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# ECHO: COUNSELING EXPERIENCED HIV PATIENTS ON BEST ART REGIMEN

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**[video transcript]**

00:08
So now I'm going to before we jump into the didactic presentation, I'm just going to ask our hub members to introduce themselves. And I'm going to start with our medical director, Dr. Antonio Urbina. Good

00:20
afternoon, everyone. My name is Tony Urbina. I am the medical director for the HIV and Primary Care and Prevention Center of Excellence for CDI and internist, here at Mount Sinai Hospital. Welcome.

00:34
Thank you. And let's go with Dr. Jeff Kwong.

00:42
Hi, good afternoon, everybody. I'm Jeff Kwong. I'm a nurse practitioner professor at Rutgers University and a clinician and Gotham medical group in New York City.

00:53
Dr. Max Lichtenstein.

00:56
Hi, everyone. I'm a psychiatrist who specializes in psychiatric care for the medically ill. And I'm the director of psychiatry at the Institute for Advanced medicine with Dr.Urbina at Mt. Sinai.

01:08
Wonderful. And Dr. Judy Parra.

01:13
Good afternoon. My name is Judy Parra. I'm a family medicine physician. And I'm also the medical director of Harlem United, which is a FQHC with a homeless health designation in Harlem.

01:27
And last but not least, Dr. John Faragon.

01:30
I am John Faragon. I'm a pharmacist here at Albany Medical Center in upstate New York.

01:35
And oh, I'm sorry, actually the true last. Dr. Danforth, would you like to introduce yourself? Sure.

01:42
I'm Alex Danforth. I am a clinical pharmacist and I worked in Rochester at Trillium Health.

01:48
Wonderful. Thank you so much for being with us today, Dr. June 4, and now I will turn the presentation over to you. Awesome. Okay,

01:56
so today we're going to talk a little bit about counseling patients and some different regimen changes. So I don't have any disclosures. Um, learning objectives, I started broken to three things talk about mainly regimen, simplification, how to use some patients specific stuff out of the guidelines, and then what kind of follow up. So this is from the DHHS guidelines, like what our goals for regimen simplification might be. And that's really just for patients who are virally suppressed, help them maintain viral load suppression, and don't jeopardize any of their future options. So when I find patients coming to me to talk about regimen, simplification, or switches or changing regimens, there can be all kinds of reasons for that maybe there's interactions with a new medication they're starting, or the medication they're taking has some sort of food requirement that's not working with their lifestyle, they want to become pregnant. They feel like they're taking too many pills, they're having some sort of issues. So patients come with a whole host of reasons for why they might be looking to simplify or switch or do some different things. And so a lot of times I find that, particularly my patients who are more treatment experienced or have been positive longer might still be on sort of complex multi tablet regimens, and they're really looking to see a can I be on one of those one pill once a day is like is Will that work for me? And that's really part of their reasons. I also run into the patients that are like, Oh, hell no, don't touch my regimen. didanosine saved my life. Alicia is the best drug I'd known to humankind, please don't do anything. And so for those patients, I find the conversation is often very different. Because it focuses more around helping them realize that if you were newly diagnosed today, I would never put you on these medications. And there is definitely room for improvement as far as either pill burden or side effects or things like that. So even though you feel your regimen is not broken, and your regimen is working, like let's see what we can do. As far as patient history, you always want to look back and think about what have they previously been on? Do you have any resistance testing available? And then are you looking to do kind of an in class switch like maybe you're looking to switch from an NNRTI like a favour NS over to another NNRTI like directory, or are you looking to classes entirely, you're looking to go from a protease based regimen to an integrates. So you What kind of different things are you looking at and then taking into account, maybe patients have had, you know, a previous negative experience with one class of medications and so they're not willing to retry. Thinking about if patients are co infected with hep B, particularly if you're looking to go to an NRTI sparing regimen or regimen that doesn't contain tenofovir pregnancy potential. So that often will come up sometimes with my younger patients who have potential for pregnancy, if they're looking to become pregnant, trying to pick a regimen that well, you know, do well throughout the pregnancy. And then this comes up again, a lot of times as patients start and stop other meds, are there going to be drug drug interactions with their HRVs, that we need to change one metre, the other for previous treatment. So in the guidelines that calls out that if you have a patient who really has like no history of any drug resistance mutations, they've never really failed, they can

probably switch to pretty much anything that's considered highly effective for a night patient. So if you have somebody that's, you know, never had any issues and say they're on a darunavir based regimen, and you want to really avoid maybe those drug interactions or avoid boosters, or simplify as long as they've never had failure, and you don't have any resistance mutations, you can probably pick anything that's one of the first line regimens, any of the integrase based single tablets, things like that. You can always order a lot of times for my older patients who've been positive for a long time, I might not have any, you know, baseline genotypes or any real resistance tests that are buried in a storage facility somewhere in a paper chart that I don't have access to easily. So in those cases, you can consider doing a genome short archive. So that will pull a lot of those old mutations up I'm not 100% all of the time, but at least gives you a starting point. Also, the guidelines say that if you have any NRTI resistance, please make sure you have tenofovir with some either entree side of being or limit eating. And you use that with either Dahlia Tegra, Vir boosted darunavir orbix, Tegra Vir. So really, if you have NRTI resistance, you probably don't want to go to something like Divaldo, which is just going to be three TC with W Tegra. Vir, you really want to keep the 10 off of your onboard. And then monotherapy just doesn't work. So don't do that. So I pulled some patient cases of just cases that have come up in my clinic. So I thought we could kind of look through these things. So the first one, Amina, she's a 55 year old positive sis woman, she recently moved to the US from Cameroon, and she's currently taking Combivir Sustiva. And she says this is the only regimen she's ever taken. So sometimes I see patients come from outside the US on regimens that I wouldn't consider sort of our first line regimens, but this is where they are. So besides the Combivir and Sustiva, the only thing else she takes his Simba statin and her only medical problems is HIV and then hyperlipidemia with this MSN. So she comes in she does her intake appointment, her viral load is undetectable her CD four counts 350 And she has good normal renal function. So some things to think about for me and I hear is we could certainly switch to do an like an in class switch. Do you want to go from Combivir a favour and you want to go to another non nuke so she could go to something perhaps like Odessey, which is a real pivoting based single tablet. Or perhaps you want to consider something like Dahlia Tegra, Vir real peppery and as a single tablet, so you could look to kind of keep her on an NNRTI based regimen and maybe also update the NRT eyes at the same time. So thinking about like okay, well we could put her on like tenofovir and preside to being with either any of the NRTIs or you could just do a class which maybe put her on an integrase inhibitor or protease based regimen, you could do that as well. So do it out of class switch. So thinking about drug drug interactions, so she's on send the statin so send, the statin is going to have interactions with the three a four inhibitors so those are like your boosters. So if you were to put her on something that had Kobe systat or had a protease inhibitor, just consider you might then need to also update her Stanton system. thing like a torva sat nervously this that. And then maybe talking to her too. Another thing to consider would be if she has any side effects from being on the DeSoto V dean or the fiver ins I've seen, sometimes in practice that patients often don't notice some of the side effects from a favour ends because they get so accustomed if they've been taking it for a long time, some of the mood issues and when they come off, they actually realize they felt better. And then I always like to try to give my patients options as far as regimens and kind of go through the pros and cons of what I see for the regimens and what their preferences are. So does she really care about how big the pills are? Because something like some tuza or try UMAC? Those are some pretty big single tablets? Or did she not bothered by pill size? She's more concerned about does

she have to take it with food or something like that. I always tell patients like the best regimen is the one you'll agree to take. So it's not going to work if you don't take it. So I try to always when I'm talking to patients, take into account, you know, letting them have some preference and some say in what we're going to go with.

11:18
Okay, so here is so he, here's another patient I saw in clinic. So Kevin is a 67 year old HIV positive sis male. He was originally diagnosed back in the 90s. He's been undetectable as long as I've known him, but he did have a lot of regimen changes, particularly when he was first diagnosed because of urologic failures. And what he told me in clinic was like this is the only regimen that's ever worked for me. He used to be on this regimen with Fuzion. And he was like I will do anything but Fuzion again. So Fuzion is in Phurba tide, which is the inject the original kind of Og injectable that you have to reconstitute and it's sub q and you do it twice a day. And it's really quite a cumbersome injectable for patients to do. So. The provider in particular, when he inherited this patient was like this regimen looks like nothing I've ever seen before it's so many pill and also like is there a way we can give Kevin less pills and also maybe decrease some metabolic stuff because this patient as he's gotten older has also developed type two diabetes and some lipid issues. So this patient's regimen, so they were on TDF FTC, so they were on Truvada vi d, rail Tegra Vir or Isentress vi d and talents, which is Etravirine. And then B ID darunavir ritonavir. So altogether, that's like nine pills a day for HIV, which is pretty far if you think about it from being on a single tablet regimen. And then they further hyperlipidemia and their diabetes are on a torva statin and sin jority, which is one of those combo tablets, which is a stLt two with metformin. So that's twice a day as well. And then they're they've been on low pyramide for ages because he has like chronic issues with like GI upset and diarrhea. But other than that he's been undetectable forever. He's got great renal function, his T cells are good. So when I started to think and talk to him about this case, and I know this is kind of hard to see, but considering how the ARV is interplay with each other when you're looking to simplify or streamline somebody's regimen, because a lot of the air of ease have interactions between each other. So like one example that I pulled out here is like Etravirine, or intelligence is actually an inducer. So if I'm gonna take a retrovirus in a way, it's then going to affect the metabolism of W Tegra, Vir, and then Etravirine and darunavir kind of have an interaction involving integrase inhibitors. And so there's some recommendations. So the other place this one comes up is like simplifying if you have someone on maraviroc, or cells entry that also has a lot of like other ARV interactions. So just thinking kind of about how the ARV is might be playing with each other here. So as you're like simplifying or changing regimens, so the two places so this is from the DHHS guidelines, the interaction tables, and then my other favorite place to double check HIV interactions is the Liverpool checker. So when I'm okay, so Kevin, so what we did in this scenario was we got a Gino shirt archive because we really had no idea of really what all these regimens were except that he'd just been on a lot of stuff. So this is what we got back. And from there, what we decided to do was to stop the Truvada and we decided to leave on the intelligence at the edge of Bahrain and we thought about switching over to Dalia Tegra Vir, but at Proviron and Dalia Tegra Vir have an interaction where then you need to keep a boosted protease inhibitor on board and we really wanted to get rid of the twice a day darunavir. So we stopped the darunavir and then left it as route Tegra Vir, but what we did was we added on FOSS tem severe or route cobia, which he'd never taken before. And so we were able to get

him down to six tabs, everything's still kind of twice a day, which I had one provider used to work with who used to love what he called like dosing symmetry that the morning and the evening doses kind of match. And so Kevin likes this regimen. He was cool, he's he likes getting off ritonavir he likes having fewer pills, and he was actually able after we made the switch to stop using the low Parramatta as much which was kind of nice and his LDL went down a little bit which was also helpful. So just that was another scenario we ran into in clinic just some things to think about. Happy coinfection so if you're on air V's that are active for heavy and you have chronic heavy and you pull them off, you risk a flare. So if you have somebody who has chronic hep B, don't just do FTC or three TC with for heavy so that would be an example of like if you went to a regimen like devata, which is the Dolly feger Three TC single tablet, or in the guidelines, there's also like an option to do like a boosted darunavir with limited eating. So you wouldn't want to do that either. Okay, so I think this is my last patient case. So Rob is a 65 year old positive sis male. This one came up because he's been going to nephrology for a while for chronic kidney disease. And they were like we want you to take Rob off, tenofovir. Now severe is just evil for the kidneys and we want it gone. So he ended up getting referred over to me for that and this patient, so he was on TDF. So Truvada, as well as CO Leatrice double clutching this Coleoptera the lopinavir ritonavir he was like it's the best it saved my life. I just really liked this Kalita and then also on crest store and Januvia sitagliptin. And he has been undetectable forever but his renal function has been declining over the last few years. So now is granting clearances down in the low 50s which is sort of the cut off or getting rid of the TDF or considering changing to Taff things like that. So we had and this I apologize that this looks really junky but I couldn't get like a better copy. But so you can see that basically in this archive we ended up getting, he has a classwide pretty much resistance to the NRTIs and then k 103. And for the non nukes, which is common if people have been on a favour ins based regimens before, but no mutations in integrase or protease. So the provider decided to switch him over. He said, Okay, let's go let's get him off TDF let's switch him over to this new expanding regimen. We're going to do dally take revere real pepper in which is the juluca single tablet. So switched him over Rob's doing great but like strangely enough, his LFTs start to go up all of the sudden, and it turns out, he has chronic hep B. So what we did, what happened in this scenario was that we had actually changed medical records, like a year or two prior to all of this happening and we didn't pull over problem list so no one pulled over his hep B. So and he switched providers during that time too. So the new provider didn't realize that he had chronic Hepatitis B. So we took him off all the hep B agents. So what we ended up doing this scenario was we added on the TAF that then Liddy tablet because he really the patient was really liking juluca And he didn't want to make another switch but he was willing to add back Taff. So he said, Okay, we will we will do what you want. If you really liked the jewelry so you can stay on that. And we'll just add back to NASA fear. But we use TAF because that's a little more kidney friendly. If you have patients who have pregnancy potential, you definitely want to avoid switching over to the long acting injectable, there's really no data and pregnancy for that wouldn't be recommended, or any other regimens that aren't recommended, you probably avoid those. And my favorite place to check for what the updates are, they're just the perinatal guidelines. So those will be a good place to look. Follow up, suggested to recheck the viral load in two to eight weeks to confirm that you still have viral load suppression. In clinical practice. I like to see people back around like the three to four week mark, because then I figure, they're like doing for refill anyways. And I want to just double check before we refill their meds that, you know, everything's going well.

They really like it how any issues with side effects, adherence, that kind of stuff. So anytime between two and eight weeks, that's fine. I just personally like to go in there, like three to four week interval. And then just follow up with them for kind of closely for those first couple of months to make sure everything's going okay, and see how they're doing.

21:18
Anyone have any questions? And this is my email, and you're welcome to email me if you think of something later.

21:29
Thank you for that presentation. Do you have any initial thoughts, Tony? Yeah,

21:36
no, Alex, that's a really great presentation. I just wanted to just get your sense to have Have you started with any multidrug resistant patients to use Linac cap Revere.

21:54
So I tossed it around for a few people, but we haven't because we've just been what Ciana coin Nestle's. Dealing with that, but I like the idea of Atlanta kappa Vir, we actually had a patient that I wanted to try it out on because he had multi drug resistance. And he wrote, we tried him on FOSS time severe and he hated it. He got virally suppressed. He was failing a regimen we put them on last time severe and he got suppressed, but he hated it. So we ended up taking away and leaving him on, I think a couple other drugs. And he was still suppressed. But the provider was like well, maybe. But have you guys used it at all? Yeah, we

22:44
have used it just a couple of patients just kind of really like, blacked out like resistance panels similar to that and generally have paired it with off stem severe, plus others, because patients really just didn't have any options. And they've done really well.

23:04
Yeah, I think I actually have like a lot of patients who are very interested, who are more like in the not multi drug, they just they are they're like just jazzed about sort of every six month injection, plus or minus not having to take something else. Yeah. But I'm like, Nope, that's not available for you yet.

23:26
We have a question here in that shot in someone with a history of multi drug resistance, but no access to a genotype, how much can we trust the archive?

23:42
I would put pretty good faith in the archive. I haven't really I mean, I personally haven't gotten burned by them. I have run into this scenario where the archive comes back, like basically read and then tells me the patient's on, in essence, like big Tegra Vir monotherapy. And we're like, huh, yet they're suppressed. Like, should we start panicking? You know, we ordered an archive,

because at my clinic, we have like a quality project around trying to get a genotype for everybody, whether it's an archive or not. So we've been just kind of ordering them to have on file for these scenarios. And then when it comes back, and it's a lot of read, and you're like, Well, do I change the regimen? They've been suppressed for four years. So that's the more of the situation I've run into lately. I haven't run into anything really where I've gotten burned, but I think they say what messes like 10% up to 10%. You can be missed on the mutations. That are

24:45
that. Yeah. Gary, do you have any other thoughts of the archive?

24:51
So there are time not so much but I wanted to ask a follow up question related to that. So I know Like, especially in the FQHC setting, we have to limit sometimes we had to look at costs from like the ordering the, you know, short prime and the archive, right? Because sometimes we don't get reimbursed and all those issues so, but it's the standard of care, right that we need to order and achiness your prime in, in the absence of any data, and so I was kind of thinking at the patient that was on raltegravir year, the integral he wasn't raltegravir year it was also on the protease inhibitor. Like why would you suggest simplifying in the absence of any information and we need to do the change now, because it's going to take a while to get the archive? What are your suggestions are still maybe without any information, how can you simplify the regimen? Um,

26:00
well, in that scenario, if you wanted, you probably could have, if you knew he didn't have B, you probably could have at least eliminated the tenofovir emtricitabine because patients that my patients have generally like lived through the 90s and been through a lot of regimens have developed a lot of NRTI mutations. So like that would probably be an easy one to like, let go. If I knew nothing, I'd probably be more hesitant to get rid of say like the darunavir simply because it's such a powerful one I might get rid of the intelligence and then have last to like Raul Tegra veer darunavir because in this scenario, he'd always been suppressed since he'd started this kind of funky regimen with a Fuzion and that involve the rail tech revere so he never had failed on a rail tech revere on rail tech revere so I'd be like, okay, he probably doesn't have Integrys resistance. So maybe if I do just rail tech Revere and the Tarun veer probably wouldn't have dropped the darunavir to once a day because I wouldn't know if he had during the Vir mutations or not. So if I knew absolutely nothing, and I really wanted to decrease his pills, I probably would have gone with the rune of your boosted twice today with Realtech revere twice today.

27:22
Okay, and what would be your thoughts about let's say keeping all the regimens and like doing some tussah with raltegravir year and at traversing because I'm not changing the regimen I just reducing the bill so think to set to keep the NRTIs with a protease inhibitors and Rasik revere an intro Vereen, but I'm not reducing any compounds, I'm just reducing the pills by using Yeah, just throwing. And this is you

27:51

do that. I mean, the only thing was if you would do that you would get rid of like the twice a day to run a beer. Right? So it might be like a plus minus, but I've done some things like that, like what you're saying, like try to damage things into a single tablet. Where I've done like, like, oh, def c plus W Tegra. Vir separately to kind of getting it, you know, have a single tablet that's got two nooks and NNRTI plus the integrates as a separate, or like, another one I've done is like big tech or big TRV. So your big tech, reverse single tablet with press kopecks? Yes, something kind of created to like you said, try to get things into a single tablet, but then also keep on maybe an additional drug or additional class if you're worried about resistance.

28:45
Got it. Thank you. And I think sometimes the challenges of like just having to get creative without very limited information. And last question, how much of your patients are responding to marketing? Because I'm getting a lot of patients come in, oh, I heard the commercial because nobody is really good. And like every single channel, and I just want to be on Novato or I want to be on Kevin Nuva how much of that are you seeing?

29:10
So I think we see it more for the injectables. A lot of times the patients don't seem to bring up like an oral med switch unless they're on a multi tablet regimen. And a lot of times I think the provider is in that those instances when the person has started because I've done some like projects trying to streamline people off multi tablets and single tablet regimens as much as I can. So we've more started the conversations but they are definitely seeing like and the PrEP patients are seeing the aptitude advertising so I've gotten more questions about hey, can I take this injectable thing? More than switching oral meds I don't know what everybody else's experience has been. Yeah, no, I think more For

30:00
more I definitely for the injectables I'm seeing but I'm also seeing more for Novato as well.

30:05
I must be pushing that somewhere then.

30:11
All right. Well, thank you so much for that presentation. Alex. I know.

[End Transcript]