The newest hepatitis C medications are changing lives, are easier to take, and curing nearly everyone. There is a menu of choices, and wading through the ins and outs of each can be daunting. In a perfect world, your medical provider will evaluate your condition and make a recommendation about the best course of treatment for you.

Unfortunately, the world is not perfect. The price of the newest hepatitis C drugs is making it difficult to get hep C treatment from some private and government insurance plans. Many people have successfully fought these denials. However, there is one obstacle that is hard to get around—your own provider. What can you do if your doctor won’t prescribe hepatitis C treatment, or wants to prescribe an older regimen, when clearly there are newer ones available?

I’ve seen a fair amount of data showing the percentages of denials by insurance companies for treatment of chronic hepatitis C viral infection (HCV); I’ve seen

--- CONTINUED ON PAGE 2 ---
none about denials of treatment by providers. When a person contacts me because their insurer has denied treatment, I can provide resources to help them appeal the denial. When a person is offered an inferior or no hep C treatment, the only suggestion I have is, “Find a new doctor.” Not everyone can, particularly if they live in an area where there are few medical specialists, or their choices are restricted by their health plan.

If your doctor isn’t going to treat you, good luck changing his or her mind. However, that doesn’t mean it isn’t worth trying. We are talking about your health, and you are worth fighting for. Some medical providers are open-minded, and are genuinely happy to learn new information. You have little to lose by speaking up on your own behalf.

If you don’t get the response you want from your doctor, here are some suggestions:

• **Document** every exchange you have with your doctor, insurance company, and other involved parties. Write down who you talked to, what you talked about, and when the conversation occurred.

• **Ask your doctor to explain her recommendations.** Understanding your doctor’s reasoning will help you to determine what to do next. For instance, your doctor may want to hold off treating you because he knows that a new drug is about to be approved. Or, she may have had terrible experience with your insurance plan and knows you will be denied. Perhaps your doctor is misinformed about the current qualifications for treatment.

• **Bring an advocate to your appointment.** Sometimes a friend or family member can make your case for you better than you can.

• **Join a support group.** Fighting for your health can be frustrating. A support group can help keep you fortified and focused.

• **Be a source of information.** You need to know what the latest hepatitis C treatment recommendations are in order to know if your doctor knows them. The [HCV Guidelines](#) are provided by the American Association for the Study of Liver Diseases (AASLD) and the Infectious Diseases Society of America (IDSA), in collaboration with the International Antiviral Society–USA (IAS–USA). The guidelines state that nearly everyone can be treated, “Treatment is recommended for all patients with chronic HCV infection (emphasis mine), except those with short life expectancies that cannot be remediated by treating HCV, by transplantation, or by other directed therapy. Patients with short life expectancies owing to liver disease should be managed in consultation with an expert.” In addition to knowing that you have the right to treatment, know which regimens the HCV Guidelines recommend for you.
• **Be armed with resources.** Your doctor may be feeling discouraged by repeated insurance denials. His staff may be burned out, and your doctor must pay the staff for their time, which isn’t reimbursed by insurance. If your doctor doesn’t work with a specialty pharmacy or patient assistance program (PAP), ask her if she’d like the name of one. The HCV Advocate provides a resource list with reliable PAPs. My current favorite is the Patient Advocate Foundation’s Hepatitis C CareLine. They offer case management services to providers, as well as to consumers.

• **Stay flexible.** Your doctor may suggest a regimen that isn’t your first choice, but maybe it is a good enough choice. For instance, there are six different treatment recommendations for genotype 1 patients without cirrhosis, none using peginterferon or ribavirin. Perhaps you wanted the newest HCV treatment, but the others may be as good or better.

• **Enlist help.** Find a doctor to advocate for you by asking her to reach out to your doctor and community. Some physicians are writing letters to community physicians and providing continuing education seminars to bring the latest practice guidelines to busy clinicians. Ask your support network, Help4Hep, and the National Viral Hepatitis Roundtable’s (NVHR) for any leads. NVHR’s Hepatitis C Treatment Access page provides templates for letters of appeal that your provider can use, as well as links to helpful resources.

If the treatment your doctor prescribed for you isn’t on your plan’s formulary, **consider changing insurance plans** during the next open enrollment period. The Patient Advocate Foundation’s Hepatitis C CareLine keeps track of formulary changes, and will provide information to you.

**File a complaint.** There are multiple websites where you can review and rate your medical provider, such as Healthgrades or Vitals.

**Consider travel or telemedicine.** Some physicians see their patients using web-based services, and prescribe lab tests and treatment accordingly. Click here for information about accessing generic hepatitis C drugs.

**Speak up.** Talk to advocacy groups such as NVHR and Help4Hep (877Help-4-Hep/877-435-7443). If you have trouble accessing treatment through your state Medicaid program, report this to NVHR.

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**Don’t despair. Despair serves no one. It will steal all the life out of you and will not help you get your hepatitis C medications. The “system” may deny your hepatitis C treatment, but don’t let them also have your precious joy.**

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**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](http://www.LucindaPorterRN.com) and [HepMag.com](http://HepMag.com)
This month’s HCV Drugs has two exciting study results—phase 3 study results of Gilead’s triple combination of sofosbuvir, velpatasvir and voxilaprevir to treat treatment-naïve and treatment experienced patients with genotypes 1 through 6, and the phase 3 study results of AbbVie’s Viekirax plus Exviera to treat treatment naïve genotype 1b patients.

Gilead

Gilead issued a press release announcing the results of four phase 3 studies (POLARIS) of the triple combination of sofosbuvir (polymerase inhibitor), velpatasvir (NS5A inhibitor), and voxilaprevir (protease inhibitor) or sofosbuvir and velpatasvir (Epclusa). The study included 1,056 patients who received the triple combination (sofosbuvir (SOF), velpatasvir(VEL), plus voxilaprevir (VOX)—611 were treatment naïve and 455 were treatment experienced. The results are listed below:

<table>
<thead>
<tr>
<th>Study</th>
<th>Population</th>
<th>Genotype</th>
<th>Treatment</th>
<th>Duration</th>
<th>SVR12 Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>POLARIS-1</td>
<td>NS5A inhibitor-experienced 41 percent (172/415) had cirrhosis</td>
<td>1, 2, 3, 4, 5, 6</td>
<td>SOF/VEL/VOX</td>
<td>12 Weeks</td>
<td>96% (253/263)</td>
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<td></td>
<td></td>
<td></td>
<td>Placebo</td>
<td>12 Weeks</td>
<td>0% (0/152)</td>
</tr>
<tr>
<td>POLARIS-4</td>
<td>DAA-experienced (No NS5A inhibitor) 46 percent (153/333) had cirrhosis</td>
<td>1, 2, 3, 4</td>
<td>SOF/VEL/VOX</td>
<td>12 Weeks</td>
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This combination was granted Breakthrough Therapy designation by the Food and Drug Administration (FDA) for those with HCV genotype 1 who had failed a previous course of therapy that contained a NS5A inhibitor.

Gilead is expected to apply to the FDA for marketing approval of this triple combination in the fourth quarter of 2016.

Editorial Comments:
These are excellent results and give hope to those who have been treated but have not been cured. Additional results will be released at The Liver Conference at the beginning of November, Stay Tuned.


AbbVie
AbbVie also issued a press release about an 8-week treatment of Viekirax (ombitasvir/paritaprevir/ritonavir tablets) plus Exviera (dasabuvir tablets) to treat HCV genotype 1b.

The study included 163 treatment naïve, non-cirrhotic patients who did not have cirrhosis. The treatment duration was 8 weeks. The cure rate was 98% (160 of 163 patients).

The most common side effects were headache, fatigue, nasopharyngitis (cold or cough), itching, nausea, and lack of energy. Only one patient discontinued treatment due to side effects. The combination is already approved in Europe to treat HCV genotype 1.

Editorial Comment:
These are great results for HCV genotype 1b.


Note: The press releases indicated that further information will be released at the The Liver Meeting in Boston. We will be covering it on our Blog and in our January 2017 newsletter.

"These are excellent results and give hope to those who have been treated but have not been cured."
In this month’s SnapShots I describe two studies—the first one is about positive health outcomes of curing people infected with chronic hepatitis C followed by a study of low rates of relapse after being cured of chronic hepatitis C.

**Article: Eradication of Hepatitis C Virus Infection in Patients With Cirrhosis Reduces Risk of Liver and Non-Liver Complications—Nahon et. al**

*Source:* [http://dx.doi.org/10.1053/j.gastro.2016.09.009](http://dx.doi.org/10.1053/j.gastro.2016.09.009)

**Study Aims and Results**

The authors evaluate if curing hepatitis C reduces illness and death. Information was collected from 35 centers located throughout France. The data included 1,323 hepatitis C patients with compensated cirrhosis—the cirrhotic patients did not have complications from cirrhosis. Compensated cirrhosis was confirmed by liver biopsy.

*Editorial Note: Compensated cirrhosis is the first stage of cirrhosis. People with compensated may experience few or no symptoms. The medical goal of people infected with chronic hepatitis C who have progressed to compensated cirrhosis is to treat it, and cure it.*

The patients were treated with interferon-based therapy and direct-acting antiviral therapies.

**Conclusion**

After a mean follow-up period of 58 months, 50.5% (668 patients) were cured. Being cured of hepatitis C was associated with decreased rate of liver cancer, and decreased progression to decompensated cirrhosis. Curing hepatitis C also lowered the risk of cardiovascular events (heart disease), and bacterial infections.

In the entire study, 175 patients or 13.5% died during the follow-up period—this means that there was an 88.6% 5-year survival. Ninety-one patients died of liver complications and 66 patients died of non-liver complications.

The study was able to confirm that being cured of chronic hepatitis C improved liver related health and importantly non-liver related health issues such as cardiovascular deaths.

*Editorial Comments*

This is a fairly large and encouraging study. Most people who were cured of hepatitis C had positive long-term outcomes. There is a need for more and larger studies with only direct-acting antiviral medications to fully understand the long-term benefits of curing people with hepatitis C.

Anecdotally, I hear from many people that they feel so much better physically, emotionally and spiritually after being cured that it feels like a second lease on life.

“Being cured of hepatitis C was associated with decreased rate of liver cancer, and decreased progression to decompensated cirrhosis. Curing hepatitis C also lowered the risk of cardiovascular events (heart disease), and bacterial infections.”

— CONTINUED ON PAGE 7
Article: Late relapse versus HCV reinfection in patients with sustained virologic response after sofosbuvir-based therapies—Sarrazin et. al
Source: Clin Infect Dis. first published online October 12, 2016 doi:10.1093/cid/ciw676

Study Aims and Results
The aim of the study was to determine the number of people who relapsed after achieving a cure on sofosbuvir-based therapies. The study evaluated eleven phase 3 studies that included ledipasvir plus sofosbuvir (Harvoni) and sofosbuvir-based treatment trials. The studies included 3,004 patients who were cured (12-week post-treatment sustained virological response). The blood samples of the people who relapsed were sequenced looking for variances in the structure of the hepatitis C virus.

Conclusion
Twelve people were found to have relapsed. But it was determined that 7 of the 12 people who relapsed had different genetic strains indicating reinfection. This means that of the 3,004 successfully cured patients that only 5 people relapsed—a relapse rate of .01%.

Editorial Comments
In another study that was presented at the 2016 International Liver Congress—Long-Term Follow-up of Patients With Chronic HCV Infection Following Treatment With Direct-Acting Antiviral Regimens: Maintenance of SVR, Persistence of Resistance Mutations, and Clinical Outcomes presented by Eric Lawitz concluded that 99.7% (5414 of 5433 people) as of October 2015 maintained their cure. Of the people who relapsed, 6 were late relapses and 12 were reinfected. There were also low rates of liver cancers and low rates of treatment-emergent RAVs (resistant associated variants). It will be interesting to follow this study. To view the presentation visit: http://www.natap.org/2016/EASL/EASL_18.htm

The studies confirm important information about long-term cure rates. The Sarrazin study is a fairly large study and will add to the growing body of evidence that direct-acting antiviral medications have high cure rates that have long-term durability.

“This means that of the 3,004 successfully cured patients that only 5 people relapsed—a relapse rate of .01%.”
Educating people about hepatitis C (HCV) and harm reduction brings me a lot of enjoyment. It doesn’t matter if I’m in a small group at a treatment facility, guest lecturing in a college classroom, or leading a community workshop. Teaching others while also learning from them is a blast! The foundation of a training, workshop or small group is about sharing information with people that they can use to foster positive change at work or in their communities and personal lives.

Every solid house is built on a stronger foundation, but not every strong foundation supports a sturdy house. You won’t find the reasons for a training, workshop or small group having far-reaching success in a formula or outline. Beginning a project with a strong foundation and a good set of blueprints is important, but ultimately it’s the builder’s skill and vision that will determine success. If two builders were to begin a project with the same blueprints and poured foundation (workshop materials, subject matter and equipment) any differences in overall quality would come from their attention to detail, use of materials and creativity.

The HCV Train-the-Trainer (TOT) workshop has been given in all 50 U.S. states and certified over 11,000 people. These HCV educators have gone on to foster change by providing HCV education to people in their places of work and communities. These may be areas that previously had limited or no access to HCV education. This “pay it forward” effect means that over 700,000 people have benefited in some form or another from the HCV TOT workshops. That’s a pretty big and pretty strong house.

You can lead a training or workshop in many different ways, and for a lot of different reasons. That flexibility is what’s so exciting and scary about presenting or leading a workshop. Recently, I had the opportunity to lead a few HCV TOT trainings in Indiana and Kentucky. It was a great experience that also came with mishaps and a renewed appreciation for presenting.

There are two reasons why educating people about HCV and harm reduction is important to me. I’ll quickly share each of them, and mix in a few tips I’ve learned the hard way.
UNDER THE UMBRELLA

HCV Community Education - Teaching and Learning — CONTINUED FROM PAGE 8

First, I don’t believe that information should be unavailable or hard to find for anyone. A person’s status in life shouldn’t be a barrier to having access to information. Much of my work is teaching people about HCV and harm reduction with the goal of improving their overall health and wellness. I’m often more successful at this by sharing information with them in a way that encourages collaboration and mutual growth among everyone in the workshop.

I’ve learned through trial and error that the way information is presented not only has an affect on whether people remember it, but also their willingness to participate and engage during the workshop. This is one of the reasons why each time I present I aim to deliver the information in the same way regardless if I’m presenting to a room of providers who have extensive HCV knowledge, or a college class room that has never heard of it. I might change the pieces of what makes up a presentation, depending on the audience, but I never change the difficulty of the language or the complexity of how the material is explained. Delivering information in a neutral way consistently makes it easier to prepare and more enjoyable for everyone participating.

Second, I truly feel as though there are many promising collaborations, and potential partnerships, that have fallen apart because one party involved was offended and the other didn’t want to apologize or “back down”. You have to be able to present information in a balanced way because that respects all those in the room because you never really know about the beliefs and opinions of everyone present. This is where the adage, “it’s not what you say, it’s how you say it” becomes important.

As an example harm reduction and syringe exchange programs are often controversial topics, but they don’t have to be. The truth of the statement, “the war on drugs has failed” doesn’t matter if once said it has a good chance of alienating and upsetting people. We need to always ask ourselves if there is a benefit of saying something a certain way and what it’s purpose is. To be honest, leaving out such a statement wouldn’t reduce the quality or effectiveness of a presentation, it would actually improve it. The causes of substance use, the opiate epidemic and rising rates of HIV/HCV are more complex than a failed policy. As cliché’ as it sounds, always remember that words have power, so use them in a way that creates a welcoming environment.

“I don’t believe that information should be unavailable or hard to find for anyone. A person’s status in life shouldn’t be a barrier to having access to information.”

I always go into a presentation or workshop knowing it isn’t about me. It’s the people participating, connecting to each other and discovering ways they can increase awareness and access to HCV education. For any presentation, small group or workshop you’ll bring a lot of materials. Pens, cards, handouts, exercises and candy! One thing you should never bring is your ego. Be humble, be flexible. Presenting and leading workshops isn’t a body building competition, so there’s no need to try and impress by flexing.😊

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
HCV Advocate
Monthly Pipeline Update

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:** There is more detailed information about the drugs in development in our newsletter (http://hcvadvocate.org/publications/newsletter/2016-2/) and our blog (http://hepatitis.hcvadvocate.org/).

If you are interested in finding out about clinical trials visit HCV Advocate Clinical Trial Reference Guide (http://hcvclinical.hcvadvocate.org/) for a list of trials that are currently recruiting patients.

<table>
<thead>
<tr>
<th>AbbVie</th>
<th>Genotype(s): 1, 2, 3, 4, 5, 6 (Pan-genotypic)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COMMENTS:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Genotype 1 – Phase 2 Study:</strong> Information from the International Liver Congress 2016: AbbVie’s once-daily therapy of ABT-493 (protease inhibitor) and ABT-530 (NS5A inhibitor).</td>
<td></td>
</tr>
<tr>
<td><strong>Non-cirrhotic patients Treatment period - 8 weeks:</strong></td>
<td></td>
</tr>
<tr>
<td>• Genotype 1: 85% were treatment-naive; 15% were pegylated interferon(PEG)/ ribavirin (RBV) experienced, cure rates—97% (33 of 34 patients)</td>
<td></td>
</tr>
<tr>
<td>• Genotype 2: 87% were treatment-naive: 13% were PEG/RBV treatment experienced: cure rate—98% (53 of 54 pts)</td>
<td></td>
</tr>
<tr>
<td>• Genotype 3: 100% were treatment-naive: cure rate—97% (28 of 29 pts)</td>
<td></td>
</tr>
<tr>
<td><strong>Treatment period 12 weeks:</strong> Cirrhotic treatment-naive patients, genotype 3 – cure rate —100% (24 of 24 patients)</td>
<td></td>
</tr>
<tr>
<td>Non-cirrhotic treatment-naive patients (85%), PEG/RBV (15%); genotype 4 (22 pts), genotype 5 (1 pt), genotype 6 (11 pts)—cure rate—100% (34 of 34 pts)</td>
<td></td>
</tr>
<tr>
<td><strong>Bottom line:</strong> cure rates were 97% to 100%. <strong>Now in Phase 3 clinical trials</strong></td>
<td></td>
</tr>
</tbody>
</table>
**COMMENTS:**
Gilead released the results of four phase 3 studies (POLARIS) of the triple combination of sofosbuvir (polymerase inhibitor), velpatasvir (NS5A inhibitor), and voxilaprevir (protease inhibitor). The study included 1,056 patients who received the triple combination (sofosbuvir (SOF), velpatasvir(VEL), plus voxilaprevir (VOX)—611 were treatment naïve and 455 were treatment experienced.

*Note: I am only listing the results from the triple therapy below – you will note that the percentage and numbers include all the patients treated. For a complete breakdown of all treatment regimens see November 2016 newsletter.*

<table>
<thead>
<tr>
<th>Study</th>
<th>Population</th>
<th>Genotype</th>
<th>Treatment</th>
<th>Duration</th>
<th>SVR12 Rates</th>
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<td>41 percent (172/415) had cirrhosis</td>
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<td>Placebo</td>
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<tr>
<td>POLARIS-4</td>
<td>DAA-experienced (No NS5A inhibitor)</td>
<td>1, 2, 3, 4</td>
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<td>DAA-naïve</td>
<td>1, 2, 3, 4, 5, 6</td>
<td>SOF/VEL/VOX</td>
<td>8 Weeks</td>
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<td>POLARIS-3</td>
<td>DAA-naïve</td>
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<td>All had cirrhosis</td>
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The side effects were similar between the placebo (sugar pills) group, sofosbuvir plus velpatasvir, and the sofosbuvir, velpatasvir plus voxilaprevir groups. The most common side effects were headache, fatigue, diarrhea and nausea. Only one patient in the entire study discontinued therapy due to side effects.

This combination was granted Breakthrough Therapy designation by the Food and Drug Administration (FDA) for those with HCV genotype 1 who had failed a previous course of therapy that contained a NS5A inhibitor.

Gilead is expected to apply to the FDA for marketing approval of this triple combination in the fourth quarter of 2016.
**Janssen (Achillion/Alios)**

**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 study 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. The results are listed in the October 2016 HCV Advocate newsletter.

- **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 began in June 2016 and will end in July 2017.
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%.

### Merck

<table>
<thead>
<tr>
<th>Genotype(s) 1, 2, 3, 4, 5, 6 (Pan-genotypic)</th>
</tr>
</thead>
</table>

#### COMMENTS:

Regulus Therapeutic Inc.

The study included 79 treatment-naive 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.

*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.*
ATTENTION TRAINERS

We have posted our slides to our website to download for your use. The PowerPoint slide sets include a basic slide set that can be presented in 30 to 60 minutes and a comprehensive slide set that can be presented in 4 to 6 hours. There are references and notes on some of the slide note pages.

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