Good afternoon. My name is Matt Sharp and I am coming up on my twenty year anniversary of living with HIV. I have been an AIDS activist for over 20 years and am now an AIDS educator with TPAN in Chicago. I'm also a founding member of the Drug Development Committee of the AIDS Treatment Activist Coalition. Copies of another statement on behalf of the Drug Development Committee are available today.

For disclosure sake I am a consumer advocate for the FDA having served on the advisory committee for Reyataz and for the blood products committee. I am on several pharmaceutical company community advisory boards, including that of Merck. I was also the 2nd person enrolled in the raltegravir expanded access program when it was still called MK-0518. TPAN, my agency in Chicago also receives unrestricted and educational support from the pharmaceutical industry.

Although most of the raltegravir data will speak for itself, I am going to speak to you today about my use of the drug and that will hopefully bring an added perspective to this hearing. I want to also offer some key elements in the further developments of raltegravir and the integrase drug class.

My HIV treatment history cannot be told without saying that I am extremely fortunate to be here speaking with you today after several treatment failures and several close calls with death. There are not many of us AIDS veterans that have survived, and we are lucky, but many of us that have survived have been very active with their treatment and care and have fought for every new drug. The fight will not end with raltegravir.

My background in HIV started with the desperation days of AZT monotherapy in 1989 when my community was becoming decimated by a frightening and little understood disease. Over the next nineteen years my strategy was simply to buy time with any and all the newest drugs, and some alternative therapies as well. As we have learned though better understanding of HIV resistance many people were sub-optimally treated with sequential monotherapy due to the way the drugs were developed and offered one by one and the fact that people had no other choices for treatment.

I would add a new upcoming drug to an older drug regimen even though my T-cells kept slowly moving south. I am one of those who tried everything that became available and have paid the price with a multi drug resistant virus, yet through determination and hope I have managed to stay alive.

Fast forward to 2006 when I had used up most of my treatment options:
I had recently been treated with Aptivus and Fuzeon, my T-cells were falling and viral load was climbing again—clearly an indication that the new drugs were no longer effective. I was aware of the BENCHMRK raltegravir trials as early as late 2005 but the Chicago site was not able to open and I had to defer treatment over several agonizing months until the EAP opened in September 06. It was a frustrating time as I knew I was once again completely out of options as I had been many times before. At that point I could have gone ahead and used Prezista as it was my only option at the time, but for the

first time I could afford the opportunity to wait for two drugs I had not taken before that were most likely going to be active.

I added Prezista and Truvada to raltegravir in the EAP. I achieved an undetectable viral load in less than two weeks and have experienced almost a doubling of CD4 cells, maintained now almost to a year. It appears my immune system is gaining ground as my T-cells are higher that they have been in 16 years. I have a history of recalcitrant cutaneous warts that have started to literally dry up and fall off, clearly a sign of immune recovery. My health is excellent, working a full time job with a regular gym workout routine and a very active national travel schedule.

For someone with as beat up a virus as I had, the success with ralegravir is a significant achievement. Since the advent of viral load testing I have never been undetectable save one week on Fuzeon. My case shows that raltegravir, especially if used with at least one another effective antiretroviral drug is going to save lives.

Merck has listened to the community and provided many mechanisms for inclusion, enrollment and access in the BENCHMRK studies and the EAP. The BENCHMRK design allowed for experimental agents for the first time, offering people more options but also better data for the company. 90% of those who added Prezista to raltegravir in BENCHMRK went below 400 copies at 24 weeks. Good was done for patients and for the company. It's clear how many people need this drug as enrollment in the expanded access program is over 4000. As with most other HIV trials Merck needs to work in better recruitment and retention of women in studies.

We can be assured the sustainability of raltegravir is good for the duration of the 24 week data but beyond that there are still some unknowns. We understand that there is a low barrier to resistance and there will be cross-resistance with elvitegravir, the next integrase inhibitor in the pipeline. Since raltegravir is a new drug from a new class there needs to be more work done on resistance and cross-resistance.

The raltegravir side effect profile appears clean and may offer a safer option in treatment experienced people where side effects are a common and sometimes debilitating problem. There is some concern that malignancies appeared early on in the BENCHMRK studies. Longer term data should confirm that this won't be a cause for concern. However, follow up studies need to be supported and carried out by the company to qualify resistance patterns seen thus far, and to track longer term side effects.

One of the big obstacles with current HIV therapies is drug interactions. Since raletgravir is metabolized via glucuronidation, it should not have many drug-drug interactions with cytochrome P450 substrates, inducers, and inhibitors, such as the current widely used NNRTIs and PIs.

As we know from the past approved HIV antiretroviral drugs there have been issues with companies committing to follow up studies and there has been no teeth from the FDA to require such studies. Issues such as cardiovascular complications, kidney disease and

lipodystrophy are discovered late in the antiretroviral development process. This is a growing area of concern for people living with HIV as we are living longer and want to see longer term safety data. A good drug is only as good as the proof that it's going to be safe and effective over the long haul and that doctors will prescribe it correctly. So far, raltegravir looks good and the HIV community can support it as long as the post marketing commitments are all carried out. Remaining issues are the understanding of how raltegravir may work differently in women. Frequent monitoring of liver function tests and bilirubin tests are necessary since this is a first-in class agent. I mentioned that more work needs to be done on resistance in this class. There should be a better definition of adverse advents including long term follow-up on the malignancies reported early on.

One point needs to be made here that I think is highlighted by my story:
It's a very unique time in the history of HIV treatment with several new agents available for people who have previously had few or no options. People today can afford to wait until they can use another new drug with raltegravir to get the best treatment effect. Doctors should test for resistance and carefully construct regimens that will be the most effective to add to raltegravir. We have more time and more options to enhance the most optimal treatment effect.

I am also advocating for as low a cost as possible for raltegravir especially given the fact that it should be optimally used with other active agents-that are likely to be the higher priced drugs. The company should be decide upon as low a cost possible to ensure people have access to this new successful treatment strategy for those who may have no other options.

While I am here today to support accelerated approval of raltegravir I am concerned that after Tibotec's TMC-125, the HIV treatment pipeline is running low. I urge the FDA to make sure that the raltegravir label reflects this dwindling pipeline by giving clear, concise instructions on how best to use the drug so it is not wasted through misuse.

Thank you.