Sustaining Momentum and Increasing Access to PrEP in Uncertain Times

Helping individuals start and stay on pre-exposure prophylaxis (PrEP) is a critical part of efforts to end the HIV epidemic in the United States. Investments in PrEP and HIV prevention not only help protect lives, but lower costs, save taxpayer dollars, and alleviate pressure on healthcare delivery systems. While other effective HIV prevention tools exist, including condoms and various risk reduction strategies, none are as effective or offer the same durability of protection as PrEP.

The Centers for Disease Control and Prevention (CDC) has recently updated its estimates of the size of the U.S. population that can benefit from PrEP estimating that there are 2.2 million potential users.[1] While PrEP use has increased — with nearly 600,000 people using it in 2024, according to AIDSVu — overall uptake remains limited.[2] Persistent use is low among the populations with the greatest need, and significant inequities in access still exist. Moreover, many of the policies put in place to support PrEP access and use are under threat and there would be significant consequences if they were eliminated. **One study found that a 3.3% annual reduction in PrEP use over the next decade could result in 8,618 new and avoidable HIV infections, with increased lifetime medical costs of over $3.6 billion**.[3] Threats to HIV prevention funding and policies to increase and support persistent PrEP use demand urgent action from stakeholders at all levels:

At this time, there is uncertainty and significant disruption to HIV prevention in the United States. A June 2025 decision by the U.S. Supreme Court maintains the current requirement that PrEP be provided without cost-sharing in most private insurance plans and Medicaid expansion plans, but cuts and staff reductions at the Department of Health and Human Services (HHS) including essentially decimating the Division of HIV Prevention (DHP) at the Centers for Disease Control and Prevention (CDC) have created chaos. Preventing HIV is a necessity and not a luxury. Sustaining access to effective prevention must remain a national priority.

POLICY ACTIONS AT THE FEDERAL, STATE, LOCAL, AND CLINIC LEVELS ARE CRITICAL

There are many policies and actions needed to expand and maintain access to PrEP. These are four priority issues:

1) Ensuring Adequate Funding for HIV Prevention

Protect federal funding for HIV prevention and retain the core HIV prevention and surveillance functions of the CDC Division of HIV Prevention

2) Protecting patient access to all PrEP regimens with no cost-sharing or barriers

Federal and state regulators should continue policy efforts to fully implement the nationwide PrEP coverage mandate

Insurance regulators should take enforcement actions to ensure compliance with PrEP coverage mandates

State legislatures should pass laws to ensure zero cost-sharing and limit barriers to PrEP such as inappropriate utilization management

3) Maintaining the capacity to monitor trends and deliver resources to yield the biggest public health impact

State health departments should work with providers and community partners to disseminate and use state epidemiological data

Adopt the PrEP-to-Need Ratio (PnR) as a core metric at the clinic and jurisdictional level for achieving public health impact from greater PrEP use

4) Making it easier to start and stay on PrEP

Make rapid start of PrEP the standard practice at most PrEP enrollment sites

Promote strategies to reduce barriers to remaining on PrEP

State legislatures should pass laws expanding scope of practice for pharmacists allowing them to prescribe PrEP

STATUS OF PrEP USE IN THE U.S.

In June 2025, AIDSVu published new data on PrEP use in the U.S. From 2023 to 2024, PrEP use rose by 17% to an estimated 591,475, an all-time high. But, only a small fraction of people who could benefit from it are using it.

BY SEX

In 2024, 91% of PrEP users were male, a rate ten times higher than women. Women represented roughly one in five diagnoses in 2022, yet only accounted for roughly one in ten PrEP users in 2024.

BY AGE

Young people aged 13-24 represented 18% of new diagnoses in 2023, but only 11% of PrEP users in 2024. PrEP use was highest among those 35-44 and 65+ with a PrEP-to-need ratio (PnR) of 19 PrEP users for every new diagnosis. The PnR was lowest for those 13-24 with only 10 PrEP users for every new diagnosis.

BY RACE

Black and Latino persons remain disproportionately impacted by HIV but underrepresented in PrEP use. Black persons accounted for 38% of diagnoses in 2022, but just 15% of PrEP users in 2024. Latino individuals made up 32% of diagnoses in 2022, but just 18% of PrEP users in 2024. White individuals made up 24% of diagnoses in 2022, yet 63% of PrEP users in 2024.

BY REGION

The South has the greatest unmet need for PrEP. The South accounted for 53% of diagnoses in 2022, but just 39% of PrEP users in 2024. The Northeast had the highest PnR of 25 and the South the lowest of 12.

Source: AIDSVu, https://aidsvu.org/news-updates/aidsvu-releases-2024-prep-use-data-showing-growing-use-across-the-u-s/.

1) ENSURING ADEQUATE FUNDING FOR HIV PREVENTION

National efforts to prevent HIV and control the epidemic require sustained and coordinated efforts with key functions and services provided by the CDC, other federal agencies, state and local health departments, and a network of community based organizations and federally-funded health centers. The Ending the HIV Epidemic Initiative (EHE) launched by President Trump in 2019 increased funding for HIV prevention and enabled the CDC and other federal agencies to work with jurisdictions most heavily impacted by HIV to build capacity to provide HIV prevention services. The President's FY 2026 budget request, however, while retaining funding for the EHE, would implement significant funding cuts for HIV prevention and the complete elimination of the CDC's Division of HIV Prevention (DHP). Our investments in a comprehensive HIV prevention program led by the DHP and the focused investments in PrEP access through the EHE are having an impact and should be retained.

POLICY ACTION:

Protect federal funding for HIV prevention and retain the core HIV prevention and surveillance functions of the CDC Division of HIV Prevention.

In FY 2025, Congress appropriated $1.014 billion for HIV prevention efforts through the CDC DHP; this includes $220 million for prevention activities through the EHE Initiative. Since the start of the second Trump Administration, funds have been withheld, projects stopped, many of DHP's unique HIV prevention branches were eliminated and significant numbers of DHP staff have been laid off through a reduction in force (RIF).[4] In early June, it was reported that 460 CDC staff who had been subject to the RIF were being called back, more than 200 of whom are with the DHP.[5] It was also reported that four of five branches within DHP are being re-established. The abrupt termination of critical projects and activities and the resumption of the work with limited staff raise questions about the remaining capacity of DHP and how effectively it can mitigate the harm caused by these reductions while delivering critical prevention services.

The Trump Administration has proposed establishing a new health agency called the Administration for a Healthy America (AHA) and would move some, but not all the functions of the CDC DHP to AHA. While there could be some benefit to deploying some prevention staff to AHA, the de-linking of HIV prevention from sexually transmitted infection (STI) prevention, prevention of other infectious diseases, and the move away from the broader prevention infrastructure at the CDC will undermine national HIV prevention efforts at a critical time. Regardless of the new structure, it is imperative that the size and scope of federal HIV prevention funding be preserved. Every day there are around 100 new HIV diagnoses in the U.S, and each new infection can result in $1.1 million in additional lifetime healthcare costs.[6]

A critical element of the EHE was to leverage the Health Centers network that is administered by the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care (BPHC) to extend access to PrEP deeper into primary care and into clinical sites whose primary focus is not HIV prevention and care. The EHE Health Centers program, known as the Primary Care HIV Prevention (PCHP) Program has demonstrated real impact towards that goal. HRSA reported that as of 2023, the PCHP program has awarded funds to over 400 health centers in EHE jurisdictions funding HIV testing, PrEP provision, patient outreach and care coordination. It has administered nearly 2.4 million HIV tests and was providing PrEP to nearly 70,000 people.[7] While the President's budget would continue the EHE, it must be integrated into a broader plan to support critical HIV prevention services and fund the programs necessary to avoid new HIV cases, and additional healthcare costs, in the future.

2) PROTECTING PATIENT ACCESS TO ALL PrEP REGIMENS WITH NO COST-SHARING OR BARRIERS

Research has shown that making preventive services free-of-charge is important for supporting broad uptake.[8,9,10] Over the last decade, significant progress has been made in advancing coverage of PrEP and associated ancillary services with no cost-sharing to patients by most U.S. healthcare payers. For example, in 2024 CMS issued a National Coverage Determination (NCD) requiring all PrEP medications, including injectable and oral, to be covered under Medicare Part B without cost-sharing.[11] The NCD ensures that PrEP should be covered free-of-charge for Medicare beneficiaries, including the HIV testing and behavioral counseling associated with PrEP use. STI screening is free for Medicare beneficiaries annually, but since this is recommended more frequently as part of the PrEP regimen, beneficiaries may be charged cost-sharing for additional STI screening.

POLICY ACTION:

Federal and state regulators should continue policy efforts to fully implement the nationwide PrEP coverage mandate.

The most comprehensive PrEP access policy covering the largest number of PrEP users came about because of the Affordable Care Act (ACA) that was enacted in 2010. The ACA requires Medicaid expansion plans, and most private health insurance plans to cover without cost-sharing, all preventive services with an Grade "A" or "B" rating from the United States Preventive Services Task Force (USPSTF). The USPSTF has given HIV PrEP an "A" rating twice, first in 2019 and with a subsequent update in 2023. In July 2021, HHS and the Departments of Labor and Treasury jointly issued guidance to insurers on what is required by the PrEP recommendation, in the form of frequently asked questions (FAQs), to clarify coverage obligations for PrEP medications and services.[12] The guidance clarified that all aspects of the PrEP regimen must be covered, including laboratory monitoring and HIV and STI screening. On October 21, 2024, the Departments issued another FAQ requiring insurers to cover, without cost-sharing, specified oral and long-acting injectable PrEP (Truvada, Descovy, and Apretude) and prohibited plans from using medical management techniques to direct individuals prescribed PrEP to utilize one formulation over another. The FAQs and related guidelines should be updated to include all FDA-approved PrEP drugs.[13]

In 2025, in the case of *Kennedy v. Braidwood Management*, the U.S. Supreme Court agreed to hear a challenge to the USPSTF related to the U.S. Constitution's appointments clause and in June 2025 the Court held that members of the USPSTF were validly appointed as inferior officers to the Secretary of HHS. **The Court's decision means that the existing**

WHY WE NEED THE UNITED STATES PREVENTIVE SERVICES TASK FORCE (USPSTF)

The United States Preventive Services Task Force (USPSTF) was first established by Congress in 1984. It is administered by the Agency for Healthcare Research and Quality, a component of the Department of Health and Human Services (HHS). It currently consists of members appointed by the Secretary of HHS with expertise in prevention, primary care, and evidence-based medicine. Their fields of practice include behavioral health, family medicine, geriatrics, internal medicine, pediatrics, obstetrics and gynecology, and nursing.

Why is the USPSTF important?

The USPSTF conducts systematic evidence-based analysis of peer-reviewed science on the effectiveness of preventive service topics.

The USPSTF reviews focus on the overall effectiveness of preventive interventions in various populations, while weighing the risks and benefits to the patient. The Task Force's mission is to assess the available evidence on a particular clinical preventive service, assessing both the potential benefits and harms to patients. It is also to provide primary care clinicians with the appropriate evidence on the effectiveness of clinical preventive services.

USPSTF recommendations are based on systematic evidence review and full consideration of the certainty and magnitude of net benefit, considering most strongly "patient-oriented health benefits and harms." To formulate their recommendations, the Task Force reviews available scientific data. An "A" grade means the USPSTF recommends the service and there is a "high certainty that the net benefit is substantial." A low grade may indicate a lack of data, or low effectiveness. Their findings and rationale are explained in the statement accompanying each grade. While the Task Force has congressional authority to review evidence related to cost-effectiveness, it excludes costs from its determination of the benefits and harms of a clinical preventive service. This deliberate decision was made to maintain a clear focus on the science of clinical effectiveness (i.e., "what works") of a preventive service.

What evidence-based recommendations has the USPSTF made with regard to HIV PrEP?

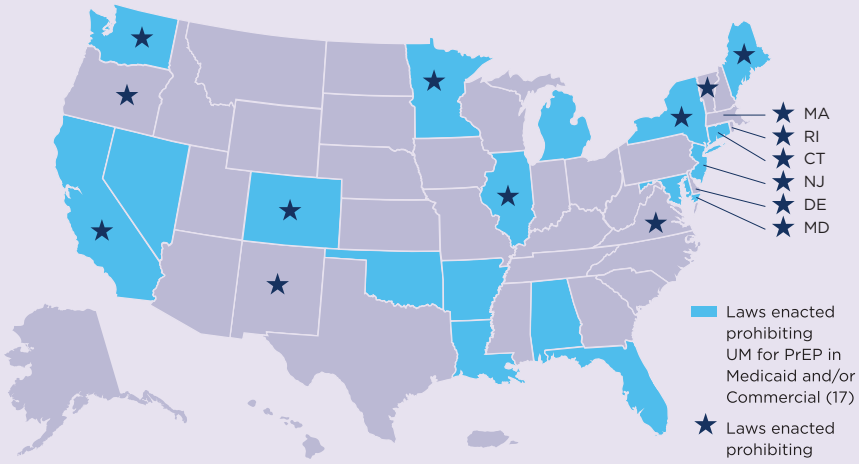
In its most recent PrEP recommendation in August 2023, the USPSTF has given an A rating to offering PrEP with effective antiretroviral therapy to adults and adolescents at increased risk for HIV acquisition. This recommendation was based on evidence reviewed on tenofovir emtricitabine, tenofovir alafenamide, and cabotegravir.

STATE LEGISLATION TO PROHIBIT COST-SHARING AND UTILIZATION MANAGEMENT FOR PrEP

States can help increase access to PrEP by:

1. Passing laws to ensure open access to PrEP (i.e., coverage without PA and/or ST)
2. Prohibiting cost-sharing for PrEP

- **17 states** have laws prohibiting UM for PrEP in Medicaid and/or Commercial plans
- **17 states plus DC** have laws prohibiting cost-sharing for PrEP



Source: Gilead Sciences. Analysis: State Law and Regulations Protecting Access to HIV/AIDS Prevention Medication.

Grade A PrEP recommendation remains in force and PrEP must be provided without cost-sharing or medical management in most private market health plans and in Medicaid expansion plans; however, the Secretary has the authority to replace members of the USPSTF and review the recommendations they issue. This preserves current PrEP policy and can shift the focus to other Federal, state, and local policy actions to support PrEP access.

The USPSTF PrEP recommendation and associated federal guidance are important for ensuring access to a comprehensive PrEP regimen, including HIV and STI screening, laboratory monitoring and other services. It is important that HHS starts monitoring compliance. Importantly, this must extend to monitoring coverage (without cost-sharing or medical management) of all FDA-approved PrEP medications, but also all components of the PrEP regimen.

POLICY ACTION:

Insurance regulators should take enforcement actions to ensure compliance with PrEP coverage mandates.

Reports exist of individuals being unable to access non-preferred PrEP products when their provider recommends an alternative PrEP product for an individual patient.[14] Further, there are indications that suggest a more widespread problem of plans inappropriately charging cost-sharing for PrEP medications, labs or office visits (cost-sharing cannot be charged for office visits if PrEP is the primary purpose of the visit).[15,16] Enforcing laws and policies that mandate access to the full PrEP regimen, free-of-charge to individuals who can benefit from HIV prevention is critically important. Open access to the full range of PrEP options must be ensured.

While PrEP was first approved as a daily oral option, some individuals experience challenges with taking medication daily. A longer-acting injectable PrEP option is preferred by some people, and less frequent dosing can support adherence. Policies should be promoted to ensure access to the PrEP regimen that is best for each individual, as determined through consultation with their health care provider.

Depending on the type of coverage, different agencies are responsible for enforcing the coverage requirement (see text box on prior page). Consumer advocates, providers, and health departments can play a role in educating patients, providers, and pharmacists on ways to urge enforcement of coverage for PrEP. For example, providers and advocates can urge state Departments of Insurance to reiterate federal guidance to insurers of coverage for PrEP and ancillary services with no cost-sharing. They also can conduct training or offer individualized support for submitting complaints to the insurance regulator. Health departments can collaborate with state regulators to help them understand the significance of the PrEP coverage requirements and document barriers faced by consumers. This can include conducting surveys of providers and PrEP users. State regulators could create platforms for reporting non-compliance with current PrEP coverage requirements, and they could conduct training with providers and community groups to broaden awareness of PrEP coverage requirements.

POLICY ACTION:

State legislatures should pass laws to ensure zero cost-sharing and limit barriers to PrEP such as inappropriate utilization management.

WHERE TO TURN TO ENFORCE PREP COVERAGE REQUIREMENTS

Private-Employer Group Health Plans

The federal Department of Labor, through its Employee Benefits Security Administration (EBSA), regulates private-employer group health plans and can take steps to bring them into compliance with federal requirements. Complaints may be filed by contacting EBSA at https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa or 1-866-444-EBSA (3272).

Group or Individual Health Insurance

Patients covered by state-regulated group or individual health insurance, including insured group health plans and marketplace plans, may contact their state insurance regulator for assistance in most states.

A directory of state insurance regulators is available from the National Association of Insurance Commissioners at https://content.naic.org/state-insurance-departments.

State and Local Government Employee Plans

In addition to oversight by their states, state and local government employee plans are subject to HHS enforcement of federal requirements. HHS may impose civil monetary penalties on noncompliant plans (which HHS refers to as non-Federal governmental plans). Complaints regarding these plans may be emailed to NonFed@cms.hhs.gov.

Federal Government Employee Plans

The federal Office of Personnel Management (OPM) requires that health insurance carriers in the Federal Employees Health Benefits Program provide the ACA-required preventive services. Complaints can be directed to the OPM.

Source: For more information, see Health HIV's Know Your Rights: Patient Coverage of PrEP with No Costing-Share guide available at https://healthhiv.org/wp-content/uploads/2022/03/Patient-Advocacy-Toolkit-USPSTF-Patient-Protections-for-HIV-Prevention-Drugs-1-1.pdf.

States have an important role to play in ensuring stable and affordable access to PrEP. Elected officials can do this by reducing burdensome utilization management (i.e. prior authorization and step therapy) designed to limit access. At least seventeen states have laws that prohibit utilization management for PrEP in Medicaid and/or state-regulated private insurance plans, and at least seventeen states plus the District of Columbia prohibit cost-sharing for PrEP and ancillary services.[17] Additionally, eleven states plus the District of Columbia and three counties (Howard County, Maryland; San Antonio, Texas; and Wayne County, Michigan) have PrEP assistance programs that typically cover the cost of PrEP, as well as the cost of seeing a provider and obtaining required laboratory tests, while others utilize a combination of state assistance and manufacturer assistance and copay programs.[18] More states should develop PrEP assistance programs, enact legislation to prevent utilization management, and codify cost-sharing protections to ensure better uptake and access for PrEP and ancillary services.

3) MAINTAINING THE CAPACITY TO MONITOR TRENDS AND DELIVER RESOURCES TO YIELD THE BIGGEST PUBLIC HEALTH IMPACT

Preventing HIV requires numerous overlapping activities, including: funding and collaborating with state and local health departments for the collection of HIV surveillance data, outbreak response inclusive of CDC staff rapid deployment to a jurisdiction experiencing an outbreak, and providing technical assistance to bolster health department capacity to identify and respond to outbreaks (also called clusters). Additionally, preventing HIV requires prevention education, implementing research programs, and funding community partnerships with organizations that have trust within communities and can deliver information and services in a culturally appropriate manner. As stated, there has been significant disruption at HHS, including the almost complete elimination of the CDC DHP. While the CDC appears to be resuming the operation of most of the Division's branches, the long-term impact on national HIV surveillance from canceled projects, delayed funding for health departments, and greatly diminished staff capacity is unclear. There are serious questions over whether the federal government can produce a reliable picture of national epidemiological trends needed to monitor and respond to the epidemic, and whether such information will be publicly available. **While there is no substitute for the unique role of the CDC in providing high-quality and comprehensive HIV surveillance data, new approaches are needed to supplement federal surveillance capacity.**

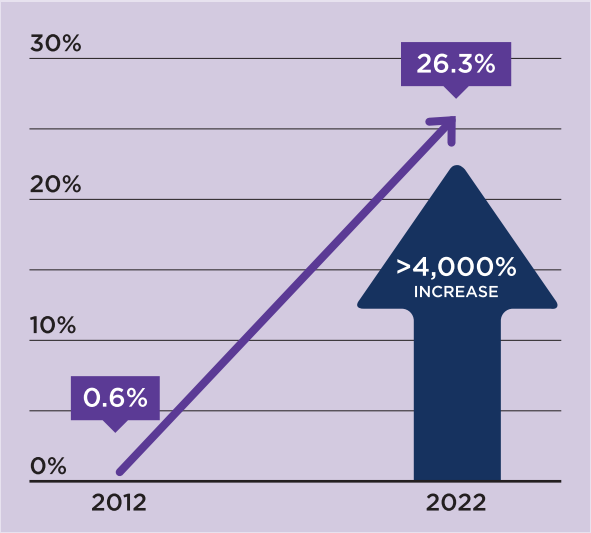
POLICY ACTION:

State health departments should work with providers and community partners to disseminate and use state epidemiological data.

At a time when questions have been raised about the capacity of the CDC to monitor the epidemic, a greater focus should be placed on accessing state public health data. State health departments typically publish an annual state epidemiological profile that can be accessed from their website. States should consider releasing their HIV epidemiologic data in ways that make it accessible to providers and PrEP advocates

PREP USE IS RISING, BUT FAR BELOW THE GOAL OF 50%

Average PrEP coverage increased from 0.6% to 26.3% from 2012-2022—But this is far below President Trump's Ending the HIV Epidemic (EHE) goal of 50% PrEP coverage.



Source: AIDSVu, https://aidsvu.org/news-updates/aidsvu-releases-2024-prep-use-data-showing-growing-use-across-the-u-s/.

and also enable it to be used to develop consumer-friendly tools such as infographics and slide sets. Moreover, groups such as NASTAD and the Council of State and Territorial Epidemiologists (CSTE) should review state data and identify best practices for making state-level data more useful for policy action.

POLICY ACTION:

Adopt the PrEP-to-Need Ratio (PnR) as a core metric at the clinic and jurisdictional level for achieving public health impact from greater PrEP use.

Focusing resources to have the biggest impact is a critical strategy, and the PrEP-to-Need Ratio (or PnR) is a much needed metric that is increasingly used to guide resource allocation decisions. The PnR is calculated by taking the number of PrEP users in each population and dividing it by the number of new HIV diagnoses in that group. Groups with a comparatively low PnR relative to other priority groups are those in need of greater attention through education, access to services, and focused outreach to expand uptake of PrEP. For example, Black communities experience a disproportionately high burden of HIV, yet PrEP use lags, leading to a lower PNR for Black people compared to other racial/ethnic groups. To reduce the number of new HIV transmissions among Black persons, all subpopulations need greater access and attention. The PnR for Black women may be higher than for Black gay and bisexual men which indicates the need for greater focus on reaching Black women. At the same time, HIV diagnoses among Black gay and bisexual men may be much higher indicating that a smaller increase in the PnR would avert more new transmissions. No single metric will yield a resource allocation answer, but greater use of the PnR and focusing attention on specific geographic areas and populations will help in using PrEP to achieve population-level reductions in HIV transmission.

4) MAKING IT EASIER TO START AND STAY ON PREP

Essential policy work is needed to make it easier to start and stay on PrEP. While it is very important to ensure that an individual is truly HIV negative before starting PrEP, staying on a PrEP regimen also requires periodic appointments and screenings. These requirements can present barriers to persistent use of PrEP. Innovative practices have been developed, however, to address some of these issues. Not all PrEP users will need supplemental support, but it can be critical for sustaining PrEP use, especially for individuals with the greatest barriers to staying on PrEP.

POLICY ACTION:

Make rapid start of PrEP the standard practice at most PrEP enrollment sites.

Rapid Start of ART for persons who are newly diagnosed with HIV has been found to have transformative benefits.[19] The same benefits can extend to increasing uptake and persistence of PrEP use. Numerous clinics around the country have evaluated rapid start programs where they either provide a same-day prescription for PrEP that an individual fills and starts once baseline laboratory tests are completed or in which the individual is prescribed, and initiates PrEP on the same day as the initial visit.[20] The CDC and HRSA have jointly funded the development of a National HIV PrEP Curriculum that can assist clinics and providers adopt rapid start of PrEP.[21] Evidence at several sites suggests that it greatly increases actual PrEP initiation and continuation.

A study at a New York Sexual Health Clinic from January 2017 to June 2018 found that 97% of people evaluated qualified for immediate initiation of PrEP. Of 1,387 individuals who started same-day PrEP, only four discontinued PrEP (within 10 days) due to laboratory-identified contraindications.[22] Additionally, a study at the Washington University Adult Infectious Diseases Clinic in St. Louis, MO from 2014 to 2018 found that of those that received a same-day prescription, 97% started PrEP and 78% continued PrEP for at least three months.[23] A major provider concern with same-day initiation of PrEP has been the potential for abnormal lab results, either resulting in an HIV diagnosis or identification of abnormal kidney function, but in these and other studies, such results were very rare

TOOLBOX OF STRATEGIES FOR SUPPORTING PREP ADHERENCE

Numerous strategies are available to facilitate user access and adherence to sustained ongoing PrEP use. Not all people will need these options and they may not all be feasible in every clinic setting. Nonetheless, they offer effective tools for better supporting PrEP access:

Telehealth visits

Telehealth has been shown to be beneficial for enrolling individuals on PrEP and for regular clinical visits. Numerous states have established Tele-PrEP programs. Health departments should continue to build out these programs and expand access to populations with the greatest PrEP need.

Walk-In and Extended Hour Laboratory Visits

For many PrEP users, the currently recommended frequency of laboratory screening is every three months. Some clinics require scheduled appointments, and this can be challenging for persons with limited flexibility in work hours or for whom being reliably on-time for appointments is a huge burden. Clinics are encouraged to expand walk-in options, extend service hours, or have agreements with laboratory services to give users greater options for where to go for their screenings.

Mail-In Sample Collection

In many places, especially in rural areas, and notably in the southern U.S. which has a heavy burden of HIV, having the transportation and time to get to clinics can be a significant burden.[1] Research has shown that individuals can effectively swab themselves for three-site STI testing, and dried blood spot (DBS) testing where a user pricks a finger and places drops of blood on a testing card is effective for kidney function and HIV testing.[2] This can facilitate home sample collection wherein individuals are given sample collection tools and they are provided with paid shipping envelopes to mail the tests back to a laboratory or clinic. More state health department Tele-PrEP programs should adopt mail-in sample collection.

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and often did not change the HIV PrEP management. A greater emphasis should be placed on making rapid start of PrEP the default practice in most settings.

POLICY ACTION:

Promote strategies to reduce barriers to remaining on PrEP.

An ongoing challenge with sustaining PrEP use is that many people start but subsequently discontinue PrEP even when they could still benefit from it. Remaining adherent to a PrEP regimen involves regular medical visits, appointments, regular laboratory screening to monitor kidney function and to confirm that the individual remains HIV negative, and to test for sexually transmitted infections (STIs). This can be a burden for many users. There are many practices that clinics and providers should consider addressing specific barriers to their patient populations (see text box).

POLICY ACTION:

State legislatures should pass laws expanding scope of practice for pharmacists allowing them to prescribe PrEP.

The required screening to initiate a PrEP regimen and obtain medication refills requires prescriptions from a licensed provider. To make it easier to access PrEP, states should enact legislation expanding the scope of practice to allow pharmacists to prescribe PrEP (inclusive of mechanisms to reimburse pharmacists for their time and services). In addition to prescribing authority, in a case where an individual has not obtained a refill prescription and is out of medication, pharmacists should be authorized to fill and receive payment for emergency refills to ensure continuity of care. Collaborative Practice Agreements may also be adopted to allow pharmacists to assess patients, order labs, and prescribe PrEP. This may be achieved through a standing order authorizing a pharmacist to prescribe PrEP, a statewide protocol, or legislation at the state level.

THE TIME IS NOW

Effectively preventing HIV is at the center of any national plan to end the HIV epidemic. We have the tools and a growing number of options for delivering PrEP to large numbers of people. Translating effective interventions from research studies into the real world, however, remains challenging. Overcoming financial barriers, health system obstacles, and integrating PrEP into individuals' lives remains a work in progress. In addition to advocating to preserve federal funding for HIV prevention and care, all stakeholders must remain focused on the tangible actions we can take to better support more people to obtain and persist in using PrEP for effective HIV prevention.

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