March 2021

CCHCS Care Guide: Hepatitis C

SUMMARY

GOALS

- Identify Hepatitis C (HCV) infected patients.
- Monitor all HCV patients for signs of cirrhosis.
- Use the most appropriate HCV treatment regimen based on AASLD/IDSA** guidelines.
- Monitor patients on treatment and stop treatment when indicated (futility rules).
- The goal of HCV antiviral treatment is to achieve a sustained virologic response (SVR) - cure.
- Complete pretreatment labs and imaging with a FibroScan, FibroTest (if FIB-4 is ≥1.45 and <3.25) and/or Liver Ultrasound (if F4 cirrhosis) within 180 days of establishing diagnosis of chronic HCV.
- Initiate HCV treatment within 90 days of completing the pretreatment evaluation or as soon as possible based on operational considerations and the patient’s parole date.
- Annual retesting for HCV is recommended for all patients with a history of HCV that was treated or self-cleared by checking an HCV viral load.*
- Consider periodic sexual health screening and risk reduction counseling and education for all patients identified with active HCV as part of their overall health due to the risk of acquiring HCV through sexual contact.
- All patients with HCV should be screened for an underlying substance use disorder according to the CCHCS Care Guide: Substance Use Disorder.

*Consider periodic retesting of all other patients if they have a history of injection or inhalation drug use or symptoms/signs of acute hepatitis (right upper quadrant abdominal pain, nausea, vomiting, jaundice, or transaminits) by checking an HCV Antibody with reflex to viral load.

TREATMENT

Patient Selection

- AASLD/IDSA** recommends treatment for all patients with chronic HCV infection, except those with life expectancies < 12 months that cannot be remitted by treating HCV, by liver transplantation, or by other directed therapy.
  - Unless there is a medical contraindication, all patients with chronic HCV are treatment candidates if they desire treatment and are willing to adhere to a medication and monitoring plan.

Treatment

- The recommended medication regimen depends on genotype and many clinical factors including the presence or absence of cirrhosis, co-infection with Human Immunodeficiency Virus (HIV) or Hepatitis B Virus (HBV), other comorbidities, and any history of prior treatment.
- The Food and Drug Administration (FDA) is approving new medications frequently and treatment regimens are changing rapidly as new agents are being released. For this reason, all patients should be referred to the HQ HCV Central Treatment Team for selection of the most appropriate treatment regimen by submitting an HCV TSR (See page 7).

MONITORING

All chronic HCV infected patients:

- **Annual clinical assessment:** Consider labs including CBC, CMP, PT/INR every 12 months to assess progression of liver disease. Determine FIB-4 (see page 4) annually. Calculate the Child-Turcotte-Pugh (CTP) score (see page 6) as indicated.
- **Vaccines:** Offer and document Hepatitis A Virus (HAV), HBV, and pneumococcal (PPSV23 once 19-64 years and all > 65 years, consider PCV13 also for > 65 years if immuneuncompetent but comorbid conditions present, or smokers; followed by a second PPSV23 one year later. See the CDC website (for complete guidance). Encourage an annual influenza vaccination.
- All patients with acute and chronic HCV should be evaluated for underlying co-morbid substance use disorder (See CCHCS Substance Use Disorder Care Guide).

HCV patients receiving antiviral therapy:

- See page 7 regarding intervals for CMP.
- Clinic visits are recommended as clinically indicated during treatment. At each visit, ensure medication adherence, and monitor for adverse events and potential drug-drug interactions with newly prescribed medications.
- Education and monitoring of HCV treatments should be managed using the Complete Care Model. Patients receiving HCV treatment are listed on the Daily Care Team Huddle Report, and these patients are to receive education, care coordination, and follow up from the primary care team, Licensed Vocational Nurses (LVNs), Registered Nurses (RNs), Primary Care Providers, and Case Managers only as clinically indicated.

Chronic HCV infected patients with cirrhosis:

[Metavir score F4 (liver stiffness kPa ≥ 12.0 or Liver Stiffness Score F4 on Fibroscan):]
- Liver ultrasound every 6 months to screen for hepatocellular carcinoma (HCC). **Continue HCC screening after HCV treatment.**
- See the CCHCS Advanced Liver Disease Care Guide.
- Patients with Chronic HCV but without cirrhosis do not require a baseline ultrasound or HCC screening.
- Annual rescreening of patients successfully treated for HCV is recommended with an HCV viral load (Hepatitis C RNA, Quant, PCR 35645).

**American Association for the Study of Liver Diseases, Infectious Diseases Society of America

Information contained in the Care Guide is not a substitute for a health care professional’s clinical judgment. Evaluation and treatment should be tailored to the individual patient and the clinical circumstances. Furthermore, using this information will not guarantee a specific outcome for each patient. Refer to “Disclaimer Regarding Care Guides” for further clarification. https://cchcs.ca.gov/clinical-resources/
**Who to Screen**

All patients, especially:
- Anyone who wants screening
- History of injection drug use or tattoos
- Other risk factors
- Clinical findings of liver disease

**Order HCV Antibody Test with reflex to HCV RNA, PCR with reflex to genotype 94345**

If Hepatitis C Antibody is reactive, Hepatitis C Viral Load Polymerase Chain Reaction (PCR) will automatically be performed and if this is positive, an HCV genotype will also be performed.

**What are the lab results?**

- **HCV antibody NEGATIVE**
  - Normal liver enzymes
  - No HCV infection - educate the patient on risks of infection

- **HCV antibody NEGATIVE**
  - Liver enzymes ELEVATED
  - Rule out: Early acute HCV (see page 3) OR Chronic HCV in immunosuppressed patient (e.g., HIV)
    - Consider checking the HCV viral load if not already done
    - Ensure newly diagnosed cases of acute HCV are reported to the local health department*
    - Screen annually for HCV with the HCV antibody test with reflex to HCV RNA, PCR with reflex to genotype 94345

- **HCV antibody POSITIVE**
  - HCV viral load NEGATIVE
  - Resolved or Treated HCV OR Acute HCV with transient viral clearing OR False positive HCV Ab
    - Consider rechecking the HCV viral load in 6-12 months to confirm that the patient is not chronically infected
    - Rescreen annually for HCV reinfection by checking an HCV viral load

- **HCV antibody POSITIVE**
  - HCV viral load POSITIVE
  - Chronic HCV
    - Assess for treatment (see page 4)

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*The institution should ensure a process to report acute Hepatitis C infections to the local health department via a Confidential Morbidity Report (CMR) at: [https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Public-Health-Reporting.aspx](https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Public-Health-Reporting.aspx). In many institutions the public health nurses do the reporting. Please refer to the HCDOM Public Health Disease Reporting (3.8.1).*
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Acute HCV: Diagnosis, Evaluation, and Treatment

Definition

- Positive HCV viral load with negative HCV antibody, OR
- Documented change in HCV antibody from negative to positive within a 6 month time period, OR
- A new (within the last 3 months) positive HCV antibody accompanied by:
  - A new elevation of ALT (defined as at least 5 times prior baseline level obtained within the last 24 months), or
  - An increase of ALT to more than 5 times > normal ALT levels if no baseline labs in last 24 months, and
  - No other concomitant conditions to explain the rise in liver enzymes.

Evaluation

- The majority of patients are asymptomatic. Clinical presentation may include jaundice, dark urine, fatigue, and/or right upper quadrant abdominal pain.
- “Time Zero” is the date of the first signs and symptoms of acute hepatitis or first lab abnormalities. If none of these are present, the most recent date of IV drug use or tattooing can be used to determine the interval for HCV lab surveillance.

LAB EVALUATION of Acute HCV:

<table>
<thead>
<tr>
<th></th>
<th>CBC</th>
<th>CMP</th>
<th>PT/INR</th>
<th>HCV viral load</th>
<th>HIV test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline: Time Zero</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Week 8 to 12</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Week 16</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓*</td>
<td></td>
</tr>
</tbody>
</table>

*If the HCV viral load at week 8 to 12 is negative, order an additional HCV viral load to confirm that the patient cleared the acute infection. Repeat the HCV viral load every 4-6 weeks until 2 negative HCV viral loads are obtained. Rescreen for HCV annually thereafter.

INTERPRETATION of Diagnostic Studies:

<table>
<thead>
<tr>
<th>HCV antibody</th>
<th>HCV antibody signal: cut off</th>
<th>HCV viral load</th>
<th>Alanine aminotransferase (ALT)</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>Low</td>
<td>Negative High</td>
<td>Normal</td>
<td>HCV negative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Positive</td>
<td>High</td>
<td>Acute HCV</td>
</tr>
<tr>
<td>Positive</td>
<td>Low</td>
<td>Negative</td>
<td>Normal</td>
<td>False positive HCV Antibody</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Negative</td>
<td>High</td>
<td>Early acute HCV</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Positive</td>
<td>High</td>
<td>Acute HCV</td>
</tr>
<tr>
<td>Positive</td>
<td>High</td>
<td>(New) Positive</td>
<td>High</td>
<td>Acute re-infection</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Positive</td>
<td>Normal</td>
<td>Chronic HCV</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Negative</td>
<td>Any</td>
<td>Treated or cleared HCV</td>
</tr>
</tbody>
</table>

- Consult the HCV warmline: CDCR CPHCS HCV Questions@cdcr.ca.gov if the diagnosis (acute or chronic) is uncertain.
- Counsel the patient regarding risk reduction.

Treatment

- Approximately 20% of patients with acute HCV will clear their infection without treatment within 3-6 months of the initial exposure. Newer recommendations highlight early treatment during the acute phase to decrease the risk of transmission. Consideration will be made to treat the patients at high risk of transmission during the acute phase. Please submit a TSR for evaluation to determine the best treatment course for these patients. All patients should be assessed for underlying substance use disorder (see the CCHCS Care Guide: Substance Use Disorder)
- Provide patient education to patients who spontaneously clear HCV to include the risk of reinfection with high risk exposures.
**SUMMARY**

**DECOMPENSATED CIRRHOSIS**
A patient has decompensated cirrhosis if they have one or more of the following:
- Esophageal variceal hemorrhage
- Ascites
- Hepatic encephalopathy
- Spontaneous bacterial peritonitis
- Hepatopulmonary/or Hepatorenal disease
- CTP score of ≥ 7 (CTP ≥ 6 if HIV/HCV co-infected) (See page 6)

**FIBROSCAN™** uses transient elastography to measure liver stiffness. The shear wave velocity has been correlated with stages of fibrosis in HCV patients in the following manner:
A FibroScan is only recommended prior to HCV treatment (not during or after HCV treatment) to determine the patient’s degree of liver fibrosis if the FIB-4 is consistently between 1.45 and 3.25. If the patient has not yet received HCV treatment, an updated FibroScan is recommended every 2-3 years to monitor their liver fibrosis progression and stage their degree of fibrosis when they are ready for treatment.

**LIVER BIOPSY** is used infrequently due to non-invasive alternatives and some issues with sampling and observer variability.

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*Ziol, M et al, Noninvasive Assessment of Liver Fibrosis by Measurement of Stiffness in Patients With Chronic Hepatitis C. Hepatology 2006; 48-64.
### HCV Patient Risk Stratification

<table>
<thead>
<tr>
<th>Risk Group</th>
<th>Clinical Examples</th>
</tr>
</thead>
</table>
| 1* (Highest) | • Any previous FibroScan, FibroTest or liver biopsy demonstrating stage 3 or 4 fibrosis (≥ 9.5 kPa)  
• Cirrhosis otherwise diagnosed  
• Diagnosis of decompensated cirrhosis (see page 4)  
• Diagnosis of hepatocellular carcinoma (see exclusion criteria below)  
• HIV co-infection and any previous FibroScan, FibroTest or liver biopsy demonstrating greater than stage 1 fibrosis (> 7.0 kPa)  
• Liver Transplantation (consult with transplant and HCV specialists required)  
• Women of childbearing age who wish to get pregnant in the next 12 months  
• Serious extra-hepatic manifestations of HCV (e.g., leukocytoclastic vasculitis, membranoproliferative glomerulonephritis, or symptomatic cryoglobulinemia) |
| 2 (Medium) | • Any previous FibroScan, FibroTest or liver biopsy demonstrating stage 2 fibrosis (> 7.0 kPa)  
• Age > 50 years old  
• HIV or HBV co-infection  
• Patients with diabetes  
• HCV genotype 3  
• Body mass index > 30 kg/m²  
• GFR < 30  
• Does not meet any priority group 1 criteria |
| 3 (Lowest) | • Any previous FibroScan or FibroTest demonstrating stage 0-1 fibrosis (≤ 7.0 kPa)  
• Does not meet any priority group 1 or 2 criteria |

*Risk Group 1 patients will be treated by experienced primary care providers, HCV champions, or the HQ HCV Central Treatment Team.

### HCV Treatment Exclusion Criteria

#### Release Date Exclusion

<table>
<thead>
<tr>
<th>Clinical History</th>
<th>Minimum # of Months*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not cirrhotic</td>
<td>5</td>
</tr>
<tr>
<td>Decompensated cirrhotic and/or previous Direct Acting Agents (DAA) treatment failure</td>
<td>8</td>
</tr>
</tbody>
</table>

*Patients will be excluded from treatment consideration in CCHCS if they will be released before the evaluation and course of treatment can be completed. The minimum # of months noted above shows the minimum number of months of incarceration needed to complete HCV therapy based on patient factors. *More time may be required in some cases.*

#### Exclusion Criteria: HCV Treatment (all)
- Life expectancy < 12 months that cannot be remediated by treating HCV, by transplantation, or by other directed therapy
- Inability to cooperate with treatment
- Inability to give informed consent
- Pregnancy or inability to practice contraception

#### Exclusion Criteria: DAA
- On a medication contraindicated for use with DAA and unable to substitute
- Allergy to DAA
- Allergy to Ribavirin (RBV) (if regimen requires RBV)

#### Exclusion Criteria: RBV
- Poorly controlled or unstable cardiopulmonary disease
- Anemia; hemoglobin < 11 g/dl or hematocrit < 33%
- Allergy to RBV
- Inability to practice contraception during and for 6 months after treatment completion (teratogen)
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Summary

For persons with cirrhosis (Metavir stage F4), the severity of liver dysfunction can be estimated using the CTP. Variations in the timing and subjectivity inherent in the scoring (e.g., in grading ascites or encephalopathy) are the major limitations of CTP scoring.

<table>
<thead>
<tr>
<th>Number of points</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encephalopathy *</td>
<td>None</td>
<td>Grade 1-2</td>
<td>Grade 3-4 (or chronic)</td>
</tr>
<tr>
<td>Ascites</td>
<td>None</td>
<td>Mild/Moderate (diuretic-responsive)</td>
<td>Severe (diuretic-refractory)</td>
</tr>
<tr>
<td>Bilirubin (mg/dl)§ OR Modified total bilirubin§</td>
<td>&lt; 2</td>
<td>2-3</td>
<td>&gt; 3</td>
</tr>
<tr>
<td></td>
<td>&lt; 4</td>
<td>4-7</td>
<td>&gt; 7</td>
</tr>
<tr>
<td>Albumin (g/dl)</td>
<td>&gt; 3.5</td>
<td>2.8-3.5</td>
<td>&lt; 2.8</td>
</tr>
<tr>
<td>INR</td>
<td>&lt; 1.7</td>
<td>1.7-2.3</td>
<td>&gt; 2.3</td>
</tr>
</tbody>
</table>

* Encephalopathy Grading

- Grade 1: mild confusion, anxiety, restlessness, fine tremor, slowed coordination
- Grade 2: drowsiness, disorientation, asterixis
- Grade 3: somnolent but arousable, marked confusion, incoherent speech, incontinence, hyperventilation
- Grade 4: coma, decerebrate posturing, flaccidity

HIV Co-Infection (requires co-management by a CCHCS HCV specialist)
- Note multiple interactions exist with HCV and HIV medications. Do not adjust HIV medications without HIV specialist input.

Renal Impairment
- No dosage adjustment is required for any GFR. Specific HCV treatment recommendations exist for patients on dialysis or with GFR < 30 mL/min.

Pregnancy
- RBV is a known teratogen and cannot be used in pregnancy. Also, extreme care must be taken to avoid pregnancy during therapy and for 6 months after completion of therapy in both female patients and in female partners of male patients who are, or have recently taken RBV therapy.

Transplant (requires co-management by a CCHCS HCV specialist)
- Specific HCV treatment recommendations exist for patients with a kidney or liver transplant.

Special Populations

HBV Co-Infection (requires co-management by a CCHCS HCV specialist)
- Persons with HBV/HCV co-infection and detectable viremia of both viruses are at increased risk for disease progression, decompensated liver disease, and the development of HCC.
- During HCV treatment, cases of HBV reactivation have been reported, in some cases resulting in fulminant hepatitis, hepatic failure, and death.
- Screening for HBV infection and viremia is required prior to starting HCV treatment. If HBV infection is noted, treatment for HBV viremia may be recommended; otherwise, monthly HBV viral loads are recommended during HCV treatment.

HIV Co-Infection
- Note multiple interactions exist with HCV and HIV medications. Do not adjust HIV medications without HIV specialist input.

Renal Impairment
- No dosage adjustment is required for any GFR. Specific HCV treatment recommendations exist for patients on dialysis or with GFR < 30 mL/min.

Pregnancy
- RBV is a known teratogen and cannot be used in pregnancy. Also, extreme care must be taken to avoid pregnancy during therapy and for 6 months after completion of therapy in both female patients and in female partners of male patients who are, or have recently taken RBV therapy.

Transplant (requires co-management by a CCHCS HCV specialist)
- Specific HCV treatment recommendations exist for patients with a kidney or liver transplant.

Cirrhosis Scoring

<table>
<thead>
<tr>
<th>Class</th>
<th>Points</th>
<th>One year survival (%)</th>
<th>Two year survival (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>5-6</td>
<td>95</td>
<td>90</td>
</tr>
<tr>
<td>B</td>
<td>7-9</td>
<td>80</td>
<td>70</td>
</tr>
<tr>
<td>C</td>
<td>10-15</td>
<td>45</td>
<td>38</td>
</tr>
</tbody>
</table>

† Modified total bilirubin used to score the patients who have Gilbert’s syndrome or who are taking atazanavir or indinavir
§ Trey C., Burns D.G., Saunders S.J., Treatment of hepatic coma by exchange blood transfusion. NEJM. 1966; 274:473
Special Populations Continued

Substance Use Disorder (SUD) Co-infection
All patients with recurrent viremia from an HCV re-infection should be screened for SUD (see the CCHCS Care Guide: Substance Use Disorder) as the rate of recurrent viremia in CCHCS is higher than the general population primarily due to the high prevalence of co-morbid substance use disorder. If present, the patient should be referred to and evaluated by the ISUDT program according to the CCHCS Care Guide: Substance Use Disorder. Addressing an underlying SUD (identification, referral, and evaluation) is recommended prior to retreatment of HCV in order to optimize successful HCV retreatment and maintenance of an SVR.

Selection of HCV Treatment Regimen
Chronic HCV treatment is advancing more rapidly than CCHCS Care Guide revision cycles. In order to avoid the publication of outdated HCV treatment regimens in this Hepatitis C Care Guide, the provider is referred to HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C; www.hcvguidelines.org (AASLD/IDSA) for information regarding the most up to date specific recommended treatment regimens. Treatment protocol selection depends on HCV genotype, whether the patient is treatment naive or treatment experienced, and additional clinical factors.

All patients requesting treatment should be referred by submitting a TSR in EHRS for selection of the most appropriate treatment regimen by the HQ HCV Central Treatment Team. The TSR can be found in EHRS under AdHoc forms in the Case Management folder—HCV Treatment Selection Review Request. CCHCS’s goal is to initiate HCV treatment within 90 days of completing the pretreatment evaluation (labs and/or imaging if indicated, see page 4.)

Patients who are treatment experienced (not recurrent viremia from a re-infection) require pretreatment labs and the SVR lab (12 week post-treatment HCV viral load) according to the table, but the active treatment labs may differ depending upon the particular regimen selected. Please submit an eTSR for patients who are treatment experienced and the HCV Central Team will select the most appropriate regimen and follow the patient (if applicable).

Labs Recommended For Patients that Require On-Treatment Monitoring
The table below applies only to select patients who are treatment experienced with or without cirrhosis. For those that do not require monitoring, there is no need for the week 4 labs.

<table>
<thead>
<tr>
<th>Rx week</th>
<th>Result</th>
<th>Action/Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any week</td>
<td>ALT: &gt; 10 fold increase</td>
<td>Stop treatment, clinical evaluation recommended</td>
</tr>
<tr>
<td></td>
<td>ALT increase but &lt; 10 fold; with increased</td>
<td></td>
</tr>
<tr>
<td></td>
<td>bilirubin, alkaline phosphatase or INR and/or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>symptomatic (weakness, nausea, vomiting, jaundice)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ALT increase but &lt; 10 fold and asymptomatic</td>
<td>Recheck ALT in 2 weeks</td>
</tr>
<tr>
<td>Week 4</td>
<td>HCV VL: if &gt; 15 detected, repeat VL</td>
<td>If &gt; 15 detected at week 4, repeat VL at week 6</td>
</tr>
<tr>
<td>Week 6</td>
<td>HCV VL: 1 log increase from week 4</td>
<td>Stop treatment</td>
</tr>
<tr>
<td></td>
<td>HCV VL: &lt; 1 log increase from week 4</td>
<td>Continue treatment</td>
</tr>
<tr>
<td>12 weeks post Rx</td>
<td>HCV VL: Detectable</td>
<td>Treatment failure or reinfection</td>
</tr>
<tr>
<td></td>
<td>HCV VL: Undetectable</td>
<td>SVR=Cure. Annual VL testing recommended.</td>
</tr>
<tr>
<td></td>
<td>AST or ALT abnormal</td>
<td>Assess for other causes of liver disease if the HCV VL is undetectable</td>
</tr>
<tr>
<td></td>
<td>AST or ALT within normal limits</td>
<td>No further action required</td>
</tr>
</tbody>
</table>
### Labs Recommended For HCV Treatment

<table>
<thead>
<tr>
<th>Pretreatment</th>
<th>Treatment</th>
<th>Active</th>
<th>Treatment</th>
<th>End of treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Naïve Cirrhosis</td>
<td>Experienced Cirrhosis</td>
<td>Experienced No Cirrhosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Any time frame</td>
<td>Within past 3 months</td>
<td>Within past 1 month</td>
<td></td>
</tr>
<tr>
<td></td>
<td>βHCG</td>
<td>CBC</td>
<td>CMP</td>
<td>PT/INR</td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Within past 6 months</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Within past 1 month</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Any time frame</td>
<td>Within past 12 months</td>
<td>Within past 3 months</td>
<td>Within past 1 month</td>
</tr>
<tr>
<td></td>
<td>βHCG</td>
<td>CBC</td>
<td>CMP</td>
<td>PT/INR</td>
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<tr>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Within past 12 months</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td></td>
<td>Within past 3 months</td>
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<td></td>
<td>Within past 1 month</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td></td>
<td>Within past 12 months</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td></td>
<td>Within past 3 months</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Within past 1 month</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Week 2</td>
<td>Week 4</td>
<td>Week 8</td>
<td>Week 12</td>
</tr>
<tr>
<td></td>
<td>βHCG</td>
<td>CBC</td>
<td>CMP</td>
<td>PT/INR</td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
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<tr>
<td></td>
<td>Week 4</td>
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<tr>
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</tr>
<tr>
<td></td>
<td>Week 8</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Week 12</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>12 weeks after treatment ends</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

---

1. Recommended for women of child bearing age.
2. Obtain CBC at treatment week 2, 4, 8, 12, 16 (if applicable) if taking RBV.
3. Obtain CMP at treatment week 8 if taking the 12 week regimen of elbasvir/grazoprevir.
4. If HBV surface antigen and HBV surface antibody are negative but HBV core antibody is positive, obtain an HBV viral load.
5. If the HCV VL is undetectable and the AST or ALT are abnormal, assess for other causes of liver failure.

Note: Updated AASLD/IDSA Guidelines showing simplified treatment model can be found here: [https://www.hcvguidelines.org/treatment-naive](https://www.hcvguidelines.org/treatment-naive)
Resistance to Direct Acting Oral Agents

HCV is an approximately 9.5 kilobase RNA virus that replicates at a rate of billions of copies daily. Many of these viral copies are not functional due to errors during replication. However, the rate of replication allows for drug-resistant virus to develop when a patient is taking an HCV combination that is suboptimal or if the patient is not adherent with medication.

An area of the HCV virus conferring resistance to a particular medication is called a resistance associated substitution (RAS). An RAS name identifies the amino acid position where the substitution took place, the amino acid that is normally coded for (preceding the amino acid position), and the amino acid that is now being coded for. Multiple letters following the amino acid position indicate a mixed virus with more than one resistant variant present.

<table>
<thead>
<tr>
<th>HCV RNA Viral Structure</th>
<th>Replication Complex</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Structural proteins</strong></td>
<td><strong>Non-structural proteins</strong></td>
</tr>
<tr>
<td>C</td>
<td>E1</td>
</tr>
</tbody>
</table>

### HCV Medication Class

<table>
<thead>
<tr>
<th>NS3/4A Protease Inhibitors</th>
<th>NS5A Inhibitors</th>
<th>NS5B Polymerase Inhibitors Nucleotide</th>
<th>NS5B Polymerase Inhibitors Non-Nucleotide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glecaprevir, Grazoprevir, Voxilaprevir</td>
<td>Daclatasvir, Elbasvir, Ledipasvir, Pibrentasvir, Velpatasvir</td>
<td>Sofosbuvir</td>
<td>Dasabuvir</td>
</tr>
</tbody>
</table>

The presence of RAS impacts HCV treatment depending on patient genotype, the level of liver fibrosis, and if the patient is treatment experienced or naïve. RAS can remain present for weeks to months. Some RAS confer cross class resistance, while others only affect specific members of a medication class. Resistance can be overcome in some cases with the addition of ribavirin or additional agents and/or the extension of treatment duration.

### Testing for Resistance

The most common drug resistant virus develops as a result of NS3 or NS5A failures; NS5B failures are rarely seen in clinical settings. There are commercially available assays to detect RAS in genotype 1 NS3/4a, NS5A and NS5B and in genotype 3 NS5A regions. RAS testing is to be ordered in only specific instances; see hcvguidelines.org for more information. RAS testing is not recommended prior to retreatment of DAA failures. It is required prior to treatment with elbasvir/grazoprevir [Zepatier®] in patients with Genotype 1 or 1a infection.
<table>
<thead>
<tr>
<th>Medication</th>
<th>Genotype</th>
<th>Pills/Day</th>
<th>Duration (treatment naïve, no cirrhosis)</th>
<th>Resistance Testing Required? (treatment naïve, no cirrhosis)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ledipasvir/Sofosbuvir [Harvoni®]</td>
<td>1, 4, 5, 6</td>
<td>1</td>
<td>8, 12 weeks</td>
<td>No</td>
</tr>
<tr>
<td>Sofosbuvir/Velpatasvir [Epclusa®]</td>
<td>1, 2, 3, 4, 5, 6</td>
<td>1</td>
<td>12 weeks</td>
<td>No</td>
</tr>
<tr>
<td>Glecaprevir/Pibrentasvir [Mavyret®]</td>
<td>1, 2, 3, 4, 5, 6</td>
<td>3 pills once/day</td>
<td>8 weeks</td>
<td>No</td>
</tr>
<tr>
<td>Elbasvir/Grazoprevir [Zepatier®]</td>
<td>1, 4</td>
<td>1</td>
<td>12, 16 weeks</td>
<td>If Genotype 1A and going to use Zepatier, then resistance testing is required (Hepatitis C Viral RNA Geno 1 NS5a Drug Resist-92447)</td>
</tr>
</tbody>
</table>

HCV Medication Comparison Overview

March 2021

CCHCS Care Guide: Hepatitis C

Medication Genotype Pills/Day Duration (treatment naïve, no cirrhosis) Resistance Testing Required? (treatment naïve, no cirrhosis)

Ledipasvir/Sofosbuvir [Harvoni®] 1, 4, 5, 6 1 8, 12 weeks No
Sofosbuvir/Velpatasvir [Epclusa®] 1, 2, 3, 4, 5, 6 1 12 weeks No
Glecaprevir/Pibrentasvir [Mavyret®] 1, 2, 3, 4, 5, 6 3 pills once/day 8 weeks No
Elbasvir/Grazoprevir [Zepatier®] 1, 4 1 12, 16 weeks If Genotype 1A and going to use Zepatier, then resistance testing is required (Hepatitis C Viral RNA Geno 1 NS5a Drug Resist-92447)
## Medications

**WARNING:** Risk of Hepatitis B virus reactivation in patients co-infected with HCV and HBV. Test all patients for evidence of current or prior HBV infection before initiating HCV treatment.

- If treatment interruption occurs or is anticipated, contact the HCV warmline immediately.
- Multiple drug-drug interactions may occur. Consult the pharmacy or HCV warmline prior to initiating new medications during the HCV treatment course (see page 15).

### Direct Acting Oral Agents

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosing</th>
<th>Adverse Effects/Interactions*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elbasvir/grazoprevir [Zepatier®]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tablet: 50/100 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elbasvir NS5a inhibitor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grazoprevir NS3 / 4a protease inhibitor</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Activity in genotype 1 and 4</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Dose:</strong> One tablet once daily with or without food</td>
<td></td>
</tr>
<tr>
<td>Renal dosing:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• No dose adjustment required including hemodialysis patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatic impairment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Contraindicated in patients with moderate to severe hepatic impairment (CTP B or C)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>If GT1a, then resistance testing (Hepatitis C Viral RNA Geno 1 NS5a Drug Resist-92447) is required prior to treatment and cannot use if elbasvir resistance is predicted</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>ALT elevations &gt; 5x upper limit of normal (ULN) at or after 8 weeks of treatment</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Perform hepatic lab testing prior to therapy, at treatment week 8, and as clinically indicated. Perform additional hepatic lab testing at week 12 if on 16 weeks of therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Discontinue if ALT persistently &gt; 10x ULN; Consider d/c if ALT elevation is accompanied by signs/symptoms of liver inflammation or increasing conjugated bilirubin, alkaline phosphatase, or INR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Fatigue</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Headache</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Nausea</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Contraindicated with nafcillin, oral ketoconazole, bosentan, rifampin, tacrolimus, etravirine, cobicistat, modafinil, carbamazepine, oxcarbazepine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Caution with statins: not to exceed 20 mg atorvastatin or 10 mg rosvastatin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Caution with warfarin, close monitoring of the INR is recommended</td>
<td></td>
</tr>
<tr>
<td>Glecaprevir/Pibrentasvir [Mavyret®]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tablet: 100/40 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glecaprevir NS3 protease inhibitor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pibrentasvir NS5a inhibitor</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Activity in all genotypes</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Dose:</strong> Three tablets orally once daily with food</td>
<td></td>
</tr>
<tr>
<td>Renal dosing:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• No adjustments needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatic impairment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Not recommended in patients with moderate hepatic impairment (CTP B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Contraindicated in patients with severe hepatic impairment (CTP C)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Fatigue</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Headache</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Contraindicated with atazanavir, rifampin, carbamazepine, efavirenz, ethinyl estradiol, darunavir, lopinavir/ritonavir, atorvastatin, lovastatin, simvastatin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Caution with digoxin, dabigatran, cyclosporine, pravastatin (pravastatin dose 50%), rosvastatin (not to exceed rosvastatin 10 mg)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Caution with warfarin, close monitoring of the INR is recommended</td>
<td></td>
</tr>
</tbody>
</table>

*Bold = Formulary

*See prescribing information for complete description of adverse effects and drug interactions.*
### Direct Acting Oral Agents Continued

**Medication** | **Dosing** | **Adverse Effects/Interactions***
--- | --- | ---
**Ledipasvir/sofosbuvir (HAR)**  
[Harvoni®]  
Tablet: 90/400 mg  
Ledipasvir NS5A inhibitor  
Sofosbuvir NS5B inhibitor  
*Activity in genotype 1, 4, 5, 6*  
*Dose:* One tablet once daily with or without food  
*Renal dosing:*  
• No dose adjustment required including hemodialysis patients  
  • Fatigue  
  • Headache  
  • Nausea  
  • Significant drug-drug interaction with acid lowering agents  
  • Bradycardia when administered with amiodarone (not recommended)  
  • Contraindicated with certain P-gp inducers (e.g., carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifampin, rifabutin, rifapentine, tipranavir, topotecan)  
  • Caution with digoxin, statins, tenofovir DF  
  • Caution with warfarin, close monitoring of the INR is recommended

**Sofosbuvir/Velpatasvir**  
[Epclusa®]  
Tablet: 400/100 mg  
Sofosbuvir NS5B inhibitor  
Velpatasvir NS5A inhibitor  
*Activity in all genotypes*  
*Dose:* One tablet once daily with or without food  
*Renal dosing:*  
• No dose adjustment required including hemodialysis patients  
  • Fatigue  
  • Headache  
  • Significant drug-drug interaction with acid lowering agents  
  • Bradycardia when administered with amiodarone (not recommended)  
  • Contraindicated with certain P-gp inducers (e.g., carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifampin, rifabutin, rifapentine, efavirenz, tipranavir, topotecan)  
  • Caution with digoxin, statins, tenofovir DF  
  • Caution with warfarin, close monitoring of the INR is recommended

**Sofosbuvir/Velpatasvir/  
Voxilaprevir**  
[Vosevi®]  
Tablet: 400/100/100 mg  
Sofosbuvir NS5B inhibitor  
Velpatasvir NS5A inhibitor  
Voxilaprevir NS3/4A protease inhibitor  
*Activity in all genotypes*  
*Dose:* One tablet once daily with food  
*Renal dosing:*  
• No dose adjustment required including hemodialysis patients  
  • Fatigue  
  • Headache  
  • Diarrhea  
  • Nausea  
  • Significant drug-drug interaction with acid lowering agents  
  • Bradycardia when administered with amiodarone (not recommended)  
  • Contraindicated with certain P-gp inducers (e.g., carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifampin, rifabutin, rifapentine, atazanavir, lopinavir, tipranavir, efavirenz, tipranavir, topotecan)  
  • Caution with statins, cyclosporine, digoxin  
  • Caution with warfarin, close monitoring of the INR is recommended

**WARNING:** Risk of Hepatitis B virus reactivation in patients co-infected with HCV and HBV. Test all patients for evidence of current or prior HBV infection before initiating HCV treatment.  
If treatment interruption occurs or is anticipated, contact the HCV warmline as soon as possible.  
Multiple drug-drug interactions may occur. Consult the pharmacy or HCV warmline prior to initiating new medications during the HCV treatment course (see page 15).

*See prescribing information for complete description of adverse effects and drug interactions.*

**Bold = Formulary**
# Medications continued

## HCV Agents—Other

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosing</th>
<th>Adverse Effects/Interactions*</th>
</tr>
</thead>
</table>
| Ribavirin (RBV)  | **Activity in all genotypes**<br><br>**Dose:** Based on body weight (total daily dose, divided two times a day)<br>  
< 75 kg: 1000 mg<br>  > 75 kg: 1200 mg<br>  
**Renal dosing:**<br>  CrCl 30-50 ml/min: Alternating doses, 200 mg and 400 mg every other day<br>  CrCl < 30 ml/min: 200 mg daily<br>  Hemodialysis (HD): 200 mg daily | **Anemia:**<br>  • The primary clinical toxicity of RBV is hemolytic anemia (See anemia management, page 14).<br>  • After about 2 weeks of RBV treatment, approximately 10% develop severe anemia; this may result in worsening of cardiac disease and has led to fatal and nonfatal myocardial infarctions. |

## Colony Stimulating Factors (epoetin alfa)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosing</th>
<th>Adverse Effects/Interactions*</th>
</tr>
</thead>
</table>
| Epoetin alfa     | **Usual Dose:**<br>  
• 50-100 units/kg subQ, (IV preferred if dialysis) three times weekly or<br>  • 150-300 units/kg subQ once weekly (maximum 40,000 units weekly)<br>  
Titrates to maintain Hgb 10-12 g/dl<br>  • Frequent Hgb monitoring is required<br>  • Avoid increase of Hgb > 1 g/dl over a two week period | • Epoetin alfa does not have a U.S. FDA indication for the treatment of RBV associated anemia although it is commonly used for this complication of treatment<br>  • Epoetin alfa is associated with significant toxicities, including pure red cell aplasia and cardiovascular risks such as thromboembolic events and strokes<br>  • Use with caution in patients with malignancies, hypertension (HTN), cardiovascular disease, hypercoagulable conditions, sickle cell disorders and seizures<br>  • “FDA Drug Safety Communication: Erythropoiesis-Stimulating Agents (ESAs): Epogen® states:”<br>  • Health care professionals who prescribe epoetin alfa to patients with anemia from causes other than cancer chemotherapy are required to provide a copy of the Medication Guide to each patient. Please see http://www.fda.gov/downloads/Drugs/Drugsafety/ucm088988.pdf for a copy of this medication guide.<br>  • Patients need to know about increase risks of CV related conditions, stroke, death<br>  • Prior to the initiation of epoetin for the correction of anemia in the patient receiving HCV treatment, a consultation with the CCHCS HCV warline is **strongly recommended at:** CDCR CPHCS HCV Questions@cdcr.ca.gov |

**Bold = Formulary**

*See prescribing information for complete description of adverse effects and drug interactions.*
**Management of Side Effects of HCV Treatment with Ribavirin**

<table>
<thead>
<tr>
<th>Hemoglobin g/dl</th>
<th>Action</th>
</tr>
</thead>
</table>
| < 10 g/dl in patients with no history of cardiac disease | • Decrease RBV to 600 mg/day*  
• Recheck Hgb weekly |
| ≥ 2 g/dl decrease during any 4 week period and history of stable cardiovascular disease | • Decrease RBV to 600 mg/day*  
• Recheck Hgb weekly |
| Hgb 8.6-9.0 g/dl                            | • RBV dose reduction to 600 mg/day if not already done  
• Weekly Hgb monitoring  
• Consider epoetin alfa if the dose has been reduced to 600 mg/day for at least two weeks with continued drop in Hgb  
  - Careful review with patient of risks/benefits of epoetin alfa versus stopping HCV treatment.** §  
  Provide the epoetin alfa medication guide (see page 13)  
• Symptomatic anemia: discontinue HCV treatment** § |
| Hgb 8.0-8.5 g/dl                            | • RBV dose reduction to 600 mg/day if not already done  
• Weekly Hgb monitoring  
• Careful review with patient of risks/benefits of epoetin alfa vs. stopping HCV treatment** §  
• If considered clinically stable to continue HCV treatment and if the patient agrees, provide epoetin alfa medication guide (see page 13)  
• Symptomatic anemia: Consider inpatient management and RBC transfusion and consider discontinuing HCV treatment** § |
| Hgb 7.5-7.9 g/dl                            | • Review with patient the risks of anemia and stopping HCV treatment vs. the risk of continuing HCV treatment and epoetin alfa.** §  
  Provide epoetin alfa medication guide to patients starting epoetin alfa (see page 13).  
• Stop RBV (If on DAA, discontinue medication and contact the HCV warmline)  
• Weekly CBC monitoring  
• Symptomatic anemia: Discontinue HCV treatment** § and consider inpatient management and RBC transfusion |
| Hgb < 7.5 g/dl or symptomatic anemia         | • Terminate HCV treatment§ |

*If RBV dose is reduced for anemia:*  
- Once Hgb has increased to > 10.0 g/dl, increase the ribavirin dose by 200 mg/day at two week intervals until the initial dose is reached

**If RBV is temporarily stopped due to anemia:**  
- Recheck Hgb within two weeks and at two week intervals until stable  
- If Hgb is > 10.0 g/dl, restart RBV at a dose of 600 mg/day if patient’s weight < 75 kg; 800 mg/day if the patient’s weight is ≥ 75 kg  
- If hemoglobin remains > 10.0 g/dl, increase dose by 200 mg/day at two week intervals until the initial dose is reached

§ Consultation with the CCHCS HCV warmline is strongly recommended prior to stopping HCV Treatment [CDCR CPHCS HCV Questions@cdcr.ca.gov](mailto:CDCR CPHCS HCV Questions@cdcr.ca.gov).
Drug-Drug Interactions

Multiple drug-drug interactions exist between the direct acting HCV medications and other medication classes including, but not limited to, certain antimicrobials, analgesics, antiarrhythmics, oral contraceptives, anxiolytics, lipid lowering agents, acid lowering agents, antiretrovirals, herbal preparations, corticosteroids, and anticonvulsants and specific medications such as rifampin, salmeterol, and warfarin.

The HCV Central Treatment Team at HQ will use the patient’s current medication list when choosing the appropriate HCV treatment regimen for that patient. If the patient requires an addition of any medication during their HCV treatment course, the prescribing provider will need to address possible drug-drug interactions prior to prescribing.

For more information on drug-drug interactions:
- Contact the HCV warmline at CDCR CPHCS HCV Questions@cdcr.ca.gov
- [http://www.hep-druginteractions.org](http://www.hep-druginteractions.org)

Using the Drug-Drug Interaction Tool on Lifeline:
1. Go to Lifeline ([http://lifeline/Pages/Home.aspx](http://lifeline/Pages/Home.aspx)).
2. Under Divisions/Programs, select Quality Management.
4. Under Care Team Tools, select All Care Team Tools.

Or select the hyperlink below:
WHAT YOU SHOULD KNOW: HEPATITIS C VIRUS

WHAT IS HEPATITIS C?

- Hepatitis C is a virus that causes swelling and irritation of the liver.
- The liver helps with digestion and filters waste products out of the blood.
- Hepatitis C can cause serious damage to the liver.
- Hepatitis C has no vaccine, but you can be vaccinated for hepatitis A and B to prevent more damage to your liver.

HOW DO YOU GET HEPATITIS C?

You can get hepatitis C from:

- Dirty needles (tattoos or piercing)
- Snorting drugs with infected equipment
- Sharing needles to inject drugs
- Unprotected sex (rarely)
- A blood transfusion if you got one in the USA before 1992 (All blood now tested for hepatitis C before transfusion)

HOW DO YOU KNOW IF YOU HAVE HEPATITIS C?

- Most people who have hepatitis C look and feel fine.
- You can have hepatitis C for a long time and not know it.
- Usually hepatitis C is found by doing blood tests.
- If hepatitis C damages the liver, it can cause scarring. This is called cirrhosis (sir-oh-sis).
- Your health care provider may order more tests to see how much liver damage you have.

WHAT CAN YOU DO TO TAKE CARE OF YOURSELF?

- Get vaccinated for hepatitis A and B. Get yearly vaccinations for pneumonia and the flu.
- Do not drink alcohol or use illegal drugs - these will damage your liver more.
- Do not take a lot of medications like acetaminophen (Tylenol®) and ibuprofen (Motrin®). Talk to your health care provider about all medications, including over-the-counter medications, vitamins, and herbs to be sure they will not damage your liver. Ask your health care provider before you take any pain medicine.
- Do not get tattoos in prison because of the risk of new infection with hepatitis C, hepatitis B, or HIV.
- Do not share your toothbrush, razor, or other personal items.
- Eat a healthy diet and try to lose weight if you are overweight.
- Drink plenty of water.
- Get plenty of rest and regular exercise.
- Quit smoking cigarettes.
- Follow your health care provider’s instructions about medications for hepatitis C treatment.
- See your health care provider regularly.

CAN HEPATITIS C BE CURED?

- For many years hepatitis C treatment was difficult and took up to 12 months – the treatment is better now and many patients can be cured of hepatitis C (but if they continue to inject drugs or do other risky things, they can get it again).
- Hepatitis C treatment is not an emergency. The liver damage/scar tissue happens over many years, and some people never get much damage or scarring.
- What specific hepatitis C treatment to use, how long the treatment needs to be given, and how soon a person should be treated all depend on many things which are different for each person. You should discuss your case with your health care provider.
- You can get re-infected if you are exposed to the hepatitis C virus again. Successful treatment does not provide protection from repeat infections.
¿QUÉ ES LA HEPATITIS C?
- La hepatitis C es un virus que produce inflamación e irritación del hígado.
- El hígado ayuda a la digestión y filtra los productos de desecho fuera de la sangre.
- La hepatitis C puede causar daños serios al hígado.
- No existe vacuna para prevenir la hepatitis C, pero usted puede vacunarse contra la hepatitis A y B para evitar dañar más su hígado.

¿CÓMO SE PUEDE CONTRAER LA HEPATITIS C?
La hepatitis C se puede contraer de las siguientes maneras:
- Agujas contaminadas (tatuajes o perforaciones).
- Inhalar drogas usando un equipo infectado.
- Compartir agujas para inyectarse drogas.
- Practicar sexo sin protección (raras veces).

¿CÓMO SABER SI USTED SUFRE DE LA HEPATITIS C?
- La mayoría de las personas enfermas lucen y se sienten sanas.
- Se puede sufrir de la hepatitis C por un tiempo largo y no saberlo.
- Usualmente se puede detectar la hepatitis C mediante un examen de sangre.
- Si la hepatitis C daña el hígado, puede producir cicatrices. Esto se conoce como cirrosis.
- Su médico puede indicarle otros exámenes para verificar el daño que tiene su hígado.

¿QUÉ PUEDE HACER USTED PARA CUIDARSE?
- Hágase vacunar contra la hepatitis A y B. Vacúnese anualmente contra la neumonía y la gripe.
- No consuma alcohol ni use drogas ilícitas - estas producirán más daño al hígado.
- No ingiera gran cantidad de medicamentos como el paracetamol (Tylenol®) y el ibuprofeno (Motrin®). Consulte con su médico acerca de todos los medicamentos, incluyendo los medicamentos de venta sin prescripción, vitaminas y hierbas para evitar dañar el hígado. Consulte con su médico antes de ingerir cualquier medicamento analgésico.
- No se realice tatuajes en la prisión para evitar enfermedades de transmisión sanguínea.
- No comparta su cepillo de dientes, rasuradora u otros objetos personales.
- Trate de adelgazar si tiene sobrepeso.
- Mantenga una dieta sana.
- Ingiera abundante cantidad de agua.
- Tenga mucho descanso y realice ejercicio con regularidad.
- Abandone el hábito de fumar cigarrillos.
- Siga las instrucciones de su médico acerca de los medicamentos para tratar la hepatitis C.
- Consulte con regularidad con su médico.

¿SE PUEDE CURAR LA HEPATITIS C?
- Durante muchos años el tratamiento de la hepatitis C era muy difícil y tomaba hasta 12 meses – el tratamiento es mejor ahora y muchos pacientes pueden ser curados de la hepatitis C (pero si continúan inyectándose drogas o haciendo otras cosas riesgosas, pueden volver a contagiarse).
- El tratamiento de la hepatitis C no es una emergencia. El daño al hígado o los tejidos de cicatriz que se forman toman muchos años para realizarse, y algunas personas nunca tienen mucho daño o muchas cicatrices
- El tratamiento específico que debe ser usado contra la hepatitis C, cuánto tiempo debe durar el tratamiento y qué tan pronto una persona debe tratarse depende de muchos factores y estos varían en cada persona. Discuta su caso con su médico.
- Puede volver a infectarse si vuelve a estar expuesto al virus de la hepatitis C. Un tratamiento que tiene éxito no protege contra las infecciones recurrentes de la hepatitis C.