ACCEPT

Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics

How to Join:
https://iecho.org/public/program/PRGM1708646970665RHK0C7J5TR

For attendance purposes please text the following code: VOZWAD to 608-260-7097

Session Date: Friday, February 20, 2026

Didactic Topic and Presenter:
Managing Hepatitis C Treatment with Incomplete Adherence

Kelly Eagen, MD
Maggie Gray, MD
Content experts: Sheila Weix and Joe Galey

- 12:15 PM: Attendance text-in – Introductions
- 12:25 PM: Didactic Presentation
  - Presenter: Kelly Eagen, MD
- 12:50 PM: Case Presentation
  - Presenter: Maggie Gray, MD
- 1:15 PM End of Session

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Interprofessional Continuing Education Partnership
UNIVERSITY OF WISCONSIN–MADISON
School of Medicine and Public Health
School of Nursing
School of Pharmacy

ECHO ACCEPT
Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics 2026
Managing Hepatitis C Treatment with Incomplete Adherence
2/20/2026
Didactic and Case Presenters: Kelly Eagen, MD and Maggie Gray, MD
Provided by the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience:
Nurses, Nurse Practitioners, Pharmacists, Physicians, Physician Assistants, Pharmacy Technicians, Psychologists, Social Workers, Patient/Caregivers, Students

Objectives:
1. Discuss strategies to support adherence when treating chronic HCV
2. Explain the AASLD/IDSA guideline for managing incomplete adherence
3. Identify resources to support clinicians to retreat HCV

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Name	Role	Financial Relationship Disclosures	Discussion of Unlabeled/Unapproved uses of drugs/devices in presentation?	COI completion date
David Leinweber	RSS Chair	No relevant financial relationships to disclose	Yes	12/9/2025
Nada Rashid	RSS Coordinator	No relevant financial relationships to disclose	No	12/10/2025
Kathleen Maher	RSS Coordinator	No relevant financial relationships to disclose	No	12/9/2025
Randall Brown	Planner	No relevant financial relationships to disclose	Yes	12/10/2025
Ritu Bhatnagar	Planner	No relevant financial relationships to disclose	Yes	12/6/2025
Paul Hutson	Planner	usona (Independent Contractor - Consultant), Midwest Pharmacokinetic Consulting, LLC (Independent Contractor - Consultant), Otsuka America Pharmaceutical, Inc. (Independent Contractor - Consultant), Tryptamine Therapeutics (Independent Contractor - Consultant)	Yes	12/9/2025
Susan Mindock	Planner	No relevant financial relationships to disclose	No	12/8/2025
Sheila Weix	Planner	No relevant financial relationships to disclose	No	12/11/2025
Kellene Eagen	Planner	No relevant financial relationships to disclose	No	12/8/2025
Joseph Galey	Planner	No relevant financial relationships to disclose	No	12/19/2025
Kelly Eagen	Presenter	No relevant financial relationships to disclose	Yes	1/16/2026
Maggie Gray	Presenter	No relevant financial relationships to disclose	No	2/13/2026

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Hepatitis C Treatment with Incomplete Adherence

Kelly Eagen, MD

UW Madison, DFMCH

Addiction Medicine Fellowship

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Learning Objectives

- Review strategies to support adherence when treating chronic hepatitis C (HCV)
- Review the AASLD/IDSA guideline for managing incomplete adherence
- Provide resources for HCV re-treatment

AASLD/IDSA Simplified Treatment Guidelines

Goal of Treatment

RECOMMENDED	RATING
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 hepatocellular carcinoma, by the achievement of virologic cure as evidenced by a sustained virologic response.	I, A

Recommendation for When and in Whom to Initiate Treatment

RECOMMENDED	RATING
Treatment is recommended for all patients with acute or chronic HCV infection, except those with a short life expectancy that cannot be remediated by HCV therapy, liver transplantation, or another directed therapy. Patients with a short life expectancy owing to liver disease should be managed in consultation with an expert.	I, A

Project ECHO University of Wisconsin

https://www.hcvguidelines.org

Benefits of HCV Treatment

- Reduced risk of progression to advanced liver disease and associated sequelae (cirrhosis, ESLD, HCC)
- Mortality benefit
- Reduced extrahepatic symptoms
  - Fatigue, dermatologic, glucose metabolism/DM, cryoglobulinemia, etc
- Prevent transmission
  - IDU
  - MSM
- Mortality and graft survival in transplant recipients

Simplified Treatment Algorithm

- Two simplified algorithms
  - No cirrhosis
  - Compensated cirrhosis

- No cirrhosis
  - Pangenotypic options:
    - Glecaprevir/pibrentasvir (GLE-PIB) [Mavyret] x 8 weeks
    - Sofosbuvir/velpatasvir (SOF-VEL) [Epclusa] x 12 weeks
  - Monitoring on treatment
    - No labs required on treatment
    - Consider visits to support adherence (in person, telehealth) PRN
    - SVR12 – HCV RNA 12 weeks after completion (gold standard)

Case

- 49 year male with chronic HCV (no cirrhosis) and severe methamphetamine use disorder returns to clinic after 41 days of missed treatment requesting a refill of GLE-PIB.
  - Treatment initiated via simplified treatment guideline
  - Adherence support with weekly medisets
    - Received 5 on-time 7-day supplies of meds
  - Did not come in for 41 days after being due

- Patient is eager to restart: "I need to be cured!"

What to do?

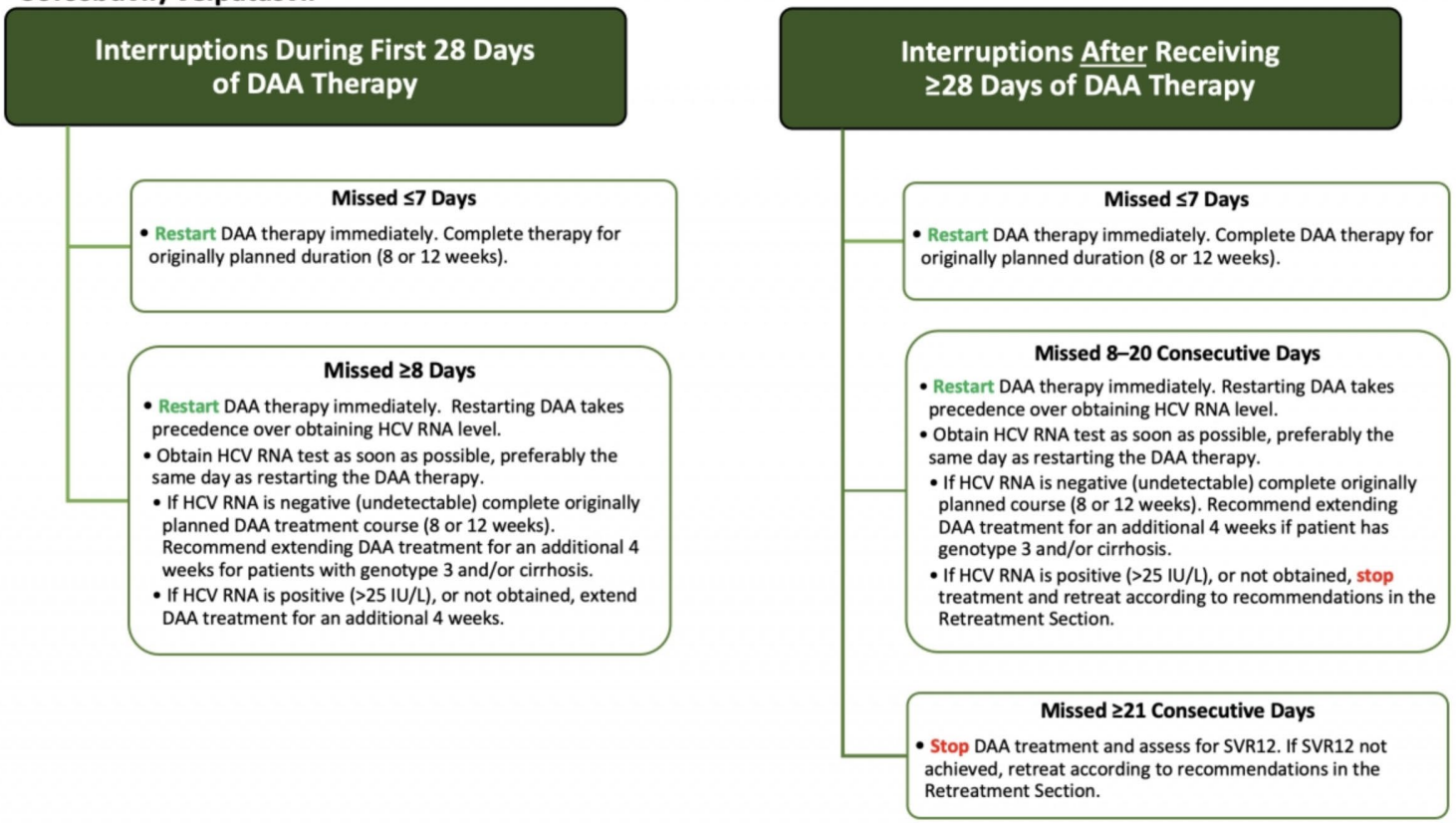
Strategies to support adherence

- Be your best cheerleader
  - Education on importance of adherence for cure
  - "You can do it!"
  - "Only" 8-12 weeks
- Frequent visits (in person, telemedicine)
  - Partner with pharmacy/nursing staff for support
- Pair DAA refills with buprenorphine
  - Dispense 1-2 weeks at a time
- With ROI, involve case manager, peer, family to support
- Consider HCV RNA 4 weeks on treatment
  - *SHOULD* be undetectable

So… what to do when someone misses doses???

Management of incomplete adherence

Figure 1. Recommended Management of DAA Treatment Interruptions for Treatment-Naive Patients, Without Cirrhosis or With Compensated Cirrhosis, Receiving Glecaprevir/Pibrentasvir or Sofosbuvir/Velpatasvir

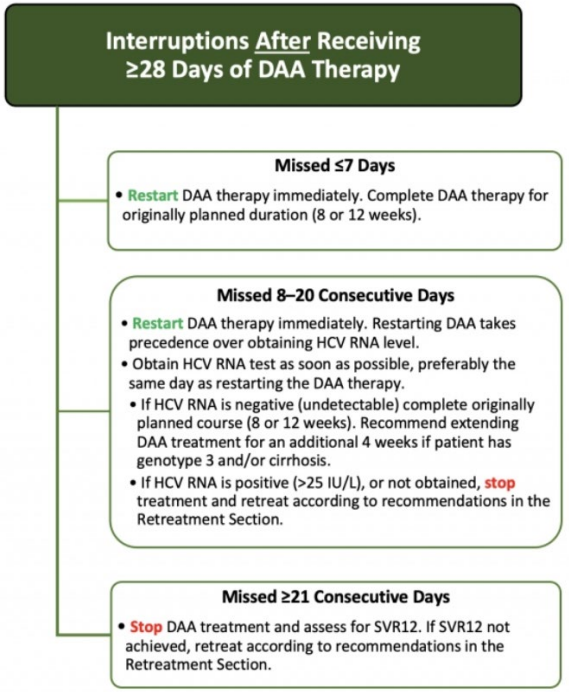


DAA, direct-acting antiviral; HCV RNA, hepatitis C virus ribonucleic acid; SVR12, sustained virologic response 12 weeks after end of treatment.

Case

- Received 5 weeks of treatment which he reports taking as prescribed
- Missed 41 days

- Guideline recommends:
  - Stop DAA
  - Assess for SVR12
    - If cure not achieved, → retreat



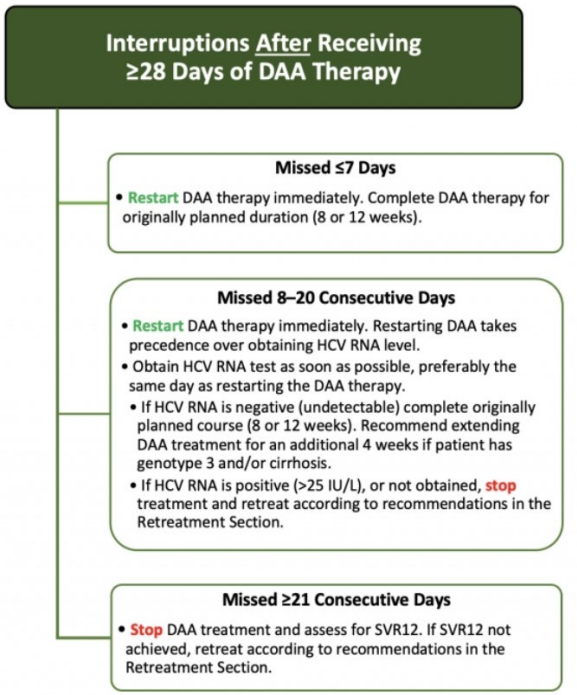
What I actually did in 2018?

- *Restarted treatment*
- *Sent HCV RNA same day*
  - *Came back not detected*
  - *Completed treatment*
  - *Cured*

(Did he get more meds than necessary?)

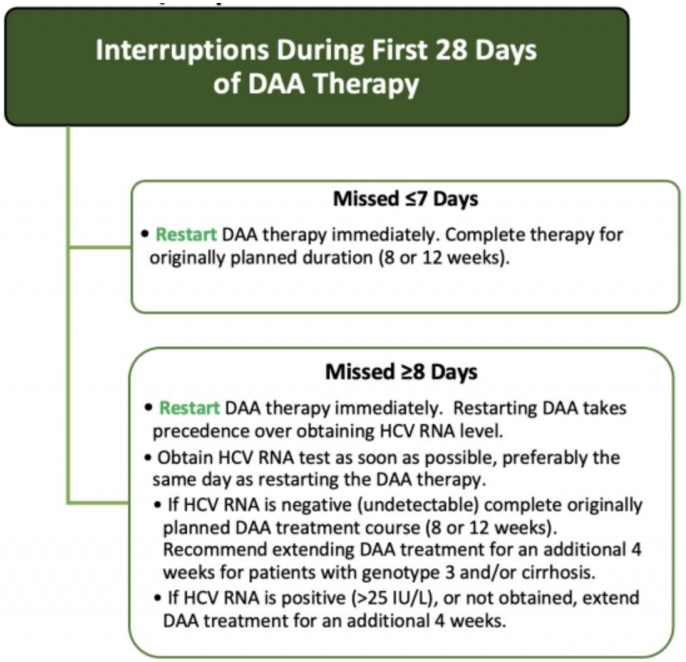
What if 15 days missed?

- Guideline recommends:
  - Restart DAA immediately
  - Obtain HCV RNA
    - If HCV RNA undetectable → complete treatment as planned
    - If HCV RNA detected, stop and retreat



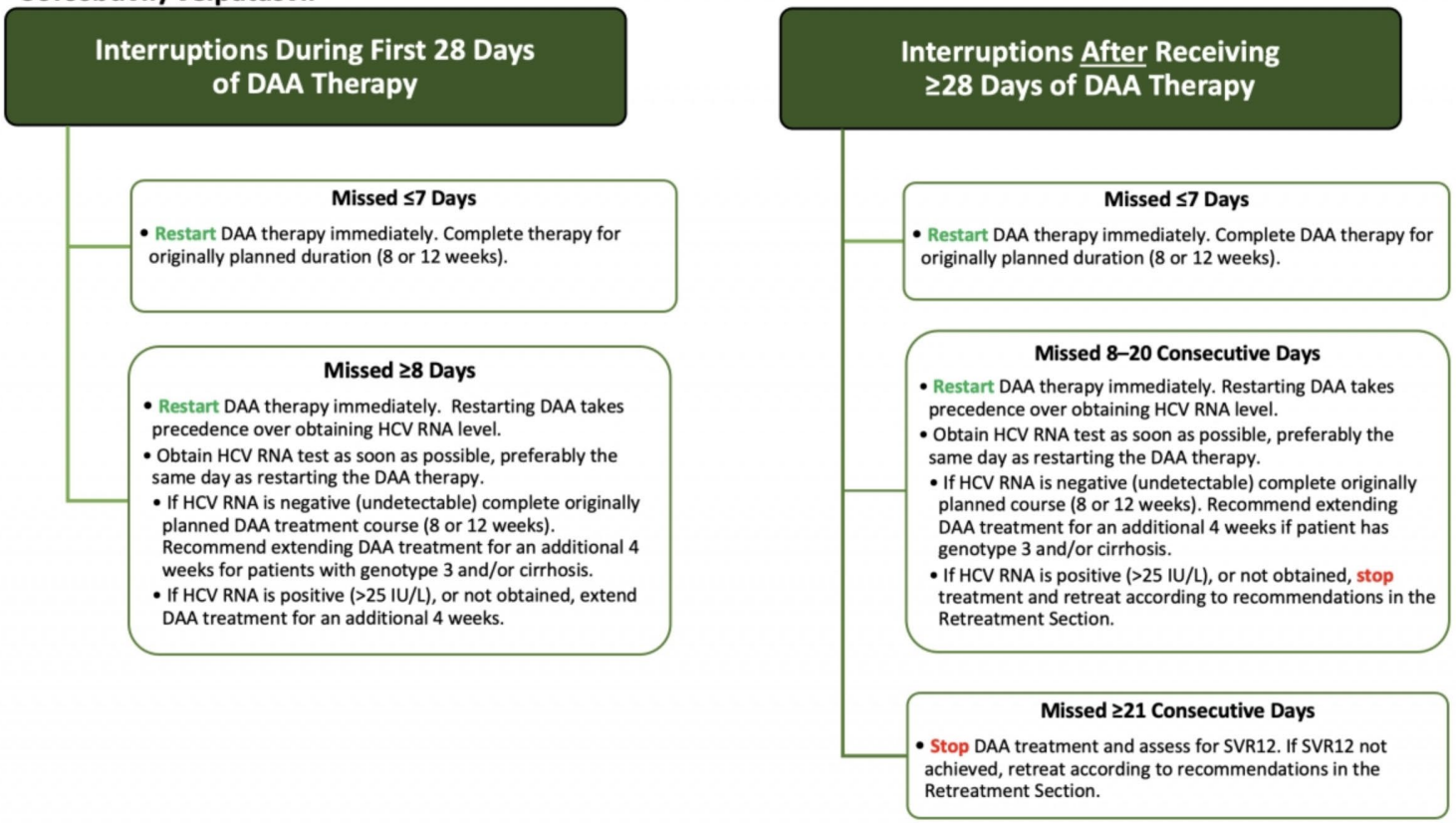
What if 10 days missed after 2 weeks on treatment?

- Guideline recommends:
  - Restart DAA immediately
  - Obtain HCV RNA immediately
    - If HCV RNA undetectable → complete treatment as planned
    - If HCV RNA positive (>24 IU/L) or unable to be obtained, extend treatment for 4 additional weeks



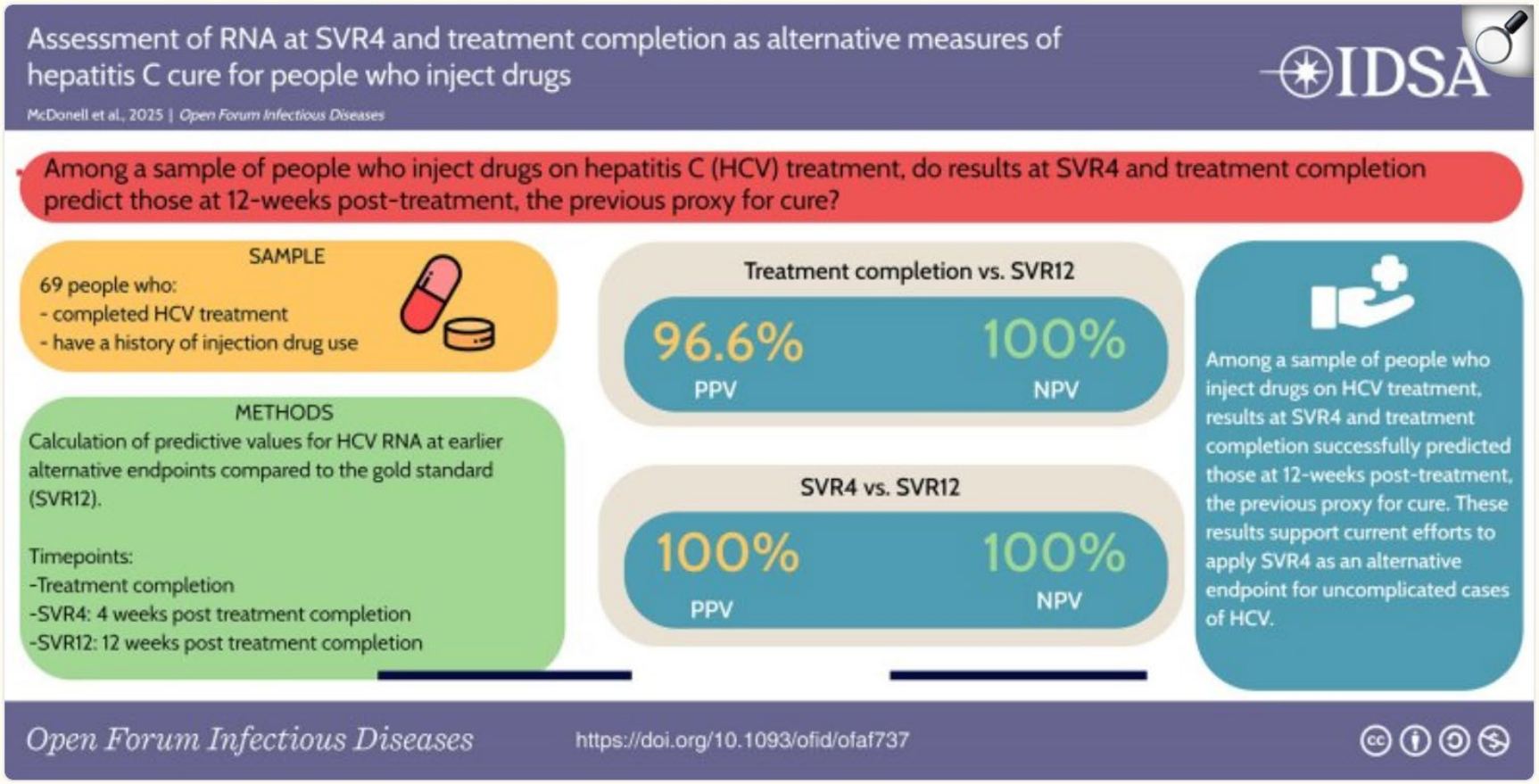
Management of incomplete adherence

Figure 1. Recommended Management of DAA Treatment Interruptions for Treatment-Naive Patients, Without Cirrhosis or With Compensated Cirrhosis, Receiving Glecaprevir/Pibrentasvir or Sofosbuvir/Velpatasvir



DAA, direct-acting antiviral; HCV RNA, hepatitis C virus ribonucleic acid; SVR12, sustained virologic response 12 weeks after end of treatment.

Proxy assessments for cure?



<u>Take home</u>:
Consider RNA at treatment completion and/or 4 weeks later.

Retreatment

- Re-infection vs treatment failure?
  - Review adherence, completion, etc
  - Review SVR12
    - SVR4?
  - Review reinfection risks
  - Compare genotype, if available
- Re-infection
  - Treat as if naive

Retreatment

- Treatment-Experienced Guideline
  - https://www.hcvguidelines.org/treatment-experienced-patients/
- Resistance
  - DAA exposure may select for Resistance Associated Substitutions (RASs), however, clinical trials have not shown a negative impact of NS5A RAS on the efficacy of retreatment utilizing 3 DAAs with unique mechanisms.
  - If multiple DAA failures, more evaluation and research are needed → Send to specialist

Recommended regimens listed by evidence level and alphabetically for:

Glecaprevir/Pibrentasvir Treatment Failures (All Genotypes), With or Without Compensated Cirrhosis[a]

RECOMMENDED	DURATION	RATING
Daily fixed-dose combination of glecaprevir (300 mg)/pibrentasvir (120 mg) plus daily sofosbuvir (400 mg) and weight-based ribavirin	16 weeks	IIa, B
Daily fixed-dose combination of sofosbuvir (400 mg)/velpatasvir (100 mg)/voxilaprevir (100 mg)	12 weeks	IIa, B
For patients with compensated cirrhosis, addition of weight-based ribavirin is recommended	12 weeks	IIa, C

[a] For decompensated cirrhosis, please refer to the appropriate section.

Recommended and alternative regimens listed by evidence level and alphabetically for:

Sofosbuvir-Based Treatment Failures, With or Without Compensated Cirrhosis[a]

RECOMMENDED	DURATION	RATING
Daily fixed-dose combination of sofosbuvir (400 mg)/velpatasvir (100 mg)/voxilaprevir (100 mg)[b]	12 weeks	I, A
ALTERNATIVE	**DURATION**	**RATING**
Daily fixed-dose combination of glecaprevir (300 mg)/pibrentasvir (120 mg) except for NS3/4 protease inhibitor inclusive combination DAA regimen failures[c] • **Not** recommended for genotype 3 infection with sofosbuvir/NS5A inhibitor experience	16 weeks	I, A

[a] For decompensated cirrhosis, please refer to the appropriate section.

[b] Genotype 3: Add weight-based ribavirin if cirrhosis is present and there are no contraindications.

[c] This regimen is not recommended for patients with prior exposure to an NS5A inhibitor plus NS3/4 PI regimens (e.g., elbasvir/grazoprevir).

Conclusions

- Screen
- Treat!
  - Support adherence
    - Refer to guideline for missed doses
- Consider early assessment of cure (completion or SVR4)
- Retreatment is possible!

You can (should) do this.

Resources

- AASLD-IDSA. Recommendations for testing, managing, and treating hepatitis C. https://aasldhcvguidelines.kinsta.cloud [Accessed February 13, 2026].

- AASLD-IDSA. Simplified HCV Treatment* for Treatment-Naive Adults Without Cirrhosis. https://www.hcvguidelines.org/guidance/simplified-hcv-treatment-for-treatment-naive-adults-without-cirrhosis/. [Accessed February 13, 2026].

- AASLD-IDSA. Treatment-Experienced Patients. https://www.hcvguidelines.org/treatment-experienced-patients/. [Accessed February 13, 2026].

- McDonell C et al. Assessment of RNA at SVR4 and Treatment Completion as Alternative Measures of Hepatitis C Cure for People Who Inject Drugs. Open Forum Infect Dis. 2025 Dec 19;13(1):ofaf737. doi: 10.1093/ofid/ofaf737. PMID: 41477535; PMCID: PMC12750323.

DSM-5 Substance Use Disorder ("Addiction")

- Tolerance
- Withdrawal

} **Physical Dependence ≠ Use Disorder**

- Larger amts/longer periods than intended
- Persistent desire/failed attempts to quit/control use
- Much time obtaining/using/recovering
- Important activities sacrificed
- Continued use despite known adverse effects
- Failure to fulfill major obligations
- Recurrent hazardous use
- Craving
- Ongoing use despite interpersonal problems

2-3 = mild
4-5 = moderate
≥ 6 = severe

February 2026 Project ECHO Case Presentation

Maggie Gray MD

Addiction Medicine Fellow

University of Wisconsin-Madison School of Medicine and Public Health

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Case Introduction

36 year old man hx of bilateral pulmonary embolism, bipolar affective disorder, cocaine use disorder, opioid use disorder on methadone maintenance, hx of injection drug use, chronic right forearm wound with hx of recurrent SSTI, and chronic Hepatitis C viral (HCV) infection.

- Primary question for discussion:
  - Evaluation of Hepatitis C treatment

Medical & Behavioral Health Diagnosis:	Current Medications:
• Hx of bilateral pulmonary embolism, not on anticoagulation • Bipolar Affective Disorder • Attention Deficit Hyperactivity Disorder • Cocaine Use Disorder • Opioid Use Disorder • Chronic HCV without cirrhosis • Chronic R forearm wound complicated by recurrent SSTI, chronic blood loss with prior admission for symptomatic anemia • Iron deficiency anemia	• Dalbavancin • Ferrous Sulfate • Methadone • Silvadene 1% cream • IN naloxone PRN • Hx of 8 weeks of glecaprivir-pibrentasvir (Sept-November 2025)

Substance Use

- History:
  - History of cocaine and heroin/fentanyl use via injection (IV, skin popping). January 2026 report significant decrease in substance use, both frequency and quantity. Using intranasal rather than injection.
- Consequences of Substance Use:
  - Social/occupational/educational: involvement in carceral system, housing instability
  - Physical: tolerance, withdrawal, xylazine-related chronic wound with recurrent infections, prior bacteremia with pulmonary septic emboli

Substance Use

- Past treatments:
  - Remote hx of buprenorphine-naloxone
  - Remote hx of IOP
  - Currently engaged in treatment at OTP on methadone 80 mg daily

Social History:	Family History:
• Social Factors/History: Housed with family, Pet Owner, Currently not partnered, Considers himself to be spiritual • Education/Literacy: Associates in Business Management and Accounting	• Father with Alcohol Use Disorder and Bipolar Affective Disorder • Mother with Cocaine Use Disorder and Bipolar Affective Disorder • Brother and sister deceased from opioid overdose

Patient strengths & protective factors:	Risk factors:
• Daily engagement with OTP and related counseling • Engagement with Addiction Medicine Consult Service • Reduction in quantity and frequency of use • Engagement in harm reduction including transition to intranasal use (Jan 2026)	• Ongoing substance use • Recurrent medical complications of IDU

Patient Goals

- Patient is interested in treatment for Chronic HCV to prevent related complications

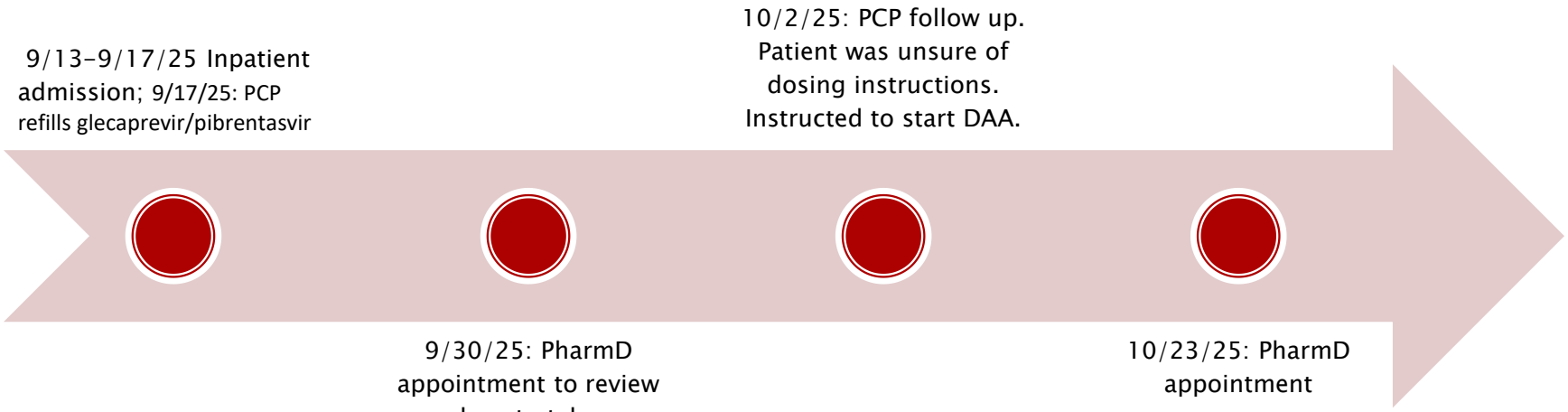
Labs

- WBC 5.6, Hgb 9.5, Plt 298
- Alk phos 131, ALT 94, AST 72, Tbili 0.3, Albumin 3.6
  - FIB-4: 0.9
- CT AP (1/31/25) with hepatosplenomegaly, smooth liver contours

2/2/25: HCV Ab: Reactive; HCV VL 70

3/5/25: Discharged from hospital. Per DC summary discharged without DAA due to rising LFTs.

3/25/25: Seen in Compass clinic. Patient reports he received DAA via mail order pharmacy. Patient was instructed not to start medication until after completion of repeat lab work.


9/13-9/17/25 Inpatient admission; 9/17/25: PCP refills glecaprevir/pibrentasvir
9/30/25: PharmD appointment to review how to take glecaprevir/pibrentasvir
10/2/25: PCP follow up. Patient was unsure of dosing instructions. Instructed to start DAA.
10/23/25: PharmD appointment

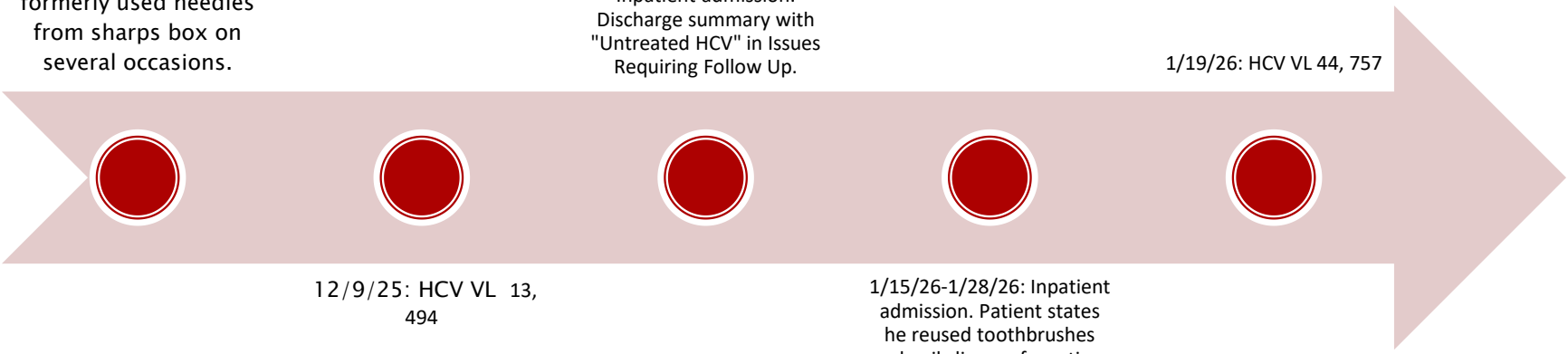
12/5/25–12/10/25: Inpatient admission. Patient indicates his access to safe use supplies has been limited. Has re-used formerly used needles from sharps box on several occasions.

12/9/25: HCV VL 13, 494

12/19/25-12/21/25: Inpatient admission. Discharge summary with "Untreated HCV" in Issues Requiring Follow Up.

1/15/26-1/28/26: Inpatient admission. Patient states he reused toothbrushes and nail clippers from time prior to DAA.

1/19/26: HCV VL 44, 757



Proposed Diagnoses

- Glecaprevir/Pibrentasvir Treatment Failure in patient with Gentotype 1a Chronic HCV without cirrhosis vs HCV re-infection
- Less concern for non-adherence playing a role, as SVR is typically high in individuals without cirrhosis who take > 4 weeks of therapy (Fabbiani et al, 2021)
  - If a patient misses 8-20 consecutive days of therapy and has a positive viral load, they are treated in the same manner as a treatment failure.

Proposed Treatment Plan

- Per AASLD/IDSA 2023 HCV Treatment Guidelines:

Active or recent drug use or a concern for reinfection is **not** a contraindication to HCV treatment.	IIa, B

- Multidisciplinary care?

"Ideally, treatment of HCV-infected persons who inject drugs should be delivered in a multidisciplinary care setting with services to reduce the risk of reinfection and for management of the common social and psychiatric comorbidities in this population."

- Patient Education to prevent transmission and re-infection.

- Promote greater access to syringe services.

Proposed Treatment Plan

- Per AASLD/IDSA 2023 HCV Treatment Guidelines:

Recommended regimens listed by evidence level and alphabetically for:

Glecaprevir/Pibrentasvir Treatment Failures (All Genotypes), With or Without Compensated Cirrhosis[a]

RECOMMENDED	DURATION	RATING
Daily fixed-dose combination of glecaprevir (300 mg)/pibrentasvir (120 mg) plus daily sofosbuvir (400 mg) and weight-based ribavirin	16 weeks	IIa, B
Daily fixed-dose combination of sofosbuvir (400 mg)/velpatasvir (100 mg)/voxilaprevir (100 mg)	12 weeks	IIa, B
For patients with compensated cirrhosis, addition of weight-based ribavirin is recommended	12 weeks	IIa, C