



SELZENTRY™ (MARAVIROC) HIV TREATMENT

A Panel Discussion among Five HIV Specialists

Prepared by Panel Intelligence, LLC

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STUDY DESCRIPTION AND OBJECTIVES

To conduct a panel among HIV specialists to better understand changes in physicians' treatment regimens and prescription patterns since Selzentry™ (maraviroc) was released on August 6, 2007.

- Understand the market size and patient population that uses maraviroc
- Identify physicians' adoption of maraviroc and inclusion in treatment plans (patient and provider drivers)
- Assess how maraviroc has changed treatment plans (prescription patterns, dosing, etc.)
- Discuss physician and patient experiences with maraviroc
 - Identify the side effects and their effect on prescribing
 - Assess the benefits and risks of incorporating maraviroc in a treatment plan
- Examine recent clinical data about maraviroc
- Discuss barriers and facilitators to treating with maraviroc
- Review coverage and reimbursement for maraviroc
- Explore other possible uses of maraviroc and the impact of other products in the CCR5-coreceptor antagonist class currently in the pipeline
- Examine future trends in the next 6 months to 1 year

COMPANIES AND PRODUCTS MENTIONED IN THIS REPORT

Company	Ticker Symbol	Product(s)
Pfizer	PFE	Selzentry™
Roche Laboratories Inc.	RHHBY	Fuzeon®
Tibotec Therapeutics/Ortho Biotech		INTELENCE™
Merck	MRK	ISENTRESS™

PANEL HIGHLIGHTS

- **Uptake of Selzentry™ (maraviroc) Less Than Expected.** Panelists are prescribing maraviroc in approximately 3% - 10% of their patients. Maraviroc is only approved for use in treatment-experienced patients with the R5 virus, a small subpopulation of HIV patients, and requires additional testing not required with other medications, to determine if patients are eligible for use.
- **Experience Has Been Favorable.** All panelists indicate that maraviroc has been very effective in controlling viral loads of patients with R5 virus and most patients have experienced minimal to no side effects so far. The drug seems to be very well tolerated by patients.
- **Additional Testing and Inconvenient Dosing Are Limiting Adoption.** The need to use trofile testing, a costly additional test used to determine eligibility for use of maraviroc, is unanimously identified as a barrier to greater uptake. Twice daily (BID) dosing is another factor limiting greater use as patients strongly prefer once-daily dosing.
- **Impact of Other Medications.** All panelists indicated a decrease in their use of Fuzeon® since maraviroc was approved. The approval of Isentress™ (raltegravir), an integrase inhibitor, and Intelence™ (etravirine), a non-nucleoside reverse transcriptase inhibitor (NNRTI) have also resulted in decreased prescriptions of Fuzeon®. These two new medications for treatment-experienced patients appear to be more readily prescribed than maraviroc since additional testing is not required.
- **Possible Future Use.** Panelists had mixed reactions on their future use of maraviroc. Entry of other medications for treatment-experienced patients (i.e. Intelence and Isentress) that have less requirements and restrictions may keep maraviroc from greater adoption. Some panelists felt that maraviroc should be used earlier in treatment when there is two class resistance rather than wait for deep salvage situations. A possible new market opportunity exists if clinical trials can demonstrate improved efficacy and outcomes in treatment-naïve patients. Use in the post-exposure market is not likely due to the trofile testing requirement.

INCLUSION CRITERIA

Inclusion Criteria	<ul style="list-style-type: none"> ▪ US Board-certified in specialty ▪ 2 to 30 years of experience post-training ▪ Must have treatment experience with maraviroc ▪ From academic medical centers and community practices <ul style="list-style-type: none"> ○ Goal is for 50% from academic centers and 50% from community practices ▪ Treat at least 50 HIV patients per month ▪ Request disclosure of past and current consulting relationships
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PANELISTS AND DEMOGRAPHICS

Specialty	Hospital affiliation	State	Setting
Family Medicine/HIV	Private Practice	DC	Private
Infectious Diseases	Private Practice	NY	Private
Infectious Diseases	University Hospital, Newark	NJ	Academic
Internal Medicine/HIV	University of California	CA	Academic
Internal Medicine	University of Washington School of Medicine	WA	Academic

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SELZENTRY™ (MARAUIROC) HIV TREATMENT

Discussion Transcript

i Identifying Icons:

- Questions are marked with .
- Important Information is marked with .
- Moderator Questions are marked with .
- Supporting Documents are marked with .

i Introduction

Welcome to this discussion among HIV specialists in which we will explore the impact Selzentry™ (maraviroc) has had since its market release. Our primary goals are to understand your current use of maraviroc and examine factors that might alter your treatment of HIV patients. Panel Intelligence discussions are enhanced when you, as a panelist, not only respond to the posted questions, but also reply to comments made by our moderator and your fellow panelists. We look forward to a lively and interactive discussion.

Please note: In your participation on this panel, Panel Intelligence expects and requires that you comply with the terms of the Consultant Confidentiality Agreement to which you previously agreed. If you have any questions about the terms of that agreement, please review them through the link provided on your Panel Intelligence home page after you've logged in.

Q Q1: Market size

In what percentage of your HIV patients are you currently prescribing maraviroc? In which patients do you prescribe maraviroc and why?

Panelist 5: Small percentage 5%. Usually prescribing for treatment experienced patient currently because of need for trofile as well as results from trofile demonstrating X4 variant.

Panelist 2: Approximately 10% of total patients, approximately 20% of treatment experienced patients. I do not currently use Maraviroc for any patients other than treatment-experienced patients with high levels of drug resistance

Panelist 3: Since its approval, I've been using it for my patients with drug resistance - accounts for probably no more than 5-10% of my current patient population

Panelist 4: probably 3-5 % in 3 line therapy

Panelist 1: I have nine patients on Maraviroc out of a total of 800+ patients on treatment under my care.

Panelist 1: I prescribe maraviroc in patients with underlying drug resistance who have the R5 virus.

Q Q2: Treatment plan

What other medications do you prescribe in combination with maraviroc? What criteria do you currently use to determine whether or not to prescribe a regimen that contains maraviroc versus one that does not? Please describe your thought process in detail.

Panelist 5: Patients on maraviroc are currently on other antiretrovirals that are susceptible to the regimen based on phenotypic testing. I use phenosense testing to determine the proper regimen for the individual patient. More significantly I use the trofile information to make this determination.

Panelist 2: The other medications used depend on the background resistance of the patient (determined by genotype testing) and the optimal regimen for that patient, without set preexisting criteria. Use of Maraviroc in treatment experienced patients depends on the results of tropism assay.

Panelist 3: Since I'm using this in my drug-resistance patients, the indications for maraviroc and the other components of the antiretroviral regimen are based almost exclusively on the results of drug resistance testing

Panelist 4: all depends on Geno/phenotype of experienced patient, in most cases combination therapy with integrase inhibitor or new Pi such as Darunavir is appropriate

Panelist 1: Fuzeon; Prezista; aptivus; isentress; Maraviroc is the preferred drug if the patient has R5 virus in the setting of at least two class resistance. I want to use this drug before the virus changes into X4.

MF1-1. Follow-up ALL

Have patients requested to include maraviroc in their treatment plan? If so, please describe the characteristics of these patients? Why did they want to make the change to their regimen?

Panelist 5: None of my patients have specifically asked for maraviroc.

Panelist 2: Some patients have asked about Maraviroc, but none have specifically requested treatment with it.

Panelist 4: my patients did not ask for maraviroc, I think the decisions regarding treatment of experienced patients should be left for physicians, this issue is too complicated and we need to help patients to make the right choice

Panelist 3: Surprisingly, I have had no patient-inquiries about maraviroc (I say surprising because I have an pretty informed panel of patients who usually grill me - even about drugs in the pipeline)

Panelist 1: patients have not specifically requested for maraviroc; however some are requesting oral substitutes for fuzeon injections.

QQ3: Expectations

Has the clinical uptake of maraviroc met your expectations? In other words, are you using the drug as much as you initially thought you would when it was first released? Has it met the expectations of the clinical and scientific community? Please explain your reasoning behind your answers.

Panelist 5: The clinical uptake has been weak with the availability of the integrase and efavirenz which are also BID regimens but require no special testing. I was initially excited about the new class and thought I would be using it more, but the testing has limited my usage. The release of the two other medications at the same time has limited its utility in my patient cohort as well as others in the community.

Panelist 2: Yes, I am using it primarily in treatment-experienced patients with CCR5-tropic virus, which is to say, a small subpopulation of patients. My use of the drug is not that

extensive, but it looks extremely promising for the subset of patients who meet the prescribing criteria.

Panelist 3: The drug is only of utility in a very specific subset of the treatment population. That being said, it seems to work well and provides much needed options for that population.

Panelist 4: I use it less than initially expected, due to additional testing requirement as well as initial reports of increase in lymphomas

Panelist 1: The clinical use of Maraviroc has been much slower than expected since a lot of patients on deep salvage therapy are turning up as X4 or D/M type of virus. I am starting to do the trofile assay sooner than in deep salvage therapy in order to be able to use this class of agents. The patients on maraviroc have done exceedingly well so far without any side effects and with excellent efficacy results.

MF1-2. Follow-up ALL

Panelists have stated that the uptake of maraviroc has been less than expected due to: 1. The need for testing prior to use (Panelist 5) 2. Initial reports of an increase in lymphomas (Panelist 4) 3. "a lot of patients on deep salvage therapy are turning up as X4 or D/M type of virus" (Panelist 1) Are there any other reasons that the uptake of maraviroc has been less than you initially expected? Please rank, in order of significance, the reasons why uptake has been less than expected.

Panelist 5: BID dosing has also been a factor in less use.

Panelist 2: No additional issues. The need for testing is the greatest barrier, though after testing the large number of treatment experienced pts with mixed or CXCR4 virus then becomes the major issue.

Panelist 4: 1. Need for additional testing 2. Long term side effects unknown

Panelist 3: 1. definitely the testing 2. bid dosing

Panelist 1: long term side effects not known yet. The most significant reason for the less than expected use of maraviroc has been the need to identify R5 virus type by trofile assay testing. Once the test is done then it cannot be used in X4 type of virus.

MF1-3. Follow-up ALL

Panelist 1 stated: "The clinical use of Maraviroc has been much slower than expected since a lot of patients on deep salvage therapy are turning up as X4 or D/M type of virus. I am starting to do the trofile assay sooner than in deep salvage therapy in order to be able to use this class of agents." What do you think of this statement? Are any other panelists modifying their practices in order to use maraviroc more regularly? Please explain why or why not.

Panelist 5: Payment for the assay by insurance companies have been variable; therefore, in my patient population I am unable to perform the trofile earlier. The trofile assay has caused the slower uptake in use the maraviroc.

Panelist 2: I would now generally screen patients for tropism when checking for resistance, regardless of whether planning to use maraviroc at that time, in order to establish possibility of use in the future.

Panelist 4: there are many other options in earlier stages of therapy, and little need for agent that requires additional test

Panelist 3: it think it would be worthwhile to perform the trofile assay earlier, provided insurance will cover it

Panelist 1: With limited choices available for multidrug resistant HIV virus it is imperative that all possible classes of drugs be used to their maximum potential. By not using the CCR5 antagonist class earlier in therapy when the R5 virus predominates, we risk losing this class forever.

MF1-4. Follow-up ALL

Panelist 4 referenced lymphoma as a possible side effect of maraviroc. What is your opinion of this? How would the risk of lymphoma impact your use of maraviroc? How does the risk with maraviroc compare to other CCR5's in development?

Panelist 5: This is deeply concerning and may signal less use of other CCR5's in development. The mechanism of why increased risk of lymphoma is unclear and I don't feel confident using maraviroc in greater numbers of patients.

Panelist 2: Although concerned about risk of lymphoma, most of my patients on maraviroc don't have many other options for control of HIV. Due to similarities in mechanism, it would seem that other CCR5 inhibitors would have similar issues.

Panelist 3: I educate my patients regarding this potential risk - but usually those that require this Rx have few other options, and no one has declined the Rx yet. This might change as we get more data regarding the risk of lymphoma, but so far, it's not having an appreciable effect on my practice

Panelist 1: have not seen lymphoma as a side effect in any evidence/literature published/presented to date on maraviroc, so this comment is speculative by panelist 4.

Panelist 4: 1.this issue was with initial trial reports,increase incidence of lymphoma,it did not affected package insert info re maraviroc and increased incidence of lymphoma 2.I cant comment re the sideeffect profile of other CCR5 ,since most of them are still in development and adverse event profile may change

QQ4: Experience with maraviroc

Please describe in detail the type of clinical impact maraviroc has had on your patients so far. What type of side effects have been experienced by your patients? How have they been managed?

Panelist 5: Side effects have actually been minimal with occasional headache or nausea (and this is not clear if it is a result of other parts of the current regimen). My patients on maraviroc seem to tolerate the medication well.

Panelist 2: Maraviroc, along with other newly introduced ARVs, has been very effective in controlling viral load of patients with resistant virus. I have not observed any significant side effects from treatment.

Panelist 3: Thus far, both my patients and myself have been very pleased about the tolerance profile - no real limiting side effects (yet). However, the population of treated patients is relatively small, so it wouldn't surprise me if we see something pop up as we get more experience with it.

Panelist 4: generally well tolerated drug,with minimal GI sideeffects,but unfortunately long term sideeffect profile remains unknown

Panelist 1: All the patients on maraviroc so far have achieved HIV viral loads of <400 in early therapy and 50% have achieved viral loads of <50. No discontinuations so far and no major side effects seen so far. CD4 counts have also shown a healthy rise on therapy with maraviroc.

M F1-5. Follow-up ALL

Panelist 1 stated: "All the patients on maraviroc so far have achieved HIV viral loads of <400 in early therapy and 50% have achieved viral loads of <50.....CD4 counts have also shown a healthy rise on therapy with maraviroc." Have other panelists seen similar changes in these clinical parameters? If not, please share your experience with these clinical parameters in your patients in maraviroc.

Panelist 5: I too have seen viral loads less than 400 copies and CD4 rises have been modest.

Panelist 2: Yes, maraviroc has been very effective in achieving suppression.

Panelist 4: most of my patients on maraviroc achieve desired results in suppression of virus loads, of course with 2 other active agents

Panelist 3: yes, similar results in my patients (although a pretty small number so far)

Panelist 1: this is my experience as posted

M F1-6. Follow-up ALL

What do patients on maraviroc say about their treatment experience? In your answer, please comment on overall patient satisfaction, patient impression of clinical efficacy, BID dosing, side effects, and anything else you think is important.

Panelist 5: Patients on maraviroc in my care have been happy with minimal side effects. They don't mind the BID regimen and overall happy with the medication. A few patients have inquired about reading about increased lymphomas and the patients are concerned about this issue.

Panelist 2: There have been some minor complaints about BID dosing and some concern about the possibility of lymphoma.

Panelist 4: most of my patients tolerate this drug well, BID in most of patients (experienced in other therapeutic options) is not a problem

Panelist 3: i would say about 1/3 of the patient keep asking about other options that have QD dosing; the rest have no complaints. Although no significant side effects yet

Panelist 1: no complaints yet about this drug from the 9 patients I have prescribed this drug to so far. patient satisfaction is good and would be excellent if it was once daily.

Please discuss the **strengths** and **weaknesses** of maraviroc.

Panelist 5: Strength: New class, good dosing schedule, no food requirements, good pill size, minimal side effects as experienced by patient Weakness: 2500+ trofile testing which has variable insurance coverage lately with the possibility of not being able to use maraviroc if X4 variant is present. BID dosing is a weakness also since it may limit its usage in the naive patient of 2008.

Panelist 2: Strengths: New class of treatment for treatment-experienced patients, minimal side effects, limited drug interactions. Weaknesses: Tropism assay is very expensive and would limit use of the drug outside of well-insured patient population; limited target population.

Panelist 3: Strengths: well-tolerated; good option for a small subpopulation of drug-resistant patients Weakness: with all the press surrounding once-daily dosing regimens, patients express some disappointment about BID dosing; still only of utility for small population

Panelist 4: availability of new class of drugs in pill form, weakness would be additional testing requirement prior to therapy initiation

Panelist 1: strengths : Efficacy, no cross resistance, excellent tolerability weakness: useful in R5 virus only, cost, pill burden, dosing is complicated because of drug interactions

M F1-7. Follow-up ALL

Panelist 2 stated that a strength of maraviroc was: “limited drug interactions.” However, panelist 1 stated that a weakness of maraviroc is that: “dosing is complicated because of drug interactions.” Please share your opinion regarding maraviroc’s risk of drug interactions. Do you agree with panelist 2 or panelist 1? Please explain your reasoning behind your answer.

Panelist 5: There are a handful of medications with interactions with maraviroc since it is a substrate of CYP3A and Pgp. Currently these are ketoconazole, lopinavir/ritonavir, ritonavir, saquinavir, and atazanavir. Therefore monitoring while on these medications concurrently is warranted.

Panelist 2: Yes, there are dosing issues with other ARVs, though risks of toxic drug interactions is low.

Panelist 4: there is a need for dose adjustments of maraviroc ,but this not constitute a major problem to use it in experienced patients

Panelist 3: some dosing adjustments when used with other ARVs, otherwise not really a big deal

Panelist 1: With experienced HIV treaters, dosing is not usually a problem although occasionally wrong doses may be prescribed if one does not pay attention to the drug interactions.

Q Q6: Changes in treatment plans

Please explain how your prescription patterns have changed since you began prescribing maraviroc. In your answer, please consider whether you have:

- decreased the use of other medications;
- stopped prescribing other medications; and/or
- changed the dose of medications used in combination with maraviroc.

Panelist 5: I have decreased use of T20 which maraviroc has partially replaced, however the integrase inhibitor has taken a larger share of that market. With a drop in T20 usage, there has been an increase in not only maraviroc but also the other two medications.

Panelist 2: Maraviroc hasn't so much replaced other medications (except T20) as supplemented regimens. Availability of Maraviroc and other new agents has allowed me to

modify regimens of treatment-experienced patients with high levels of resistance who were previously waiting for the availability of multiple new agents.

Panelist 3: Since it's only good for a small subsection of patient, it hasn't significantly impacted my prescribing habits (with the exception of a decrease in T20 use)

Panelist 4: prescription pattern affected small number of experienced patients

Panelist 1: some decline in use of fuzeon

M F1-8. Follow-up ALL

A few panelists mentioned that their use of FUZEON® has decreased recently and that maraviroc is one of the medications used in its place. To how many patients in your practice does this situation apply? What other medications, in addition to maraviroc, are being used instead in FUZEON? Among all your patients who had been receiving FUZEON, what percentage is receiving each of the other medications you mentioned?

Panelist 5: I have substituted T20 for the integrase inhibitor and etravirine depending on the patient. A few are also on maraviroc. This is perhaps 15-20 patients on my panel. A greater number are on the integrase inhibitor.

Panelist 2: Approximately 20 patients have been switched from T20 to Maraviroc. Other options are Raltegravir and Etravirine. Approximately 80% of the patients formerly on Fuzeon are now on one of these agents.

Panelist 4: there are not numerous patients using Fuseon in my practise due to injection requirement and injection side sideeffects,most of them expressed wishes to be switched to maraviroc,but this will not significantly affect maraviroc prescriptions ,since the total number of patients on Fuseon is low

Panelist 3: I estimate about 10 of my patients have switched from T20 to maraviroc

Panelist 1: Only a handful of patients. Isentress and now intelence are being used instead of fuzeon in some of these patients. Most patients on fuzeon are now receiving either prezista or aptivus alongwith one or two of these three new drugs.

Q Q7: Barriers and facilitators

Please discuss any **barriers to** and **facilitators of** treatment with maraviroc.

Panelist 5: Trofile testing and cost of testing is a barrier. Insurance coverage variability if limiting for now. I believe a drop in price in the testing as well as possibility of a QD regimen if pharmacokinetics allow would help.

Panelist 2: The biggest barrier is the need for the tropism assay and the exclusion of patients with CXCR4 tropic or duotropic virus. I don't know of any facilitators to treatment.

Panelist 3: Testing cost is pretty huge. I just recently changed practices to a more heavily insured population - when I was working at the county hospital, there is a larger population that could have benefited from this agent, but the testing cost was a significant barrier. Obviously, subsidizing the testing costs would facilitate treatment

Panelist 4: main barrier is the need for additional testing

Panelist 1: barriers: cost and availability of trofile assay; cost of medication facilitators: new

class of drugs for use in treating multidrug resistant HIV virus

Q8: Cost and reimbursement

Please discuss any challenges related to cost and reimbursement that your patients have experienced associated with maraviroc. How have these issues been resolved?

Panelist 5: Cost at this point of the medication is similar to others. Our ADAP covers it currently. The testing though again is variable in coverage.

Panelist 2: My patients have not had major problems with cost or reimbursement.

Panelist 3: Just changed to a heavily insured population; haven't had any problems, though I suspect the case would be a bit different in my former position at the county hospital

Panelist 4: cost of the drug is not a problem since most of patients are eligible for medicaid or NJ ADDP program

Panelist 1: insurance coverage for the trofile test is still a problem however monogram sciences has done a great job in taking over the paperwork for this and in doing the test for free when coverage was not available.

Q9: Off-label uses

Are you currently using maraviroc off-label? If so, please describe these experiences. Are you aware of others using maraviroc off-label? If so, please describe their experiences.

Panelist 5: Not using it off label at this time.

Panelist 2: No

Panelist 3: No.

Panelist 4: do not use it off -label

Panelist 1: No I am not using it off label and I am not aware of anyone else using it off label.

M F1-9. Follow-up ALL

If clinicians were to start using maraviroc off-label, how do you think they might use it?

Panelist 5: Naive treatment, post-exposure/post-sexual prophylaxis.

Panelist 2: There is no reason I would use it off label at this time

Panelist 4: do not plan to use it off label at this time due to unknown long term sideeffect profile so will not speculate re:off label use

Panelist 3: i don't feel comfortable using it off label at this time, but I've heard discussion about using it in treatment-naive pts

Panelist 1: Use in naive patients. Use in post exposure prophylaxis is not possible since it has to be instituted early and the trofile test takes 3 weeks to do.

Q10: Others in class

Please describe any knowledge you have of other CCR5-coreceptor antagonists in development. How do you think they may impact your clinical practice in the future? **In your answer, please do not**

discuss experiences or observations derived from ongoing or completed clinical trials that have not been published in the medical literature or presented at a conference.

Panelist 5: Any potential QD dosing would be helpful. I am not clear at this time when vicriviroc will pass.

Panelist 2: I am aware of other entry inhibitors in development with more convenient dosing profiles. However, as all will probably be limited by the same tropism issue as Maraviroc, so I am not sure what impact they will have on practice.

Panelist 3: Honestly, I could pick them out of a list, but can't come up with specific agents of the top of my head. From what I can tell from the meetings, the others aren't quite ready for prime-time yet

Panelist 4: since maraviroc is first on the market it will retain most of the volume do to clinical experiance provided that safety profile will remain favorable

Panelist 1: Vicriviroc. If the dosing is once daily then it will be the preferred R5 antagonist provided the efficacy is not compromised.

Q11: Future trends

How do you think your use of maraviroc will change, if at all, in the next 6 months? How will your use change in the next year after that? Please explain your reasoning behind your answers.

Panelist 5: If testing is covered by insurance more universally I believe the trend should be slightly up. The introduction of two other new medications for treatment experienced patients makes it more difficult. By mechanism alone I believe it will have utility in the post exposure market as well as patients that are treatment naive.

Panelist 2: I don't anticipate any major changes in the future. If Maraviroc is shown to be an effective first-line agent it could substitute for other first-line treatments in the distant future, but right now I am skeptical of that happening.

Panelist 3: I don't anticipate any increase in its use over the next several years - possibly a decrease as other options are introduced for drug-resistant patients. Of course, we need more data regarding its utility in treatment-naive patients, would might change this paradigm

Panelist 4: dont think it will change significantly

Panelist 1: Since I am doing the trofile assay earlier now, I anticipate my use of maraviroc will continue to see an increase for the forseable future.

M F1-10. Follow-up ALL

Please discuss in greater detail the potential for maraviroc to be used in the following scenarios: • The post-exposure market • Treatment-naïve patients (i.e., as a first-line agent) In your answer for each clinical situation, please explain how the drug's mechanism impacts its use in this manner. Please also discuss why you think maraviroc will or will not be used in these situations.

Panelist 5: The trofile testing limits the use of maraviroc in this matter. Unless the price of the trofile assay is cheaper or covered more by the insurance I don't see maraviroc used in these circumstances since we have access to the integrase inhibitor also.

Panelist 2: Use in PEP is minimal since would require previous testing with tropism assay; for treatment naive patients I would avoid use with a goal of reserving for later use in case

of resistance. Unless long-term use shows Maraviroc to have similar efficacy with decreased risk of adverse metabolic effects.

Panelist 4: there are lack of studies re post exposure market including use of maraviroc in treatment naive patients ,again the lack of experience including sideeffect profile(long term toxicities) are major concerns

Panelist 3: I'm skeptical about tis utility for PEP - how would you get the trofile results before starting therapy? As for treatment-naive - have to wait for some data!

Panelist 1: this is off label use. Even though most sexual exposure transmission is with the R5 virus this is not universal and so a trofile assay would be required prior to using it in this setting. Use in low viral load patients is definitely a possibility if one wants to use a PI and NNRTI sparing regimen. Since most naive patients have R5 virus this is a real possibility in the future if the evidence supports it i.e. long term results of merit study.

MF1-11. **Panelist 4 Follow-up**

In your answer you noted: "don't think it will change significantly." Why don't you think the use of maraviroc will change in the next 18 months?

Panelist 4: the use of this drug is limited by testing requirement,unknown long term sideeffect profile,need for dose adjustments in patients taking other drugs,lack of experience in most of HIV providers to use this product ,lack of teaching programs re :maraviroc and 18 months is not long time frame to address above issues

Panelist 1: As more data emerges ans post marketing safety is established, maraviroc use will increase.

MF1-12. **Panelist 5 Follow-up**

In your answer you noted: "The introduction of two other new medications for treatment experienced patients makes it more difficult." Can you please specify the two medications to which you are referring? Thank you.

Panelist 5: Integrase inhibitor, Isentress and etravirine of intelence.

Panelist 1: To not use a unique class of drugs with limited choices against multidrug resistant HIV is a foolhardy strategy.

QQ12: **Other Issues**

Other than what has been discussed, what is important to know for someone trying to understand the clinical impact of maraviroc, its current uses, and future trends?

Panelist 5: I think this medications should have a naive indications also (based on mechanism) and should be studied extensively. That in theory would have less X4 or mixed variants on trofile testing. I believe sparing the protease inhibitor side effects would be helpful in the majority of patients who are naive.

Panelist 2: I think that more information on long-term efficacy and side effects will be important for determining the place of Maraviroc in regimens of treatment-experienced and (possibly) naive patients. Once long-term longitudinal data is available there will be more to say.

Panelist 3: It's still a black box at this point. We need to see how outcomes pan out over the

next few years to really understand its place in our current treatment landscape.

Panelist 4: more patients may benefit from this drug in the future depending on safety profile with long term use

Panelist 1: New class of drugs for use with R5 virus and so must be used before the virus changes to X4 type. The drug should be used when there is two class resistance rather than wait for deep salvage situations.

M F1-13. Follow-up ALL

Panelist 1 stated: “new class of drugs for use with R5 virus and so must be used before the virus changes to X4 type. The drug should be used when there is two class resistance rather than wait for deep salvage situations.” Do you agree with this statement? Please explain your reasoning behind your answer.

Panelist 5: Emphasizes and argues for earlier use of the medication based on the theory that more experienced patients would have the X4 type. I agree with the thought but again the trofile test is the limiting factor.

Panelist 2: Yes, but reasons for reserving use are the ability to switch to a different class of medications in case of need for salvage therapy. Also, given less experience with use of the drug, I would be less eager to use it earlier in treatment.

Panelist 4: I agree that this drug probably should be used earlier in course of therapy when patients have more options

Panelist 3: Interesting notion but goes against the strategy of holding Rx with novel mechanisms in reserve for viral breakthrough. The key is getting some outcome data related to this strategy from RCTs - otherwise the benefits and detriments are all just speculation

Panelist 1: my thoughts as stated. More long term experience and safety data will provide the evidence for such practice.