Management of Unique & Key Populations With HCV Infection

The following pages include guidance for management of patients with HCV in unique and key populations.

- Patients With HIV/HCV Coinfection
- Patients With Decompensated Cirrhosis
- Patients Who Develop Recurrent HCV Infection Post Liver Transplantation
- Patients With Renal Impairment
- Kidney Transplant Patients
- Management of Acute HCV Infection
- HCV in Pregnancy
- HCV in Children

- Key Populations:
  - Identification and Management of HCV in People Who Inject Drugs
  - HCV in Key Populations: Men Who Have Sex With Men
  - HCV Testing and Treatment in Correctional Settings

Last update: May 24, 2018
Patients With HIV/HCV Coinfection

This section provides guidance on the treatment of chronic HCV infection in HIV/HCV-coinfected patients. For individuals with acute HCV infection, please refer to the Acute HCV section. HIV/HCV-coinfected patients suffer from more liver-related morbidity and mortality, nonhepatic organ dysfunction, and overall mortality than HCV-monoinfected patients (Lo Re, 2014); (Chen, 2009). Even in the potent HIV antiretroviral therapy era, HIV infection remains independently associated with advanced liver fibrosis and cirrhosis in patients with HIV/HCV coinfection (Thein, 2008a); (de Ledinghen, 2008); (Fierer, 2013); (Kirk, 2013). As such, treatment of HCV in HIV-infected patients should be a priority for providers, payers, and patients. However, if HCV treatment is delayed for any reason, liver disease progression should be monitored at routine intervals as recommended in the guidance (see When and in Whom to Initiate Therapy, recommendation for repeat liver disease assessment).

Similar to HCV-monoinfected patients, HIV/HCV-coinfected patients cured with peginterferon/ribavirin have lower rates of hepatic decompensation, hepatocellular carcinoma, and liver-related mortality (Berenguer, 2009); (Limketkai, 2012); (Mira, 2013). Uptake of HCV therapy was lower in the HIV/HCV-coinfected population owing to historically lower response rates, patient comorbidities, patient and practitioner perceptions, and adverse events associated with interferon-based therapy (Mehta, 2006a); (Thomas, 2008).

With the availability of HCV direct-acting antivirals (DAAs), efficacy and adverse event rates among those with HIV/HCV coinfection are similar to those observed with HCV monoinfection (Bhattacharya, 2017); (Naggie, 2015); (Sulkowski, 2015); (Wyles, 2015); (Wyles, 2017b) and many prior barriers have diminished. However, treatment of HIV/HCV-coinfected patients requires continued awareness and attention to the complex drug-drug interactions that can occur between DAAs and antiretroviral medications. Drug interactions with DAAs and antiretroviral agents are summarized in the text and tables of this section as well as in the US Department of Health and Human Services HIV treatment guidelines (https://aidsinfo.nih.gov/guidelines). Another resource for screening for drug-drug interactions with DAAs is the University of Liverpool website (www.hep-druginteractions.org).

Risk for Hepatitis B Virus Reactivation

Due to shared modes of transmission, HIV/HCV-coinfected patients are also at risk for hepatitis B virus (HBV) infection. Reactivation of HBV has been reported in patients starting DAA HCV therapy who are not on active HBV agents. Consistent with general recommendations for the assessment of both HIV- and HCV-infected patients, all patients initiating HCV DAA therapy should be assessed for HBV coinfection with HBsAg, anti-HBs, and anti-HBc testing. HIV-infected patients who have evidence of HBV infection should be on antiretroviral agents with activity against HBV, preferably tenofovir disoproxil fumarate or tenofovir alafenamide. For patients who are only anti-HBc positive and not on tenofovir-based antiretroviral therapy, subsequent monitoring for HBV reactivation should be as detailed in the Monitoring section of the guidance.
## Recommendations Related to HCV Medication Interactions With HIV Antiretroviral Medications

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antiretroviral drug switches, when needed, should be done in collaboration with the HIV practitioner. For HIV antiretroviral and HCV direct-acting antiviral combinations not addressed below, expert consultation is recommended.</td>
<td>I, A</td>
</tr>
<tr>
<td><strong>Daclatasvir when used in combination with other antivirals</strong></td>
<td></td>
</tr>
<tr>
<td>Daclatasvir requires dose adjustment with ritonavir-boosted atazanavir (decrease to 30 mg/d), cobicistat-boosted atazanavir (decrease to 30 mg/d), elvitegravir/cobicistat (decrease to 30 mg/d), and efavirenz or etravirine (increase to 90 mg/d).</td>
<td>IIa, B</td>
</tr>
<tr>
<td><strong>Daily fixed-dose combination of elbasvir (50 mg)/grazoprevir (100 mg)</strong></td>
<td></td>
</tr>
<tr>
<td>Elbasvir/grazoprevir should be used with antiretroviral drugs with which it does not have clinically significant interactions: abacavir, emtricitabine, enfuvirtide, lamivudine, raltegravir, dolutegravir, rilpivirine, and tenofovir.</td>
<td>IIa, B</td>
</tr>
<tr>
<td><strong>Daily fixed-dose combination of glecaprevir (300 mg)/pibrentasvir (120 mg)</strong></td>
<td></td>
</tr>
<tr>
<td>Glecaprevir/pibrentasvir should be used with antiretroviral drugs with which it does not have clinically significant interactions: abacavir, emtricitabine, enfuvirtide, lamivudine, raltegravir, dolutegravir, rilpivirine, and tenofovir. Given the limited data on the safety of elvitegravir/cobicistat with glecaprevir/pibrentasvir, monitoring for hepatic toxicity is recommended until additional safety data are available in HIV/HCV-coinfected patients.</td>
<td>IIa, B</td>
</tr>
<tr>
<td><strong>Simeprevir used in combination with other antivirals</strong></td>
<td></td>
</tr>
<tr>
<td>Simeprevir should be used with antiretroviral drugs with which it does not have clinically significant interactions: abacavir, emtricitabine, enfuvirtide, lamivudine, maraviroc, raltegravir, dolutegravir, rilpivirine, and tenofovir.</td>
<td>IIa, B</td>
</tr>
<tr>
<td><strong>Daily fixed-dose combination of sofosbuvir (400 mg)/velpatasvir (100 mg)</strong></td>
<td></td>
</tr>
<tr>
<td>Sofosbuvir/velpatasvir can be used with most antiretrovirals, but not efavirenz, etravirine, or nevirapine. Because velpatasvir has the potential to increase tenofovir levels when given as tenofovir disoproxil fumarate, concomitant use mandates consideration of renal function and should be avoided in those with an eGFR &lt;60 mL/min. Due to limited experience with this drug combination, renal monitoring is recommended during the dosing period. Tenofovir alafenamide may be an alternative to tenofovir disoproxil fumarate during sofosbuvir/velpatasvir treatment for patients who take cobicistat or ritonavir as part of their antiretroviral therapy.</td>
<td>IIa, B</td>
</tr>
<tr>
<td><strong>Daily fixed-dose combination of ledipasvir (90 mg)/sofosbuvir (400 mg)</strong></td>
<td></td>
</tr>
<tr>
<td>Ledipasvir/sofosbuvir can be used with most antiretrovirals. Because this therapy increases tenofovir levels when given as tenofovir disoproxil fumarate, concomitant use mandates consideration of renal function and should be avoided in those with an eGFR &lt;60 mL/min.</td>
<td>IIa, C</td>
</tr>
</tbody>
</table>
## Recommendations Related to HCV Medication Interactions With HIV Antiretroviral Medications

The absolute tenofovir levels are highest, and may exceed exposures for which there are established renal safety data, when tenofovir disoproxil fumarate is administered with ritonavir- or cobicistat-containing regimens. Due to lack of sufficient safety data with this drug combination, consideration should be given to changing the antiretroviral regimen. If the combination is used, renal monitoring is recommended during the dosing period. Tenofovir alafenamide may be an alternative to tenofovir disoproxil fumarate during ledipasvir/sofosbuvir treatment for patients who take cobicistat or ritonavir as part of their antiretroviral therapy.

For combinations expected to increase tenofovir levels, baseline and ongoing assessment for tenofovir nephrotoxicity is recommended.

**Daily fixed-dose combination of paritaprevir (150 mg)/ritonavir (100 mg)/ombitasvir (25 mg) with dasabuvir (600 mg) as part of an extended-release regimen or plus twice-daily dosed dasabuvir (250 mg)**

Paritaprevir/ritonavir/ombitasvir plus dasabuvir should be used with antiretroviral drugs with which they do not have substantial interactions: atazanavir, dolutegravir, emtricitabine, enfuvirtide, lamivudine, raltegravir, and tenofovir.

The dose of ritonavir used for boosting atazanavir should be held when administered with paritaprevir/ritonavir/ombitasvir plus dasabuvir and then restored when HCV treatment is completed. Atazanavir (300 mg) should be administered at the same time as the fixed-dose HCV combination.

**Daily fixed-dose combination of sofosbuvir (400 mg)/velpatasvir (100 mg)/voxilaprevir (100 mg)**

Sofosbuvir/velpatasvir/voxilaprevir should be used with antiretroviral drugs with which they do not have substantial interactions: dolutegravir, emtricitabine, enfuvirtide, lamivudine, rilpivirine, and raltegravir.

Given increases in voxilaprevir AUC with darunavir/ritonavir or elvitegravir/cobicistat coadministration and lack of clinical safety data, monitoring for hepatic toxicity is recommended until additional safety data are available in HIV/HCV-coinfected patients.

Because this therapy has the potential to increase tenofovir levels when given as tenofovir disoproxil fumarate, concomitant use mandates consideration of renal function and should be avoided in those with an eGFR <60 mL/min. In patients receiving sofosbuvir/velpatasvir/voxilaprevir and tenofovir disoproxil fumarate concomitantly, renal monitoring is recommended during the dosing period.

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*a This is a 3 tablet coformulation. Please refer to the prescribing information.*
### Regimens Not Recommended for Patients with HIV/HCV Coinfection

<table>
<thead>
<tr>
<th>Regimen Description</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antiretroviral treatment interruption to allow HCV therapy is <strong>not</strong> recommended.</td>
<td>III, A</td>
</tr>
<tr>
<td>Elbasvir/grazoprevir should <strong>not</strong> be used with cobicistat, efavirenz, etravirine, nevirapine, or any HIV protease inhibitor.</td>
<td>III, B</td>
</tr>
<tr>
<td>Glecaprevir/pibrentasvir should <strong>not</strong> be used with atazanavir, ritonavir-containing antiretroviral regimens, efavirenz, or etravirine.</td>
<td>III, B</td>
</tr>
<tr>
<td>Sofosbuvir/velpatasvir should <strong>not</strong> be used with efavirenz, etravirine, or nevirapine.</td>
<td>III, B</td>
</tr>
<tr>
<td>Sofosbuvir/velpatasvir/voxilaprevir should <strong>not</strong> be used with ritonavir-boosted atazanavir, efavirenz, etravirine, or nevirapine.</td>
<td>III, B</td>
</tr>
<tr>
<td>Sofosbuvir-based regimens should <strong>not</strong> be used with tipranavir.</td>
<td>III, B</td>
</tr>
<tr>
<td>Paritaprevir/ritonavir/ombitasvir plus dasabuvir should <strong>not</strong> be used with darunavir, efavirenz, ritonavir-boosted lopinavir, ritonavir-boosted tipranavir, etravirine, nevirapine, cobicistat, or rilpivirine.</td>
<td>III, B</td>
</tr>
<tr>
<td>Paritaprevir/ritonavir/ombitasvir with or without dasabuvir should <strong>not</strong> be used in HIV/HCV-coinfected individuals who are not taking antiretroviral therapy.</td>
<td>III, B</td>
</tr>
<tr>
<td>Ribavirin should <strong>not</strong> be used with didanosine, stavudine, or zidovudine.</td>
<td>III, B</td>
</tr>
<tr>
<td>Simeprevir should <strong>not</strong> be used with cobicistat, efavirenz, etravirine, nevirapine, or any HIV protease inhibitor.</td>
<td>III, B</td>
</tr>
</tbody>
</table>

### Clinical Trial, Pharmacokinetic, and Drug Interaction Data

Extensive recommendations for antiretroviral therapy use, including for persons anticipating HCV treatment, are available at [jama.jamanetwork.com](http://jama.jamanetwork.com) and [aidsinfo.nih.gov](http://aidsinfo.nih.gov).

Antiretroviral drug switches may be performed to allow compatibility with DAAs with the goal of maintaining HIV suppression without compromising future options. Considerations include prior treatment history, responses to antiretroviral therapy, resistance profiles, and drug tolerance ([Gunthard, 2014](#); [DHHS, 2017](#)). Treatment interruption in HIV/HCV-coinfected individuals is **not** recommended as it is associated with increased cardiovascular events ([SMART, 2006](#)) and increased rates of fibrosis progression and liver-related events ([Tedaldi, 2008](#); [Thorpe, 2011](#)). The availability of multiple effective HCV DAA and HIV antiretroviral regimens makes it possible for all HIV/HCV-coinfected patients to safely and successfully receive HCV treatment. Switching an optimized antiretroviral regimen carries risks, including adverse effects and HIV viral breakthrough ([Eron, 2010](#)). HIV viral breakthrough is a particular concern for those with substantial antiretroviral experience or known resistance to antiretroviral drugs. If necessary, antiretroviral therapy switches should be done in close collaboration with the treating HIV provider prior to HCV treatment initiation.

Although fewer HIV/HCV-coinfected patients than HCV-monoinfected patients have been treated in DAA trials, efficacy rates to date have been remarkably similar between the groups ([Sulkowski, 2013](#); [Sulkowski, 2014](#); [Dieterich, 2014b](#); [Rodriguez-Torres, 2015](#); [Osinusi, 2015](#); [Sulkowski, 2015](#); [Dieterich, 2015](#); [Naggie, 2015](#); [Wyles, 2015](#)). Thus, results from HCV monoinfection studies largely justify the recommendations for HIV/HCV coinfection (discussed in the Initial Treatment and Retreatment sections). Discussion specific to studies of HIV/HCV coinfection is included here.
**Daclatasvir + Sofosbuvir**

The phase 3 ALLY-2 study evaluated the 12-week regimen of daclatasvir plus sofosbuvir in patients with HIV/HCV coinfection with genotype 1, 2, 3, or 4 (Wyles, 2015). This open-label clinical trial enrolled both treatment-naive (n=151) and -experienced (n=52) HIV/HCV-coinfected patients. Treatment-naive patients were randomly assigned (2:1), with stratification by cirrhosis status and genotype, to receive 12 weeks or 8 weeks of once-daily daclatasvir (60 mg dose adjusted based on antiretroviral regimen) and sofosbuvir (400 mg). Treatment-experienced patients received daclatasvir and sofosbuvir for 12 weeks. Genotype distribution was 83%, 9%, 6%, and 2% of patients, respectively, for genotype 1, 2, 3, and 4 HCV infection; 14% of all participants had compensated cirrhosis. Antiretroviral drugs allowed were ritonavir-boosted darunavir, atazanavir, or lopinavir, efavirenz, nevirapine, rilpivirine, raltegravir, and dolutegravir.

The combination of daclatasvir and sofosbuvir once daily for 12 weeks achieved SVR12 in 97% of HIV/HCV-coinfected patients with genotype 1, 2, 3, or 4 infection, and was safe and well tolerated. Ninety-seven percent of treatment-naive patients and 98% of treatment-experienced patients achieved SVR. However, among patients who received 8 weeks of therapy, only 76% of patients achieved SVR. Factors associated with relapse in this patient group included high baseline HCV RNA level (>2 million IU/mL; 69%), concomitant use of a boosted darunavir-based antiretroviral regimen with 30 mg of daclatasvir (67%), and the presence of compensated cirrhosis (60%).

**Pharmacology and Drug Interaction Data**

Daclatasvir is metabolized by cytochrome P450 (CYP) 3A4 and is therefore susceptible to drug interactions with potent inducers and inhibitors of this enzyme (Eley, 2014). The dose of daclatasvir should be increased from 60 mg to 90 mg when used with efavirenz, etravirine, or nevirapine (Bifano, 2013). The dose of daclatasvir should be decreased from 60 mg to 30 mg when used with ritonavir-boosted atazanavir, cobicistat-boosted atazanavir, or elvitegravir/cobicistat (Smolders, 2017). A daclatasvir dose of 60 mg should be used with ritonavir-boosted darunavir and ritonavir-boosted lopinavir (Gandhi, 2015).

**Elbasvir/Grazoprevir**

The safety, tolerability, and efficacy of the second-generation NS3/4A serine protease inhibitor grazoprevir (MK-5172) plus the NS5A inhibitor elbasvir (MK-8742) were assessed in patients with HIV/HCV coinfection in the C-EDGE COINFECTION study. C-EDGE COINFECTION was a phase 3, nonrandomized, open-label, single-arm study in which treatment-naive patients with genotype 1, 4, or 6 infection and HIV coinfection, with or without compensated cirrhosis, were enrolled in Europe, the US, and Australia (Rockstroh, 2015). All patients were either naive to treatment with any antiretroviral therapy (ART) with a CD4 cell count >500/mm$^3$ (n=7), or stable on current ART for at least 8 weeks with a CD4 cell count >200/mm$^3$ (n=211) and undetectable HIV RNA. All 218 enrolled patients received the once-daily fixed-dose combination of elbasvir (50 mg) plus grazoprevir (100 mg) for 12 weeks. All 218 patients completed follow-up at week 12. The median baseline CD4 cell count was 568 (424-626)/mm$^3$. Limited antiretrovirals were allowed, specifically a nucleoside/nucleotide backbone of abacavir (21.6%) versus tenofovir (75.2%), in combination with raltegravir (52%), dolutegravir (27%), or rilpivirine (17%).

SVR12 was achieved by 96% (210/218) of patients (95% CI, 92.9-98.4). One patient did not achieve SVR12 for a nonvirologic reason and 7 patients without cirrhosis relapsed (2 subsequently confirmed as reinfections, highlighting the requirement of continued harm-reduction strategies after SVR). Thirty-five patients with compensated cirrhosis achieved SVR12. The most common adverse events were fatigue (13%; 29), headache (12%; 27), and nausea (9%; 20). No patient discontinued treatment because of an adverse event. Three out of 6 patients who relapsed before SVR12 had NS3 and/or NS5A resistance-associated substitutions (RASs) while the others had wild type virus at the time of relapse. Two patients receiving ART had transient HIV viremia but subsequently returned to undetectable levels without a change in ART. No significant changes were observed with CD4 cell counts or new opportunistic infections. Elbasvir/grazoprevir without ribavirin seems to be effective and well tolerated among patients coinfected with HIV, with or without compensated cirrhosis. These data are consistent with previous trials of this regimen in the monoinfected population (Zeuzem, 2017).
Pharmacology and Drug Interaction Data

Elbasvir is a substrate for CYP3A4 and the efflux transporter P-glycoprotein (P-gp). Grazoprevir is a substrate for CYP3A4, P-gp, and the liver uptake transporter OATP1B1. Moderate and strong CYP3A and P-gp inducers (including efavirenz) are not recommended for coadministration with elbasvir/grazoprevir. OATP1B1 inhibitors are also not recommended with grazoprevir.

Elbasvir/grazoprevir is not compatible with any ritonavir- or cobicistat-boosted HIV protease inhibitor, elvitegravir/cobicistat, efavirenz, or etravirine (Feng, 2016).

Glecaprevir/Pibrentasvir

The safety and efficacy of glecaprevir (ABT-493), a pangenotypic NS3/4A protease inhibitor, coformulated with pibrentasvir (ABT-530), a pangenotypic NS5A inhibitor, were evaluated in the phase 3, multicenter EXPEDITION-2 study (Rockstroh, 2017). This study evaluated 8 weeks of the daily fixed-dose combination of glecaprevir (300 mg)/pibrentasvir (120 mg) administered as three 100 mg/40 mg fixed-dose combination pills in 137 HIV/HCV-coinfected adults without cirrhosis and 12 weeks of glecaprevir/pibrentasvir in 16 HIV/HCV-coinfected patients with compensated cirrhosis. Treatment-naive and -experienced patients with genotype 1, 2, 3, 4, or 6 infection were enrolled. Patients were either antiretroviral naive with a CD4 cell count ≥500/mm$^3$, or on a stable ART regimen for at least 8 weeks with a CD4 cell count ≥200/mm$^3$. ART drugs included raltegravir, dolutegravir, rilpivirine, tenofovir disoproxil fumarate, tenofovir alafenamide, abacavir, emtricitabine, and lamivudine. One patient received elvitegravir/cobicistat. Overall SVR12 was 98% (136/136 among those without cirrhosis on the 8-week regimen, and 14/15 in those with compensated cirrhosis on the 12-week regimen). Four serious adverse events were reported, none of which were DAA related. One of these led to treatment discontinuation.

Pharmacology and Drug Interaction Data

Glecaprevir and pibrentasvir area under the curve (AUC) are increased roughly 3-fold and 1.57-fold, respectively, with tenofovir alafenamide/emtricitabine/elvitegravir/cobicistat (Koslowski, 2017). Only 1 patient received this combination in the EXPEDITION-2 study. Although the increases in AUC of glecaprevir and pibrentasvir when coadministered with elvitegravir/cobicistat are not considered clinically relevant by the manufacturer or the US Food and Drug Administration (FDA), due to lack of sufficient clinical safety data, close monitoring for hepatic toxicity is recommended until additional safety data are available in HIV/HCV-coinfected patients. Consider liver enzyme testing every 4 weeks. Ritonavir-boosted protease inhibitors are not recommended with glecaprevir/pibrentasvir.

Glecaprevir and pibrentasvir AUCs are reduced 25% and 27%, respectively, with abacavir/lamivudine/dolutegravir. These reductions are unlikely to have clinical relevance. Raltegravir and rilpivirine AUCs are increased 47% and 84%, respectively, with glecaprevir/pibrentasvir (Oberoi, 2016). These interactions do not require dose adjustment. Forty-five and 32 individuals received raltegravir or rilpivirine, respectively, in the EXPEDITION-2 study.

Glecaprevir absorption is pH dependent and glecaprevir exposures are reduced approximately 50% with 40 mg of omeprazole daily.

Ledipasvir/Sofosbuvir

The safety and efficacy of 12 weeks of ledipasvir/sofosbuvir were evaluated in the phase 2, single-center, open-label ERADICATE trial, which included 50 HIV/HCV-coinfected patients with genotype 1 infection who were treatment naive without cirrhosis (Osinusi, 2015). Thirteen patients were not receiving antiretroviral therapy and 37 patients were on protocol-allowed medications (tenofovir, emtricitabine, rilpivirine, raltegravir, and efavirenz). Although the inclusion criteria for patients receiving antiretroviral therapy allowed CD4 cell counts >100/mm$^3$, the median CD4 cell count was 576/mm$^3$. Overall, 98% achieved SVR12 (13/13 in the treatment-naive arm and 36/37 in the treatment-experienced arm). There were no deaths, discontinuations, or clinically significant, serious adverse events. Renal function was monitored frequently.
during this trial and after administration of study drugs using a battery of tests (serum creatinine, eGFR, urinary beta-2 microglobulin, and urine protein and glucose). No clinically significant changes in these parameters or renal toxicity were observed.

A larger study, ION-4, reported similar outcomes with ledipasvir/sofosbuvir (Naggie, 2015). A total of 335 HCV treatment-naive and -experienced HIV/HCV-coinfected patients were enrolled in the study and received ledipasvir/sofosbuvir once daily for 12 weeks. Patients received tenofovir disoproxil fumarate and emtricitabine with raltegravir (44%), efavirenz (48%), or rilpivirine (9%). Genotypes included were 1a (75%), 1b (23%), and 4 (2%). Twenty percent of patients had compensated cirrhosis, 34% were black, and 55% had not responded to prior HCV treatment. The overall SVR12 rate was 96% (321/335). Two patients had on-treatment virologic failure judged to be a result of nonadherence, 10 had virologic relapse after discontinuing treatment, 1 died from endocarditis associated with injection drug use, and 1 was lost to follow-up. SVR12 rates were 94% (63/67) among patients with compensated cirrhosis and 97% (179/185) among treatment-experienced patients. No patients discontinued the study drugs because of an adverse event. Although all patients had an eGFR >60 mL/min at study entry, drug interaction studies suggested that patients receiving tenofovir disoprolx fumarate could have increased tenofovir levels. There were 4 patients in whom serum creatinine level rose to ≥0.4 mg/dL. Two remained on tenofovir disoproxil fumarate, 1 had the tenofovir disoproxil fumarate dose reduced, and the other stopped taking tenofovir disoproxil fumarate.

Neither the ERADICATE nor the ION-4 study investigators reported clinically significant changes in CD4 cell counts or HIV RNA levels in the study participants. Thus, these data suggest that 12 weeks of ledipasvir/sofosbuvir is a safe and effective regimen for HIV/HCV-coinfected patients with genotype 1 infection taking selected antiretroviral therapy (Osinusi, 2015); (Naggie, 2015). There are limited data regarding an 8-week course of ledipasvir/sofosbuvir in HIV/HCV-coinfected patients (Ingiliz, 2016). Additionally, clinical trial data of daclatasvir (an NS5A inhibitor similar to ledipasvir) plus sofosbuvir in HIV/HCV-coinfected patients demonstrated a lower SVR rate (76%) with 8 weeks of treatment compared to 12 weeks of therapy (97%). Therefore, a shortened treatment course for HIV/HCV-coinfected persons cannot be recommended at this time.

Pharmacology and Drug Interaction Data

Drug interaction studies of ledipasvir (with or without sofosbuvir) with antiretroviral drugs in uninfected persons did not identify clinically significant interactions with abacavir, dolasetravigra, emtricitabine, lamivudine, raltegravir, or rilpivirine (German, 2014); (Garrison, 2015). Interactions with maraviroc and enfuvirtide are not expected based on their pharmacologic profiles. Ledipasvir AUC is decreased by 34% when coadministered with efavirenz-containing regimens and increased by 96% when coadministered with ritonavir-boosted atazanavir (German, 2014). No dose adjustments of ledipasvir are recommended to account for these interactions.

Ledipasvir absorption is pH dependent. Refer to product labeling for guidance on temporal separation and dosing of gastric acid modifying agents.

Ledipasvir/sofosbuvir increases tenofovir levels when given as tenofovir disoproxil fumarate, which may increase the risk of tenofovir-associated renal toxicity. This combination should be avoided in patients with an eGFR <60 mL/min. With the addition of ledipasvir/sofosbuvir, tenofovir levels (when given as tenofovir disoproxil fumarate) are increased with efavirenz, rilpivirine (German, 2014), dolasetravigra, ritonavir-boosted atazanavir, and ritonavir-boosted darunavir (German, 2015). The absolute tenofovir levels are highest, and may exceed exposures for which there are established renal safety data, when tenofovir disoproxil fumarate is administered with ritonavir- or cobicistat-containing regimens. Due to lack of sufficient safety data with this drug combination, consideration should be given to changing the antiretroviral regimen. Tenofovir alafenamide may be an alternative to tenofovir disoproxil fumarate during ledipasvir/sofosbuvir treatment for patients who take cobicistat or ritonavir as part of their antiretroviral therapy.

In patients with an eGFR <60 mL/min who are taking tenofovir disoproxil fumarate with ledipasvir/sofosbuvir, renal parameters should be checked at baseline and at the end of treatment. Baseline parameters should include measuring creatinine level, electrolytes (including phosphorus), and urinary protein and glucose, according to recent guidelines for the management of chronic kidney disease in those with HIV, which include indications for nephrology consultation (Lucas, 2014). Changing antiretroviral therapy may be considered for those at high risk for renal toxicity—especially those with an eGFR between 30 mL/min and 60 mL/min or who have preexisting evidence of Fanconi syndrome, and particularly...
those taking tenofovir disoproxil fumarate and a ritonavir- or cobicistat-containing regimen. Tenofovir disoproxil fumarate should also be properly dosed and adjusted for eGFR at baseline and while on therapy (Lucas, 2014).

Although there is an absence of data at this time on the renal safety of tenofovir when given as tenofovir alafenamide with ledipasvir/sofosbuvir, a study of tenofovir pharmacokinetics in healthy volunteers receiving the combination of tenofovir alafenamide, emtricitabine, and cobicistat-boosted elvitegravir with ledipasvir/sofosbuvir found that tenofovir levels were only 20% of the typical tenofovir exposures seen with tenofovir disoproxil fumarate (Garrison, 2015). Based on these pharmacokinetic data in healthy volunteers, tenofovir alafenamide may be an alternative to tenofovir disoproxil fumarate during ledipasvir/sofosbuvir treatment for patients on ritonavir- or cobicistat-containing regimens.

**Paritaprevir/Ritonavir/Ombitasvir + Dasabuvir**

Paritaprevir/ritonavir/ombitasvir plus dasabuvir was approved by the FDA for use in genotype 1a and 1b infection because of its efficacy and safety in treatment-naive patients and peginterferon/ribavirin treatment-experienced patients, with or without compensated cirrhosis. Available information about response rates with this regimen in HIV/HCV-coinfected patients comes from the first part of the phase 2 TURQUOISE-1 study. In this study, treatment-naive (n=42) and -experienced (n=21) patients were randomly assigned to 12 weeks or 24 weeks of paritaprevir/ritonavir/ombitasvir plus dasabuvir and weight-based ribavirin (100 mg [<75 kg] to 1200 mg [≥75 kg]). Of the 63 study participants, 12 had compensated cirrhosis, 56 had genotype 1a infection, and 7 had genotype 1b infection. Two study-permitted antiretroviral regimens were chosen based on pharmacokinetic data from uninfected volunteers; 35 patients entered taking tenofovir disoproxil fumarate and emtricitabine with raltegravir, and 28 patients entered taking tenofovir disoproxil fumarate and emtricitabine with ritonavir-boosted atazanavir (with the ritonavir coming from the HCV regimen during the time of coadministration). Of the 31 patients who received 12 weeks of paritaprevir/ritonavir/ombitasvir plus dasabuvir and ribavirin, 93.5% (29/31) achieved SVR12, 1 relapsed, and 1 withdrew consent from study participation. Among the 32 patients in the 24-week arm, 90.6% (29/32) achieved SVR12, 1 experienced viral breakthrough, and 2 had apparent HCV reinfection. No treatment-related serious adverse events occurred, and no patients discontinued treatment because of medication intolerance (Sulkowski, 2015).

**Pharmacology and Drug Interaction Data**

Paritaprevir is an inhibitor of the hepatic uptake transporter OATP1B1. Ritonavir is coformulated with paritaprevir and ombitasvir to improve the pharmacokinetics of paritaprevir. As ritonavir has anti-HIV activity, HIV/HCV-coinfected patients should have achieved HIV RNA suppression with an ART regimen prior to initiation of this DAA therapy. Those not taking antiretroviral therapy should not receive this fixed-dose combination due to the potential for low-dose ritonavir to select for HIV protease-inhibitor resistance.

Ritonavir-boosted paritaprevir, ombitasvir, and dasabuvir are metabolized by and inhibitors of CYP enzymes (3A4 and 2C8), P-gp, BCRP, and OATP1B1. Studies of uninfected volunteers did not reveal notable pharmacologic interactions with paritaprevir (150 mg), ritonavir (100 mg), and ombitasvir (25 mg) plus dasabuvir (250 mg), or tenofovir disoproxil fumarate and emtricitabine (when tested separately from other fixed-dose combinations), raltegravir (Menon, 2015), abacavir, lamivudine, or dolutegravir (Khatri, 2015). In uninfected volunteers, when paritaprevir/ritonavir/ombitasvir plus dasabuvir was combined with efavirenz, emtricitabine, and tenofovir disoproxil fumarate, clinically significant gastrointestinal and neurologic adverse events occurred, coincident with elevations of alanine aminotransferase levels. When paritaprevir/ritonavir/ombitasvir plus dasabuvir was combined with rilpivirine, exposures to rilpivirine were substantially increased. Therefore, rilpivirine and efavirenz should not be used with paritaprevir/ritonavir/ombitasvir plus dasabuvir.

Because ritonavir is a component of the fixed-dose combination of paritaprevir and ombitasvir, the total daily dose of ritonavir must be carefully considered when using paritaprevir/ritonavir/ombitasvir plus dasabuvir with ritonavir-boosted HIV protease inhibitors. Coadministration with ritonavir-boosted lopinavir would result in a 300 mg daily dose of ritonavir, a dose associated with substantial gastrointestinal adverse effects; this combination is not recommended. In uninfected individuals, darunavir troughs are reduced with paritaprevir/ritonavir/ombitasvir plus dasabuvir. Thus, paritaprevir/ritonavir/ombitasvir plus dasabuvir should not be used with ritonavir-boosted darunavir.
Paritaprevir/ritonavir/ombitasvir plus dasabuvir can be given with atazanavir but the separate ritonavir-boosting tablet should be held during paritaprevir/ritonavir/ombitasvir plus dasabuvir therapy, and atazanavir (300 mg) should be administered at the same time as the fixed-dose combination of ritonavir-boosted paritaprevir and ombitasvir. Paritaprevir levels are increased 1.5- to 3-fold with atazanavir but no dose adjustment of paritaprevir is recommended (Khatri, 2016). Inhibition of OATP1B1 by paritaprevir/ritonavir/ombitasvir plus dasabuvir increases indirect bilirubin concentrations and this effect may be attenuated in individuals taking atazanavir (Eron, 2014).

Simeprevir + Sofosbuvir

The combination of simeprevir plus sofosbuvir, with or without ribavirin, has been studied in the phase 2 COSMOS trial in patients with HCV monoinfection (Lawitz, 2014b). This study is the main basis for the recommendation supporting use of this combination for genotype 1a or 1b monoinfection. Simeprevir plus sofosbuvir has been used anecdotally in patients with HIV/HCV co-infection, with a recent report of achieving SVR in 92% (11/12) of patients (Del Bello, 2016). Despite the dearth of study data, this regimen may be considered for the treatment of genotype 1 infection in patients with HIV/HCV coinfection who are receiving an antiretroviral therapy regimen that may be coadministered with simeprevir plus sofosbuvir.

Similarly, few data exist for the combination of sofosbuvir plus simeprevir for the retreatment of HCV infection in HIV/HCV-coinfected patients. However, preliminary results obtained for HCV-monoinfected patients, including those with prior treatment failure and advanced fibrosis, support the expectation that this regimen will be highly effective in HIV/HCV-coinfected patients receiving compatible antiretroviral therapy (see Retreatment section) (Lawitz, 2014b).

Pharmacology and Drug Interaction Data

Simeprevir is metabolized primarily by CYP3A4 and is therefore susceptible to drug interactions with inhibitors and inducers of this enzyme. Simeprevir is also an inhibitor of OATP1B1 and P-gp. Drug interaction studies with antiretroviral drugs in HIV-uninfected volunteers suggest no substantial interactions with tenofovir, rilpivirine, dolutegravir, or raltegravir. However, simeprevir concentrations were substantially decreased when dosed with efavirenz, and substantially increased when dosed with ritonavir-boosted darunavir (MacBrayne, 2017). Use with efavirenz, etravirine, cobicistat, or boosted HIV protease inhibitors is not recommended (Ouwerkerk-Mahadevan, 2016).

Sofosbuvir/Velpatasvir

The safety and efficacy of 12 weeks of sofosbuvir/velpatasvir were evaluated in a phase 3 study among 106 antiretroviral-controlled, HIV/HCV-coinfected patients (Wyles, 2016). Patients with genotype 1, 2, 3, or 4 infection were included; 18% (19/106) had compensated cirrhosis. HIV was controlled on ART including non-nucleoside reverse-transcriptase inhibitor- (rilpivirine), integrase inhibitor- (raltegravir or elvitegravir/cobicistat), or ritonavir-boosted protease inhibitor- (atazanavir, lopinavir, or darunavir) based regimens with either tenofovir/emtricitabine or abacavir/lamivudine. Fifty-three percent (56/106) of participants were on tenofovir disoproxil fumarate with a pharmacologic boosting agent (either ritonavir or cobicistat). Neither efavirenz nor etravirine were allowed in this study as concomitant dosing with sofosbuvir/velpatasvir in healthy volunteers resulted in clinically significant decreases in velpatasvir exposure. SVR12 was 95% with 2 relapses, both occurring in genotype 1a-infected patients. Similar results were noted in patients with compensated cirrhosis and in those with baseline NS5A RASs (n=12 at 15% threshold; SVR12=100%). There were no clinically significant changes in serum creatinine or eGFR, and no patients required a change in their antiretroviral therapy during the study period.

In general, few HIV/HCV-coinfected patients with compensated cirrhosis have been included in clinical trials of DAAs, and no data are available regarding HIV/HCV-coinfected patients with renal insufficiency or who have undergone solid organ transplantation. Despite a lack of data, it is highly likely that response rates are similar to those of HCV-monoinfected patients, as no study to date in the DAA era has showed a lower efficacy for HIV/HCV-coinfected patients. Therefore, the respective guidance from these sections should be followed if treatment is otherwise warranted, with consideration of drug interactions.
Pharmacology and Drug Interaction Data

Velpatasvir is available only in a fixed-dose combination tablet with sofosbuvir. Velpatasvir is metabolized by CYP3A4, CYP2C8, and CYP2B6. It does not appear to inhibit or induce any CYP enzymes. Velpatasvir is a substrate for P-gp and BCRP, and inhibits P-gp, BCRP, and OATP1B1/1B3 but does not induce any transporters.

Velpatasvir absorption is pH dependent. Refer to product labeling for guidance on temporal separation and dosing of gastric acid modifying agents.

Drug interaction studies with sofosbuvir/velpatasvir have been performed in HIV and HCV seronegative volunteers. As with ledipasvir/sofosbuvir, tenofovir exposures are increased, which may be problematic for individuals with an eGFR <60 mL/min or in those receiving ritonavir- or cobicistat-containing antiretroviral therapy with tenofovir disoproxil fumarate. Fifty-six HIV/HCV-coinfected individuals receiving the combination of tenofovir disoproxil fumarate with ritonavir- or cobicistat-containing antiretroviral therapy were treated with sofosbuvir/velpatasvir in the ASTRAL-5 study with no difference in median creatinine clearance before and after sofosbuvir/velpatasvir treatment (but poor renal function was an exclusion for this study) (Wyles, 2017b). In individuals with an eGFR <60 mL/min, consider use of tenofovir alafenamide in place of tenofovir disoproxil fumarate in those requiring ritonavir- or cobicistat-containing antiretroviral therapy. If the combination of tenofovir disoproxil fumarate with a ritonavir- or cobicistat-containing antiretroviral therapy is required in patients with an eGFR <60 mL/min, renal parameters should be checked at baseline and regularly thereafter while on sofosbuvir/velpatasvir.

Velpatasvir exposures are significantly reduced with efavirenz and this combination is not recommended. Etravirine has not been studied with sofosbuvir/velpatasvir and is also not recommended. Indirect bilirubin level increases have been reported when sofosbuvir/velpatasvir was used in patients on atazanavir/ritonavir. These changes are not considered clinically significant.

Based on data from healthy volunteers, tenofovir pharmacokinetics are lower with tenofovir alafenamide relative to tenofovir disoproxil fumarate. Thus, tenofovir alafenamide may be an alternative to tenofovir disoproxil fumarate during sofosbuvir/velpatasvir treatment for patients who take cobicistat or ritonavir as part of their antiretroviral therapy. However, there are no safety data for this combination in HIV/HCV-coinfected patients.

Sofosbuvir/Velpatasvir/Voxilaprevir

The data supporting use of sofosbuvir/velpatasvir/voxilaprevir are described in the Initial Treatment of HCV Infection and Retreatment of Persons in Whom Prior Therapy Has Failed sections of the guidance. This regimen has not been studied in HIV/HCV-coinfected patients. Despite a lack of data, it is highly likely that response rates in HIV/HCV-coinfected patients will be similar to those of HCV-monoinfected patients, as no study to date in the DAA era has shown a lower efficacy for HIV/HCV-coinfected patients. Therefore, the respective guidance from the aforementioned treatment and retreatment sections of the guidance should be followed, with consideration of drug-drug interactions.

Pharmacology and Drug Interaction Data

Voxilaprevir is a substrate for P-gp, OATP, BCRP, CYP3A, CYP1A2, and CYP2C8. Voxilaprevir inhibits OATP, P-gp, and BCRP. Voxilaprevir AUC is increased 331% with ritonavir-boosted atazanavir and this combination is not recommended (Garrison, 2017). Voxilaprevir AUC is increased 171% with tenofovir alafenamide/emtricitabine/elvitegravir/cobicistat, and 143% with tenofovir disoproxil fumarate/emtricitabine and ritonavir-boosted darunavir. Although these increases in voxilaprevir AUC were not deemed clinically relevant by the manufacturer or the FDA, due to lack of clinical safety data, close monitoring for hepatic toxicity is recommended until additional safety data are available in HIV/HCV-coinfected patients. Consider liver enzyme testing every 4 weeks.

Tenofovir concentrations are increased with sofosbuvir/velpatasvir/voxilaprevir when given as tenofovir disoproxil fumarate (Garrison, 2017). In individuals with an eGFR <60 mL/min, consider use of tenofovir alafenamide in place of
tenofovir disoproxil fumarate in those requiring ritonavir- or cobicistat-containing antiretroviral therapy. No substantial interactions were observed with dolutegravir, emtricitabine, raltegravir, or rilpivirine.

Velpatasvir absorption is pH dependent. Velpatasvir AUC is reduced approximately 50% when given with omeprazole 20 mg daily as part of the fixed-dose sofosbuvir/velpatasvir/voxilaprevir combination. Refer to product labeling for guidance on temporal separation and dosing of gastric acid modifying agents.

Table 1.
Drug Interactions Between Direct-Acting Antivirals and Antiretroviral Drugs—Recommended Regimens
Green indicates coadministration is safe; yellow indicates a dose change or additional monitoring is warranted; and pink indicates the combination should be avoided.

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ritonavir-boosted atazanavir (ATZ)</td>
<td>▲ LDV ▲ ATZ&lt;sup&gt;a&lt;/sup&gt;</td>
<td>▲ VEL ▲ ATZ&lt;sup&gt;a&lt;/sup&gt;</td>
<td>▲ ELB ▲ GRZ ▲ ATZ</td>
<td>▲ GLE ▲ ATZ ▲ ATZ</td>
<td>▲ VOX ▲ ATZ</td>
</tr>
<tr>
<td>Ritonavir-boosted darunavir (DRV)</td>
<td>▲ LDV ▲ DRV&lt;sup&gt;a&lt;/sup&gt;</td>
<td>▲ VEL ▲ DRV&lt;sup&gt;a&lt;/sup&gt;</td>
<td>▲ ELB ▲ GRZ ▲ DRV</td>
<td>▲ GLE ▲ DRV ▲ DRV</td>
<td>▲ VOX ▲ DRV</td>
</tr>
<tr>
<td>Ritonavir-boosted lopinavir (LPV)</td>
<td>ND&lt;sup&gt;a&lt;/sup&gt;</td>
<td>▲ VEL ▲ LPV&lt;sup&gt;a&lt;/sup&gt;</td>
<td>▲ ELB ▲ GRZ ▲ LPV</td>
<td>▲ GLE ▲ PIB ▲ LPV</td>
<td>ND</td>
</tr>
<tr>
<td>Ritonavir-boosted tipranavir (TPV/r)</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
</tr>
<tr>
<td>Efavirenz (EFV)</td>
<td>▲ LDV ▲ EFV&lt;sup&gt;a&lt;/sup&gt;</td>
<td>▲ VEL ▲ EFV</td>
<td>▲ ELB ▲ GRZ ▲ EFV</td>
<td>ND</td>
<td>ND</td>
</tr>
<tr>
<td>Rilpivirine (RPV)</td>
<td>▲▲ LDV ▲▲ RPV</td>
<td>▲▲ VEL ▲▲ RPV</td>
<td>▲▲ ELB ▲▲ GRZ ▲▲ RPV</td>
<td>▲▲ GLE ▲▲ PIB ▲▲ RPV</td>
<td>▲▲ VOX ▲▲ RPV</td>
</tr>
<tr>
<td>Etravirine (ETV)</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
</tr>
<tr>
<td>Raltegravir (RAL)</td>
<td>▲▲ LDV ▲▲ RAL</td>
<td>▲▲ VEL ▲▲ RAL</td>
<td>▲▲ ELB ▲▲ GRZ ▲▲ RAL</td>
<td>▲▲ GLE ▲▲ PIB ▲▲ RAL</td>
<td>ND</td>
</tr>
<tr>
<td>Cobicistat-boosted elvitegravir (COB)</td>
<td>▲ LDV ▲ COB&lt;sup&gt;a&lt;/sup&gt;</td>
<td>▲ VEL ▲ COB&lt;sup&gt;a&lt;/sup&gt;</td>
<td>▲ ELB ▲ GRZ ▲ COB</td>
<td>▲ GLE ▲ PIB ▲ COB</td>
<td>▲ VOX ▲ COB&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Dolutegravir (DTG)</td>
<td>▲▲ LDV ▲▲ DTG</td>
<td>▲▲ VEL ▲▲ DTG</td>
<td>▲▲ ELB ▲▲ GRZ ▲▲ DTG</td>
<td>▲ GLE ▲ PIB ▲ DTG</td>
<td>ND</td>
</tr>
<tr>
<td>Tenofovir</td>
<td>▲ LDV</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>▲▲ VOX</td>
</tr>
</tbody>
</table>
### Table 2. Drug Interactions Between Direct-Acting Antivirals and Antiretroviral Drugs—Alternative Regimens

Green indicates coadministration is safe; yellow indicates a dose change or additional monitoring is warranted; and pink indicates the combination should be avoided.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alafenamide (TAF)/ Emtricitabine (FTC)/ Bictegravir (BIC)</td>
<td>▲ BIC</td>
<td></td>
<td></td>
<td>▲ BIC</td>
<td></td>
</tr>
<tr>
<td>Maraviroc (MVC)</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
</tr>
<tr>
<td>Tenofovir (TFV) disopropil fumarate</td>
<td>▲ LDV ▲ TFV&lt;sup&gt;c&lt;/sup&gt;</td>
<td>▲ VEL ▲ TFV&lt;sup&gt;b&lt;/sup&gt;</td>
<td>▲ ELB ▲ GRZ ▲ TFV</td>
<td>▲ TFV</td>
<td>▲ TFV&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Tenofovir (TFV) alafenamide</td>
<td>▲ LDV ▲ TFV&lt;sup&gt;d&lt;/sup&gt;</td>
<td>▲ VEL ▲ TFV&lt;sup&gt;d&lt;/sup&gt;</td>
<td>ND</td>
<td>▲ TFV</td>
<td>▲ TFV&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

ND, No data

<sup>a</sup> Caution only with tenofovir disopropil fumarate

<sup>b</sup> Increase in tenofovir depends on which additional concomitant antiretroviral agents are administered.

<sup>c</sup> Avoid tenofovir disopropil fumarate in patients with an eGFR <60 mL/min; tenofovir concentrations may exceed those with established renal safety data in individuals on ritonavir- or cobicistat-containing regimens.

<sup>d</sup> Studied as part of fixed-dose combinations with ledipasvir/sofosbuvir or sofosbuvir/velpatasvir plus TAF, emtricitabine, elvitegravir, and cobicistat.
<table>
<thead>
<tr>
<th>Drug</th>
<th>SMV/SOF (ETV)</th>
<th>DCV/SOF (RAL)</th>
<th>PrOD (COB)</th>
<th>PrO (COB)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Etravirine (ETV)</td>
<td>ND</td>
<td>▼ DCV&lt;sup&gt;b&lt;/sup&gt;</td>
<td>ND</td>
<td>ND</td>
</tr>
<tr>
<td>Raltegravir (RAL)</td>
<td>▲▲ SMV</td>
<td>ND</td>
<td>▲▲ PrOD</td>
<td>▲▲ PrO</td>
</tr>
<tr>
<td>Cobicistat-boosted elvitegravir (COB)</td>
<td>ND</td>
<td>▲ DCV&lt;sup&gt;a&lt;/sup&gt;</td>
<td>ND</td>
<td>ND</td>
</tr>
<tr>
<td>Dolutegravir (DTG)</td>
<td>▲▲ SMV</td>
<td>▲▲ DCV</td>
<td>▲ PRV</td>
<td>ND</td>
</tr>
<tr>
<td>Tenofovir Alafenamide (TAF)/Emtricitabine (FTC)/Bictegravir (BIC)</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
</tr>
<tr>
<td>Maraviroc (MVC)</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
</tr>
<tr>
<td>Tenofovir (TFV) disoproxil fumarate</td>
<td>▲▲ SMV</td>
<td>▲▲ DCV</td>
<td>▲▲ PrOD</td>
<td>▲▲ PrO</td>
</tr>
<tr>
<td>Tenofovir (TFV) alafenamide</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
</tr>
</tbody>
</table>

ND, No data  
<sup>a</sup> Daclatasvir dose should be reduced to 30 mg.  
<sup>b</sup> Daclatasvir dose should be increased to 90 mg.
Ribavirin

Ribavirin has the potential for dangerous drug interactions with didanosine, resulting in mitochondrial toxicity with hepatomegaly and steatosis, pancreatitis, and lactic acidosis. Thus, concomitant administration of these 2 drugs is contraindicated (Fleischer, 2004). The combined use of ribavirin and zidovudine has been reported to increase the rates of anemia and the need for ribavirin dose reduction. Thus, zidovudine is not recommended for use with ribavirin (Alvarez, 2006).

### Treatment Recommendations for Patients With HIV/HCV Coinfection

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/HCV-coinfected persons should be treated and retreated the same as persons without HIV infection, after recognizing and managing interactions with antiretroviral medications (see Initial Treatment of HCV Infection and Retreatment of Persons in Whom Prior Therapy Has Failed).</td>
<td>I, B</td>
</tr>
<tr>
<td>Daily daclatasvir (refer to information above for dose) plus sofosbuvir (400 mg), with or without ribavirin, is a recommended regimen when antiretroviral regimen changes cannot be made to accommodate alternative HCV direct-acting antivirals. Refer to Initial Treatment of HCV Infection and Retreatment of Persons in Whom Prior Therapy Has Failed sections for treatment duration.</td>
<td>I, B</td>
</tr>
</tbody>
</table>

### Regimens Not Recommended for Patients With HIV/HCV Coinfection

<table>
<thead>
<tr>
<th>NOT RECOMMENDED</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ledipasvir/sofosbuvir for 8 weeks is not recommended, regardless of baseline HCV RNA level.</td>
<td>IIb, C</td>
</tr>
</tbody>
</table>

### Mixed Genotypes

Rarely, genotyping assays may indicate the presence of a mixed infection (eg, genotypes 1a and 2). Treatment data for mixed genotypes with direct-acting antivirals are sparse but utilization of a pangenotypic regimen should be considered. When the correct combination or duration of treatment is unclear, expert consultation should be sought.

**Last update:** May 24, 2018
**Patients With Decompensated Cirrhosis**

### Recommended for All Patients With HCV Infection Who Have Decompensated Cirrhosis

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with HCV infection who have decompensated cirrhosis—moderate or severe hepatic impairment, ie, Child-Turcotte-Pugh (CTP) class B or class C—should be referred to a medical practitioner with expertise in that condition, ideally in a liver transplant center.</td>
<td>I, C</td>
</tr>
</tbody>
</table>

Clinical trial data demonstrate that in the population of persons with decompensated cirrhosis, most patients receiving direct-acting antiviral (DAA) therapy experience improvement in clinical and biochemical indicators of liver disease between baseline and post-treatment week 12, including patients with CTP class C cirrhosis (Manns, 2016); (Curry, 2015); (Charlton, 2015); (Welzel, 2016). However, improvements may be insufficient to avoid liver-related death or the need for liver transplantation (Belli, 2016), highlighting that not everyone benefits from DAA therapy (Fernandez-Carrillo, 2016). Most deaths among those receiving DAA therapy relate to the severity of underlying liver disease. The predictors of improvement or decline have not been clearly identified, though patients with a Model for End-Stage Liver Disease (MELD) score >20 or severe portal hypertension complications may be less likely to improve and might be better served by transplantation than treatment (Terrault, 2017); (Belli, 2016).

Real-world data comparing DAA response rates demonstrate that patients with cirrhosis and hepatocellular carcinoma (HCC) have lower SVR rates than cirrhotics without HCC (Prenner, 2017); (Beste, 2017). In a large VA study including sofosbuvir, ledipasvir/sofosbuvir, and paritaprevir/ritonavir/ombitasvir plus dasabuvir regimens (with and without ribavirin), overall SVR rates were 91% in patients without HCC vs 74% in those with HCC (Beste, 2017). After adjusting for confounders, the presence of HCC was associated with a lower likelihood of SVR (AOR=0.38). Whether this lower rate of SVR can be overcome with an extended duration of therapy is unknown.
### Decompensated Cirrhosis Genotype 1, 4, 5, or 6 Infection

#### Patients With Decompensated Cirrhosis Who Have Genotype 1, 4, 5, or 6 Infection and Are Ribavirin Eligible

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>DURATION</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily fixed-dose combination of ledipasvir (90 mg)/sofosbuvir (400 mg) with low initial dose of ribavirin (600 mg, increase as tolerated)</td>
<td>12 weeks</td>
<td>I, A&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Daily fixed-dose combination of sofosbuvir (400 mg)/velpatasvir (100 mg) with weight-based ribavirin&lt;sup&gt;c&lt;/sup&gt;</td>
<td>12 weeks</td>
<td>I, A&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Genotype 1 or 4 infection only:</strong> Daily daclatasvir (60 mg)&lt;sup&gt;e&lt;/sup&gt; plus sofosbuvir (400 mg) with low initial dose of ribavirin (600 mg, increase as tolerated)</td>
<td>12 weeks</td>
<td>I, B</td>
</tr>
</tbody>
</table>

<sup>a</sup> Includes CTP class B and class C patients who may or may not be candidates for liver transplantation, including those with hepatocellular carcinoma.

<sup>b</sup> Only available data for genotypes 5 and 6 are in a small number of patients with compensated cirrhosis.

<sup>c</sup> Low initial dose of ribavirin (600 mg) is recommended for patients with CTP class C cirrhosis; increase as tolerated.

<sup>d</sup> Only available data for genotype 6 are in patients with compensated cirrhosis.

<sup>e</sup> The dose of daclatasvir may need to be increased or decreased when used concomitantly with cytochrome P450 3A/4 inducers and inhibitors, respectively. Please refer to the prescribing information for daclatasvir.

### Patients With Decompensated Cirrhosis Who Have Genotype 1, 4, 5, or 6 Infection and Are Ribavirin Ineligible

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>DURATION</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily fixed-dose combination of ledipasvir (90 mg)/sofosbuvir (400 mg)</td>
<td>24 weeks</td>
<td>I, A&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Daily fixed-dose combination of sofosbuvir (400 mg)/velpatasvir (100 mg)</td>
<td>24 weeks</td>
<td>I, A&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Genotype 1 or 4 infection only:</strong> Daily daclatasvir (60 mg)&lt;sup&gt;d&lt;/sup&gt; plus sofosbuvir (400 mg)</td>
<td>24 weeks</td>
<td>II, C</td>
</tr>
</tbody>
</table>

<sup>a</sup> Includes CTP class B and class C patients who may or may not be candidates for liver transplantation, including those with hepatocellular carcinoma.

<sup>b</sup> Only available data for genotypes 5 and 6 are in a small number of patients with compensated cirrhosis.

<sup>c</sup> Only available data for genotype 6 are in patients with compensated cirrhosis.

<sup>d</sup> The dose of daclatasvir may need to be increased or decreased when used concomitantly with cytochrome P450 3A/4 inducers and inhibitors, respectively. Please refer to the prescribing information for daclatasvir.
## Recommended regimens listed by evidence level and alphabetically for:

**Patients With Decompensated Cirrhosis\(^a\) and Genotype 1, 4, 5, or 6 Infection in Whom Prior Sofosbuvir- or NS5A-Based Treatment Failed**

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>DURATION</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prior sofosbuvir-based treatment failure only:</strong> Daily fixed-dose combination of ledipasvir (90 mg)/sofosbuvir (400 mg) with low initial dose of ribavirin (600 mg; increase as tolerated)</td>
<td>24 weeks</td>
<td>II, C(^b)</td>
</tr>
<tr>
<td>Daily fixed-dose combination of sofosbuvir (400 mg)/velpatasvir (100 mg) with weight-based ribavirin(^c)</td>
<td>24 weeks</td>
<td>II, C(^d)</td>
</tr>
</tbody>
</table>

\(^a\) Includes CTP class B and class C patients who may or may not be candidates for liver transplantation, including those with hepatocellular carcinoma.  
\(^b\) Only available data for genotype 6 are in patients with compensated cirrhosis.  
\(^c\) Low initial dose of ribavirin (600 mg) is recommended for patients with CTP class C cirrhosis.  
\(^d\) Only available data for genotypes 5 and 6 are in a small number of patients with compensated cirrhosis.

## Ledipasvir/Sofosbuvir

The US-based, multicenter, randomized, open-label, phase 2 SOLAR-1 trial included 108 patients with genotype 1 or 4 infection and decompensated cirrhosis; 59 were categorized as CTP class B (score 7 to 9) and 49 were categorized as CTP class C (score 10 to 12). Participants were randomly assigned to 12 weeks or 24 weeks of the daily fixed-dose combination of ledipasvir (90 mg)/sofosbuvir (400 mg) plus ribavirin (initial dose of 600 mg, increased as tolerated) (Charlton, 2015b). After excluding the 7 patients who underwent liver transplantation during the study, the SVR rate was 87% in CTP class B patients who received 12 weeks of treatment and 89% in those who received 24 weeks of treatment. Similarly, the SVR rates were 86% and 87%, respectively, with 12 weeks and 24 weeks of antiviral therapy in the CTP class C patients. Post-therapy virologic relapse occurred in 8% and 5% of the 12- and 24-week groups, respectively.

In the majority of participants with CTP class B or C disease, the MELD and CTP scores decreased between baseline and post-treatment week 4. As expected, the frequency of serious adverse events increased with treatment duration in both the CTP class B group (10% week 12; 34% week 24) and the CTP class C group (26% week 12; 42% week 24). Most of the serious adverse events were related to ribavirin. The mean daily dose of ribavirin in the patients with decompensated cirrhosis was 600 mg. Therapy was discontinued in 7% of the CTP class B patients and 8% of the CTP class C patients in the 24-week treatment arm.

The multicenter (Europe, Canada, Australia, and New Zealand), randomized, open-label, phase 2 SOLAR-2 study included 160 genotype 1- or 4-infected patients with decompensated cirrhosis (CTP class B or C). Study participants, who were treatment-naïve or -experienced, were randomly assigned to 12 weeks or 24 weeks of daily fixed-dose ledipasvir (90 mg)/sofosbuvir (400 mg) plus ribavirin (initial dose of 600 mg, increased as tolerated). All participants had a hemoglobin level >10 g/dL and an estimated glomerular filtration rate (eGFR) >40 mL/min (Manns, 2016). Among the 150 patients with decompensated cirrhosis who completed therapy and had evaluable efficacy results, SVR12 was achieved in 85% (61/72) of those in the 12-week study arm (90% [43/48] CTP class B; 75% [18/24] CTP class C). SVR 12 was achieved by 90% (70/78) of patients with decompensated cirrhosis in the 24-week study (98% [47/48] CTP class B; 77% [23/30] CTP class C). Post-therapy virologic relapse occurred in 6% (9/150) of the patients with decompensated cirrhosis who completed therapy (7 in 12-week arm; 2 in 24-week arm).

Baseline CTP and MELD scores improved in the majority of the treated patients, but some participants experienced...
worsening hepatic function. Among nontransplanted patients whose MELD score was ≥15 at baseline, 80% (20/25) had a MELD score <15 at SVR12. Among those with a MELD score <15 at baseline, 4% (2/56) had a MELD score ≥15 at SVR12. During the study, 8% (13/160) of the enrolled patients with decompensated cirrhosis (2 CTP class B, 11 CTP class C) died from various causes but none of the deaths were attributed to antiviral therapy. Serious adverse events occurred in approximately 28% of patients with decompensated cirrhosis with no significant difference between the 12-week and 24-week treatment arms.

A multicenter, double-blind study from France reported on the use of daily ledipasvir/sofosbuvir for 24 weeks compared to daily ledipasvir/sofosbuvir plus ribavirin for 12 weeks (with a 12-week placebo phase). Study participants included 154 patients with compensated cirrhosis and genotype 1 infection in whom prior peginterferon/ribavirin treatment failed (for most patients, treatment with peginterferon/ribavirin plus a protease inhibitor also failed) (Bourliere, 2015). The mean MELD score was 7 (range, 6 to 16), 26% of patients had varices, and 13% had low serum albumin levels. The SVR12 rate was 96% with the 12-week regimen and 97% with the 24-week regimen. The most common adverse events were asthenia, headache, and pruritus; the frequency of severe adverse events and the need for early drug discontinuation were low in both treatment groups. In light of these results, it is reasonable to consider daily ledipasvir/sofosbuvir plus ribavirin for 12 weeks in patients with decompensated cirrhosis in whom prior sofosbuvir-based treatment has failed.

Collectively, these results indicate that a 12-week course of ledipasvir/sofosbuvir and ribavirin (initial dose of 600 mg, increased as tolerated) is an appropriate regimen for patients with decompensated cirrhosis and genotype 1 or 4 infection. Such therapy may lead to objective improvements in hepatic function and reduce the likelihood of recurrent HCV infection after subsequent transplantation. Most patients received a ribavirin dose of 600 mg/d. Of 17 patients (16 genotype 1; 1 genotype 4) in the SOLAR-1 and SOLAR-2 trials (6 CPT class B; 11 CPT class C) who received ledipasvir/sofosbuvir plus ribavirin for 12 weeks or 24 weeks prior to or up to the time of liver transplant, all had HCV RNA <15 IU/mL at the time of transplantation. Sixteen of the 17 patients achieved post-transplant SVR12; 1 patient died at post-op day 15, but the HCV RNA was <15 IU/mL on day 14 (Yoshida, 2017).

Real-world cohort studies have reported SVR rates in patients with decompensated cirrhosis. Foster and colleagues reported on the use of ledipasvir (90 mg)/sofosbuvir (400 mg) or daclatasvir (60 mg)/sofosbuvir (400 mg), with or without ribavirin, for 12 weeks in 235 genotype 1-infected patients from the United Kingdom (Foster, 2016). The SVR rates were similar in the 235 genotype participants receiving ledipasvir/sofosbuvir plus ribavirin or ledipasvir/sofosbuvir (86% and 81%, respectively). In this observational cohort study, 91% of the patients received ribavirin; only 6% discontinued ribavirin while 20% required a ribavirin dose reduction. MELD scores improved in 42% of treated patients and worsened in 11%. There were 14 deaths and 26% of the patients had a serious adverse event; none were treatment related.

The multicenter, prospective, observational HCV-TARGET study examined the real-world efficacy of ledipasvir/sofosbuvir (with or without ribavirin) for various treatment durations. The SVR12 rate among genotype 1 patients with a history of clinically decompensated cirrhosis was 90% (263/293) among evaluable patients (Terrault, 2016). In this cohort, 29% of patients with decompensated cirrhosis were treated with ribavirin and 48% received 24 weeks treatment.

A phase 2a, open-label study of 14 patients with compensated cirrhosis and genotype 1 infection in whom prior sofosbuvir-based therapy failed demonstrated that ledipasvir/sofosbuvir for 12 weeks was associated with a 100% SVR rate (Osinusi, 2014). In addition, results of an open-label, phase 2 study of 51 genotype 1-infected patients in whom prior sofosbuvir-based therapy failed demonstrated that a 12-week course of ledipasvir/sofosbuvir plus weight-based ribavirin (1000 mg/d to 1200 mg/d) led to an overall SVR12 rate of 98%, including 100% (14/14) among those patients with compensated cirrhosis (Wyles, 2015b).

**Sofosbuvir/Velpatasvir**

The phase 3, open-label, multicenter, randomized ASTRAL-4 study enrolled 267 patients with genotype 1, 2, 3, 4, or 6 infection and decompensated cirrhosis (CTP class B at the time of screening) who were treatment naive (45%) or experienced (55%). Notably, 10% of patients were CTP class A or class C at treatment baseline. Patients were randomly assigned (1:1:1 ratio) to 12 weeks of a daily fixed-dose combination sofosbuvir (400 mg)/velpatasvir (100 mg); 12 weeks of sofosbuvir/velpatasvir plus weight-based ribavirin (1000 mg/d, weight <75 kg; 1200 mg/d, weight ≥75 kg); or 24 weeks of sofosbuvir/velpatasvir. Randomization was stratified by HCV genotype. All participants had a hemoglobin level >10 g/dL.
and an eGFR ≥50 mL/min (Curry, 2015b). The genotype/subtype distribution of the participants was 60% (159/267) genotype 1a; 18% (48/267) genotype 1b; 4% (12/267) genotype 2; 15% (39/267) genotype 3; 3% (8/267) genotype 4; and <1% (1/267) genotype 6. Ninety-five percent of patients had a baseline MELD score ≤15.

The SVR rates were 83% among those in the 12-week sofosbuvir/velpatasvir study arm, 94% in the 12-week sofosbuvir/velpatasvir plus ribavirin arm, and 86% in the 24-week sofosbuvir/velpatasvir arm. Among patients with genotype 1 infection, the SVR rates were 88%, 96%, and 92%, respectively. Twenty-two participants had virologic failure, including 20 patients with relapse and 2 patients (genotype 3) with on-treatment virologic breakthrough. The presence of baseline NS5A resistant substitutions was not associated with virologic relapse.

At post-treatment week 12, 47% of patients had an improvement in CTP score, 42% had no change, and 11% had an increased CTP score. Nine patients (3%) died due to various causes during the study; no deaths were judged to be related to antiviral therapy. Serious adverse events were reported in 16% to 19% of the treated patients. Anemia (ie, hemoglobin <10 g/dL) was reported in 23% of the group receiving ribavirin, and 8% and 9% in those who received 12 weeks and 24 weeks of sofosbuvir/velpatasvir without ribavirin, respectively.

A phase 2, open-label, single-arm study conducted by Gane and colleagues evaluated a 24-week course of sofosbuvir/velpatasvir plus weight-based ribavirin among 65 patients with a history of treatment failure with an NS5A-containing regimen (Gane, 2016). Twenty-six percent of enrolled patients had compensated cirrhosis. The overall SVR12 rate was 91% (59/65), including 97% (33/34) among genotype 1-infected patients, 91% (13/14) in those with genotype 2 infection, and 76% (13/17) in patients with genotype 3. To date, there are no data for this regimen given for 24 weeks in patients with decompensated cirrhosis.

The phase 3, multicenter ASTRAL-1 trial evaluated the efficacy and safety of a 12-week course of daily fixed-dose sofosbuvir/velpatasvir among treatment-naive and-experienced patients with genotype 1, 2, 4, 5, or 6 infection. The study included 35 patients with genotype 5 infection and 41 patients with genotype 6 infection (Feld, 2015). The overall SVR12 rates were 97% (34/35) in genotype 5-infected patients and 100% (41/41) in those with genotype 6 infection. Of note, 100% SVR12 was achieved in the small number of genotype 5 patients (n=5) and genotype 6 patients (n=6) with compensated cirrhosis enrolled in ASTRAL-1.

Daclatasvir + Sofosbuvir

The phase 3, open-label ALLY-1 trial evaluated the efficacy and safety of 12 weeks of daily daclatasvir (60 mg) and sofosbuvir (400 mg) plus ribavirin (600 mg with possible escalation to 1000 mg as tolerated) among patients with cirrhosis (CTP class A, B, or C; n=60) or HCV recurrence after liver transplantation (n=53). Treatment-naive and -experienced patients were enrolled. More than 75% of participants had genotype 1 infection, although patients with genotype 2, 3, or 4 infection were also represented in the cirrhosis cohort. The CTP breakdown was 20% (12/60) class A, 53% (32/60) class B, and 26% (16/60) class C.

The SVR12 rates were 83% (50/60) among those in the cirrhosis group and 94% (50/53) among those with recurrent HCV infection post liver transplant. In the population with cirrhosis, SVR12 rates by genotype were: 82% (37/45) genotype 1; 80% (4/5) genotype 2; 83% (5/6) genotype 3; and 100% (4/4) genotype 4. Response rates differed based on severity of cirrhosis; SVR12 rates were 92% (11/12) among those with CTP class A cirrhosis, 94% (30/32) among those with class B, and 56% (9/16) in patients with class C cirrhosis (Poordad, 2016).

An observational cohort study from the United Kingdom conducted by Foster and colleagues examined various combinations of DAA agents in patients with decompensated cirrhosis (CTP score ≥7), recurrent HCV after liver transplantation, or a severe extrahepatic manifestation of HCV disease. The study treatment regimens included a 12-week course of daclatasvir plus sofosbuvir, with or without ribavirin. Among the 200 genotype 1-infected patients with decompensated cirrhosis enrolled in the study, the SVR12 for 12 weeks of daclatasvir/sofosbuvir plus ribavirin was 88% (30/34). SVR12 for daclatasvir/sofosbuvir without ribavirin was 50%, but only 4 patients received this regimen (Foster, 2016).

Overall SVR12 rates were similar in the genotype 1-infected participants receiving ledipasvir/sofosbuvir plus ribavirin or
ledipasvir/sofosbuvir (86% and 81%, respectively) and those receiving daclatasvir/sofosbuvir with ribavirin or daclatasvir/sofosbuvir therapy (82% and 60%, respectively). In this real-world study, 91% of the patients received ribavirin; only 6% discontinued ribavirin but 20% required a ribavirin dose reduction. MELD scores improved in 42% of treated patients and worsened in 11%. There were 14 deaths and 26% of the participants had a serious adverse event; none were treatment related. These data highlight the lower efficacy and increased safety concerns when treating patients with more advanced liver failure.

Protease-Inhibitor Containing Regimens

To date, the fixed-dose combination of elbasvir (50 mg)/grazoprevir (100 mg) has not been rigorously studied in patients with decompensated cirrhosis. A phase 2, nonrandomized, open-label study of elbasvir/grazoprevir for 12 weeks was completed in 30 genotype 1-infected patients with CTP class B cirrhosis (Jacobson, 2015). The SVR12 rate was 90% (27/30); 1 patient died of liver failure at post-treatment week 4 and 2 patients relapsed. MELD scores improved in 15 treated patients, were unchanged in 9, and increased in 6. However, there are no safety or efficacy data regarding the US Food and Drug Administration (FDA)-approved elbasvir/grazoprevir doses in patients with decompensated cirrhosis. Therefore, until further data are available, treatment of patients with decompensated cirrhosis with elbasvir/grazoprevir is not recommended.

Recent data reported by the FDA have demonstrated that some patients with compensated cirrhosis treated with paritaprevir/ritonavir/ombitasvir ± dasabuvir may develop rapid-onset direct hyperbilirubinemia without ALT elevation within 1 to 4 weeks of starting treatment, which can lead to rapidly progressive liver failure and death. A multicenter cohort study from Israel reported 7 patients who received paritaprevir/ritonavir/ombitasvir plus dasabuvir developed decompensation within 1 to 8 weeks of starting therapy, including 1 patient who died (Zuckerman, 2016). Therefore, paritaprevir/ritonavir/ombitasvir ± dasabuvir is contraindicated in all patients with decompensated cirrhosis due to concerns about hepatotoxicity. In addition, all patients with compensated cirrhosis receiving this regimen should be monitored for clinical signs and symptoms of hepatic decompensation and undergo hepatic laboratory testing at baseline and at least every 4 weeks while on therapy.

The daily fixed dose combination of glecaprevir (300 mg)/pibrentasvir (120 mg) administered as three 100 mg/40 mg fixed-dose combination pills has not been studied in patients with decompensated cirrhosis and, pending additional safety data, is not recommended.

Similarly, the daily fixed-dose combination of sofosbuvir (400 mg)/velpatasvir (100 mg)/voxilaprevir (100 mg) has not been studied in patients with hepatic decompensation. Thus, this regimen is not recommended for patients with decompensated cirrhosis (CTP class B or C) until further data are available.
## Decompensated Cirrhosis Genotype 2 or 3 Infection

### Recommended Regimens listed by evidence level and alphabetically for:

#### Patients With Decompensated Cirrhosis\(^a\) Who Have Genotype 2 or 3 Infection and Are Ribavirin Eligible

| RECOMMENDED                                                                 | DURATION | RATING  \\ | i |
|----------------------------------------------------------------------------|----------|------------|
| Daily fixed-dose combination sofosbuvir (400 mg)/velpatasvir (100 mg) with weight-based ribavirin | 12 weeks | I, A       |
| Daily daclatasvir (60 mg)\(^b\) plus sofosbuvir (400 mg) with low initial dose of ribavirin (600 mg, increase as tolerated) | 12 weeks | II, B      |

\(^a\) Includes CTP class B and class C patients who may or may not be candidates for liver transplantation, including those with hepatocellular carcinoma.

\(^b\) The dose of daclatasvir may need to be increased or decreased when used concomitantly with cytochrome P450 3A/4 inducers and inhibitors, respectively. Please refer to the prescribing information for daclatasvir.

### Recommended regimens listed by evidence level and alphabetically for:

#### Patients With Decompensated Cirrhosis\(^a\) Who Have Genotype 2 or 3 Infection and Are Ribavirin Ineligible

| RECOMMENDED                                                  | DURATION | RATING  \\ | i |
|--------------------------------------------------------------|----------|------------|
| Daily fixed-dose combination of sofosbuvir (400 mg)/velpatasvir (100 mg) | 24 weeks | I, A       |
| Daily daclatasvir (60 mg)\(^b\) plus sofosbuvir (400 mg)      | 24 weeks | II, C      |

\(^a\) Includes CTP class B and class C patients who may or may not be candidates for liver transplantation, including those with hepatocellular carcinoma.

\(^b\) The dose of daclatasvir may need to be increased or decreased when used concomitantly with cytochrome P450 3A/4 inducers and inhibitors, respectively. Please refer to the prescribing information for daclatasvir.
Recommended regimens listed by evidence level and alphabetically for:

**Patients With Decompensated Cirrhosis** and Genotype 2 or 3 Infection in Whom Prior Sofosbuvir- or NS5A-Based Treatment Failed

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>DURATION</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily fixed-dose combination of sofosbuvir (400 mg)/velpatasvir (100 mg) with weight-based ribavirin&lt;sup&gt;b&lt;/sup&gt;</td>
<td>24 weeks</td>
<td>II, C</td>
</tr>
</tbody>
</table>

<sup>a</sup> Includes CTP class B and class C patients who may or may not be candidates for liver transplantation, including those with hepatocellular carcinoma.

<sup>b</sup> Low initial dose of ribavirin (600 mg) is recommended for patients with CTP class C.

**Sofosbuvir/Velpatasvir**

The phase 3, open-label, multicenter, randomized ASTRAL-4 study enrolled 267 patients with genotype 1, 2, 3, 4, or 6 infection and decompensated cirrhosis (CTP class B at the time of screening) who were treatment naive (45%) or experienced (55%). Patients were randomly assigned (1:1:1 ratio) to 12 weeks of a daily fixed-dose combination sofosbuvir (400 mg)/velpatasvir (100 mg); 12 weeks of sofosbuvir/velpatasvir plus weight-based ribavirin (1000 mg/d, weight <75 kg; 1200 mg/d, weight ≥75 kg); or 24 weeks of sofosbuvir/velpatasvir. Randomization was stratified by HCV genotype.

The SVR rates among the 12 patients with CTP class B cirrhosis and genotype 2 infection were 100% (8/8) with sofosbuvir/velpatasvir for 12 weeks (with or without ribavirin), and 75% (3/4) with sofosbuvir/velpatasvir for 24 weeks. Among 39 patients with CTP class B cirrhosis with genotype 3 infection, the SVR rates were 50% (7/14) for 12 weeks of sofosbuvir/velpatasvir without ribavirin, 85% (11/13) for 12 weeks of sofosbuvir/velpatasvir plus ribavirin, and 50% (6/12) for 24 weeks of sofosbuvir/velpatasvir. Therefore, genotype 3-infected patients in particular appear to benefit from the addition of ribavirin to the regimen (Curry, 2015b). For patients with decompensated cirrhosis who are ribavirin ineligible, sofosbuvir/velpatasvir for 24 weeks is currently recommended, but additional studies involving larger numbers of patients are needed to define the optimal duration of therapy.

Sofosbuvir/velpatasvir has not been studied in CTP class C patients. There are no data on the outcomes of patients with decompensated cirrhosis and a history of prior sofosbuvir plus NS5A failure. However, among 69 patients (28% with compensated cirrhosis) with prior NS5A failure treated with sofosbuvir/velpatasvir plus ribavirin for 24 weeks, the SVR rates were 97% for genotype 1 (83% with compensated cirrhosis), 93% (13/14) for genotype 2 (no patients with cirrhosis), and 78% (75% with compensated cirrhosis) for genotype 3 (Gane, 2017).

**Daclatasvir + Sofosbuvir**

Daily daclatasvir (60 mg) plus sofosbuvir (400 mg) for 12 weeks was approved by the FDA for the treatment of genotype 3 infection in patients without and with cirrhosis. Although daclatasvir/sofosbuvir was not approved for the treatment of genotype 2 infection, daclatasvir maintains adequate activity against genotype 2 despite a 50% effective concentration (EC<sub>50</sub>) that increases by several logs in the presence of the prevalent M31 substitution (Wang, 2014). In clinical trials, daclatasvir/sofosbuvir was associated with high SVR rates in treatment-naive patients with genotype 2 infection with both 12 weeks and 24 weeks of therapy (Wyles, 2015); (Sulkowski, 2014). It is unclear if there is a subgroup of genotype 2-infected patients who would benefit from extending treatment to 24 weeks. For patients with genotype 2 infection who require treatment but cannot tolerate ribavirin, an alternative regimen of daclatasvir/sofosbuvir for 12 weeks is
recommended with consideration of extending treatment to 24 weeks for patients with poor baseline characteristics (ie, decompensated cirrhosis).

Relevant data from the ALLY-1 study support use of daclatasvir/sofosbuvir plus ribavirin in patients with genotype 2 or 3 infection who have decompensated cirrhosis. Sixty patients with predominantly (80%) decompensated cirrhosis (CPT class B/C) were treated with daclatasvir/sofosbuvir plus ribavirin (600 mg/d, increased to tolerability). SVR rates were 80% (4/5) for genotype 2 patients and 83% (5/6) for genotype 3 patients with advanced cirrhosis (Poordad, 2016).

Broader experiences with treatment of genotype 3-infected patients with decompensated cirrhosis have been reported from real-world cohort studies. In a cohort from the United Kingdom, 110 patients with decompensated cirrhosis and genotype 3 infection treated with daclatasvir/sofosbuvir with or without ribavirin (600 mg/d, increased to tolerability) demonstrated SVR12 rates of 71% (75/105) and 60% (3/5), respectively (Foster, 2016). In comparison, among 62 patients with decompensated cirrhosis and genotype 3 infection treated with ledipasvir/sofosbuvir with or without ribavirin, the SVR12 rates were 65% (37/57) and 40% (2/5), respectively. In a multicenter Spanish study of daclatasvir/sofosbuvir with or without ribavirin in 123 genotype 3-infected patients (71% receiving 24 weeks), SVR12 was 94% in both CPT class A and CPT class B/C patients (Alonso, 2017). However, compared to CPT class A patients, the CPT class B/C patients had more frequent serious adverse events (16.7% vs 3.6%) and episodes of hepatic decompensation (5.2% vs 2.3%).

**Protease-Inhibitor Containing Regimens**

The daily fixed-dose combination of glecaprevir (300 mg)/pibrentasvir (120 mg) administered as three 100 mg/40 mg fixed-dose combination pills has activity against genotypes 2 and 3 but has not been studied in patients with decompensated cirrhosis. Pending additional safety data, this regimen is not recommended.

Similarly, the daily fixed-dose combination of sofosbuvir (400 mg)/velpatasvir (100 mg)/voxilaprevir (100 mg) is effective in patients with genotypes 2 and 3 but this drug combination has not been studied in patients with decompensated cirrhosis. Thus, this regimen is not recommended for patients with decompensated cirrhosis (CPT class B or C) until further data are available.

**Mixed Genotypes**

Rarely, genotyping assays may indicate the presence of a mixed infection (eg, genotypes 1a and 2). Treatment data for mixed genotypes with DAAs are sparse but utilization of a pangenotypic regimen should be considered. When the correct drug combination or treatment duration is unclear, expert consultation should be sought.
Regimens not recommended for:

**Patients With Decompensated Cirrhosis (Moderate or Severe Hepatic Impairment; Child-Turcotte-Pugh Class B or C)**

<table>
<thead>
<tr>
<th>Regimen</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paritaprevir-based regimens</td>
<td>III, B</td>
</tr>
<tr>
<td>Simeprevir-based regimens</td>
<td>III, B</td>
</tr>
<tr>
<td>Elbasvir/grazoprevir-based regimens</td>
<td>III, C</td>
</tr>
<tr>
<td>Glecaprevir/pibrentasvir</td>
<td>III, C</td>
</tr>
<tr>
<td>Sofosbuvir/velpatasvir/voxilaprevir</td>
<td>III, C</td>
</tr>
</tbody>
</table>

Interferon should not be given to patients with decompensated cirrhosis (moderate or severe hepatic impairment, CTP class B or C) because of the potential for worsening hepatic decompensation. Limited data exist for the use of simeprevir in patients with CPT class B cirrhosis (Modi, 2016; Lawitz, 2017). In a study of 40 patients (19 CPT class A, 21 CPT class B) with genotype 1 or 4 infection treated with simeprevir, sofosbuvir and daclatasvir for 12 weeks, the mean pharmacokinetic exposure to simeprevir at week 8 of therapy was 2.2-fold higher in patients with CPT class B versus CPT class A cirrhosis. (Lawitz, 2017). All patients achieved SVR12 but grade 3 or 4 bilirubin elevations were seen in 18% and 5% of patients, respectively, though none were associated with an ALT increase or the need for drug discontinuation. No data are available for use of the currently approved doses of elbasvir/grazoprevir, glecaprevir/pibrentasvir, or sofosbuvir/velpatasvir/voxilaprevir in patients with decompensated cirrhosis.

Recent data reported by the FDA have demonstrated that some patients with compensated cirrhosis treated with paritaprevir/ritonavir/ombitasvir ± dasabuvir may develop rapid-onset direct hyperbilirubinemia without ALT elevation within 1 to 4 weeks of starting treatment, which can lead to rapidly progressive liver failure and death. A multicenter cohort study from Israel reported 7 patients who received paritaprevir/ritonavir/ombitasvir plus dasabuvir developed decompensation within 1 to 8 weeks of starting therapy, including 1 patient who died (Zuckerman, 2016). Therefore, paritaprevir/ritonavir/ombitasvir ± dasabuvir is contraindicated in all patients with decompensated cirrhosis due to concerns about hepatotoxicity. In addition, all patients with compensated cirrhosis receiving this regimen should be monitored for clinical signs and symptoms of hepatic decompensation and undergo hepatic laboratory testing at baseline and at least every 4 weeks while on therapy.

**Last update:** September 21, 2017
Patients Who Develop Recurrent HCV Infection Post Liver Transplantation

Post Liver Transplantation: Genotype 1, 4, 5, or 6 Infection

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>DURATION</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily fixed-dose combination of glecaprevir (300 mg)/pibrentasvir (120 mg)</td>
<td>12 weeks</td>
<td>I, A</td>
</tr>
<tr>
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<td>12 weeks</td>
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</tr>
</tbody>
</table>

^ This is a 3-tablet coformulation. Please refer to the prescribing information.

Recommended regimen for:

Treatment-Naive and -Experienced Patients With Genotype 1, 4, 5, or 6 Infection in the Allograft With Compensated Cirrhosis

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</tbody>
</table>
Alternative regimens listed by evidence level and alphabetically for:

### Treatment-Naive and -Experienced Patients With Genotype 1, 4, 5, or 6 Infection in the Allograft, With or Without Compensated Cirrhosis

<table>
<thead>
<tr>
<th>ALTERNATIVE</th>
<th>DURATION</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily daclatasvir (60 mg)(^a) plus sofosbuvir (400 mg) with low initial dose of ribavirin (600 mg, increase as tolerated)</td>
<td>12 weeks</td>
<td>I, B</td>
</tr>
<tr>
<td><strong>Genotype 1 or 4 infection only:</strong> Daily simeprevir (150 mg) plus sofosbuvir (400 mg) with or without weight-based ribavirin</td>
<td>12 weeks</td>
<td>I, B</td>
</tr>
<tr>
<td>Daily fixed-dose combination of glecaprevir (300 mg)/pibrentasvir (120 mg)(^b)</td>
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<td>IIa, C</td>
</tr>
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\(^a\) The dose of daclatasvir may need to be increased or decreased when used concomitantly with cytochrome P450 3A/4 inducers and inhibitors, respectively. Please refer to the prescribing information and the section on HIV/HCV coinfection for patients on antiretroviral therapy.

\(^b\) This is a 3-tablet coformulation. Please refer to the prescribing information.

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**Recommended regimen for:**

### Treatment-Naive and -Experienced Patients With Genotype 1, 4, 5, or 6 Infection in the Allograft and Decompensated Cirrhosis

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
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<tbody>
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<td>I, B</td>
</tr>
</tbody>
</table>

\(^a\) Includes CTP class B and class C patients.
# Post Liver Transplantation: Genotype 2 or 3 Infection

Recommended regimens listed by evidence level and alphabetically for:

**Treatment-Naive and -Experienced Patients With Genotype 2 or 3 Infection in the Allograft Without Cirrhosis**

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Note</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>a</strong></td>
<td>This is a 3-tablet coformulation. Please refer to the prescribing information.</td>
</tr>
<tr>
<td><strong>b</strong></td>
<td>The dose of daclatasvir may need to be increased or decreased when used concomitantly with cytochrome P450 3A/4 inducers and inhibitors, respectively. Please refer to the prescribing information and the section on HIV/HCV coinfection for patients on antiretroviral therapy.</td>
</tr>
</tbody>
</table>

Recommended and alternative regimens listed by evidence level and alphabetically for:

**Treatment-Naive and -Experienced Patients With Genotype 2 or 3 Infection in the Allograft With Compensated Cirrhosis**

<table>
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<tr>
<th>RECOMMENDED</th>
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Recommended regimens listed by evidence level and alphabetically for:

**Treatment-Naive and -Experienced Patients With Genotype 2 or 3 Infection in the Allograft and Decompensated Cirrhosis**

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<td>II, C</td>
</tr>
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</table>

\(^a\) Includes CTP class B and class C patients.

\(^b\) The dose of daclatasvir may need to be increased or decreased when used concomitantly with cytochrome P450 3A/4 inducers and inhibitors, respectively. Please refer to the prescribing information and the section on HIV/HCV coinfection for patients on antiretroviral therapy.

### Glecaprevir/Pibrentasvir

The MAGELLAN-2 trial was an open-label, multicenter, single-arm, phase 3 study that evaluated a 12-week course of the daily fixed-dose combination of glecaprevir (300 mg)/pibrentasvir (120 mg) administered as three 100 mg/40 mg fixed-dose combination pills in 80 liver transplant recipients and 20 kidney transplant recipients without cirrhosis. All genotypes were represented except genotype 5; 57% of participants had genotype 1 infection and 24% had genotype 3. Except for genotype 3-infected patients (all of whom were treatment naive), treatment-experienced patients were included (interferon or peginterferon ± ribavirin, or sofosbuvir plus ribavirin ± peginterferon). Eighty percent of patients had Metavir stage F0 or F1 fibrosis, 6% had F2, and 14% had F3. Any stable immunosuppressive regimen was allowed, except cyclosporine >100 mg/d and prednisone >10 mg/d. SVR was achieved in 98% (98/100) of patients with no virologic breakthroughs on treatment and 1 post-treatment relapse (Reau, 2017). There were no treatment discontinuations due to drug-associated adverse effects. One episode of mild rejection occurred that was assessed to be unrelated to drug interactions. This regimen offers a ribavirin-free option for noncirrhotic liver or kidney transplant recipients. Although glecaprevir/pibrentasvir has not been studied in transplant recipients with compensated cirrhosis, this regimen may be considered in patients who are ribavirin ineligible.

### Ledipasvir/Sofosbuvir

The SOLAR-1 study was a large, US-based, multicenter, open-label, phase 2 trial that included 223 liver transplant recipients with genotype 1 or 4 infection whose baseline characteristics encompassed a broad spectrum of histologic and clinical severity of HCV recurrence. One hundred and eleven patients were Metavir stage F0 to F3, 51 had compensated CTP class A cirrhosis, and 61 had decompensated CTP class B or class C cirrhosis. Study participants were randomly assigned to 12 weeks or 24 weeks of a fixed-dose combination of ledipasvir (90 mg)/sofosbuvir (400 mg) plus ribavirin. The ribavirin dose was weight based for patients without cirrhosis or with compensated cirrhosis (1000 mg [<75 kg] to 1200 mg [≥ 75 kg]). For patients with CTP class B or class C cirrhosis, ribavirin was initiated at 600 mg/d followed by dose escalation as tolerated. Only 4% of enrolled participants discontinued treatment prematurely because of adverse events related to the study drugs (Charlton, 2015b).

On an intention-to-treat basis, SVR was achieved in 96% (53/55) and 98% (55/56) of liver transplant patients without cirrhosis in the 12- and 24-week treatment arms, respectively. Among those with compensated cirrhosis, SVR was 96% in both the 12- and 24-week treatment arms. Efficacy was lower in patients with CTP class B or class C cirrhosis post liver transplantation. Among those with CTP class B cirrhosis, SVR rates were 86% and 88% in the 12- and 24-week treatment...
arms, respectively. Among patients with CTP class C cirrhosis, SVR rates were 60% and 75% in the 12- and 24-week treatment arms, respectively. Mortality rate during the study was 10% among patients with CTP class B or class C cirrhosis (Charlton, 2015b).

Similar results were achieved using an identical study design in the SOLAR-2 study, which was conducted in Europe, Australia, Canada, and New Zealand. The study included 168 liver transplant recipients with genotype 1 or 4 infection. Among the post-transplantation patients, 101 had no cirrhosis (Metavir stage F0 to F3), 67 had CTP class A compensated cirrhosis, 45 had CTP class B cirrhosis, and 8 had CTP class C decompensation. SVR rates in post-transplantation, noncirrhotic patients were 94% (49/52) and 100% (49/49) for 12 weeks and 24 weeks of treatment, respectively. Among patients with compensated cirrhosis after transplantation, SVR was 97% (33/34; 32/33) in both the 12- and 24-week treatment arms. For patients with CTP class B cirrhosis, comparable SVR rates were 95% (21/22) and 100% (23/23), respectively. Among those with CTP class C cirrhosis, SVR rates were 33% (1/3) and 80% (4/5), respectively. Considering both pre- and post-transplantation patients with CTP class B or class C cirrhosis, SVR rates were 85% (61/72) and 90% (70/78) for 12 weeks and 24 weeks of treatment, respectively.

As the relative importance of ribavirin cannot be ascertained from the SOLAR studies (all patients received ribavirin), the safest presumption is that ribavirin may contribute to the high SVR rates observed.

Most clinical trials to date have focused on patients who were at least 6 months post transplantation, but there is no a priori reason not to consider earlier treatment if the patient is on stable immunosuppression and has recovered from postoperative complications. Treatment during the first 6 to 12 months post transplantation certainly seems reasonable to reduce the likelihood of treating patients with more advanced liver disease. A phase 2 study of prophylactic ledipasvir/sofosbuvir enrolled 16 genotype 1-infected liver transplant recipients (most with hepatocellular carcinoma as the indication). Treatment was initiated immediately preoperatively and continued for 4 weeks post transplantation (Levitsky, 2016). SVR12 post transplantation was attained in 88% (15/16) of patients. While these results are too preliminary upon which to base recommendations, the findings provide additional data on the safety of ledipasvir/sofosbuvir early in the post-transplantation period.

An observational HCV-TARGET cohort study provides real-world data based on experience with 347 liver, 60 kidney, and 36 dual liver kidney transplant recipients. Among the enrolled patients, 86% had genotype 1 infection, 44% had cirrhosis, 26% had a history of liver decompensation, and 54% had a prior treatment failure with a non-NS5A inhibitor regimen (Saxena, 2017). Among the 279 participants treated with ledipasvir/sofosbuvir for 12 weeks or 24 weeks, the SVR rates were 97% (152/157) for those also taking ribavirin and 95% (116/122) for patients not taking ribavirin. Patients who received ribavirin were more frequently genotype 1a (versus genotype 1b), treatment experienced, and without renal dysfunction. The rate of therapy discontinuation due to an adverse event was 1.3%, highlighting the safety of the drug combination. Acute graft rejection occurred during or after cessation of therapy in 1.4% (6/415) of patients. These episodes were not judged to not be a direct consequence of the antiviral regimen but serve to remind clinicians of the need to monitor immunosuppressive agent levels during direct-acting antiviral (DAA) therapy.

Another multicenter cohort of 162 patients (98% genotype 1) assessed treatment with ledipasvir/sofosbuvir (with or without ribavirin) for 8 weeks, 12 weeks, or 24 weeks. Duration of treatment and ribavirin use were provider determined. Overall SVR12 rates were 94% and 98% in those treated with ledipasvir/sofosbuvir without or with ribavirin, respectively (Kwok, 2016). SVR12 rates in patients treated for 8 weeks, 12 weeks, or 24 weeks with the ribavirin-free regimen were 86% (6/7), 94% (65/69), and 95% (39/41), respectively. SVR12 rates in the ribavirin inclusive groups were 97% (38/39) and 100% (6/6) for 12 weeks and 24 weeks of treatment, respectively.

Collectively, these real-world experiences indicate high SVR rates can be attained without inclusion of ribavirin in liver transplant patients. However, since all factors leading clinicians to include or exclude ribavirin cannot be discerned from these observational studies, inclusion of ribavirin is recommended for patients with unfavorable baseline characteristics (eg, cirrhosis, prior treatment experience) and ribavirin-free therapy is recommended for patients with a favorable baseline profile.
**Daclatasvir + Sofosbuvir**

The phase 3, open-label ALLY-1 trial evaluated the efficacy and safety of a 12-week course of daily daclatasvir (60 mg) and sofosbuvir (400 mg) plus ribavirin (600 mg with possible escalation to 1000 mg as tolerated) among 60 patients with cirrhosis (CTP class A, B, or C) and 53 patients with HCV recurrence after liver transplantation. Treatment-naive and -experienced patients were enrolled. Seventy-six percent (86/113) of participants had genotype 1 infection, including 77% (41/53) in the post-transplantation group. Eleven patients with genotype 3 infection and 1 patient with genotype 6 infection were also included in the post-transplantation group. The SVR12 rate was 94% (50/53) among those with recurrent HCV infection post transplantation. Among patients with genotype 3 infection, SVR12 rates were 83% (5/6) and 91% (10/11), respectively, in those with advanced cirrhosis and recurrent HCV infection post transplantation (Poordad, 2016).

Fontana and colleagues reported on the use of daclatasvir-containing regimens with sofosbuvir (n=77), simeprevir (n=18), or both (n=2) for 24 weeks in 97 liver transplant recipients with severe recurrent HCV infection (Fontana, 2016). Thirty-five percent of the cohort received ribavirin. Ninety-three percent of patients had genotype 1 infection, 31% had biopsy-proven cirrhosis, and 37% had severe cholestatic HCV. The proportion of patients with CTP class A, B, or C cirrhosis was 51%, 31%, and 12%, respectively. The mean MELD score was 13.0 ± 6.0. The overall SVR12 rate was 87% (84/97). SVR12 rates were 91% (70/77) in the daclatasvir/sofosbuvir ± ribavirin group and 72% (13/18) in the daclatasvir/simeprevir ± ribavirin group. Although 8 patients died during or after therapy from graft dysfunction, CTP and MELD scores were stable or improved in 87% and 83% of patients, respectively. Three virologic breakthroughs and 2 relapses occurred in patients treated with daclatasvir/simeprevir. These data are consistent with findings from Herzer and colleagues who described 6 liver transplant recipients with recurrent genotype 1 infection, 4 (67%) of whom achieved SVR with a regimen of daclatasvir/simeprevir plus ribavirin (Herzer, 2015).

These data along with those from other studies suggest that daclatasvir should preferentially be combined with sofosbuvir rather than simeprevir in liver transplant recipients, particularly among patients with advanced liver disease (EASL, 2017). Daclatasvir-containing regimens appear to be well tolerated overall, with anemia noted when ribavirin is used. Cyclosporine and tacrolimus increase daclatasvir area under the curve (AUC) by 40% and 5%, respectively; these changes are not clinically significant. Daclatasvir does not cause clinically meaningful changes in calcineurin inhibitor, mammalian target of rapamycin (mTOR) inhibitor, steroid, or mycophenolate levels.

**Simeprevir + Sofosbuvir**

The prospective, randomized, phase 2 GALAXY study assessed the use of simeprevir (150 mg) plus sofosbuvir (400 mg), with or without weight-based ribavirin, for 12 weeks or 24 weeks in 46 liver transplant recipients (44 noncirrhotic) with recurrent genotype 1 infection (O’Leary, 2017). Among the randomized participants, the SVR12 rates were 100% with simeprevir plus sofosbuvir for 12 weeks, 82% with simeprevir plus sofosbuvir and ribavirin for 12 weeks, and 94% with simeprevir plus sofosbuvir for 24 weeks.

A retrospective multicenter analysis evaluated the efficacy and safety of simeprevir plus sofosbuvir, with or without ribavirin, among 123 liver transplant recipients with recurrent genotype 1 infection. Excluding 2 patients with nonvirologic failure, the SVR4 and SVR12 rates by modified intention-to-treat analysis were 92% and 91%, respectively (Pungpapong, 2015).

Another retrospective study from 21 HCV-TARGET centers reported on the efficacy of simeprevir plus sofosbuvir (79%; n=119) or simeprevir plus sofosbuvir and ribavirin (21%; n=32) among 151 liver transplant recipients with recurrent genotype 1 infection (Brown, 2016). Duration of therapy was 12 weeks for most patients; 10% (15/151) of participants received simeprevir plus sofosbuvir for 24 weeks. Allograft cirrhosis had developed in 64% (97/151) of patients and 40% (60/151) had decompensated hepatic function. Overall SVR12 was 88% (133/151); 7% of patients experienced virologic relapse. Serious adverse events were reported in 12% of patients, and 3 deaths occurred that were unrelated to therapy.

In healthy volunteers, coadministration of a single dose of cyclosporine with simeprevir resulted in a 19% increase in cyclosporine concentration and simeprevir concentration similar to historical data (Olysio prescribing information, 2017).
However, the phase 2 SATURN study reported that HCV-infected liver transplant recipients with genotype 1b infection taking simeprevir plus daclatasvir and ribavirin concomitantly with cyclosporine experienced a 5-fold increase in plasma simeprevir exposure compared with phase 3 trials of simeprevir in the absence of cyclosporine (Forns, 2017b). This interaction may be caused by cyclosporine’s inhibition of organic anion transporting polypeptide 1B1 (OATP1B1), P-glycoprotein (P-gp), and cytochrome P450 3A (CYP3A). Given these findings, simeprevir should not be coadministered with cyclosporine.

Coadministration of a single dose of tacrolimus with simeprevir in healthy volunteers did not result in a notable change in tacrolimus concentration (Olysio prescribing information, 2017). An interim analysis of the SATURN study data noted an 85% increase in plasma simeprevir exposure when used concomitantly with tacrolimus compared with historical data (Forns, 2017b; Ouwerkerk-Mahadevan, 2016b). Based on phase 1 studies, a 2-fold increase in simeprevir concentration is unlikely to be clinically significant. Clinicians may consider use of sofosbuvir plus simeprevir in patients receiving tacrolimus with therapeutic drug monitoring, particularly in those expected to have difficulty tolerating ribavirin (eg, patients with impaired renal function or anemia) or in patients who are unable to forgo proton pump inhibitor therapy (these agents attenuate ledipasvir absorption).

### Sofosbuvir/Velpatasvir

To date, there have been no studies evaluating the safety and efficacy of the fixed-dose combination of sofosbuvir (400 mg)/velpatasvir (100 mg) in liver transplant recipients. For this reason, very limited recommendations on its use post liver transplantation can be made. However, with no treatment options for liver transplant recipients with genotype 2 or 3 infection who have decompensated cirrhosis, expert opinion led to the recommendation to use sofosbuvir/velpatasvir with weight-based ribavirin for these patients. Similarly, recognition of the need for alternative options for patients with genotype 2 or 3 infection and cirrhosis—especially those who are treatment experienced—led to inclusion of sofosbuvir/velpatasvir as an alternative regimen for patients with compensated cirrhosis. The safety of sofosbuvir and other NS5A inhibitors has been demonstrated and discussed above.

In the nontransplant setting (discussed in detail in the initial and retreatment sections), the phase 3, double-blind, placebo-controlled ASTRAL-1 study reported on 742 treatment-naive or -experienced patients with genotype 1, 2, 4, 5, or 6 infection who were randomly assigned in a 5:1 ratio to sofosbuvir/velpatasvir or placebo for 12 weeks (Feld, 2015). All patients with genotype 5 infection (n=35) received active treatment. Thirty-two percent (201/624) of patients randomized to active therapy were treatment experienced and 19% (121/624) had compensated cirrhosis (CTP class A). The genotype distribution in the active treatment arm was 34% (n=210) genotype 1a; 19% (n=118) genotype 1b; 17% (n=104) genotype 2; 19% (n=116) genotype 4; 6% (n=35) genotype 5; and 7% (n=41) genotype 6. The overall SVR was 99% (95% CI, 98 to >99). The side effect/adverse event profile of sofosbuvir/velpatasvir was similar to placebo.

In the phase 3, open-label ASTRAL-3 study, 552 treatment-naive or -experienced patients with genotype 3 infection (with or without compensated cirrhosis) were randomized in a 1:1 ratio to 12 weeks of sofosbuvir/velpatasvir or 24 weeks of sofosbuvir plus weight-based ribavirin. The SVR12 rate was 95% (95% CI, 92 to 98) for the sofosbuvir/velpatasvir treatment arm, which was superior to the SVR12 rate of 80% (95% CI, 75 to 85) for patients receiving sofosbuvir plus ribavirin for 24 weeks (Foster, 2015a).

The phase 3, open-label ASTRAL-4 study enrolled 267 treatment-naive or -experienced (55%) patients with genotype 1, 2, 3, 4, or 6 infection and decompensated cirrhosis (CTP class B at the time of screening). Patients were randomized in a 1:1:1 ratio to 12 weeks of sofosbuvir/velpatasvir, 12 weeks of sofosbuvir/velpatasvir plus weight-based ribavirin, or 24 weeks of sofosbuvir/velpatasvir. SVR12 rates were 83% (75/90) for the 12-week sofosbuvir/velpatasvir regimen, 94% (82/87) for the 12-week sofosbuvir/velpatasvir plus ribavirin regimen, and 86% (77/90) for the 24-week sofosbuvir/velpatasvir regimen (Curry, 2015b). Among patients with genotype 1 infection, SVR12 rates were 88% and 96% with 12 weeks of sofosbuvir/velpatasvir without and with ribavirin respectively, and 92% with sofosbuvir/velpatasvir for 24 weeks. Virologic relapse occurred in 12% and 9% of patients in the 12-week and 24-week sofosbuvir/velpatasvir arms, respectively, compared to 2% in the 12-week sofosbuvir/velpatasvir plus ribavirin study arm. Although the ASTRAL-4 study was not powered to generate statistical significance, these results suggest that sofosbuvir/velpatasvir with ribavirin for 12 weeks is the optimal choice for patients with genotype 1 or 3 infection who have decompensated cirrhosis. The participant numbers were too small for genotypes 2, 4, and 6 to differentiate the comparative efficacy of the
treatment arms. Reflecting the approach in nontransplant patients with decompensated cirrhosis, liver transplant recipients with hepatic decompensation are recommended to receive sofosbuvir/velpatasvir plus ribavirin for 12 weeks.

Velpatasvir is a substrate for CYP3A4, CYP2C8, and CYP2B6, a weak inhibitor of P-gp and OATP transporters, and a moderate inhibitor of the breast cancer resistance protein (BCRP) membrane transporter. As such, velpatasvir is moderately affected by potent inhibitors and, to a greater extent, potent inducers of enzyme/drug transporter systems (Mogalian, 2016). Based on this profile, which is similar to ledipasvir, clinically significant drug-drug interactions would not be expected for coadministration of sofosbuvir/velpatasvir with common immunosuppressive agents (eg, tacrolimus, cyclosporine, corticosteroids, mycophenolate mofetil, or everolimus).

**Mixed Genotypes**

Rarely, genotyping assays may indicate the presence of a mixed infection (eg, genotypes 1a and 2). Treatment data for mixed genotypes with DAAs are sparse but utilization of a pangenotypic regimen should be considered. When the correct combination or treatment duration is unclear, expert consultation should be sought.

**Drug Interactions Between DAAs and Calcineurin Inhibitors**

The interaction of DAA agents and calcineurin inhibitors is complex and unpredictable without formal studies of drug-drug interactions. A summary of drug interactions between calcineurin inhibitors and DAAs with recommended dosing is provided in the table below. Based on the metabolism of grazoprevir and elbasvir, a 15-fold increase in grazoprevir AUC and a 2-fold increase in elbasvir AUC can be expected with cyclosporine coadministration. Therefore, this combination should be avoided. Since a 40% to 50% increase in tacrolimus level is predicted during coadministration with grazoprevir, no dosing adjustments are anticipated but tacrolimus levels should be monitored.
Table. DAA Interactions With Calcineurin Inhibitors

<table>
<thead>
<tr>
<th>Drug Combination</th>
<th>Cyclosporine (CSA)</th>
<th>Tacrolimus (TAC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sofosbuvir (SOF)</td>
<td>4.5-fold ↑ in SOF AUC, but GS-331007 metabolite unchanged; no a priori dose adjustment</td>
<td>No interaction observed; no a priori dose adjustment</td>
</tr>
<tr>
<td>Ledipasvir</td>
<td>No data; no a priori dose adjustment</td>
<td>No data; no a priori dose adjustment</td>
</tr>
<tr>
<td>Paritaprevir / ritonavir / ombitasvir + dasabuvir (PrOD)</td>
<td>5.8-fold ↑ in CSA AUC; modeling suggest using 1/5 of CSA dose during PrOD treatment, monitor CSA levels and titrate CSA dose as needed</td>
<td>57-fold ↑ in TAC AUC; modeling suggests TAC 0.5 mg every 7 days during PrOD treatment, monitor TAC levels and titrate TAC dose as needed</td>
</tr>
<tr>
<td>Elbasvir / grazoprevir (EBR/GZR)</td>
<td>15-fold ↑ in GZR AUC and 2-fold ↑ in EBR AUC; combination is not recommended</td>
<td>43% ↑ in TAC; no a priori dose adjustment</td>
</tr>
<tr>
<td>Velpatasvir</td>
<td>No interaction observed; no a priori dose adjustment</td>
<td>No data; no a priori dose adjustment</td>
</tr>
<tr>
<td>Glecaprevir / pibrentasvir (GLE/PIB)</td>
<td>5-fold ↑ in GLE AUC with higher doses (400 mg) of CSA; not recommended in patients requiring stable CSA doses &gt;100 mg/day</td>
<td>1.45-fold ↑ in TAC AUC; no a priori dose adjustment, monitor TAC levels and titrate TAC dose as needed</td>
</tr>
<tr>
<td>Sofosbuvir / velpatasvir / voxilaprevir (SOF/VEL/VOX)</td>
<td>9.4-fold ↑ in VOX AUC; combination is not recommended</td>
<td>No data; no a priori dose adjustment</td>
</tr>
</tbody>
</table>

AUC=area under the curve

**Last update:** September 21, 2017
Patients with Renal Impairment

Chronic hepatitis C is independently associated with the development of chronic kidney disease (CKD) (Rogal, 2016); (Fabrizi, 2015). A meta-analysis published in 2015 demonstrated that chronic HCV infection was associated with a 51% increase in the risk of proteinuria and a 43% increase in the incidence of CKD (Fabrizi, 2015). There is also a higher risk of progression to end-stage renal disease (ESRD) in persons with chronic HCV infection and CKD, and an increased risk of all-cause mortality in persons on dialysis (Lee, 2014); (Fabrizi, 2012).

### Recommendations for Patients With CKD Stage\(^a\) 1, 2, or 3

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>No dose adjustment is required when using:</td>
<td></td>
</tr>
<tr>
<td>• Daclatasvir (60 mg)(^b)</td>
<td>I, A</td>
</tr>
<tr>
<td>• Daily fixed-dose combination of elbasvir (50 mg)/grazoprevir (100 mg)</td>
<td></td>
</tr>
<tr>
<td>• Daily fixed-dose combination of glecaprevir (300 mg)/pibrentasvir (120 mg)(^c)</td>
<td></td>
</tr>
<tr>
<td>• Fixed-dose combination of ledipasvir (90 mg)/sofosbuvir (400 mg)</td>
<td></td>
</tr>
<tr>
<td>• Fixed-dose combination of sofosbuvir (400 mg)/velpatasvir (100 mg)</td>
<td></td>
</tr>
<tr>
<td>• Simeprevir (150 mg)</td>
<td></td>
</tr>
<tr>
<td>• Fixed-dose combination of sofosbuvir (400 mg)/velpatasvir (100 mg)/voxilaprevir (100 mg)</td>
<td></td>
</tr>
<tr>
<td>• Sofosbuvir (400 mg)</td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) Chronic kidney disease (CKD) stages: 1 = normal (eGFR >90 mL/min); 2 = mild CKD (eGFR 60-89 mL/min); 3 = moderate CKD (eGFR 30-59 mL/min); 4 = severe CKD (eGFR 15-29 mL/min); 5 = end-stage CKD (eGFR <15 mL/min)

\(^b\) Refer to the prescribing information and the section on HIV/HCV coinfection for patients on antiretroviral therapy.

\(^c\) This is a 3-tablet coformulation. Please refer to the prescribing information.

### Recommended regimens listed by evidence level and alphabetically for:

**Patients With CKD Stage\(^a\) 4 or 5 (eGFR <30 mL/min or End-Stage Renal Disease)**

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>GENOTYPE</th>
<th>DURATION</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily fixed-dose combination of elbasvir (50 mg)/grazoprevir (100 mg)</td>
<td>1a, 1b, 4</td>
<td>12 weeks</td>
<td>I, B</td>
</tr>
<tr>
<td>Daily fixed-dose combination of glecaprevir (300 mg)/pibrentasvir (120 mg)(^b)</td>
<td>1, 2, 3, 4, 5, 6</td>
<td>8 to 16 weeks(^c)</td>
<td>I, B(^c)</td>
</tr>
</tbody>
</table>

\(^a\) Chronic kidney disease (CKD) stages: 1 = normal (eGFR >90 mL/min); 2 = mild CKD (eGFR 60-89 mL/min); 3 = moderate CKD (eGFR 30-59 mL/min); 4 = severe CKD (eGFR 15-29 mL/min); 5 = end-stage CKD (eGFR <15 mL/min)

\(^b\) This is a 3-tablet coformulation. Please refer to the prescribing information.

\(^c\) Patients in this group should be treated as would patients without CKD. Duration of glecaprevir/pibrentasvir should be based on presence of cirrhosis and prior treatment experience (please refer to appropriate section). As such, strength of rating may be lower for certain subgroups.
Recommended Regimens

Elbasvir/Grazoprevir

The C-SURFER trial evaluated the safety and efficacy of 12 weeks of the daily fixed-dose combination of elbasvir (50 mg)/grazoprevir (100 mg) versus placebo among genotype 1-infected patients with CKD stage 4 or 5 (eGFR <30 mL/min). The initial study randomized eligible patients to immediate or deferred treatment with elbasvir/grazoprevir. The delayed treatment arm initially received placebo and was later treated with elbasvir/grazoprevir. Notably, both elbasvir and grazoprevir are primarily hepatically metabolized and undergo minimal renal elimination.

The data for the immediate treatment arm have been published (Roth, 2015). Seventy-five percent of the study participants were on hemodialysis, and 45% were African American. A small number of patients with compensated cirrhosis were included. Intention-to-treat (ITT) and modified intention-to-treat (mITT) SVR12 rates were 94% and 99%, respectively. There were no changes in erythropoietin use, hemoglobin or other adverse events in the treatment groups compared to placebo. None of the genotype 1a-infected patients with baseline NS5A resistance-associated substitutions (RASs) experienced viral relapse. The only reported relapse occurred in a patient with genotype 1b infection. The basis for the lack of impact of NS5A RASs on SVR rates in this population is unclear but may relate to the moderately increased area under the curve (AUC) with grazoprevir and elbasvir observed in patients with stage 4/5 CKD (Zepatier prescribing information, 2017).

Based on these data, daily fixed-dose elbasvir/grazoprevir is recommended for the treatment of genotype 1 infection in patients with severely compromised renal function. While C-SURFER did not evaluate patients with genotype 4 infection, it is likely that the high efficacy of elbasvir/grazoprevir in genotype 1 and 4 infection in persons with normal renal function can be extrapolated to genotype 4-infected persons with CKD stage 4/5. Treatment with elbasvir/grazoprevir in persons with CKD has been shown to be cost-effective in the United States (Elbasha, 2016).

Glecaprevir/Pibrentasvir

The EXPEDITION-4 trial evaluated the safety and efficacy of 12 weeks of the pangenotypic NS3/NS4A protease inhibitor glecaprevir and the pangenotypic NS5A inhibitor pibrentasvir for genotype 1, 2, 3, 4, 5, or 6 infection (Gane, 2017b). This open-label study enrolled treatment-naive and -experienced patients (previous interferon or peginterferon ± ribavirin, or sofosbuvir and ribavirin ± peginterferon) with CKD stage 4 or 5, including hemodialysis dependence. Baseline characteristics of the 104 patients enrolled in the study were 76% male; 25% black; 19% compensated cirrhosis; 40% treatment experienced; and 82% hemodialysis dependent. The genotype distribution was 22% genotype 1a; 28% genotype 1b; 16% genotype 2; 11% genotype 3; 19% genotype 4; 1% genotype 5; and 1% genotype 6. In the study, the daily fixed-dose combination of glecaprevir (300 mg)/pibrentasvir (120mg) was administered as three 100 mg/40 mg fixed-dose combination pills.

The study reported ITT and mITT SVR12 rates of 98% and 100%, respectively. There were no virologic failures. Two patients did not achieve SVR12; 1 patient discontinued the study due to diarrhea in the context of recent gastrointestinal bleeding and the other experienced a cerebral hemorrhage due to uncontrolled hypertension (had achieved SVR4). Adverse events included pruritus (20%), fatigue (14%), and nausea (12%). There were no serious adverse events related to the study drugs, and there were no grade 4 laboratory abnormalities reported.

The EXPEDITION-4 trial supports the efficacy and safety of glecaprevir/pibrentasvir in patients with CKD and ESRD. The recommended duration of therapy is the same as for patients without CKD.

Sofosbuvir-Based Regimens

Safe and effective doses of sofosbuvir in persons with an eGFR <30 mL/min have not been established. However, there is accumulating evidence on use of sofosbuvir-based regimens in those with an eGFR <30 mL/min (Desnoyer, 2016); (Nazario, 2016).
The HCV-TARGET study is an ongoing prospective, observational cohort study that evaluates the use of direct-acting antiviral agents across clinical practices in North America and Europe. The study reported the safety and efficacy of sofosbuvir-containing regimens in patients with mild to severe renal dysfunction (eGFR groups: <30 mL/min; 31-45 mL/min; 46-60 mL/min; and >60 mL/min) (Saxena, 2016). The patients received different regimens that included sofosbuvir (peginterferon/ribavirin plus sofosbuvir; simeprevir and sofosbuvir ± ribavirin; and sofosbuvir plus ribavirin). Overall, the regimens were well tolerated with no increased discontinuation among patients with low eGFRs. The SVR12 rates were similar across the eGFR groups. Notably, there was progressive deterioration of renal function and related symptoms in patients with an eGFR <30 mL/min, suggesting the need for close monitoring of these patients. In summary, patients with low baseline renal function have a higher frequency of anemia, worsening renal dysfunction, and more severe adverse events, but treatment responses remain high and comparable to those without renal impairment.

Daclatasvir, Elbasvir, Grazoprevir, Ledipasvir, and Simeprevir

Daclatasvir, elbasvir, grazoprevir, ledipasvir, and simeprevir are primarily hepatically metabolized and undergo minimal renal elimination. While exposures to many of these agents are higher in severe renal impairment—presumably due to effects of uremic toxins, parathyroid hormone, and/or cytokines on hepatic metabolism—they do not require dose adjustments in the setting of renal impairment.

Mixed Genotypes

Rarely, genotyping assays may indicate the presence of a mixed infection (eg, genotypes 1a and 2). Treatment data for mixed genotypes with direct-acting antivirals are sparse but utilization of a pangenotypic regimen should be considered. When the correct combination or treatment duration is unclear, expert consultation should be sought.

Last update: September 21, 2017
## Kidney Transplant Patients

### Genotypes 1 and 4

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>DURATION</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily fixed-dose combination of glecaprevir (300 mg)/pibrentasvir (120 mg)</td>
<td>12 weeks</td>
<td>I, A&lt;sup&gt;c&lt;/sup&gt; IIa, C&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td>Daily fixed-dose combination of ledipasvir (90 mg)/sofosbuvir (400 mg)</td>
<td>12 weeks</td>
<td>I, A</td>
</tr>
</tbody>
</table>

*<sup>a</sup> For [decompensated cirrhosis](#), please refer to the appropriate section.  
<sup>b</sup> This is a 3-tablet coformulation. Please refer to the prescribing information.
<sup>c</sup> Evidence for patients without cirrhosis
<sup>d</sup> Evidence for patients with compensated cirrhosis

### Genotypes 2, 3, 5, and 6

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>DURATION</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily fixed-dose combination of glecaprevir (300 mg)/pibrentasvir (120 mg)</td>
<td>12 weeks</td>
<td>I, A&lt;sup&gt;c&lt;/sup&gt; IIa, C&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td>Daily daclatasvir (60 mg) plus sofosbuvir (400 mg) plus low initial dose of ribavirin (600 mg; increase as tolerated)</td>
<td>12 weeks</td>
<td>II, A</td>
</tr>
</tbody>
</table>

*<sup>a</sup> For [decompensated cirrhosis](#), please refer to the appropriate section.  
<sup>b</sup> This is a 3-tablet coformulation. Please refer to the prescribing information.
<sup>c</sup> Genotypes 2, 3, and 6
<sup>d</sup> Genotype 5

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**DAA Therapy in Kidney Transplant Patients**
A recent phase 2, open-label clinical trial evaluated the safety and efficacy of the daily fixed-dose combination of ledipasvir (90 mg)/sofosbuvir (400 mg) in 114 kidney transplant recipients who were more than 6 months post transplant (Colombo, 2017). Enrolled patients had genotype 1 (91%) or 4 infection; 69% were treatment naive, and 15% had compensated cirrhosis. Patients were randomized to 12 weeks or 24 weeks of ledipasvir/sofosbuvir. Median eGFR prior to treatment was 50 mL/min for patients in the 12-week study arm and 60 mL/min for those in the 24-week arm. Overall SVR12 was 100% (114/114). Adverse events were common (64%) and serious adverse events occurred in 13 patients (11%); only 1 participant discontinued treatment because of an adverse event (Colombo, 2017). Four patients with an eGFR >40 mL/min at baseline experienced a decrease to <30 mL/min during therapy. In 3 of these patients, eGFR increased to >30 mL/min at the last visit recorded; 1 patient who had interrupted study treatment had a final value of 14.4 mL/min. All but 1 of the 6 patients with compensated cirrhosis whose eGFR decreased to <40 mL/min continued study treatment without interruption; none permanently discontinued study treatment.

Several additional reports have described successful outcomes with combination direct-acting antiviral (DAA) therapy in kidney transplant recipients (Sawinski, 2016); (Kamar, 2016); (Saxena, 2017). Sawinski and colleagues treated 20 HCV-infected kidney transplant recipients (88% genotype 1; 50% with advanced fibrosis; 60% treatment-experienced with an interferon-based regimen) with sofosbuvir-based therapy. Various regimens were used, including simeprevir plus sofosbuvir (n=9); ledipasvir/sofosbuvir (n=7); sofosbuvir plus ribavirin (n=3); and daclatasvir plus sofosbuvir (n=1). SVR12 was 100% (Sawinski, 2016). Two patients required dose reductions due to anemia (associated with ribavirin use). However, no significant changes in serum creatinine or proteinuria, or graft rejection were seen before or after treatment. Forty-five percent of patients required dose reduction of immunosuppressive agents while on antiviral therapy (Sawinski, 2016).

Real-life data from the ongoing HCV-TARGET study have also demonstrated the efficacy of DAA therapy in patients with kidney transplant and in those with dual liver kidney transplant (Saxena, 2017). Various regimens were used, including sofosbuvir/ledipasvir ± ribavirin (85%); sofosbuvir plus daclatasvir ± ribavirin (9%); and ombitasvir/paritaprevir/ritonavir plus dasabuvir ± ribavirin (6%). The SVR12 rate was 94.6% in those with kidney transplant and 90.9% in dual liver kidney transplant recipients.

A pilot study conducted by Kamar and colleagues evaluated 25 kidney transplant recipients with chronic HCV infection who were treated with sofosbuvir-based regimens. The reported SVR12 was 100% (Kamar, 2016). Among the study participants, 76% were infected with genotype 1 and 44% had advanced fibrosis. All participants had an eGFR >30 mL/min. Treatment regimens included ledipasvir/sofosbuvir (n=9); daclatasvir plus sofosbuvir (n=4); sofosbuvir plus ribavirin (n=3); ledipasvir/sofosbuvir plus ribavirin (n=1); simeprevir and sofosbuvir plus ribavirin (n=1); simeprevir and sofosbuvir (n=6); and sofosbuvir plus peginterferon/ribavirin (n=1). Treatment was well tolerated without any discontinuations, dose reductions, graft rejections, or changes in serum creatinine levels. No drug interactions with calcineurin inhibitors were observed (Kamar, 2016).

Another small study that treated 3 genotype 4-infected kidney transplant patients with sofosbuvir (400 mg) plus ribavirin (1000 mg) for 24 weeks reported 100% SVR (Hussein, 2016). Anemia was reported in 2 patients related to concomitant ribavirin use. No other adverse events were reported.

The phase 3, open-label, single arm MAGELLAN-2 study evaluated a 12-week course of the pangenotypic regimen of glecaprevir/pibrentasvir in 100 liver (n=80) and kidney (n=20) transplant recipients. SVR 12 was achieved in 99% of patients (Reau 2017). The safety profile was excellent, and there was only 1 rejection episode in a liver transplant recipient. While this is an effective pangenotypic regimen as demonstrated in the nontransplant population, there were no genotype 5 transplant recipients in the study.

Drug interactions are an important consideration with antiviral therapy in renal transplant recipients. Please see Unique Patient Populations: Patients Who Develop Recurrent HCV Infection Post Liver Transplantation for a table of drug interactions with DAAs and calcineurin inhibitors.

**Last update:** September 21, 2017
Management of Acute HCV Infection

This section provides guidance on the diagnosis and medical management of acute HCV infection, which is defined as presenting within 6 months of the exposure. During this period, there is a 20% to 50% chance of spontaneous resolution of the infection (Kamal, 2008). In the past, cure rates of acute infection with interferon-based treatment were very high (Grebely, 2014). The present guidance reflects current trends transitioning toward safer, interferon-sparing treatments for chronic infection and the implications for the approach to acute HCV treatment.

Acute HCV infection may result from exposure to the virus through various routes. The highest risk is associated with repeated parenteral exposure from contaminated equipment in an injection drug use setting. Lower rates of HCV transmission occur from needle-stick injuries in which healthcare workers are exposed to the blood of an HCV-infected patient. Heterosexual exposure risk is very low. Transmission rates among HIV-infected men who have unprotected sex with men are much higher, particularly among those who engage in high-risk sexual practices that increase trauma to the mucosal membranes and exposure to blood (Boesecke, 2012).

Diagnosis of Acute HCV

Recommended Testing for Diagnosing Acute HCV Infection

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCV antibody and HCV RNA testing are recommended when acute HCV infection is suspected due to exposure, clinical presentation, or elevated aminotransferase levels (see Testing Algorithm figure).</td>
<td>I, C</td>
</tr>
</tbody>
</table>

Recommendations for HCV testing are also found in the HCV Testing and Linkage to Care section.

Diagnosis of acute HCV infection enables estimation of annual incidence rates and transmission patterns, thereby facilitating implementation and assessment of prevention programs. At the individual level, a diagnosis of acute infection expedites linkage to care, counseling regarding high-risk behavior, and timely interventions to reduce virus transmission and liver disease progression (Bruneau, 2014). Indeed, some persons involved in high-risk behaviors practice serosorting, defined as using HCV antibody serostatus to determine whether to engage in high-risk behaviors with certain individuals (Smith, 2013). Thus, undiagnosed acutely-infected persons may be at greater risk of transmitting HCV to their presumably seronegative contacts than would be expected by chance.

The best laboratory evidence to support a diagnosis of acute HCV infection is: (1) a positive HCV RNA test in the setting of a negative HCV antibody test (identification during the seronegative window period) (Cox, 2005), or (2) a positive HCV antibody test after a prior negative HCV antibody test (seroconversion). There are rare instances in which these approaches may be misleading, such as in immunosuppressed individuals with impaired antibody production (Chamot, 1990).

Discrete Exposure

The aforementioned types of clear, laboratory-based documentation of acute HCV infection are most easily achieved when there has been a discrete, known or suspected exposure (eg, after new onset or a change in drug injection practice, a percutaneous needle-stick exposure to an HCV-infected individual, a potentially nonsterile tattoo, or sexual assault). In those instances, baseline HCV antibody and RNA testing should be done within 48 hours of the exposure to document whether there was antecedent HCV infection (see Testing Algorithm Figure).

If baseline testing is negative, repeat testing is recommended. Frequency of testing can be tailored based on management
objectives (eg, monthly testing to identify and treat acute infection). If baseline HCV antibody testing is positive but RNA testing is negative, repeat HCV RNA and alanine aminotransferase (ALT) testing is recommended to identify an acute reinfection. When baseline HCV antibody and RNA testing are both positive, the person most likely already has chronic HCV infection from prior exposure(s). The frequency of repeat testing should reflect management goals. At a minimum, repeat testing should be done 4 to 6 months after baseline testing. When earlier identification of infection or reinfection is desired, HCV RNA and ALT testing every 4 to 6 weeks for 6 months is recommended.

No Discrete Exposure

Individuals suspected of having acute HCV infection often do not have a discrete exposure or have no prior baseline testing, making a diagnosis of acute infection more difficult (see Blood Test Interpretation Table). Acute infection should be suspected if there is a new rise in the ALT level without an alternate cause (Blackard, 2008); (Kim, 2013). Acute infection should also be suspected when there are low (especially $<10^4$ IU/mL) or fluctuating ($>1 \log_{10}$ IU/mL) HCV RNA values, or spontaneous clearance. These patterns do not commonly occur outside of the first 6 months after HCV infection (McGovern, 2009). A low signal-to-cutoff ratio of HCV antibody along with detectable HCV RNA might also be suggestive of the early weeks of acute primary infection, although this information may need to be specifically requested from the testing laboratory (Araujo, 2011).

Patients suspected of having acute HCV infection should also have a laboratory evaluation to exclude other or coexisting causes of acute hepatitis (eg, hepatitis A virus, hepatitis B virus, hepatitis delta virus if chronically infected with hepatitis B, and autoimmune hepatitis) (Kushner, 2015). Patients should also have HIV testing.

Table. Interpretation of Blood Tests for Diagnosis of Acute HCV Infection

<table>
<thead>
<tr>
<th>TEST</th>
<th>INTERPRETATION FOR DIAGNOSIS OF ACUTE HCV</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCV Antibody</td>
<td>• Test may be negative during the first 6 weeks after exposure.</td>
</tr>
<tr>
<td></td>
<td>• Seroconversion may be delayed or absent in immunosuppressed individuals.</td>
</tr>
<tr>
<td></td>
<td>• Presence of HCV antibody alone does not distinguish between acute vs chronic infection.</td>
</tr>
<tr>
<td></td>
<td>• A low signal-to-cutoff ratio may be present during acute HCV infection or represent a false-positive result.</td>
</tr>
<tr>
<td>HCV RNA</td>
<td>• Viral fluctuations $&gt;1 \log_{10}$ IU/mL may indicate acute HCV infection.</td>
</tr>
<tr>
<td></td>
<td>• HCV RNA may be transiently negative during acute HCV infection.</td>
</tr>
<tr>
<td></td>
<td>• Presence of HCV RNA alone does not distinguish between acute vs chronic infection.</td>
</tr>
<tr>
<td>ALT</td>
<td>• Fluctuating ALT peaks suggest acute infection.</td>
</tr>
<tr>
<td></td>
<td>• ALT may be normal during acute HCV infection.</td>
</tr>
<tr>
<td></td>
<td>• ALT may be elevated due to other liver insults, such as alcohol consumption.</td>
</tr>
</tbody>
</table>
Pharmacologic Prophylaxis

Pharmacologic Prophylaxis Not Recommended

<table>
<thead>
<tr>
<th>NOT RECOMMENDED</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-exposure or post-exposure prophylaxis with antiviral therapy is not recommended.</td>
<td>III, C</td>
</tr>
</tbody>
</table>

Pre-exposure or post-exposure prophylaxis with antiviral therapy is not recommended.
Although direct-acting antiviral (DAA) treatment regimens are highly efficacious and more tolerable than interferon-based therapy, there are no data on the efficacy or cost-effectiveness of antiviral therapy for pre-exposure or post-exposure prophylaxis of HCV infection. Some studies have shown that post-exposure treatment with an interferon-based regimen does not prevent infection (Nakano, 1995; Arai, 1996).

### Medical Management and Monitoring of Acute HCV Infection

<table>
<thead>
<tr>
<th>Recommendations for Medical Management and Monitoring of Acute HCV Infection</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RECOMMENDED</strong></td>
</tr>
<tr>
<td>Regular laboratory monitoring is recommended in the setting of acute HCV infection. Monitoring HCV RNA (eg, every 4 to 8 weeks) for 6 to 12 months is also recommended to determine spontaneous clearance versus persistence of HCV infection.</td>
</tr>
<tr>
<td>Counseling is recommended for patients with acute HCV infection to avoid hepatotoxic insults, including hepatotoxic drugs (eg, acetaminophen) and alcohol consumption, and to reduce the risk of HCV transmission to others.</td>
</tr>
<tr>
<td>Referral to an addiction medicine specialist is recommended for patients with acute HCV infection related to substance use.</td>
</tr>
</tbody>
</table>

Patients with acute HCV infection should be counseled to reduce behaviors that could result in virus transmission, such as sharing injection equipment and engaging in high-risk sexual practices. Because the risk of transmission of other bloodborne, sexually transmitted infections (eg, HIV and HBV) is higher in the acute infection phase, some experts counsel patients with acute HCV to consider using barrier precautions, even in a stable monogamous relationship (see HCV Testing and Linkage to Care). For individuals with acute HCV infection who have a history of recent injection drug use, referral to an addiction medicine specialist is recommended when appropriate (Litwin, 2009; Strathdee, 2005).

Patients with acute hepatitis C are often asymptomatic or have nonspecific symptoms (eg, fatigue, anorexia, mild or moderate abdominal pain, low-grade fever, nausea, and/or vomiting) that frequently are not recognized as being associated with acute HCV infection. A small proportion (<25%) of patients with acute HCV develop jaundice. Patients diagnosed with acute HCV should initially be monitored with hepatic panels (ALT, aspartate aminotransferase [AST], bilirubin, and international normalized ratio [INR] in the setting of an increasing bilirubin level) at 2- to 4-week intervals (Blackard, 2008). Laboratory monitoring should continue until the ALT level normalizes and HCV RNA becomes repeatedly undetectable, suggesting spontaneous resolution. If this does not occur, frequency of laboratory monitoring for patients with persistently detectable HCV RNA and elevated ALT levels should follow recommendations for monitoring patients with chronic HCV infection (see Monitoring Patients Who Are Starting Hepatitis C Treatment, Are on Treatment, or Have Completed Therapy).

HCV infection spontaneously clears in 20% to 50% of patients (Kamal, 2008). In at least two-thirds of patients who spontaneous clear acute HCV infection, this occurs within 6 months of the estimated time of infection (median, 16.5 weeks). Only 11% of those who remain viremic at 6 months will spontaneously clear the infection at a later time (Grebely, 2014). Thus, detectable HCV RNA at 6 months after the time of infection will identify most persons who need antiviral
therapy (see [When and in Whom to Initiate HCV Therapy](#)).

Patients who spontaneous clear should not be treated with antiviral therapy. However, they should be counseled about the possibility of reinfection and tested routinely for this development if risk behaviors are ongoing (see [HCV Testing and Linkage to Care](#)). Of note, transient suppression of viremia can occur in those with acute HCV infection, even among those who progress to chronic infection. Thus, a single undetectable HCV RNA test result is insufficient to declare spontaneous clearance (see [HCV Testing and Linkage to Care](#)); (Villano, 1999); (Mosley, 2008).

Predictors of spontaneous clearance include jaundice, elevated ALT level, hepatitis B virus surface antigen (HBsAg) positivity, female sex, younger age, genotype 1 infection, and host genetic polymorphisms, most notably those near the IL28B gene (Kamal, 2008); (Mosley, 2008).

There is no need to alter concomitant medications that are metabolized by hepatic enzymes unless there is concern for developing acute liver failure (eg, increasing bilirubin level and INR). Acetaminophen and alcohol consumption should be avoided during acute HCV infection (Proeschold-Bell, 2012); (Dieperink, 2010); (Whitlock, 2004). Hospitalization is rarely indicated unless nausea and vomiting are severe.

Although acute liver failure is very rare (<1%), it represents a serious and life-threatening complication of acute HCV infection. Patients with an INR >1.5 and those who exhibit any signs of acute liver failure (eg, hepatic encephalopathy) should be referred to a liver transplant center immediately. The use of HCV antiviral regimens in acute liver failure should be managed by a clinician experienced in HCV treatment, ideally in consultation with a liver transplant specialist.

**Antiviral Therapy**

### Recommended Treatment for Patients With Acute HCV Infection

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>RATING 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the clinician and patient decide that a delay in treatment initiation is acceptable, monitoring for spontaneous clearance is recommended for a minimum of 6 months. When the decision is made to initiate treatment after 6 months, treating as described for chronic hepatitis C is recommended (see <a href="#">Initial Treatment of HCV Infection</a>).</td>
<td>IIa, C</td>
</tr>
<tr>
<td>If a decision is made to initiate treatment during the acute infection period, monitoring HCV RNA for at least 12 to 16 weeks before starting treatment is recommended to allow time for possible spontaneous clearance.</td>
<td>IIa, C</td>
</tr>
</tbody>
</table>

### Recommended Regimens for Patients With Acute HCV Infection

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>RATING 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owing to high efficacy and safety, the same regimens that are recommended for chronic HCV infection are recommended for acute infection.</td>
<td>IIa, C</td>
</tr>
</tbody>
</table>

### When Antiviral Therapy Is Not Recommended

<table>
<thead>
<tr>
<th>NOT RECOMMENDED</th>
<th>RATING 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>For patients in whom HCV infection spontaneously clears, antiviral treatment is not recommended.</td>
<td>III, B</td>
</tr>
</tbody>
</table>
In the interferon era, the efficacy of acute HCV infection treatment (particularly for genotype 1), including abbreviated regimens, was superior to the treatment of chronic infection (Ghany, 2009). There are emerging data on the treatment of acute HCV infection with shortened courses of all-oral, DAA regimens both in HCV monoinfection and HIV/HCV coinfection. But as yet, there are insufficient data to support a particular regimen or treatment duration. Until more definitive data are available, monitoring for spontaneous clearance for a minimum of 6 months before initiating treatment is recommended. When the decision is made to initiate antiviral therapy after 6 months, treatment as described for chronic hepatitis C is recommended (see Initial Treatment of HCV Infection and When and in Whom to Initiate HCV Therapy).

There are instances wherein a clinician may decide that the benefits of early treatment outweigh waiting for possible spontaneous clearance. These include situations where importance is placed on:

- HCV transmission prevention (eg, a surgeon, a person with ongoing intravenous drug use, or an HIV-positive man who engages in sex with other men)
- Mitigation of clinical consequences (eg, a patient with cirrhosis who is acutely superinfected with HCV)
- Reduction in the likelihood of loss to follow-up (eg, a patient who may not be engaged in care in 3 to 6 months)

Referral to an addiction specialist and harm reduction counseling should be provided if relevant. If a decision is made to initiate treatment during the acute infection period, the same regimens recommended for chronic HCV infection are recommended for acute infection, given their high efficacy and safety in chronic HCV infection (see Initial Treatment of HCV Infection and When and in Whom to Initiate HCV Therapy sections).

Last update: September 21, 2017
HCV in Pregnancy

Testing

Recommendation for Universal Hepatitis C Screening in Pregnancy

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>All pregnant women should be tested for HCV infection (see Recommendations for Initial HCV Testing and Follow-Up), ideally at the initiation of prenatal care.</td>
<td>IIb, C</td>
</tr>
</tbody>
</table>

It has been estimated that up to 29,000 HCV-infected women gave birth each year from 2011 to 2014 (Ly, 2017). With the current increases in HCV among young adults, including women of childbearing age (Koneru, 2016); (Kuncio, 2016); (Watts, 2017), there is now discussion about universal screening of pregnant women (Prasad, 2016). Risk factor-based testing has never been shown to be effective (Kuncio, 2015); (Waruingi, 2015); (Fernandez, 2016) and inconsistent screening and counseling practices have been reported among obstetricians and gynecologists (Boaz, 2003). The Society for Maternal-Fetal Medicine recommends several obstetrical practices in women with HCV infection, including preference for amniocentesis over chorionic villus sampling when invasive prenatal diagnostic testing is indicated, as well as avoidance of internal fetal monitoring during labor, prolonged rupture of membranes, and episiotomies (Hughes, 2017). There are, however, no data to support elective cesarean delivery for HCV-infected women. Identifying HCV as women engage in prenatal care would allow for appropriate assessment of liver disease status and ideally facilitate linkage to HCV care after delivery. In addition, prenatal HCV diagnosis is a prerequisite for appropriate screening and care for the exposed children. Moreover, the cost-effectiveness of HCV screening in other clinical settings has improved with progressively lower costs of direct-acting antiviral-based treatment (Selvapatt, 2015); (Assoumou, 2018).

To enhance mothers’ health and address public health concerns, universal testing of pregnant women for current HCV infection is recommended (see Recommendations for Initial HCV Testing and Follow-Up). Testing at the initiation of prenatal care is considered optimal to maximize opportunities for education, referral, and appropriate testing for the exposed infant. Early identification is key as women living with HCV and their exposed infants are at significant risk for not linking to appropriate evaluation or care. Women should be tested with an HCV-antibody test. If positive, this should be followed with testing for HCV RNA. HCV-infected pregnant women should be linked to care so that antiviral treatment can be initiated at the appropriate time (see the HCV Testing and Linkage to Care section). Infants of HCV-infected women should be tested and followed as described in the HCV in Children section.

Whom to Treat

Recommendation Regarding HCV Treatment and Pregnancy

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>I, B</td>
</tr>
</tbody>
</table>
Women of reproductive age with HCV should be counseled about the benefit of antiviral treatment prior to pregnancy to improve the health of the mother and eliminate the low risk of mother-to-child transmission (MTCT). The safety of direct-acting antivirals (DAAs) in pregnancy is unknown, and there are no data on the effect of DAAs on male or female fertility. However, ribavirin is contraindicated in pregnancy due to its known teratogenicity. In addition, the risk for teratogenicity persists for up to 6 months after ribavirin cessation and applies to women taking ribavirin and female partners of men taking ribavirin. Women who become pregnant while on DAA therapy (with or without ribavirin) should discuss the risks versus benefits of continuing treatment with their physicians. If exposed to ribavirin, they should also have their maternal and fetal outcomes reported to the ribavirin pregnancy registry (see also, Recommended Monitoring for Pregnancy-Related Issues Prior to and During Antiviral Therapy That Includes Ribavirin).

**Monitoring During Pregnancy**

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>I, B</td>
</tr>
<tr>
<td>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.</td>
<td>I, B</td>
</tr>
<tr>
<td>In HCV-infected pregnant women with pruritus or jaundice, there should be a high index of suspicion for intrahepatic cholestasis of pregnancy (ICP) with subsequent assessment of alanine aminotransferase (ALT), aspartate aminotransferase (AST), and serum bile acids.</td>
<td>I, B</td>
</tr>
<tr>
<td>HCV-infected women with cirrhosis should be counseled about the increased risk of adverse maternal and perinatal outcomes. Antenatal and perinatal care should be coordinated with a maternal-fetal medicine (ie, high-risk pregnancy) obstetrician.</td>
<td>I, B</td>
</tr>
</tbody>
</table>

**Pregnancy Impact on HCV Infection**

Pregnancy itself does not appear to negatively affect chronic HCV infection. In general, serum ALT levels decrease during the first and third trimesters of pregnancy and increase after delivery. HCV RNA levels rise during the first and third trimesters, reaching a peak during the third trimester, and decrease postpartum (Conte, 2000); (Gervais, 2000). These effects are likely due to the immunosuppressive effects of pregnancy. HCV-infected pregnant women have a higher incidence of intrahepatic cholestasis of pregnancy (ICP) (pooled OR 20.40 [95% CI, 9.39-44.33, I2=55%]) based on a meta-analysis of 3 studies when compared to noninfected pregnant women (Wijarnpreecha, 2017). ICP is associated with an increased rate of adverse maternal and fetal outcomes; all patients with this syndrome should be immediately referred...
to a high-risk obstetrical specialist for monitoring and treatment.

**HCV Infection Impact on Pregnancy and Perinatal Outcomes**

Although some studies show an increased risk of adverse perinatal outcomes (eg, preterm delivery, low birth weight infants, and congenital anomalies) with maternal HCV infection, these risks are confounded by comorbid conditions, such as substance use (Connell, 2011). However, pregnant women with cirrhosis are at increased risk for poor maternal outcomes (ie, preeclampsia, cesarean section, hemorrhagic complication, and death) and neonatal outcomes (ie, preterm delivery, low birth weight, and neonatal death) (Puljic, 2016); (Tan, 2008). Women with cirrhosis should be counseled about these increased risks and care should be coordinated with specialists in maternal-fetal medicine.

Hepatitis C MTCT occurs at an overall rate of 5% to 15% (Mast, 2005); (Ceci, 2001); (Shebl, 2009); (Jhaveri, 2015), with the number that progress to chronic infection being 3% to 5%. No specific risk factor predicts transmission and no specific intervention (eg, antiviral, mode of delivery, or others) has been demonstrated to reduce transmission—except for suppression of HIV replication in women with HIV/HCV coinfection (Checa Cabot, 2013). Given the potential associated risk of MTCT, it is advisable to avoid invasive procedures (eg, fetal scalp monitors and forceps delivery).

The neuropsychiatric and systemic side effects of interferon-based agents and the pregnancy category X rating of ribavirin made studies involving these drugs to interrupt MTCT untenable for safety reasons. It is important to note that DAAs have not been studied as a way to interrupt MTCT. These drugs have not demonstrated significant toxicity in animal studies, and antiviral medication use has become the standard of care for people with HIV and hepatitis B infection. Therefore, it is realistic to think that DAAs could be used in the future to interrupt MTCT. However, with a low transmission rate, improved methods to identify mothers who are likely to transmit are needed to reduce the number needed to treat below 20 to prevent 1 transmission event. DAA therapy is not recommended during pregnancy to reduce MTCT due to the current lack of safety and efficacy data.

**Postpartum Issues**

**Recommendations Regarding Breastfeeding and Postpartum Care for HCV-Infected Women**

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastfeeding is not contraindicated in women with HCV infection, except when the mother has cracked, damaged, or bleeding nipples, or in the context of HIV coinfection.</td>
<td>I, B</td>
</tr>
<tr>
<td>Women with HCV infection should have their HCV RNA reevaluated after delivery to assess for spontaneous clearance.</td>
<td>I, B</td>
</tr>
</tbody>
</table>

**HCV and Breastfeeding**

Breastfeeding is not a risk for HCV MTCT (CDC, 1998) with studies showing similar rates of maternal infection in breastfed and bottle-fed infants (Resti, 1998). However, given the associated risks of HCV transmission with blood exposure and HIV transmission with breastfeeding, we recommend that HCV-infected women who breastfeed abstain from doing so while their nipples are cracked, damaged, or bleeding, or in the context of HIV/HCV coinfection.

**Spontaneous Clearance in the Postpartum Period**

HCV RNA levels can fluctuate during pregnancy and the postpartum period. The most frequently observed pattern is a steady rise in HCV RNA levels during pregnancy followed by a slight or significant drop (>3-4 log) in the postpartum period.
(Lin, 2000). This is most likely due to the release of tolerance in HCV-specific T lymphocyte responses that develops during pregnancy (Honegger, 2013). Spontaneous clearance of HCV can occur in the postpartum period. Previous studies with small numbers of patients demonstrated that up to 10% of postpartum women became HCV RNA undetectable (Hattori, 2003); (Lin, 2000); (Honegger, 2013). A recent study from Egypt demonstrated a 25% rate of spontaneous resolution that was strongly associated with the favorable IL28B allele (Hashem, 2017).

Given these findings, women should have their HCV RNA reevaluated after delivery. In that time, HCV RNA could become undetectable or rebound to prepregnancy levels. The possibility of spontaneous viral clearance should be considered for any woman who is being assessed for DAA treatment in the postpartum period.

Last update: May 24, 2018
HCV in Children

Testing

**Recommendations for HCV Testing of Perinatally Exposed Children and Siblings of HCV-Infected Children**

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>All children born to HCV-infected women should be tested for HCV infection. Testing is recommended using an antibody-based test at or after 18 months of age.</td>
<td>I, A</td>
</tr>
<tr>
<td>Testing with an HCV-RNA assay can be considered in the first year of life, but the optimal timing of such a test is unknown.</td>
<td>IIa, C</td>
</tr>
<tr>
<td>Repetitive testing by HCV RNA is not recommended.</td>
<td>III, A</td>
</tr>
<tr>
<td>Children who are anti-HCV positive after 18 months of age should be tested with an HCV-RNA assay after age 3 to confirm chronic hepatitis C infection.</td>
<td>I, A</td>
</tr>
<tr>
<td>The siblings of children with vertically-acquired chronic HCV should be tested for HCV infection, if born from the same mother.</td>
<td>I, C</td>
</tr>
</tbody>
</table>

Although the prevalence of chronic HCV is lower in children than adults, an estimated 5 million children worldwide have active HCV infection (Gower, 2014). Data from the National Health and Nutrition Examination Survey (NHANES) collected between 2003 and 2010 indicates that 0.2% of 6- to 11-year-olds (31,000 children) and 0.4% of 12- to 19-year-olds (101,000 adolescents) in the US are chronically infected with HCV (Denniston, 2014).

As birth to an HCV-infected mother is a known risk for infection, such offspring should be evaluated and tested for HCV. The rate of mother-to-child transmission (MTCT) of HCV infection is approximately 5%, although rates are higher among women with inadequately controlled HIV coinfection, and women with higher HCV-RNA levels, or viral loads (>6 log IU/mL) (Benova, 2014); (Delotte, 2014); (Cottrell, 2013). Identifying, following, and treating exposed children is recommended. The basis for evaluation early in life is HCV-RNA testing, as maternal antibodies and consequently anti-HCV assay positivity may persist for 18 months. About 25% to 50% of infected infants spontaneously resolve HCV infection (loss of previously detectable HCV RNA) by 3 years of age (EPHCVN, 2005); (Mast, 2005).

There is considerable debate about the utility of HCV-RNA testing within the first year of life. Proponents argue that use of a highly sensitive RNA assay early in life can increase the rate of infected infants detected, and that a negative result strongly suggests the infant is not infected while a positive result helps identify HCV cases earlier. Opponents argue that early testing does not change the need for definitive testing at or after 18 months; HCV RNA is more expensive than an antibody-based test; and there is no intervention or treatment that will occur prior to age 3—because of lack of approved drugs for this age group and to allow for possible spontaneous clearance. On balance, optional early HCV-RNA testing may facilitate more infants getting tested and retained in care if they are positive. The optimal timing of HCV-RNA testing is still unknown, but 2 to 6 months after birth is reasonable. There is no value in repeated HCV-RNA testing prior to 18 months of age, but anti-HCV testing should take place at or after 18 months of age.
Transmission and Prevention

Recommendations for Counseling Parents Regarding Transmission and Prevention in HCV-Infected Children

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents should be informed that hepatitis C is not transmitted by casual contact and, as such, HCV-infected children do not pose a risk to other children and can participate in school, sports, and athletic activities, and engage in all other regular childhood activities without restrictions.</td>
<td>I, B</td>
</tr>
<tr>
<td>Parents should be informed that universal precautions should be followed at school and in the home of children with HCV infection. Educate families and children about the risk and routes of HCV transmission, and the techniques for avoiding blood exposure, such as avoiding the sharing of toothbrushes, razors, and nail clippers, and the use of gloves and dilute bleach to clean up blood.</td>
<td>I, B</td>
</tr>
</tbody>
</table>

HCV-infected children often face discrimination and stigmatization in school and child-care settings that is driven by inadequate public understanding of hepatitis C. HCV is not transmitted by casual contact in the absence of blood exposure. Families should not be forced to disclose a child’s HCV infection status, and children should not be restricted from any routine childhood activity.

The risk of sexual transmission of hepatitis C is considered very low/rare. Sexual transmission occurs but generally seems to be inefficient except among HIV-infected men who have unprotected sex with men (see HCV Testing and Linkage to Care) (Schmidt, 2014). Adolescents with HIV infection and those with multiple sexual partners or sexually transmitted infections (STIs) should be encouraged to use barrier precautions to prevent sexual transmission of HCV and other STIs. Other adolescents with HCV infection should be counseled that the risk of sexual transmission is low but barrier precautions are recommended for other reasons (see Testing and Linkage to Care: Table 2 - Measures to Prevent Transmission of HCV).
Monitoring and Medical Management

### Recommendations for Monitoring and Medical Management of HCV-Infected Children

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine liver biochemistries at initial diagnosis and at least annually thereafter are recommended to assess for disease progression.</td>
<td>I, C</td>
</tr>
<tr>
<td>Appropriate vaccinations are recommended for HCV-infected children not immune to hepatitis B virus and/or hepatitis A virus to prevent these infections.</td>
<td>I, C</td>
</tr>
<tr>
<td>Disease severity assessment via routine laboratory testing and physical examination, as well as use of evolving noninvasive modalities (ie, elastography, imaging, or serum fibrosis markers) is recommended for all children with chronic HCV.</td>
<td>I, B</td>
</tr>
<tr>
<td>Children with cirrhosis should undergo hepatocellular carcinoma (HCC) surveillance and endoscopic surveillance for varices per standard recommendations.</td>
<td>I, B</td>
</tr>
<tr>
<td>Hepatotoxic drugs should be used with caution in children with chronic HCV after assessment of potential risk versus benefit of treatment. Use of corticosteroids, cytotoxic chemotherapy, or therapeutic doses of acetaminophen are not contraindicated in children with chronic HCV.</td>
<td>II, C</td>
</tr>
<tr>
<td>Solid organ transplantation and bone marrow transplantation are not contraindicated in children with chronic HCV.</td>
<td>II, C</td>
</tr>
<tr>
<td>Anticipatory guidance about the potential risks of ethanol for progression of liver disease is recommended for children with HCV and their families. Abstinence from alcohol and interventions to facilitate cessation of alcohol consumption, when appropriate, are advised for all persons with HCV infection.</td>
<td>I, C</td>
</tr>
</tbody>
</table>

In children, liver disease due to chronic HCV infection generally progresses slowly, and cirrhosis and liver cancer are infrequently encountered. Although elevated serum aminotransferase levels are often noted, HCV-infected children younger than 3 years virtually never have advanced liver disease.

The initial assessment of children with chronic HCV infection includes exclusion of other causes of liver disease, assessment of disease severity, and detection of extrahepatic manifestations of HCV. Testing for concomitant HBV (HBsAg, anti-HBc, and anti-HBs), HIV (anti-HIV), and immunity to HAV (anti-HAV IgG) are recommended due to shared risk factors and the need to vaccinate all nonimmune children that may not have received routine childhood vaccines against HAV and HBV.

Disease staging in children can be accomplished via physical examination and the assessment of routine laboratory parameters including albumin, serum aminotransferase levels, total bilirubin, international normalized ratio (INR), and platelet count every 6 to 12 months. Serum fibrosis markers also hold promise to stratify disease severity but require further validation (Mack, 2012). Of note, serum aminotransferase levels are not consistently reflective of disease severity in children. In one study nearly 33% of children had normal aminotransferase levels despite substantial necroinflammation on biopsy (Casiraghi, 2004).
For children in whom advanced liver disease is a concern, liver imaging to evaluate for splenomegaly or venous collaterals is recommended initially, using liver ultrasound instead of CT or MRI due to its widespread availability and lack of ionizing radiation. Although liver biopsy is considered the gold standard regarding the grade of inflammation and stage of fibrosis, sampling artifact is problematic and most patients and practitioners prefer noninvasive alternatives, such as liver elastography, to determine the presence/absence of cirrhosis, particularly in children. Ultrasound-based liver elastography in children requires the use of specialized probes and cutoff values for advanced fibrosis/cirrhosis that differ from those used in adults, but this approach appears promising for monitoring children with chronic HCV infection (Behairy, 2016); (Geng, 2016); (Lee, 2013).

Due to the slow rate of fibrosis progression among children, there are few, if any, established bona fide risk factors for disease progression. Development of advanced liver disease in children is infrequent until more than 30 years of infection (Jhaveri, 2011); (Goodman, 2008); (Minola, 2002). However, as in adults, children with comorbid disease—such as obesity with nonalcoholic fatty liver disease and congenital heart disease with elevated right heart pressures—and those receiving hepatotoxic drugs should be monitored carefully for disease progression.

Hepatocellular carcinoma (HCC) is rarely encountered among children and has been reported almost exclusively in children with cirrhosis. There are reports that children with chronic HCV and a history of childhood leukemia may be at increased risk of developing HCC, but evidence is limited (González-Peralta, 2009). In children with cirrhosis, liver ultrasound with or without serum alpha-fetoprotein (AFP) testing every 6 months is recommended for HCC surveillance per AASLD guidelines (Bruix, 2011). A baseline endoscopy is advisable to detect esophageal varices in children with cirrhosis and every 3 years thereafter in the absence of antiviral therapy. After successful antiviral therapy, the risk for cirrhosis complications is substantially less.

In children with advanced fibrosis from chronic HCV, medications that are known to accelerate hepatic fibrosis (eg, methotrexate) should be avoided if possible. Similarly, abstinence from alcohol use is strongly advised to minimize disease progression. Although corticosteroids and other immunosuppressants may enhance HCV replication, they are not contraindicated in children with HCV and should be prescribed for appropriate indications based on overall risk vs benefit. Of note, icteric flares of HCV—as reported in children and adults with chronic HBV—have not been reported in children receiving organ transplants or cytotoxic chemotherapy. Although underlying liver disease is a risk factor for development of sinusoidal obstruction syndrome following bone marrow transplantation, the presence of HCV infection should not delay this therapy.

To remain well, untreated children with chronic hepatitis C are encouraged to maintain a healthy body weight due to the known deleterious effects of insulin resistance on fibrosis progression with HCV infection. Other commonly used medications, such as antimicrobial agents, antiepileptics, and cardiovascular agents, should be dosed per standard recommendations. However, NSAIDs and aspirin should be avoided, if possible, in children with cirrhosis and esophageal varices due to concerns of gastrointestinal bleeding and nephrotoxicity. Acetaminophen is a safe and effective analgesic for children with chronic HCV infection when dosed per package insert recommendations.
# Treatment

## Recommendations for Whom and When to Treat Among HCV-Infected Children

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>If direct-acting antiviral (DAA) regimens are available for a child’s age group, treatment is recommended for all HCV-infected children older than 3 years as they will benefit from antiviral therapy, independent of disease severity.</td>
<td>I, B</td>
</tr>
<tr>
<td>Treatment of children aged 3 to 11 years with chronic hepatitis C should be deferred until interferon-free regimens are available.</td>
<td>II, C</td>
</tr>
<tr>
<td>The presence of extrahepatic manifestations—such as cryoglobulinemia, rashes, and glomerulonephritis—as well as advanced fibrosis should lead to early antiviral therapy to minimize future morbidity and mortality.</td>
<td>I, C</td>
</tr>
</tbody>
</table>

## Recommended regimens listed by evidence level and alphabetically for:

### Adolescents ≥12 Years Old or Weighing ≥35 kg, Without Cirrhosis or With Compensated Cirrhosis

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>DURATION</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily fixed-dose combination of ledipasvir (90 mg)/sofosbuvir (400 mg) for patients with genotype 1 who are treatment-naive without cirrhosis or with compensated cirrhosis[^a], or treatment-experienced[^b] without cirrhosis</td>
<td>12 weeks</td>
<td>I, B</td>
</tr>
<tr>
<td>Daily fixed-dose combination of ledipasvir (90 mg)/sofosbuvir (400 mg) for patients with genotype 1 who are treatment-experienced[^b] with compensated cirrhosis[^a]</td>
<td>24 weeks</td>
<td>I, B</td>
</tr>
<tr>
<td>Daily sofosbuvir (400 mg) plus weight-based ribavirin[^c] for patients with genotype 2 who are treatment-naive or treatment-experienced[^b] without cirrhosis or with compensated cirrhosis[^a]</td>
<td>12 weeks</td>
<td>I, B</td>
</tr>
<tr>
<td>Daily sofosbuvir (400 mg) plus weight-based ribavirin[^c] for patients with genotype 3 who are treatment-naive or treatment-experienced[^b] without cirrhosis or with compensated cirrhosis[^a]</td>
<td>24 weeks</td>
<td>I, B</td>
</tr>
<tr>
<td>Daily fixed-dose combination of ledipasvir (90 mg)/sofosbuvir (400 mg) for patients with genotype 4, 5, or 6 who are treatment-naive or treatment-experienced[^b] without cirrhosis or with compensated cirrhosis[^a]</td>
<td>12 weeks</td>
<td>I, B</td>
</tr>
</tbody>
</table>

[^a]: Child-Pugh A  
[^b]: Patients who have failed an interferon-based regimen, with or without ribavirin  
[^c]: See ribavirin dosing table for recommended weight-based dosages.
**Table. Dosing for Ribavirin in Combination Therapy With Sofosbuvir for Adolescents ≥12 Years Old or Weighing ≥35 kg**

<table>
<thead>
<tr>
<th>Body Weight (kg)</th>
<th>Daily Ribavirin Dosage (in 2 divided doses)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;47</td>
<td>15 mg/kg/day</td>
</tr>
<tr>
<td>47–49</td>
<td>600 mg/day</td>
</tr>
<tr>
<td>50–65</td>
<td>800 mg/day</td>
</tr>
<tr>
<td>66–80</td>
<td>1000 mg/day</td>
</tr>
<tr>
<td>&gt;80</td>
<td>1200 mg/day</td>
</tr>
</tbody>
</table>

Advanced liver disease due to HCV infection is uncommon during the childhood years. However, liver disease progresses over time with increasing fibrosis severity. Although uncommon, cirrhosis is occasionally seen in infected children and adolescents younger than 18. Children have a long life expectancy during which HCV complications may develop. Infected children and adolescents may also transmit HCV to others.

DAA regimens have a very high success rate in adults with chronic HCV infection. In addition, interferon-based regimens have limited success in children with genotype 1 or 4 infection. Interferon and ribavirin have general and pediatric-specific toxicities (eg, temporary growth impairment) that do not occur with DAA regimens. Several clinical trials are underway, early data have been published, and DAA regimens are now available for adolescents 12 years and older. It is anticipated that additional safe and effective DAA regimens will be available for children aged 3 through 11 in the near future.

In a phase 2, multicenter open-label study of 100 adolescents with chronic genotype 1 infection treated for 12 weeks with the adult formulation of ledipasvir-sofosbuvir, sustained virologic response (SVR) was documented in 98% of participants (Balistreri, 2017). The two patients who did not achieve SVR12 were lost to follow-up during or after treatment. Most of the patients were treatment naive (80%). One patient had cirrhosis, 42 did not, and the cirrhosis status was unknown in the remaining 57. The regimen was safe and well tolerated in this population, and the adult dosage formulation resulted in pharmacokinetic characteristics similar to those observed in adults.

The combination of sofosbuvir and ribavirin at doses approved for adults was tested in adolescents with chronic genotype 2 (12 weeks of treatment) or genotype 3 (24 weeks of treatment) infection (Wirth, 2017). Of the 52 adolescents, 75% had genotype 3 infection, and 83% were treatment naive. Cirrhosis status was negative in 40% and unknown in 60% of the participants. SVR12 rates were 100% (13/13) and 97% (38/39) in genotype 2 and 3 infections, respectively. This regimen was safe and well tolerated, and pharmacokinetic properties of sofosbuvir were equivalent to those observed in adults.

**Last update:** May 24, 2018
Management of Key Populations With Chronic HCV Infection

People who inject drugs (PWID), men who have sex with men (MSM), and individuals in jails and prisons bear a particularly high burden of chronic HCV infection. Injection drug use accounts for the majority of new HCV infections, and the rising opioid epidemic has become an important force in the perpetuation of the HCV epidemic. Acute HCV infection is also increasingly being reported among HIV-infected and -uninfected MSM due to a variety of risk factors. Finally, HCV infection disproportionately affects individuals in correctional institutions, where the prevalence of infection ranges from 17% to 23% (Varan, 2014); (Edlin, 2015), far exceeding the 1.0% prevalence in the general population (Denniston, 2014). More than 90% of these individuals are ultimately released and re-enter the general population, where they can contribute to HCV transmission and develop liver-related and extrahepatic complications (Macalino, 2004); (Rich, 2014).

Achieving the goal of HCV elimination will depend on diagnosing HCV and treating HCV infection in these groups, and implementing harm reduction strategies to prevent future infections. As a result, the panel has chosen to focus attention on HCV management among these key populations to reduce HCV transmission and decrease HCV-related morbidity and mortality. The first subsection of the key populations guidance focuses on recommendations for HCV testing, treatment, and harm reduction among PWID. The second subsection focuses on testing, treatment, and prevention of HCV among MSM. The final subsection provides recommendations for screening and treatment of HCV in jail and prison settings. Chronic HCV cannot be eliminated without implementation of strategies to reach these populations, and the recommendations in these subsections provide guidance in this effort.

The following subsections include guidance for management of patients with HCV in key populations.

- Key Populations: Identification and Management of HCV in People Who Inject Drugs
- HCV in Key Populations: Men Who Have Sex With Men
- HCV Testing and Treatment in Correctional Settings

Last update: May 24, 2018
Key Populations: Identification and Management of HCV in People Who Inject Drugs

Prevalence of HCV Among People Who Inject Drugs

Injection drug use (IDU) is the most common risk factor for HCV infection in the United States and Europe, with an HCV seroprevalence of 10% to 70% depending on geographic location and duration of IDU exposure (Hagan, 2008); (Amon, 2008); (Nelson, 2011). In this section, the term people who inject drugs (PWID) includes individuals who are actively using drugs and those who have previously used injection drugs.

The first few years after an individual begins to inject drugs constitute a high-risk period in which the rate of HCV infection can exceed 40% (Maher, 2006). According to the National Survey on Drug Use and Health, heroin use has increased across the US among men and women, most age groups, and all income levels (CDC, 2015b). IDU accounts for the majority of new HCV infections (approximately 70%) and is the driving force in the perpetuation of the epidemic. Given these facts and the absence of a vaccine against HCV, testing and linkage to care combined with HCV treatment have the potential to dramatically decrease HCV incidence and prevalence (Martin, 2013); (NAS, 2017).

Recommendations for Screening and Treatment of HCV Infection in People Who Inject Drugs (PWID)

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
<th>RATING</th>
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<tbody>
<tr>
<td>Annual HCV testing is recommended for PWID with no prior testing, or past negative testing and subsequent injection drug use. Depending on the level of risk, more frequent testing may be indicated.</td>
<td>IIa, C</td>
</tr>
<tr>
<td>Substance use disorder treatment programs and needle/syringe exchange programs should offer routine, opt-out HCV-antibody testing with reflexive or immediate confirmatory HCV-RNA testing and linkage to care for those who are infected.</td>
<td>IIa, C</td>
</tr>
<tr>
<td>PWID should be counseled about measures to reduce the risk of HCV transmission to others.</td>
<td>I, C</td>
</tr>
<tr>
<td>PWID should be offered linkage to harm reduction services when available, including needle/syringe service programs and substance use disorder treatment programs.</td>
<td>I, B</td>
</tr>
<tr>
<td>Active or recent drug use or a concern for reinfection is <strong>not</strong> a contraindication to HCV treatment.</td>
<td>IIa, B</td>
</tr>
</tbody>
</table>

HCV Testing Among PWID

All individuals who currently inject drugs or have used injection drugs in the past should be tested for HCV infection. Data are limited regarding the optimal interval for repeat testing among individuals actively using drugs. An HCV-antibody test is recommended and if the result is positive, current infection should be confirmed by immediate HCV-RNA testing (see HCV Testing and Linkage to Care). This can be accomplished using phlebotomy for a combined reflex test performed by a laboratory, which is appropriate for clinical settings. In certain community settings, a point-of-care antibody test with an immediate blood draw for a confirmatory HCV-RNA test may be implemented.

Among persons at risk of HCV reinfection after previous spontaneous or treatment-related viral clearance, HCV-RNA testing is recommended because an HCV-antibody test is expected to remain positive. Among persons with a negative HCV-antibody test who are at high risk for a new HCV infection due to current IDU, testing for HCV RNA or follow-up
testing for HCV antibody is recommended if HCV exposure may have occurred within the past 6 months.

Integration of HCV testing services into harm reduction services provided by medication-assisted treatment (MAT) programs, needle/syringe programs, and acute detoxification programs provide an opportunity for routine screening in this key population (Harris, 2010; Aronson, 2017).

**Linkage to HCV Care and Treatment Adherence**

Ideally, treatment of HCV-infected PWID should be delivered in a multidisciplinary care setting with services to reduce reinfection risk and manage the common social and psychiatric comorbidities in this population. Regardless of the treatment setting, recent and active IDU should not be seen as an absolute contraindication to HCV therapy. There is strong evidence from various settings in which PWID have demonstrated adherence to treatment and low rates of reinfection, countering arguments that have been commonly used to limit HCV therapy access in this patient population (Aspinall, 2013; Hellard, 2014; Grebely, 2011; Dore, 2016). Indeed, combining HCV treatment with needle/syringe exchange and opioid substitution treatment programs in this population with a high prevalence of HCV infection has shown great value in decreasing the burden of HCV disease.

Modeling studies illustrate the high return on the modest investment of addressing this often-ignored segment of the HCV-infected population (Martin, 2013b). Conversely, there are no data to support the utility of pretreatment screening for illicit drug or alcohol use in identifying a population more likely to successfully complete HCV therapy. These requirements should be abandoned because they create barriers to treatment, add unnecessary cost and effort, miss an opportunity to decrease HCV transmission, and potentially exclude populations that are likely to obtain substantial benefit from therapy. Instead, scaling up HCV treatment in PWID is necessary to positively impact the HCV epidemic in the US and globally.

In addition, recent hepatitis C test-and-link programs have identified the use of patient navigators or care coordinators to be an important intervention in overcoming challenges to linkage to and retention in care (Trooskin, 2015; Coyle, 2015; Ford, 2017). The Check Hep C program in New York City compared services delivered at 2 clinical care sites to 2 sites that linked patients to off-site care. Participants receiving clinical care co-located with testing services had higher odds of initiating treatment than those linked to off-site care (Ford, 2017). Ongoing assessment of efficacy and comparative effectiveness of this and additional strategies is a crucial area of future research for patients with chronic HCV. Replication and expansion of best practices and new models for linkage to HCV care will be crucial to maximize the public health impact of newer HCV treatment paradigms.

**HCV Treatment Among PWID**

Clinical trials among PWID reporting current IDU at the start of HCV treatment and/or continued use during therapy demonstrate SVR12 rates approaching 95% (Dore, 2016; Grebely, 2018). Moreover, high SVR rates among PWID are not limited to clinical trials but are also observed in clinical practice settings. A cohort study was conducted with 89 patients initiating HCV treatment between January 2014 and August 2015 at a primary care clinic in the Bronx, New York. Four patient groups were compared: no active drug use or MAT; no active drug use with MAT; active drug use without MAT; and active drug use with MAT. The study found that regardless of active drug use or MAT, patients who received direct-acting antiviral (DAA) therapy achieved high HCV cure rates (SVR ≥95%) (Norton, 2017).

Furthermore, MAT does not compromise HCV treatment outcomes. Similar SVR12 rates are achieved by PWID engaged in MAT compared to individuals not engaged in MAT in clinical trials involving various DAA regimens (Feld, 2014; Lalezari, 2015; Grebely, 2016; Zeuzem, 2015; Dore, 2016). HCV-infected patients receiving MAT who were treated with elbasvir/grazoprevir had high rates of adherence to antiviral treatment and SVR12 rates >89% regardless of ongoing IDU (Dore, 2016). Similarly, an SVR12 of 97.4% was reported in a clinical trial evaluating ombitasvir/paritaprevir/ritonavir plus dasabuvir and ribavirin for 12 weeks among patients receiving MAT (Lalezari, 2015). Further, an analysis of a clinical trial evaluating outcomes of sofosbuvir/velpatasvir treatment in patients receiving MAT (n=51) compared to those not receiving MAT (n=984) demonstrated that MAT did not significantly reduce treatment completion, antiviral adherence, SVR12, or safety (Grebely, 2016).
Reinfection

As HCV therapy is expanded to populations of PWID with high-risk behaviors for re-exposure, acknowledgement that HCV reinfection will occur in some individuals is critical, and appropriate strategies must be in place to maximize prevention of reinfection and offer retreatment for reinfection (Grebely, 2017). Importantly, the rate of HCV reinfection in the PWID population is lower (2.4/100 person-years) than the rate of incident HCV infection in the general population of PWID (6.1 to 27.2/100 person-years), although the rate of reinfection increases with active or ongoing IDU (6.44/100 person-years) and available data on follow-up duration are limited (Aspinall, 2013); (Grady, 2013).

Data suggest that reinfection is rare in drug users who clear HCV with therapy even if they continue to inject drugs, as long as steps are taken to minimize the risk. Studies of HCV reinfection in PWID have demonstrated rates of reinfection post SVR ranging from 1 to 5/100 person-years in patients who have ever injected drugs, increasing to 3 to 33/100 person-years in patients with continued injecting risk behavior (Midgard, 2016b); (Marco, 2013); (Grebely, 2010); (Grebely, 2012); (Bate, 2010); (Currie, 2008); (Dalgaard, 2002); (Grady, 2012). Relapse into drug use has been associated with HCV reinfection after cure (Midgard, 2016b) while interventions that reduce drug use, such as utilization of opiate agonist therapy and mental health services, have been associated with a reduction in HCV reinfection risk (Islam, 2017). These services should be made available to PWID. PWID found to be HCV reinfected should be retreated. Retreatment of a new reinfection should be as detailed in the Initial Treatment section.

Increasing the HCV treatment rate among the PWID population would reduce numbers of new HCV and liver-related disease cases (Jiang, 2017). In a study that evaluated reinfection and injecting risk behavior following DAA therapy, participants on MAT for ≥3 months had a reinfection rate of 2.3/100 person-years, with a persistent reinfection rate of 1.6/100 person-years and a reinfection rate of 4.2/100 person-years among those who reported IDU (Dore, 2017).

Harm Reduction

Harm reduction is a way of preventing disease and promoting health that “meets people where they are” and provides the tools and information they need to keep themselves and those around them well (Logan, 2010). Harm reduction places drug use within the larger sociopolitical spheres of poverty, criminalization, and mental health. Accepting that not everyone is ready or able to curtail or stop high-risk behavior, harm reduction focuses on promoting a spectrum of scientifically proven, practical strategies for reducing the negative consequences of drug use and other high-risk behaviors. Harm reduction strategies include but are not limited to: condom distribution; access to sterile syringes; medication-assisted treatment for opioid dependence (such as methadone, buprenorphine and naltrexone); safe injection spaces; and overdose prevention. Heroin overdose deaths in the US increased 286% from 2002 to 2013 (CDC, 2015b). Naloxone should be prescribed to all PWID. Broad implementation of harm reduction strategies has the potential to significantly impact the HCV epidemic.

Medication-Assisted Treatment

MAT options have been developed for drugs such as heroin, oxycodone, and morphine. The therapies (agonist pharmacotherapy and methadone maintenance) were identified to provide a less harmful opioid (eg, methadone) or an
opioid-receptor agonist (eg, buprenorphine) under medical supervision in both specialty and outpatient clinics. Several reviews have identified opioid substitution therapy as effective in reducing illicit opioid use (Mattick, 2009); (Mattick, 2014) and opioid-related death and all-cause mortality (Degenhardt, 2009); (Sordo, 2017), and improving quality of life (Lawrinson, 2008); (Ward, 1999). Participation in methadone maintenance treatment has been demonstrated to be protective against hepatitis C incidence among PWID, with a dose-response protective effect with increasing methadone exposure on hepatitis C incidence (Nolan, 2014).

**Syringe Service Programs**

Syringe service programs (SSPs) were developed to reduce the spread of bloodborne diseases among injection drug users. These programs provide PWID with sterile syringes and other equipment (cookers, filters, sterile water, alcohol swabs) to reduce the risk of bloodborne disease (eg, HIV and HCV) transmission associated with sharing injection equipment. These programs were developed in the 1980s and often include drug treatment referrals, peer education, and HIV prevention. Areas with greater syringe access through SSPs have lower rates of hepatitis C among PWID. A prospective study of PWID in New York City found a significant decline in HCV rates from 1990 to 2001, corresponding to an increase in the number of syringes distributed by SSPs during this period (Des Jarlais, 2005).

**Benefit of Treatment to Reduce HCV Transmission**

Persons cured of chronic HCV no longer transmit the virus to others. As such, successful HCV treatment benefits public health. Several health models have shown that even modest increases in successful HCV treatment among PWID can decrease prevalence and incidence (Martin, 2013); (Durier, 2012); (Martin, 2013b); (Hellard, 2014). Models developed to estimate the impact of HCV testing and treatment on the burden of HCV at a country level reveal that large decreases in HCV prevalence and incidence are possible as more persons are successfully treated (Wedemeyer, 2014); (Martin, 2015). Elimination of HCV among PWID will also require scaling up harm reduction services (Fraser, 2018).

**Last update:** May 24, 2018
Incidence and Risk Factors for HCV Infection Among HIV-Infected Men Who Have Sex With Men

Several outbreaks of sexually transmitted HCV infection among HIV-infected men who have sex with men (MSM) have been reported since 2000 (Matthews, 2007); (Urbanus, 2009); (van de Laar, 2010); (Wandeler, 2012). A recent systematic review reported an HCV incidence of 6.35/1000 person-years among HIV-infected MSM (Jin, 2017). The determinants of sexually transmitted, incident HCV among HIV-positive MSM have not been thoroughly characterized but risk factors have been identified. Group sex practices that can cause trauma to rectal mucosal tissue (eg, receptive anal intercourse without a condom, receptive fisting) and rectal bleeding are associated with HCV transmission among HIV-infected MSM (Apers, 2015); (CDC, 2011); (Danta, 2007); (Daskalopoulou, 2017); (Page, 2016); (Schmidt, 2011); (Vanhommerig, 2015); (Wandeler, 2012); (Witt, 2013).

The recent proliferation of ChemSex (also known as Party and Play or PNP)—use of crystal methamphetamine, mephedrone, or gamma-hydroxybutyrate, sometimes with phosphodiesterase type 5 inhibitors (which lowers inhibitions, creates feelings of invulnerability, increases stamina, and inhibits ejaculation) before or during sex—has also been associated with incident HCV infection (56 Dean Street, 2014); (Pufall, 2016); (Hegazi, 2017). These HCV infections have been occurring especially in men who already have ulcerative and rectal sexually transmitted infections including syphilis, lymphogranuloma venereum, and genital herpes (Bottieau, 2010); (Browne, 2004); (Gambotti, 2005); (Ghosn, 2004); (Gotz, 2005); (van de Laar, 2007).

While it is not completely clear why higher rates of incident HCV have been reported in HIV-infected compared to uninfected MSM, behavioral factors such as serosorting (sex between partners of the same HIV status with the aim of minimizing HIV transmission risk) and increased rates of anal sex without condoms by HIV-infected men have been implicated (Mao, 2011). In a recent study of 33 HIV/HCV-coinfected MSM, one-third shed HCV in their semen (Turner, 2016). In addition to being found in semen, rectal shedding of HCV has also been reported in HIV/HCV-coinfected MSM (Foster, 2017b).

Incidence and Risk Factors for HCV Infection Among HIV-Uninfected Men Who Have Sex With Men

Acute HCV infections have been recently reported among HIV-uninfected MSM who present for pre-exposure prophylaxis (PrEP) (Hoornenborg, 2017). These HIV-uninfected men became infected with HCV strains known to be circulating in HIV sexual transmission networks. Thus, there is growing concern that with the implementation of PrEP, high risk HIV-uninfected MSM may be at increased risk of incident HCV through unprotected sexual intercourse with HCV-infected MSM. The risk factors for acute HCV infection in these patients remain unknown but may be similar to those reported in HIV-infected MSM.
Testing

**Recommendations for Testing and Prevention of HCV Infection in Men Who Have Sex With Men (MSM)**

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
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<tbody>
<tr>
<td>Annual HCV testing is recommended for sexually active HIV-infected adolescent and adult MSM. Depending on the presence of high-risk sexual or drug use practices, more frequent testing may be warranted.</td>
<td>IIa, C</td>
</tr>
<tr>
<td>HCV testing at HIV pre-exposure prophylaxis (PrEP) initiation and at least annually thereafter (while on PrEP) is recommended in HIV-uninfected MSM. Depending on sexual or drug use risk practices, more frequent testing may be warranted.</td>
<td>IIa, C</td>
</tr>
<tr>
<td>All MSM should be counseled about the risk of sexual HCV transmission with high-risk sexual and drug use practices, and educated about measures to prevent HCV infection or transmission.</td>
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</table>

**Screening for HCV Infection Among MSM**

Practitioners treating HIV-infected adolescent and adult MSM should be on high alert for acute HCV infection, which is most often asymptomatic (see the HCV in Children section). In accordance with Centers for Disease Control and Prevention sexually transmitted diseases (STDs) screening recommendations, HCV screening should be performed at least annually and may be done more frequently, depending on the presence of local and individual factors such as high HCV prevalence and/or incidence locally, high-risk sexual behavior (eg, unprotected [by a condom] receptive anal intercourse, group sex, fistng, ChemSex), and ulcerative STD(s) or STD-related proctitis (Apers, 2015; Bottieau, 2010; Browne, 2004; CDC, 2011; 56 Dean Street, 2014; Danta, 2007; Daskalopoulou, 2017; CDC, 2015; Pufall, 2016; Gambotti, 2005; Ghosn, 2004; Gotz, 2005; Page, 2016; Schmidt, 2011; van de Laar, 2007; Vanhommerig, 2015; Wandeler, 2012; Witt, 2013).

Screening should be performed using an HCV-antibody test in most instances. However, individuals with self-reported recent high-risk exposures and/or newly elevated alanine aminotransferase (ALT) levels should have HCV screening with both HCV-antibody and HCV-RNA tests due to concern for acute HCV infection. Those found to be chronically HCV-infected should be offered antiviral treatment to prevent liver disease progression and transmission to others. These patients should also be counseled about risk factors for HCV transmission and the potential for HCV reinfection after cure (Ingiliz, 2014; Ingiliz, 2017; Lambers, 2011). Subsequent care for acute HCV should be as detailed in the Management of Acute HCV section.

**Prevention of HCV Infection**

To reduce the risk of sexually transmitted HCV and other STDs, MSM should be counseled to use condoms with all sex acts. They should also be informed about the high risk of HCV transmission associated with sharing any equipment used for preparing and injecting or snorting drugs. If indicated (and available), providers should offer referrals to syringe service programs and culturally competent counseling/drug treatment, and encourage patients to seek testing for sexually transmitted infections if they have been at risk. Among patients who are using opioids, discussion of preventing HCV infection is also an opportunity to provide opioid education and naloxone distribution (OEND), which is an effective
intervention to prevent overdose death.

Although PrEP can prevent sexual transmission of HIV, it is not protective against HCV or other sexually transmitted infections. HIV-uninfected MSM who present for PrEP should receive risk reduction counseling. HIV-uninfected MSM on PrEP should also receive at least annual HCV screening for identification of incident infections.

### Treatment

#### Recommendation on Treatment of HCV in Men Who Have Sex With Men (MSM)

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
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<tbody>
<tr>
<td>Antiviral treatment for HCV-infected MSM should be coupled with ongoing counseling about the risk of HCV reinfection, and education about methods to reduce HCV reinfection risk after cure.</td>
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</tr>
</tbody>
</table>

Since MSM may be at high risk of transmitting HCV to others, HCV infection should be treated both for individual benefit and to prevent HCV transmission. HIV-infected MSM are considered an important population for HCV elimination through treatment as prevention (Martin, 2015). The population-level benefit of expansion of HCV treatment in populations of HIV-infected MSM has been evaluated in modeling studies (Martin, 2016; Salazar-Vizcaya, 2016). Additionally, real-world data support the potential for HCV treatment as prevention in cohorts of HIV/HCV-coinfected MSM. Analysis of data from the Dutch acute HCV in HIV study group (DAHHS) showed a 50% reduction in acute HCV incidence between 2014 and 2016 within 1 year of expansion of HCV therapy through unrestricted direct-acting antiviral (DAA) availability to HIV-infected MSM (Boerekamps, 2017).

HCV treatment should be coupled with education addressing the potential for HCV reinfection and risk factors for transmission to reduce the risk of transmission to others and subsequent reinfection after HCV cure. Brief counseling interventions delivered in clinical settings have been shown to reduce HIV transmission risk and may be effective in reducing HCV transmission risk (Boerekamps, 2017; Myers, 2010; Richardson, 2004).

#### Testing for HCV Reinfection

#### Recommendation on Prevention of HCV Reinfection in Men Who Have Sex With Men (MSM)

<table>
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<th>RECOMMENDED</th>
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<tr>
<td>At least annual (and risk-based, if indicated) HCV testing with HCV RNA is recommended for sexually active MSM after successfully treated or spontaneously cleared HCV infection.</td>
<td>IIa, C</td>
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</tbody>
</table>

High HCV reinfection rates, ranging from 7.3 to 15.2/100 person-years, have been reported after HCV treatment and cure among HIV-infected MSM (Ingiliz, 2017; Lambers, 2011; Martin, 2015b). The risk of HCV reinfection may also increase with each subsequent infection treated or cleared. In an analysis of 606 MSM from 8 centers in Europe, an increase in
HCV reinfection incidence rates was reported with each subsequent reinfection (HCV reinfection incidence 7.3/100 person-years for the first reinfection and 18.8/100 person-years for the second reinfection) (Ingiliz, 2017). For this reason, it is important to provide patients with clear, nonjudgmental, accurate information about reducing their risk for sexually transmitted HCV. This counseling should be ongoing. Additionally, clinicians should monitor and test for HCV reinfection in sexually active MSM after cure, regardless of HIV status. Individuals found to be HCV reinfected should be retreated. HCV treatment in this setting should be as detailed in the Initial Treatment of HCV section.

**Last update:** May 24, 2018
HCV Testing and Treatment in Correctional Settings

Prevalence of HCV infection in Correctional Settings

HCV infection disproportionately affects individuals in correctional institutions, which include jails (short-stay facilities that typically house persons for sentences of up to 1 year) and prisons (long-term facilities for persons with a felony conviction). A 2003 Centers for Disease Control and Prevention (CDC) survey based on data derived from 8 states estimated that 16% to 41% of US inmates had serological evidence of prior HCV exposure and 12% to 35% had chronic infection (Allen, 2003); (Weinbaum, 2003). More recent analyses suggest that the seroprevalence of HCV infection in incarcerated populations ranges from 17.4% to 23.1% (Varan, 2014); (Edlin, 2015). However, HCV prevalence in correctional populations is not geographically uniform and can vary by state and region (Varan, 2014). These estimates far exceed the 1.0% HCV prevalence in the general population (Denniston, 2014). Injection drug use is the most common risk factor for HCV transmission in correctional settings (Ruiz, 1999); (Spaulding, 2006). HCV-associated liver disease is a frequent cause of death in inmates and has recently surpassed death from HIV (Spaulding, 2011); (Spaulding, 2015).

Approximately 30% of all persons with HCV infection in the US spend at least part of the year in a correctional institution (Hammett, 2002); (Varan, 2014). Unfortunately, most HCV-infected individuals in correctional facilities are unaware of their infection (Spaulding, 2012). Given the high prevalence of HCV infection in correctional settings coupled with the fact that more than 10 million individuals pass through jails and prisons each year, as many as 1 million persons with undiagnosed HCV infection might come into contact with the correctional system each year (Spaulding, 2012); (Rich, 2014). More than 90% of these individuals are eventually released and re-enter the general population, where they can contribute to HCV spread in the community (Macalino, 2004); (Rich, 2014) and may have little contact with the healthcare system (Fox, 2005); (Bushway, 2006); (Rich, 2014b); (Neate, 2016). Moreover, 68% of prisoners are reincarcerated for a new crime within 3 years of their release from prison (Durose, 2014). Recidivism can further promote the spread of HCV within correctional settings.

Both the US Preventive Services Task Force and the World Health Organization recommend that all incarcerated persons undergo HCV testing (WHO, 2016); (Moyer, 2013b). Despite these recommendations and the high prevalence of HCV infection in correctional institutions, HCV testing is not universally performed in this setting.

Current Approaches to HCV Testing and Treatment in Jails

HCV testing and treatment have been historically uncommon in jails, primarily because of the short duration of incarceration and lack of available resources (Maurer, 2015). With approximately 11 million jail admissions annually (Minton, 2016), jails represent an important public health setting in which to test for HCV infection and treat persons with chronic HCV.

Jails have also not had the resources and systems to enable continuation of community-initiated HCV therapy. If detainees are unable to continue HCV treatment while incarcerated in jail, the interruption in therapy will adversely affect the likelihood of achieving a cure and could promote development of viral resistance. Without systems to facilitate continuation of HCV therapy, jails may interfere with community HCV treatment efforts and societal payers will suffer losses on investments.

Current Approaches to HCV Testing and Treatment in Prisons

The bulk of the evidence on current HCV testing and treatment in the prison setting is based on a 2015 national survey conducted by the American Correctional Association and the Coalition of Correctional Health Authorities research and health outcomes working group (Maurer, 2015). According to this survey, some type of HCV testing is performed in the majority of prisons but routine opt-out testing is generally not conducted across the prison system. Additionally, there are major differences in approaches to HCV testing and prevention counseling. The most common triggers for HCV testing in a prison setting were physician request, identified risk factors, and inmate request. Only 16% of prison facilities tested all inmates with an HCV-antibody test upon entry. Selection of patients for antiviral therapy also varied across prison systems. The survey found that antiviral therapy for chronic HCV was available in 90% of prisons. However, few inmates actually received treatment, primarily due to antiviral therapy expense and lack of availability of trained staff. Moreover, despite the fact that injection drug use was the major risk factor for HCV transmission in this population, only half of the prison facilities combined substance use disorder treatment with HCV therapy.
More recently, investigators at Yale University administered a survey to the directors of the departments of corrections in all 50 US states that inquired about current HCV practices within state correctional facilities (Beckman, 2016). This survey included questions about the number of inmates in the state’s prisons known to be HCV-infected on or about December 31, 2014; the number of prisoners receiving any form of HCV treatment at that time; and the availability of relevant resources for inmates with known HCV infection. Representatives from 41 states completed the questions on the number of inmates with chronic HCV infection and the proportion receiving antiviral treatment. The overall number of inmates who were reported to have chronic HCV in the 41 reporting states was 106,266 prisoners, corresponding to 10% of the overall prison population in these states. Among these inmates, only 0.89% (n=949) received any form of HCV treatment on or about December 31, 2014. States used a variety of factors to prioritize HCV treatment among inmates, particularly cirrhosis, sentence length, likelihood of recidivism, potential for antiviral adherence, and chance of HCV reinfection. States with a relatively high proportion of inmates reported to have HCV infection did not treat a greater number of patients than states with a low proportion of infections.

Representatives from 49 of the state departments of corrections completed the questions on resources related to HCV infection. Seventeen states reported offering routine opt-out HCV testing of inmates. Among the 32 states without routine opt-out HCV testing, the main indications for HCV testing were abnormal results from other tests, HIV infection, or a substance use disorder. Medication-assisted treatment programs for substance use disorders were available through 14 state departments of corrections. Four states reported that they followed all of the Federal Bureau of Prisons guidelines (FBP, 2016). Increased HCV Testing and Treatment in Correctional Institutions Will Aid HCV Elimination

Given the high prevalence of HCV among persons in the US correctional system, the success of the national HCV elimination effort will depend on identifying chronically infected individuals in jails and prisons, linking these persons to medical care for management, and providing access to antiviral treatment (NAS, 2017). Diagnosis of chronic HCV in correctional settings followed by linkage to care and successful antiviral treatment can ultimately reduce the risk of liver-related and extrahepatic complications, and has the potential to decrease HCV transmission in correctional facilities and the community after release (van der Meer, 2012); (Harris, 2016); (He, 2016).

### Recommendations for Screening and Treatment of HCV Infection in Jails

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<tr>
<th>RECOMMENDED</th>
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<tbody>
<tr>
<td>Jails should implement opt-out HCV testing consisting of HCV-antibody testing followed by confirmatory HCV-RNA testing if antibody-positive.</td>
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</tbody>
</table>

- Chronically infected individuals should receive counseling about HCV infection and be provided linkage to follow-up community healthcare for evaluation of liver disease and treatment upon release.
- Chronically infected individuals whose jail sentence is sufficiently long to complete a recommended course of antiviral therapy should receive treatment for chronic HCV infection according to AASLD/IDSA guidance while incarcerated. Upon release, patients should be provided linkage to community healthcare for surveillance for HCV-related complications.
**Recommendations for Screening and Treatment of HCV Infection in Prisons**

<table>
<thead>
<tr>
<th>RECOMMENDED</th>
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<tbody>
<tr>
<td>Prisons should implement opt-out HCV testing. Chronically infected individuals should receive antiviral therapy according to AASLD/IDSA guidance while incarcerated. Upon release, patients should be provided linkage to community healthcare for surveillance for HCV-related complications.</td>
<td>IIa, C</td>
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<tr>
<td>To prevent HCV reinfection and reduce the risk of progression of HCV-associated liver disease, prisons should provide harm reduction and evidence-based treatment for underlying substance use disorders.</td>
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**Recommendation for Continuation of HCV Treatment in Jail and Prison Settings**

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<tr>
<td>Jails and prisons should facilitate continuation of HCV therapy for individuals on treatment at the time of incarceration.</td>
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**Opt-Out Testing for HCV Infection in Jails and Prisons**

Interventions to reduce HCV transmission and HCV-related liver disease can only be implemented if infected patients are diagnosed. Given the variable approaches to HCV testing across correctional facilities (Maurer, 2015), patients with chronic HCV in these settings may not have the opportunity to be diagnosed (Varan, 2014). Universal opt-out testing of inmates for chronic HCV is highly cost-effective and has been shown to reduce ongoing HCV transmission and the incidence of advanced liver disease (He, 2016). Based on a microsimulation model of HCV transmission and disease progression, this approach would enable diagnosis of 122,700 new HCV infections in prisons in the next 30 years; prevent 12,700 new HCV infections caused by release of infected inmates; and avert 11,700 liver-related deaths (He, 2016).

In October 2016, the Federal Bureau of Prisons recommended an opt-out strategy of testing for HCV infection for all sentenced inmates (FBP, 2016). With this approach, an inmate is informed of the indications and plan for HCV testing, and the test is ordered and performed unless the inmate declines it. However, the Federal Bureau of Prisons clinical guidelines state that HCV testing is not required by policy or law. Thus, it is unclear if prisons are conforming to these recommendations.

HCV-infected individuals in jails frequently cycle in and out of this setting, are unaware of their infection, and can contribute to HCV transmission in the community (Rich, 2014). Therefore, providing opt-out HCV testing in jails followed by linkage to community healthcare providers for those found to be infected is an advantageous approach to HCV case finding in these settings. A recent prospective cohort study evaluated an HCV testing and linkage-to-care program implemented in selected jails in North Carolina and South Carolina from December 2012 to March 2014 (Schoenbachler, 2016). HCV testing and linkage-to-care services were conducted by noncorrectional staff in parallel with correctional healthcare staff. Forty-eight percent of detainees with chronic HCV who were referred for management after release attended a follow-up appointment. Similar programs have been established in New York (Akiyama, 2016), Texas (de la Flor, 2017), and Rhode Island (Beckwith, 2016) with the latter using rapid, point-of-care HCV-antibody testing. These studies demonstrate the feasibility of HCV testing in jails followed by linkage to medical care after release for those who...
are chronically infected.

**HCV DAA Treatment in Jails**

A recent observational cohort study demonstrated the feasibility of initiating and completing direct-acting antiviral (DAA) HCV treatment in a jail setting (MacDonald, 2017). In this study, 104 detainees in the New York City jail system received DAA treatment between January 1, 2014 and June 30, 2016, of whom 60% (n=62) entered the jail on DAA therapy and 40% (n=42) initiated DAA treatment in jail. HCV viral loads were undetectable in 94% of community-initiated patients and 97% of jail-initiated patients. This study provides evidence that jail-based initiation of HCV treatment is feasible and prompt access to DAAs in jail can preserve the effectiveness of community-initiated HCV regimens.

**HCV DAA Treatment in Prisons**

HCV DAA therapy for chronic HCV is now logistically feasible within the prison setting and would aid the HCV elimination effort (Spaulding, 2013). The availability of all-oral DAA regimens that commonly require no more than 12 weeks of therapy and cause few adverse effects overcomes many of the logistical challenges associated with interferon-based HCV treatment (Spaulding, 2013). Directly observed therapy is the norm in prison settings, and the risk of drug diversion is low. Returning inmates to their communities cured of chronic HCV would be an invaluable step toward HCV elimination. In addition to these clinical benefits, treating chronic HCV in incarcerated persons is cost-effective. A recent analysis found that sofosbuvir-based treatment for HCV genotype 1 mono-infection met the benchmark for cost-effectiveness in terms of the benefits gained (Liu, 2014).

**Treatment of Substance Abuse Disorders**

Given that injection drug use is the major risk factor for initial HCV infection and reinfection, and because alcohol abuse/dependence is a major cofactor in HCV-related liver disease progression, treatment of concomitant substance use disorders along with HCV therapy is of major importance in the incarcerated population. The most effective way to prevent HCV transmission in people who inject drugs is to combine harm reduction strategies that improve the safety of injection (ie, needle/syringe exchange) with interventions that treat the underlying addiction, particularly medication-assisted treatment (MacNeil, 2011; Volkow, 2014) (see Identification and Management of HCV in People Who Inject Drugs). Alcohol prevention and treatment programs have not been given the same priority as those for drug addiction in correctional settings, and access to treatment for alcohol abuse/dependence after release is often limited. Addressing hazardous alcohol use among inmates with chronic HCV could help slow liver disease progression, decrease HCV transmission, and might reduce recidivism. However, according to the 2015 survey by the American Corrections Association (Maurer, 2015), slightly more than half of correctional systems treat the fundamental substance use disorders among patients receiving HCV antiviral therapy.

**Overcoming Barriers to HCV Testing and Treatment in Correctional Settings**

To expand HCV testing and prevention counseling and increase access to HCV therapy in correctional institutions, it will be necessary to overcome several important barriers. First, appropriately trained staff are needed to screen inmates for HCV infection and, depending on the result, provide counseling on HCV prevention, linkage to care, and access to antiviral treatment. Offsite providers can assist in these endeavors but add expense and logistical complications. The use of telemedicine to link inmates to specialists has been shown to be effective for the evaluation and treatment of chronic HCV in underserved settings (Arora, 2011). The National Commission on Correctional Health Care supports telemedicine in corrections. However, only 30 of the 45 states responding to the 2016 National Survey of Prison Health Care reported using telemedicine (Maruschak, 2016).

Second, unplanned transfers and releases could disrupt ongoing HCV treatment (Spaulding, 2013). Most state correctional facilities do not have a process in place to smoothly transition a patient receiving DAA treatment in a prison setting to continuing community-based care without a lapse in antiviral therapy. However, the New York State Hepatitis C Continuity Program demonstrated that it is possible to establish a network of community-based providers to facilitate continuation of HCV treatment without interruption after release (Klein, 2007). In this program, inmates who initiated HCV treatment in prison were transitioned to a community-based provider for completion of therapy after release. Inmates diagnosed with chronic HCV who remained untreated while incarcerated were referred to a community provider for
Finally, the costs of HCV testing and antiviral treatment in correctional facilities are also formidable barriers. Strategies for financing HCV treatment have been put forward by the National Academy of Medicine’s Committee for a National Strategy for the Elimination of Hepatitis B and C (NAS, 2017). These strategies might help to overcome cost barriers to HCV testing and treatment in correctional settings.

Addressing these barriers will help ensure that persons residing in jails and prisons can undergo HCV testing and be diagnosed; have access to HCV prevention counseling; and receive treatment for chronic HCV and underlying substance use disorders. Improving the diagnosis and management of HCV infection in correctional settings will greatly facilitate efforts to eliminate HCV infection in the US.

**Last update:** May 24, 2018
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