SOUTHERN AIDS COALITION

April 28, 2017

DCH Pharmacy Unit
2 Peachtree Street
Atlanta, Georgia 30303

RE: Maintaining Access to Single Tablet Regimens for Georgians Living with HIV

Dear Drug Utilization Review Board (DURB) Members,

The Southern AIDS Coalition (SAC) is a non-partisan coalition of government, community, and business leaders working alongside thousands of individual members to end the HIV epidemic in the South. On behalf of the more than 54,000 Georgians living with HIV and the organizations that serve them, we are writing to strongly urge the Georgia Department of Community Health (DCH) to ensure broad access to antiretroviral therapy for its Medicaid beneficiaries living with HIV. **Specifically, we urge the DURB to maintain single tablet regimens as "preferred" on the Georgia Medicaid Preferred Drug List.**

The HIV epidemic in Georgia is among the worst in the nation. According to the most recent CDC surveillance data (from 2015), Georgia ranked 3rd among states in rate of new HIV diagnoses[i], and Atlanta ranked 5th among metropolitan areas.[ii] The state ranked 4th in rate of new stage three (AIDS) diagnoses.[iii] One in four people diagnosed with AIDS in Georgia die within five years.[iv] Clearly, too few people living with HIV in Georgia are benefiting from treatment. The state estimates that only 45% of Georgians diagnosed with HIV infection achieve viral suppression, far below the goal of 80% established in the updated *National HIV/AIDS Strategy (NHAS)*.[v, vi] For Georgia to achieve the goals of the *NHAS* and end AIDS, DCH must ensure that all low-income people living with HIV have unfettered access to lifesaving antiretroviral therapy, including the newest and most effective single tablet regimens.

Restricting access to single tablet regimens is dangerous for Georgians living with HIV. The choice of HIV treatment regimen should always depend on a person's individual needs, as determined by his or her provider, with consideration of possible side effects and potential drug interactions. Any effort to restrict access to the optimal HIV treatment regimen for some Medicaid beneficiaries with HIV may permanently limit their future treatment options. Unlike some other conditions, step therapy is never appropriate for persons living with HIV. HIV treatment failure results in drug resistance and viral mutations that limit future therapeutic options and can cause irreversible damage to the immune system. Providers and their patients must be able to select the HIV treatment regimen that will most effectively suppress the virus.

Restricting access to single tablet regimens threatens the health of all Georgians. We now know the benefits of HIV treatment as an effective prevention method. In 2011, a landmark study, HPTN 052, showed early initiation of antiretroviral treatment for the HIV-positive partner in a serodiscordant couple reduced HIV transmission to the HIV-negative partner by 96 percent.[vii] A number of follow-up studies since have also reported significant reductions in HIV transmission and numbers of new infections averted.[viii, ix, x] Consequently, HHS guidelines now recommend that all persons with HIV be offered treatment not only for their own health, but also to significantly reduce the risk of HIV transmission to others. To realize the public health benefits of treatment as prevention (TasP), DCH should consider the efficacy of single tablet regimens in ensuring that Georgians living with HIV remain virally suppressed. Single tablet regimens simplify pill burden, which has been shown to significantly improve treatment adherence and health outcomes.[xi, xii]

Requiring prior authorization for single tablet regimens is an inefficient use of Georgia's limited HIV provider network. HIV requires a highly trained, skilled, and culturally competent workforce to achieve treatment and prevention goals. Prior authorization requirements weaken an already fragile HIV care infrastructure in Georgia by imposing substantial administrative burdens on providers that detract from their ability to care for patients. Indeed, a 2010 American Medical Association survey found that providers spend an average on 20 hours per week (a number that some providers say is too low) on prior authorization activities.[xiii]

Lastly, the short-term savings from restricting access to single tablet regimens will ultimately cost Georgia more in the long term. While we appreciate the challenges of managing prescription drug costs, any short-term sacrifice in cost will be more than repaid by decreases in other areas of healthcare utilization. Single tablet regimens have been linked to lower hospitalization rates and reduced health care costs.[xiv] Further, as noted earlier, suppression of viral load achieved through adherence to treatment greatly reduces the likelihood of further transmissions. Each new HIV infection averted saves countless life years and $379,668 in lifetime treatment costs.[xv]

We share your commitment to the health of all Georgians, especially those living with HIV, and we appreciate the opportunity to voice our concerns and share recommendations. For the abovementioned reasons, all based upon sound scientific evidence, we strongly urge the DURB to designate all single tablet regimens as "preferred" on the Georgia Medicaid Preferred Drug List. For more information or to discuss this matter further, please contact Nic Carlisle, Executive Director of the Southern AIDS Coalition, at (888) 745-2975 or nic@southernaidscoalition.org.

Sincerely,

Nic Carlisle, JD
Executive Director

Cc: Linda Wiant
Chief, Medicaid Assistance Plans
Georgia Department of Community Health

Peter D'Alba, R.Ph
Pharmacy Director
Georgia Department of Community Health

---

[i] Centers for Disease Control and Prevention. HIV Surveillance Report: Diagnoses of HIV Infection in the United States and Dependent Areas, 2015, Table 22; http://www.cdc.gov/hiv/pdf/library/reports/ surveillance/cdc-hiv-surveillance-report-us.pdf.

[ii] Centers for Disease Control and Prevention. HIV Surveillance Report: Diagnoses of HIV Infection in the United States and Dependent Areas, 2015, Table 26; http://www.cdc.gov/hiv/pdf/library/reports/ surveillance/cdc-hiv-surveillance-report-us.pdf.

[iii] Centers for Disease Control and Prevention. HIV Surveillance Report: Diagnoses of HIV Infection in the United States and Dependent Areas, 2015, Table 23; http://www.cdc.gov/hiv/pdf/library/reports/ surveillance/cdc-hiv-surveillance-report-us.pdf.

[iv] Reif, S. et al (2014), *HIV Diagnoses, Prevalence and Outcomes in Nine Southern States,* J Community Health, DOI 10.1007/s10900-014-9979-7; https://southernaids.files.wordpress.com/2015/01/hiv-diagnoses-prevalence-and-outcomes-in-nine-southern-states-final.pdf.

[v] Georgia Department of Public Health. HIV Care Continuum Report, 2014; https://dph.georgia.gov/sites/dph.georgia.gov/files/HIV%20Care%20Continuum%20Georgia%202014_07%2007%2016_final.pdf

[vi] White House Office of National AIDS Policy. *National HIV/AIDS Strategy for the United States: Update to 2020*; https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf.

[vii] Cohen, M.S. et al (2011), *Prevention of HIV-1 Infection with Early Antiretroviral Therapy,* The New England Journal of Medicine 365:493-505; http://www.nejm.org/doi/full/10.1056/ NEJMoa1105243#t=articleResults.

[viii] Baeten, J.M. et al (2012), *Antiretroviral Prophylaxis for HIV Prevention in Heterosexual Men and Women*, The New England Journal of Medicine 367:399-410; http://www.nejm.org/doi/full/10.1056/ NEJMoa1108524.

[ix] Thigpen, M.C. et al (2012), *Antiretroviral Preexposure Prophylaxis for Heterosexual HIV Transmission in Botswana*, The New England Journal of Medicine 367:423-434; http://www.nejm.org/doi/full/10.1056/ NEJMoa1110711.

[x] Das, M. et al (2010), *Decreases in Community Viral Load Are Accompanied by Reductions in New HIV Infections in San Francisco*, PLOS One 5:e11068; http://journals.plos.org/plosone/article?id=10.1371/ journal.pone.0011068.

[xi] Nachega, J.B. et al (2014), *Lower Pill Burden and Once-Daily Dosing Antiretroviral Treatment Regimens for HIV Infection: A Meta-Analysis of Randomized Controlled Trials*, Clin Infect Dis. 2014 May:58(9); http://cid.oxfordjournals.org/content/58/9/1297.long.

[xii] Sweet D. et al (2014), *Real World Medication Persistence with Single Versus Multiple Tablet Regimens for HIV-1 Treatment,* J Int AIDS Soc. 2014 November 2:17; http://www.jiasociety.org/index.php/jias/ article/view/19537.

[xiii] American Medical Association, *Standardization of Prior Authorization Process for Medical Services*, June 2011; http://massneuro.org/Resources/Transfer%20from%20old%20sit/AMA%20White%20Paper%20on%20Standardizing%20Prior%20Authorization.pdf.

[xiv] Cohen, C.J. et al (2013), *Association Between Daily Antiretroviral Pill Burden and Treatment Adherence, Hospitalization Risk, and Other Healthcare Utilization and Costs in a US Medicaid Population with HIV*, BMJ Open 2013;3; http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3733306/.

[xv] Centers for Disease Control and Prevention, HIV Cost-effectiveness, 2014; http://www.cdc.gov/hiv/prevention/ongoing/costeffectiveness/.