New Zealand AIDS Foundation
Te Tūāpapa Mate Āraikore o Aotearoa

20 January 2020

PHARMAC
PO Box 10254
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Feedback on the proposed changes to HIV pre-exposure prophylaxis prescribing

Dear Lindsay Ancelet,

We are writing in support of PHARMAC's proposal to widen the PrEP prescriber group to include sexual health specialists, infectious disease specialists and vocationally registered general practitioners and nurse practitioners. To facilitate equitable PrEP uptake we also recommend the patient eligibility criteria is revised to meet the needs of the New Zealand epidemic and reduce barriers to access for those at risk of HIV.[1]

The New Zealand AIDS Foundation (NZAF) is a registered charity and non-governmental organisation funded through contracts with the Ministry of Health and independent fundraising to provide a range of HIV and AIDS related services, including: HIV prevention and health promotion, HIV testing, counselling and support, research, policy, and information services.

Knowledge of PrEP amongst men who have sex with men (MSM) has strongly increased in the last two years, yet low uptake has remained an issue. Recent PHARMAC data suggests only 40% (2462) of the estimated 5847 eligible individuals have accessed PrEP between March 2018 and October 2019.(1) There are a number of possible reasons for the slow uptake of PrEP including:

- Difficulty in accessing PrEP through the special authority process, due to a lack of awareness among GPs, and a lack of approved HIV specialists available to aprove requests for prescriptions.
- High demand on sexual health clinics which are already stretched to capacity due to reduced resources and funding.
- The necessity to disclose the intimate details of sexual practices with clinicians. Research shows that half of gay and bisexual men in New Zealand are not open with their GP about their sexual orientation or behaviour.(2) These barriers were greater among non-European ethnicities, due to issues in accessing and navigating healthcare.
- Comfort in discussing PrEP with a GP. A recent survey of MSM found that of those who aren't using PrEP but want to, 34% stated that a barrier to access was discussing PrEP with their doctor.(3)

We support PHARMAC's proposal to widen the PrEP prescriber group to include sexual health physicians, infectious disease specialists and vocationally registered nurse practitioners and general practitioners who have undergone appropriate training. This will enable greater access to PrEP nationally. The former process of prescribing on special authority from an approved HIV specialist

[1] This is further to our support to the proposed changes to the PEP prescriber group and eligibility criteria which was provided in December 2019.

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added a layer of complexity to the PrEP prescription process, due to a limited number of approved HIV specialists (approximately 16 current valid specialists according to our review of the prescriber list), who were only available across ten of the twenty DHBs, adding considerable strain to the system.

Widening the PrEP prescriber group will also help to improve sexual health and HIV care nationally. Health practitioner knowledge of PrEP has been increasing but remains low amongst GPs. To enable rapid scale up we need efficient systems and ongoing training, such as the ASHM online course supported by local workshops to enable health practitioners to prescribe PrEP and provide culturally appropriate, ongoing sexual health care. We support the inclusion in the PrEP Special Authority criteria that the applicant has an up to date knowledge of the safety issues and is competent to prescribe PrEP.[2]

We are concerned that the proposed changes to the PrEP Special Authority criteria require results of comprehensive testing, including of renal function, *before* PrEP can be prescribed. This will delay PrEP uptake by increasing the number of appointments needed and increasing costs for PrEP patients. Previously the initial testing required to prescribe PrEP was for an HIV test only at the first appointment, enabling prescribers to develop systems that reduced the time burden and appointment costs for patients while still meeting the need to confirm HIV status, review medical history and assess for STI and viral hepatitis. If this new criteria is introduced, patients will be required to return for their prescription once test results are available, and this could create a barrier to uptake. NZAF supports the criteria issued by ASHM, recommending that for patients with no recent HIV test result, PrEP can be prescribed on the same day as an HIV test and the patient advised to only start PrEP once informed the HIV test is negative.[3] All other baseline laboratory evaluations can be managed by follow-up and should not delay the provision of a PrEP prescription.

We strongly recommend further changes to the PrEP eligibility criteria are considered that address key barriers to access and could increase PrEP uptake. We recommend:

- **Patients accessing PrEP should be assessed for their future (prospective) risk AND/OR previous history of risk (when they have had an STI or used methamphetamine).** The criteria should be revised to allow patients to present as either having a history of risk or potential future risk. The current criteria is unnecessarily restrictive for patients whose circumstances have changed and they cannot demonstrate previous risk in the last three months. There could be a wide range of reasons for this including age (i.e. no sexual history), change in relationship status or planned future travel. The latest 2019 ASHM PrEP guidelines no longer require an individual to demonstrate HIV risk in the previous 3 months, with having had a risk event seen as an excessive requirement for patients. (4)
- **Widening the criteria in 6.1.4.1 to include both receptive and insertive anal sex.** Discussing sexual practice can be a barrier to accessing PrEP, with feedback from patients accessing PrEP reporting shame at needing to disclose receptive anal sex to their GP. This barrier may be greater among non-European ethnicities who may experience additional stigma disclosing receptive anal intercourse than other gay and bisexual men. (5)

[2] refer to local health pathways or https://ashm.org.au/HIV/PrEP/ for training materials

[3] ASHM in collaboration with NZAF have developed a PrEP prescribing tool for clinicians 'Prescribing HIV Pre-Exposure Prophylaxis in New Zealand. Available at https://www.ashm.org.au/products/product/decision-making-prep-nz

- **Extend criteria for patient history of STIs from 3 months to 12 months.** STI rates in New Zealand are high. Syphilis continues to be concentrated among MSM however it is also appearing within heterosexual populations.(6, 7) There has been a rise in gonorhoea particularly amongst males in Auckland, with one in three male cases of gonorrhoea occurring among MSM.(6) Extending the time period of STI history from 3 months to 12 months will connect more at-risk MSM with PrEP and offer regular screenings as part of sexual health care. Scottish PrEP guidelines allow for patients who have had a bacterial rectal STI in the last 12 months. After two years of implementation this was the second highest eligibility reason for PrEP, with 19.7% receiving PrEP due to a documented bacterial rectal STI in the previous 12 months.(8) It was found that the criteria for PrEP was appropriate and was engaging individuals at risk of HIV into sexual health care, HIV and STI prevention for the first time.
- **Allowing for clinical discretion in prescribing PrEP.** The current criteria do not allow for clinical discretion in assessment of an individual patient's HIV risk and situation. ASHM and other international guidelines (e.g. Scotland) recommend clinical discretion to allow for a range of situations where PrEP may be beneficial to a patient. This allows clinicians to respond to patients' on a case by case basis such as at-risk (heterosexual or MSM) patients travelling to a HIV prevalence country or heterosexual females who's male partners have sex with men. The 2019 ASHM PrEP Guidelines outline a number of potential scenarios where PrEP should be considered including patients who present with high levels of anxiety about their risk of HIV infection. (4) Recent research has shown that PrEP can reduce HIV anxiety and improve the quality of life of these patients. (9)

The World Health Organisation now recommends two regimes for taking PrEP to prevent HIV. PrEP taken daily (daily PrEP) is suitable for all people at risk of HIV. However in addition to daily PrEP, event-driven PrEP (ED-PrEP) which involves taking PrEP around episodes of sex, is now recognised as safe and effective in reducing the risk of HIV acquisition for cisgender MSM when taken as prescribed. (10) It is as an alternative regime to daily PrEP for cisgender MSM who are having infrequent sex (less than twice per week), and who are able to predict, plan or delay their sexual activity for at least two hours. ED PrEP may provide an alternative strategy for some MSM and increase PrEP uptake.

Thank you again for the opportunity to feed back. Please don't hesitate to contact Senior Policy Officer Kate Macpherson on 09 300 6963 or kate.macpherson@nzaf.org.nz should you require clarification on any of the points made.

Yours sincerely,

Jason Myers
Chief Executive

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