



MINUTES

Southern Nevada HIV Prevention Planning Group

July 15, 2026, 2:00 PM - 4:00 PM

SNHD, 280 S Decatur Blvd, Lone Mountain Conference Room/ and virtual via TEAMS

MEMBERS/VISITORS/PUBLIC ATTENDANCE

Please see attached sign-in sheet for further information on attendance. This meeting was solely an informational meeting, and no voting took place.

I. CALL TO ORDER - NOTICE OF POSTING AGENDA

SoNV HPPG Co-chair Chris Reynolds confirmed this was an informational meeting only. Chris reviewed meeting etiquette, stated no AI tools are not to be utilized, or member will be removed from meeting, also stated the meeting will be recorded.

II. WELCOME AND INTRODUCTIONS OF MEMBERS AND GUESTS

This meeting was recorded. No public health information was shared during the meeting.

III. ESTABLISHMENT OF QUORUM – This meeting is solely informational. Attendance did meet quorum guidelines; however, no voting took place.

IV. PUBLIC COMMENT

Public comment is a period devoted to comments by the public on items appearing on the agenda. All comments are limited to five (5) minutes. Public Health Co-Chair Albert Sedano asked if anyone wished to address the group pertaining to items appearing on the agenda.

- Dominic Calhoun – Nevada Stronger Testing event in Pahrump, NV – Thursday, July 16, 2026 from 9:30am – 2pm; 1141 S NV-160 Suite#4, Pahrump, NV 89048

V. CONSENT AGENDA

Chris Reynolds motioned and Albert Sedano seconded.

Co-chair Cheryl Radeloff announced that the Bylaws had been approved by the voting members.

VI. INFORMATIONAL ITEMS

A. HIV PrEP Choices – Dr. Samantha Strong, PharmD, BCACP, AAHIVP, CDCES Gilead

- HIV epidemic – as of 2023, 1.1 million people are living with HIV in the US
- PrEP Choices – oral and injectable
 - Importance of PrEP choices based on the patient; convenient user, social user, independent user, discreet user
 - Summary of Choices
 - Twice yearly injectable – Lenacapavir
 - Daily F/TAF
 - Daily F/TDF
 - Q2M injectable

- Purpose 1 and 2 trials
 - Efficacy analysis – In Purpose 1 trial, 100% efficacy demonstrated; in Purpose 2 trial, 96% efficacy; there were two incidents of HIV positives; 1 case stopped Lenacapavir; the other case's viral load was too low for genotyping
 - ❖ Adherence data – injections were on time for ~91%; no data on F/TAF on cis-gendered women
 - ❖ Safety data – most common side effects were injection site reactions
 - ❖ Dosing
 - Dosing and administration of twice-yearly Lenacapavir
 - Oral must be taken to allow full concentration of Lenacapavir
 - Must test for HIV prior to starting any treatment
 - Missed dosage – Injectable - depending on time span from last dose; client may need to start treatment process over from a beginning dose, but if client knows they will miss the second injection, they can take oral tablets one every seven days until the next injection; oral – take missed dose as soon as possible, but do not take day 1 and day 2 on the same day
 - ❖ Pregnancy data – 9% of participants were confirmed pregnant and stayed on the medication; pregnancy outcomes were similar to the regular population
 - ❖ Drug to drug interactions – no contraindications when it comes to Lenacapavir; however, medications to consider are anticonvulsants and TB meds like rifampin which need a supplemental Lenacapavir dosage
 - Cabotegravir - Bi-monthly injectable (every two months)
Oral lead-in dose or an injectable loading dose
 - ❖ Trials – HPTN 083 and 084 (blinded trials)
 - 083 - men who have sex with men and transgender women who have sex with men; cisgender women
 - 084 - cisgender women population
 - Randomized participants getting either the study drug or placebo pill for FTDF; the other half were randomized in getting oral FTDF
 - ❖ Efficacy analysis
 - HPTN 083 – participants in the Q2M IM CAB group had a 66% lower likelihood of acquiring HIV compare with those in the daily F/TDF group, and was consistent across prespecified subgroups
 - 13 HIV acquisitions in IM CAB group compared to 39 in FTDF group
 - HPTN 084 – participants in the Q2M IM CAB group had an 88% lower likelihood of acquiring HIV compared with those in the daily F/TDF group
 - 4 HIV cases were observed in the CAB group
 - ❖ Adherence data – for the injections, 90% of people received their injections on time in both groups, and that's for those in the active arm and giving the placebo injection
 - For 083, 74% of participants that had tenofovir concentrations that were consistent with daily FTDF doses, and using the dried spot analysis they found that 72% of samples had concentrations that were consistent with at least 4 doses per week.
 - For 084 group in cisgender women, the daily doses with the adherence were a little bit lower in this group with 41/42% of participants with tenofovir concentration that were consistent with daily use, using the dried spot analysis, 55% of samples yielded quantifiable plasma tenofamir concentrations.
 - 38% revealed less consistent adherence over time based on unquantifiable concentrations of FTDF.

- ❖ Safety data - most common side effects were injection site reactions, overall, for both 083 and 084, 81% reporting ISRs in the CAB group versus 31% in the placebo injection group; hypersensitivity reactions have been reported with CAB and include Stevens-Johnson syndrome (SJS)/toxic epidermal necrolysis (TEN); contraindications unknown with positive HIV-1 status
- ❖ Dosing and Administration – optional oral lead-in or the 600 milligram, 3 milliliter injection, intramuscular gluteal injection on day one, another injection one month later; and then every two months
 - Missed dose – if missed dose less than 2 months, continue every two-month injection; if missed dose more than 2 months, you must restart with the loading dose; one injection and starting again one month later
 - Planned missed dose - take the oral tablet for up to two months. They should start the oral tablet two months after that last injection. And then when they restart the injections, it should be the day they end the oral tablet or within three days.
 - Missed dose – second injection - less than two months, you can give that dose and continue every two-month injections, but if it's been over two months, you must restart the whole loading phase.
 - Missed dose – third or subsequent injection - if less than three months, continue with every two-month injection; and then if greater than three months, you must restart.
- ❖ Pregnancy data - for 084, which is the trial that was in our heterosexual women, they were supposed to be on contraception for this trial, but sometimes that does not happen; and therefore, there were 29 confirmed pregnancies.
 - If a participant had a positive pregnancy test or was suspected of pregnancy, the injectable study product was withheld and daily open label FTDF was offered if the participant wanted to continue with PrEP. The participant was unblinded and moved over to the open label FTDF throughout pregnancy and breastfeeding.
 - Pregnant participants continued quarterly follow-up visits through pregnancy outcomes. All pregnant participants were referred for first trimester ultrasound for fetal anomaly assessment.
 - Live infants were assessed again 12 months after delivery to assess for any congenital anomalies; no congenital anomalies were reported
 - Following pregnancy outcomes and cessation of breastfeeding, unblinded participants could return to the original study product if they wanted.
- ❖ Drug to Drug Interactions
 - Contraindicated with anticonvulsants and TB meds (carbamazepine, oxcarbazepine, phenobarbital, phenytoin, rifampin, rifapentine)
 - Rifabutin is the one exception; can be taken with cabotegravir with supplemental dosing recommendations
- Oral PrEP – FTAP and FTDF - one tablet, once a day
 - ❖ Not suitable for persons with unknown or positive HIV status
 - ❖ Activity against hepatitis B – patients should be tested for hepatitis B before treatment; if patient with chronic hepatitis B is taking oral PrEP, and comes off FTDF or FTAF, there are reports of severe acute exacerbation of hepatitis B, make sure to monitor hepatic function in individuals that are choosing to discontinue oral PrEP options if they have chronic hepatitis B

- ❖ Very similar to FTAF with the only difference or importance is that the indication does not include those at risk for HIV due to receptive vaginal sex or cisgender women. This is not FDA approved.
- Partners and DISCOVER PrEP Study Design
 - ❖ Partners PrEP – 36-month safety and efficacy study – randomized study of HIV serodiscordant heterosexual couples in Kenya and Uganda
 - July 2008-November 2010 – followed monthly up to 36 months
 - Outcome: HIV incidence for oral daily TDF, F/TDF, or placebo
 - Primary endpoint: Seropositivity in partners previously seronegative for HIV
 - Assessments: Safety, adherence, HIV lab testing, HIV risk behavior
 - Efficacy: 13 HIV incidents in the daily FTDF group, 17 in the TDF alone, and then 52 incidents in the placebo group
 - Adherence: study medication was used during about 92% of the total follow-up time; 98% of dispensed study bottles were returned and 97% of dispensed study tablets were taken
 - Safety: adverse events reported in $\geq 2\%$ in either study arm; diarrhea, nausea, headache, fatigue, abdominal pain, and gas
 - Renal and bone - less impact on EGFR and tubular biomarkers with FTAF versus FTDF; renal and bone is important when comparing FTDF and FTAF
 - ❖ DISCOVER – 96-week safety and efficacy study – Phase 3, randomized, double-blind, active-controlled study conducted in cities/sites with high HIV incidence; one-to-one with over 5,000 MSM and transgender women
 - September 2016 – January 2019
 - Outcome: HIV incidence for oral daily F/TAF vs. Oral daily F/TDF
 - Primary analyses: HIV incidence/ 100 PY when 100% complete at Week 48, $\geq 50\%$ complete at Week 96
 - Secondary analyses: efficacy and safety, 100% complete at Week 96
 - Assessments: safety, adherence, HIV lab testing, HIV risk behavior
 - Efficacy: seven cases of HIV incidents in the FTAF group compared to 15 cases at week 48; at week 96 there was one more case in FTAF, still the same 15 cases in FTDF. The Discover trial did show that FTAF was not inferior to FTDF in preventing HIV acquisition through week 96.
 - Adherence: 98% adherence for both arms, showing 99% efficacy in both FTAF and FTDF arms
 - Safety: adverse events reported; diarrhea, nausea, headache, fatigue, abdominal pain, and gas
 - Renal and bone - less impact on EGFR and tubular biomarkers with FTAF versus FTDF; renal and bone is important when comparing FTDF and FTAF
 - FTDF is not recommended for those with a creatinine clearance less than 60 milliliters per minute
 - ❖ Pregnancy Data: no increased risk of major birth defects; observational study that followed 78 HIV negative women who use FTDF for PrEP during pregnancy and delivered live-born infants with no major malformations
 - FTAF in pregnancy is not FDA approved in cisgender women
 - ❖ Medications with drug interactions: anticonvulsants, carbamazepine, phenobarbital, phenytoin, TB meds, and the herbal product St. Johns Wort

❖ Contact: Samantha Strong, PharmD, BCACP, AAHIVP @
Samantha.strong@gilead.com or 725-352-4694

B. “Update on PrEP and Pharmacy Initiatives” – Dr. Christina Madison, PharmD, FCCP, AAHIVP
See presentation titled: “*Update on PrEP and Pharmacy Initiatives*”

- Why pharmacy based PrEP matters
 - Highly accessible healthcare entry points
 - Varying business hours such as evenings and weekends
 - Serving all neighborhoods
 - Closes prevention gaps
- SB 325/ NRS 639.28085 - grants pharmacists a robust scope of practice for HIV prevention
 - Order and perform lab tests
 - Prescribe, dispense and administer
 - Full PrEP and PEP coverage
- Pharmacists requirements to provide PrEP/PEP
 - Complete, maintain, and retain all training documentation for a minimum of two years post prescribing activity
 - Use current treatment algorithm aligned with CDC clinical guidance
 - Maintain a minimum of \$1million in professional liability coverage
- Pacific AIDS Education and Training Center (PAETC) - actively updating Nevada pharmacist PrEP/PEP continuing education presentation to reflect the latest clinical guidelines, regulatory changes, and newly approved medications; will be available before the Autumn Update Conference in November 2026
- Clinical workflow for pharmacy-based PrEP - ensures patient safety, regulatory compliance, and appropriate linkage to ongoing care (see slide 6)
 - Required baseline screening/testing assessments for PrEP and PEP (see slide 7)
- PrEP options – daily oral TDF/FTC, daily oral TAF/FTC, long-acting injectable Cabotegravir, twice-yearly injectable Lenacapavir
- PEP – urgent prevention opportunity – start within 72 hours, 28-day regimen, bridge to PrEP
- Implementation barriers (see slide 10)
 - Lab testing limitations
 - Medication administration clarity
 - Prescribing and medication adjustment limitations
 - Payment for clinical services
- Support resources - pharmacists no longer have to navigate complex HIV prevention cases alone; Goldschmidt Collective & National Clinician consultation Center – 844-275-6222; services are completely free: National Clinician Consultation Center <https://nccc.ucsf.edu>

Q: When calling the consultation line, is there information given where people can get PEP after hours?

A: Yes, the consultation line had weekend hours now, and we have on call. Clarification – this is for clinicians only, not patients. If we get patient calls, we refer them to other resources.

C: When discussing the changes in recommendations, if someone comes in and says, I want to be on PrEP, I always think there's a caveat to that because how she stated they're looking at people who started on PrEP and then found they had HIV. Those people may have been very good candidates for PEP when they initially came in.

It's a good practice that if somebody comes in and talks to you about PrEP to really get into that sexual history and find out if, when was the last time that they had sex without a condom because the person sitting in front of you may have seen something to be on PrEP and they don't know the difference between PrEP and PEP, and they're just thinking they need to get PrEP and then not have to worry about this when they may need full PEP. There's a way to prevent an infection, and then you just transition them to PrEP after that 30 days.

Q: What is the timeframe for reaching the therapeutic level with Lenacapavir if client is engaging in receptive anal sex or receptive vaginal sex?

A: If the client is on Lenacapavir and takes the second dose, they will most likely reach that target concentration that same day. And I think it's somewhere between two to four hours after that second dose.

C/Q: As the HIV services director for ASP Cares Pharmacy, I have been trying and trying and trying to get our pharmacy to provide PrEP services. And the barriers that exist, but the hardest barrier is getting accounts set up for them to order labs. They don't have time or where are we going to do the testing at? It's like there's a thing where there's just constant barrier after barrier to do this. In the places here, the health centers, the Center, who have actually been able to have successful pharmacist-led PrEP programs, are all pharmacies tied to clinics. And I think that that's the reason they've been successful, is the clinic is right there. And so even though it's the pharmacist that's ordering everything, it's already built in, but they have access to an EMR. How do we cross this barrier?

A: The federal government really was pushing that both HIV and hepatitis patients should be able to be seen by primary care because it is so manageable now that it's very easy. They're giving grants to FQHCs to do more HIV treatment, being able to do testing to really promote PrEP. What we've seen is that it's not expanding in primary care. The infectious disease doctors are now doing primary care, so it's had this kind of reverse effect. I think that that's a big issue that kind of really needs to be addressed because there's not just one thing that we can solve. We can't say, once we get Medicaid to recognize forms to be able to pay for that, they can bill for that. It's much more than that. It's about having to be able to set those accounts up if they're not associated with a clinic. The whole purpose of this law was not to do collaborative agreements. It was to get away from that, to be able to say pharmacists could just do this on their own. In fact, the patient never has to see a provider outside the pharmacist as long as nothing's ever positive, so they can continue getting their PrEP through the pharmacist alone. Unfortunately, that's just not happening here.

There was discussion of PrEP studies; links provided below.

The PrEP Pharmacy Reach Study: Protocol for the Creation of Maps to Visualize the Impact of Expanding Access to HIV Prevention Services Through Pharmacies:

<https://pmc.ncbi.nlm.nih.gov/articles/PMC12558562/>

<https://www.prepwatch.org/products/mk-8527/>

2026 International AIDS Conference in Rio de Janeiro. <https://www.prepwatch.org/wp-content/uploads/2026/07/AIDS-2026-MK-8527-Schedule.pdf>

Q: With the four typologies of the different type of PrEP users, do you see any who lean towards one modality over another? Or do they switch from one type of PrEP to another?

A: Not necessarily the PrEP options, but definitely with the place of treatment; a mobile clinic versus telehealth versus coming into someplace like the center where you have a clinic, but you also have a peer support group. I think to answer your question is the actual PrEP option actually matters depending on where

you're getting the PrEP. The discrete user maybe wouldn't want to have pills on hand, so they might focus on long-acting injectable. Maybe someone who wants that social support. Maybe it could go both ways. You could see them wanting maybe oral or an injectable because they like going in. It's about really finding what works best for the patient.

More discussion on clients starting one method of PrEP and possibly having to change due to insurance plan changes or funding from where the client accesses PrEP.

VII. PUBLIC COMMENT: A period devoted to comments by the general public, if any, and discussion of those comments about matters relevant to the planning group's jurisdiction will be held. No action may be taken upon a matter raised under this item on this Agenda until the matter itself has been specifically included on the agenda as an item upon which action may be taken pursuant to NRS

241.020. Comments will be limited to five (5) minutes per speaker. If any member of the general public wishes to make a public comment, either in person or via MS Teams, request time from a SoN HPPG co-chair, clearly state your name and address, and spell your last name for the record. Please state whether you have any direct or indirect interest in or relationship with any individual or organization that proposes to enter any transaction with Southern Nevada HIV Prevention Planning Group. If any member of the Southern Nevada HIV Prevention Planning Group wishes to extend the length of a public comment, this may be done by the Co-Chairs or the Southern Nevada HIV Prevention Planning Group by majority vote.

- Chad Hendry - I am the community liaison replacing Heather Smith and I am transitioned into Vegas. I lived in Utah prior to this role. I worked in North and South Carolina as a community liaison for five years, and then I worked at Howard Brown Health Center in Chicago as the director of public health for 10 years. I've done just about every job related to sexual health, including being a DIS or partner services person and supervisor and a million other things. I'm excited to be here and collaborate, and if anybody needs anything, I'll be happy to work with you.
- AETC, Ryan White Part F funding has been granted so our program will continue. We'll be able to offer free education to providers throughout the state. I'm going to be coming back on in a more involved capacity than I was last year.

Organizational Activities

- AETC - AETC, Ryan White Part F funding has been granted so our program will continue. We'll be able to offer free education to providers throughout the state. I'm going to be coming back on in a more involved capacity than last year.
 - Webinar – July 28, 2026; 12:00pm – 1:00pm - Hidden barriers to engagement, intimate partner violence, and reproductive cohesion in HIV care; registration is free:
https://paetc.caspio.com/dp/050e700090280c9da9194a3daf9c?ER_ID=20019526
 - Autumn Update – November 7-8, 2026; Incline Village, NV: <https://med.unr.edu/cme/au2026>

Q: What are the CEUs required for the training?

A: It was for the HIV Stigma training. There were several trainings on our website that had to be pulled due to changes to the language. We are re-recording these trainings, and the HIV Stigma training will be posted soon. It will be on the UNR Med's Office of Continuing Medical Education's website. we are also re-recording and revamping the pharmacy and PrEP training.

- SNSMOPS – The Summit – August 13, 2026 at the Tuscany; 8:00am – 5:00pm
Summit website: https://whova.com/web/cLSavqEOooBA1Fz1V7Ix1y6jKVr7LyiDdAHm7E3AGyw=

Summit scholarship application: <https://survey.alchemer.com/s3/8803883/2026-SNSMOPS-Scholarship-Application>

- Inaugural Poster presentations
- International Overdose Awareness Day (IOAD) – 10th anniversary, August 29, 2026; 12:00pm – 4:00pm at Las Vegas City Hall
 - Resource Fair - 12:00pm - 4:00pm
 - Candlelight Vigil – 3:00pm – 4:00pm
 - Soles for Souls Exhibit – collecting 714 pairs of shoes to represent each soul lost to overdose; shoes will be donated to community agencies to supply those in need
- Southern Nevada Health Consortium
 - 16th Annual Black HIV AIDS Awareness Day event; West Las Vegas Library; health fair style event
 - Community Health Fair – free – February 7, 2026; 12pm – 3pm; West Las Vegas Library, 1861 N MLK Blvd, North Las Vegas, NV 89032
 - Consortium Community Calendar – if your organization has an event, you can submit it to the calendar page, and it will be posted; SNVhealthconsortium.org
- SNHD
 - SoNV HPPG Bylaws – a topic came up that we hadn't included in the bylaws
 - Events – If anyone is interested in having SoNV HPPG sponsor, participate in or lend the logo, you must submit a request via email to the co-chairs as SoNV HPPG is a planning body to address or lead the health district in a lot of the planning around HIV prevention and help with the state planning. This will be added to the bylaws, and during the October meeting, a vote will be taken regarding the new language.
 - SoNV HPPG – next meeting April 22, 2026; 2pm – 4pm, 280 S Decatur Blvd
 - If you have suggestions on presentations for HPPG 2026 contact: radeloff@snhd.org
 - Saber es Poder (Spanish Empower Change training) – not only translated but culturally adapted as well. First training was June 24-25, 2026 and was a complete success. Link to the interest form for those wanting to participate: <https://survey.alchemer.com/s3/8902397/Formulario-inter-s-Saber-es-Poder>
Contact: Belen Campos-Garcia at campos-garcia@snhd.org
 - Empower Change training – September 9-10, 2026 and November 9-10, 2026; SNHD, 280 S Decatur Blvd, if interested email empowerchange@snhd.org
- The Center
 - Condom Couture – Friday, July 24, 2026; 7:00pm at Dust, 855 E Twain Ave #114, Las Vegas, NV 89169
 - CAN (Victim Advocacy Program) – week long training from July 27-31, 2026; lunch will be provided. At the completion of the program, you will become a nationally accredited victim advocate.
- Leana Ramirez – no longer at The Center. Now at Gilead as the medical science liaison here in the Las Vegas community covering Nevada, Utah, and Idaho.

VIII. ADJOURNMENT

Motion was made to adjourn by Chris Reynolds and seconded by Albert Sedano. Meeting adjourned at 3:17pm.