

Canadian Treatment Action Council



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Who, How and Why –
A consumer's participation on Ontario's CED committee...page 3

Prisoners find ways to become involved in policy making...page 5

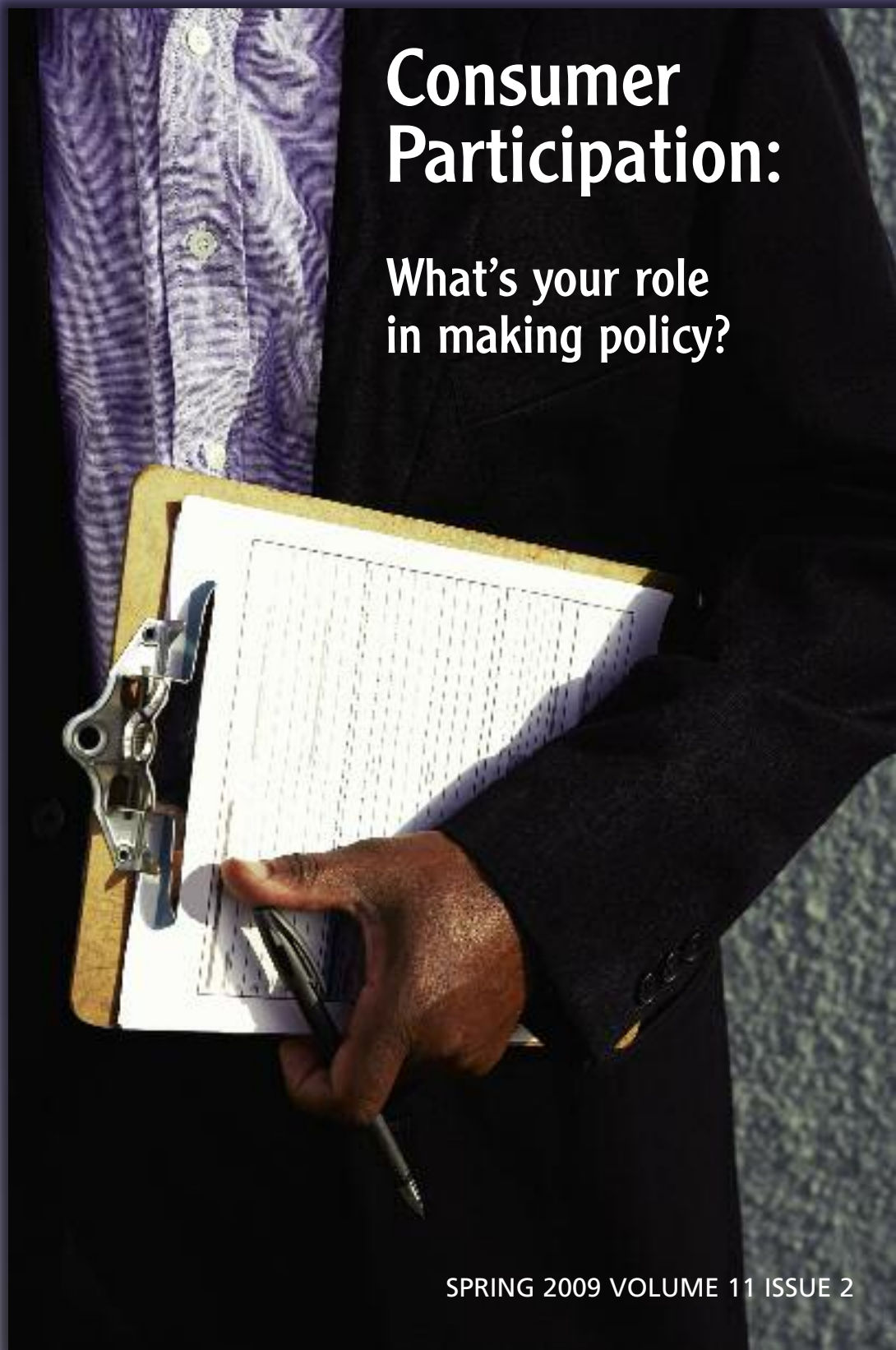
CROI Report – Ron Rosenes sits in...page 8

INSIDE

Chair's Report.....	2
HIV Drugs in Ontario: Who, How and Why?.....	3
Involvement of Prisoners in Policy Making.....	5
Formularies Series: Manitoba.....	6
Update on CROI (Conference on Retroviruses and Opportunistic Infections): Research is Good, Interventions are Better.....	8
Towards Equity: Catastrophic Drug Coverage in Canada.....	12
Calendar of Events.....	13

Consumer Participation:

What's your role in making policy?





Canadian Treatment Action Council

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CHAIR'S REPORT

Spring 2009

This issue is dedicated to consumer involvement and participation in decision making. CTAC has always taken the position that consumer participation is central to a strong and effective response to all aspects of the HIV/AIDS epidemic. CTAC has certainly been aware for some time that the epidemic bears more than one face. The face we saw in the Globe and Mail newspaper on April 22 was of those who have had great success with the medications that have been discovered in the last twenty years. It was particularly satisfying to see Vice-Chair, Ron Rosenes, in that number. He is among those who have contributed greatly to our movement and has helped open the doors to participation of others. If it were true that everyone was well enough to participate as meaningfully, perhaps CTAC would have much less work to do, yet it does not.

Why? There are numerous reasons: not everyone can tolerate these toxic medications well and terrible illnesses result from organ failure to heart disease to bone death. Some people do not get treatment at all, particularly those in marginalized communities, either because of their fear of the medical system or its fear of them. Hepatitis C coinfecting people, women and those living in poverty also fare badly in the system. Since many of these groups overlap, their chances for a graceful, if challenging, aging process are minimal indeed. This is not to mention that the whole idea of healthy aging has little currency in the developing world, where they are fortunate to get first line therapy, let alone second and third line state of the art drugs.

HIV is a disease in transition. In some places and for some people it is a disease that is chronic and manageable, while for others it remains the death sentence it always was. Stigma and discrimination are other related diseases that are still rampant everywhere. Until the picture of a graceful aging process enabling the decision-making participation of all people with HIV and those coinfecting is equal for all, and stigma is gone, there is still much for CTAC and this community to do.

HIV Drugs in Ontario:



By Harlon Davey, CTAC Ontario Representative

WHO

Ontario's Committee to Evaluate Drugs (CED) is an expert advisory board established in 1968 to provide independent and specialized advice to the Ministry of Health and Long-Term Care, including the executive officer for the Ontario public drug program, on the operations of programs designed to assist the people of Ontario in obtaining prescribed pharmaceutical products of quality at reasonable cost.

Its key functions are:

- to establish, maintain, and apply criteria to evaluate the quality and therapeutic value and cost of drug products,
- to make recommendations about products which should be considered for publicly funded drug programs, and
- to set the conditions under which such products should be funded.

The CED also recommends to the executive officer which drug products should be designated as interchangeable products. The CED, under the Ontario Drug Benefit Act, monitors and evaluates on a continuous basis the list of drugs available in the light of drug use patterns, experience and current scientific knowledge. The CED also makes recommendations, when requested, regarding Ministry efforts to facilitate education about publicly funded drugs and related

issues. It reviews and assesses information related to drugs and pharmaceutical products prepared for the Committee and for the Minister by selected consultants. In addition, the CED acts as liaison between the Minister or executive officer and professional, educational and other concerned groups. It provides advice on relevant drug, pharmaceutical, policy, and therapeutic questions and issues solicited or requested by the Ministry of Health and Long-Term Care.

I am the patient member of this committee and I sit alongside practicing physicians and pharmacists who have expertise in a wide range of specialties, including geriatrics, infectious disease, family medicine, pharmacology, health economics, epidemiology and other disciplines. My specific role on this committee is to provide real-world perspectives of the evaluation process of the drug and the direct implications these drugs may have on patients.

HOW

The process all begins when the manufacturer submits a new product to Health Canada who then reviews it for general safety, effectiveness and efficacy. Health Canada monitors safety in "real" usage and upon approving new drugs for sale in Canada, issues a Notice of Compliance and a Drug Identification Number. This number essentially allows the pharmaceutical company to market its drug in Canada.

After this, the product is considered by the Common Drug Review (CDR), a single national process for undertaking reviews and providing listing recommendations for new drugs. The CDR uses the Canadian Expert Drug Advisory Committee (CEDAC), a national expert advisory committee, to make recommendations to all provinces and territories (except Quebec) to list or not to list. The CDR does not replace the decision-making responsibility of provincial drug plans. Each provincial drug plan decides whether to list the drug product as a benefit in its own provincial drug formulary.

WHY

At the CED we ask the fundamental question: “Will the drug provide good clinical value and good use of scarce health care resources if it is funded?”

In order to make this decision we review the clinical or scientific evidence based on several criteria.

- **Efficacy:** does it work in comparison to other available therapies?
- **Safety:** does it cause no more harm than other available therapies?
- **Pharmacoeconomic data:** how much will this drug actually cost Ontario taxpayers?
- **Patient needs:** does the drug meet patient needs effectively? What impact does it have on their quality of life?

HIV drugs are treated the same as all other drugs in terms of the review and recommendation process. However, drugs that meet very specific criteria regarding innovation and the potential to immediately improve health outcomes can apply to be fast tracked through the system in order to receive a priority review. Some HIV drugs have met this criteria, and thus, access has been granted sooner.

In 2006, Bill 102 was passed in Ontario. This is an exciting piece of legislation which made several recommendations

to improve patient access to drugs, ensure better value for money, promote the appropriate use of drugs, reward innovations and strengthen transparency and accountability.

There has already been a few progressive steps in this regard with more still to come. In July and September 2007, the CED appointed two patient members, making it the first jurisdiction worldwide to give patients an active role in both decision making and policy settings of drugs. The terms of reference were updated to include “patient impact” as criteria for evaluating drugs, a real victory for patients!

It’s an exciting experience to be a part of this process and making big real live decisions. The process, however, is not perfect. For example, as a patient member I am expected to represent all patients. It is difficult to represent all patient groups since each chronic illness has its own unique challenges and needs. I have brought forth recommendations that would help make my role more effective and I am pleased to say that members of the committee have been very responsive.

There is a trend to include patient members in decision making in all aspects of health care. I think it’s a movement in the right direction and will lead to increased transparency and accountability, the two big words in health care right now. I urge you to learn about the drug approval process specific to your province and find out how you can get involved. It only makes sense that those who will consume the drugs be involved in their review and approval process and participate in the decision making. ■

As an ex-prisoner who is living with HIV/AIDS, I was surprised by the first written response I received for this column which stated that prisoners do not have much of an impact on policies or on the committees that are formed to try to change the current policies affecting them. Prisoners may not be present physically, but they certainly have found ways to get the issues that affect them into the hands of advocates, front line workers and prisoners rights organizations.



CTAC and the Prisoners HIV/AIDS Support Action Network (PASAN) involve ex-prisoners in their work by appointing them as representatives to their organizations and inviting them to sit on committees that help form policy. As an ex-prisoner, I have had the good fortune to be invited to present at conferences, and gain membership on committees from Corrections Service Canada (CSC) and the Provincial Ministry of Corrections. These kinds of endeavors are important because they allow ex-prisoners to give the people they have left behind a voice. They can speak firsthand about the way they have been impacted by policy decisions, and voice their concerns about future policies that will affect current and future prisoners.

The Community Consultation Committee (CCC) was formed by CSC in the hope that it would help find common grounds on policy issues with concerned community organizations. After a few meetings were held prior to 2003, community organizations felt that these meeting did not result in significant improvements in HIV and HCV services for federal prisoners and withdrew from further consultation. This committee resumed its meetings this year with a first meeting held on February 17th. The meeting was attended by Community AIDS Service Organizations from across Canada and different departments of CSC and was greatly anticipated by the com-

Involvement of Prisoners in Policy Making

By Greg Simons,
CTAC prisoners/ex-prisoners representative

munity since it was the first meeting after a five-year hiatus. After sifting through reports on this meeting, I am getting a sense of unfulfilled promises yet again. The community will not tolerate inaction from CSC and is meeting to see what can be done to address this once again.

I believe one missing component from these policy meetings is the presence of the people affected by the policies: PRISONERS! I believe allowing prisoners and ex-prisoners to attend this meeting would bring first hand information and a healthier dynamic to this and other committees CSC is involved with. I believe directly involving concerned individuals is the best way to effect a positive change that all parties, especially prisoners living with HIV/AIDS, can live with.

Earlier this year, I also attended a provincial Corrections Institutional Health Care committee sponsored by Ontario's AIDS Bureau. This was a positive experience and I believed it helped bridge a gap between prisoners and nurses from across Ontario that I feel would have taken many more years to bridge without these meetings. We learned that instituted discharge planning procedures have been drafted for prisoners living with HIV/AIDS released back into the community. These will help prisoners living with HIV/AIDS leave with the proper medications and appointments with physicians. Most importantly, a dialogue was initiated between AIDS Service Organizations, the Ministry of Community Safety and Correctional Service and the administration of the many facilities across the province. This is a formula that CSC and the Community Consultation Committee should continue to use in the future. ■

MANITOBA

by Shanna Chan,
Manitoba HIV Program Pharmacist

For people living in Manitoba, there are a variety of publicly funded programs to help offset the high cost of prescription medications. Programs available include:

- the federally administered Non-Insured Health Benefits program for First Nations and Inuit persons,
- the Federal Interim Health Program for refugees,
- the Federal Correctional Services of Canada program for federal inmates,
- the province’s Social Assistance program and
- Manitoba’s Pharmacare program.

Pharmacare is the province’s drug benefit program and is administered through Manitoba Health under *The Prescription Drugs Cost Assistance Act*. It is available to any Manitoban, regardless of age. To qualify for the program one must meet all of the following criteria:

- Eligible for Manitoba Health coverage
- Prescriptions are not covered through other provincial or federal programs
- Prescription costs are not covered by a private drug insurance program

- Eligible prescription drug costs exceed the person’s Pharmacare deductible

To enrol in the Pharmacare program, one must complete a one page application form (available at all pharmacies or can be downloaded from the internet). Applicants have the choice of either: one-time enrolment (automatic renewal of enrolment annually) or applying and enrolling yearly. Pharmacare coverage is family based, so once enrolled in the program all members of the family are eligible including dependant children <18 years old. If there are changes to the family status, then a new application must be made. Once a person turns 18 years old, they no longer are covered under their parents’ plan.

Families are required to pay a portion of the cost of eligible prescription drugs each year. The amount they are required to pay is called the deductible and is a calculation based on total family income. The amount is tiered so that those with higher family incomes pay more towards their prescription drug costs than those with lower family incomes – see table. The deductible amount is a percentage of the family’s total income from two years prior to the current Pharmacare year (e.g. for the 2009/2010 Pharmacare year the deductible is based on total income from the 2007 Canada Revenue Agency Notice of Assessment – line 150).

Each year families pay the cost of eligible prescriptions to their pharmacy until they reach their deductible

Table—deductible rate and example calculation

Total family income	Deductible Rate
< \$15 000	2.69%
\$15 000 – \$39 999	4.02%
\$40 000 – \$74 999	4.63%
≥ \$75 000	5.79%

Credit of \$ 3,000 for spouse and each dependant child

Example:

Individual income	\$ 40,000
Spouse income	+ \$ 25,000
Total family income	= \$ 65,000
Minus spouse credit	- \$ 3,000
	= \$62,000 x 4.63%
	deductible rate
	= \$ 2,870.60 deductible
	for year

The Canadian Institute for Health Information last year reported that 53 per cent of prescription drug costs in Manitoba were publicly funded, the highest percentage in Canada.

amount, after which they no longer pay (the Pharmacare program pays 100% for the remainder of the Pharmacare year). The amount a family pays for eligible prescription drugs and towards their deductible amount is automatically tracked electronically and in real-time through Manitoba's Drug Programs Information Network (DPIN). The Pharmacare year runs from April 1 to March 31.

Families can also apply to enrol in the Pharmacare Deductible Instalment Payment Program allowing them to pay their annual Pharmacare deductible in monthly instalments. To participate in the program, families must have a monthly drug expense that equals or exceeds 25 per cent of their monthly income.

The **Manitoba Drug Benefits Formulary** is a listing of drugs that have been approved as eligible benefits under the Pharmacare drug benefit program.

Drugs are listed in the formulary under different categories:

- Part 1 – lists drugs that are eligible under all prescribed circumstances. (Example: Amoxicillin)
- Part 2 – lists drugs that are eligible under specified terms and conditions. (Example: Fluconazole 50 and 100 mg—the prophylaxis and treatment of (a) oropharyngeal and esophageal candidiasis in immunocompromised patients; and (b) systemic fungal infections other than oropharyngeal candidiasis.)
- Part 3 – lists drugs that approved for coverage under the Exception Drug Status (EDS) Program when they meet specific criteria and upon review and recommendation of the Manitoba Drug Standards and Therapeutics Committee (MDSTC). (Example: Etravirine 100 mg tablets – For the treatment of HIV-1 infection in treatment experienced patients who have failed prior anti-

continued on page 13

FORMULARIES SERIES

The process by which new drugs are considered for coverage under the Pharmacare drug benefit program

SUBMISSION BY THE MANUFACTURER

- The manufacturer must send the new drug submission to the Manitoba Drug Standards and Therapeutics Committee (MDSTC), which includes reviews of scientific literature, comparable drug therapies, anticipated drug costs, and therapeutic benefits.

DRUGS REVIEWED BY MANITOBA DRUG STANDARDS AND THERAPEUTICS COMMITTEE

- The Manitoba Drug Standards and Therapeutics Committee (independent of government; comprised of three physicians and three pharmacists) reviews the drug submission taking into consideration therapeutic and economic value. In the evaluation process the MDSTC may obtain expert/specialist opinion and take into consideration the Common Drug Review (CDR) produced by the Canadian Agency for Drugs and Technologies in Health (CADTH).
- The MDSTC (with aid from Manitoba Health staff) prepares a report of drug submission recommendations to be presented to the Minister of Health.

MINISTER OF HEALTH

- Based on the MDSTC's recommendations, the Minister of Health gives the final approval for benefits under the Pharmacare Drug Benefit program.
- Once the drug is approved by the Minister of Health a notification bulletin is distributed to all pharmacies in Manitoba announcing drug benefit coverage by the Pharmacare program, criteria for eligibility and the date coverage comes into effect.

Update on 16th CROI (Conference on Retroviruses and Opportunistic Infections)

This was my first trip to CROI and the first time that CROI was held outside of the US—at the Palais des Congrès in Montreal. CROI is a strictly controlled environment that seeks to put science and researchers first. Pharmaceutical companies sponsor the conference but do not have any commercial exhibits. Also, the number of personnel allowed to attend sessions is extremely limited. I was hard pressed to choose which sessions to attend outside of the plenaries and the only way to present the highlights in a short article is to give you the view from 35,000 feet.

Dr. Robert Siliciano opened the 16th CROI with a talk that focused on the remaining obstacles to the eradication of HIV using cART (combination antiretroviral therapy)—still thought to be the holy grail of treatment. He began by reviewing the steps that occur after treatment is initiated:

1. Initial decay of most of the virus found in activated cells in plasma;
2. A second, slower phase of decay among long-lived macrophage cells, improved by intensification with an integrase inhibitor;
3. The slow decay of infection in resting CD4 T cells, which are found in reservoirs such as the lymph nodes.



Research is Good

**Interventions
are Better**

by Ron Rosenes, CTAC Vice-Chair

There is evidence that current ART completely interrupts ongoing cycles of replication. A detailed analysis of the remaining viremia (viral activity) suggests that this activity is archival and non-evolving; that is, no signs of new drug resistant mutations have been found despite continued viremia in the presence of intensified ART. However, another group of researchers did not see any effect of intensification with an integrase inhibitor on low-level viremia. Obviously, further study and validation is required to sort this out; in any case, the problem continues to be the release of the virus from stable reservoirs.

Other researchers presented new strategies aimed at purging persistent HIV from reservoirs using IV immunoglobulin therapy or IL-7. Overall, these presentations at CROI offered an exciting and detailed new picture of persistent HIV infection in patients on ART. However, there is still much work to be done and eradication remains an elusive goal.

One interesting abstract (Douek abstr. 20) presented a sweeping vision of how HIV causes AIDS, beginning with depletion of CD4+ T cells from the gastrointestinal tract. A link was shown between the systemic immune activation observed in the chronic phase

of infection in humans (HIV) versus that found in monkeys (SIV); there was also a link found in the breakdown of the mucosal barrier in the GI tract that leads to leakage of bacteria through the gut wall and into the systemic circulation. Recent findings have suggested a further association between levels of bacteria in the plasma (blood) and levels of inflammatory interferon alpha. The amount of bacteria correlates with the degree of immune activation and CD4 T cell decline, independent of the level of viral load. The result of immune system activation is inflammation, a hallmark of HIV and other active diseases. This is a worry for those of us who are aging with HIV. Understanding the activity of HIV in the gut and protecting the integrity of the gut wall are now seen to be very important areas for future research. It is equally important to understand why SIV does not manifest the same symptoms in monkeys.

Certainly, the long-term effects of the virus and the treatments (ART) were a hot topic at CROI. It is becoming clear that we are aging prematurely compared to the general population.

“HIV+ Die More Quickly in FRAM & Low CD4 Predicts Death” according to the FRAM Study (of Fat Redistribution and Metabolic Change in HIV Infection). It showed that the mortality risk was 3 times higher among HIV-infected individuals than it was for the general population (in the US). That is, despite the widespread use of cART. For people living with HIV/AIDS, the factors independently associated with death include current smoking, increasing age and low baseline CD4 count.

The good news is that the prevalence of HIV in people who are over sixty-five years of age has increased more than ten-fold in the past decade

in North America. In some regions, more than half of HIV patients are currently over 50 years and it would appear that this will be the case everywhere by 2015. The number of people living long term with HIV continues to rise.

While many discussed emerging issues related to aging with HIV infection, there was little meaningful research presented. Despite many papers describing age-related vulnerability, there continues to be a large gap in research that might lead to effective interventions. As a result we are far from having any guidelines with which to direct age-specialized care. Even resource-limited settings will soon be facing challenges related to the management of chronic HIV in aging populations, as was noted in data presented by researchers from Senegal.

The areas of concern form a long and daunting list.

CARDIOVASCULAR DISEASE

Cardiovascular complications, including MI (Myocardial Infarction or heart attack), have clearly become more frequent among people living with HIV/AIDS over the past decade. While HIV itself is an independent risk factor according to a broad array of papers presented, promising data from the California Kaiser Permanente database showed that rates of MI have decreased in recent years and are now similar to background rates; that is possibly due to aggressive management of risk factors. Nonetheless, one study found changes in carotid thickness greater than would be anticipated in HIV-negative controls 25 years or older, suggesting vascular changes due to accelerated aging.

The relationship between abacavir use and cardiovascular problems was summarized in one present-

tation which claimed that most but not all studies have identified an association. While the jury is still out on how to interpret the studies, some of the data suggest that problems can occur early on in treatment and that if you are well established on abacavir and not at significant risk for CVD, the drug retains benefits, including the treatment of HIV in the brain and a favourable lipid profile. As always, talk to your doctor.

OSTEOPOROSIS AND RENAL DISEASES

Osteoporosis is largely associated with age in HIV-negative women and some men. However, it has also been shown to occur more frequently and at an earlier age due in part

to a predisposition to the disease among women and low testosterone in HIV+ men. As with other complications, the presence and pattern of osteo-

porosis may suggest that both age-related changes—such as the increased rate of t-cell premature aging—as well as HIV treatment are playing a role.

Renal function decreases with age, regardless of HIV status, often requiring medication adjustments. One paper identified that the rate of decline is increased with HIV and that this increase is not arrested by cART. Age and the use of tenofovir were both shown to increase the risk for renal tubular disease. Preliminary data on a new boosting agent that might eventually replace ritonavir was also presented. It has the potential to reduce GI side effects, something that would greatly improve our quality of life as we age.

MALIGNANCIES AND MORTALITY

Cancer rates are elevated with HIV and with age (a rate of 29.7/10,000 person-years for infection-related non-AIDS-defining cancers in HIV+ subjects, compared to a background rate of 4.4/10,000). This rate has not changed dramatically in the last decade. Cancers found to be elevated in HIV despite cART include: anal cancer, Hodgkin's Lymphoma, head and neck cancers, gynecological cancers, kidney cancers, lung cancers and melanomas. The notable exception is prostate cancer. Co-infection with HCV and HBV increase the risk of liver cancer.

Although aging is associated with increased mortality, modifiable risk factors, such as smoking, are also predictors of illness and death. One controlled study—of an intervention to help people stop smoking—had a very poor result and showed how difficult it is for many people to quit. An evaluation of thirteen cohort studies identified non-AIDS-related causes of death due to malignancies to be more frequent than AIDS deaths, showing how important it is to address non-AIDS related risks. The bottom line seems to be that the rate of AIDS-related malignancies has remained constant but that non-AIDS malignancies are on the rise.

COGNITIVE IMPAIRMENT

The signs that cognitive impairment—memory function and loss—is worse in HIV+ people than it is in the general population is worrisome (not to mention the increased rates of depression). The advent of more effective cART has not led to a decrease in prevalence rates. The figures appear similar to data shown in cohorts before the medications were available. There are also many confounding factors that result from metabolic disorders and other illnesses, such as co-infection with HCV, that

Areas of concern:

cardiovascular disease
osteoporosis and renal diseases
malignancies and mortality
cognitive impairment
immunology

make it difficult to diagnose and, more importantly, to develop the treatment options that will be needed. More research is urgently needed to understand the disease process that causes accelerated brain aging despite an undetectable viral load. The bad old days of HIV-related dementia are not yet behind us.

IMMUNOLOGY

The debate about when to start treatment continued at CROI 2009. Both age and starting ARV at CD4<500 appear to negatively impact survival. Age appears to reduce the benefits of starting treatment during primary infection. These findings could inform future research designed to determine if age-specific treatment recommendations would improve outcomes for older individuals.

It appears fair to say: “It’s HIV AND the drugs, stupid!” when it comes to understanding the causes of accelerated aging. In the coming year, CTAC will advocate for research that moves beyond confirmatory observations of negative outcomes to identify meaningful and effective interventions. Another priority will be the creation of a tool that we can use in conjunction with our health care providers to ensure that we are being closely monitored for the effects of HIV and the medications we take to treat it. ■

Other abstracts/presentations of interest:

1. The costly failure of the SILCAAT and ESPRIT Trials of IL 2 to show any benefit from an expanded quantity of T4 cells.
2. Pro 2000 Microbicide Gel shows promise in an early trial. The study involved 3,099 women in five countries, four of them in sub-Saharan Africa, where women comprise nearly 60% of HIV-infected adults. Women assigned to use the microbicide Pro 2000 before sex experienced a 30% reduction in incidence of HIV infection compared with those who used a different microbicide, a placebo gel, or no gel at all. The results were not statistically significant, but they were promising. A much larger trial is planned.
3. Development of maturation inhibitors continues to move forward, but it will probably be several years before these agents reach late stage clinical development. This will depend on their ability to pass the phase IIB hurdle of activity and safety with dosing greater than 7-14 days.

**CTAC
Community Skills Building
and AGM**

**October 3rd and 4th
Vancouver, British Columbia**

Join us!



Canadian Treatment Action Council

www.ctac.ca

TOWARDS EQUITY: Catastrophic Drug Coverage in Canada

By Sarah Benn, Project Coordinator, CTAC

Over the past few months the Canadian Treatment Action Council (CTAC) has conducted consultations on Catastrophic Drug Coverage in Canada. The consultations were held in Halifax, Montreal, Ottawa, Toronto, Calgary and Vancouver and were a two part process allowing for the HIV/AIDS, co-infection, and the Cross Disability communities to formulate a Catastrophic Drug Plan for Canada. These interactive consultations were well attended and as a result, CTAC was able to gather grass root concept validation of a catastrophic drug plan as well as input regarding the role of private plans and orphan drugs.

As consultations occurred in different provinces, administrators of the process were not surprised to find that the consultation participants insisted on a Catastrophic Drug program that would positively affect all Canadians regardless of geography or economic status.

A questionnaire was also created and distributed to ensure CTAC reached those who were not able to attend the in-person consultations. The questionnaire was available until the end of May. CTAC is now synthesizing the results from both the consultations and the questionnaire, and the suggestions and ideas generated will be used in our white paper on a Catastrophic Drug Plan for Canada, entitled "Towards Equity." Once this is complete, the white paper will be edited and re-circulated to the every-

one who participated in the process. We hope to have the final version of the White Paper signed off by consultation participants, AIDS Service Organizations and various cross disability groups within the next few months.

CTAC's long term goal is to convene a summit of the Ministers of Health and representatives of all concerned groups, and to present the finalized document with its analysis of the need for a Catastrophic Drug Plan for all Canadians. ■



▶ JUNE

28-29

2009 Consensus Conference on HIV Lab Testing
Canadian Association of HIV Clinical Laboratory Specialists (CAHCLS)
Moncton, NB
www.cahcls.ca/Announcement.htm

28-July 1

18th ISSTD
International Society for STD Research
London, UK
www.isstdlondon2009.com

▶ JULY

19-22

IAS Conference on HIV Pathogenesis, Treatment and Prevention (IAS 2009-5th Annual)
Cape Town, South Africa
www.ias2009.org

▶ AUGUST

7-13

9th Annual International Congress on AIDS in Asia and the Pacific
Bali, Indonesia
www.icaap9.org

▶ OCTOBER

3-4

CTAC Community Skills Building and AGM
Vancouver, BC
www.ctac.ca

7-8

Atlantic Region Educational Conference
CATIE
Truro, NS
www.catie.ca

15-16

Western Region Educational Conference
CATIE
Calgary, AB

28-29

Pacific Region Educational Conference
CATIE
Richmond, BC

Formulary Series: Manitoba

continued from page 5

retroviral therapy and have HIV-1 strains resistant to multiple antiretroviral agents including other NNRTIs.)

To apply for EDS coverage, physicians, dentists, or other professionals authorized by physicians can submit a request by telephone, mail or fax. Information required include: prescriber information, patient information, drug information and justification.

For drugs not normally eligible for Part 3 EDS coverage, physicians may request drug benefit coverage for their patient by applying in writing to the Provincial Drug Programs Review Committee. Requests are reviewed case by case based on information provided in the application including background information, previous therapies tried and response to those therapies as well as supporting literature. If approved the approval is generally given for a one-year period, after which time the person's doctor must reapply. ■

For more information about the Manitoba Pharmacare program: www.gov.mb.ca/health/pharmacare

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Authors: CTAC and Ward Health Strategies.
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- 2001 – “Making Treatments Accessible: A Policy Paper on Determining Appropriate Pricing for Brand-name Pharmaceutical Treatments for HIV/AIDS in Canada.” Author: Glen Brown.
- 2000 – “Position Paper on Direct to Consumer Advertising (DTCA) of Prescription Medications.” Author: Philip Lundrigan.

Permission is given to reproduce all or any part of the papers provided appropriate accreditation is given. Papers are available free of charge electronically at www.ctac.ca/en/resources/position_papers or on hard copy from the CTAC office (see contact information below).

MEMBERSHIP

Membership applications are available by contacting the CTAC office or by visiting the CTAC web site at www.ctac.ca/en/membership.

Full Membership is reserved for

- Persons living with HIV/AIDS
- Groups, organizations and/or projects with a substantial HIV/AIDS mandate

Associate Membership is open to

- Any individual, group, organization or project that supports CTAC's mandate and objectives

CONTACT US

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CTAC's Mandate

To secure and ensure access to therapies and treatments for people living with HIV/AIDS by working with the public, private and not-for-profit sectors.

CTAC...

- Informs research and public policy, and promotes public awareness;
- Provides mentoring and skills building in these areas to people living with HIV/AIDS;
- Encourages and facilitates the exchange of related information to stakeholders;
- Builds and works with coalitions to address broader health care issues impacting access to therapies and treatments.