(*P*< 0.001) and ultimately prescribed to 29 (49.2%) and 71 (80.7%) patients (*P*< 0.001) in pre and post periods respectively.

Renal function (37.3% vs 88.6%; P< 0.001), pregnancy (39.0% vs 79.6%; P< 0.001), syphilis (3.4% vs 89.8%; P< 0.001), hepatitis B (15.3% vs 95.5%; P< 0.001) and hepatitis C (27.1% vs 94.3%) screening occurred more frequently during the post period.

Labratory, nPEP Prescription and Follow up Details for Patients Prescribed nPEP

	Pre (N=29)	Post (N=71)	P value
HIV Screen Performed Prior to nPEP, n (%)	15 (51.7)	71 (100)	**<0.001**
Appropriate nPEP Duration and Drug Selection, n (%)	16 (55.2)	69 (97.2)	**<0.001**
Verified nPEP Prescription Filled, n (%)	10 (34.5)	40 (56.3)	**0.047**
28d Follow up set up during ED visit, n (%)	1 (3.5)	25 (35.2)	**0.002**
28d Follow-Up Clinic Visit Completed, n (%)	1 (3.5)	8 (11.3)	0.215

Conclusion. The standardization of an nPEP ED protocol for sexual assault victims resulted in increased nPEP administration, appropriateness of prescription, screening for other sexually transmitted infectious and scheduling follow up care. While guideline compliance dramatically improved, further interventions are likely warranted in this vulnerable population.

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987. Improving Patient Access to HIV Post-Exposure Prophylaxis with Pharmacist Involvement

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Session: P-46. HIV: Prevention

Background. Appropriate use of post-exposure prophylaxis (PEP) after isolated sexual, injection drug use, or other exposures to HIV is an effective tool to reduce the risk of HIV acquisition. PEP completion rates are low, with literature reporting only 40% of sexual assaulted persons adhering to a full 28-day course. One important barrier to adherence can be access to medications in a timely manner. In the United States, a four week course of PEP costs nearly $4,000 without insurance and can remain unaffordable with high copays and deductibles for patients who are underinsured.

Methods. A pharmacist in the Infectious Disease (ID) clinic was notified of all non-occupational post-exposure prophylaxis (nPEP) cases referred from the Emergency Department for follow up and coordinated benefits investigation, ensured low or no cost medication access, completed medication reconciliation, counseled on PEP adherence, and coordinated filling of same day prescriptions at the hospital based pharmacy. To assess the impact of pharmacist involvement, a retrospective review of nPEP cases over a 6 month period were compared to a 6 month period prior to pharmacist presence in clinic.

Results. 16 nPEP cases were seen by a pharmacist compared to 8 nPEP cases seen in the ID clinic without pharmacist involvement. 100% of patients received medications prior to leaving the medical center, compared to 63% of cases filling at the hospital pharmacy prior to pharmacist presence. 25% of patients required an insurance related override in order to access PEP urgently. The average out of pocket cost was $2.25 with maximum total cost being $7.30. Prior to pharmacist involvement, the average out of pocket cost was $475 for complete PEP regimen with a maximum total cost of $3,733.40. 42% of patients completed their entire PEP course and came to follow up appointment after pharmacist involvement, compared to 31% of patients prior to pharmacist presence.

Conclusion. Pharmacist involvement led to a substantial cost savings to patients receiving nPEP. It was also associated with higher capture rates of prescriptions filled at the hospital pharmacy along with a higher rate of PEP completion and follow up.

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

988. Overcoming Prescriber Concerns through Successful Access and Affordability of PrEP

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Session: P-46. HIV: Prevention

Background. Increasing the number of human immunodeficiency virus (HIV) pre-exposure prophylaxis (PrEP) providers expands PrEP access to more eligible patients and aids in ending the HIV epidemic. Non-prescribers of PrEP have noted perceived financial barriers as a limitation to prescribing. The purpose of this study is to describe the PrEP medication access process and outcomes in patients seen at a multidisciplinary PrEP clinic.

Methods. We conducted a single-center, retrospective, cohort study of patients prescribed PrEP with emtricitabine-tenofovir disoproxil fumarate from a multidisciplinary clinic with prescriptions filled by Vanderbilt Specialty Pharmacy between 9/1/2016 and 3/31/2019. Patient data were gathered from the electronic health records and pharmacy claims data. We evaluated three different time periods: patient initial evaluation to PrEP initiation, prescription of PrEP to insurance approval, and PrEP insurance approval to initiation. Treatment initiation was considered a delay of > 7 days from initial evaluation, and reasons for delay were recorded. Continuous variables are presented as median (interquartile range, IQR) and categorical variables are presented as percentages.

Results. Characteristics of the 63 included patients are in Table 1; most were male (97%), white (84.%), commercially insured (94%) with a median age of 38 years (IQR 29—47). The primary indication for PrEP was men who have sex with men at high risk for acquiring HIV (97%). The median time from initial appointment to treatment initiation was 7 days (IQR 4—8); Figure 1. Treatment delays were observed in 25% of patients and were mostly driven by patient preference (50% of delays). Insurance prior authorization was required in 27% of patients, all of which were approved. Median total out of pocket medication costs for the entire study period were $0 (IQR $0 – $0); Figure 2. Most patients (86%) used a manufacturer copay card.

Table 1 Patient Characteristics

	Number (%) N=63
Age at PrEP start (years; median (IQR))	38 (29,47)
Gender, male	61 (96.8)
Race	
White	53 (84.1)
Black	5 (7.9)
Other/Unknown	5 (7.9)
Insurance type	
Commercial	59 (93.7)
Medicaid	3 (4.8)
Tricare	1 (1.6)
Indication for PrEP	
MSM* at high risk	61 (96.8)
Serodiscordant heterosexual contact	2 (3.2)
Number of sexual partners in last 6 months	
1	13 (21)
2-5	21 (33)
6-10	7 (11)
>10	8 (13)
Not reported	14 (22)
Reported condom use	
Inconsistent (<100%)	28 (60.3)
Consistent (100%)	14 (22.2)
No condom use	5 (7.9)
Not reported	5 (7.9)
Not sexually active at initial appointment	1 (1.6)
eGFR ≥ 60 mL/min	63 (100)
Hepatitis B status	
Susceptible at baseline	33 (52.4)
Immune due to vaccination	27 (42.9)
Immune due to natural infection	2 (3.2)
Indeterminate (isolated cAb positive)	1 (1.6)

*MSM: men who have sex with men

Figure 1 Time to Treatment Initiation

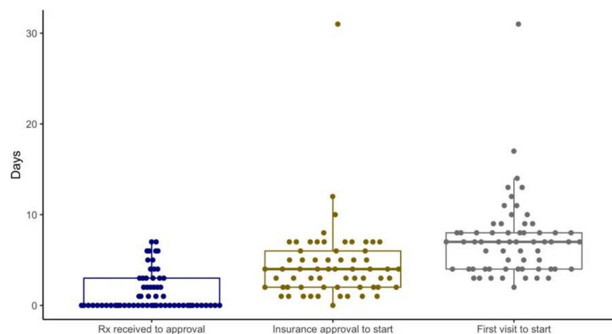
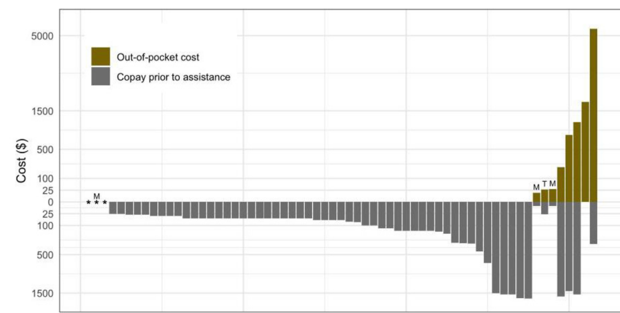


Figure 2 Patient Out of Pocket Cost and Savings



Conclusion. In our cohort of mostly commercially insured men, the majority were able to access PrEP with low out of pocket costs facilitated by manufacturer assistance. Though generalizability beyond this population is limited, these results contradict perceived financial barriers to PrEP access.

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989. Pre-exposure Prophylaxis (PrEP) Short-Term Retention Among Heavy Alcohol Users in Rural South Africa

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Session: P-46. HIV: Prevention

Background. Despite widespread access to HIV testing and antiretroviral therapy (ART), men, and especially young men, remain difficult to engage in HIV services. Alcohol use disorder (AUD) further complicates engagement. Congregate alcohol venues, known as shebeens, are an ideal place to engage with young men for HIV testing, treatment, and prevention services, including pre-exposure prophylaxis (PrEP). Here we report on one-month retention in care in eligible patrons recruited from shebeens into a community-based model of PrEP delivery.

Methods. An all-male field team offered HIV testing at mobile clinics outside shebeens in rural Msinga sub-district of Kwazulu-Natal (KZN) province. Eligible participants were offered enrollment into a community-based model of PrEP delivery. PrEP initiators completed the AUDIT scale, with hazardous alcohol use defined as score > 6 for women and > 8 for men, and had dried blood spot (DBS) analysis for phosphatidylethanol (PEth). Loss to follow up was defined as not attending the 1 month follow up appointment, non-response to 3 separate phone calls on three separate days, and unsuccessful tracing at least once at participant's home address.

Results. Between February and May 2020, 16 eligible shebeen patrons initiated PrEP, a median of 14.5 days (IQR 12.5 – 19) after initial screening. Among initiators, 93.8% were male, median age was 29.5 years (IQR 22.25 - 37), 31.2% were employed, 56.3% had running water, and 68.8% were hazardous alcohol users. One-month follow-up visits were completed with 68.8% (11/16) participants. Of those retained in care, 90.9% reported at least one sexual partner in the last month, and 54.5% reported more than one sexual partner. All sexually active participants reported inconsistent condom use. In the prior 7 days, 63.7 % of participants reported taking "all of my medication" and 36.4% reported taking "most of my medication," verified by pill count. Hazardous alcohol use and PEth results did not predict one-month retention in this small sample

Conclusion. Young men engaging in risky behavior were interested and willing to engage in PrEP through a community-based PrEP model. The majority were retained in care, and all reported good adherence to PrEP, suggesting the value of differentiated service delivery to engage men in HIV prevention.

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990. Prophylaxis against spontaneous bacterial peritonitis: too much or too little?

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Session: P-46. HIV: Prevention

Background. Prophylaxis against spontaneous bacterial peritonitis (SBP) is a guideline-recommended strategy; there are limited data on rates of concordance with guideline recommendations. We sought to evaluate rates of concordance, hypothesizing that antibiotics would overprescribed for prophylaxis against SBP.

Methods. This retrospective cohort study included all patients at the Boston Veterans Affairs Medical Center who underwent paracentesis between 1/1/2014 and 12/31/2018. Exclusion criteria included absence of cirrhosis and hepatic transplantation, either prior to enrollment or during the study period. Manual review was used to capture demographic data, guideline concordance, microbiology results and healthcare utilization within one year of enrollment. Descriptive and analytical statistics were performed.

Results. Of 259 patients eligible for analysis, 181 (70%) met inclusion criteria; 65 patients (25%) were excluded as cirrhosis was not confirmed. Small numbers of other patients were excluded for other reasons [Figure 1].

Incorrect antibiotic utilization was noted in 80 patients (44%) [Figure 2]. Among 93 patients meriting antibiotics, 65 (70%) did not receive them. Conversely, among 90 who did not have an indication for antibiotic prophylaxis, 15 (17%) received it ($p = 0.03$, chi-squared test).

Receipt of SBP prophylaxis was not correlated with gastroenterologist involvement, infection by antibiotic-resistant bacteria or development of illness due to *Clostridioides difficile*. No difference in hospital readmission rates was observed between groups receiving guideline-concordant and guideline-discordant prophylaxis.

Figure 1

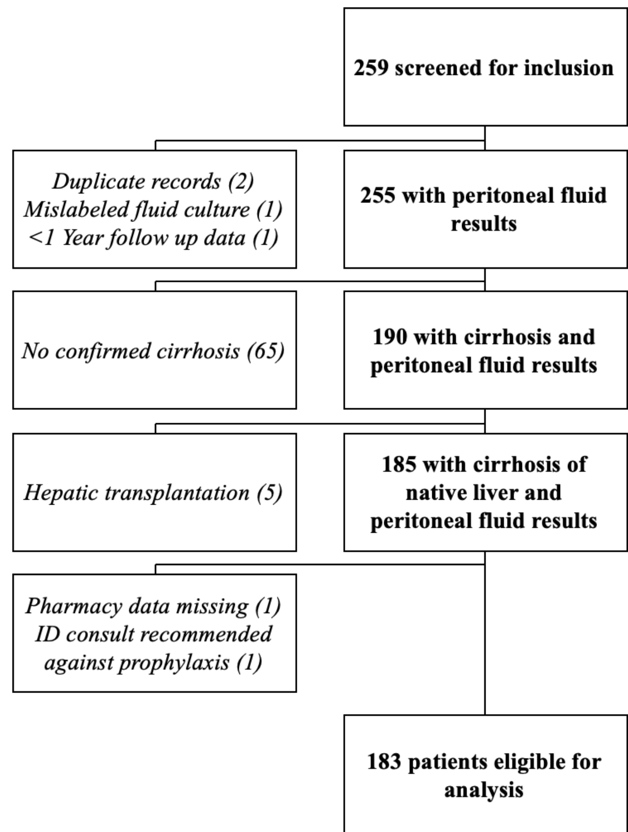
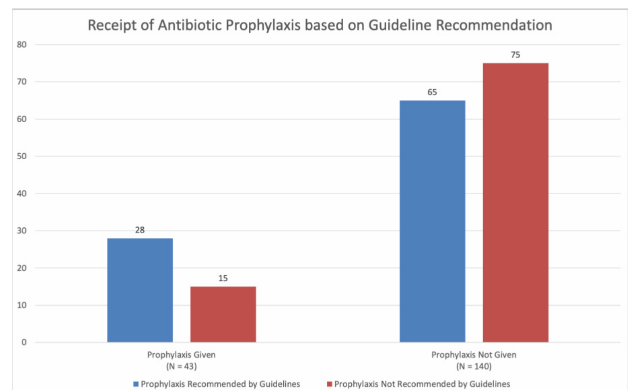


Figure 2



Conclusion. We expected to find overprescription of SBP prophylaxis. In fact, we found that the largest error in prescribing was underprescribing, which may be equally as harmful as inappropriate use of antibiotics. SBP prophylaxis may be an important target for antibiotic stewardship and education.

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991. Psychosocial Factors and HIV Risk among Transgender Women Living in Miami

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Session: P-46. HIV: Prevention

Background. Transgender (TG) women are disproportionately affected by HIV infection and have poor health outcomes when compared to cisgender women. This