Hello Chair Prusak and members of the Committee on Health Care. My name is Daniel O'Neill, and I have practiced as a general internal medicine physician in the state of Oregon since 2016. Thank you for the opportunity to submit testimony in support HB 2958. As a certified HIV specialist through the American Academy of HIV Medicine, I prescribe pre-exposure prophylaxis (PrEP); post-exposure prophylaxis (PEP); and HIV treatment to patients on a regular basis and engage frequently with those most at risk for HIV infection in the Portland area - including gay and bisexual men who have sex with men; transgender and gender-nonconforming individuals; and those using injection drugs.

My testimony addresses several topics all in support of safely increasing access to PEP and PrEP for medically underserved Oregonians. While PEP and PrEP have made significant progress in curbing the transmission of HIV, the burden of the epidemic has disproportionately shifted further to those with more limited access to these interventions - namely young, disenfranchised black and Latino men who have sex with men. Of the 10-20 new HIV cases I have diagnosed while practicing in Oregon, all but one were a racial or ethnic minority. As such, I am confident that providing greater access to PEP and PrEP to underserved populations would go a long way to improve this concerning trend.

1. Mandated coverage of medications and pharmacists' time for consultation: While pharmacists in Oregon already have the authority to prescribe PrEP and PEP through both Public Health and Pharmacy Formulary Advisory Committee (PHPFAC) and Collaborative Drug Therapy Management (CDTM) protocols, the state still needs to provide the incentive structure for busy pharmacists to move forward in providing this service. Guaranteed reimbursement for the medication and the pharmacists' time is a necessary first step. Moreover, PHPFAC and CDTM protocols currently limit pharmacists to dispensing medications only in the context of face-to-face encounters. Broadening these rules through this bill both to reimburse and to allow for tele-health PEP and PrEP prescribing would safely expand this access even further.

2. Eliminating insurance barriers such as prior authorizations and network restrictions: Insurance companies should not interfere with timely coverage of urgent, proven interventions that would prevent HIV infection in high risk individuals. Removing these restrictions frees patients to receive PEP and PrEP in a far less stigmatizing pharmacy setting and provides more opportunities for accessing these interventions via extended pharmacy hours and at a greater number of locations than before.

3. Reducing barriers to PEP: Expanded access through pharmacists alleviates the urgent time constraint of PEP initiation needing to occur within 72 hours after a high-risk exposure. I have personally encountered cases of patients who became infected with HIV due to their inability to access PEP within this short window. Having assurance that these medications would be covered even in more rural settings would increase the likelihood that pharmacists would have medications on hand and be able to prescribe them to patients in need. I have often struggled to quickly find pharmacies stocked with PEP medications and facilitate their coverage; and this bill would help to streamline that process.

4. Bridging patients into primary care: Current protocols direct pharmacists to notify patients' existing primary care providers (PCP) or to link patients to primary care for ongoing management of their PrEP - either revealing to providers unmet sexual health needs of their existing patients or transitioning patients without a PCP into care. I fully support pharmacists facilitating this bridge into care and using their discretion in continuing to prescribe PrEP according to their established protocols.

Thank you for your time and consideration.

Daniel O'Neill, MD, MBA, AAHIV