Treatment-Naive Genotype 1b Without Cirrhosis

Recommended regimens listed by pangenotypic, evidence level, and alphabetically for:

Treatment-Naive Persons With Genotype 1b Infection Without Cirrhosis

RECOMMENDED	DURATION	RATING
Daily fixed-dose combination of glecaprevir (300 mg)/pibrentasvir (120 mg)[a]	8 weeks	I, A
Daily fixed-dose combination of sofosbuvir (400 mg)/velpatasvir (100 mg)	12 weeks	I, A
Daily fixed-dose combination of elbasvir (50 mg)/grazoprevir (100 mg)	12 weeks[b]	I, A
Daily fixed-dose combination of ledipasvir (90 mg)/sofosbuvir (400 mg)	12 weeks	I, A
Daily fixed-dose combination of ledipasvir (90 mg)/sofosbuvir (400 mg) for persons who are HIV uninfected and whose HCV RNA level is <6 million IU/mL	8 weeks[c]	I, B

[a] Dosing is 3 coformulated tablets (glecaprevir [100 mg]/pibrentasvir [40 mg]) taken once daily. Please refer to the prescribing information.
[b] For persons with HIV/HCV coinfection, a treatment duration of 12 weeks is recommended.
[c] An 8-week regimen can be considered in those with genotype 1b infection and mild fibrosis (see text for details).

Recommended Regimens

Glecaprevir/Pibrentasvir

Based on favorable data for 8 weeks of treatment for persons without cirrhosis in the phase 2 SURVEYOR-1 study (33/34 participants with SVR and no virologic failures) (Kwo, 2017b), ENDURANCE-1 enrolled 703 genotype 1 participants without cirrhosis who were DAA-naive or in whom a previous interferon-based regimen failed. Participants were randomized to receive 8 weeks or 12 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 (Zeuzem, 2018). Of those enrolled, 43% had genotype 1a, 85% had fibrosis stage 0 or 1, and 62% were treatment naive. Overall SVR12 rates for the intention-to-treat population were 99% (348/351) in the 8-week arm and 99.7% (351/352) in the 12-week arm. The 8-week arm met the predefined study criteria for noninferiority to the 12-week arm. A single person experienced on-treatment virologic failure in this study (genotype 1a, day 29). Notably, there were no documented relapses in either arm.

EXPEDITION-1 investigated the use of glecaprevir/pibrentasvir in DAA-naive (75%) or DAA-experienced (interferon or peginterferon ± ribavirin, or sofosbuvir plus ribavirin ± peginterferon) participants with

compensated cirrhosis. Of 146 persons with genotype 1, 2, 4, 5, or 6 infection given 12 weeks of glecaprevir/pibrentasvir, 99% (145/146) achieved SVR12. All genotype 1b participants achieved SVR (Forns, 2017).

EXPEDITION-2, a study of glecaprevir/pibrentasvir in 153 persons with HIV/HCV coinfection with genotype 1, 2, 3, 4, 5, or 6 infection, utilized 8 weeks of treatment for those without cirrhosis and 12 weeks for participants with cirrhosis (the recommended durations approved by the FDA). The overall SVR12 rate was 98% (150/153); there were no observed virologic failures among the 94 participants with genotype 1 infection (Rockstroh, 2018). In EXPEDITION-1 and EXPEDITION-2, neither subtype (1a versus 1b) nor the presence of baseline RASs impacted SVR12 rates in DAA-naive genotype 1 participants.

CERTAIN-1 evaluated 8 weeks of glecaprevir/pibrentasvir among 129 Japanese DAA-naive participants without cirrhosis (97% genotype 1b); SVR12 rate was of 99% (128/129) (Chayama, 2018). Real-world cohorts from Germany (34% genotype 1a) and Italy (67% genotype 1a) demonstrate similarly high efficacy among treatment-naive persons with genotype 1 infection without cirrhosis treated with 8 weeks of glecaprevir/pibrentasvir using a modified intention-to-treat analysis (excluding those not completing treatment or lost to follow-up). SVR rates were 100% in both the German (228/228) (Berg, 2019) and the Italian (307/307) (D'Ambrosio, 2019) cohorts.

Sofosbuvir/Velpatasvir

The fixed-dose combination of 12 weeks of sofosbuvir (400 mg)/velpatasvir (100 mg) was approved by the FDA for the treatment of genotype 1 infection in treatment-naive persons based on ASTRAL-1. This placebo-controlled trial involved a 12-week course of sofosbuvir/velpatasvir administered to 624 participants with genotype 1, 2, 4, 5, or 6 infection who were treatment naive (n=423) or previously treated with interferon-based therapy, with or without ribavirin or a protease inhibitor (n=201); (Feld, 2015). Of the 328 genotype 1 participants included, 323 achieved SVR12 with no difference observed by subtype (98% 1a; 99% 1b). Of 121 participants (all genotypes) classified as having cirrhosis, 99% (120/121) achieved SVR12. The presence of baseline NS5A RASs (at 15% cutoff)—reported in 11% of genotype 1a and 18% of genotype 1b participant samples tested—did not influence SVR rate for genotype 1 (Hézode, 2018). Of the 2 virologic failures in ASTRAL-1 (<1% of treated participants), both were genotype 1 and had baseline RASs. There was no significant difference in the rates of adverse events in the sofosbuvir/velpatasvir vs placebo groups.

The phase 3 POLARIS-2 study randomized 941 DAA-naive participants with genotype 1, 2, 3, 4, 5, or 6 infection—with or without compensated cirrhosis—to receive either 8 weeks of sofosbuvir (400 mg)/velpatasvir (100 mg)/voxilaprevir (100mg) or 12 weeks of sofosbuvir/velpatasvir (Jacobson, 2017). Of participants treated with sofosbuvir/velpatasvir, 99% (170/172) with genotype 1a and 97% (57/59) with genotype 1b achieved SVR with a single relapse observed in each subtype.

Elbasvir/Grazoprevir

The fixed-dose combination of elbasvir (50 mg)/grazoprevir (100 mg) is recommended based on data from the phase 3 C-EDGE trial, which assessed the efficacy and safety of this regimen for 12 weeks in treatment-naive adults (genotype 1, 4, or 6) (Zeuzem, 2015f). Participants were enrolled from 60 centers in 9 countries on 4 continents. Three hundred eighty-two persons (91% of the study cohort) were infected with genotype 1 (50% genotype 1a; 41% genotype 1b). The SVR12 rate was 92% (144/157) in treatment-naive participants with genotype 1a and 99% (129/131) in those with genotype 1b. Findings from this phase 3 study support earlier phase 2 findings from the C-WORTHY trial in which SVR12 rates of 92% (48/52) and 95% (21/22) were demonstrated among genotype 1a and genotype 1b treatment-naive persons without cirrhosis, respectively,

who received 12 weeks of elbasvir/grazoprevir without ribavirin (Sulkowski, 2015b). The C-WORTHY trial enrolled both people with HCV monoinfection and those with HIV/HCV coinfection.

A phase 3, global STREAGER trial of 89 treatment-naive persons with genotype 1b infection and low fibrosis stage (defined as a transient elastography score <9.5 or a Fibrotest® score <0.59 [F0 to F2]) evaluated the efficacy of 8 weeks of elbasvir/grazoprevir and found an SVR rate of 98% (87/89), supporting the option of using a shorter treatment duration for persons with genotype 1b infection with low scores using these fibrosis staging modalities (Abergel, 2020).

In contrast to genotype 1a, the presence of baseline substitutions associated with NS5A resistance did not appear to affect genotype 1b response to elbasvir/grazoprevir. Thus, current data do not support extending the treatment duration or adding ribavirin in persons with genotype 1b infection with NS5A RASs.

Ledipasvir/Sofosbuvir

The fixed-dose combination of ledipasvir (90 mg)/sofosbuvir (400 mg) was approved by the FDA for the treatment of genotype 1 infection in treatment-naive persons based on a pair of registration trials: ION-1 (865 treatment-naive participants; those with cirrhosis were included) and ION-3 (647 treatment-naive participants; those with cirrhosis were excluded). ION-1 investigated length of treatment (12 weeks versus 24 weeks) and the need for ribavirin (Afdhal, 2014a). SVR12 rates were 97% to 99% across all study arms with no difference in SVR rate based on length of treatment, use of ribavirin, or genotype 1 subtype. Sixteen percent of participants enrolled were classified as having cirrhosis. There was no difference in SVR12 rate in those with cirrhosis (97%) versus those without cirrhosis (98%).

ION-3 excluded persons with cirrhosis and investigated shortening ledipasvir/sofosbuvir therapy from 12 weeks to 8 weeks (with or without ribavirin) (Kowdley, 2014). SVR12 rates were 93% to 95% across all study arms, with no difference in SVR rate in the intention-to-treat analysis. However, relapse rates were higher in the 8-week arms (20/431)—regardless of ribavirin use—compared with the 12-week arm (3/216). Post hoc analyses of the ribavirin-free arms assessed baseline predictors of relapse and identified lower relapse rates in participants receiving 8 weeks of ledipasvir/sofosbuvir who had baseline HCV RNA levels <6 million IU/mL (2%; 2/123). The same held true for participants with similar baseline HCV RNA levels who received 12 weeks of treatment (2%; 2/131). This analysis was not controlled, which limits the generalizability of this approach to clinical practice.

Real-world cohort studies of ledipasvir/sofosbuvir for treatment-naive, Black persons without cirrhosis reported lower SVR12 rates with shorter duration therapy compared with White persons, although the absolute difference in SVR12 rates was <5% (Su, 2017); (Ioannou, 2016); (Wilder, 2016); (O'Brien, 2014). A subsequent real-world study among a Northern California Kaiser Permanente cohort of 436 Black persons—most of whom were treated with an 8-week regimen—found comparable SVR12 rates with 8 weeks and 12 weeks of therapy (95.6% and 95.8%, respectively) (Marcus, 2018). Similarly, a Maryland Veterans Health Administration real-world cohort of Black persons with predominantly genotype 1 infection found SVR12 rates of 93.7% (131/140) and 91.4% (332/363) with 8-week and 12-week regimens, respectively (Tang, 2018). These data coupled with the availability of excellent rescue therapies for persons in whom initial DAA therapy fails support the use of 8 weeks of ledipasvir/sofosbuvir for Black persons without cirrhosis and HCV RNA <6 million IU/mL.

Based on available data, shortening treatment to less than 12 weeks is not recommended for person with HIV/HCV coinfection (see HIV/HCV Coinfection section).

Related References

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Additional Reading

- Persons With HIV/HCV Coinfection
- Persons With Renal Impairment
- Management of Acute HCV Infection

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