

## AAHIVM Treatment Guidelines and Recommendations for treating HCV in people with HIV

Current AASLD Guidelines for Simplified Treatment of HCV are available and emphasize that HCV treatment is relatively simple and can be done by a wide range of prescribers. However, it is worth noting that these guidelines state that HIV positivity is a contraindication for Simplified Treatment. Nonetheless, people with HIV (PWH) can be safely and effectively treated for HCV taking into account special considerations which we delineate below.

### OVERARCHING PRINCIPLES

- Treat everyone for HCV as soon as possible. Rationale: (i) PWH and HCV progress to fibrosis faster. (ii) Reduce the community hepatitis viral load for public health
- Current DAAs are 95% effective in treatment-naïve individuals and are equally effective in PWH
- States and insurance companies should remove barriers to treatment such as sobriety restrictions and prescriber restrictions but each state has varying practices (see [www.StateofHepC.org](http://www.StateofHepC.org))
- Adherence counseling is important to reinforce both HCV treatment success and promoting HIV viral suppression
- Counsel all PWH on risk-reduction efforts to prevent HCV infection and re-infection (if successfully cured)
- Consider annual rescreening of PWH who have ongoing risk factors such as active injection drug use and sexually active MSM
- Rely on existing resources such as [www.hcvguidelines.org](http://www.hcvguidelines.org) for specific HCV treatment guidelines



## RECOMMENDED BEST PRACTICES

### ADOPT A TEAM APPROACH

*Build a team to facilitate your ability to treat HCV;  
team members to include:*

- A CLINIC CHAMPION: clinician who is trained to be a HCV treatment prescriber
- PHARMACY CONTACT: Community Pharmacist, Specialty Pharmacist, Mail Order Provider who can communicate with the clinic and patients during treatment and can help navigate insurance issues
- ADMINISTRATIVE SUPPORT: clinic staff person who is responsible for monitoring clinic progress on persons undergoing treatment (e.g. contact patients for lab monitoring, tracking treatment success via a dedicated registry, communicating with pharmacist)
- Identify a treatment network of hepatologists, gastroenterologists to co-manage complicated cases (e.g. decompensated cirrhosis)
- Identify network of Substance Abuse providers (e.g., providers of medication assisted treatment) for co-management of persons with concomitant substance use issues
- Consider an outreach specialist/community health worker/peer navigator to support patients.

### ENGAGE INSURANCE/THIRD PARTY PAYER OPTIONS

- Utilize [www.StateofHepC.org](http://www.StateofHepC.org) as a resource to understand state policies regarding treatment
- Advocate for the removal of limitations on the ability of all medical providers to prescribe HCV treatments
- Prior to prescribing, call a pharmacist or an experienced HCV provider to identify which medications are covered by a patient's medical insurance or third-party payer
- If a preferred drug is declined or requires a pre-authorization that is declined, consider alternatives; this can be done in concert with Pharmacist
- Advocate for the removal of sobriety restrictions to treat patients with active substance or alcohol use





## CONSIDER SPECIAL POPULATIONS

### PEOPLE WHO INJECT DRUGS (PWID)

- Active Substance use is **NOT** a contraindication for treatment, but may represent a state level barrier
- Use a substance use disorder screening mechanism that looks at active versus historic dependency such as the Substance Abuse Subtle Screening Inventory, 3rd Edition (SASSI-3)
- Patients with active substance use may be re-infected so annual rescreening for HCV is important
- Incorporate harm reduction education: use of clean needles/works, emphasize self-injection as a foray into drug treatment
- For Medication Assisted Treatment (MAT) providers—incorporate routine screening for HIV and HCV and create programs to provide HCV treatment on site or refer to HIV clinical partners
- Consider drug interactions with drug of choice/Methadone/Suboxone/Vivitrol

### PERSONS WITH ALCOHOL USE DISORDERS

- Use an alcohol use screening disorder tool to determine active versus historic dependency such as the Alcohol Use Disorders Identification Test (AUDIT) or CAGE Assessment
- If a patient has problem drinking, consider their adherence to other factors – do they come to appointments? Are they adherent to HIV medications? If so, treatment for HCV should be considered
- Be aware of state sobriety requirements for third party payments.
- Incorporate liver disease progression education and harm reduction education with resources for alcohol use reduction/cessation
- Consider Naltrexone/Vivitrol/Antibuse medication option for alcohol use reduction

### WOMEN OF CHILDBEARING POTENTIAL/PREGNANT WOMEN

- All pregnant women should be tested for HCV as part of routine pre-natal care
- In general, HCV treatment should be offered before considering pregnancy
- If a woman is pregnant, defer HCV treatment but treat HCV as soon as possible post-partum
- Offer breast feeding counseling: breastfeeding is currently contraindicated in developed countries for prevention of HIV transmission
- Consider HCV screening of sexual partners
- Women of child-bearing potential should be offered birth control options while treating HCV and counsel women about delaying pregnancy until treatment is complete.
- Consider birth-control and drug-drug interactions with HCV treatment options

### PATIENTS WITH CIRRHOSIS

- Patients should have assessment for cirrhosis as part of pre-treatment assessment; this includes non-invasive scoring (laboratory tests, imaging, transient elastography) and invasive in some cases (e.g. liver biopsy) as well as clinical evaluation
- PWH with compensated cirrhosis can be treated with simplified regimens (REF: AASLD guidelines)
- PWH with current or prior decompensated cirrhosis should be managed with a specialist (e.g. hepatologist)
- Consider referral to a hepatologist for PWH with advanced liver disease (e.g. FIB-4 >3.25) as these patients need additional follow-up for liver related health (e.g. screening for HCC)

### RENAL INSUFFICIENCY/CKD/END STAGE RENAL DISEASE

- Chronic HCV is independently associated with development of CKD
- PWH with renal insufficiency can and should be treated for HCV
- Available DAA options for this group include: glecaprevir/pibrentasvir and elbasvir/grazoprevir (genotype 1)
- Consult sources (e.g. HCVguidelines.org) for potential drug interactions with HIV medications
- For patients on dialysis, discuss HCV treatment with their nephrologist.
- Potential transplant may be impacted by the timing of HCV treatment so consult transplant nephrologist

### HOMELESS/UNSTABLE HOUSED

- Homeless/unstably housed patients require support services including mobile treatment/transportation assistance and third-party payment assistance
- Utilize your treatment team – outreach workers/community health workers, and pharmacists to enable directly observed treatment or other support services (e.g. dispense a week's worth of medication at a time to ensure adherence/ongoing access to medications).
- Identify where the person normally stays or can be found or a contact with a phone who can reach him or her
- Consider repackaging of medications/pill boxing to avoid disclosure concerns

### FORMERLY INCARCERATED/HIGH RECIDIVISM

- Formerly incarcerated/high recidivism populations require additional support services. Utilize the team with medical case management/outreach identifying the patient support network to assist with patient location.
- Inquire if the patient is currently on probation or parole and if they have bench warrants or pending court dates. Timing factors may indicate a treatment delay.
- Inform the patient if they are arrested/incarcerated to inform the civic justice team they are on HCV treatment. Help them to self-advocate with civic justice network to complete treatment.
- Treatment prescribers should be contacted when patients are incarcerated in order to streamline completion of HCV treatment.