Thank you all for having me. My name is Andrew Garcia and I am currently the clinical pharmacist at the outpatient infectious disease clinic at The University of Vermont Medical Center. I work closely with the infectious disease physician group to provide direct patient care to folks with a variety of conditions, including HIV and those seeking HIV prevention care. My background includes extensive training in clinical pharmacy at the University of Pittsburgh Medical Center, where I completed a pharmacy residency focused in underserved care and global health, and I am also credentialed as an HIV Pharmacist through the American Academy of HIV Medicine. I have had the privilege of working directly with patients who are marginalized or face large barriers to care, as do many of our HIV patients, and I am very happy to be here today to speak in support of this amendment that would allow pharmacists in the state of Vermont to directly provide care for HIV prevention.

As a nation, we have come a long way from the 1980s and 1990s, when the AIDS crisis was hitting its peak. In 1994, AIDS was the leading cause of death for young adults in America and the only available medication at the time, AZT, could lose efficacy and cause serious side effects. It was because of the dedication of activists and the tireless work of researchers from across the globe that many new HIV medications were developed. Today, not only is HIV not a death sentence, but the medications we have are extremely effective at preventing HIV acquisition when started either before or within 72 hours after exposure to an HIV positive source. For exposure via sex, we are talking almost 100% effective when these medications are taken as prescribed. And for folks who use injection drugs, these medications are over 75% effective in preventing HIV through exposure via an infected needle. And yet, despite having highly effective medications to prevent HIV, the HIV epidemic continues worldwide. In 2022, the Centers for Disease Control reported 38,000 new HIV diagnosis across the country. And while Vermont has a relatively low incidence of HIV compared to other parts of the country, the Vermont Department of Health reported over 100 new cases between 2008 and 2017. This number should be zero. We have the public health tools needed to end HIV, but still see new cases every year. What is happening that people continue to become infected when we have such great preventative medications?

Well, I can tell you what I see every day as part of my job. A patient might go to the emergency room, urgent care, or their primary care doctor and report that they stepped on a needle or maybe they had condomless sex with someone of unknown HIV status or maybe they were sexually assaulted. Their physician does the right thing and prescribes them HIV prevention medication – something extremely effective if started within 72 hours of exposure. And the patient goes to their pharmacy and is met with one or multiple barriers. The co-pay for the medication is in the thousands of dollars. The physician didn't prescribe the HIV medication that the pharmacy has in stock and it will take at least a day

to order. The patient's insurance forces them to fill at a mail-order pharmacy. Or the patient doesn't have insurance at all, and a 28 day course of preventative HIV medicine will be over $4,000 out of pocket. These aren't hypotheticals – I have gotten every single one of these calls from patients or from pharmacies. The pharmacy is the exact point where ideal medical care breaks down and the unfortunate harsh realities of our healthcare system set in – financial and logistical barriers that make the difference between a patient's being able to start their HIV prevention medication in time. And so, I strongly believe that pharmacists are in the perfect position to remedy that, should the legislature empower them to do so. The pharmacist would be able to say "We don't have this medication, let me switch that to a different one". Or – "this medication is expensive, but this other medication has a co-pay card available or a free drug voucher available – let's switch you to that one". Those actions might literally be life-saving when we are talking about a very short window to start prevention treatment. And that is only talking about the best-case scenarios – when patients have already sought care from a physician. In Vermont, where emergency room and primary care wait times can be extensive and visits often are accompanied by a large bill, and where folks living in rural areas may have significant barriers to quickly accessing care, patients may be discouraged from seeking HIV prevention at all. The community pharmacist might be the only healthcare professional these patients can or feel comfortable going to for help, and should absolutely be able to do so.

But – you don't have to take my personal experience with these patients as the only proof that the current system is not working. In 2022, the Centers for Disease Control published an alarming finding. Out of every American who would benefit from taking HIV pre-exposure prophylaxis, also known as PrEP, to prevent HIV acquisition, only 36% of those people were actually prescribed PrEP. That means almost 2 in 3 people that we should be reaching are completely left out. And unfortunately, the statistics show that these are already marginalized folks – for example only 13% of Black patients who would benefit from PreP received PrEP, while 94% of white Americans who would benefit did. Further disparities exist in other groups like women, who are greatly under prescribed PrEP, as well as folks experiencing substance use disorder. We really need all hands on deck to expand the provision of PrEP and to ensure all Vermonters who need it can access it free of charge. Pharmacists have the clinical knowledge and the proximity to patients and will be a necessary part of expanding PrEP access. For these reasons, I wholeheartedly support this amendment and welcome any questions you may have. Thank you for your time.