

**Ending the Epidemic Task Force  
Committee Recommendation  
CR21**

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**Recommendation Title: Access and Payment of Pre-Exposure Prophylaxis (PrEP) and Non-Occupational Post-Exposure Prophylaxis (nPEP) and linkage of HIV-negative People to Prevention Focused Care**

1. **For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply?** 3
  
  2. **Proposed Recommendation:** Implementation of antiretroviral prophylaxis (ARV-P) (both PrEP and nPEP) as a scalable public health intervention to “bend the curve” relies on access to antiretrovirals. Access includes both payment for ARV-P medications and the associated healthcare services (including mental health (individual or group) and substance-related services) attached to ARV-P interventions. Lowering the financial threshold for these interventions must occur to put PrEP and nPEP in the hands of those placed most at risk for HIV infection. ARV-P service assistance programs will allow us to realize PrEP and nPEP as gateways to a continuum of care for people at risk of HIV.
    - 1) PrEP/nPEP Assistance Program for uninsured, under-insured and under-utilizers of insurance: To scale up PrEP and nPEP as public health interventions to “bend the curve,” these drugs and associated preventive care MUST be made available to individuals who are uninsured or underinsured. Embedded in this program should be navigation and entitlement specialists to identify non-assistance program payers for eligible PrEP/nPEP users. ARV-P drug assistance programs should pay for:
      - a. ARV-P medications using a reliable and sustainable mechanism of payment
      - b. Focused HIV and STD preventive care needed by an at risk population including:
        - ARV-P related laboratory testing (creatinine, etc.)
        - STD and HIV tests
        - Mental health services (group and/or individual)
        - Substance use-related services
        - Condom provision, education, and distribution
        - Transportation assistance to ensure adherence to care visits
        - Patient navigation services to maintain adherence and connection to care for patients on nPEP and PrEP
  
    - 2) Insurance Mandates: Payers must be mandated to cover ARV-P medications and provide these services in an administratively streamlined fashion.
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- a. PrEP and nPEP medications must be paid for by private insurers
  - b. The requirements for mail order delivery of these medicines especially in the time-sensitive case of nPEP must be removed.
  - c. More medical providers in primary care should prescribe ARV-P
    - In the case where providers are not able to or do not have the expertise to provide ARV-P service and decide to use referral clinics, requirements for a referral must be waived and primary care providers to ARV-P clinics should be waived.
    - A “HIV Prevention” consultation visit must be covered by insurance regardless of the specialty of the consultant.
    - Medical providers should be supported by guidelines and regulations to provide starter packs for HIV-negative partners in serodifferent relationships and individuals at high behavioral risk (but not on PrEP) to expedite nPEP initiation.
    - Drug companies must be asked to change labeling so pharmacists may provide less than 30 days of medications as a starter pack. Current labeling is often interpreted as restrictive to starter pack distribution. The NYS DOH nPEP guidance should also be revised to mirror this.
    - Additionally, pharmacists must be allowed to dispense nPEP without prescription similar to Plan B for contraception using a collaborative agreement with medical providers.
- 3) Optimizing coverage of ARV-P by including it in programs that cover Sexual/Reproductive Health Interventions: Lowering the threshold for access to ARV-P for adolescents at risk for HIV acquisition must be explored both from the policy and financial perspective. The ARV-P sub-subcommittee recommends that the state reviews this with legal counsel and pursue addition of antiretrovirals as HIV prevention to the Family Planning Benefit Program or Title X as a payment mechanism for PrEP/nPEP.
- 4) Expand access to ARV-P to Adolescents and Incarcerated populations by removing administrative barriers to coverage:
- a. A process or policy must be in place that allows for young adults and youth to gain access to nPEP and PrEP without parental consent.
  - b. Protections must be in place to ensure that “explanation of benefits” (EOB) documents are sent to the patient (i.e. young adult) rather than to the policy holder (i.e. the parents) if that young person is using parental insurance to support ARV-P services.
  - c. HIV prevention in the correctional system must include access to ARV-P as well as other preventive measures, such as condoms.



- 5) Enhanced Support for Community Based Organizations to support provision of PrEP and nPEP: Use of the complete infrastructure available to the broader healthcare system is critical to the implementation of PrEP and nPEP as public health interventions. Specific interest in DSRIP and PPS electing to undertake HIV projects provides an opportunity to support upscale of these interventions. Although beyond the scope of this sub-subcommittee, DSRIP alignment with EOE will be a critical step and must support ARV-P. Central to the scale up of these interventions is a clear recognition that community-based organizations are the first point of contact for many of those placed at risk of HIV infection. Programs supporting PrEP/nPEP services must be established in these community settings.
- a. Community Based Organizations are central to the scale up and delivery of ARV-P interventions. Although they may not be prescribers of ARV-P, these organizations must be funded to provide ARV-P education and support in a community-sensitive way that will supplement and support the work of healthcare providers.
  - b. Faith-based organizations must be funded to host outreach, education, screening and support programs among their populations.
  - c. Non-medical providers should be supported to promote ARV-P, refer their clients to these services and educate their clients about these services.
  - d. Telemedicine to support PrEP and nPEP in non-urban communities must be explored.

**3. Would implementation of this recommendation be permitted under current laws or would a statutory change be required? N/A**

**4. Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)? N/A**

**5. Please list the TF numbers of the original recommendations that contributed to this current version: TF14, TF18, TF31, TF57, TF66, TF91, TF114, TF118, TF123, TF160, TF187, TF193, TF214, TF221, TF224, TF229, TF230, TF232, TF236, TF259, TF264.**

