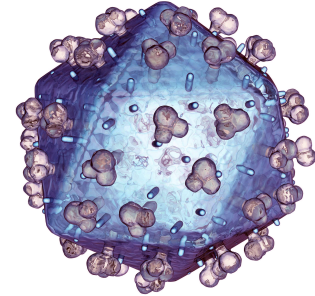
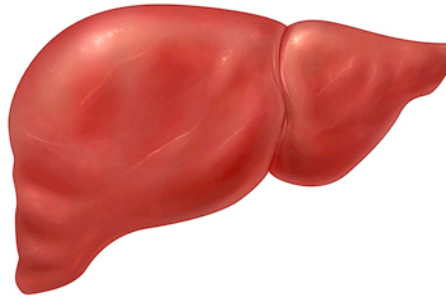
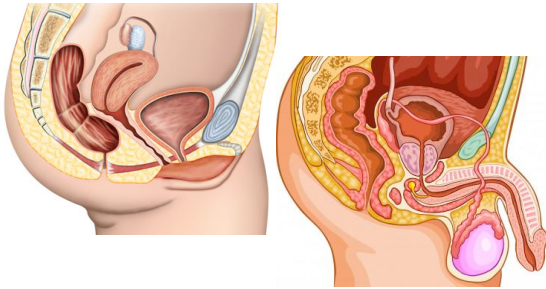


- RNA precedes p24 Ag by 5–7 days
- Earliest Ab detection around 20–25 days (IgM in 3rd – 5th gen)
- Earliest 2nd gen Ab detection at 35–40 days (as IgG begins rising)
- Rapid tests with oral ransudate may take up to 90 days to convert (self-test implications)

IgM = immunoglobulin M; IgG = immunoglobulin G.

CDC. Laboratory testing for the diagnosis of HIV infection: updated recommendations. www.cdc.gov. Accessed 10/10/16.

What tests do we need to obtain?



Sexual health

Syphilis
Gonorrhea NAAT*
Chlamydia NAAT*

Pregnancy

*from **all** exposed sites

Viral hepatitis

HBV surface Ab
HBV surface Ag
HBV core Ab

Hepatitis C Ab

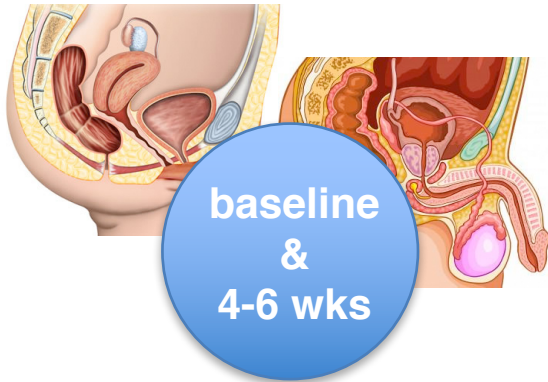
HIV testing

Ag/Ab combo[§]

- rapid test, if possible

§ Ab-only is acceptable if Ag testing unavailable

What tests do we need to obtain?

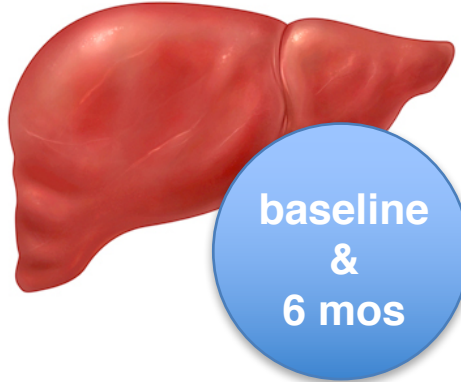


Sexual health

Syphilis
Gonorrhea NAAT*
Chlamydia NAAT*

Pregnancy

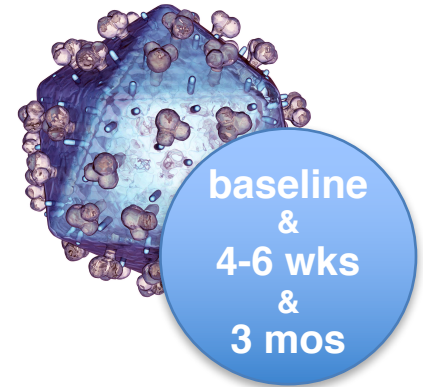
*from **all** exposed sites



Viral hepatitis

HBV surface Ab
HBV surface Ag
HBV core Ab

Hepatitis C Ab



HIV testing

Ag/Ab combo[§]
• rapid test,
if possible

Too early for RNA

§ Ab-only is acceptable if
Ag testing unavailable

Differences in Time to Protection After PrEP Initiation

| Cervico-vaginal tissues | | | | | | |
|-------------------------|---|---|---|---|---|---|
| | | ① | ② | ③ | ④ | ⑤ |
| ⑥ | ⑦ | ⑧ | ⑨ | ⑩ | ⑪ | ⑫ |
| ⑬ | ⑭ | ⑮ | ⑯ | ⑰ | ⑱ | ⑲ |
| ⑳ | | | | | | |
| | | | | | | |

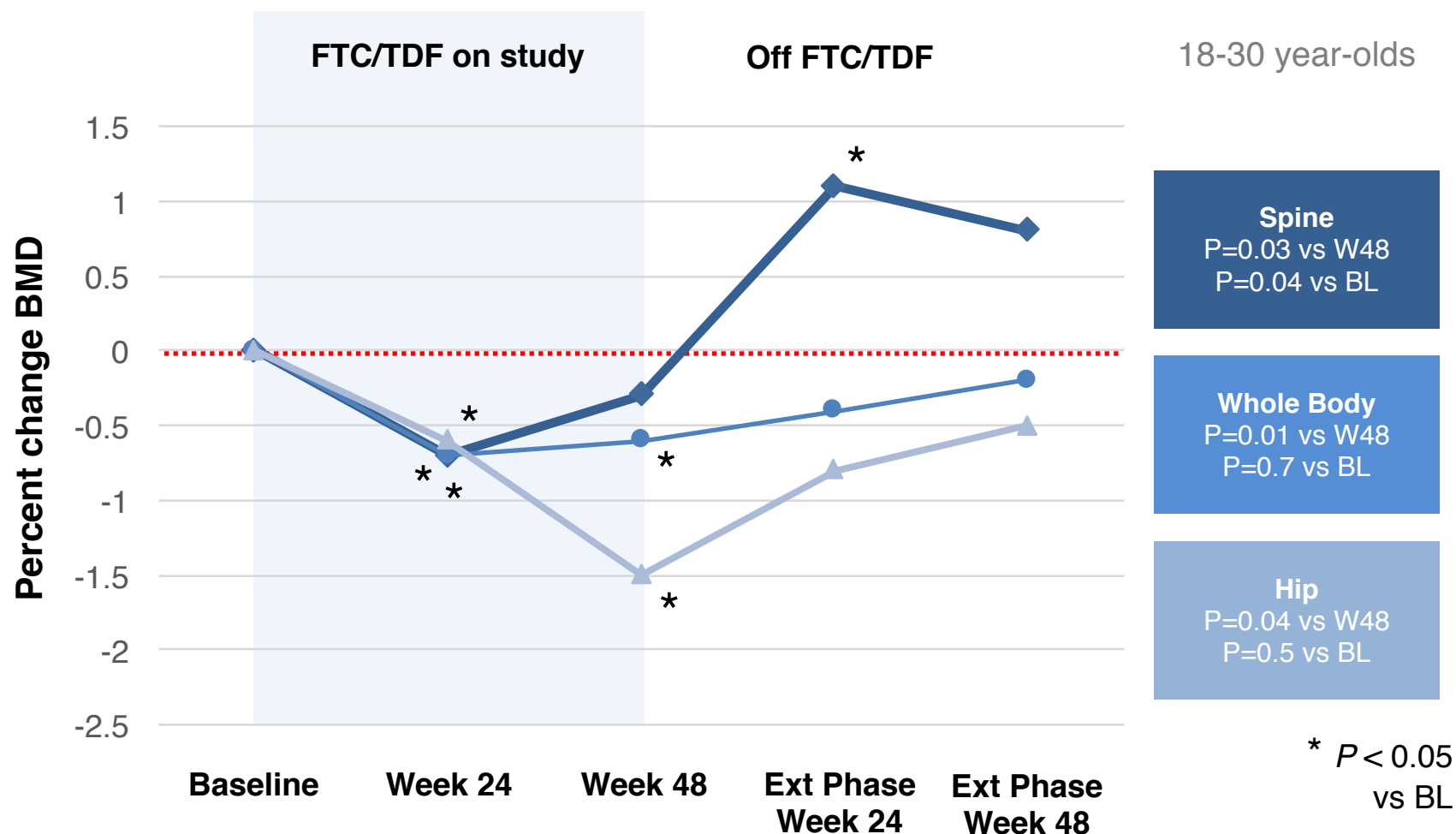
20 days

| Rectal tissues | | | | | | |
|----------------|---|---|---|---|---|---|
| | | ① | ② | ③ | ④ | ⑤ |
| ⑥ | ⑦ | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

7 days

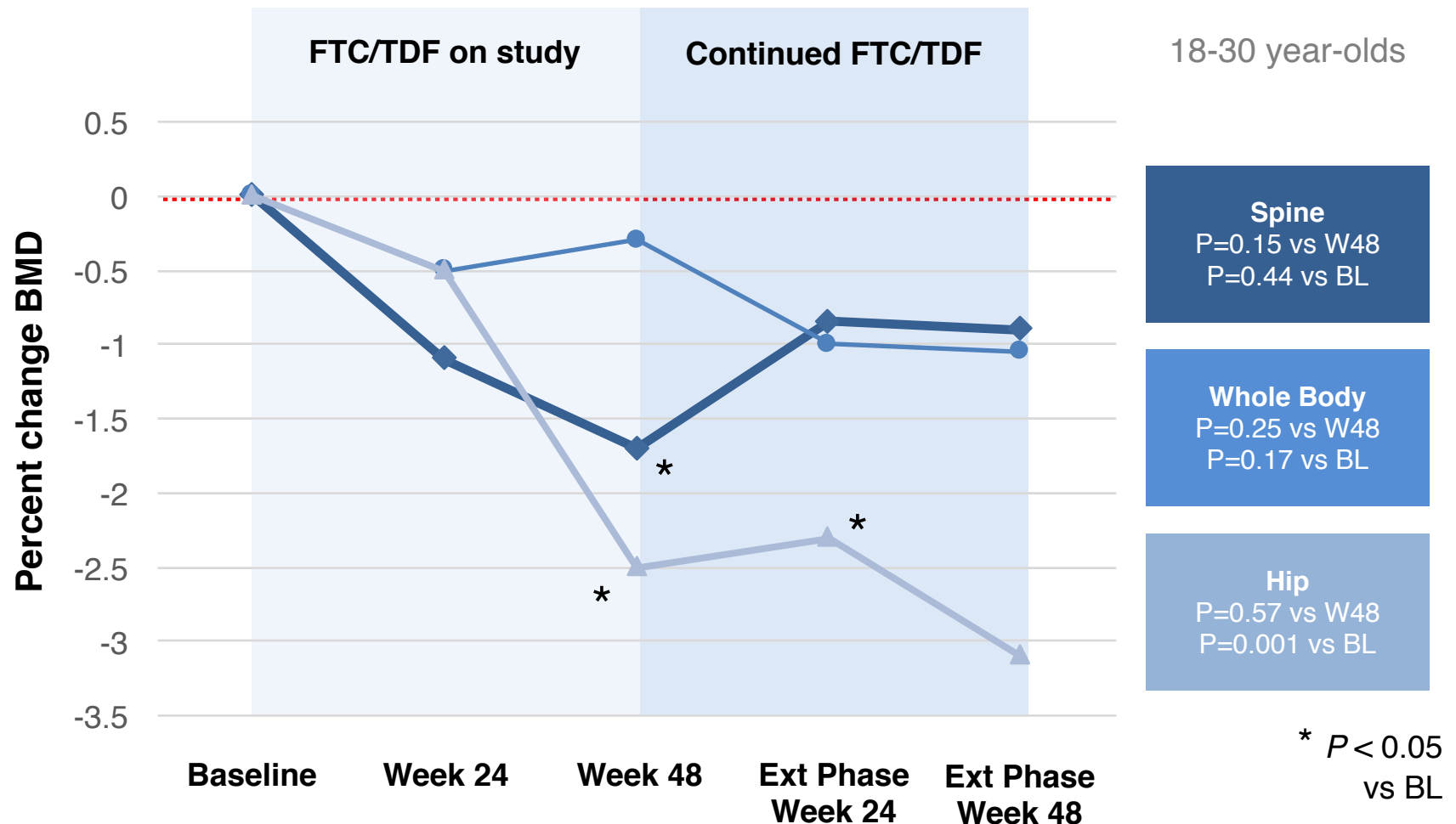
What about bone health in young adults?

Project PrEPare 2 (ATN 110), 72 who stopped FTC/TDF



What about bone health in young adults?

Project PrEPare 2 (ATN 110), 15 who continued FTC/TDF



Can my patient afford PrEP?

Cost to PrEP users

- Out-of-pocket (uninsured) = around \$1300/mo.
- Insurance covers (even Medicaid) – **pre-auths**
- Access programs and co-pay assistance
- Potentially free from Gilead if income <\$58K

BUT, associated costs (office visits, labs, not always covered)

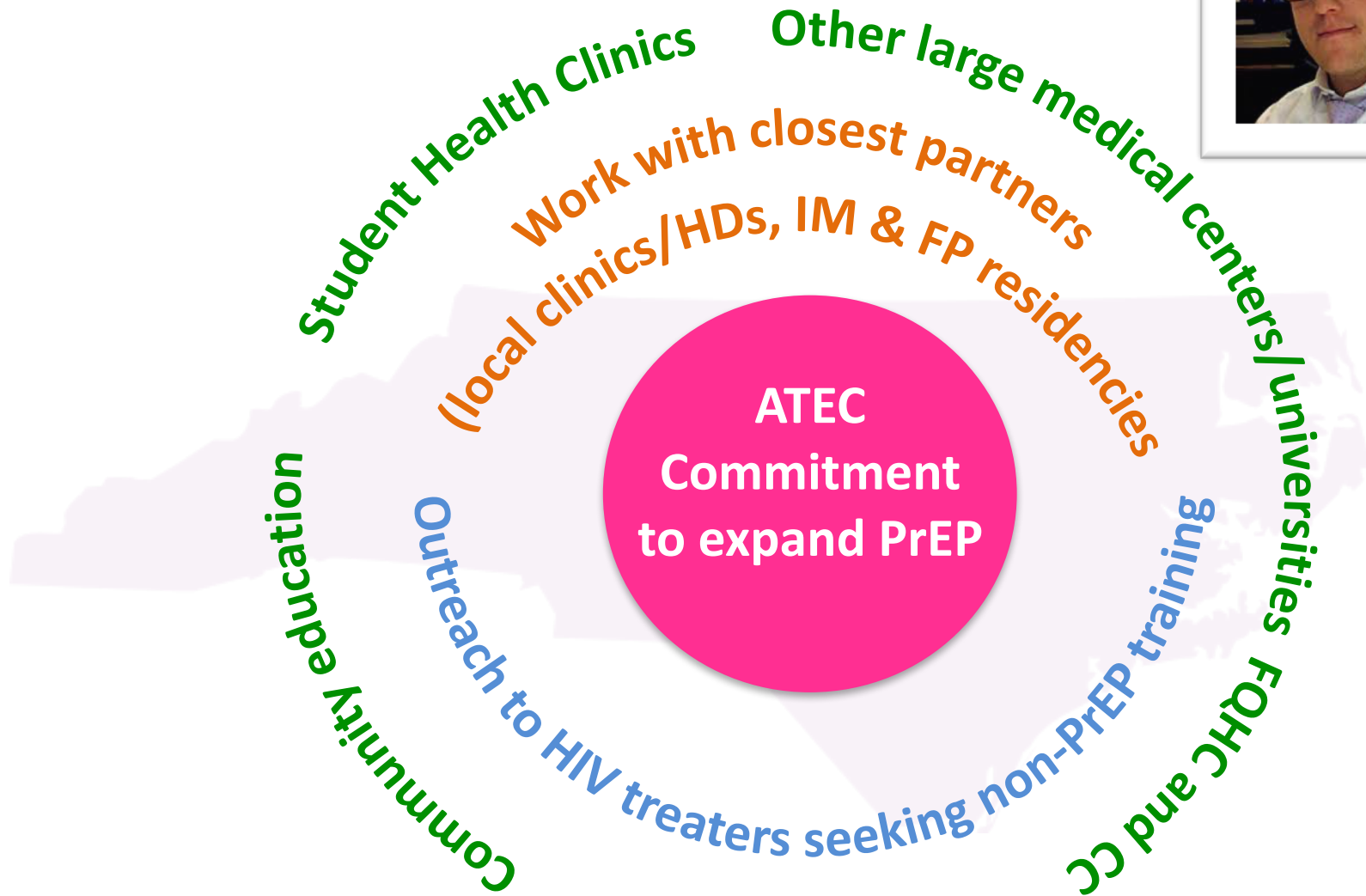
- See NCATEC's "**For PrEP prescribers**" page

Schackman BR, et al. *Curr Opin HIV/AIDS*. 2012;7:587

Juusola JL, et al. *Ann Intern Med*. 2012;156:541

Gomez GB, et al. *PLoS Med*. 2013;10(3):e1001401

NC Approach



Advocacy: ASO, LGBT groups, Pharma, Medical Assns

More info: www.med.unc.edu/ncaidstraining

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North Carolina AIDS Training and Education Center

Home About Us Request Training Clinician Resources **PrEP** Videos/Slides/Webinars Events CAPUS Pharmacy/Dentistry Excellence in HIV Care

For Providers ▶

Consumers Interested in or Currently Taking PrEP

North Carolina DHHS PrEP Memorandum for World AIDS Day 2014

PrEP Resources

Pre-exposure prophylaxis (PrEP) is a new way of preventing becoming infected with HIV. We have put together these resources to help you to decide whether you are a provider or a consumer.



HIV Training That Makes a Difference



University of North Carolina at Chapel Hill
AIDS Training and Education Center

WHAT'S NEW

**Excellence in HIV Care
Webinar Series**

**Clinical Care in 2015:
HIV, Hepatitis C and
Vulnerable Populations**

**Check out our new *PrEP*
resources page.**

**WOHL STREET JOURNAL:
Becoming Less Super as
a Specialist**

NCATEC Clinician Line



855-UNC-ATEC

855-862-2832

Do you have clinical questions
regarding the management of
HIV?

Call Mon.-Fri. 9-5 to get
connected to an HIV expert!

NCATEC has lots of resources

<http://www.med.unc.edu/ncaidstraining/prep>

For PrEP Prescribers

These resources are intended to help you initiate and manage y

On this page, we have condensed the [2014 US Public Health S supplement](#) into a step-by-step guide for providers managing pa

If after reviewing the information here you still have a specific q this page for contacts who can help.

Step-by-Step Guidance

To download this information in checklist form, click [here](#).

The UNC Infectious Diseases Clinic's working group on PrEP me which sets some "ground rules" at baseline.

Step 1: Assess Need for PrEP

Step 2: Determine Clinical Eligibility

Step 3: Consider STI Screening

Step 4: Counsel the Patient

Step 5: Initiate PrEP

Step 6: Follow-Up

Clinician Contacts for Help with PrEP

- Call [PrEPline](#), a service of the [Clinician Consultation Cent](#) **955-448-7737** (11 AM and 6 PM EST)
- Contact a UNC Infectious Diseases clinical fellow or attend **862-6264**. Between 8 AM and 5 PM on weekdays, you'll s

Consumers Interested in or Currently Taking PrEP

Pre-exposure prophylaxis (PrEP) is a new way of protecting yourself from becoming infected with HIV. We have put together these resources to help you to learn more about PrEP and to find a local provider who can prescribe PrEP and help you maintain your sexual health.



To the left is a short video from [My PrEP Experience](#) about PrEP basics.

Below, you'll find a list of frequently asked questions (FAQs) about PrEP, provided by the San Francisco AIDS Foundation. If you don't find an answer to a question you have here, feel free to check out their website, [PrEPfacts.org](#), for more information. They have separate FAQ pages for [women](#) and for [men \(along with transwomen\)](#).

Map of North Carolina PrEP Providers

There is a search bar in the lower right-hand section of the map. You can search by zip code or city.

