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PREP-ARING ADOLESCENTS AND YOUNG ADULTS TO PROMOTE SEXUAL HEALTH

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PrEP Aware Week Programming: PrEP-aring Adolescents and Young Adults to Promote Sexual Health
[video transcript]

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Kelly Farrow is a senior nurse practitioner at the University of Rochester Medical Center in the infectious disease clinics, HIV and AIDS center. Her clinical focus is on the prevention and management of infectious diseases, including HIV AIDS, Hepatitis B and Hepatitis C. She has worked on a number of projects across New York State to advance access to PrEP and PEP services, including most recently the development of the university's ID clinics injectable program for HIV treatment and PrEP. With cabotegravir. Also speaking will be Dr. Jamie Behringer. Dr. Behringer earned his undergraduate degree at MIT, graduated AOA from medical school at Case Western and then completed his pediatrics residency and an additional chief year at the University of Vermont, where he co-founded Vermont's first clinic dedicated to providing gender affirming care for transgender youth. He then completed his fellowship training and Adolescent Medicine at the Children's Hospital of Philadelphia. He's worked for many years to advocate and improve health services for LGBTQ youth. His most recent research has focused on the impact of chest dysphoria and masculinizing reconstructive chest surgery and trans masculine use. Dr. Behringer is passionate about serving youth from marginalized communities, transgender health, sexual and reproductive health and justice, fighting to eliminate health inequities and dismantling systemic oppression. We're very, very appreciative to both of you for presenting today. So with that, I'll turn it over to our speakers. And we look forward to hearing from your presentation.

01:55
Thank you so much, Dr. Urban. So I have no financial disclosures, and Kelly has served as an advisory panel participant for Viv. So our learning objectives today are to describe the need for PrEP among adolescents and young adults, including barriers and solutions to getting PrEP in this population, to describe basic management of PrEP and how this can be incorporated into routine care, and to discuss strategies for discussing and counseling on PrEP and young people in a way that's non stigmatizing and gender affirming. So now, our discussion today centers on PrEP. So we've got to start by talking about HIV. We're several decades into the HIV epidemic now. And we've come a long way. But still, today, an estimated 1.2 People 1.2 million people in the US are living with HIV. And of these folks living with HIV, about one and seven are about 13% don't know it. And when we look specifically at young people, ages 13 to 24, were living with HIV, about one and two don't know their status. Now in this infographic from the CDC, it illustrates a diverse group of folks living with HIV. And that's true HIV impacts every single demographic in our country. But that burden is not evenly distributed in our population. There are major disparities that exist in new diagnoses of HIV these days, with Black and African American folks being way disproportionately affected. And it's important to acknowledge why

that is it really comes down to social and economic disparities, stigma, racism, and the fact that treatment and prevention efforts have not reached everybody equitably. And when individuals have multiple marginalized identities, the burden of HIV is even higher. So for example, we can see that the prevalence of HIV is incredibly high in trans women of color, due to the combined impact of racism and transphobia. And the high rates of victimization, systemic oppression, and lack of access to care of that results. And there are so many things that need to be done to end this epidemic. And today, we're here to talk about PrEP and what you can do to help promote HIV prevention among young people. So what is PrEP? And how is it different from PEP? So PrEP stands for pre-exposure prophylaxis for HIV, it is medication taken before sexual contact or blood exposure to help prevent acquiring HIV from that exposure, whereas PEP is post-exposure prophylaxis for HIV. And so its medication taken after a sexual contact or blood borne exposure to help prevent acquiring HIV from that exposure. It's got to be started ASAP within 72 hours of the exposure. And when people are struggling to understand the nuance as between these I draw an analogy to contraception, which I think providers are very, very familiar with. And so PrEP is kind of similar concepts as birth control pills or the Depo shot to preventing pregnancy, you got to be on it before you have sex for it to work. Whereas PEP is kind of similar to Plan B, or emergency contraception, you take it after the contact has happened, but it's got to be as soon as possible and within a certain window of time after the contact. So how old does a person need to be in order to be eligible for PrEP? Well, that's kind of a trick question, because there's no age cut off just a weight cut off. So all forms of PrEP are FDA approved for youth who are at least 35 kilos or 77 pounds, which is pretty much all adolescents. And the use of PrEP and adolescents and young adults has been rising over the past decades. So amongst 16 to 24 year olds who have risk factors that lead them to be most likely to benefit from PrEP, the uptake is more than doubled between 2017 and 2021. But when we break it down by age among people who are considered to be the most likely to benefit from PrEP, we see that adolescents and young adults age range is actually the least likely to actually be prescribed PrEP. And the racial disparities in PrEP prescribing are even more troubling. So among people who are most likely to benefit from PrEP, white people are seven times more likely than black individuals to actually receive PrEP. And so we need a lot of things to happen to really start moving the needle, and especially to start ending these disparities that exist. But we were asked today to focus on with you was how to help youth serving providers get more comfortable with discussing and offering PEP. So I've heard a lot of excuses from pediatric providers over the years as to why they're not offering PEP like this sounds complicated that they're not ID specialists are fellowship trained or even concerns over whether they have the licensure to do it. And so I'm here today as a pediatrician to say that if you are capable of prescribing amoxicillin, you are totally capable of prescribing PEP. Alright, I first prescribed PEP when I was just a peds resident and I was actually the first person in my department at the time to prescribe it. It was just me and the CDC guidelines, and a preceptor who had an open mind. Alright, so this is not rocket science, you can do this. So let's get into the nuts and bolts of PrEP management. So there's two different oral PrEP options that are available right now. There's this guy, the brand name is Truvada and it's a

combination of two drugs emtricitabine and tenofovir, disoproxil fumarate, which commonly gets abbreviated as TDF FTC, or F TDF. And then there's this one, the brand name is disco V. It's a combo of also emtricitabine and a different type of tenofovir, tenofovir Alfetta might, which gets abbreviated as Taff FTC or F TAF. And I will be the first to admit as somebody who's not an ID specialist, these drug names and abbreviations were a bit intimidating when I started out, so do not let it intimidate you. Okay. On our slides, we're gonna keep referring to these meds both by the abbreviations and by the brand name, not for brand promotion, but just for clarity. Alright, Truvada and disco V are both taken once a day. Just to be clear, people take one or the other, but not both. Truvada can be used as PrEP by all people and prevents against HIV acquisition both from sex and from injection drug use. Discovery is newer, so there aren't yet as many studies out yet. So for now, it is only recommended for PrEP for preventing HIV acquisition from sex, not from injection drug use yet, and it isn't recommended yet for people assigned female at birth of vaginal sex, because there still aren't enough studies yet. The most common side effects of Truvada are headache, abdominal pain, and weight loss. But this really tends to be worse than the first few weeks if at all of taking the medication, and then tends to fade after that. The most common side effect of discovery is diarrhea also tended to be worst over the first week or two of taking the medication and tends to subside after that. And I'm going to turn it over to Kelly to tell you about injectable PrEP.

09:43
So injectable PrEP, there's only one and that's Cabo Tegra Vir the trade name on that is aptitude and it's approved for everyone I you know I often say in my clinic aptitude is for everyone because it's it whether someone was assigned male or female at birth, irrespective it works or at greater than 99% efficacy, it really was only studied at this point though and people who whose risk was, was sex, their risk for acquisition, it was not studied in people who have injection drug use. That's not to say that wouldn't work. It's just not on label yet. The most common side effect that we see by and large is injection site reaction. If you are giving this drug, I tell patients, that one out of five injections result in some sort of reaction. But they're what they is defined in the studies as a reaction is going to be grade one or grade two, which means you know, just pain at the injection site, small amount of redness, that would be like a grade two, we're typically not seeing grade three or four reactions, that would be a risk with any sort of deep intramuscular injection, but it's not something that I've seen in my clinic, it's certainly possible, but not something that we're expecting. It's a it's a big needle, b a n, that's it's a 20 gauge needle, one and a half inches long. And this is given on something called a Z track. So that sounds complicated, but it's not, it basically just means you push the skin up on the glute, and then the needle goes in. And then as the nurse is taking the needle out, you let the skin sort of slide back into place. And this just prevents the drug from coming back out of the skin, which happens, you know, with vaccines, but when the vaccines are studied, we know that's okay. But we don't want that to happen with our antiviral. So when we can advance slide.

11:53
So when we're talking about how we get patients started, there's two options. I would say most patients go with option two, which is to get the shot, they come back one month later, and they get the shot again. And after that they come every other month. So we tell patients, you know, say that they were going to come in today for their loading dose today's October 24. After that, they're going to be their targets gonna be the 24th of odd months, because they're going to come back in November. And then after that, they're going to come back in January, and March and so on. They there's always a seven day window when we're giving that injection, so plus or minus seven days from the 24th. I can't stress enough, it's not the last time the shot was administered very often with like, like depo, for example, you're going to look at the last time the shot was given and then go from there. But with this drugs to say the patient comes in the 30th, you're not going to go plus or minus seven days from the 30th. We always bring it right back to that target date, because it's very important that they're getting for patents, patients that are on the maintenance phase, those six shots in a year if they're just starting in their first year getting those seven shots in that year. The option one is really over we just go back one option one eye is if they just take the oral pills for a month. It's provided at no charge through Thera comm. You can't get it at a commercial pharmacy. Why would anyone want to do this? There's very few patients that do want to do it. But there's a few that do and like if they have a lot of sensitivities to medications, I tell patients, once we give you the shot, we can't take it back and it takes months for it to work its way out of your system. So if you have any patients that have had particular sensitivities to medications, where they're really not sure you know how they'll do with it, you can definitely use the oral lead in and then the dosing is just the same. The oral lead in has absolutely nothing to do with getting the dose up to speed and getting the drug levels to a certain level. It's just a trial for the patient. When they come in for their first shot, they still follow the same schedule of coming back one month later and then going into the q2 month. And then we can advance sorry, Jamie. So how long does it take for PrEP to work? When we're talking about Truvada and disco V. We've told patients that it's you know, for receptive anal sex, it's going to be within seven days of daily use for any sort of receptive vaginal sex injection drug use. And we think probably insertive sex, it's about 21 days of daily use. We're not really sure. And for Cabo Tegra Vir, we really don't have exact guidance on that in the store. Studies, you know, they patients were loaded, but they weren't told not to have sex that they were, you know, doing their usual activity. There wasn't anything that was identified in the studies of, you know, seeing patients who failed as a result of drug level being, you know, being too low, early on. But, but what we really don't know. So when patients ask, you know, we do try to provide some, some counseling around that, we think it's pretty quick, but we can't, we can't give an exact, exact timeframe. Excellent. But the thing to remember is, PrEP is very effective, no matter what method you're doing, whether it's oral, or injectable, when it's used correctly and consistently, it reduces the risk of getting HIV from stocks by 99%. Can Dance. And these are the studies that we have that have brought us to being able to make that statement. There's a combination of studies here, some of the bigger ones are, you know, the partners study, and is

probably the biggest one I practice is also a very big study that we really have used to say that PrEP is effective. There are some other studies where it was not effective, but a lot of that was tied to low drug levels and poor patient adherence. So if the patients aren't adherent, then the patients aren't going to have the drug level in their system that's needed to prevent infection. So when we adjust for that, we can see that PrEP is truly effective when people are compliant on it in advance, this is one of my favorite studies for PrEP, because it's focused around one of the most difficult populations to treat with PrEP, because there's so few options, you know, for cisgendered women, it's Truvada or nothing, before we had aptitude, and unfortunately, with Truvada, you really have to take it every single day, if you were assigned female at birth, otherwise, your drug levels just don't stay good enough to get adequate protection. For patients that were assigned male at birth, we've actually seen, they can miss, you know, two or three doses a week and drug level stay pretty good. Of course, we don't tell patients that, you know, oh, you can miss two or three doses. But it is it is something that that we have seen. So this study the HVTN Oh, 84 was a you know, industry sponsored study. This is what part of what was used to get aptitude approved for use in women. And they had to, to control arms. And you can see, as the study went on, it became very clear that that there was a lower risk of new HIV infections in the patients on the aptitude arms. So they actually stopped the study early and offered everybody to get on to aptitude. And a lot of that goes back to adherence, you know, and sort of how patients have to really be, I say, pre perfect if it was with their doses if they were assigned female at birth. So we can advance. What about PrEP on demand, people will often ask about this. And it is it is starting to make its way onto some guidelines. It's not universally recommended. And I would say it's not recommended definitely to the same level as daily PrEP. And I'm sorry, I just was looking at the confused about Truvada versus aptitude. Truvada is the oral PrEP and aptitudes, the injectable PrEP. And we're flipping back to Truvada. Sorry if I didn't make that clear. So for PrEP on demand, this is only done with Truvada. It's not done with disco v. And it's certainly not done with aptitude. What it is people take they're supposed to take two Truvada is anywhere between two and really, ideally 24 hours before sex. And then they take one pill per day until they're two days after the sex. So, for example, in this graphic if the sex was going to happen on Thursday night, the person would take two pills, ideally 24 hours or at least two hours before and then they would stay on the PrEP for one pill Friday night and Saturday night. If they had sex again on Friday night. They would have continued through Sunday. If they had sex again on Saturday, they would continue one pill a day through Sunday and Monday on this graphic, so it's a little confusing, right? So if you're saying gosh, slow down that that doesn't make sense to me. It's confusing for some patients too. And a lot of the studies that showed that PrEP on demand is effective, which it is. But it was in patients who were having sex fairly frequently. So, you know, generally they were having like four or five encounters a month. And so they tend to got about, you know, about 1212 to 15 pills in at least per, you know, every month. So I think that's another reason why I would not offer a patient PrEP on demand, and presented as an equally effective option when we compare it to daily prop. We can advance. So who should we discuss PrEP with? And really, the answer is E for Everyone. Anyone who could

potentially be sexually active, we should be discussing PrEP with can advance all sexually active adults and adolescents, you know, should be informed about PrEP for HIV acquisition, that's a CDC recommendation, you know, very recent, within the last two years, we can advance. So when is PrEP indicated, if this looks complicated to you, we can skip to the bottom and you can see all roads can lead to PrEP. So when in doubt, always, you know, talk to the patients about PrEP. And certainly prescribe PrEP, if the patient's telling you that they feel that they're at risk. You know, if patients have an HIV positive partner, that's a reason to certainly prescribe PrEP, if we don't know their viral load, if the patient does have that their partner does have an undetectable viral load, we still do some shared decision making with the patients on that because, you know, we'll tell patients, you, you can control if you take a pill every day, or if you get a shot every two months, you can't really control if your partner takes their pills every day. And sometimes it's if the patient's really worried about acquisition, it can actually improve people's relationships, we found when they don't feel like they have to double remind their partner to take the pills every day, and the partner goes, I'm taking my pills, but they keep asking me if I'm taking my pills. You know, sometimes it helps take the pressure off.

22:28
Anyone who's had a bacterial STI in the last six months, this is all the way on the right side. Up at the top here, you can see they're transmitted the same way. So if they've had any sort of, you know, that bacterial STI, right there, I think that's a very good conversation point. And anyone who's having one or more sex partners who have an unknown status, or if they're not in a committed relationship, I think those are good reasons to prescribe. And even if they are always using condoms, patients will sometimes still have concerns or they'll say, Yeah, I'm always using condoms right now. But you know, I'm going to be going on a trip or I'm going somewhere or my behavior, I've had some patients who their behavior changes seasonally. That sounds kind of silly, but it is true. I have patients who say, you know, in the summertime, I go out more I go on certain types of vacations, and I'm more likely to meet people in the winter, I, you know, I tend to not be as social or vice versa. So I think you No, we don't have to really overthink it. For anyone who is, is sexually active or has the potential to be sexually active, this is a good thing to be talking to patients about. And it's, you know, the CDC, when we talk about sexual history, the CDC will often you know, suggest, you know, do people have sex with men, women or both. But it really doesn't tell you a ton of meaningful information to you know, about whether or not somebody needs to be on purpose. So, if you're feeling uncomfortable about taking a sexual history, you can even just get to know your patient, find out if they're sexually active and not go any farther than that. And as you get to know your patient, you'll find they'll actually reveal quite a lot to you if they're sexually active. We know we don't necessarily need to know what type of sex initially. Next. So when is PrEP indicated? So we're gonna do a little case study Ryan's a 17 year old coming to see you for an annual wellness visit today, and he reports that he's never had sex of any kind before. He's not in a relationship and he's never used any recreational substances. He mentioned that he heard about Prop from one of his friends and is interested in

getting a prescription Go for it. So this is a good reinforcement, I think of the previous slide where all roads can lead to PrEP. What should you do? You know, certainly think the patient for bringing it up and commend him for being proactive. Because again, this is not someone who's having sex, but it's someone who has the potential to have sex. And it sounds like they're thinking of becoming sexually active. So you would want to provide information about PrEP, find out what you know, his goals are, and then plan it for I would plan to prescribe PrEP if he wants it, as long as there's no obvious contra indications, and we'll talk about what some of those are. Because the other thing is not every young person feel safe enough to disclose their full history, they might say they're not having sex, because they're worried that you know, maybe their parents are going to, you know, find out that they're having sex or that they're not allowed to tell a provider that, you know, or there might be risk factors that they don't feel safe really talking about right now. Also, not everyone defined sexes the same way. So some patients will, you know, I went in working with young people in the past to say, Well, I'm not sexually active, like I'm a virgin. So I'm not having sex, but they are having, you know, sexual intercourse in in other ways. It's not penile vaginal. Or maybe they're not having annual receptive sex, but they are having sexual contact with people which will lead can lead the way to further contact so there, do not try to talk anyone out or proper tell them that they don't need it, I would say, I let the patients sort of rule themselves in or out for treatment. Next one is PrEP contra indicated. So this is the big one, if they have HIV, don't prescribe PrEP. If you've tested them for HIV, and they are negative, and you go ahead and prescribe PrEP, you're very unlikely to seriously harm the patient. The big thing is make sure they do not have HIV. The reason we don't want to give PrEP to somebody who has HIV is because it's actually not a complete antiviral regimen against HIV, it's only half of a regimen. And so what would happen is, it would actually treat their HIV but not for very long. And eventually they develop resistance to that class of medications. You will always want to assess patients for signs and symptoms of acute HIV infection. Another contraindication would be if the patient was under 77 pounds. And that's maybe where you would want to work or partner with like your peds ID counterparts because, you know, these medications are used in patients under 77 pounds for treatment of HIV. So there depending on what the risk is in the patient's situation, there might be a way but it should certainly give pause. Kidney function is a big one, especially when it comes to Truvada. If someone's creatinine clearance is not 60 mils per minute, or per minute, you want to move forward to desko V if there were a patient that was assigned male at birth, if they were assigned female at birth, then aptitude is really your next and only option. Okay, we can advance. When we look at the labs, this looks like a lot. Again, I promise you if you just don't miss the HIV test, you're in pretty good shape. You know, so when we, when we start with Oracle PrEP, we always want to get an HIV test, you'd like to get their kidney function test. As a best practice, you can get their lipid panel and you'd also want to get your Hepatitis B Serologies. And vaccinate them please if they are not immune, please vaccinate them, and your Hepatitis C serology and any STD testing. If you forget any of that, you can get it the next time. Just don't miss the HIV test. And then every three months, you're going to be doing an HIV test on your patient and then you're going to be

doing STD testing. These are guidelines if your patient tells you that they have not had any sexual exposure. You could make a decision with the patient to not do the STD testing, but you must do the HIV test no matter what that must be done every three months. You can eventually move on the Creatinine level you can just do that every six months. If they've been stable, you could even put Get it out to like one year if they're if they're less than 50 years old. And since we're talking about adolescents, everyone's going to be less than 50. But it's just something that you want to monitor again, if it's totally normal, if it was sort of borderline, I would probably check it more frequently. When we're talking about the injury, the injectable, we don't have to do the kidney function monitoring, but it's all the same labs. Instead, we're going to be doing that though. Every time they get an injection, which is going to be q2 months when they're on the maintenance phase. And it's going to be a month, you know, a month apart from their initiation to their second loading dose. And then your STD testing. You know, we recommend that that's done. They say q for months, but I would say you can I have the nurses trained, you know, we have in our clinic to ask at every time their patients getting an injection, do you need any STD testing, it's really not hard for us to put that that with those orders, and even if they're not seeing a provider, so we offer those really anywhere between Q two to Q six months depending on the situation. And then with Cabo Tegra Vir, it does not have any activity against hep B, whereas disco V and Truvada are actually antivirals that could be used to suppress Hepatitis B, and therefore probably give some pre-exposure prophylaxis against Hepatitis B in and of itself, kind of a nice, nice bonus. But aptitude does not do that. That's the injectable Cabo tag, Revere. So I think really talk to the patient, about the risk for Hepatitis B acquisition if they're not immune, and how vaccine is their best shot at preventing getting an infection. Because Hepatitis B can be transmitted sexually,

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we can advance what kind of HIV test to order. So HIV, fourth generation antigen antibody we want, that's the test that we want to do at all points in time for both the oral and the injectable. And the recommendation now is to get an HIV RNA assay for anyone when they are first starting PrEP. So they haven't been on PrEP, this is not a maintenance visit for them. So at the initiation, we're always getting an HIV RNA assay. And then for the for oral, you don't have to do it. Again, unless they are, you know, had non compliance with oral dosing or there's any symptoms that are concerning for acute zero conversion. You can repeat it at the one-month visit, if there was any high risk exposure like just prior to initiating PrEP. But if there wasn't so like if it was our case, study patient, you know, that we talked about who had not been sexually active, we wouldn't need to repeat a viral load on him. The guidelines on the CDC are a little bit more aggressive about that these were the New York State Department of Health guidelines that that were going by for the injectable, it's actually a little easier to remember, because just every time you do an HIV test, we're also doing a viral load. The reason for that is this is sort of a newer, newer mode of prevention, and it has failed in a handful of patients. And when that happens, there is delayed zero conversion on that antigen antibody tests. And we want to make sure that

we're capturing those as quickly as possible. If somebody does fail. Can we go to the next slide? Oh, and yeah, just we don't have to go back to the slide. But just to reinforce, the patients can't tell you, Oh, I went to the STD clinic and I already had a test, you have to do the test or have the actual test result in hand that came from the other place. Even some of the insurance companies are actually getting hip to that and then saying, well, nobody billed us for an HIV test. So we want to know, was it done before they'll release? You know, the authorization for the PrEP? Does PrEP increase the risk of resistant HIV? That is a great question and a very fair point, because we talk about resistance all the time and treating HIV. You know, if the patient was HIV positive and stayed on PrEP, it certainly would increase the risk. But the general use of PrEP, I wanted to point out despite oral PrEP being used for more than 10 years, the most common antiviral resistance that we see at baseline for patients is not to a class of medications that we use for PrEP. It's the K 103 N mutation which confers resistance to efavirenz, which is a non nucleoside reverse transcriptase inhibitor. So um, it to me, this is very reassuring that we're not seeing tons of baseline NRTI nucleoside reverse transcriptase inhibitor resistance at baseline, because of the use of crap. So that was something we were very worried about in the early days. And, you know, knock on wood is not coming to fruition. When we're talking about aptitude, this is a risk that is unique to aptitude that we don't really see with the oral medication. So I do some extra counseling with patients on this. I explained to patients, when you have appropriate drug level of aptitude in your system, you're going to have protection. But then when the drug level starts to fall, it doesn't leave the body, you know, within a few days, it stays in the system for months, the manufacturers actually said up to a year. And when that happens, there's not enough drug level to prevent an infection. And if an infection were to develop, while that sub optimal drug level is in the patient's system, this is a very high risk of the patient developing drug resistant HIV. And aptitude is an integrase inhibitor, and almost all the first line drugs right now are integrase inhibitor base, you know, all the ones that we see all the nice commercials for where everyone's you know, going to the beach and playing basketball and living their best life, none of those would work for those patients. So I tell patients, if you are going to stop aptitude, and you still have risk for HIV acquisition, I strongly encourage patients to get on to oral PrEP. If they're able to do that. If they're not, you know, then the condom conversation. You know, condoms are always a part of the conversation, but I think then we really have to talk to patients about other ways to prevent HIV, you know, transmission. Okay, how we can advance clinical considerations. We've kind of talked about the Hepatitis B stuff, both tenofovir disoproxil fear are made and to not figure off annamite are FDA approved to treat hep B. It doesn't mean if your patient had had the you could not give them oral PrEP, it just means when they are going to stop if they want to stop those agents or say they wanted to go to the injectable PrEP, there really needs to be some good counseling points around the risk of Hepatitis B flare monitoring for rebound by viremia. Those types of things. pregnancy and lactation. Truvada is really the only product that has been studied in patients who are pregnant and who are lactating. And really, it's a shared decision making. It's not an absolute contraindication. Although we don't want to leave people on Truvada during pregnancy, if there is no risk for HIV acquisition. So it's

really a shared decision making. And then when we talk about bone and kidneys, you know, thanks to all the attorneys out there talking about tenofovir and, you know, for our patients with HIV, if you were on these drugs at a certain time, call this number if you have bone density or kidney problems. A lot of that is because of tenofovir. So when we're talking about Truvada, the older version, there is more of a concern about bone density and kidney issues. And certainly, if somebody at baseline, you knew how to osteoporosis, maybe we would not want to go with Truvada. This is less of a concern with disco V. But I wouldn't say it's zero concern. The most favorable product, you know, would be to go with the injectable if renal toxicity or bone health was a big concern. can advance.

39:24
So a concern that a lot of folks have about PrEP in adolescents and young adults is whether they can actually be adherent. So this was a 2021 meta-analysis that looked at a bunch of studies that looked at adherence in individuals under 30. And what they found is that overall, a majority of these young people were found to be adherent. There were no difference based on participant age, although there were very few studies that actually had a focus on under eighteens. And the adherence tended to be lower in studies that happened pre 2012 Which is when Truvada was first approved for PrEP and adults. So it may be that people may have been more likely to be adherent once PrEP had more name recognition and wasn't just some random experimental drug. But this overall tells us that adolescents and young adults can be adherent with PrEP. So what about condoms, but we still always need to recommend condoms or other barrier methods. The studies have found that PrEP use is associated with decrease in condom use. And I know that scares a lot of providers. But we actually see mixed findings on whether PrEP use is actually associated with an increase in other STIs. And so we need to remember that frequent STI testing is a built-in feature of being on PrEP, because like who else is coming in every two to three months for comprehensive testing, other than focus on PrEP, not very many people. So this means that for folks who are on PrEP, we're looking more, so we may find more. But that also gives us the opportunity to be able to diagnose more and treat more. So there have been a number of modeling studies that have actually found that with increasing PrEP uptake, other STI rates could plummet, even if condom use were to go down. Some things to consider when you're working with trans and gender diverse folks are for people who are on estrogen or anti androgen regimens, we can provide reassurance that PrEP does not impact hormone levels or the effects of hormones. But estrogen may decrease tenofovir levels in the rectal tissue. So daily adherence is going to be especially important. The SCOBY or F TAF is not yet recommended for PrEP for anyone who has receptive vaginal sex, because again, there's not yet enough data to prove its efficacy. And so when we look through the CDC guidelines that were updated in 2021, they really spell out quite well how to best manage PrEP for folks who are quote MSM, for transgender women, for folks who have heterosexual contact, but they really don't say much of anything about trans men or non-binary individuals, mainly because there's a very minimal data. So well, it's clear that the CDC really in the latest updates was trying to use inclusive language in

their guidelines, we really have kind of an erasure of these populations. And we're essentially kind of left on our own to figure out how to best apply the guidelines there. So I will share with you my approach that I use until we have better data and guidelines, which is for trans males. And for non-binary people who were assigned female at birth, I generally just avoid prescribing disco v. And for trans males and for all non-binary individuals, I generally just follow the same lab testing and screening schedule that they suggest for MSM and trans women, unless the patient has strong feelings otherwise. So when should we be discussing PEP? There's lots of opportunities for talking about PrEP that you can integrate into your usual flow, like during visits for STI screening, testing, or treatment. This is for contraception. Well, visits are pretty much anytime you're taking a sexual history. If somebody's having contact that can put them at risk of a pregnancy or at risk of getting another STI, then essentially, they're also having contact that could put them at risk of HIV acquisition. So PEP could be relevant. How do we go about bringing it up? One way is just to ask, have you heard about PrEP, and given a simple explanation of what it is like PrEP is a medicine that people can take to help keep them from getting HIV. And going from there, we really got to get in the habit of bringing it up with all adolescents proactively, a because that's what CDC is telling us to do. And because it normalizes that this is a thing that exists that can help keep people safe. And it isn't this thing that marks people as being high risk or promiscuous or a thing that we just reserved for gay men. The more we can talk about it, the more we can help to fight stigma. Whenever we're taking a sexual history or providing PrEP care, or really anytime we're talking sensitive subjects, we always need to be using judgment free and affirming language. And remember to set up the conversation with a discussion about confidentiality being as clear as possible about what can and can't be kept private. Whenever we're asking sensitive questions, we should normalize that this is stuff that we discuss with everyone. And we need to be clear about why we're asking these questions. And we need to make sure that patients know that it's up to them how much they feel comfortable sharing with us Um, we want to avoid unnecessarily gendered language or making assumptions about a person's partners or practices. And we should all be remaining unfazed, no matter what they share. There's not one right way to take a sexual history. And there's plenty of different scripts that you can develop that incorporate these principles. So let's talk about minors accessing PrEP in New York state. So a 16 year old patient is interested in getting started on PrEP, but they aren't comfortable discussing that with their family. Which of the following best describes current New York state law? Review that minors can consent to PrEP without a parent guardian involvement? Can they consent to HIV testing and HIV treatment, but not to PrEP without a parent guardian involvement? Or is New York law vague about whether minors can consent to PrEP without parent guardian involvement? Well, it is a so minors can in fact, consent to PrEP without parent involvement. So in 2017, the state law was actually amended to explicitly grant minors the capacity to consent to PrEP and PEP on their own. But even though miners can consent to PrEP on their own, and even though we as providers can feel totally fine about this, and can intend to keep this information confidential, there's actually a lot of things that we need to think through with young people who want to use PrEP without their family

knowing. And I would argue that this is actually the part that is more complicated to do than the actual medical management of PrEP itself. But it's essentially all the same stuff that we're thinking about whenever we have got a patient to say wants to be on birth control without their family knowing. So some of the things we have to consider is, how are we going to communicate with the patient, we're going to be doing a lot of STI and HIV testing that we've got a notify patient about. And we also want to be able to reach the patient to check in when they're first getting started on PrEP. I like to usually check in after the first week, which is when people are most likely to have side effects, great opportunity to offer reassurance and encouragement or help troubleshoot difficulties with adherence. So we need to make sure that we've nailed down in advance a really clear way of getting in touch with them. We also got to think about the electronic patient portals now, we need to think about whether a parent or guardian has access to that portal too. And will they inadvertently see notes, results, prescriptions or clinic appointments? Do you need to shut off the parent portal access or adjust the settings, we need to think about what phone number the pharmacy has on file and who they're going to call to notify the prescriptions ready. Sometimes I actually will during the visit with the patient call the pharmacy with them together to update their information if the patient's not sure if they've got their parents number on file there. And oftentimes, I will write in the prescription that if there's any issues with filling the script, that the pharmacy should call me and our office, not the family that this medication is to remain confidential from a family. Unfortunately, even though discovery and Truvada are just pills that can be stocked and dispense from pretty much any pharmacy. There's some insurers that still are insisting that because these are HIV meds, they gotta be dispensed by a specialty pharmacy, sometimes by a mail order pharmacy. And so when that's the case, oftentimes I find it most helpful for me or social worker or a nurse in our office, to just sit in the room with the patient and get on the phone and call the insurer or the mail order pharmacy together with the patient to help them get that set up. We got to think about where they're going to keep their meds if they're on the pills at home. And are they how are they going to handle that if they were to be discovered by somebody else at home? How are they going to get to and from appointments, you can totally do PrEP prescribing by telemedicine, but they're still going to need to get themselves to a lab or to the clinic for labs at least every three months. So how are they going to get there?

49:22
And are they going to use their parent's insurance? If so, are parents going to receive an explanation of benefits? So when that's a concern, I will call the insurance company together with the patient and we can request that EOB is not be sent for any care relating to PrEP or can request that EOB is be sent to an alternate address that typically works but again, there's never any guarantee you when you're dealing with an insurance company. Fortunately, under the ACA because PrEP has a great a recommendation from USPS TF. It has to be covered by insurance without Cost Sharing that includes appointments, the labs meds, which is great news for a lot of young people who are on their parent's insurance that they have the ability to access that care

on their own without generating bills. And we all got this circular letter last year from the Department of Health, reminding us that PrEP and all the associated care must be free for anyone with insurance. Unfortunately, though, there's still a lot of caveats. And there's still a lot of folks left that aren't able to access PrEP. And just because it's the law doesn't mean that all insurers are abiding by it. So for the insurers that do play by the rules and adhere to covering the care with no cost sharing, it's important to use the right ICD codes when you're doing your billing so that they recognize that this is for PrEP and for covered services. So the billing codes that the Department of Health advises, get used are here. This primary code that we're using these days is z 20.6. Contact with and suspected exposure to HIV. There used to be another set of ICD codes that were commonly used that have really stigmatizing language, which thankfully seem to be getting kind of phased out. And then for folks with commercial insurance only, it is suggested that modifier 33 be added, which was developed in response to the ACA, which gets used when a service carries A or B rating from us PSDF to signify that it's supposed to be covered without cost sharing. Wrap app is the PrEP assistance program that offers reimbursement for office visits and testing related to PrEP. When somebody's uninsured or underinsured, doesn't pay for the meds themselves, those get covered through one of the patient assistance programs offered through the drug companies. So this is a great program that increases access. But it does not cover people who have insurance and just don't want to use it. So for example, if we've got a kid on their parent's insurance that doesn't want to use it due to privacy concerns, they're not eligible for PrEP at the Department of Health AIDS Institute has put together a really helpful guide on additional payment options for PrEP that you can access online. And so our take home points for today are that PrEP is super effective when it's taken consistently. Adolescents can take PrEP and they can consent to it on their own, we got to start talking about PrEP with all adolescents and young adults, especially those who are sexually active. And if you are capable of prescribing amoxicillin, then you are totally capable of prescribing PrEP. And there's a lot of resources available to help you. So some good starting points for resources are the CDC guidelines, and even more user friendly as the New York AIDS Institute's websites. And then I know CI has a number of other resources. And so I'm going to turn this back over to Dr. Ron.

53:09
Thank you both for a very comprehensive presentation, I'll just make one plug for our CI line, which is a 1866 number, where you can call as a clinician with clinical questions about HIV, Hep C, Drug User Health, sexually transmitted infections, PEP, or PrEP, and you'll reach a clinician expert to assist with those questions. I see we have a few minutes less left. And in the chat, there have been a number of questions that actually had been answered sort of in an ongoing way in the chat, but maybe we can get some of those verbally. And one of the first ones was what a patient with chlamydia? Who was a man having sex with women or when having sex with men? Would that be an indication or a PrEP?

54:04
And I typed in the chat, it's on the guidelines. It's not an automatic indication, but we recommend, you know, shared decision making with the patient because it's certainly something I would be concerned about. But it's not something that was called out on the New York State guideline.

54:19
But it does count as a bacterial list. Yeah, exactly.

54:23
Yeah, exactly.

54:25
And then there are a few questions about insurance some of which I think you've answered. Do you navigate insurance in the same way for adolescent patients? Moving who you are a screening for STIs prior to PrEP?

54:44
And I said yes, any patient, any patient under someone else's insurance, including adolescents can request any OB to go to a different address. So and that also applies to if you have somebody who's maybe an adult and they're under their partner's insurance, but they don't want their partner to know, you know that they have access to care. There was a question about across state lines. I, that I don't actually know the answer to about the nationwide if it's a regulation nationwide for it to be covered under preventative care or just New York State. I know there's movements for you know, moving towards that, but I don't know that every state, nor has there nationally been something that's come down.

55:36
I didn't leave, I believe it is supposed to be covered. But again, like the enforcement of that is not consistent.

55:48
And then there's a question Do you have a handout or recommended website for patients

55:53
to like I do. So CEI has these really great treatment cards that sort of like they're like the type of cards that are about the size of your badge. And right off the CEI website, you can order those for free, and you can order as many as you need for your practice. And it talks about the recommended labs and then also gives you a little cheat sheet about which products you know,

like disco V versus Truvada and what the doses are on the product. And then Jamie or Dr. Irvin, if you have any others.

56:28
I oftentimes direct the CDC, CD CBC has a couple of really helpful, user friendly and patient friendly things that can be printed out to.

56:44
I'm going to see if I can grab the link for or on set, put it right in the chat for ordering the materials. Thank

56:51
you, Jamie and Kelly so much. A lot of what you talked about is going to be intertwined with some other upcoming trainings about once a month, specifically adolescent confidentiality, contraception and how to take an affirming sexual history for young adults and adolescents. And this eventually will all be part of a learning pathway on CIA's website, so please keep an eye out for that.

57:18
That website is CEItraining.org. Right, so we're just at one o'clock. So again, thank you to our presenters and thank you.

[End Transcript]