Methods. ART-naïve adults, initiating a DTG- or EVG-based regimen and meeting all study eligibility criteria (Figure 1) were identified in the OPERA® Observational Database, a collaboration of HIV caregivers following 100,000+ people living with HIV (PLWH) through electronic medical records. PLWH were followed from the date of first prescription until DTG- or EVG discontinuation, death, or study end (July 31, 2018). The primary outcome was verified (2 consecutive viral load (VL) ≥200 copies/mL or 1 VL ≥200 copies + discontinuation) virologic failure (VF), defined as either failure to achieve suppression (<50 copies/mL) prior to 36 weeks or failure to maintain suppression once achieved. Survival analyses were conducted with Kaplan–Meier methods and multivariate Cox Proportional Hazards modeling.

Results. A total of 1,688 (DTG) and 2,537 (EVG) met all eligibility criteria. Median (IQR) length of follow-up in the DTG users was 21 (14–30) months, in the EVG users was 20 (14–32) months. Figure 2 characterizes baseline demographic/clinical characteristics. Figures 3 and 4 depict Kaplan–Meier curves and Cox model results, respectively. VF was experienced by 8.2% DTG and 10.9% EVG initiators at a rate (95% CI) per 1,000 person-years of 40.2 (33.8, 47.8) and 51.3 (45.3, 58.1), respectively. Younger age (18–25), being African American, having a baseline CD4 count ≤ 200, or having a government-based payer (ADAP, Ryan White, Medicaid, or Medicare) at baseline were associated with a significant (P < 0.05), increased hazard of VF. Initiating on DTG or initiating therapy with a lower baseline VL was associated with a significant, reduced hazard of VF. Compared with DTG, the adjusted hazard ratio for VF was 1.29 (95% CI: 1.02, 1.63) for EVG.

Conclusion. Among ART-naïve patients, DTG users were significantly less likely to experience virologic failure than EVG users after adjustment for important baseline covariates.

Disclosures. All authors: No reported disclosures.
Conclusion. In a southern, predominantly African American overweight population, our results demonstrate low discontinuation rates associated with BIC/FTC/TAF, with rash being the predominant cause. Overall, 4% discontinued BIC/FTC/TAF due to AEs compared with 1% as reported in the package insert. VS rates were high throughout the evaluation period. Ongoing post-marketing evaluation is important for early recognition of unexpected adverse outcomes.

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2490. Longer-Term Safety and Efficacy of Elvitegravir/Cobicistat/Emtricitabine/Tenofovir Alafenamide in Virologically Suppressed Adults Living With HIV and End-Stage Renal Disease on Chronic Hemodialysis

Joseph L. Eron, MD; Daniel Lalivier, MD; Robert Kalayjian, MD; Bhd Slim, MD; Anson K. Wurapa, MD; Jeffrey L. Stephens, MD; Cheryl McDonald, MD; Eric Cu, MD; Arjun Wilkin, MD, MPH; Mehr McKellar, MD; Stephanie Cox, BS; Sophia Phelan, PhD; Christiana Blair, MS; Christoph C. Carter, MD; Devi SenGupta, MD; Diana M. Brainard, MD; Moupali Das, MD; University of North Carolina, Chapel Hill, Chapel Hill, North Carolina; Hôpital Henri Mondor, Créteil, Ile-de-France, France; Saint Michael’s Medical Center, Newark, New Jersey; Infectious Disease Specialists of Atlanta, Atlanta, Georgia; Mercer University School of Medicine, Macon, Georgia; Tarrant County Infectious Disease Associate, Fort Worth, Texas; University Hospital, Nice, Provence-Alpes-Cote d’Azur, France; Wake Forest University, Winston-Salem, North Carolina; Duke University Hospital, Durham, North Carolina; Gilead Sciences Inc., Foster City, California; Gilead Sciences, Foster City, California

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Background. HIV treatment for individuals with end-stage renal disease (ESRD) on hemodialysis (HD) has previously required complex dose-adjusted regimens. We evaluated the safety and efficacy of single-tablet, once-daily elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide (E/C/F/TAF) in people living with HIV (PLH) on ESRD on chronic HD.

Methods. Virologically suppressed adult PLH with ESRD on chronic HD for ≥6 months were switched to open-label E/C/F/TAF 150/150/200/10 mg once daily for 96 weeks. Efficacy was assessed as the proportion of participants who maintained virologic suppression (HIV RNA < 50 copies/mL) using the snapshot algorithm. Safety and participant satisfaction were assessed throughout the study.

Results. We enrolled 55 participants with median age 51 years (range 23–64) with median HD years (range 1–17). In the per protocol analysis set, virologic suppression was maintained in 30 of 53 participants (94.6%, 95% CI [83.3%, 99.9%]) at week 96. In the full analysis set, virologic suppression was maintained in 30 of 55 participants (54.5%; 95% CI [40.6%, 68.0%]); one discontinued therapy due to lack of efficacy, and 96 weeks were unattainable for 24 of the 24 participants lacking 96 weeks data. At 7 days or 24 weeks following discontinuation of study drug, all had HIV RNA < 50 copies/mL at the last pre-week 96 check. Treatment-emergent AEs occurred in 53 patients (96.4%) participants, and study-drug-related AEs occurred in 7 (12.7%). Treatment-emergent AEs leading to premature study drug discontinuation occurred in 4 (7.3%) participants; two were considered study-drug-related (allergic pruritus and peripheral neuropathy in one participant each). No study-drug-related serious AEs were observed. 85.7% (30/35) of responding participants reported they were ‘much more satisfied’ with their regimen. In the per protocol E/C/F/TAF was effective in maintaining virologic suppression in PLH on chronic HD over 96 weeks of follow-up. E/C/F/TAF was well tolerated and was associated with improved participant satisfaction. These data demonstrate that E/C/F/TAF is a safe and effective alternative to more complicated regimens in PLH on chronic HD, with the potential to improve patient satisfaction and quality of life.

Disclosures. All authors: No reported disclosures.

2491. Virologic Response of Switching Tenofovir Disoproxil Fumarate (TDF)-Based Regimen to Abacavir (ABC)-Based Regimen or Not on Therapy in Patients with TDF-Induced Nephrotoxicity at Week 96

Rajat K. Das, MD; Anson K. Wurapa, MD; Robert Kalayjian, MD; Bhd Slim, MD; Anson K. Wurapa, MD; Jeffrey L. Stephens, MD; Cheryl McDonald, MD; Eric Cu, MD; Arjun Wilkin, MD, MPH; Mehr McKellar, MD; Stephanie Cox, BS; Sophia Phelan, PhD; Christiana Blair, MS; Christoph C. Carter, MD; Devi SenGupta, MD; Diana M. Brainard, MD; Moupali Das, MD; University of North Carolina, Chapel Hill, Chapel Hill, North Carolina; Hôpital Henri Mondor, Créteil, Ile-de-France, France; Saint Michael’s Medical Center, Newark, New Jersey; Infectious Disease Specialists of Atlanta, Atlanta, Georgia; Mercer University School of Medicine, Macon, Georgia; Tarrant County Infectious Disease Associate, Fort Worth, Texas; University Hospital, Nice, Provence-Alpes-Cote d’Azur, France; Wake Forest University, Winston-Salem, North Carolina; Duke University Hospital, Durham, North Carolina; Gilead Sciences Inc., Foster City, California; Gilead Sciences, Foster City, California

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Background. Agents from the integrase inhibitor (INSTI) therapeutic class only are recommended as initial therapy for most patients with HIV. Clinicians now face a decision when treating ART-experienced patients on non-INSTI regimens: continue current therapy or switch to INSTI. Multiple factors may be considered in this decision: clinician/patient preference, comorbidities, tolerability, and resistance history. The objective of this analysis was to examine patient factors associated with currently taking INSTI-based regimens in both arms after discontinuation of TDF. There was a significant change in triglyceride levels in LPV/r +3TC regimen.

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2492. Differences between Individuals Currently Taking Integrase Inhibitor (INSTI)-Based Therapy and Those Not Taking INSTIs in the Era of INSTIs as Recommended First-line Therapy

Anne K. Monroe, MD, MSPH; Matthew E. Levy, PhD; Alan E. Greenberg, MD, MPH; Richard Moore, MD, MHS; Jeanne Keruty, NP; Michael A. Horberg, MD; Bernadine Mohanraj, MD; Princy Kumar, MD; Amanda Castel, MD, MPH; The George Washington University, Washington, DC; George Washington University, Washington, DC; George Washington University Milken Institute School of Public Health, Washington, DC; The Johns Hopkins University School of Medicine, Baltimore, Maryland; Kaiser Permanente, Rockville, Maryland; Georgetown University School of Medicine, Washington, DC

Session: 262: HIV: Antiretroviral Therapy Saturday, October 5, 2019: 12:15 PM

Background. Among the agents from the integrase inhibitor (INSTI) therapeutic class only are recommended as initial therapy for most patients with HIV. Clinicians now face a decision when treating ART-experienced patients on non-INSTI regimens: continue current therapy or switch to INSTI. Multiple factors may be considered in this decision: clinician/patient preference, comorbidities, tolerability, and resistance history. The objective of this analysis was to examine patient factors associated with currently taking INSTI-based regimens.

Methods. We used data from the DC Cohort, a longitudinal observational cohort of patients receiving HIV care at 14 clinics between 2011–2018. Participants in the sample had ≥1 encounter between 4/1/17 and 3/1/18, were aged ≥18 years and were ART experienced. Participants were classified as currently, previously, or never on an INSTI-based therapy or not on therapy. Further research should explore whether this is detrimental for long-term HIV outcome in these patient groups. Additionally, these results suggest resistance history as an important driver of INSTI prescription.

Table 1. Presence of Major Resistance Mutations among Individuals on ART in the DC Cohort, 2017–2018, n=5464

| Mutation | Current on INSTI (n=4798) | Prevalently on INSTI (n=1107) | Never on INSTI (n=3929) | p-value |
|----------|--------------------------|------------------------------|--------------------------|--------|
| Major MTFI mutation present | 628 (21.3) | 76 (6.9) | 120 (3.1) | <0.0001 |
| Major NRFI mutation present | 625 (21.0) | 66 (5.9) | 135 (3.4) | <0.0001 |
| Major PI mutation present | 507 (18.8) | 29 (2.6) | 65 (1.6) | 0.3511 |

Disclosures. All authors: No reported disclosures.