Hepatitis C Virus Guidance

Universal screening, simplified treatment eligibility, initial DAA regimens by genotype/cirrhosis, retreatment, monitoring/adherence, and special populations.

2023 AASLD-IDSA HCV Guidance
Diagnosis, Management, and Treatment of Hepatitis C Virus Infection
Bhattacharya, Aronsohn, Price, Lo Re · Clin Infect Dis 2023

FORMAT *Narrative guidance + regimen tables (not GRADE-rated numbered statements); condensed from full web guidance at hcvguidelines.org.*

1 Universal Screening & Diagnosis

•	STATEMENT
•	Screen all adults ≥18 yr at least once, and all pregnant persons during each pregnancy, regardless of risk factors
•	Initial test: HCV antibody with automatic reflex HCV RNA to confirm active (vs. resolved/cleared) infection
•	Universal DAA treatment recommended for all with acute or chronic HCV, except those with short life expectancy unremediable by HCV therapy, LT, or other directed therapy

2 Simplified Treatment — Eligibility

CATEGORY	REGIMEN / CRITERIA
Eligible	Any genotype; treatment-naive; without cirrhosis or with compensated cirrhosis (Child-Pugh A); includes persons with HIV coinfection and resolved HBV (anti-HBc+)
Excluded	HBsAg-positive (active HBV); compensated cirrhosis + ESRD (eGFR <30); current/prior decompensated cirrhosis (Child-Pugh ≥7); pregnancy; known/suspected HCC; prior liver transplant

3 Simplified Regimens — Treatment-Naive

STATUS	REGIMEN / CRITERIA
No cirrhosis	Glecaprevir/pibrentasvir (300/120 mg) 8 wk, OR sofosbuvir/velpatasvir (400/100 mg) 12 wk — either, any genotype
Compensated cirrhosis	Glecaprevir/pibrentasvir 8 wk (GT 1–6), OR sofosbuvir/velpatasvir 12 wk (GT 1,2,4,5,6)

4 Initial Treatment by Genotype/Status

GENOTYPE/STATUS	REGIMEN / CRITERIA
GT 1–6, no/comp. cirrhosis	Glecaprevir/pibrentasvir 8 wk (rec.); sofosbuvir/velpatasvir 12 wk (rec.)
GT 1,4,5,6	Ledipasvir/sofosbuvir 12 wk (rec., not GT6 if subtype known)
GT1 no cirrhosis, HCV RNA <6M IU/mL	Elbasvir/grazoprevir 8 wk (rec.)
GT 1b, 4	Elbasvir/grazoprevir 12 wk (rec.)
GT1a	Elbasvir/grazoprevir 12 wk (alt. — requires NS5A RAS testing; switch regimen if RAS +)
GT3 + comp. cirrhosis	Sofosbuvir/velpatasvir/voxilaprevir 12 wk (alt.); add ribavirin if baseline NS5A Y93H RAS+
Decompensated cirrhosis	Sofosbuvir/velpatasvir + weight-based ribavirin 12 wk (GT1–6); low-dose ribavirin 600 mg if CTP-C, uptitrate as tolerated. Ribavirin-ineligible: sofosbuvir/velpatasvir 24 wk, or ledipasvir/sofosbuvir 24 wk (GT1,4,5,6)

5 Retreatment After DAA Failure

PRIOR FAILURE	REGIMEN / CRITERIA
Sofosbuvir-based	Sofosbuvir/velpatasvir/voxilaprevir 12 wk (add ribavirin if GT3 + compensated cirrhosis); alt.: glecaprevir/pibrentasvir 16 wk (not for GT3 with prior sofosbuvir/NS5A exposure)
Glecaprevir/pibrentasvir	Glecaprevir/pibrentasvir + sofosbuvir + weight-based ribavirin (per MAGELLAN-3 regimen)
Multiple DAA failure	Refer to HCV-management specialist for individualized regimen selection

6 Monitoring & Incomplete Adherence

•	STATEMENT
•	Short nonadherence gaps (1–2 days) generally do not affect SVR12 (~94% regardless of adherence status)
•	No cirrhosis: SVR12 only 50% if <4 wk of DAA received vs. 99% if ≥4 wk — reinforces importance of completing therapy
•	Compensated cirrhosis: SVR12 83% if <8 wk of therapy vs. 95% if ≥8 wk
•	MINMON minimal-monitoring approach (validated, SVR 95%): no baseline genotyping, dispense full course at entry, no scheduled visits/labs, remote check at week 4 (adherence) and week 22 (schedule SVR-24 test)

7 Special Populations & Key 2023 Updates

•	STATEMENT
•	HIV/HCV coinfection now eligible for simplified treatment algorithm (comparable SVR12 to HCV-only in MINMON trial)
•	HBsAg-positive patients excluded from simplified pathway (HBV reactivation risk); resolved HBV (anti-HBc+, HBsAg−) remains eligible
•	Pediatric treatment/retreatment now extends down to age 3 years (see AASLD-IDSA pediatric tables for regimens)
•	Glecaprevir/pibrentasvir shortened to 8 wk for compensated cirrhosis (EXPEDITION-8: SVR12 98%)
•	New algorithm added specifically for managing incomplete DAA adherence in treatment-naive, non-decompensated patients
•	Continue HCC ultrasound surveillance (± AFP) every 6 months in cirrhotic patients, even after SVR is achieved
•	Refer to specialist for worsening LFTs, jaundice, ascites, encephalopathy, or new liver-related symptoms during/after treatment

Bhattacharya D, Aronsohn A, Price J, Lo Re V; AASLD-IDSA HCV Guidance Panel. 2023 AASLD-IDSA HCV Guidance Update. *Clin Infect Dis.* 2023. Full regimen tables: hcvguidelines.org.