GILEAD | Medical Information

Descovy for PrEP® (FTC/TAF) Ongoing Studies in Cisgender Women

This document is in response to your request for information on Descovy for PrEP® (emtricitabine/tenofovir alafenamide [FTC/TAF] for HIV-1 pre-exposure prophylaxis [PrEP]) and ongoing studies in cisgender women.

Some data may be outside of the US FDA-approved prescribing information. In providing this data, Gilead Sciences, Inc. is not making any representation as to its clinical relevance or to the use of any Gilead product(s). For information about the approved conditions of use of any Gilead drug product, please consult the FDA-approved prescribing information.

The use of FTC/TAF for prevention of HIV-1 from receptive vaginal sex in cisgender women is investigational and has not been approved by any regulatory authority. The full indication, important safety information, and boxed warning(s) are available at:
www.gilead.com/-/media/files/pdfs/medicines/hiv/descovy/descovy_pi;
www.gilead.com/-/media/files/pdfs/medicines/hiv/yeztugo/yeztugo_pi;
www.gilead.com/-/media/files/pdfs/medicines/hiv/truvada/truvada_pi.

Summary

Product Labeling

FTC/TAF is indicated in at-risk adults and adolescents weighing ≥35 kg for PrEP to reduce the risk of HIV-1 infection from sexual acquisition, excluding individuals at risk from receptive vaginal sex. Individuals must have a negative HIV-1 test immediately prior to initiating FTC/TAF for HIV-1 PrEP.[1]

Limitations of use: The indication does not include the use of FTC/TAF in individuals at risk of HIV-1 from receptive vaginal sex because effectiveness in this population has not been evaluated.[1]

Ongoing Studies of FTC/TAF for HIV-1 PrEP in Cisgender Women

PURPOSE 1 is an ongoing phase 3, double-blind, randomized study evaluating the efficacy and safety of twice-yearly SUBQ LEN (n=2138) and once-daily oral FTC/TAF (n=2137) or FTC/TDF (active control; n=1070) for HIV-1 PrEP in 5345 cisgender women and adolescent girls (16–25 years old) across South Africa and Uganda.[2]

- A total of 39 participants acquired HIV in the FTC/TAF group (incidence rate, 2.02 per 100 PY), 0 HIV cases occurred in the LEN group, and 16 HIV cases occurred in the FTC/TDF group (incidence rate, 1.69 per 100 PY). The bHIV in the screened population was 2.41 per 100 PY.
- The incidence rate of HIV in the FTC/TAF group was not different from bHIV (IRR, 0.84; 95% CI: 0.55–1.28; *P*=0.21), and there was no evidence of a difference from the incidence rate in the FTC/TDF group (IRR, 1.2; 95% CI: 0.67–2.14). LEN significantly reduced the incidence rate of HIV by 100% compared with FTC/TDF (IRR, 0; 95% CI: 0–0.1; *P*<0.001) and with bHIV (IRR, 0; 95% CI: 0–0.04; *P*<0.001).

- FTC/TAF, LEN, and FTC/TDF were all generally well tolerated with few discontinuations due to study drug-related AEs. The overall incidences of non-ISR AEs were generally similar across groups. Nausea and vomiting occurred at higher rates in the FTC/TAF and FTC/TDF groups than in the LEN group. ISRs were the most common AE in all groups and occurred at a higher rate with LEN than with the placebo injections that participants in the FTC/TAF and FTC/TDF groups received.

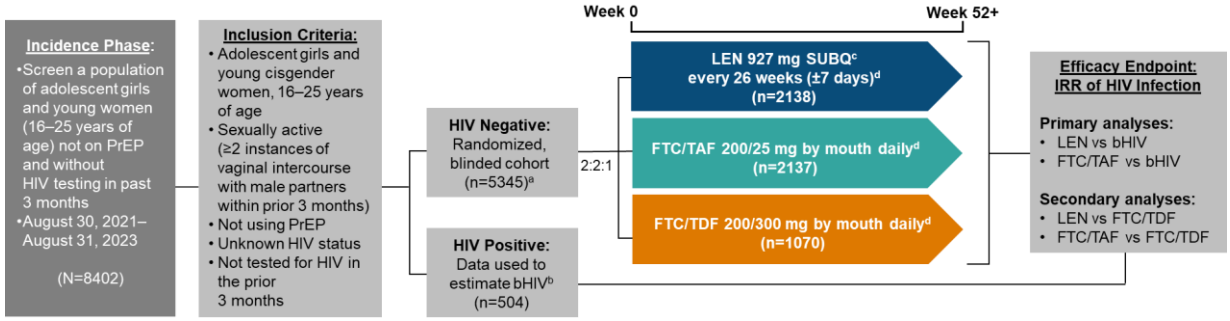
Ongoing Studies of FTC/TAF for PrEP in Cisgender Women

PURPOSE 1: Phase 3 Study

Study design and demographics[2]

PURPOSE 1 (NCT04994509) is an ongoing phase 3, double-blind, randomized, active-controlled study evaluating the efficacy and safety of twice-yearly SUBQ LEN and once-daily oral FTC/TAF for HIV-1 PrEP in cisgender women and adolescent girls across South Africa and Uganda (Figure 1). Additionally, a third group was assigned once-daily oral FTC/TDF, which served as the active control. Eligible women and adolescent girls were tested for HIV at screening, and those who tested negative were randomly assigned in a 2:2:1 ratio to receive LEN 927 mg SUBQ every 26 weeks, oral FTC/TAF 200/25 mg daily, or oral FTC/TDF 200/300 mg daily. Those who tested positive for HIV at screening were referred for care at a local center, and their samples underwent additional testing to determine the recency of the infection; these data were used to estimate the bHIV that would be expected without PrEP. Participants who discontinued the blinded study drug were given the option to take open-label FTC/TDF. Testing for HIV in the randomized cohort was conducted at Weeks 4, 8, and 13, and every 13 weeks thereafter.

Figure 1. PURPOSE 1: Study Design[2]



[a]Of the 5345 participants who underwent randomization and received study drug, 7 were subsequently found to have HIV at baseline (LEN, n=4; FTC/TAF, n=1; FTC/TDF, n=2); therefore, the mITT population included 5338 participants.
[b]The bHIV was determined based on a cross-sectional incidence estimate derived from rates of recent HIV infection in 8094 screened participants with available HIV test results; these participants were not followed longitudinally.
[c]All participants randomly assigned to receive LEN received an initial oral loading dose of 600 mg (two 300 mg tablets) administered on Days 1 and 2.
[d]Participants in the LEN group also received placebo FTC/TAF or placebo FTC/TDF (2:1), and participants in the FTC/TAF and FTC/TDF groups also received placebo LEN oral loading doses and placebo LEN SUBQ.

A total of 5345 participants were randomly assigned and received ≥1 dose of study drug. Baseline characteristics at randomization among the three groups were similar. Overall

retention in the study was high and was similar across groups, with 4855/5020 participants (96.7%) completing 26 weeks of follow-up, 2439/2612 participants (93.4%) completing 52 weeks, and 39/43 participants (91%) completing 104 weeks.

An independent committee determined that the planned interim efficacy analysis (when 50% of participants had completed ≥52 weeks of follow-up; data cutoff for clinical data, May 28, 2024, and data cutoff for laboratory data, May 29, 2024) met the prespecified criteria for stopping the randomized, blinded portion of the trial. Starting July 8, 2024, all participants were offered open-label LEN.

Table 1. PURPOSE 1: Baseline Demographics[2]

Key Demographics and Characteristics		LEN (n=2138)	FTC/TAF (n=2137)	FTC/TDF (n=1070)
Age	Median (range), years	21 (16–25)	21 (16–26)	21 (16–25)
	16 or 17 years of age, n (%)	56 (2.6)	45 (2.1)	23 (2.1)
Black race, n (%)		2135 (99.9)	2136 (>99.9)	1068 (99.8)
Living with primary partner, n/N (%)		148/2136 (6.9)	132/2134 (6.2)	73/1069 (6.8)
Previous use of PrEP, n (%)		143 (6.7)	121 (5.7)	71 (6.6)
Previously tested for HIV, n (%)		1713 (80.1)	1731 (81)	860 (80.4)
Time since last HIV test, median (IQR), months		6.8 (4.7–11.5)	6.6 (4.8–11)	6.5 (4.6–11)
Country, n (%)	South Africa	1809 (84.6)	1790 (83.8)	909 (85)
	Uganda	329 (15.4)	347 (16.2)	161 (15)

Primary and secondary efficacy analyses results[2]

A total of 55 incident HIV acquisitions occurred in the randomized cohort; 39 HIV cases occurred in the FTC/TAF group (1932 PY), none occurred in the LEN group (1939 PY), and 16 HIV cases occurred in the FTC/TDF group (949 PY; Figure 2). The bHIV in the screened population was 2.41 per 100 PY. The incidence rate of HIV in the FTC/TAF group did not significantly differ from the bHIV (IRR, 0.84; 95% CI: 0.55–1.28; *P*=0.21), and there was no evidence of difference from the incidence of HIV with FTC/TDF (IRR, 1.2; 95% CI: 0.67–2.14). LEN significantly reduced the incidence rate of HIV by 100% compared with both the bHIV (*P*<0.001) and the rate with FTC/TDF (*P*<0.001; Figure 3).

Figure 2. PURPOSE 1: Incidence of HIV (mITT Population)[2]

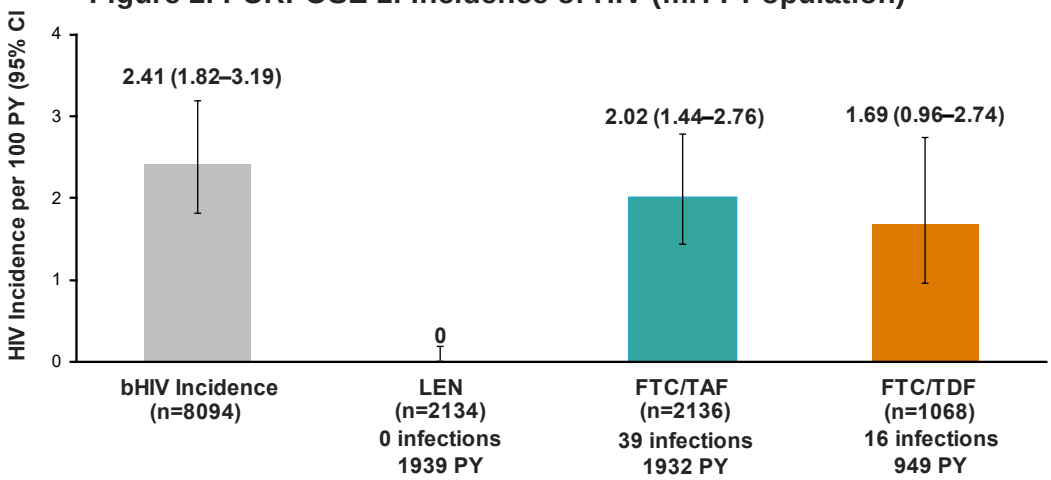
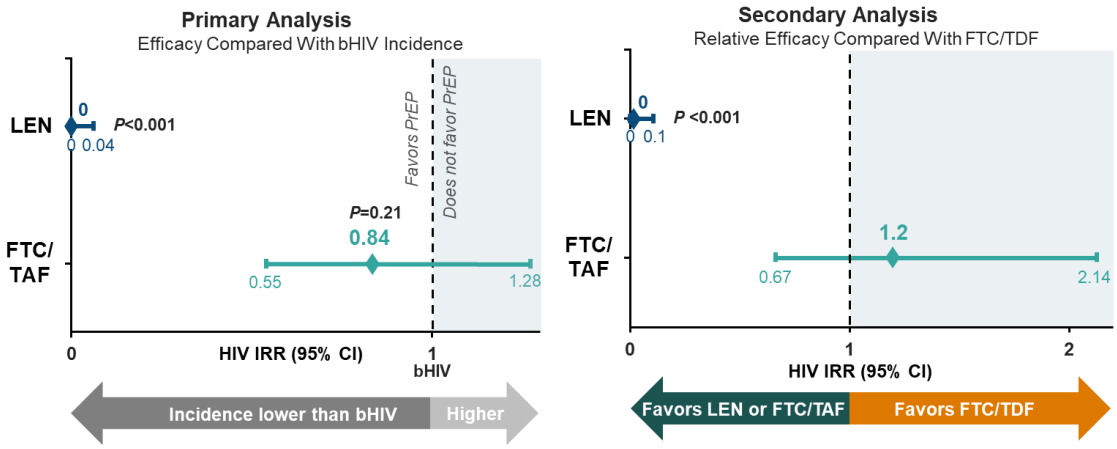


Figure 3. PURPOSE 1: Primary and Secondary Analyses[2]



Adherence results[2]

Adherence to FTC/TAF and FTC/TDF was evaluated at study visits using dried blood spot analyses of TDF levels in 10% of participants, who were randomly preselected from each group. Adherence in the 10% sample of participants in the FTC/TAF and FTC/TDF groups was low and decreased over time. At Week 8, in the FTC/TAF and FTC/TDF groups, adherence was low (<2 doses/week) in 34% and 50% of participants, respectively; at Week 52, adherence was low in 84% and 93%. Among participants who acquired HIV and had data available, 34/37 participants in the FTC/TAF group and 13/14 participants in the FTC/TDF group had low or undetectable levels of TDF. In a matched case-control analysis to assess the association between adherence and efficacy in the FTC/TAF group, participants with medium (2 or 3 doses/week) or high (≥4 doses/week) adherence had lower odds of acquiring HIV than those with low adherence (odds ratio, 0.11; 95% CI: 0.01–0.49).

Adherence to LEN was defined as on-time injections (within 28 weeks after the last injection). Most participants received their injections (LEN and placebo LEN) on time at Weeks 26 (91.5%; 4545/4967) and 52 (92.8%; 2025/2181), and adherence to injections was similar across groups.

Safety results

FTC/TAF, LEN, and FTC/TDF were generally well tolerated with higher rates of gastrointestinal AEs in the FTC/TAF and FTC/TDF groups than in the LEN group (Table 2). LEN ISRs were relatively common, and most were Grade 1 or 2 in severity. Six deaths occurred, all in the FTC/TAF group; none of these were considered by the investigator to be related to study drug.[2]

The most common AEs were ISRs.[2] A total of 25,329 injections were administered, with 10,154 administered to 2138 participants in the LEN group and 15,175 administered to 3206 participants receiving placebo injection in the FTC/TAF and FTC/TDF groups. SUBQ nodules, injection site pain, and swelling were the most common ISRs; these events occurred in 63.8%, 31.2%, and 4.4% of participants, respectively, who received LEN injections and in 16.6%, 23.7%, and 5.4% of participants, respectively, who received placebo injections.[3] No Grade 4 ISRs occurred, and the frequency of ISRs decreased over time. No keloid scars were reported in any group.[2]

Table 2. PURPOSE 1: Safety Summary[2]

AE, n (%)		LEN (n=2138)	FTC/TAF (n=2137)	FTC/TDF (n=1070)
Any AE (excluding ISRs)		1631 (76.3)	1665 (77.9)	830 (77.6)
Grade ≥3 AE		88 (4.1)	95 (4.4)	50 (4.7)
Serious AE		59 (2.8)	85 (4)	35 (3.3)
AEs that led to discontinuation of study drug[a]		5 (0.2)	2 (<0.1)	0
Common AEs (≥10% of participants in any group; excluding ISRs)	Urinary tract infection	307 (14.4)	305 (14.3)	163 (15.2)
	Genitourinary tract chlamydia infection	300 (14)	317 (14.8)	129 (12.1)
	Headache	285 (13.3)	352 (16.5)	155 (14.5)
	Upper respiratory tract infection	271 (12.7)	274 (12.8)	121 (11.3)
	Nausea	144 (6.7)	234 (10.9)	142 (13.3)
	Vomiting	125 (5.8)	235 (11)	107 (10)
Laboratory abnormalities[b]	Any	1929 (90.7)	1904 (90.1)	959 (91)
	Grade 3	92 (4.3)	81 (3.8)	50 (4.7)
	Grade 4	20 (0.9)	22 (1)	11 (1)
ISRs[c]	Any related to LEN, placebo LEN, or trial procedures	1470 (68.8)	755 (35.3)	363 (33.9)
	Led to discontinuation of study drug[d]	4 (0.2)	0	0
	Grade 3[e]	4 (0.2)	2 (<0.1)	2 (0.2)

[a]AEs that led to discontinuation of LEN were nausea (n=1), decreased CrCl (n=1), increased liver enzyme levels (n=1), spontaneous abortion (n=1), and suicide attempt with major depression (n=1); in the FTC/TAF group, AEs that led to discontinuation were suicide attempt, depressive symptoms, and drug overdose (n=1, all in the same participant) and angioedema (n=1).
[b]Percentages shown are based on the number of participants who had ≥1 postbaseline laboratory result (LEN, n=2126; FTC/TAF, n=2113; FTC/TDF, n=1054).
[c]Reactions to trial-related injections only; percentages shown are based on the number of participants who received ≥1 placebo or LEN injection (LEN, n=2138; FTC/TAF, n=2136; FTC/TDF, n=1070).
[d]All ISRs that led to discontinuation were SUBQ nodules, including 1 that was also reported as injection site pain.
[e]Grade 3 ISRs consisted of injection site ulcer (LEN, n=3; FTC/TAF, n=2; FTC/TDF, n=1), nodule (LEN, n=1), and pain (FTC/TDF, n=1).

In total, 510 pregnancies occurred in 487 participants (FTC/TAF, n=219; LEN, n=193; FTC/TDF, n=98). Of the 277 completed pregnancies, 121 pregnancies (23.7%) resulted in births, 66 (12.9%) resulted in spontaneous abortions, and 90 (17.6%) resulted in induced abortions. One congenital abnormality of polydactyly, which was not considered related to study drug, was observed in a participant in the LEN group who had a strong family history of the condition. Among pregnant participants, HIV occurred in 4 participants in the FTC/TAF group and in 1 participant in the FTC/TDF group.[2]

References

1. Enclosed. Gilead Sciences Inc, DESCOVY® (emtricitabine and tenofovir alafenamide) tablets, for oral use. U. S. Prescribing Information. Foster City, CA.
2. Bekker LG, Das M, Abdool Karim Q, et al. Twice-Yearly Lenacapavir or Daily F/TAF for HIV Prevention in Cisgender Women. *N Engl J Med.* 2024;391(13):1179-1192.
3. Bekker LG, Das M, Abdool Karim Q, et al. Twice-Yearly Lenacapavir or Daily F/TAF for HIV Prevention in Cisgender Women [Supplementary Appendix]. *N Engl J Med.* 2024:1-69.

Abbreviations

AE=adverse event
bHIV=background HIV incidence
FTC=emtricitabine
IRR=incidence rate ratio
ISR=injection site reaction
LEN=lenacapavir
mITT=modified intent-to-treat
PrEP=pre-exposure prophylaxis
PY=person-years
SUBQ=subcutaneous(ly)
TAF=tenofovir alafenamide
TDF=tenofovir disoproxil fumarate

Product Label

For the full indication, important safety information, and boxed warning(s), please refer to the Descovy, Yeztugo, and Truvada US Prescribing Information available at:
www.gilead.com/-/media/files/pdfs/medicines/hiv/descovy/descovy_pi;
www.gilead.com/-/media/files/pdfs/medicines/hiv/yeztugo/yeztugo_pi;
www.gilead.com/-/media/files/pdfs/medicines/hiv/truvada/truvada_pi.

Follow-Up

For any additional questions, please contact Gilead Medical Information at:

☎ 1-866-MEDI-GSI (1-866-633-4474) or 🖱 www.askgileadmedical.com

Adverse Event Reporting

Please report all adverse events to:

Gilead Global Patient Safety ☎ 1-800-445-3235, option 3 or
🖱 www.gilead.com/utility/contact/report-an-adverse-event

FDA MedWatch Program by ☎ 1-800-FDA-1088 or ✉MedWatch, FDA, 5600 Fishers Ln, Rockville, MD 20852 or 🖱 www.accessdata.fda.gov/scripts/medwatch

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