Hepatitis C Primary Care Clinical Pathway

1. Who should be tested for Hepatitis C Virus (HVC)?
- Current or history of injection drug use
- Born, resided, or had medical/dental treatment in HCV-endemic countries
- Received health care where there is a lack of universal precautions
- Children >18 months of age born to mothers with HCV
- Received blood transfusions, blood products, or organ transplant before 1992
- Other risk factors: high-risk sexual behaviours, homelessness, intranasal/inhalation drug use, tattooing, body piercing, or sharing sharp instruments/personal hygiene materials with someone who is HCV positive

2. Connect patient to harm reduction support programs
- See Harm reduction support link above for details

3. Testing and blood work (at least 3 months after exposure)
- If no history of HCV infection, complete antibody testing
- If antibody positive lab will automatically complete reflex testing to confirm patient is RNA positive (viremix/infected)
- If prior history of HCV infection, complete RNA testing

3a. Anitibody Negative

3b. Antibody Positive / RNA Negative
- HCV has cleared
- Complete blood work as per 3c

3c. Antibody Positive / RNA Positive
- Complete blood work to inform treatment plan
- Anti-Hep A IgG antibody, Hep B surface antigen, anti-Hbc antibody, anti-Hbs antibody & HIB antibody
- AST, ALT, platelets, creatinine

10. Maintain harm reduction supports & retest annually if at risk of infection/reinfection. See Harm reduction support link above for details.

4. Is treatment appropriate at this time?
- Discuss with patient what supports are required for adherence to treatment and link patient to these supports
- Postpone treatment if pregnant, lactating, or at risk of pregnancy
- If treatment is postponed, maintain supports & monitor patient to determine when treatment is appropriate

5. Determine appropriateness of treatment in the Patient Medical Home
- Consider primary care provider's comfort to deliver treatment
- Consider requirements of patient's healthcare insurance coverage
- Always refer: prior HCV treatment, HBV or HIV co-infection, chronic kidney disease (eGFR <30), pediatric patients with HCV

11. Refer to hepatology, infectious disease, gastroenterology, or internal medicine specialty care (as available). See referral guideline tab for details.

STOP: Do not treat patients with decompensated cirrhosis – complete urgent referral to hepatology

Treat in the Patient Medical Home

6. Calculate FIB-4 score
- Assess liver fibrosis and risk or cirrhosis
- Free FIB-4 calculator

FIB-4 > 3.25

FIB-4 < 3.25

7. Seek advice from hepatology, infectious disease, or gastroenterology specialist
- If required by insurance provider
- Phone or written advice is sufficient. No referral required. See referral guideline tab for details.

8. Offer pan-genotypic HCV therapy (8-12 weeks)
- Treatment regimens: Epclusa or Maviret
- Assess drug-drug interactions
- Facilitate insurance coverage, if not already in place
- Assess and address barriers to adherence

9. Complete HCV RNA test to confirm cure
- 12 weeks after completion of therapy
- Re-test AST, ALT. If not normalized, investigate other causes of elevated liver enzymes

Negative result (95% of patients)

Positive result (5% of patients)

NOTE: Patients at risk for reinfection should be retested annually (use RNA). Patients who are reinfected with HCV should be referred to a specialist