HIV/Guidelines.org

New York State Public Health law mandates that clinicians report all suspected or confirmed cases of HCV infection, specifying acute or chronic, to the local health department of the area where the patient resides.

**All Recommendations** P.4 Consult the full guideline for additional information.

**HAV and/or HBV Immunity Status**
- Clinicians should obtain HAV antibody (IgG or total) and administer the full HAV vaccine series in patients who are not immune to HAV. (A3)
- Clinicians should obtain HBsAg, anti-HBs, and anti-HBc, total, and recommend administration of the anti-HBV vaccine series (0, 1, and 6 months) for HBV-susceptible patients (negative for all serologies). (A3)
  - In patients with positive HBsAg, clinicians should perform HBV DNA testing to assess for active HBV infection. (A1)
  - If HBV DNA is detectable, clinicians new to HCV treatment should consult a clinician experienced in the management of both HBV and HCV. (A1)

**HBV Infection in Patients with HIV/HCV Coinfection**
- In patients who exhibit a pattern of aCD4 positivity, defined as aCD4 with negative sAg and sAb, clinicians should:
  1. Perform HBV DNA testing to assess for active HBV infection (A1);
  2. Vaccinate patients who have a negative HBV DNA test (B3).
- If an adjustment in ART is required for compatibility with HCV treatment in patients who are HBV sAg+, clinicians should maintain use of TDF or TAF as part of the patient’s ART regimen. (A1)

**Pregnancy Status and Contraception**
- Clinicians should perform a pregnancy test in all women of childbearing potential before initiation of HCV treatment and defer HCV treatment in pregnant women. (A2)
- Before initiating RBV, clinicians should:
  1. Confirm a negative pregnancy test;
  2. Advise patients to use 2 methods of birth control to avoid pregnancy during therapy and for 6 months after completion of therapy; and
  3. Counsel female and male patients on effective contraceptive use.
- Contraindication: Clinicians should not use RBV in treatment of female or male patients planning conception within 6 months of the last dose of RBV (A2) or in male patients who have pregnant partners. (A2)
- Contraindication: Clinicians should not use paritaprevir/ritonavir/ombitasvir/dasabuvir (PRD) in treatment of women taking ethinyl estradiol–containing contraceptives. (A2)

**Reporting** New York State Public Health law mandates that clinicians report all suspected or confirmed cases of HCV infection, specifying acute or chronic, to the local health department of the area where the patient resides.

**Clinical Guidelines Program** 1/4-folded guide

**HCV Pocket Guide 1: Diagnosis and Pre-Treatment Assessment**

- **HCV Infection**
  - **HCV Antigen**: Nonreactive
  - **HCV RNA**: Not Detected
  - **No HCV Antibody Detected**: Stop
  - **Current HCV Infection**: Link to Care
  - **No Current HCV Infection**: Additional Testing as Appropriate

*For people who might have been exposed to HCV within the past 6 months, testing for HCV RNA or follow-up testing for HCV antibody is recommended. For people who are immunocompromised, testing for HCV RNA can be considered.

†To differentiate past, resolved HCV infection from biologic false positivity for HCV antibody, testing with another HCV antibody assay can be considered. Repeat HCV RNA testing if the person tested is suspected to have had HCV exposure within the past 6 months or has clinical evidence of HCV disease, or if there is concern regarding the handling or storage of the test specimen.
**CHECKLIST: PRE-DAA ASSESSMENT**

**MEDICAL HISTORY**
- **Previous HCV treatment** guides choice and duration of therapy
- **History of hepatic decompensation** warrants referral to a liver disease specialist
- **History of renal disease** may influence choice of regimen
- **Medication** history and current medications, including OTC and herbal products, may guide choice of DAA therapy
- **Pregnancy status and plans**: 1) HCV treatment is deferred during pregnancy; 2) Birth control use is essential during HCV treatment and for 6 months after treatment if patients are receiving RBV
- **HIV infection**: 1) If HIV infection is confirmed, offer patient ART; 2) If the patient is being treated with ARVs, assess potential drug–drug interactions; 3) Presence of HIV infection may influence fibrosis assessment modality, choice of treatment, duration, and monitoring
- **History of infection and vaccination status**:  
  - HAV: Obtain HAV antibody (IgG or total)
  - HBV: Obtain HBsAg, anti–HBs, and anti–HBe (total)
  - Administer PPSV23 vaccine to all patients with cirrhosis, which is associated with increased susceptibility to bacterial infections
    - As indicated by the CDC/ACIP Recommended Immunization Schedule for Adults Aged 19 Years and Older
  - Annual influenza vaccine
- **Cardiac status** may influence choice of RBV–containing regimen, RBV dosing, or CBC monitoring frequency

**PHYSICAL EXAM**
- **Presence of signs that suggest cirrhosis or decompensated cirrhosis** and may require additional evaluation and management or treatment: ankle edema, abdominal veins, jaundice, palmar erythema, gynecomastia, spider telangiectasia, ascites, encephalopathy, asterixis
- **Presence of signs related to extrahepatic manifestations** of HCV, such as porphyria cutanea tarda, vasculitis, or lichen planus, may increase urgency of HCV treatment and may require additional evaluation and treatment needs
- **Liver size** by palpation or auscultation for hepatomegaly or splenomegaly, as well as tenderness or hepatic bruits, may suggest severity of liver disease and may require additional evaluation

**LABORATORY TESTING**
- **HCV RNA quantification** confirms active HCV infection and determines HCV viral load
- **Genotype/subtype** guides choice of regimen
- **CBC**: Low platelets (<140,000 platelets/μL) suggest cirrhosis and portal hypertension; anemia may necessitate choice of a regimen that does not contain RBV
- **Serum electrolytes with creatinine**: Marked electrolyte abnormalities may suggest decompensated cirrhosis (e.g., hyponatremia); renal function will influence choice of regimen
- **Hepatic function panel**: Elevated direct bilirubin suggests decompensated cirrhosis; markedly elevated transaminases may suggest comorbidities
- **INR**: Elevated results suggest decompensated cirrhosis
- **Pregnancy test** for all women of childbearing potential: If pregnant, suggest treatment deferral
- **HAV antibodies** (IgG or total): Administer the full HAV vaccine series in patients not immune to HAV
- **HBV antibodies** (HBsAg, anti–HBs, and anti–HBe [total]): Administer the HBV vaccine series (0, 1, and 6 months) to HBV–susceptible patients (negative for all serologies)
  - In patients with positive HBsAg, perform HBV DNA testing to assess for active HBV infection
  - If HBV DNA is detectable, care providers new to HCV treatment should consult a liver disease specialist regarding treatment for HBV and HCV
- **HIV test** if status is unknown
- **Urinalysis**: Protein may suggest extrahepatic manifestation of HCV
- **Fibrosis serum markers**: Obtain if patient not previously evaluated by biopsy or FibroScan

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Use this code with your phone’s QR code reader to go directly to a mobile-friendly version of this guideline.

This ¼-Folded Guide is a companion to the New York State Department of Health AIDS Institute guideline Treatment Of Chronic HCV Infection With Direct-Acting Antivirals. The full guideline is available at hivguidelines.org.