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Management of Hepatitis C	ACA Standards: 4-4356M, 4-4367		
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Hepatitis C

Infection with the hepatitis C virus (HCV) can result in both acute and chronic hepatitis. Acute HCV typically leads to chronic infection; 50 to 85 percent of cases develop chronic hepatitis. Chronic hepatitis C infection affects approximately 2 % of the population of the US. It is estimated that 16-41 % of adult prison inmates have serologic evidence of HCV infection. Chronic HCV infection is usually slowly progressive and may not result in clinically apparent liver disease in many patients if the infection is acquired later in life.

Approximately 20 to 30 percent of chronically infected individuals develop cirrhosis over a 20- to 30-year period of time. Chronic HCV is the most common cause of chronic liver disease and the most frequent indication for liver transplantation in the United States. Deaths associated with chronic hepatitis C in the United States are more likely to be due to end stage liver disease rather than hepatocellular carcinoma (HCC). However, HCV accounts for approximately one-third of HCC cases in the United States.

There are at least 6 major genotypes. Genotype 1 is the most common genotype found in the United States, followed by genotypes 2 and 3. The predominant risk factor for Hepatitis C is recent or remote injection drug use. Approximately one third of young (aged 18–30 years) IDUs are HCV-infected. Older and former IDUs typically have a much higher prevalence (approximately 70%–90%) of HCV infection, reflecting the increased risk of continued injection drug use.

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Management of Acute Hepatitis C

Identification of patients with acute HCV is uncommon because the acute process is most often asymptomatic. Acute infection rarely causes hepatic failure. If symptoms are present, they usually abate within a few weeks. Symptoms of acute and chronic illness is similar and nonspecific with fatigue (most common), abdominal pain, anorexia, or jaundice. The majority of patients with acute HCV fail to spontaneously clear the virus (75- 85%) and develop chronic HCV. As a general rule, most patients who are destined to spontaneously clear HCV viremia do so within 12 weeks and usually no later than 20 weeks after the onset of symptoms.

Patients who present with risks for recent exposure to HCV (IVDU, sexual contact, or tattooing) should be screened for hepatitis C. Anti-HCV usually become detectable between 8 and 12 weeks after infection and thus significantly lags behind detectable HCV RNA levels. After 12 weeks, more than 90% of patients will have positive anti-HCV and > 97% of persons by 6 months after exposure. In most patients, HCV RNA can be detected in blood within 2 weeks after infection. Therefore both Anti-HCV screening (enzyme immunoassay) and HCV RNA should be drawn in patients who report recent exposure. Anti-HCV should be redrawn again 6 months later and the HCV RNA should be redrawn 8-12 weeks later.

If the high risk behavior occurred < 4 weeks prior to screening and the patient is seropositive with Anti-HCV, then the patient was infected prior to the reported high risk behavior.

Treatment of acute Hepatitis C involves symptomatic care only; along with enrollment in Chronic Liver Disease chronic clinic if the patient fails to spontaneously clear the virus (which would be evidenced by a negative HCV PCR RNA at 6 months after acquisition of acute HCV).

See MSRM 140125-01 (Management of Viral Hepatitis) for additional information regarding acute HCV.

Management of Chronic Hepatitis C

Previously, Hepatitis C treatment was complex and not without significant side effects; particularly regimens that involved Peginterferon and Ribavirin. New direct-acting interferon-free regimens are now the standard of care for the treatment of chronic hepatitis C and offer cure rates better than 90 %. The pace of change is expected to increase rapidly and subsequent regimens will change with each newly approved direct-acting antiviral medication (DAA). Further, non-interferon based treatments are now indicated in those with cirrhosis. In the midst of these rapidly changing treatment regimens, and evolving inclusion/exclusion treatment criteria, it is imperative that comprehensive care, including treatment prioritization be assisted by the Oklahoma Department of Correction Hepatitis C clinical coordinator. If deemed clinically appropriate, the HCV treatment regimen will be guided by the expertise of the outside Hepatology consulting service through the regularly scheduled telemedicine patient case presentations.

The goal of treatment of HCV-infected persons is to reduce all-cause mortality and liver related health adverse consequences, including end-stage liver disease and HCC by the achievement of virologic cure as evidenced by a sustained virologic response (SVR). A

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SVR is defined by the absence of HCV RNA by polymerase chain reaction 12 -24 weeks after stopping treatment.

Patients must be carefully screened for absolute and relative contraindications to treatment. Treatment is assigned the highest priority for those patients with advanced fibroses (Metavir F3), those with compensated cirrhosis (Metavir F4), HIV co-infected individuals, and patients with severe extrahepatic Hepatitis C manifestations (e.g. cryoglobulinemia, associated renal disease, and certain types of lymphomas). The Oklahoma Department of Corrections Hepatitis C Treatment Protocol allows for the selection of those patients who are most likely to benefit from treatment.

I. Hepatitis C Protocol

The Hepatitis C Management Protocol addresses the diagnosis of Chronic Hepatitis C, the identification of other types of liver disease, the screening process for medical and mental health contraindications, offender educational materials, and treatment guidelines. Further, Chronic HCV guidelines (especially regarding advanced disease) can be found in Chronic Illness Management Guidelines Attachment B (OP- 140137) and Management of Viral Hepatitis (MSRM- 140125-01). Medication treatment will take place at one of the four centers of excellence for Hepatitis C treatment (DCCC, JEHCC, MBCC or OSP). Private prison facilities may also offer Hepatitis C treatment. If an offender is transferred to another facility during the evaluation phase (Step 1-6) the “Hepatitis C

Protocol Workup Checklist” (Attachment D) will be continued. At any point during evaluation and treatment, an offender can decline further evaluation or treatment. Following counseling, a “Waiver of Treatment for Hepatitis C” (DOC 140137.6I) will be signed.

A. Step 1 – Diagnosis of Chronic Hepatitis C Infection.

Risk-based screening (based on risk for HCV infection or based on a recognized HCV exposure) has served as the hepatitis C screening strategy within the ODOC.

The United States Preventative Services Task Force does not recommend routine screening for Hepatitis C in all persons. The USPSTF found insufficient evidence to recommend for routine screening of individuals with increased risk factors for Hepatitis C. The American Association for the Study of Liver Disease recommends screening of individuals who are identified to have increased risk factors. The CDC has recommended one time screening of all “baby boomers”, born between the years of 1945 and 1965. Baby boomers are 5 times more likely to have hepatitis C than other adult Americans (CDC, 2012).

1. HCV Antibody test (CPL #4675) can be ordered at the medical provider’s discretion for any of the following indications. The HCV antibody test does not require approval from the Regional Lead Physician.

- a. To evaluate clinical signs or symptoms of liver disease

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- b. To evaluate elevated liver enzyme tests of otherwise unknown etiology.
 - c. To evaluate patients with known risk factors for HCV infection; including IV drug use, hemodialysis, known Hepatitis B infection, blood transfusion prior to 1992, and tattooing or body piercing during incarceration.
 - d. To document a claim of HCV seropositivity prior to incarceration
 - e. At the request of the offender, according to clinical judgment of the medical provider, and if at least 3 years have passed since last negative HCV screening.
 - f. Coinfection with HIV. HIV/ HCV coinfection is common (at least 30 %) since both infections share similar routes of transmission. In patients with chronic HCV infection, concomitant HIV infection is associated with higher rates of morbidity and mortality related to end-stage liver disease. All HIV infected persons should be screened for HCV infection using enzyme immunoassays. Those with antibodies to HCV should have quantitative HCV RNA testing. Patients who are found to be HCV seronegative should undergo HCV RNA testing if they have advanced immunosuppression (e.g., CD4 counts < 100 cells/mm³).
- B. Step 2 - Assess for continued drug abuse, and other high risk behaviors.
- 1. Witnessed Urine Drug Screen (CPL # 3210). The reinfection rate for those reporting ongoing injection after SVR is 5.3 per 100 person-years, suggesting a modest ongoing risk. It is prudent to obtain a witnessed drug screen the same day the offender requests HCV treatment. Additional random urine drug screens should be completed if there is high suspicion of drug abuse during treatment work-up. If the patient fails the UDS they are immediately disqualified from active treatment consideration for a minimum of 2 years. During this step, providers should also evaluate patients for additional high risk behaviors including alcohol use, body piercing, or tattooing, and tobacco usage. Smoking tobacco is a risk factor for development of hepatocellular carcinoma, is associated with reduced quality of life among persons with HCV, and has been associated with lower rates of SVR. Further, smokers have increased hepatic inflammation when compared with non-smokers. Because tobacco use is associated with numerous adverse health outcomes and may potentially adversely affect the liver, clinicians should counsel all smokers with chronic hepatitis C infection to quit tobacco completely. Continued tobacco usage is a contraindication to HCV treatment within the ODOC. Ongoing use of illicit drugs and other high risk behaviors should be

fully resolved before proceeding with evaluation. Sustained sobriety and absence of high risk behaviors should be observable over time. Sustained sobriety has been described as lasting at least 1 year, and stable sobriety as lasting at least 5 years (Betty Ford Institute Consensus Panel, 2007).

C. Step 3 – Case Manager Review

1. Send form DOC 1410137.6 A entitled “Case manager Review/Medical Treatment Evaluation” to the offender’s assigned case manager for completion (fill in offender name and DOC #). Treatment and follow-up for Genotype 1 and 2 can be expected to take up to 18 months. Treatment of Genotype 3 can be expected to take 24 months. The case manager review is also assessing the offender misconduct history. The offender may not have misconduct involving drug use/possession for at least the previous 2 years.
2. Most patients will require greater than 24 months remaining prior to earliest release date; allowing time for screening process (including initial and random urine drug screens), treatment and follow-up. Some regimens take only 12 weeks to complete. If there is known risk to a patient by delaying treatment due to him or her not having > 24 months remaining on sentence; treatment could be considered at the discretion of the ODOC HCV clinical coordinator/consulting Hepatologist.
3. If less than adequate time remains until earliest release/parole date, refer to “Conservative Treatment” (Attachment B) and Hepatitis C Algorithm (Attachment A), and provide offender education, and enroll offender in Chronic Liver Disease chronic clinic.
4. If greater than 24 months remain until earliest release/parole date proceed to step 4.

D. Step 4 – Evaluation for Mental Health Contraindications to Treatment.

Severe depression, suicidal ideations and history of psychosis are now no longer contraindications to HCV treatment, as Interferon free regimens are available. However, Patients with co-occurring psychiatric conditions (including depression, anxiety disorders and some personality disorders) have increased rates of Substance Use Disorders (SUDs, DSM V) compared to the general population. Therefore, as part of the work-up for HCV treatment, Offenders will be referred to an ODOC QMHC for his or her expertise on mental health contraindications to treatment related to a substance use disorder, recent history of substance induced psychosis, refusal of a required substance abuse program, dementia, or confirmed recent drug or alcohol use.

1. Ensure QMHP completes and signs a “Mental Health Contraindication to Treatment” form (DOC 140137.6 G)

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E. Step 5 – Evaluation for Medical Indications and Contraindications to Treatment.

1. Order lab tests-Hepatitis C differential Diagnosis Panel

- a. AFP (CPL #2625)
- b. CBC (CPL #1000)
- c. CMP (CPL # 9179)
- d. GGT (CPL # 2216)
- e. Hepatitis B surface antigen (CPL # 2739)
- f. HCV Genotype (CPL # 4804)
- g. Urine Toxicology (CPL # 3210) - Random urine drug screen may be used for ongoing substance abuse, and may be repeated at clinician discretion prior to conclusion of treatment decisions.
- h. PT/INR (CPL # 1425)
- i. TSH (CPL # 2835) to assess for associated thyroiditis
- j. Pregnancy Test for women of childbearing age (CPL # 1540)
- k. AST/Platelet Ratio Index (APRI):

<http://www.hepatitisc.uw.edu/page/clinical-calculators/apri>. The APRI model was developed as a simple, easily calculated method to predict significant, severe fibrosis or cirrhosis and has been tested in both HCV monoinfected and coinfecting (HCV and HIV) patients. The APRI is calculated using the patient's aspartate aminotransferase (AST) level and platelet count, and the upper limit of normal of aspartate aminotransferase (AST). A meta-analysis of 40 studies found that an APRI cutoff of greater than or equal to 0.7 had an estimated sensitivity of 77% and specificity of 72% for detection of significant hepatic fibrosis (greater than or equal to F2 by METAVIR). A cutoff score of at least 1.0 has an estimated sensitivity of 61% to 76% and specificity of 64% to 72% for detection of severe fibrosis/cirrhosis (F3 to F4 by METAVIR). For detection of cirrhosis, a cutoff score of at least 2.0 was more specific (91%) but less sensitive (46%).

- i. In all offenders with APRI \geq 2, thrombocytopenia (or pancytopenia), or PE findings consistent with cirrhosis Calculate the Child –Turcotte- Pugh Score.
2. Modified Child-Turcotte-Pugh classification of the severity of liver disease according to the degree of ascites, the serum concentrations of bilirubin and albumin, the prothrombin time, and the degree of encephalopathy. A total Child-Turcotte-Pugh score of 5 to 6 is considered class A (well-compensated disease); 7 to 9 is class B (significant functional compromise); and 10 to 15 is class C (decompensated disease). These classes correlate with one- and two-year patient survival: class A: 100 and 85 percent; class B: 80 and 60 percent; and class C: 45 and 35 percent.

Child-Turcotte-Pugh classification

Parameter	Points assigned		
	1	2	3
Ascites	Absent	Slight	Moderate
Bilirubin	<2 mg/dL (<34.2 micromol/liter)	2 to 3 mg/dL (34.2 to 51.3 micromol/liter)	>3 mg/dL (>51.3 micromol/liter)
Albumin	>3.5 g/dL (35 g/liter)	2.8 to 3.5 g/dL (28 to 35 g/liter)	<2.8 g/dL (<28 g/liter)
Prothrombin time			
Seconds over control	<4	4 to 6	>6
INR	<1.7	1.7 to 2.3	>2.3
Encephalopathy	None	Grade 1 to 2	Grade 3 to 4

3. Assess for obesity: Calculate BMI. Concurrent with the obesity epidemic, the prevalence of non-alcoholic fatty liver disease (NAFLD) has risen substantially as has the more severe form of NAFLD, known as non-alcoholic steatohepatitis (NASH). Even in the absence of hepatitis C infection, NASH can cause cirrhosis and end-stage liver disease. There are concerns that patients successfully treated for hepatitis C, but who have continued NAFLD or NASH, could develop further liver disease and liver complications. For this reason, any patient with a BMI greater than 30 should be counseled on weight loss, with a goal of decreasing their BMI to less than 25. Offenders with a BMI greater than 30 will not be considered for HCV treatment until 5 % of his/her baseline weight is lost.

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4. Complete history and physical examination.
 - a. Physical Exam- Although cirrhosis is ultimately a histological diagnosis, several clinical signs and symptoms strongly suggest the presence of cirrhosis. The following is a list in decreasing order of likelihood ratio of cirrhosis: Caput medusa, loss of body/pubic hair, Hepatic Encephalopathy (HE), gynecomastia, Ascites, spider angiomas, palmar erythema, jaundice and scleral icterus, and liver stiffness. Patients presenting with physical examination findings consistent with advanced liver disease can be considered as higher priority even when the APRI score reflects only mild fibrosis.
 - b. Extra-hepatic manifestations of HCV are common (38 %) and often reflect a more advanced disease. If these are found in offenders requesting HCV treatment, they could represent a higher priority for treatment. Extra-hepatic manifestations of HCV include: Hematologic diseases such as Thrombocytopenia, cryoglobulinemia and lymphoma, autoimmune disorders such as thyroiditis, renal disease such as membranoproliferative glomerulonephritis, and dermatologic conditions such as Porphyria Cutanea Tarda, Lichen Planus, or Leukocytoclastic Vasculitis.
5. Complete and sign a “Medical Contraindications to Treatment” form (DOC 140137.6 F). If there are no contraindications as specified in DOC 140137.06 F proceed to Step 6.
6. Consents and Offender Education
 - a. Review, complete and sign form DOC 140137.6 B entitled “Hepatitis C “Frequently Asked Questions”.
 - b. Issue Patient Information: Hepatitis C (The Basics) and Patient Information: Treatment for Hepatitis (The Basics) (DOC 140137.06 C)
 - c. Review, complete and sign form DOC 140137.6 D entitled “Consent for Liver Biopsy”.
 - d. Review, complete and sign form DOC 140137.6 E entitled “Agreement to Accept Treatment Plan”. If the outside Hepatology consulting service is consulting on the case, an “Outside Hepatology Consulting Service Consent” form (DOC 140137.6 H) will need to be completed and signed. Signature to accept treatment plan does not guarantee treatment.
- F. Step 6-Consult the Oklahoma Department of Corrections Hepatitis C Clinical Coordinator.

If after all above screening: $APRI \geq 2$ (or thrombocytopenia or stigmata of liver disease), no continued drug abuse or Class X write-ups within the previous 2 years, at least 1 clean UDS, detectable HCV PCR RNA, and at least 24 months

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remaining on sentence (or 12 months remaining and compelling medical indication)-the offender should be referred to the ODOC Hepatitis C Clinical Coordinator for EHR chart evaluation and further consideration for HCV treatment. If the patient is determined to be appropriate for further treatment consideration, the clinical coordinator will initiate the medical move to a treating facility; if the patient is not already at a treating facility. If the patient is currently at a treating facility, contact the ODOC Hepatitis C Clinical Coordinator for confirmation regarding continued treatment work-up with Hepatology consultation. After reception at a treatment facility, proceed to step 7.

- a. Annual APRI calculations in all HCV offenders- In addition to the case by case consideration for HCV treatment as detailed in this protocol; all offenders with an APRI score of ≥ 0.7 will be considered for HCV treatment annually. Once per year, a designated nurse at each facility will calculate the APRI: <http://www.hepatitisc.uw.edu/page/clinical-calculators/apri> and send results of all offenders to the ODOC HCV Clinical Coordinator for HCV treatment prioritization. Because a score of 0.7- 1.0 correlates with only moderate fibrosis (Metavir F2) these offenders will be at a lower priority than those with APRI scores correlated with advanced fibrosis/cirrhosis.

G. Step 7- Pretreatment Evaluation

1. Verify Steps 1-6 have been done and all forms are completed and signed
2. Treating provider repeat history and physical examination
3. Repeat Urine Toxicology (CPL # 3210) after reception at treating facility

H. Step 8- Hepatology Consultation

1. Review patient information with the Hepatologist from outside Hepatology Consulting Service via monthly scheduled Tele-Health clinics. Complete all diagnostic testing (e.g. labs, EGD, biopsy) as directed by the Hepatologist. The Hepatologist may recommend a liver biopsy versus Liver Fibrosis Panel. If Hepatologist recommends biopsy, refer patient to LMH for liver biopsy. Private prisons may consult with other Hepatitis C treatment specialists.
2. If the offender patient is considered appropriate for treatment based on the hepatology consultation, and absence of contraindications, proceed to step 9.

I. Step 9- Treatment

1. Treatment will be guided by outside Hepatology service consultants. Private prisons may consult other treatment authorities.
2. Medications for the treatment of Hepatitis C are being rapidly developed by various pharmaceutical manufacturers. Therefore, choice of medication regimens will be guided by the consulting Hepatologist. DOC treating providers must make themselves familiar

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with the indications, dosages, and side effects of the medications being prescribed.

3. FDA approved medications for the treatment of Chronic HCV include:

- a. Ledipasvir-Sofosbuvir (Harvoni): This fixed dose combination medication provides a very effective one pill once a day option for treatment of genotype 1 chronic hepatitis C infection; including those with HIV co-infection. This regimen is the first FDA-approved interferon- and ribavirin-free regimen to treat hepatitis C. Three phase 3 trials (ION-1, ION-2, and ION-3) have demonstrated SVR rates consistently above 90%. For treatment-naïve, non-cirrhotic patients who have a pretreatment HCV RNA level less than 6 million IU/ml, use of the shorter 8-week regimen is justified and will provide a major cost savings over the 12-week regimen (and it is less expensive than a 12-week regimen of sofosbuvir plus ribavirin). Insufficient data exist to recommend the use ledipasvir-sofosbuvir in genotypes other than genotype 1.
- b. Ombitasvir-Paritaprevir-Ritonavir and Dasabuvir (Viekira Pak) with or without Ribavirin, is another all oral regimen that provides another option for a wide range of patients with genotype 1a or 1b chronic hepatitis C infection, including those with compensated cirrhosis, HIV coinfection, post-transplantation, or prior treatment failure with peginterferon and ribavirin. The main clinical trials have demonstrated SV12 rates consistently greater than 90% with this regimen when used to treat patients with genotype 1 infection. In the AASLD/IDSA-IAS-USA guidance updated December 19, 2014, this regimen was listed as one of the preferred regimens for the treatment of genotype 1a or 1b infection. The Viekira Pak is packaged to minimize any dosing confusing. Overall, this combination regimen appears to be well tolerated, with minimal risk for serious adverse effects. This regimen, however, is dosed twice daily and requires a higher pill burden than some other all-oral options, particularly when ribavirin is included. In addition, significant drug-drug interactions can occur when using ombitasvir-paritaprevir-ritonavir and dasabuvir.
- c. Sofosbuvir (Sovaldi) is a nucleotide analog inhibitor of hepatitis C virus NS5B polymerase—the key enzyme mediating HCV RNA replication. Sofosbuvir has a number of ideal properties, including pangenotypic activity, once daily dosing, no meal restrictions, few adverse effects, minimal drug-drug interactions, high genetic barrier to resistance, good safety and efficacy in patients with advanced liver disease, and excellent sustained virologic response rates in patients with unfavorable baseline characteristics. For patients with genotype 2 or 3, the combination of sofosbuvir plus ribavirin is recommended. The use of sofosbuvir in combination with ribavirin provides the first FDA approved all oral therapy for hepatitis C. Of note, the activity against genotype 3 appears less than with genotype 2 and treatment of genotype 3 infection

requires a longer all-oral course of treatment than with genotype 2. It is highly anticipated that sofosbuvir will play a key role in future all-oral regimens for the treatment of genotype 1 infection.

- d. Ribavirin has been an integral component of hepatitis C therapy. When used with interferon or peginterferon, ribavirin significantly reduces relapse rates and significantly improves sustained virologic responses. Dosing of ribavirin is somewhat complicated and includes fixed-dose and weight-based ribavirin, with dosing depending on the genotype and brand of ribavirin used. In addition, ribavirin can cause severe anemia and dose adjustment is required in some patients who develop anemia.
- e. Peginterferon alfa-2a/Peginterferon alfa-2b has been the cornerstone of treatment for chronic hepatitis C since its introduction as an improved alternative to standard interferon alfa more than a decade ago. In addition, enthusiasm for peginterferon alfa-2a/2b has been hindered by its extensive adverse effects, necessity for weekly injections, and limited efficacy in certain patient populations, including those patients who are cirrhotic, HIV-coinfected, or who carry the IL28B TT genotype. For these reasons, peginterferon alfa has become near obsolete, as numerous interferon-free combination regimens have become available.
- f. Daclatasvir was discovered as a first-in-class inhibitor of the non-structural viral protein 5A (NS5A), a phosphoprotein that plays an important role in hepatitis C replication. The primary use for daclatasvir, at present, will be in combination with sofosbuvir for treatment-naïve and treatment-experience patients with chronic HCV genotype 3 infection. This regimen is the only FDA-approved all-oral 12-week regimen for the treatment of genotype 3 infection and regimen is a once-daily regimen. The recommended dose of daclatasvir is 60 mg orally once daily, with or without food. The recommended dose of sofosbuvir, when used with daclatasvir is 400 mg once daily, with or without food. For patients without cirrhosis the recommended treatment course is 12 weeks. For patients with cirrhosis, the optimal dosing duration of therapy is not known.
- g. Ombitasvir-Paritaprevir-Ritonavir (*Technivie*): Based on data from the PEARL-1 study, the ombitasvir-paritaprevir-ritonavir, given with ribavirin, is an effective all-oral regimen for treatment-naïve and treatment-experienced patients with genotype 4 HCV who do not have cirrhosis. At this time, the ombitasvir-paritaprevir-ritonavir regimen should only be used at this time for patients with genotype 4 HCV without cirrhosis; dasabuvir is not included in this regimen since it does not have activity against HCV genotype 4. The effectiveness of ombitasvir-paritaprevir-ritonavir in patients with genotype 4 HCV and cirrhosis is not known. Clinicians need to

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distinguish the ombitasvir-paritaprevir-ritonavir fixed dose medication (*Technivie*) from the closely related ombitasvir-paritaprevir-ritonavir plus dasabuvir (*Viekira Pak*); the key difference between these two is the absence of medication dasabuvir in the *Technivie* preparation.

4. Follow up during treatment

- a. Scheduled Clinic visits at weeks 4, 8, 12, 24
 1. Vitals signs and weight
 2. Physical Examination focused on stigmata of liver disease
 3. Review of adverse events
- b. Labs during the treatment phase will be directed by the Hepatologist. All laboratory results will be documented in the electronic healthcare record (EHR).
- c. Mental Health follow-up is required at weeks 4, 8, 12, 24, 36, and 48 refer to “Components of Psychosocial Evaluation” (Attachment C).
- d. Dose modifications- will be considered in conjunction with outside Hepatology service consultant based on follow-up lab and clinical evaluation

J. Step 10- Post treatment follow-up

1. 12 weeks after completion of treatment
 - a. Vitals signs/ Weight
 - b. Physical Examination focused on stigmata of liver disease
 - c. Adverse Events
 - d. Lab - CBC, CMP, Quantitative HCV – RNA (CPL # 4563), (urine pregnancy test for women of childbearing age)
 - e. The Hepatologist may also recommend the HCV RNA (CPL # 4563) be repeated at 6 and 12 months post treatment particularly if the offender was cirrhotic prior to treatment.
2. If the offender has a positive HCV-RNA at the end of treatment or 12, 24, or 48 weeks after treatment, enroll offender in Chronic Liver Disease chronic clinic and await further recommendations from Hepatologist.

II. References

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Prescribing information for Simeprevir. Lexicomp/ Olysio

Prescribing information for Sofosbuvir. Lexicomp/ Gilead

Prescribing information for Harvoni. Lexicomp/Gilead

III. Action

The chief medical officer, will be responsible for compliance with this procedure.

Any exceptions to this procedure will require prior written approval from the director.

This procedure will be effective as indicated.

Replaced: Medical Services Resource Manual 140137-06 entitled "Management of Hepatitis C" dated June 3, 2015.

Distribution: Medical Services Resource Manual

Referenced Forms	Title	Located
DOC 140137.06 A	"Case Manager Review/Medical Treatment Evaluation"	Attached
DOC 140137.06 B	"Hepatitis C Frequently Asked Questions"	Attached
DOC 140137.06 C	Offender Educations: Hepatitis C and Hepatitis C Treatment (The Basics)	Attached
DOC 140137.06 D	"Consent for Liver Biopsy"	Attached
DOC 140137.06 E	"Agreement to Accept Treatment Plan"	Attached
DOC 140137.06 F	"Medical Contraindications to Treatment"	Attached
DOC 140137.06 G	"Mental Health Contraindications to Treatment"	Attached
DOC 140137.06 H	"Outside Hepatology Consulting Service Consent"	Attached
DOC 140137.06 I	"Waiver of Treatment for Hepatitis C"	Attached

Attachments	Title	Location
Attachment A	Hepatitis C Algorithm	Attached
Attachment B	“Conservative Treatment”	Attached
Attachment C	“Components of Psychosocial Evaluation”	Attached
Attachment D	“Hepatitis C Protocol Workup Checklist”	Attached