PHARMACY GUILD OF NEW ZEALAND

20 October 2025

PHARMAC
PO Box 10254
The Terrace
Wellington 6143

Sent via email to: *consult@pharmac.govt.nz*

Dear Sir/Madam,

Re: Proposal to change funding criteria for HIV medicines

The Pharmacy Guild of New Zealand (Inc.) (the Guild) is a national membership organisation and the largest representative of community pharmacy owners in New Zealand. We provide leadership on all issues affecting the sector and advocate for the business and professional interests of community pharmacy.

This submission focuses on Guild members' concerns around general economic, funding, access, and supply issues. Guild submissions should not be taken as any endorsement of, or any attempt to comment on, medicine safety, efficacy, or appropriateness for individual patients.

We support Pharmac's proposal to remove funding restrictions and enable more flexible supply arrangements for antiretroviral medicines used in the management and prevention of HIV. Please find comments on each below.

1. Removal of funding criteria for HIV medicines

The existing Special Authority and hospital indication criteria for HIV medicines are complex, inconsistently understood and applied across settings, and can cause unnecessary delays in access and timely initiation of treatment, particularly in urgent situations such as Post-Exposure Prophylaxis (PEP).

Removing these criteria would simplify access, enabling timely initiation of antiretroviral therapy (ART) without bureaucratic hurdles, aligning with the Ministry of Health's 2023–2030 HIV Action Plan and support equitable, community-level access for Māori, Pacific, and rural populations who are disproportionately affected by service fragmentation. It would also align New Zealand's funding approach with international best practice, ensuring consistency between clinical needs, public health priorities, and funding mechanisms.

For community pharmacies, current restrictions often create operational and clinical uncertainty about eligibility and funding. Removing these barriers would allow more streamlined, equitable access to ART and allow prescribers and pharmacists to collaborate more effectively, ensuring that ART can be initiated and continued without administrative delays, supporting community-based models of care already used for Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP), where early intervention and accessibility are critical.

Integrating community pharmacy into these governance and monitoring frameworks is also essential. Pharmacists play a frontline role in HIV prevention, early intervention, and continuity of care and are well placed to provide continuity of care using existing available technology.

Your community pharmacist:
the health professional you see most often.

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2. Enabling STAT (three-monthly) dispensing

Current dispensing frequency rules can unintentionally create unnecessary logistical and emotional burdens, particularly for those managing lifelong therapy or accessing urgent prophylaxis (PrEP and PEP) through community pharmacy.

STAT dispensing will make it easier for some people to manage their medicines, reducing barriers to treatment continuity, especially for those in remote or underserved areas, those with mobility challenges, or those seeking greater privacy and convenience. It will also lead to fewer pharmacy visits, which may reduce stigma and and improve the overall treatment experience for people living with HIV, supporting a more person-centered approach, consistent with long-term management strategies for other chronic conditions.

However, there are potential disadvantages that warrant careful consideration, particularly from a community pharmacy perspective. Larger dispensing quantities can increase the risk of loss or wastage if medicines are lost or expire, or if treatment is changed or discontinued. There may also be stock management pressures on community pharmacies as sudden changes to dispensing frequency can impact inventory levels, cash flow, and ordering patterns, especially for smaller or rural pharmacies. Reduced dispensing frequency may also lessen opportunities for pharmacists to engage regularly with patients, which provides a valuable touchpoint for adherence support, side-effect monitoring, and relationship building.

To mitigate these challenges, we recommend that Pharmac consider implementation over a six-month transition period to allow wholesalers, prescribers, and pharmacies to adapt stock management systems and workflow processes, reducing the risk of supply disruptions. We also recommend clear communication to both prescribers and pharmacists, reinforcing their ability to tailor dispensing frequency based on the individual patient factors such as treatment stability, adherence history, and social circumstances.

3. Placing two HIV medicines on a Practitioner Supply Order (PSO)

While the intent of improving responsiveness through PSO supply is recognised and supported in principle, there remain significant concerns. PSO supply mechanisms inherently break the direct link between individual patients and dispensing records, making it difficult to verify who received treatment or support appropriate follow-up or pharmacovigilance. Dispensing under PSO also prevents the recording of individual patient information within dispensing systems, reducing the accuracy of national dispensing data and compromising the completeness of medicine histories captured through the NZePS and other digital health platforms.

Under section 42 of the Medicines Act 1981, the supply of a medicine via a PSO is intended for emergency treatment, teaching, or diagnostic purposes within the prescriber's professional scope. The use of tenofovir disoproxil + emtricitabine with or without dolutegravir, for post-exposure prophylaxis of HIV is an *unapproved* indication (off-label use) in New Zealand, where under the current legal and regulatory frameworks, such use requires a prescription for a specific patient, with informed consent obtained and documented. Supplying this medicine via a PSO could expose both the prescriber and the supplying pharmacist to regulatory or professional risk. We would like to understand how Pharmac intends to align this proposed change with existing legal and ethical obligations.

We recommend that a national monitoring and reporting framework be established through the NZePS, Conporto, or a similar digital platform to record PSO utilisation data and ensure

transparency, traceability and accountability across all points of supply. This will help to identify patterns of utilisation, detect inappropriate or excessive supply, and support evidence-based policy refinement, along with enhancing the ability to link PSO data with national prescribing and dispensing datasets.

Overall, we support Pharmac's proposal, however, , stakeholder feedback should be actively sought from prescribers, pharmacists, and patient advocacy groups, ensuring that operational insights and patient experiences inform any necessary refinements. This collaborative, data-driven evaluation will help strengthen accountability, promote transparency, and ensure that the expanded access model continues to align with national HIV prevention and treatment goals.

If you have any questions about our response, please contact our Senior Advisory Pharmacists, Martin Lowis (martin@pgnz.org.nz, 04 802 8218) or Cathy Martin (cathy@pgnz.org.nz, 04 802 8214).

Yours sincerely,

Nicole Rickman
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