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References

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4. Schlabe S, Rockstroh JK. *Expert Opin Pharmacother.* 2018;19(1):49-64.
5. University of Liverpool. HEP Drug Interactions. https://www.hep-druginteractions.org.
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Recommended Follow-up After SVR

AASLD/IDSA Recommendation[1]	Rating
Annual assessment for HCV recurrence is recommended if the patient has **ongoing risk factors** for HCV infection. In such cases, a quantitative HCV RNA test, rather than an HCV antibody test, is recommended.	I, A
For noncirrhotic patients, recommended follow-up is the same as if they were never infected with HCV.	I, B
Surveillance for hepatocellular carcinoma (HCC) is recommended every 6 months for patients with cirrhosis, in accordance with the AASLD guidance on the diagnosis, staging, and management of HCC.	Strong, Moderate
For cirrhotic patients, upper endoscopic surveillance is recommended in accordance with the AASLD guidance on portal hypertension bleeding in cirrhosis.	Guidance
Assessment of other causes of liver disease is recommended for patients who develop persistently abnormal liver tests after achieving SVR.	I, C

www.hcvguidelines.org/evaluate/monitoring

HCV Reinfection in PWID

Realities and Strategies[7]

Acknowledge that there will be cases of HCV reinfection

Apply harm reduction principles

Support harm reduction practices and programs such as: MAT, SSPs

Provide access to HCV retreatment without stigma or discrimination

Encourage treatment of injecting partners

Stay connected with patients after HCV cure for better long-term outcomes

MAT, medication-assisted treatment; SSPs, syringe services programs.

Key Harm Reduction Practices for PWID

Counseling Your Patients[8]

- Avoid contact with any blood; make sure your injecting space is clean
- Use sterile syringes, if possible; if you must reuse, keep a personal syringe
- Know which syringes are yours by marking them before you get off
- If you have to share, clean the needle and syringe thoroughly with bleach and water
- Use an extra sterile syringe to split drugs; use your own cooker and cotton
- Always clean your injection site by using an alcohol pad or soap and water
- Apply gentle pressure to the injection site after you've shot your drugs
- Wash your hands and arms after you inject; you have handled materials that have probably contacted your blood
- Dispose of the syringe in a sharps container
- Take control of your own injection; another person injecting you increases your chance of getting infected
- **Prevent overdose:** Test your product, go slow, and use less. Step up overdose prevention strategies if you're injecting alone.
- **Save a life:** Carry naloxone (Narcan®)

No insurance coverage?

State Medicaid restrictions on HCV treatment?

DON'T LET THE COSTS OF DAA TREATMENT KEEP YOUR PATIENT FROM ACHIEVING HCV CURE

For information on patient assistance programs

Target HIV

Patient Assistance Programs for Hepatitis C Medication Costs

https://targethiv.org/library/aim-hepatitis-c/pap-cap

DAA, direct-acting antiviral agents.

BRIDGEHCV™

BUILDING BRIDGES TO REACH PEOPLE WHO INJECT DRUGS WITH THE GOAL TO ELIMINATE HCV

POCKET GUIDE

Treatment of HCV in People Who Inject Drugs

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Who Should Be Treated?[1]

AASLD/IDSA

Treatment is recommended **for all patients with acute or chronic HCV infection, except those with short life expectancies** that cannot be remediated by treating HCV, by transplantation, or by other directed therapy.

Patients with a short life expectancy owing to liver disease should be managed in consultation with an expert

Rating: Class I, Level A

Direct-acting antiviral (DAA) therapy for people who inject drugs (PWID) is NO different just.

AASLD, American Association for the Study of Liver Diseases; HCV, hepatitis C virus; IDSA, Infectious Diseases Society of America.

Real-World Evidence

Feasibility and Efficacy of Treating HCV in PWID

REALITIES

Baseline drug use

Continued injection drug use during DAA therapy

Concurrent MAT for opioid dependence

HIV/HCV coinfection

EVIDENCE

>95% SVR12 among PWID with recent or ongoing injection drug use[2]

Near-identical SVR12 rates achieved in MAT vs non-MAT PWID[1]

No drug-drug interactions with MAT[3]

No negative impact of HIV/HCV coinfection on SVR[4]

HIV, human immunodeficiency virus; SVR12, sustained virologic response at ≥12 weeks after end of treatment.

AASLD/IDSA–Recommended First-Line DAA Regimens[1,3,a]

Patients With HCV Monoinfection and HCV in HIV/HCV Coinfection

Drug Regimen	Indications in Adults[1,2]	Duration of Treatment
EBR/GZR (Zepatier)	Patients with GT1 or GT4 HCV infection without cirrhosis or with compensated cirrhosis	12–16 weeks
GLE/PIB (Mavyret) Pangenotypic	Patients with GT1–6 HCV infection without cirrhosis or with compensated cirrhosis	8 weeks
LDV/SOF (Harvoni)	Patients with GT1, 4, 5, or 6 HCV infection without cirrhosis or with compensated cirrhosis	8-12 weeks
SOF/VEL (Epclusa) Pangenotypic	Patients with HCV GT1–6 infection without cirrhosis or with cirrhosis (compensated or decompensated)	12 weeks

Please refer to the HCV guidelines for specifics on HCV therapy.

Genotype-Based Guidance

Management of Treatment-Naïve and Treatment-Experienced Patients[1]

Treatment-naïve patients

www.hcvguidelines.org/treatment-naive

Patients in whom prior therapy failed

www.hcvguidelines.org/treatment-experienced

[a]FDA-approved first-line DAA regimens.

EBR, elbasvir; GLE, glecaprevir; GZR, grazoprevir; LDV, ledipasvir; PIB, pibrentasvir; SOF, sofosbuvir; VEL, velpatasvir.

Simplified HCV Treatment for Treatment-Naive Patients Without Cirrhosis[1]

Who Is *NOT* Eligible

Patients who have any of the following characteristics:

- Prior HCV treatment
- Cirrhosis
- Prior liver transplant
- HIV or HBsAg positive
- End-stage renal disease (ie, eGFR <30 mL/min/1.73 m^2)
- Currently pregnant

Pretreatment Assessment

Cirrhosis assessment

Liver biopsy is not required. The cutoffs of the following tests suggest cirrhosis. If any test suggests cirrhosis, treat the patient as having cirrhosis.

- FIB-4 >3.25
- APRI >2.0
- Platelet count <150,000/mm^3
- Fibroscan™ stiffness >12.5 kPa

Medication reconciliation

Potential drug-drug interaction assessment

Patient education

Streamlined pretreatment laboratory testing

Recommended Regimens

Glecaprevir/pibrentasvir x 8 weeks

Sofosbuvir/velpatasvir x 12 weeks

For on-treatment monitoring, posttreatment evaluation, and complete recommendations

https://www.hcvguidelines.org/treatment-naive/simplified-treatment

See HEP Drug Interactions[5]

www.hep-druginteractions.org

APRI, aspartate aminotransferase to platelet ratio index; eGFR, estimated glomerular filtration rate; FIB-4, fibrosis scoring system.

HBsAg-Positive Patients

Pretreatment Considerations for Patients Not Already on HBV Suppressive Therapy

AASLD/IDSA Recommendation[1]	Rating
Patients found or known to be HBsAg-positive should be assessed for whether their HBV DNA level meets AASLD criteria for HBV treatment and initiation of antiviral therapy for HBV.	Strong, Moderate
For HBsAg-positive patients not already receiving HBV suppressive therapy because their baseline HBV DNA level does not meet treatment criteria, one of two approaches may be taken: » Initiate prophylactic antiviral therapy for HBV; continue prophylaxis for 12 weeks after completion of DAA therapy **OR** » Monitor HBV DNA levels during and immediately after DAA therapy for HCV; initiate anti-HBV therapy if >10-fold rise in HBV DNA over baseline, or to >1000 IU in those with previously undetectable or unquantifiable HBV DNA level	IIa, B

See AASLD/IDSA HBV guidance.[6]

https://journals.lww.com/hep/Fulltext/2018/04000/Update_on_prevention,_diagnosis,_and_treatment_of.34.aspx

Patients with HBV/HCV co-infection should be referred to an experienced clinician for treatment.

https://www.hcvguidelines.org/evaluate/monitoring

HBsAg, hepatitis B surface antigen; HBV, hepatitis B virus.

Pregnancy-Related Considerations

Prior to or During HCV Therapies

AASLD/IDSA Recommendation[1]	Rating
All pregnant women should be tested for HCV infection, ideally at the initiation of prenatal care.	IIb, C
For women of reproductive age with known HCV infection, antiviral therapy is recommended ***before*** considering pregnancy, whenever practical and feasible, to reduce the risk of HCV transmission to future offspring.	I, B
Despite the lack of a recommendation, treatment can be considered during pregnancy on an individual basis after a patient-physician discussion about the potential risks and benefits.	
HCV RNA and routine liver function tests are recommended at initiation of prenatal care for HCV-antibody–positive pregnant women to assess the risk of mother-to-child transmission (MTCT) and degree of liver disease.	I, B
All pregnant women with HCV infection should receive prenatal and intrapartum care that is appropriate for their individual obstetric risk(s) as there is no currently known intervention to reduce MTCT.	I, B

See full recommendations for monitoring HCV-infected women during pregnancy.

www.hcvguidelines.org/unique-populations/pregnancy