Background. Enormous advances in treating/curing patients suffering from Hepatitis C (HepC) infection have occurred, resulting in many states mandating screening for HepC for older individuals. Unfortunately, no protection of screening exists for newborns. In Kentucky, rates of HepC among pregnant women are the second highest within the U.S., which has been associated to high intravenous drug use. Infants born to these women are at risk of HepC infection and other conditions such as neonatal abstinence syndrome (NAS). The current study examined the rate of HepC screening in a high-risk cohort (newborns suffering from NAS) and its impact on policy-making for this vulnerable population.

Methods. Kentucky Medicaid records, from 2015, were obtained to develop a detailed demographic, behavioral, clinical, and diagnostic data set (n = 152,749). NAS was defined by ICD-9 code 779.5 and ICD-10 code P96.1. HepC screening was defined by CPT codes (CPT 87520 [HCV, direct probe], 87521 [HCV, amplified probe], and 87522 [HCV RNA, Quantitative] or antibody [CPTs 86030–34]). Initially a descriptive study was performed, then multiple logistic regression techniques were used to test what variables impacted the odds of not being screened for HepC.

Results. A total of 1234 newborns with NAS were identified. The majority showed signs of NAS within 24 hours (64%), were white (68%) and were admitted to the hospital for an average of 24.8 days. Only one in three newborns with NAS (n = 412, 33.4%) were screened for HepC. Non-Whites (OR = 1.58, 95% CI 1.45–1.71, P < 0.001) and those living in non-urban areas (OR = 1.42, 95% CI 1.28–1.56, P < 0.001) were the only study variables to significantly impact the odds of not being screened for HepC (for newborns suffering from NAS).

Conclusion. A high-risk and vulnerable population for HepC may not be getting screened for HepC because it is not being underserved by the healthcare system. Non-Whites and those in rural areas are the most affected. Solutions and policies need to be focused on this population and area where screening is lacking. Optimization of maternal screening for HepC is crucial in high-risk populations.

Disclosures. All authors: No reported disclosures.

1693. Antiviral Treatment among Hepatitis B Virus-Infected Pregnant Women—New York City and Michigan, 2013–2015

Background. Individuals with chronic hepatitis B virus (HBV) infection are at increased risk for cirrhosis and hepatocellular carcinoma. Chronic HBV infection develops in 90% of persons infected at birth. Although postexposure prophylaxis (PEP), consisting of hepatitis B vaccine and immune globulin at birth, and completion of the three-dose vaccine series prevents up to 95% of perinatal HBV infections; however, breakthrough infections can occur, especially among infants born to women with high viral loads (VLs). Maternal antiviral treatment during pregnancy can reduce perinatal HBV transmission by 70% above the effect of infant PEP alone. We assessed factors associated with maternal antiviral treatment in a cohort of HBV-infected pregnant women with high VL.

Methods. During 2013–2015, the CDC-funded Supplemental Perinatal Hepatitis B Prevention Program collected information from interviews and medical charts of HBV-infected pregnant women in two sites. We assessed the association of demographic and clinical factors with maternal treatment in women with high VL (>200,000 IU/mL), considering statistical significance at P < 0.05.

Results. Among 1,521 women with maternal treatment and VL data, 151 (10%) had high VL. Among these 151 women, 66 (44%) received antiviral treatment (Table), all of whom were of Asian/Pacific Island race. None of the seven women of other races were treated (P = 0.02). Fifty-nine women (48%) receiving Medicaid were treated compared with six women (24%) who had private insurance (P = 0.04).

Conclusion. Mother's race, country of birth, and insurance status were significantly associated with treatment in women with high VL. Because most women with high VL did not receive antiviral treatment during pregnancy, opportunities to reduce perinatal HBV transmission exist.

Table. Association between characteristics of pregnant women with high viral load and HBV treatment status.

| Characteristic                  | Treated (n = 66) | Not treated (n = 85) | P-value |
|--------------------------------|-----------------|---------------------|---------|
| Age in years, median (IQR)      | 29 (26.8, 33.1) | 31.0 (27.3 34.7)   | 0.09    |
| Mother's race, n (%)            |                 |                     | 0.02    |
| Asian/Pacific Islander          | 66 (46%)        | 78 (54%)            |         |
| Other                           | 0               | 7 (100%)            |         |
| Country of birth                |                 |                     | 0.005   |
| China                           | 61 (49%)        | 63 (51%)            |         |
| Other                           | 5 (19%)         | 22 (81%)            |         |
| Mother’s insurance              |                 |                     | 0.04    |
| Medicaid                        | 59 (48%)        | 65 (52%)            |         |
| Private                         | 6 (42%)         | 19 (76%)            |         |
| Other                           | 1 (50%)         | 1 (50%)             |         |

Disclosures. R. T. Chung, Gilead; Investigator, Research grant; Abbvie: Investigator, Research grant; Merck: Investigator, Research grant; Janssen: Investigator, Research grant; A. Butt, Merck: Investigator, Grant recipient.