AMERICAN ACADEMY OF HIV MEDICINE

Academy Guidance and Recommendations for Pre-Exposure Prophylaxis (PrEP)

Almost a decade after the Food and Drug Administration approved the use of F/TDF for pre-exposure prophylaxis, the number of people taking PrEP has steadily increased while new HIV infections have declined. Notwithstanding, PrEP uptake has largely been among cisgender, white gay and bisexual men (MSM) with access to health insurance and care. While the U.S. Preventive Services Task Force (USPSTF) has given daily, oral PrEP an "A" grade for preventing HIV acquisition,[i] and the U.S. Centers for Disease Control and Prevention have called for broader uptake of PrEP by people at risk for acquiring HIV,[ii] barriers to uptake and retention in PrEP care continue for many. In broad terms, PrEP candidates face challenges related to costs, insurance coverage, time, lack of provider awareness, provider bias and a lack of public awareness.

Despite the effectiveness of PrEP, challenges remain reflected by low levels of utilization. As of 2019, an estimated 224,000 people in the U.S. received a prescription for PrEP comprising a fraction of the 1.1 million Americans estimated to have an indication for PrEP.[iii, iv] Unfortunately, the lack of uptake is among those most affected by HIV and who face the greatest challenges accessing the medication. For example, Black and Latin Americans comprised 69 percent of new HIV infections in 2017,[v] but only accounted for 24 percent of PrEP users.[vi] Sexually active cisgender women also have a low uptake of PrEP with a CDC analysis of 2016 prescription data finding that only two percent of women with an indication were prescribed PrEP.[vii] Lastly, compared to the national average, residents in Southern U.S. states had the lowest uptake of PrEP with 21 PrEP users per 100,000 people compared to 25.8 nationally.[viii]

This document and its companion guidelines and recommendations are intended for prescribers new to PrEP and for general education and awareness of medical providers. While there are barriers and interventions for providers to consider, any sexually active patient should be informed about PrEP regardless of perceived risk.

Barriers to PrEP Uptake

Lack of General Public Awareness

Among the general population, PrEP awareness is low. In a survey of the general public from 2009 to 2014, less than seven percent of of surveyed adults (19,806) reported PrEP awareness.[ix] In 2018, a Southern Arizona study of individuals surveyed at public health departments that provide family planning and STI testing and treatment found that only 20 percent of participants were aware of PrEP.[x] Another study in North Carolina reported only nine percent of survey participants had heard of PrEP.[xi] Overall, more public awareness about PrEP needs to occur, especially with individuals at increased risk for HIV acquisition.

Out of Pocket Costs

Despite the U.S. Preventive Services Task Force "A" grade that requires most insurers to provide PrEP at no costs to patients,[xii] many private health insurance companies are still passing the costs on to the patient. Costs associated with laboratory monitoring, especially for high deductible health insurance plans are a significant barrier for many patients. Venipuncture and laboratory analysis for HIV testing and STI monitoring along with STI swabs can cost up to $2000 per visit depending on the lab conducting the test and analysis.[xiii] If patients have yet to meet their annual deductible, this can be a pricey outlay.[xiv] Depending on the insurance plan, the costs of laboratory monitoring can still be a hefty copay. Similarly, patients with health insurance are still being charged co-pays for dispensing their PrEP medications, even if it is generic F/TDF. For lower income individuals, this serves as a barrier to adopting PrEP and continuing follow-up care.[xv]

Payer Coverage

Providers can help facilitate coverage of these services by educating patients and insurers alike of the USPSTF requirement. Most insurance plans and state Medicaid plans cover PrEP;[xvi] however, as previously stated many private insurance companies are still implementing co-pays and deductibles that can serve as a barrier to PrEP access and retention. In addition, there have been reports that patients successfully retained in PrEP care have been denied insurance coverage when shopping for a new insurance plan for having a pre-existing condition. In those states that have failed to expand Medicaid coverage, options remain limited. While the federal government's "Ready, Set, PrEP" initiative covers the cost of medications for PrEP for people without insurance, it does not cover medical visits or laboratory testing and monitoring, and is limited to U.S. citizens with a social security number, and some candidates are wary of sharing this information, especially individuals living with undocumented relatives in the same household. Similarly, most PrEP manufacturers have patient access programs, but many of these are limited to co-pay assistance.

Frequency of and Time Required for Medical Visits

Because PrEP follow-up care requires HIV testing and laboratory monitoring every three months, many candidates cite the time required attend medical appointments as a barrier. This is especially true for hourly wage workers, those who rely on public transportation and patients who have few PrEP prescribers where they live. If providers do not offer on-site specimen collection for HIV and STI testing the PrEP candidate is then required to make a second appointment for venipuncture and STI testing. This can be exacerbated when commercial laboratories offer a blood draw but do not offer STI self-swab collection kits requiring the candidate to visit a third location or rely solely on blood and urine analysis.

Stigma and Confidentiality

Many candidates for PrEP have stigma and confidentiality concerns. For individuals under the age of 26 who remain on their parents' or guardians' insurance, they may be concerned that their parents will see their PrEP prescription on their insurer's Explanation of Benefits. LGBT individuals may not be out to family or friends, and have fears about what assumptions loved ones will make about them being on PrEP. Whereas others may have concerns about being labeled or assumed as LGBT, perceptions of sexually promiscuity, so-called risk behaviors, or even partner monogamy. For people who inject drugs, issues related to criminalization and incarceration are pervasive. Notably, one focus group of transgender women found that they would be perceived as having HIV if they received a PrEP prescription.[xvii] PrEP stigma exists and can manifest in multiple ways including homophobia, transphobia, racism, and sexism and should be acknowledged.

Lack of Provider Awareness

Many medical providers, especially those who do not treat people with HIV, lack awareness about offering and prescribing PrEP. Providers' implicit bias may prevent them from considering an individual could be at risk for HIV acquisition, preventing them from starting conversations with their patients. In fact, provider bias often manifests in treatment decisions, patient-provider interactions, adherence, and patient outcomes.[xviii] While the Centers for Disease Control and Prevention has begun messaging that any person that wants PrEP should be prescribed PrEP, their most recent Guidance (2021) is daunting for new PrEP prescribers with over 75 pages of information. Lastly, many providers never received training on talking about sex with their patients, taking a sexual health history, or conducting a sexual health examination.

Interventions for Medical Providers to Increase PrEP Access

Ask All Patients if They Have Heard About PrEP

All sexually active patients should be asked if they have heard about PrEP in a non-stigmatizing manner. If the patient replies no, offer to briefly explain what PrEP is and continue the conversation as appropriate. If they patient replies affirmatively, ask if they would like additional information. This is especially true when treating confirmed STIs or confirming a pregnancy test. Patients do not need to be offered a PrEP prescription during an initial conversation; however, it is a starting point and an opportunity to raise more general public awareness about PrEP as an HIV prevention option.

Discuss PrEP as Part of Primary Care and Decouple Discussions with Stigmatizing Labels

Many individuals cite stigma as a barrier to utilizing PrEP. In response, providers need to adopt the attitude that all sexually active adults should be made aware of PrEP. More explicitly, the conversation with patients should occur in a non-stigmatizing way that avoids reliance on labels such as gay, straight, or transgender. Such labels may affect an individual's willingness to discuss their sexual behaviors or drug use and need for PrEP. Specifically, providers should avoid using the ICD10 codes of Z72.51 (high-risk homosexual behavior) and Z72.52 (high-risk heterosexual behavior). Both codes are antiquated and may reinforce stigma when patients see either on their Explanation of Benefits. Instead, the American Academy of HIV Medicine recommends using ICD D 10 code Z20.2 (contact with and suspected exposure to infections with a predominantly sexual mode of transmission) and Z20.6 (contact with and suspected exposure to human immunodeficiency virus) for serodiscordant couples.

Familiarize Yourself with Taking a Sexual History

In many health professional schools, students are taught to address sex from a pathological framework centered on diseases states (HIV, STIs) or pregnancy and screening for these conditions and treating them appropriately. Today's approach is now proactive, focusing on sexual health and wellness by creating spaces where patients are comfortable discussing their full and authentic selves. Language is key in taking a sexual health history and frame your questions in open-ended and affirming language that allows patients to tell their own narrative. Open-ended questions avoid assuming certain sexual and gender identities and the identities of sexual partners. A good way to start is, "Hi, my name is Dr/PA/NP _____, my pronouns are _____, what would you prefer to be called and what are your pronouns?"

Offer PrEP for Every Patient That Asks for It and Meets Clinical Eligibility Requirements

Any patient that believes they are at risk for HIV acquisition is at risk for HIV acquisition. Believe your patients.

Advertise PEP and PrEP Availability
Many patients come into PrEP care after needing Post Exposure Prophylaxis (PEP); however, people who need PEP often do not know where to go other than the Emergency Room. All health care facilities should include advertisements about PEP and PrEP in their literature and waiting rooms, especially Primary Care Providers, HIV Clinics, STI Clinics, Pharmacies and FQHCs. Add PrEP and PEP signage in laboratories and patient restrooms. If you need resources, the CDC's "Let's Stop HIV Together" campaign has online, printable resources that are easy to obtain.[xix] When PrEP candidates know that information about PEP and PrEP is available, they may be more likely to inquire if it is an appropriate option.

Familiarize Yourself with the Various PrEP Formulations and Eligibility
Daily oral PrEP with F/TDF has been approved for **all** sexually active adults and adolescents (>35kg/77lbs) who report sexual behaviors that place them at ongoing risk for exposure to and acquisition of HIV, for **all** people who inject drugs and their sexual partners, and/or anyone who asks for PrEP. Event-based oral F/TDF, or 2:1:1 dosing has been prescribed off label **only** for adult same gender loving men who have sex less than two times per week and can anticipate sex and event-based PrEP is an off-label use.

Daily oral PrEP with F/TAF has been approved for use **only** among cisgender men and transgender women or those assigned male at birth. For adolescent cisgender men under the age of 19 who may continue to experience bone growth, providers may want to start preferentially with F/TAF as bone density scores did not improve upon stopping F/TDF and lower bone density is correlated with PrEP adherence.

Injectable PrEP with extended release cabotegravir has been approved for **all** sexually active adults and adolescents (>35kg/77lbs) who report sexual behaviors that place them at ongoing risk for exposure to and acquisition of HIV. Injectable PrEP is given in two initiation injections administered one month a part, then every two months thereafter. Patents can start with either an injection or take oral cabotegravir for four weeks to assess tolerance.

The efficacy and safety of other antiretroviral medications for PrEP, either in place of, or in addition to oral F/TDF, oral F/TAF or injectable cabotegravir have not been studied extensively and are not recommended.

Familiarize Yourself with the Clinical Eligibility for PrEP Patients
To prescribe PrEP to new patients, all of the following conditions must be met: 1) a documented, negative HIV Ag/Ab test result within one week of the initial prescription, 2) no signs or symptoms of acute HIV infection, 3) an estimated creatinine clearance of ≥ 30 ml/min, 4) no contraindicated medications, and 5) for F/TDF, the creatinine clearance should be >60 ml/min. Before starting injectable PrEP, the guidelines recommend providers assess HIV status using RNA instead of an HV Ag/Ab tests.

Familiarize Yourself with the Follow-Up Care Requirements
Every three months/90 days, all patients need an HIV Ag/Ab test, an HIV-1 RNA assay and a discussion of medication adherence and behavioral risk reduction. In addition for same gender loving men and transgender women who have sex with men, screen for bacterial STIs with oral and rectal swabs, a urine sample and blood draw. For people who inject drugs, offer harm reduction counseling and drug treatment services.

Every six months/180 days, assess the renal function for patients ≥50 years or who have an eCrCl <90 ml/min at PrEP initiation and screen or bacterial STIs with vaginal, oral, and rectal swabs as indicated, a urine sample, and blood draw.

Every 12 months, assess the renal function for all patients, chlamydia screening for heterosexually active women and men with vaginal swabs and urine samples and for patients on F/TAF, assess weight, triglyceride and cholesterol levels.

For specific follow-up care for injectable PrEP, please refer to the Guidelines on Injectable PrEP. Please note: because of the long duration of drug exposure following injection, exclusion of acute HIV infection is necessary with the most sensitive test available, an HIV-1 RNA assay.

Familiarize Yourself with the Appropriate Billing and Coding
The ICD-10 codes for high-risk homosexual behavior (Z72.52) and high-risk heterosexual behavior (zZ72.51) are antiquated and stigmatizing. The Academy recommends using the following ICD-10 codes for billing and coding when ordering new labs, prescriptions, and for insurance purposes:

- Z20.2 – Contact with and suspected exposure to infections with a predominantly sexual mode of transmission
- Z20.6 – Contact with and suspected exposure to human immunodeficiency virus (for serodiscordant couples)
- Z29.8 – Other Specified Prophylaxis
- Z29.9– Unspecified Prophylaxis
- Z70.8 – Safe Sex and STI Prevention Counseling
- Z79 – Intravenous Drug Abuse
- Z79.51 – Drug Abuse Counseling and Surveillance

In addition to billing and coding, be prepared to offer patients information on State PrEP financial programs such as https://www.nastad.org/prepcost-resources/prep-assistance-programs and manufacturer copayment assistant programs.

Reduce the Patient Time Burden by Decoupling Medical and Laboratory Visits
For established PrEP patients, consider minimizing the follow-up care to 90-day laboratory monitoring and HIV and STI testing with standing orders. If possible, allow flexibility for the patient with walk-in laboratory appointments. Once you have received the results, order the patents' prescription with a 90-day supply. If possible, prescribe to allow the patient to receive the full 90-day supply at one time. Follow-up with in-person appointments every six months to discuss ongoing behavioral risk reduction, general health and overall desire to continue PrEP. Inform new patients that once the provider is confident in their PrEP adherence and their ability to meet the laboratory monitoring and HIV and STI testing requirements that they can move to less frequent appointments. Keep in mind that commercial laboratory sites such as Labcorps or Qwest do not routinely offer self-swab STI test collection on site and use your own laboratories when possible. If providers want to keep follow-up care to every 90 days, consider implementing telemedicine or virtual appointments or consider altering clinic hours one or two days every few weeks. Altered clinic hours can vastly improve retention in care for hourly wage workers or people reliant on public transportation. Telehealth is also a great option for patients in rural and remote settings with limited providers.

Reduce the Patient Out of Pocket Cost
When billing and coding for PrEP services, add the ICD-10 codes **with** modifier 33 to minimize patient out-of-pocket costs. Modifier 33 is a CPT modifier used to identify medical care with the primary purpose being the delivery of an evidence-based service as evidenced by the U.S. Preventive Services Task Force. Providers may also consider using Modifier 90 when laboratory procedures are performed by a party other than the treating or reporting provider and the laboratory bills the provider for those services.

Reduce the Provider Time Burden
Consider establishing electronic records with standardized and standing orders needed for follow-up care. For patients that opt for injectable PrEP, consider scheduling appointments at 1, 2, 5 and 7-month intervals and subsequently every other month in six-month increments. Encourage patients on injectable PrEP to choose a start date and time that is convenient and easily remembered to avoid unnecessary rescheduling. When possible, identify support staff and/or pharmacies that can conduct follow-up care for patients with low adherence and for patients who require prior approvals for F/TAF.

Seek out Appropriate PrEP Related Continuing Medical Education
Implicit bias, taking a sexual health history, diversity and inclusion, and motivational interviewing greatly improve the ability for medical providers to understand the need for PrEP and ability to inform patients about the intervention. The Academy is creating a course on communicating with patients that includes these topics; however, any relevant course will help inform medical providers about topics related to HIV prevention and sexual health of patients. Additional courses include PrEP 101 topics, male and female sexuality and general HIV prevention.

Encourage the Discussion of PrEP in Medical Education
As more and more states expand the role of pharmacists to deliver PEP and PrEP, all medical providers should encourage student education on these topics. Including PrEP education in medical, physician assistant, nurse practitioner and pharmacy schools. Educating students will greatly expand the pool of providers trained and educated about the importance of PrEP to reduce new HIV acquisitions. Other topics include education about sexual behaviors and consensual sex among non-married and non-monogamous partners to create an environment where patients are comfortable discussing and sharing their sexual behaviors.

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[xv] Whitfield T, John S, Rendina H, et al. Why I Quit Pre-Exposure Prophylaxis (PrEP)? A mixed-method study exploring reasons for PrEP discontinuation and potential re-initiation among gay and bisexual men. *AIDS Behav*. 2018;22(11):3566-3575
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