Models of Hepatitis C Care for People with Substance Use Disorders: Creating Treatment Champions

A national webinar sponsored by the AIDS Education and Training Center Program
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Faculty disclosures

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Learning objectives

- Understand and address common misperceptions about providing hepatitis C virus (HCV) treatment to people with substance use disorders
- Discuss the role of clinical champions in improving access to HCV treatment for persons with substance use disorders
- Describe emerging models of care for engaging people with substance use disorders in HCV treatment and support
- Describe considerations for special scenarios (including HIV and/or hepatitis B virus [HBV] co-infection, pregnant/parenting women, under/uninsured patients, and unstable housing)
- Identify available resources for additional information and clinical support
HCV Care Cascade: People Who Inject Drugs (PWID)

Vancouver (2005-2015): 86.5% linked to care, 80% underwent liver disease assessment, 10.4% started treatment, 4.5% completed treatment

San Francisco (2015-2018): 60% accepted referral to care, 17% started treatment (all completed and achieved SVR12)

Infographic used with permission from J. Grebely

HCV and substance use: common misperceptions

- “People with substance use (including alcohol) are not eligible for HCV treatment.”

- “PWID are at high risk for reinfection and therefore should not receive HCV treatment.”

- “Treating HCV among people with substance use is not cost effective for health care systems.”

- “People with HIV-HCV co-infection must have HIV viral suppression on ART before initiating HCV treatment.”
**Myth:**
Since active substance users cannot be treated for HCV, screen patients for drug and alcohol use to determine eligibility for HCV treatment.

**Reality:**
Screening for drug and alcohol use does not provide information about eligibility for HCV treatment. The purpose of screening for substance use disorders is to determine who would benefit from treatment and harm reduction support for those conditions.⁴,⁵
Myths about Treating Substance Users with Hepatitis C Virus (HCV)

In various settings, people with active substance use disorder(s) have been cured of HCV and have low rates of reinfection. The following are common misconceptions about providing HCV treatment to people with substance use disorder(s):

**Myth:**
Since active substance users cannot be treated for HCV, screen patients for drug and alcohol use to determine eligibility for HCV treatment.

**Reality:**
Screening for drug and alcohol use does not provide information about eligibility for HCV treatment. The purpose of screening for substance use disorders is to determine who would benefit from treatment and harm reduction support for these conditions.

**Myth:**
People who inject drugs are at high risk of HCV reinfection.

**Reality:**
Data suggest reinfection is rare in people who inject drugs who clear HCV with therapy, even if they continue to inject drugs.

**Myth:**
HIV VL ≥ 200 copies/ml

**Reality:**
Providing HCV treatment to people who use substances is not cost-effective.

**Reality:**
Completion of HCV treatment even among a modest number of people who use substances is cost effective.

**Myth:**
People who use substances must have an undetectable HIV viral load before they are treated for HCV.

**Reality:**
HIV viral suppression is not a requirement for HCV treatment in coinfected persons.

Infographic references and clinical resources related to HIV/HCV coinfection prevention, care, and treatment can be found here: https://aidsetc.org/hiv/hcv

Hepatitis C Basics

For People Who Use Drugs

You can take steps to prevent getting hepatitis C. If you have hepatitis C, new treatments can cure it and keep your liver healthy.

Injection drug use is the most common way people get hepatitis C. If you share injection equipment with someone who is infected with hepatitis C, this puts you at risk. Even a tiny amount of blood—so small you can’t see it—can contain the virus. This is why hepatitis C can be passed on (transmitted) by sharing any equipment that may have come in contact with someone’s blood while injecting.

If you are getting high, you can protect yourself and others from getting hepatitis C. Getting tested, talking about your status, and injecting safely can reduce your risk of contracting or passing the virus onto others.

Distributed by Harm Reduction Coalition
www.harmreduction.org
212-213-6376


https://harmreduction.org/hepatitis-c/hcv-basics/
Perceived barriers for patients on opioid agonist treatment

- **Patient concerns**: side effects, safety, effectiveness, timing
- **Attitudes towards providers**: “Nobody has been monitoring my hepatitis C… they monitor everything but that. If I got a dirty urine… they monitor that before my liver or hepatitis.”
- Some patients felt discouraged against pursuing HCV treatment by their substance use providers, and felt this represented lack of provider concern for patients’ health and well-being
- Some also felt stigmatized because of their opioid use history
- **System-level challenges**: long wait times to specialty appointments, rigid scheduling processes (no open access)

HCV treatment is highly effective for PWID

- Multiple clinical trials involving PWID who report current injection drug use (IDU) at treatment (tx) start and/or continued use during therapy: cure rates approaching 95%!
  - C-EDGE COSTAR: elbasvir (EBV)/grazoprevir (GZR) x 12 weeks (wks)
  - SIMPLIFY: sofosbuvir (SOF)/velpatasvir (VEL) x 12 wks
  - ION, ASTRAL, POLARIS: SOF-based treatment x 8-24 wks

- “Real world” cohorts also demonstrate high cure rates
  - ANCHOR: SOF/VEL x 12 wks, based at D.C. harm reduction center
  - Bronx: HCV-addiction specialist + HCV care coordinator integrated within adult primary care setting
  - Veterans Affairs (recent European Association for the Study of the Liver [EASL] presentation): EBR/GZR x 12 wks
  - German Hepatitis C Registry (EASL): EBR/GZR-based tx
**2018 systematic review & meta-analysis**

**Opioid Agonist Treatment or OAT (methadone/buprenorphine)**

**Recent injecting drug use**

First systematic review & meta-analysis to estimate direct-acting antiviral (DAA) treatment completion, sustained viral response (SVR), long term follow-up (LTFU) among people with recent drug use and those on OAT: **DAA response is highly favorable**, and LTFU seems to be main driver for differences in treatment response (in observational studies, not clinical trials).

Hajarizadeh B, Cunningham EB, Reid et al. Direct-acting antiviral treatment for hepatitis C among people who use or inject drugs: a systematic review and meta-analysis. Lancet Gastro Hep 2018.; Images used with permission from J. Grebely
Why so important? Many states maintain restrictions based on substance use status!*

2014

2018

*Medicaid FFS
CHLPI and NVHR at https://stateofhepc.org/.

No restrictions
Screening and counseling
Abstain 1 month
Abstain 3 mos
Abstain 6 mos
Abstain 12 mos
Restrictions unknown

Slide credit: clinicaloptions.com
Global HCV elimination: a call to action for the U.S.

4 countries account for 51% of burden:
Russia, U.S., China, Brazil
TraP Hep C: HCV “treatment as prevention” reduced incidence in Iceland over 2 years

Runarsdottir. AASLD/EASL HCV Special Conference 2019.

Major scale up with reasonable cure rates
- Overall SVR: 89%; SVR for patients who completed treatment: 95%

Dramatic reduction in community viral load and HCV incidence
The role of “HCV Champions”

Lessons from Australia

Endorsement from Infectious Diseases Society of America (IDSA), American Association for the Study of Liver Diseases (AASLD)

Finding, recruiting, developing

Support from AETCs, the National Clinician Consultation Center (NCCC), and other resources
Australian Audacity

In March 2016, Australia embarked on an effort to eradicate HCV by 2030 (ambitious World Health Organization goal)
Barriers in Australia

- Undiagnosed infections
- Persons unaware or unconcerned that they are infected
  - HCV frequently asymptomatic
  - Other more pressing issues – addiction, homelessness, safety, food
- Providers unconcerned with HCV infection
- Stigma of HCV

...sound familiar?

“The Australian Experience”

- HCV DAAs listed on Pharmaceutical Benefits Scheme (i.e., available via national health insurance program)
- General practitioners (GPs) and nurse practitioners (NPs) encouraged to prescribe DAAs
  - GPs increased from 8 to 31% of DAA scripts in one year

Changes in Australia

- Allowed DAAs to be dispensed at community pharmacies
- 19% of HCV-infected Australians treated in first year (nearly 20x those treated in prior 20 years!)
- Target = 20k per year until 2030 to achieve eradication

Lessons learned in Australia:
key stakeholders share their experience

- First 20% might be the easiest 20%
  (numbers already declining in 2017)
- Primary Health Networks are key to further success
- GPs need support to start or improve comfort w/ HCV treatment
  - Practitioner needs will vary greatly
  - Just-in-time / point-of-care support is essential
- Importance of multidisciplinary team

Lessons learned in Australia:
key stakeholders share their experience

- Must have multiple points of entry into treatment:
  - Primary care clinics
  - Substance abuse centers and syringe services programs
  - Prisons/jails
  - Hospitals

Lessons learned in Australia: key stakeholders share their experience

- Critical role of “local champions” in promoting HCV treatment
  - Motivate action
  - Challenge inaction
  - Approach challenges from within their systems

Lessons learned in Australia:
key stakeholders share their experience

- Paradigm shift: HCV treatment must move from specialty to primary care settings
- Champions understand setting-specific challenges and provide professional development to their peers

Lessons learned in Australia:
Champions should include PWID peers

- Dispel myths and misinformation about HCV
- Reduce HCV stigma and discrimination
- Help guide peers to care through connections and trust
- Significant evidence supports efficacy of HCV peers

Who can be a HCV Champion?

- Public Health and Policy Leaders
- Peer
- MD/DO
- MA
- NP/PA
- RN/LPN
- Pharm D
Can I be a HCV Champion?

- “All persons with current active HCV infection should be linked to a practitioner who is prepared to provide comprehensive management.”

- New potent and well-tolerated hepatitis C treatments present an opportunity to expand the number of advanced practice practitioners and primary care physicians trained in the management and treatment of HCV infection.

Finding and recruiting HCV Champions

- 2016 Family Medicine Residency Director Survey¹:
  - 78%: HCV is a significant problem for primary care
  - 62%: Their program should build HCV treatment capacity
- Otherwise very limited literature on HCV workforce
- Screening in primary care and HCV training in gastroenterology programs
- 2015 paper from Wisconsin: 1 provider per 340 HCV patients, and 51 of 72 counties had no HCV treating provider²


Finding and recruiting HCV Champions

- Veterans Health Administration (VA) clinical pharmacists with “Scope of Practice” certification
  - Allows prescribing HCV medications
  - Includes 3,200 VA pharmacists nationwide (41%)

Developing HCV Champions

- The workforce must be built within every part of the team
  - Providers, pharmacists, nurses, medical assistants, peers, advocates, officials
- Develop champions with the passion to care and make change
- Use available resources:
  - https://aidsetc.org/hivhcv – Guidebook for HCV skill-building
  - https://www.hepatitisc.uw.edu/ – HCV self-study resource
  - www.hcvguidelines.org – Definitive clinical decision-making reference
  - https://nccc.ucsf.edu/clinician-consultation/hepatitis-c-management/ – Live (point-of-care) support for HCV management advice
- Regional AETCs – Can link clinicians with local mentors for HCV care support
HCV care coordinator model: Low-threshold access, high-touch support

Marguerite Beiser, ANP-BC, AAHIVS
Boston Health Care for the Homeless Program
BHCHP

- Serving ~11,000 homeless and marginally-housed patients/year
- High prevalence of syndemic conditions
  - 23% HCV
  - 6% HIV
  - 60% any substance use disorder (SUD)
  - 48% Behavioral Health diagnosis and SUD

HCV Team
- Primary care providers with HCV expertise
- Care coordinator and RN are central to team
- Low-threshold tx access
- High-touch adherence support
- Acceptance of less than perfection
- Co-location with linked services
- Leverage existing patient engagement/relationships (street team, AHOPE, HH, red team, OBAT)

(Bharel et al., 2013)
HCV care coordinator

- **Referral hub**
  - Singular referral point for all
  - Outreach education in SUDs

- **Insurance expertise/prior authorization (PA) navigation**
  - Pharmacy coordination

- **Adherence support**
- Maintains tracking document
- Communication across teams
- Reinfection counseling/harm reduction education
- Fibroscan escorting
- Participation in policy-making, advocacy

Interested in Hep C treatment?
Call CIA, Care Coordinator at: 857-366-2338
* Ask questions about treatment
* Schedule an appointment

BHCHP
780 Albany St
Boston, MA
Figure 1. Cascade of HCV care outcomes

- Linked to HCV Treatment Evaluation: 510
  - Initiated Treatment: 300
    - Completed Treatment: 285
      - SVR Not Achieved: 17
        - Reinfaction: 7
        - Treatment Failure: 10
      - Missing SVR Data: 14
      - SVR Achieved: 254
    - Did Not Complete Treatment: 15
      - Failed with NS5a resistance: 5
        - Failed without NS5a resistance: 3
    - Unknown NS5a resistance status: 2
  - Did Not Initiate Treatment: 210
    - Lost to F/U: 11
    - Incarcerated: 2
    - Stopped due to SEs: 2
    - SVR Achieved: 1
  - Lost to F/U: 93
    - Socially Unstable: 49
    - Spontaneous Clearance: 23
    - Outside Care: 23
    - Death: 12
    - Medically Unstable: 10

SVR Achieved Total: 255
Pharmacist-managed HCV treatment: integrated, inter-professional service delivery models

Betty J. Dong, PharmD, FASHP, FAPHA, FCCP, AAHIVP
University of California, San Francisco, Schools of Pharmacy and Medicine
Perceived barriers for patients on opioid agonist treatment: young PWID

- Lack of deservingness” of HCV treatment
  - Limited insurance coverage, cost of treatment
- Illness acuity
  - Lack of urgency; asymptomatic status reduces treatment as priority
  - Adverse side effects of treatment
- Dissatisfaction with provider interactions
  - Feeling uncared for or dismissed by healthcare providers
- Provider stigma
  - Lack of referral to care
- Policies that dis-incentivize HCV treatment (i.e., sobriety, fibrosis restrictions)

Principles and practice models for HCV care: shifting the paradigm

- Patient education
- Address stigma
- Patient education
- Patient education
- Share the care/Task shifting; integrating within non-specialty settings
- Resources (e.g., Navigator, tele-health, specialty pharmacies, NCCC, ECHO)
- DAAs – simple, effective, curative
- Convenient, accessible: co-located, multi-disciplinary services
- HCV Care Cascade: bridge the gap between diagnosis and treatment
- Safe, non-judgmental, includes harm reduction interventions

SVR outcomes: pharmacist-managed programs

- Retrospective study to determine effectiveness of pharmacist-managed vs. pharmacist-assisted HCV clinic 1/2015-6/2017

- Pharm-assisted (n=63): DAA access assistance, 1 pharm visit before tx start: drug interaction screening, patient education/counseling, direct care from MD and NPs

- Pharm-managed (n=64): Direct care provision, decision making, ↑ patient contact time, consistent F/U
  - Pre-treatment visit, medication teaching visit, q4wk F/U visits (avg: 5-10 visits)

- Predictors of enrollment: male, African American, incarceration history, presence or cirrhosis, intranasal drug use history

- Outcomes: no difference between groups
  - Tx completion: OR 1.1 (95% CI 0.1-13.8, p=0.93); SVR12: OR 1.0 (95% CI 0.2-4.5, p=0.62)

- Over 200 clinical pharmacists manage HCV in VA system
  - Durham, NC: VA retrospective study 10/1/14 - 9/30/15, n=372; SVR12= 97.5% (155/159) LDV/SOF+/-RBV; 94.8% (145/153) on ombitasvir/paritaprevir/ritonavir +/- ribavirin (RBV)
  - Nevada: VA retrospective 1 year study; n=132; SVR12 rates =94%; 93% (n=88) tx-naïve; 96% (n=44) tx-experienced, 93% (n=79) no cirrhotic, 94% (n=53) compensated cirrhosis; 95.5% adherence rates.

- Vanderbilt University (TN): ↓ provider/clinic burden, time to medication approval/initiation, excellent patient/provider satisfaction, cost savings, optimal adherence, and overall improved continuity of care
Pharmacists with prescriptive authority

- Collaborative practice agreements (CPAs) between pharmacists and prescribers legal in 48 states
- Formal practice relationship between pharmacist and another health care provider (HCP) and specify what patient care services beyond the typical scope of practice can be provided
- Variability of prescriptive authority vary between states: e.g., community vs. institutional settings, pharmacist training, types of medical conditions
- 38 states allow pharmacists per CPA to initiate drug therapy, and 45 allow for the modification of existing therapy
Pharmacists can support and help optimize adherence: applying lessons learned from ANCHOR?

Sofosbuvir/velpatasvir* x 12 wks

SVR12 = primary endpoint

Monitor for reinfection

Buprenorphine

Adherence assessments: wk 4 HCV RNA, Rx interruptions, completion of study drugs, end of tx timing vs wk 12

TDF/FTC (PrEP)

Regular interval assessments

*Dispensed in 28-day increments at Day 1, week 4, week 8 (i.e., 3 bottles)
ANCHOR: weeks of DAA completed

- 1 patient completed < 1 bottle; 0% SVR
- 5 patients completed 1-2 bottles; 0% SVR
- 7 patients completed 2-3 bottles; 71% SVR (85% per protocol)
- 80+ patients completed all 3 bottles; 85% SVR (93% per protocol)
Pharmacists with HCV prescriptive authority/Advanced Pharmacy Providers (APP) delivering HCV care

Start early
- Assess readiness
- Assess adherence
- Anticipate barriers
- Obtain med history
- Explain Tx logistics
- Identify/select DAA
- Eval comorbidities
- HAV/HBV testing and follow-up
- Medication/drug interactions

Prior authorization
- Submit PA, follow up on status
- HCV genotype
- Quant HCV RNA
- Fibrosis/cirrhosis
- Comorbidities
- HAV/HBV
- Prior HCV Tx
- Manage/mitigate medication interactions

Treatment initiation
- Administration
- Manage drug interactions
- Pt education (ADR)
- Adherence
- Incentives (e.g., gift cards, transportation vouchers)
- Lab monitoring
- SVR/cure dates – coordinate testing
- Prevent reinfection
HCV drug interactions are common

- N = 664 at University of Colorado Hepatology Clinic; Pharmacist chart review ~30 min
- 5,217 meds reviewed (7.86 meds/patient)
- 781 interactions (1.18 intx/patient)
- Most common interactions (≥ 10%)
  - Vitamin and herbal supplements (284/781, 36.4%);
  - PPI/H2RA agents (117/781, 15.0%);
  - Other (126/781, 16.1%)

- Recommendations
  - Discontinue meds: 28.9%
  - Monitoring: 24.1%
  - Separate admin times: 18.2%

- Limitations/generalizability to other centers
  - Retrospective
  - Single center study
  - Less diverse patient population

Langness JA et al. World J Gastroenterol 2017; 23: 1618-1626
## Drug-drug interactions with acid-reducing agents

<table>
<thead>
<tr>
<th>HCV Regimen/Drug</th>
<th>Omeprazole 20 mg daily*</th>
<th>Antacids</th>
<th>H₂ Blocker†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ledipasvir/sofosbuvir</td>
<td>Take LDV/SOF + PPI together on empty stomach</td>
<td>Separate by 4 hrs</td>
<td>Take LDV/SOF + H₂ blocker together or 12 hrs apart</td>
</tr>
<tr>
<td>Sofosbuvir/velpatasvir[^2]</td>
<td>Not recommended, but if medically necessary, take SOF/VEL with food 4 hrs before omeprazole 20 mg</td>
<td>Separate by 4 hrs</td>
<td>Take SOF/VEL + H₂ blocker together or 12 hrs apart</td>
</tr>
<tr>
<td>Sofosbuvir/velpatasvir/voxilaprevir[^3]</td>
<td>Take SOF/VEL/VOX + PPI together with food</td>
<td>Separate by 4 hrs</td>
<td>Take SOF/VEL/VOX + H₂ blocker together with food or 12 hrs apart</td>
</tr>
<tr>
<td>Glecaprevir/pibrentasvir</td>
<td>No significant interaction</td>
<td>No intxn</td>
<td>Not significant</td>
</tr>
<tr>
<td>Elbasvir/grazoprevir</td>
<td>No interaction</td>
<td>No intxn</td>
<td>No intxn</td>
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</table>

*Contraindicated with BID PPI; other PPI not studied
†Not to exceed famotidine 40 mg BID
Having trouble viewing the interactions? Click here for the Interaction Checker Lite.

<table>
<thead>
<tr>
<th>HEP Drugs</th>
<th>Co-medications</th>
<th>Drug Interactions</th>
</tr>
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<tr>
<td>A-Z</td>
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Selected HEP Drugs will be displayed here:
- Adefovir
- Boceprevir

Selected Co-medications will be displayed here:
- Abacavir
- Abiraterone

Drug Interactions will be displayed here.
Obtaining DAAs: treatment access

- Prior authorization (PA) almost always required!! Patient access to DAAs remains essential to improving outcomes
  - 2016 failure to start due to insurance denials
  - Most common reason for denial: insufficient information to assess medical need (36%), lack of medical necessity (35%)
- Successfully navigating the PA process is critical: benefits investigation if insured, PA request, possible appeals
- Employ assistance of specialty pharmacies
  - Use the preferred pharmacy benefits manager (PBM) pharmacy
  - Use the preferred (on formulary) DAA
- Rejections/denials: know how to follow-up
PA rejection and patient assistance programs

**Rejection**
- Switch to preferred therapy if clinically appropriate
- Submit letter of appeal with clinical documentation

**Manufacturer Patient Assistance Programs/CoPay Cards**
- Gilead LDV/SOF; SOF/VEL; SOF/VEL/VOX Support Path
- AbbVie Gle/Pib Patient Assistance Program
- Merck EBR/GZR Patient Assistance Program

**Patient Advocacy Programs**
- Patient Access Network Foundation https://panfoundation.org
- Good Days https://www.mygooddays.org/
- The Assistance Fund (TAF) https://tafcares.org/
- Patient Advocate Foundation https://www.patientadvocate.org
- Healthwell Foundation https://www.healthwellfoundation.org/
Wrapping up: Special considerations, unique populations
Special populations among PWID with HCV

- HIV co-infection: it’s all about managing drug interactions
  - Immune status does not impact HCV treatment
  - An undetectable HIV viral load is not required for initiating HCV treatment
- HBV co-infection: monitor closely for HBV flare
  - During and after HCV treatment
- Medication-assisted treatment for opioid use disorder
  - Vital tool to retain patients in care and improve overall outcomes
  - Integrated medication-assisted tx (MAT)/HCV/primary/behavioral care is the ideal model
  - Very few DAA impacts on MAT meds (PROD may increase buprenorphine)
  - MAT meds do not significantly impact DAAs
- Mental illness: coordinate with mental health providers
  - Check for drug interactions between HCV and psych meds
HCV and pregnancy

- Alarming increase in HCV rates among pregnant women in U.S. (largely related to opioid use)
  - 89% increase in HCV among women at time of delivery: 1.8/1000 live births in 2009 to 3.4/1000 live births in 2014
- Perinatal HCV transmission rate: 4-7%
- DAAs not currently approved for use in pregnancy, but...
  - Conference on Retroviruses and Opportunistic Infections (CROI) 2019: first time data presented on DAAs in pregnancy

- Breastfeeding is ok, and C-section is not used for prevention of mother-to-child transmission (PMTCT)
  - women should avoid breastfeeding if nipples cracked or bleeding
- New treatment and care strategies urgently needed
- HCV eradication in pregnancy – coming soon for PMTCT?
- Remember to screen HCV-exposed infants at/by 18 months

References:
Conclusions

- DAA therapies are safe and highly effective among people with substance use disorders, including PWID.
- Find and develop HCV Champions in your community and within your organizations to make things happen!
- Make it easy for your patients to get and stay on treatment: “low threshold” services that can help “compress” the HCV care cascade may be ideal care model.
- Threshold for optimal DAA adherence that predicts SVR not known at this time, however brief periods of interrupted treatment do not seem to impact SVR.
- Pharmacists can be highly effective HCV Champions and partners.
Resources

- IDSA/AASLD hepatitis C guidelines (hcvguidelines.org)
- Medication interaction resources
  - Liverpool (https://hep-druginteractions.org/checker)
  - Toronto (https://hivclinic.ca/drug-information/drug-interaction-tables)
  - DHHS HIV Treatment Guidelines (includes DAA-ARV interaction tables)
- University of Washington HCV Web Study (https://www.hepatitisc.uw.edu)
- HIV/HCV Co-Infection- AETC National Curriculum: https://aidsetc.org/hivhcv
- CPNP Pharmacist Toolkit: Hepatitis C https://cpnp.org/guideline/hepatitis-c
- AETC program
  - NCRC: patient and provider resources (https://aidsetc.org/)
  - NCCC: HCV Warmline, HIV Warmline, Substance Use Warmline (nccc.ucsf.edu)
  - Regional AETCs: local trainings, regional webinars
- ECHO
Find clinical resources related to HIV/HCV prevention, care, and treatment here: https://aidsetc.org/hivhcv

References:


Last day to order printed resources: **Wednesday, June 26th**

- AETC National HIV Curriculum Postcard for Providers
- Myths about Treating Substance Users with Hepatitis C Virus
- Hepatitis C: Getting Cured Is Easier than Ever
- Passport to Cure Brochure for Clients (Spanish)
- Hep C Free Postcard for Clients (English & Spanish)
- Non-Occupational Post-Exposure Prophylaxis (nPEP) Provider Pocket Guide
- nPEP Prescribing Myths
- nPEP Medication Assistance Program Postcard for Providers
- Immediate ART Pocket Guide
Thank you!

Panel Discussion: Q & A