HCV Advocate Clinical Trials Reference Guide

WE ARE HAPPY TO ANNOUNCE A NEW SERVICE AVAILABLE ON HCVADVOCATE.ORG...


The Reference Guide will only list clinical trials that are actively recruiting hepatitis C and HIV/HCV coinfected patients. We will be adding new studies (and removing completed studies) on a regular basis. At this time, the studies posted to our website will be limited to the United States, Canada, Mexico, China and most of Europe.

The site has instructions on searching for a clinical trial. The article below offers some helpful tips to evaluate a clinical trial.

HOW TO EVALUATE A CLINICAL TRIAL

Observational study: a study to observe study participants to evaluate certain outcomes. For instance, an observational study may evaluate the effect of HCV treatment on quality of life, how being cured (or not cured) affects an individual’s perceived stigma, etc.

Interventional study: an experimental study to test a new medicine to treat a certain condition.

This article discusses clinical trials with an emphasis on interventional clinical studies.

— CONTINUED ON PAGE 2
Institutional Review Board (IRB)
Every clinical trial in the United States must be approved and monitored by an Institutional Review Board (IRB). The IRB evaluates the study to make sure that it is ethical and that the clinical trial participant is not harmed by the drug under study. Every study participant must read, understand and sign a consent form. The consent form lists the possible benefits and the potential dangers or health risk to a study participant. Patients should ask questions and be as actively involved as much as possible in the clinical trial process. A clinical trial coordinator is assigned to each clinical trial. The study coordinator will follow the participant throughout the study. It is the responsibility of the coordinator to make sure the patient understands the potential risks and benefits of the clinical study.

Questions patients should ask before enrolling in a clinical trial
- What is the drug(s) being tested?
- Is the study drug being tested to find out if it is better than the standard treatment for hepatitis C?

Getting support
When a patient meets with the medical provider or the study coordinator, it is important to plan ahead and write down questions. Ask a friend or relative to accompany you to hear the responses, and write down the discussion to review later. If the patient is young, bring a babysitter so parents/caregivers can speak privately, without distractions.

Randomized trials risks and benefits
Participating in a randomized trial means that some patients will receive a placebo pill (a sugar pill that provides no benefit), some patients will receive the current standard treatment for hepatitis C, and others may receive the new experimental drug. A computer program will ‘randomly’ assign patients to the different treatments.

DIFFERENT PHASES OF A CLINICAL TRIAL
Pre-clinical studies: A drug is tested in test tubes or on animals to evaluate the potential toxicities and drug exposure levels—that is how much of the drug in the body/blood. If the medicine shows promise, the medication will advance into the next clinical phase.
**Phase I:** The drug will be tested in healthy people. The main goal is to find out how the drug works in the body, the safety of the drug, and the dose of the drug that is safe and effective. The experimental drug can also be given to people who have the condition the drug is being developed to treat.

**Phase II:** In this phase, the study drug is tested in individuals who have the medical condition. The safety of the drug and the side effects are evaluated. In some phase II studies, the new investigational drug may be compared to a placebo drug or the standard treatment of the condition. The effectiveness of the drug is evaluated—that is, does it cure hepatitis C?

**Phase III:** The results of phase I and II studies are used to design the phase III study—drug dose(s), how long to treat someone, etc. The drug can be compared to the current standard treatment to find out if the study drug is superior or as effective as the current drug therapy. During a phase III study, patients are treated with the new drug, the current standard treatment, or a placebo. If the phase III results are successful, the pharmaceutical company will apply to the Food and Drug Administration (FDA) to market the drug to treat the condition tested.

**Phase IV:** These are post-marketing studies. The FDA may require that the pharmaceutical company conduct additional studies after approving a medication. The post-marketing studies can be about treating sub-populations with the same condition that may not have been included in the original studies or for the treatment of a different condition.

**FINDING A CLINICAL TRIAL**

Listed below are resources that can refer a patient to a clinical trial:

- U.S National Institutes of Health’s [www.clinicaltrials.gov](http://www.clinicaltrials.gov) registry lists clinical trials throughout the world. It is a very good site to find a clinical trial for any condition. However, it can be overwhelming to try to find a study that is recruiting patients for a certain medical condition
- Medical providers may refer patients to a clinical trial in their area
- University hospitals frequently have clinical trials
- HCV Advocate Hepatitis C Clinical Trials Blog is designed to simplify the process by listing current hepatitis C clinical trials

It is important to remember that clinical trials are conducted to find out if a medication is safe and effective. Every attempt is made to safeguard the trial participants who enroll in a clinical trial. However, there is a chance that the drugs being tested, especially in the earlier phases, could produce severe side effects. Although rare there is a possibility of death. This is why it is important to weigh the possible benefits against the potential risks in the decision-making process, especially with interventional studies.

**HCV Clinical Trials Blog**


**RELATED PUBLICATION:**

*Making Sense of Hepatitis C Research & Medical Literature*

— Lucinda K. Porter, RN

Alan Franciscus is the Executive Director of the Hepatitis C Support Project and the Editor-in-Chief of the HCV Advocate Website.
There are times when I grieve the choices our society makes. Examples of injustices that rile me are prejudice, violence, unjust laws, and not extending basic social services to others who are suffering. Looking specifically at hepatitis C, the issues that get my back up are:

- Obstacles to healthcare
- The cost of hepatitis C treatment
- Inadequate screening for hep C
- Stigma

Veterans, the poor, the incarcerated, and drug users are stigmatized and marginalized. Plainly, this is wrong and we need to keep speaking up about it.

When it comes to hepatitis C, it’s hard to quantify which injustices are the worst and which will get my immediate attention. It’s often a matter of trying to right a wrong, or to fight for something that will help the most people. Other times I am driven by personal motives, fighting for healthcare so someone I love can live longer or better.

In order to move forward, sometimes I need to look back. George Santayana’s famous quote comes to mind, “Those who do not remember the past are condemned to repeat it.” Remembering the past is more than a tool for change; it is also a reminder that we can change the present, and thus the future.

Back to hepatitis C. Many of us can recount numerous dark stories about how the Veterans Administration failed veterans, or how insurance companies and state Medicaid programs have denied treatment to people with hepatitis C. Few of us have escaped the stigma that is associated with hepatitis C. But there is one story that I don’t hear mentioned very often, and it is a story we must never forget. It’s a story about greed, fear and denial.

The story is about hemophilia, a rare genetic disorder usually passed from mother to son, although a few females are affected. People with hemophilia are missing clotting factors. Historically, kids were crippled by hemophilia and usually died before reaching adulthood.
In the 1960s, drug companies manufactured factor concentrates derived from human blood, and the world changed for people living with hemophilia. They could inject themselves at home, and avoid horrible pain and hospitalizations. Modern medicine transformed hemophilia from a fatal disease to a chronic condition and patients began to lead nearly normal lives.

Sadly, this “miracle” product had unseen consequences. Each dose of factor concentrate was made by pooling 60,000 individual blood donations. Because the process needed many donors to manufacture, people were paid to donate clotting factors. Collection centers were set up in poor neighborhoods, places more likely to attract potential donors who might need extra cash. In my pre-hep C college days, I donated to supplement my income. People needing cash to support their kids or their drug habit were frequent donors. Blood was also used from prisoners.

Patients needing clotting factors were at enormous risk of receiving contaminated blood products, and viral hepatitis infection was nearly universal. Many experts thought that hepatitis an “acceptable risk” for these patients, and patients were rarely warned.

Hepatitis may have been considered an “acceptable risk,” but HIV and AIDS were not. In 1982, the Centers for Disease Control and Prevention (CDC) announced three cases of apparent AIDS in hemophiliacs who had received clotting factors. It was a year after the first case of AIDS had been reported in anyone, and by this point, there were already 471 cases of immune suppression, including 184 deaths.

Yet even as HIV was identified, doctors and advocacy groups advised people with hemophilia to keep using clotting factors. By the time the medication was pulled from the market in 1985, 50 percent of hemophiliacs had been infected with HIV and 90 percent had hepatitis C.

Why did it take so long to intervene? A combination of circumstances converged. The CDC jumped in immediately, and called an emergency meeting in July 1982 to warn the blood industry and hemophiliacs that the clotting factors might be contaminated. The CDC recommended instituting donor deferral guidelines, namely that people who fit into the high-risk groups (gay men, Haitians, and intravenous drug users) should be asked not to donate blood. The National Hemophilia Foundation went into denial, rejecting the notion that AIDS was linked to clotting factors. Clotting factors had changed the lives of hemophiliacs and without factors, they’d go back to a horrible way of life. The FDA was skeptical, territorial and just plain acted badly. The American Red Cross and other blood bank organizations denied the evidence. Advocates representing the gay community were deeply concerned about further stigmatizing gay men, especially since the evidence wasn’t solid. In the end, the only thing they agreed on was what name to give this disease, Acquired Immune Deficiency Syndrome (AIDS).

Blogger Shawn Decker lives with the quadruple threat of hemophilia, HIV, hepatitis B and C (although hep C resolved spontaneously). He was dismissed from school because of his HIV status. He lived to share his story.

Shawn Decker
Contributing Writer, POZ
In December 1982, a baby received platelets from a donor and both of them had developed AIDS. The CDC issued a warning about possible transfusion-associated AIDS. However, Joseph Bove, MD, Director of the blood bank at Yale University Medical Center and chair of the FDA's Blood Products Advisory Committee, stated that there was simply no evidence that transfusions spread AIDS.

The problem continued, and protections for people with hemophilia weren't put into place until 1985. From 1981 to 1984, 10,000 people in the U.S. hemophilia community would be infected with HIV; most would die. Nearly everyone with hemophilia would be infected with viral hepatitis. Some would die from liver failure many years later.

The tragedy for hemophiliac children who contracted HIV and viral hepatitis was not just that they had these horrible medical problems, but they also had to contend with stigma. Ryan White was kicked out of school because he had HIV. The family was constantly harassed and threatened. The Ray brothers experienced the same horrors. They were banned from school in Arcadia, Florida. They fought and won the right to attend, but an arsonist burned down their house. HIV took the lives of Ryan White and Ricki and Robert Ray.

Blogger Shawn Decker lives with the quadruple threat of hemophilia, HIV, hepatitis B and C (although hep C resolved spontaneously). He was dismissed from school because of his HIV status. He lived to share his story. Another blogger who is also alive is Joe Burke. Joe lived with hemophilia, HIV, and hepatitis C. His hep C is now cured.

Tragically, the story does not end in 1985. Bayer's Cutter Laboratories continued to sell their contaminated products to overseas market. The financial investment in the product was considered too high to destroy the inventory. People in those countries who used the hepatitis- and HIV-contaminated factors developed serious liver disease and AIDS.

And now it is 2016 and although the blood supply is safe, our community is not. As long as we continue to turn our backs on anyone with hepatitis C, we jeopardize the health of all of us. We have an opportunity to act humanely, to practice justice in healthcare, and to put health ahead of wealth. We can use the pain of history to make a better future.

REFERENCE AND FURTHER READING

“Bad Blood”

a documentary about the medical disaster in the blood supply in the early 1980s.


Hemophilia Federation of America

The Inadequate Response of the FDA to the Crisis of Aids in the Blood Supply

Harvard Law School

The Tragic History of Aids in the Hemophilia Population, 1982–1984

B.L. Evatt, Centers for Disease Control

Lucinda K. Porter, RN, is a long-time contributor to the HCV Advocate and author of “Free from Hepatitis C” and “Hepatitis C One Step at a Time.” She blogs at www.LucindaPorterRN.com and HepMag.com
A lot of my work in Southwestern Indiana takes place in small rural communities and county jails. Of the 11 counties I work in, you would need to add 7 of their populations together to equal the 181,000 people in Vanderburgh County. The first step in improving HCV care in these communities and jails hinges on us understanding that in these places fewer financial and organizational resources exist for the prevention and treatment of HIV/HCV & STDs. The problems needing to be addressed are intertwined with poverty, limited to nonexistent transportation, rising injection drug use and insurance access. We don’t need to guess what can happen when health disparities like these begin to stack up higher and higher, in fact, everything we need to know came to light 20 months ago in almost the same spot on the other side of Indiana.

If by some chance you aren’t familiar with Scott County, here’s a quick recap. In 2015, Scott County was the epicenter of an HIV outbreak that has led to 200 positives, and a 90% HCV coinfection rate. The county has a population of 24,000, and for some time had severe health disparities with few available resources. This isolation was both unfortunate, and unnecessary considering Scott County is 40 minutes from Louisville, KY, and 90 minutes from Indianapolis, IN., two cities that have a combined population of 1.2 million. Scott County is a stone’s throw away from two cities which possess vital health and treatment resources, but it doesn’t benefit rural communities to be near resources if the people living in them are isolated because of issues like transportation.

Think of it like this. Around here, you can go from a county of 181,000 people to one of 24,000 in the same time it takes to cross a metropolitan U.S. city during rush hour traffic. If you travel from Evansville to Indianapolis along the new I-69 corridor, you will pass 6 rural counties with populations less than Scott County’s. Now, I’m not saying all rural counties in Indiana are on the verge of having an HIV/HCV outbreak, but what I want to stress is that many of these rural counties are experiencing rising rates of injection drug use, HCV and shrinking resources that indicate they may be at high risk in the future.

— CONTINUED ON PAGE 8
What is happening in these counties may not be bad enough to warrant the label outbreak, or be noticeable in surveillance reports just yet, but at some point in the past neither was Scott County. Health disparities can act a bit like compound interest. Each new health or socioeconomic concern that arises will be added to the existing pool of problems which will lead to further tangling the knot.

The people in the communities I travel to want HCV education, testing and treatment resources. Many of these same rural communities are taking steps to address these issues in pragmatic and proactive ways. For example, there are rural counties actively seeking grants for the overdose reversal medication naloxone and training so that first responders and police can be equipped. They know that their surveillance data doesn’t reflect a significant enough issue to win competitive grant funding and so they are creating systems to better track overdoses and rising HIV/HCV rates. They also know that the opioid epidemic sweeping rural America is likely to end up on their doorstep, so they are building coalitions and taking steps to limit the effects of hard to control opioid epidemic, but without more support in the form of early detection, education and treatment, HCV positive people in these areas will unnecessarily suffer poor health outcomes. There are a lot of stereotypical beliefs about rural communities being closed off, and slow to change, but I can tell you first hand my experience in Southern Indiana has been the complete opposite.

When you consider that an estimated 30% of the 2.7-3.9 million chronic HCV positive people in the U.S. will pass through the correctional system at some point in their lives it becomes clear that county jails and State and Federal Prisons play a pivotal role in addressing rural HCV needs. In Indiana, when a person enters the prison system, they pass through a processing facility called the Reception & Diagnostic Center (RDC). During their brief stay they will receive a one-time HIV/HCV screening as well as many other medical tests and assessments. This means that as long as inmates are not in a “window period” they will know their status at the start of their incarceration. This may be the last time for quite a while they receive an HIV/HCV test, because in order to receive a screening while inside people have to admit to engaging in high risk behavior that often breaks facility rules. For this reason, many inmates stay silent to avoid having time added to their sentence. This is problematic because they do not receive screenings upon leaving the correctional system, and many of them will go back to rural communities where HCV screening and education is likely to not be easily available.

In part 2 I will cover the unique challenges that jails and State prisons face in providing HCV treatment and care. I will also go into detail of some ways these challenges can be overcome, and why if they go unaddressed poor health outcomes will persist and get worse. In the meantime, if you work or live in a rural community, I encourage you to leave a comment about your experience or to send me an email. I would like to hear about your experience.

Matthew Zielske currently works as a HIV/HCV special populations prevention specialist at an HIV services organization. He utilizes a harm reduction model in his work with the substance use population focusing pointedly on persons who inject drugs. He is currently conducting research on Health Literacy and hepatitis C for his Master’s Thesis in Communications. www.umbrellaway.org
The current drugs to treat hepatitis C have high cure rates and minimal side effects (compared to the older therapies). This has created a dilemma for drug developers who must develop new drugs that somehow improve upon the current drugs. This is a difficult task, but not impossible. Probably the biggest achievement will be shorter treatment duration and lower cost. There is a percentage of patients who are the more difficult to treat, such as those with genotype 3 who have cirrhosis and have not achieved a cure with a previous course of therapy. The race is on for new, better and cheaper therapies—this is very good news for people living with chronic hepatitis C.

You will see below that the need for these new therapies has narrowed the pharmaceutical companies to a number that you can count on your fingers! As a result I have decided to rework our pipeline and list it by the pharmaceutical company. I am also just listing the major studies. This is also a new pipeline that will grow as information is released. The pipeline is a brief overview. More extensive information is listed in our newsletters and in our blog.

A brief overview of how this pipeline is laid out:

**Date:** The Pipeline will be updated on a monthly basis and will be included with the HCV Advocate Newsletter

**Genotype (s):** This lists the drugs or combination of drugs and the particular genotype or genotypes that the drug is active against.

**Comments:** This section will list the study results. Within this section, I will list the genotype(s) being studied and the phase of the study with a brief recap of the study.

You will note that many of the drugs or combinations of drugs are pan-genotypic—that is they work on many or most of the HCV genotypes. **Note:** Many of the drugs listed below have been updated with the latest information from the Liver Meeting 2015 and the International Liver Congress 2016. More detailed information about drugs in development is available in our blog and reported in the HCV Advocate newsletters.
**AbbVie**

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<tr>
<th>Genotype(s): 1, 2, 3, 4, 5, 6 (Pan-genotypic)</th>
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**COMMENTS:**

**Genotype 1 – Phase 2 Study:** Information from the International Liver Congress 2016: AbbVie’s once-daily therapy of ABT-493 (protease inhibitor) and ABT-530 (NS5A inhibitor).

**Non-cirrhotic patients Treatment period - 8 weeks:**

- Genotype 1: 85% were treatment-naïve; 15% were pegylated interferon (PEG)/ribavirin (RBV) experienced, cure rates—97% (33 of 34 patients)
- Genotype 2: 87% were treatment-naïve; 87% were PEG/RBV treatment experienced: cure rate—98% (53 of 54 pts)
- Genotype 3: 100% were treatment-naïve: cure rate—97% (28 of 29 pts)

**Treatment period 12 weeks:**

Cirrhotic treatment-naïve patients, genotype 3 – cure rate —100% (24 of 24 patients)

Non-cirrhotic treatment-naïve patients (85%), PEG/RBV (15%); genotype 4 (22 pts), genotype 5 (1 pt), genotype 6 (11 pts)—cure rate—100% (34 of 34 pts)

**Bottom line:** cure rates were 97% to 100%. Now in Phase 3 clinical trials

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**Gilead – Sofosbuvir, Valpatasvir & Voxilaprevir (GS-9857)**

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<thead>
<tr>
<th>Genotype(s) 1,2,3,4,6, (Pan-genotypic)</th>
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</thead>
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**COMMENTS:**

- **Phase 2 study results:** I am just listing the cure rates for the optimal treatment duration.
- **Genotype 1 – Phase 1:** 8-week treatment group—treatment naïve patients without cirrhosis: cure rate=100% (36 of 36 patients); treatment naïve with cirrhosis: cure rates = 94% (31 of 33 patients).

12-week treatment group—treatment-experienced patients without cirrhosis: cure rates = 100% (31 of 31 patients) and 100% (32 of 32 patients) with cirrhosis.

1 patient (less than 1%) discontinued treatment because of side effects.

- **Genotypes 2, 3, 4 and 6:** The cure rates for all of the genotypes 2,3,4 and 6 were combined. 8-week treatment group—treatment-naïve patients with cirrhosis: cure rates = 93% (28 of 30 patients).

12-week treatment group—treatment-experienced patients without cirrhosis: 100% (36 of 36 patients); treatment-experienced patients with cirrhosis: cure rate = 97% (28 of 29 patients). Three patients (1%) discontinued treatment because of side effects.

The most common side effects were headache, diarrhea, fatigue and nausea.

**The combination is now in phase 2 and 3 clinical studies.**
### Janssen (Achillion/Alios) vs Genotype(s) 1,2,3,4,5,6 (Pan-genotypic)

**COMMENTS:**

- **Genotype 1 – Phase 1:** In a small study of samatasvir, it was found to be safe and have antiviral properties against genotype 1, 2, 3 and 4. There is now a phase 2 study of samatasvir plus Olysio (simeprevir) in treatment-naïve patients with genotype 1b or 4.

- **Genotype 1 – Phase 2a Study:** Janssen (Alios Pharma) has initiated a of AL-335, odalasvir, and simeprevir to treat HCV genotype 1 treatment-naïve patients. There will be 60 patients divided into three treatment arms who are treated for 4, 6 or 8 weeks.

- **Genotype 1 – Phase 2 Study:** ACH-3422 and Odalasvir (ACH-3102) and Sovaprevir are in studies with various combinations. Recently, Johnson & Johnson Innovation – JJDC, INC (Janssen) made an investment in Achillion for co-development and distribution.

- **Genotype 1 – Phase 2 Study:** Odalasvir plus sofosbuvir (used as a proxy drug) to treat genotype 1 patients for 6 weeks achieved 100% (12 of 12 patients) cure rates. A proxy drug is a drug used to stand in for another drug. Sofosbuvir is a polymerase inhibitor so it is assumed that odalasvir plus a polymerase inhibitor that is being developed by Achillion will produce similar cure rates.

- **Genotypes 1 through 6–Phase 2b Study:** Odalasvir, AL-335, and simeprevir in treatment-naïve and treatment-experienced patients with and without cirrhosis. The trial will enroll 400 patients for six or eight weeks. The study will include four arms with different combinations of drugs. The trial will begin in June 2016 and end in July 2017.
### Merck

| Genotype(s) | 1, 2, 3, 4, 5, 6 (Pan-genotypic) |

**COMMENTS:**

- **Phase 2** - The study was to evaluate the safety and efficacy of an all-oral therapy. There were three different groups that included treatment-naïve, non-cirrhotic patients. The patient population included 93 genotype 1 patients, 61 genotype 2 patients, and 86 genotype 3 patients. The treatment duration was 8 weeks. All of the treatment groups received MK-3682 (300 mg or 450 mg) combined with grazoprevir/elbasvir or grazoprevir/MK-8408.

Twenty-four percent of genotype 1 patients had resistant associated variants (RAVs): 59% had NS3 (protease) RAVs and 21% had NS5B (polymerase) RAVs.

The overall cure rates were 91 to 100% in the genotype 1 groups; 60 to 94% in the genotype 2, and 86 to 91% in genotype 3. The drugs were well-tolerated with no treatment discontinuations.

Part B of C-CREST 1 and 2 will evaluate the most effective dose to treat prior treatment failures, cirrhotic patients and treatment in people with HIV/HCV coinfection.

**Bottom line:** The most effective dose was associated with cure rates in the 90 to 100%.

### Regulus

| Genotype(s) | 1, 2, 3, 4, 6 |

**COMMENTS:**

Regulus Therapeutic Inc.

The study included 79 treatment-naïve genotype 1 and 4 patients. RG-101 is a GalNAc-conjugated anti-miR targeting miR-122, a host factor for HCV infection. It is an injectable medication given at Day 1 and Day 29 plus 4 weeks of a once-a-day direct-acting antiviral medication—Harvoni (27 patients), Olysio (27 patients), Daklinza (25 patients). Regulus issued a press release on June 7, 2016 that reported through 24 weeks of follow-up an additional 4 patients relapsed.

<table>
<thead>
<tr>
<th>Time Since Treatment Completion</th>
<th>RG-101 + Harvoni</th>
<th>RG-101 + Olysio</th>
<th>RG-101 + Daklinza</th>
</tr>
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<tbody>
<tr>
<td>Week 12</td>
<td>27/27 pts (100%)</td>
<td>26/27 pts (96.3%)</td>
<td>22/24 pts (91.7%)*</td>
</tr>
<tr>
<td>Week 16</td>
<td>21/21 pts (100%)</td>
<td>19/20 pts (95.0%)</td>
<td>20/22 pts (90.9%)</td>
</tr>
<tr>
<td>Week 20</td>
<td>14/14 pts (100%)</td>
<td>13/15 pts (86.7%)</td>
<td>13/13 pts (100%)</td>
</tr>
<tr>
<td>Week 24</td>
<td>10/10 pts (100%)</td>
<td>8/10 pts (80.0%)</td>
<td>8/9 pts (88.9%)</td>
</tr>
</tbody>
</table>

*One patient missed the Week 12 visit. Viral load results for this patient at week 8 and 16 were collected and indicate that the patient was a responder at both time points. This trial is on clinical hold due to safety concerns.
WHAT’S UP!

WE HAVE REVIEWED AND UPDATED THE FOLLOWING FACT SHEETS:

HEPATITIS C
HCSP Fact Sheets: HCV Populations

- African Americans & HCV
- Genotype 2
- Genotype 3

CLICK TO DOWNLOAD

HEPATITIS B
We have updated the entire series on HBV Transmission and Prevention

CLICK TO DOWNLOAD

DON’T FORGET TO CHECK OUT

Our HCV Medications Blog and our new HCV Advocate’s Clinical Trials Reference Guide

HCV Medication Blog
for information about all of the direct-acting antiviral medications approved by the Food and Drug Administration (FDA) to treat chronic hepatitis C.

http://hepatitismedications.hcvadvocate.org/

HCV Advocate’s Clinical Trials Reference Guide
for information about HCV clinical trials that are currently enrolling patients.

http://hcvcclinical.hcvadvocate.org/

The HCV Advocate offers information about various forms of intervention in order to serve our community. By providing information about any form of medication, treatment, therapy or diet we are neither promoting nor recommending use, but simply offering information in the belief that the best decision is an educated one.

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