Implementing the CDC STI Treatment Guidelines, 2021: A Conversation for Family PACT Providers Webinar Q&A September 8, 2021

STI Guidelines Questions for Ina Park:

PLEASE NOTE: The answers to the following questions pertain to the 2021 CDC STI Treatments Guidelines, in general. For coverage under Family PACT, Medi-Cal or commercial health insurance, have your clinic or office staff check the written policies of the client's individual program or commercial health plan.

Gonorrhea and Chlamydia

Q 1: What was the document you were referring to during the webinar that was unable to make it into the chat?

A: The guidelines for gonorrhea treatment failure for CA: https://californiaptc.com/wp-content/uploads/2021/06/CAGCTreatmentFailureProtocol_Providers-06252021.pdf

Q 2: For patient delivered partner treatment for gonorrhea, will the partner have to take oral treatment?

A: Yes, partners receiving expedited partner treatment would need to take cefixime orally.

Q 3: Can the same treatment be used to treat the 3- different test sites?

A: Yes, the treatment for gonorrhea is the same regardless of anatomic site. Same goes for chlamydia.

Q 4: Is test of cure recommended for non-pregnant women or men, who get azithromycin for chlamydia because they don't want doxycycline, if rectal chlamydia infection identified or suspected?

A: That is not an official CDC recommendation at this point. If you wanted to do that, you should wait at least 3 weeks to do a test of cure.

Q 5: Would it be okay to give azithromycin to someone with low risk of rectal chlamydia?

A: Yes, especially if you think they will have issues adhering to doxycycline.

Q 6: If using doxycycline for chlamydia treatment, is the recommendation for abstaining 7 days from day 1, similar to azithromycin or would it be 7 days post completion treatment on day 7?

A: Abstaining 7 days starting with day 1, similar to azithromycin.

Q 7: Is there a reason why gonococcal conjunctivitis/trachoma treatment was included in the guidelines but not for chlamydia?

A: Not sure why that is.

Q 8: Why is azithromycin recommended in pregnancy over doxycycline?

A: Tetracycline antibiotics (including doxycycline) are not recommended in pregnancy due to risk of congenital abnormalities and permanent staining/discoloration of the teeth. There is debate about whether doxycycline has the same teratogenic effects as the other tetracyclines, but generally the whole class is not recommended during pregnancy.

Q 9: In a ceftriaxone allergic pregnant patient who is positive for gonorrhea, is it safe to use gentamicin or would you send them for desensitization?

A: Gentamicin has been associated with congenital abnormalities but there are not good data for gonorrhea treatment in pregnancy which only involves a single dose vs prolonged IV therapy which carries a higher risk of toxicity. One approach in these cases would be to treat with azithromycin 2g in a single dose and get a test of cure (for cervical gonorrhea 7-14 days is an appropriate interval for TOC). Consult the STD Clinical Consultation Network for more advice. https://stdccn.org

Q 10: Most providers give empirical treatment to cover both gonorrhea and chlamydia, what is the recommendation before results are back?

A: In patients with symptoms of cervicitis/urethritis, it's fine to treat for both gonorrhea/chlamydia. CDC's recommendations list empiric treatment for CT and mention to add GC depending on how likely it seems based on your setting. Many people choose to treat for both.

Q 11: Any concerns about completing therapy for subpopulations (i.e., adolescents)?

A: There are definitely concerns, which is why some providers may choose to treat with single dose therapy for chlamydia or trichomonas despite lower overall efficacy. The only concern with this approach is for rectal chlamydia because the difference in efficacy is 20-30% worse with azithromycin vs doxycycline.

Q 12: For alternative gonorrhea treatment if non-adherence is suspected why would you treat with 1 g azithromycin versus the preferred principal treatment of 500mg IM ceftriaxone? Both are a "one-and-done" approach. So why not opt for the primary treatment?

A: 1g of azithromycin is the alternative treatment for chlamydia, not gonorrhea. The primary treatment for gonorrhea should be ceftriaxone 500 mg IM. The alternative treatment for gonorrhea is cefixime 800 mg, not azithromycin.

Q 13: Is test of cure still 3 months or can you do it before that if you question whether they have taken it?

A: The three-month test is a repeat screen to look for repeat infection, not a test of cure. A test of cure should be performed if you are uncertain that the patient has taken the prescribed antibiotic and should be performed 7-14 days after treatment for GC, and 3 weeks for CT, Mycoplasma, or trichomonas.

Q 14: Is the test of cure culture or NAAT?

A: A test of cure is typically performed with a NAAT, but in cases of gonorrhea treatment failure, both a culture and a NAAT should be performed.

Q 15: Is there a time frame for test of cure when non-pregnant STI positive?

A: Test of cure should only be performed for non-pregnant patients for pharyngeal gonorrhea or if there is suspicion of treatment failure. For pharyngeal gonorrhea wait 14 days post treatment to do a TOC. For chlamydia, mycoplasma, or trichomonas, wait at least 3 weeks to perform a TOC.

Q 16: Does the test do a susceptibility report?

A: Nucleic acid amplification tests do not give a susceptibility report. Those are only included if a culture is performed.

Pelvic Inflammatory Disease (PID)

Q 17: If there is a low threshold for treating Pelvic Inflammatory Disease and the patient is having clinical symptoms and no other etiology and she is treated for Pelvic Inflammatory Disease, but no improvement should we be testing/empirically treated to cover Mycoplasma genitalium as the next step?

A: Yes, testing for Mgen and treating if positive would be a reasonable approach.

Patient Delivered Partner Therapy (PDPT)

Q 18: For patient delivered partner treatment PDPT, is it preferred to prescribe/dispense azithromycin over doxycycline because pregnancy status of partner is unknown?

A: CDC doesn't have an official statement on this, but if the partner could be or could become pregnant then azithromycin would be preferred.

Q 19: If a client has multiple current partners that may have been exposed, are all the partners eligible for patient delivered partner treatment or expediated partner therapy?

A: Yes. For GC/CT all partners in the last two months would potentially be eligible. When distributing prepackaged medication, each clinic can decide what their limit is for partner packs.

Q 20: Are you usually recommending azithromycin or doxycycline for chlamydia expedited partner therapy EPT?

A: No firm guidance here, but if likelihood of rectal infection for partner is high, doxycycline would be preferred. If compliance is a concern and/or chance of rectal infection is low, then azithromycin would be very reasonable.

Q 21: Do you have a resource I can provide to my clinic director to help provide the appropriate and specific updated 2021 guidelines for expedited partner treatment in Nebraska?

A: Legal Status of EPT - Nebraska (cdc.gov).
https://www.cdc.gov/std/ept/legal/nebraska.htm

Syphilis

Q 22: What is your opinion about point of care syphilis tests?

A: There are two that are FDA approved and they can be helpful for outreach settings, but they are limited. The two out there currently only test for treponemal antibodies, which remain positive for life in people who've had syphilis, so they aren't useful to find new infections in that population.

Q 23: Can doxycycline still be used for syphilis treatment (last resort)? It is not listed as an alternative treatment but is listed under special considerations, i.e., penicillin allergy.

A: Yes, absolutely. Doxycycline has been used for years, it's just difficult to adhere to a 2-week regimen for early syphilis or a 4-week regimen for late latent syphilis, which is why PCN is strongly preferred. But certainly, in case of allergy, doxy would be the treatment to use.

Q 24: How much less effective is doxycycline to penicillin for syphilis treatment, and if we find out a patient has been treated with doxycycline be retreated? Or should we have a very high allergy threshold before using doxycycline?

A: If a patient is treated with doxycycline, they do not need to be re-treated with PCN. If the patient has true anaphylaxis or a true allergy to PCN (hives, wheezing, not just a rash during childhood), then doxycycline is appropriate treatment in those cases.

Q 25: If rapid plasma reagin RPR is reactive with treponema pallidum particle agglutination TPPA negative; what is the next step? Would you repeat the test?

A: Those are usually false positives. You can repeat the testing if you'd like, particularly if you are suspicious the patient has syphilis. But if it's a routine screening test, then you can reassure the patient that this is a false positive RPR.

Q 26: For treatment of syphilis and chlamydia co-infection, would you still recommend using doxycycline and penicillin or would you switch to azithromycin and penicillin due to doxycycline/penicillin drug interaction?

A: While there is a theoretical concern as tetracyclines are bacteriostatic and penicillin works on an actively dividing cell wall, no specific data exist for syphilis/CT treatment. There are some data for pneumonia that demonstrate similar outcomes when doxycycline is administered with a beta-lactam vs other combination of antibiotics. So, for someone with both STIs, either therapy would be ok but doxycycline/PCN would still be preferred for a patient with rectal CT and syphilis.

Q 27: Pregnancy treatment for Infectious Syphilis, does it have to be exactly 7 days apart for penicillin 2 doses?

A: It should be 7 days or as close to 7 days as possible. The 2021 CDC guidelines give a little room to have spacing between 7-9 days, but 7-day dosing is preferred.

Mycoplasma and Ureaplasma

Q 28: Our homegrown Mycoplasma Genitalium test also reports Mycoplasma hominis and Ureaplasma species. How do you deal with those results?

A: There are two ways to approach this. If the patient was tested with the combo test because they have urethritis/cervicitis treatment failure after standard therapy and other work-up is negative, then it makes sense to treat if those are the only pathogens identified.

Sometimes people come from other countries or settings where they were screened with a combo test when they are asymptomatic. If the M. hominis and ureaplasma are

positive in those cases, there is no recommendation to treat, as people can be colonized, and these may be non-pathogenic.

Q 29: Is Ureaplasma considered an STI? I had a client who wanted her partner treated for this since she tested positive.

A: It can be an STI, but it can also be a normal colonizer of the vagina or urethra. If she was tested because she is having persistent cervicitis or UTIs and she has ureaplasma, then it makes sense to treat both her/her partner. But if she was routinely screened and this was positive, there is no recommendation to treat either**.**

Q 30: What about using a resistance test for *Mycoplasma genitalium*?

A: Resistance testing is not yet FDA approved. When it is approved, the CDC does have guidance for how to use it, with extended dose azithromycin recommended if the MG does not have a resistance mutation.

Q 31: I am concerned about using Fluoroquinolones on a routine basis for treatment of Mycoplasma/Ureaplasma due to toxicity with use. Is there another antibiotic that can be used for that second week of dosing?

A: Unfortunately, there is no other recommended treatment at this time.

Q 32: If you do not have access to Mycoplasma Genitalium testing should you be treating presumably for Mycoplasma Genitalium in cases of recurrent chlamydia or urethritis without testing?

A: Now that there are multiple NAAT tests that are FDA approved and most commercial labs offer testing, efforts should be made to get MG testing. However, if there is recurrent urethritis with documented findings (pyuria and/or discharge), GC/CT are negative and there is no access to MG testing, then empiric treatment for MG would be reasonable. In cases of recurrent chlamydia, treatment should be directed against chlamydia, not MG.

Q 33: What are the consequences of Mycoplasma Genitalium?

A: M. genitalium causes urethritis, cervicitis, and has also been associated with PID and infertility.

Vaginitis

Q 34: Is it recommended to prescribe Flagyl for trichomonas for a patient's partner and if so how?

A: Partners with a penis should be treated with metronidazole 2g orally in a single dose. Partners with a vagina should receive metronidazole 500 mg PO BID x 7 days.

Q 35: Can you explain the differences in treatment guidelines for trichomonas when comparing male and female treatments? Is it saying that females get 7 days of treatment and males get a onetime 2-gram dose of metronidazole?

A: That is right. The recommended treatment for vaginal infection is 7 days of metronidazole, for penile infection it is 2g in a single dose.

General Questions

Q 36: Is the CDC intentional with the acronym MSM? Are they not including trans women in this category? Is there a move to include trans women as a high-risk group?

A: Yes, MSM is used intentionally for cis men who have sex men. Trans people have a separate section where screening recommendations are laid out (both transmen and transwomen). They do say in the guidelines that trans people who have sex with cis men have similar risk for STIs as cis-MSM.

Q 37: The guidance for presumptive treatment for sexual assault survivors changed to 7 days of doxycycline. Would you consider an assault (that did NOT include anal assault) another good opportunity to continue azithromycin?

A: Yes, that would be a good situation where azithromycin would be appropriate.

Q 38: For prophylactic treatment for sexual assault victims, a regimen of Ceftriaxone 500mg, 1 gm of azithromycin for uncomplicated contact, and metronidazole regardless of alcohol intake would still be reasonable? I have so many concerns about giving a 7-day dose of doxycycline and metro to many of my patients.

A: I think if a patient is traumatized to the point that taking pills every day for a week will serve as a reminder of the assault or concerned about others discovering pill bottles etc., it is very reasonable to give single dose therapy for everything. (If an anal assault, would favor doxy for CT), but the difference in efficacy for trichomonas is not that great (81% vs 89%). So would trust the clinician's judgment based on the situation.

Q 39: If you are treating a husband and wife and one is diagnosed with STI, and that person does not want you to tell partner then what do you do?

A: This is a very difficult situation. The patient's diagnosis is confidential, so technically you cannot disclose without the patient's permission to do so. You could offer the other partner STI testing without disclosing the reason why you are offering.

Q 40: Can you explain when and how to report STIs?

A: Each state has different procedures; you need to consult your state's public health STD program website. For California Family PACT providers, there is some information at the CDPH website.

https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/HowToReportCMRs.pdf

Q 41: How can I get the posters or handbook?

A: Your organization can print them out if they have the budget to do so (see page below). There is also a link on that page to order printed copies from CDC. I do not know what quantities they will have, and on last check it doesn't appear that they are ready yet. https://www.cdc.gov/std/treatment-guidelines/provider-resources.htm.

Q 42: Could you please do a quick review of PrEP guidelines?

A: The current PrEP guidelines are from 2017 and can be found at this site: https://www.cdc.gov/std/treatment-guidelines/provider-resources.htm

New guidelines are forthcoming from CDC in 2021.

Q 43: Aside from the health department, do you have recommendations for anonymous partner notification apps/systems for people with safety concerns with partner notification?

A: https://tellyourpartner.org/

Q 44: Do you know what big labs are doing the Herpes HSV confirmation BIOKIT? LabCorp does a "supplemental" test after the Herpes HSV 2 serum is positive. Do you know if this is the BIOKIT test?

A: The LabCorp web site does not state whether the Biokit is used as the first-line herpes serology test. However, it states that if the HSV-2 serology is positive, "specimens equivocal and low positive for HSV-2 type specific IgG antibody will automatically reflex to *a membrane based immunoassay (*163006 HSV-2 Supplemental test). The company does not specify the commercial name of the membrane based immunoassay kit used.

REF: https://www.labcorp.com/tests/164922/herpes-simplex-virus-hsv-types-1-and-2-specific antibodies-igg-with-reflex-to-supplemental-hsv-2-testing

STI Questions for Michael Policar:

PLEASE NOTE: All answers about benefits apply only to the Family PACT Program. When answers also apply to Medi-Cal policy, this will be clearly stated. The answers *do not* necessarily apply to commercial health insurance. Always have your clinic or office staff check the written policies of the client's individual commercial health plan.

Family PACT Eligibility Questions

- Family PACT Program benefits are limited to family planning and family planning-related reproductive health services. It is not a primary care or pregnancy care program.
- Eligibility requirements
  - Resident of the state of California
  - Income requirements met
  - No other source of health care coverage for family planning services, including Medi-Cal FFS and managed care. There are exceptions for confidentiality concerns.
  - Medical necessity for family planning services
    - Males capable of causing pregnancy
    - Females capable of becoming pregnant

REF: PPBI "Client Eligibility"
https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/fpact/clientelig.pdf

Q 1: For LGBT patients (or any patients really) for whom contraception is not a concern or doesn't apply, how should we document ICD-10 Code?

What we would put down for the method of contraception in that patient population LGBT community since they are not using birth control?

A: The Family Planning, Access, Care and Treatment (Family PACT) program is a limited-benefit program, with a focus on family planning. The program also covers family planning-related services (STI, UTI, cervical cancer screening) when care is provided as part of, or follow-up to, a family planning visit.

To be eligible for Family PACT, a client must meet all the 4 criteria: California resident, income, no other source for family planning services, and medical necessity for family planning.

If, for a prospective client and "contraception doesn't apply," then she/he/LGBT does not meet all of the eligibility criteria and cannot be enrolled into the Family PACT program. Family PACT services are reimbursable only to enrolled Family PACT clients.

If, for a Family PACT client who is on a contraceptive method and "contraception is not a concern" during the visit (i.e., the client is coming in for an STD, or UTI/cervical cancer screening), then:

- List the purpose of the visit (example: STD) as the primary diagnosis code, and
- List the ICD-10 code for the contraceptive method for which the client is being seen as a secondary diagnosis.

Family PACT policy and ICD-10-CM requirements requires providers to list the primary purpose of the visit as the primary diagnosis code, whether related to contraceptive services, STD services, a urinary tract infection, etc.

For more information, you may refer to the Policies, Procedures, and Billing Instructions manual at www.familypact.org, and click on the "Clinical Resources" tab.

Q 2: Can you include a reference about how to document and be paid for trans patients we are serving?

A: As long as the client meets all of the Family PACT eligibility criteria, including medical necessity for family planning (able to cause pregnancy, or become pregnant), is enrolled into the program, and is receiving a Family PACT-covered service, claims will be reimbursed. This will not be the case for certain transgender patients who have had gender reassignment surgery that render them incapable of causing pregnancy or becoming pregnant, and therefore, are not eligible to be enrolled into Family PACT, or for services rendered be reimbursable under the program.

For more information, you may refer to the Family PACT Policies, Procedures and Billing Instructions (PPBI) manual, Benefits: Clinical Services Overview section under the header "Transgender Services." The PPBI can be accessed at www.familypact.org, and click on the "Clinical Resources" tab.

Q 3: If a young female patient has not had a sterilization procedure but was told by a previous provider that they are infertile, are they ineligible for FPACT?

A: If the person considers herself incapable of becoming pregnant and has no intention of using contraception, then she has no medical necessity for family planning services and is not eligible for Family PACT. However, if she believes that she has a "minimal-to-low risk" of pregnancy and intends to use contraception to prevent unintended pregnancy, then she does have a medical necessity for family planning services and may be eligible if she meets the other criteria for enrollment.

Q 4: If a patient has had a tubal ligation or vasectomy, can patients qualify for FPACT for STIs? This is a high-volume question that comes up from staff.

A: No. Persons who have had a successful vasectomy, tubal occlusion, hysterectomy, or have undergone menopause are not eligible for Family PACT, as there is no medical necessity for family planning services.

Q 5: What is the age range for male or female patients to be cover by FPACT?

A: The Family PACT program covers individuals that have a medical necessity for family planning (can cause a pregnancy or become pregnant) regardless of age.

Multi-Site GC and CT Screening

Q 6: Does FPACT now cover multiple site testing?

A: Yes. Family PACT (and Medi-Cal) frequency limits for GC/CT are up to three tests per recipient, per day (as of Sept. 2018). REF: PPBI, ben fam, page 54: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/fpact/benfam.pdf.

- Use separate NAAT test kits regardless of genital, anal, or oropharyngeal sample site.
- CPT codes are the same, so label samples clearly.
- Claim must include both the family planning Z-code that identifies the contraceptive method for which the client is being seen and the ICD-10 code corresponding to the indication for screening/ testing on all lab slips.

Q 7: Does FPACT cover test of cure within 30 days of their screening test? Or does the patient need to pay out of pocket?

A: Family PACT covers repeat testing. Clients treated for gonorrhea, trichomonas or chlamydia shall be counseled regarding the importance of repeat testing in three months.

Q 8: Regarding test of cure for pharyngeal gonorrhea, will Family PACT clients have to wait 30 days before re-testing since it is covered every 30 days only?

A: Family PACT (and Medi-Cal) frequency limits for GC/CT are up to three tests per recipient, per day (as of Sept. 2018).

Q 9: If someone had three site screening for gonorrhea / chlamydia, had pharyngeal gonorrhea, and got a test of cure at the pharyngeal 14 days later, would that test of cure test not be covered by Family PACT due to the 3-test limit per month?

A: Family PACT (and Medi-Cal) frequency limits for GC/CT are up to three tests per recipient, per day (as of Sept. 2018).

Q 10: Is a gonorrhea culture (not NAAT) for pharyngeal gonorrhea testing post-treatment covered by FPACT?

A: Not at the current time.

Patient Delivered Partner Therapy (PDPT)

Q 11: Is it true that medical insurance covers up to 5 partners for gonorrhea /chlamydia and that they should be prescribed as refills for patients?

A: It is accurate that Family PACT and Medi-Cal covers Expedited Partner Therapy (EPT) for up to 5 partners. If a Family PACT provider diagnoses a Family PACT client with gonorrhea, chlamydia and/or trichomoniasis and determines that offering the client EPT is medically necessary to prevent reinfection of the client, then the provider may either:

- Dispense medication directly to the Family PACT client to provide to his/her partner(s), or
- Provide the Family PACT client with a prescription, written in the name of the client, for medications with a quantity and duration of therapy sufficient to treat the acute infection in the client and to prevent reinfection of the client by treating the client's partner(s).

For more information, please refer to PPBI, Benefits: Family Planning-Related Services, pages 22-23) and the following site:

https://files.medi-cal.ca.gov/pubsdoco/BULLETINS/artinc/202012/007-30709.01_p01.htm

This may or may not be the case for other health insurance payers, so be sure to check the policy of the patient's private insurance.

Q 12: Should all health practice be able to provide partner treatment?

A: Yes. Even if your practice is unable to dispense medications for partners, you should follow the CDC guidance regarding using the patient's name to prescribe medications for partner treatment.

Q 13: Do private insurers in California cover dosage of drugs for patients to give to partners?

Q 14: Is it an insurance violation to write multiple doses of treatment in the name of the patient you are seeing? Can you clarify?

A: While many commercial health plans do cover patient-delivered partner therapy (PDPT), there is no state or federal requirement that they must do so. Always check the policy of the commercial health plan, which often is available on-line, to determine whether PDPT is a pharmacy benefit of the patient's health plan.

Q 15: When writing prescriptions for expedited partner therapy in the patient's name, do we have to write it all in one prescription ex. Chlamydia: Doxycycline #56 or can do we write it as refills? We're running into problems with pharmacies not dispensing it because they don't want patients to share their bottle with partners.

Q 16: What is the process when pharmacy pushes back and won't dispense prescription?

A: Per Family PACT (and Medi-Cal) policy, the prescription should be "written in the name of the client, for medications with a quantity and duration of therapy sufficient to treat

the acute infection in the client and to prevent reinfection of the client by treating the client's partner(s)."

If the pharmacy objects, you may send them the links to the following policies:

- https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/fpact/benfamrel.pdf (Pages 22-23) This is the Family PACT policy.
- https://files.medi-cal.ca.gov/pubsdoco/BULLETINS/artinc/202012/007-30709.01_p01.htm

Syphilis

Q 17: Does Family PACT cover a treponema pallidum particle agglutination TPPA?

A: Yes, but only as a confirmatory test, not a screening test. Family PACT covers the traditional syphilis screening algorithm, starting with a non-treponemal test (VDRL or RPR; CPT code 86592). ***If positive***, confirmatory tests such as the TP-PA or FTA-ABS (CPT code 86780) are covered, as well as 86593 (Syphilis test, non-treponemal antibody [VDRL or RPR]; *quantitative*) in order to evaluate titers.

Q 18: What are thoughts about screening for Syphilis using a reverse algorithm instead of the traditional method? If a center wanted to implement this would FPACT cover?

A: Family PACT does not cover the reverse algorithm at this time.

Q 19: Does FPACT cover syphilis treatment?

A: Yes. Family PACT cover the one-dose and 3-dose regimens of benzathine penicillin, as well as the doxycycline regimen.

Vaginitis

Q 20: Is FPACT considering ever covering Vaginitis panels that could be performed in house or sent to a lab?

A: Not at the current time and there no plans to add them. Family PACT does cover a variety of diagnostic tests for each type of infectious vaginitis. That being the case, there is no reason to cover "vaginitis panels," which often result in the performance of tests that are not medically indicated.

Q 21: Has the reimbursement for NAAT trichomonas improved to be comparable to the outside lab costs? Previously reimbursement did not cover the outside lab cost.

A: This is not an issue for clinics and office practices because the Trichomonas NAAT test must be performed by a licensed clinical lab that bills Family PACT directly, not a clinic site.

Clinic and office practices can bill Family PACT for certain point-of-care lab tests (see Benefit Grid for specifics) but not for tests that are submitted to, and performed by, a clinical lab.

Other Family PACT Benefits

Q 22: Any update on progress for FPACT to cover metabolic panel and Hep B/C screening to facilitate faster PrEP initiation?

A: PrEP medications, as well as necessary screening and surveillance tests for PrEP use, are not a current Family PACT benefit, nor are there plans to add it.

Q 23: Does Family PACT cover testing and treatment for *Mycoplasma genitalium?*

Q 24: Is FPACT reviewing/planning to cover NAAT testing for *Mycoplasma genitalium*?

A: Family PACT does cover treatment of recurrent urethritis or cervicitis presumed to be due to *Mycoplasma genitalium*.

- PPBI, benfam rel, page 11: Recurrent or persistent nongonococcal urethritis or cervicitis that has not responded to treatment with azithromycin may be treated as presumptive *Mycoplasma genitalium* with oral moxifloxacin 400 mg one tablet daily for seven days. Moxifloxacin is for pharmacy dispensing only and requires a TAR.
- Note that this benefit will be updated soon to be consistent with the 2021 CDC STI Treatment Guidelines that recommend doxycycline mg PO BID for 7 days, then Moxifloxacin 400mg PO once daily for 7 days.
- *M genitalium* NAAT tests are not a benefit currently.

Q 25: Does Family PACT cover Hepatitis screening? Are STI clinics routinely checking for Hep B?

A: The CDC strategy for control of Hepatitis B infection is vaccination, not case finding. The majority of clients seen in a family planning context were vaccinated for Hepatitis B as a part of their adolescent vaccination panel and should not be routinely screened for Hepatitis B, even with a history of high-risk sexual behaviors. Consequently, Family PACT does not cover hepatitis B screening or testing.

If you encounter a client who has not received a hepatitis B vaccination (for example, a recent immigrant from a country where Hep B vaccination is not routine), they should be referred to a community clinic for Hep B vaccination.

Q 26: Is the most recent update to the Benefits grid from 9/2020, or where can the most recent update be found?

A: The Benefits Grid and sections of the PPBI are updated frequently. The upper right-hand corner of *each page* of the Benefits Grid and the PPBI indicates the date that that page was most recently updated. The link to the Family PACT Benefits Grid is:

https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/fpact/bengrid.pdf

Q 27: For the purposes of billing and reimbursement, what part of the "reproductive plan" / 5 Ps is required for documentation?

A: It is expected that a sexual history and information about reproductive intentions will be obtained and documented for Family PACT clients. The CDC "Five Ps" as a technique for obtaining sexual history is a valuable approach. The use of this *specific* tool is not required by Family PACT or Medi-Cal.