Table 3 & Figure 3: Oral Health Care Patients by Race and Ethnicity, Table 4 & Figure 4: Oral Health Care Patient by County

Table 3 & Figure 3: *Oral Health Care Patients by Race and Ethnicity*

African American	304
White	76
Asian	1
Hispanic	14
Multiracial	4

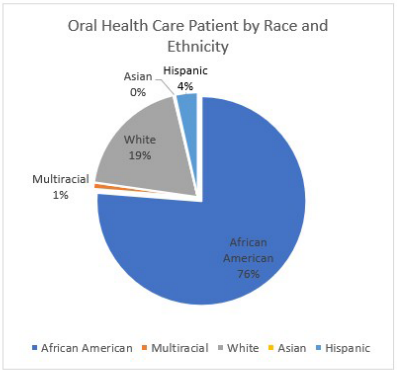
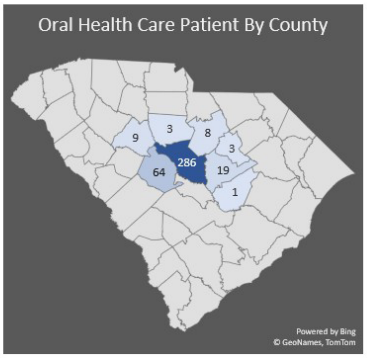


Table 4 & Figure 4: *Oral Health Care Patient by County*

Richland County	286
Lexington County	64
Sumter County	19
Newberry County	9
Kershaw County	8
Fairfield County	3
Lee County	3
Clarendon County	1



Conclusion. PLWHA have high rates of unmet oral health care needs and low utilization of oral health services. Adequate resources and coordination of care with local dentists can overcome traditional barriers and improve access to dental care.

Abstract References

1. Health Resources and Services Administration. *Ryan White HIV/AIDS Program Oral Health Data Report 2017*. http://hab.hrsa.gov/data/data-reports. Published November 2019.
2. Oral Health and HIV (2020). 5600 Fishers Lane, Room 7-05, Rockville, MD 20857: U.S. Department of Health and Human Services Health Resources and Services Administration, HIV/AIDS Bureau.

Disclosures: **All Authors**: No reported disclosures

1014. Factors Associated with Switching from Tenofovir Diproxil Phosphate to a Tenofovir Alafenamide Based Regimen in a Cohort with Unrestricted Access to Care and Medications

Anuradha Ganesan, MBBS, MPH[1]; SeungHyun Won, PhD[2]; Evan C. Ewers, MD, MPH[3]; William Bradley, MS[4]; Christina Schofield, MD[5]; Gregory Utz, MD[6]; Rhonda Colombo, MD, MHS[7]; Jason M. Blaylock, MD[8]; Tahaniyat Lalani, MBBS[9]; Karl Kronmann, MD[10]; Jason Okulicz, MD[11]; Ryan C. Maves, MD[12]; Brian Agan, MD[13]; [1]Infectious Disease Clinical Research Program and the Henry M. Jackson Foundation for the Advancement of Military Medicine and Walter Reed National Military Medical Center, Bethesda, Maryland; [2]Infectious Disease Clinical Research Program, Rockville, Maryland; [3]Naval Medical Center, San Diego, Bethesda, Maryland; [4]Infectious Disease Clinical Research Program/HJF, San Antonio, Texas; [5]Madigan Army Medical Center, Tacoma, WA, Tacoma, Washington; [6]Naval Medical Center San Diego, Infectious Disease Clinical Research Program, Bethesda, MD, and Henry M. Jackson Foundation for the Advancement of Military Medicine, Inc., Bethesda, MD, San Diego, California; [7]Madigan Army Medical Center, Tacoma, WA, Infectious Disease Clinical Research Program, Bethesda, MD, and Henry M. Jackson Foundation for the Advancement of Military Medicine, Inc., Bethesda, MD, Tacoma, Washington; [8]Walter Reed National Military Medical Center, Bethesda,, Bethesda, Maryland; [9]Infectious Disease Clinical Research Program, Bethesda, MD, The Henry M. Jackson Foundation, Bethesda, MD, and Naval Medical Center Portsmouth, VA, Portsmouth, Virginia; [10]Naval Medical Center, Portsmouth, Virginia; [11]Brooke Army Medical Center, JBSA Fort Sam Houston, TX, San Antonio, Texas; [12]Naval Medical Center San Diego, San Diego, CA and Infectious Disease Clinical Research Program, Bethesda, MD, San DIego, California; [13]Infectious Disease Clinical Research Program of the Uniformed Services University of the Health Sciences and the Henry M. Jackson Foundation for the Advancement of Military Medicine, Bethesda, MD, North Bethesda, Maryland

Session: P-47. HIV: Treatment

Background. *Background-* Tenofovir alafenamide (TAF) is associated with fewer renal and bone toxicities than tenofovir disoproxil phosphate (TDF). Hence, most experts suggest switching to TAF. We examined factors associated with switching to TAF in the US Military HIV Natural History Study (NHS), a cohort of people living with HIV who have unrestricted access to care and medications.

Methods. *Methods-* The first formulation of TAF received FDA approval on 1 November 2015; hence, we included all NHS participants with visits between November 2015 and March 2019. Patient factors including race, gender, CD4 count, antiretroviral therapies (ART), viral load, HIV diagnosis era, presence of comorbidities (cancer, heart disease, dyslipidemia, kidney disease and obesity), were assessed for association with a switch to TAF with a logistic regression model.

Results. *Results-* Of the 1678 eligible participants, 1324 (63%) had received a TDF-based regimen. Participants who received a TDF-regimen were 94% male 44% African-American [AA], 39% Caucasians and 17% Hispanic. About half the participants who received TDF-based ART switched to a TAF-based regimen (n=682, 52%). Of the 425 (32%) participants receiving TDF/FTC co-formulated with efavirenz, 48% (n=206) switched to TAF. The proportions switching to TAF were higher in those receiving TDF/FTC co-formulated with rilpivirine [59%, n=90] or elvitegravir/cobicistat [68%, n=146]. The common ART regimens after the switch were: TAF co-formulated with elvitegravir/cobicistat (46%), rilpivirine (16%) or bictegravir (12%) and TAF/FTC combined with dolutegravir (15%). In an adjusted analysis, older participants, and participants receiving TDF/FTC in combination with efavirenz, dolutegravir, raltegravir, boosted protease inhibitors or a combination of boosted protease inhibitors and integrase inhibitors (other) were less likely to switch, table 1.

Conclusion. *Conclusions-* Despite the unrestricted access to care and ART in the NHS, only half of the participants switched to TAF. Participants on efavirenz-containing regimens were less likely to switch to a TAF-based regimen, possibly due to the lack of a co-formulated single tablet. These trends need to be followed and barriers to switching to TAF (both patient and provider) need examination.

Table 1- Factors associated with switching to a Tenofovir Alafenamide Based Regimen

	Adjusted Model *			
	Odds Ratio (95% CI)			P-value
Age at HIV diagnosis	1.030	1.012	1.048	0.0010
TDF Regimen type (Referent TDF /FTC/Elvitegravir/Cobicistat)				
TDF/FTC/Efavirenz	0.380	0.251	0.576	<.0001
TDF/FTC/Rilpivirine	0.713	0.427	1.188	0.1941
TDF/FTC + Integrase strand inhibitors (other than elvitegravir)	0.520	0.323	0.838	0.0072
TDF/FTC + Boosted Protease Inhibitor	0.434	0.260	0.722	0.0013
Other TDF-based Regimens	0.197	0.107	0.361	<.0001

Table 1- Factors associated with a switch to TAF-based regimen

*adjusted for race, age, HIV diagnosis era, CD4 count, nadir CD4 count, HIV viral load, AIDS diagnosis, history of coronary artery disease, LDL-cholesterol, GFR, regimen type. These factors were significant in the univariate analysis at a p <0.25

Disclosures. **All Authors**: No reported disclosures

1015. Gastrointestinal (GI) Adverse Events With Darunavir/Cobicistat/Emtricitabine/Tenofovir Alafenamide (D/C/F/TAF) Through Week 96: An AMBER Post Hoc Analysis

Keith Dunn, PharmD[1]; Yangxin Huang, PhD, MS[2]; Bryan Baugh, MD[2]; Nika Bejou, PharmD, BCIDP, AAHIVP[1]; Donghan Luo, PhD[2]; Jennifer Campbell, PhD[1]; David Anderson, MD[1]; [1]Janssen Scientific Affairs, LLC, Titusville, NJ; [2]Janssen Research & Development, LLC, Titusville, New Jersey

Session: P-47. HIV: Treatment

Background. Ritonavir boosted protease inhibitors have been associated with GI intolerance. A post hoc analysis was conducted to assess the GI profile of D/C/F/TAF in treatment naïve patients.

Methods. The phase 3 AMBER trial (ClinicalTrials.gov: NCT02431247) enrolled treatment naïve patients randomized 1:1 to receive once daily D/C/F/TAF 800/150/200/10 mg or D/C + F/tenofovir disoproxil fumarate (TDF). This post hoc analysis evaluated the incidence, prevalence and duration of GI adverse events of interest (AEOIs) through Wk 96. Related GI AEOIs were defined as diarrhea, nausea, abdominal pain and flatulence (by preferred term using MedDRAv21) deemed very likely, probable, or possibly related to study drug by the investigator. Incidence and prevalence were examined at weekly intervals during the first month of treatment and monthly thereafter. Duration of an AE was calculated for patients whose AEs had start and stop dates.

Results. In AMBER (N = 725), 362 patients were randomized to D/C/F/TAF and 363 to D/C + F/TDF (**Table**). Through Wk 48, 14% of D/C/F/TAF patients had a study drug–related GI AEOI vs 19% of D/C + F/TDF patients; of these, all were grade 1/2 and none were serious. Incidence and prevalence of D/C/F/TAF-related GI AEOIs remained low through 96 wks (**Figure 1** & **2**). Incidence of D/C/F/TAF-related diarrhea and nausea were each 5% in Wk 1 and ≤1% after Wk 2; prevalence of each decreased to < 5% at Wk 2. There was 1 case of D/C/F/TAF-related abdominal discomfort at Wk 1 and none thereafter. Incidence of D/C/F/TAF-related flatulence was < 1% from Wk 1 through Wk 96. Only 2 (1%) patients discontinued before Wk 96 due to a D/C/F/TAF-related GI AEOI (both diarrhea). Through Wk 96, < 3% of patients required treatment with concomitant