ACUTE HCV INFECTION
- Clinicians should suspect acute HCV infection if a patient who had a negative antibody test documented within the previous 6 months has a new positive antibody test or has detectable HCV RNA in the absence of a positive antibody test. (A3)
- Clinicians should not prescribe pre- or post-exposure prophylaxis to prevent HCV infection. (A1)
- Clinicians should screen all patients with possible acute HCV infection for HIV, HAV, and HBV infections, given the similar risk factors for acquisition. (A3)

PRE-TREATMENT ASSESSMENT
- Clinicians should assess all patients with a confirmed diagnosis of chronic HCV infection for treatment. (A1)
- Clinicians should obtain HCV genotype/subtype testing for all patients before starting treatment with DAAs. (A1)

WHEN TO REFER TO A LIVER SPECIALIST
- Clinicians new to treating chronic HCV infection should consult with a liver disease specialist when treating chronic HCV infection in patients with any of the following conditions (A3):
  - Compensated or decompensated cirrhosis.
  - Concurrent hepatobiliary conditions.
  - Extrapancreatic manifestations of HCV, including renal, dermatologic, and rheumatologic manifestations.
  - Significant renal impairment (CrCl <30 mL/min) or who are undergoing hemodialysis.
  - Active HBV infection, defined as HBV surface antigen positive and detectable HBV DNA.
- Pre- or post-transplant status.
- Clinicians new to treating chronic HCV infection should consult with a liver disease specialist when evaluating patients for retreatment after any DAA treatment failure. (B3)
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 the 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.

PHYSICAL EXAM
☐ Presence of signs that suggest cirrhosis or decompensated cirrhosis 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 individuals 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 or viral hepatitis 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 not previously evaluated by biopsy or FibroScan.

DIAGNOSING HCV INFECTION [CDC. MMWR. 2013;62(18)]

- 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 hcvguidelinesny.org.

* 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.