Accelerating Action

The former AIDSmeds editor-in-chief finds a new role as HIV project director of the Treatment Action Group.

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Tim Horn is the HIV project director of the Treatment Action Group (TAG), an independent AIDS research and policy think tank based in New York City. Launched in 1992 from its origins in the AIDS Coalition to Unleash Power (ACT UP), TAG aims to accelerate research and policy for better treatment, a vaccine and a cure for HIV.

Before TAG, Horn was president and editor-in-chief of AIDSmeds.com, the treatment-focused sister site of POZ.com. He helped launch the site with Peter Staley, AIDSmeds founder and veteran activist of ACT UP and TAG. Horn has spent more than two decades in HIV/AIDS advocacy, including work as a writer and editor at amfAR, the Foundation for AIDS Research and as executive editor of the PRN Notebook, a quarterly journal for clinicians who treat HIV.

We catch up with Horn, a long-term survivor of HIV himself, on his new role at TAG. We also get his insights into new treatment guidelines from the U.S. Department of Health and Human Services (HHS) as well as the HIV treatment pipeline.

Why are the new HHS guidelines significant?
This past May, HHS released new HIV treatment guidelines that no longer categorize everything into preferred and alternative. They made a few key recommendations based on regimens that are applicable for everyone and for individuals who meet certain criteria based on viral load and CD4 count.

The guidelines include a listing of the average wholesale prices for drugs. It is very clear that there is a cost consideration, even though they don't explicitly mention it. Like it or not, we are moving into a very new era under the Affordable Care Act where cost is a key factor in treatment decisions moving forward.

As a result, we're going to see abacavir [generic version of Ziagen] and 3TC [a.k.a. lamivudine, the generic version of Epivir] back in the limelight. While there has been some debate around whether they will increase the risk of heart attack, the data has been very mixed in that regard.

Under the guidelines, once you're virally suppressed for a certain period of time they recommend you hold back testing CD4 counts. Right now, CD4 counts are usually tested every three to four months. HHS is saying once you're suppressed and once your CD4 counts show signs of improvement, you can hold back on regular CD4 testing.

It's an interesting cost-saving approach, but CD4 testing is one of the cheapest laboratory parameters we have available right now. Regardless, people with HIV still need to get their viral load checked on a regular basis, especially while they're on therapy.

What's in the HIV treatment pipeline?
There aren't really a lot of truly novel agents in critical development. We do see a number of agents being developed in pre-clinical studies, animal studies and tested studies that do show some potential value, but those have been very slow to move into clinical trials.

When we look at the current regimens available for first-line therapy, they are massively suppressive. They are as potent as they are going to be. The next barrier in treatment development is making drugs even safer and easier to take. Combination pills are making HIV drugs easier to take. The safer aspect is a bit more difficult.

We definitely need treatment for drug-resistant HIV, but we are just not at a point in the United States where we have a massive epidemic of people with multiple drug-resistant virus. However, this is not to say there aren't those folks out there. There are certainly a number of people who are at the end of their rope therapeutically because they are basically resistant to everything.

One thing to keep an eye on is tenofovir alafenamide fumarate (TAF), which is under development by Gilead Sciences. It's basically a chemical cousin to tenofovir disoproxil fumarate (TDF), which is in Atripla, Complera, Stribild, Truvada and Viread.

Gilead is moving forward with Phase II and Phase III studies of TAF. In fact, it's looking at a new version of Stribild using TAF instead of TDF, which has been in Stribild since its inception.

TAF requires a very low milligram dosage, from 10 to 25 milligrams, versus 300 milligrams for TDF. Even with such a low milligram dose, we see very high levels of tenofovir in people's cells. Since there's actually a very little amount of the drug circulating in the bloodstream, the potential is that TAF is less likely to cause things like bone loss and kidney toxicity, which are two of the potential drawbacks of TDF.

Another thing people have their eyes on are long-acting drugs injected intramuscularly, such as GSK1265744 from ViiV and Edurant (rilpivirine) from Janssen. It looks like they would be injected once a month, primarily as maintenance therapy. ViiV is going to be conducting a study that should open before the end of 2014 to look at these two drugs used together.

When people reach an undetectable viral load, after three months or so, then they could potentially switch to a long-acting formulation. They could inject the drugs once a month instead

of taking pills orally daily. Long-acting agents are showing a great deal of promise not only for treatment but also as pre-exposure prophylaxis (PrEP) to prevent HIV.

Tell us about your work at TAG.
I oversee a number of resource, policy and advocacy priorities. Much of my focus is related to two issues I'm passionate about in the field, which are antiretroviral research and development, as well as understanding the resources and complications around HIV and non-AIDS complications of HIV.

Apart from my personal role, TAG is working on numerous fronts. One of them is the National HIV/AIDS Strategy. Launched in 2010, it set out targets to be achieved by 2015, which included reducing the rate of new HIV cases by 25 percent and to get treatment to 85 percent of HIV-positive people within three months of their diagnosis.

A great deal of work still needs to be done to achieve even very mediocre goals. By 2020, we need to be even more ambitious. We are seeing some improvements nationally in the number of people who are being diagnosed with HIV, but we need a lot more data. We need more input in ways to improve linkage to and retention in care.

I don't think we are going to end the epidemic on a national level. Where I do think we will end the epidemic is on a state level. What is going to be a critical issue going forward is getting the advocacy in those states and getting those health departments, as well as the clinicians and community service providers, to set statewide targets.

Even though the national government pumps a fair amount of resources and funding into various programs, the fact is the states have to meet the federal government halfway. So many programs that we depend on for HIV really do depend on state involvement, everything from Medicaid to putting money into AIDS Drug Assistance Programs.

What else is TAG working on?
Apart from ongoing programs, we're excited about our HIV prevention partnership with amfAR, The Foundation for AIDS Research; the National Institutes of Health (NIH); community-based groups; and federal agencies.

Getting people on treatment and keeping them healthy remain priorities, but we also want to get them undetectable to prevent transmission. We want to reinvigorate the importance of prevention for all people in the United States. It's a critical part of our public health response because we can't treat our way out of the epidemic.

We're also interested in comprehensive health services under the Affordable Care Act for those at risk of HIV, which means determining who that is and to not just focus on keeping them HIV negative, but keeping them well. This approach works for people living with HIV. It also may be very beneficial for people at risk.

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