Of 682 treatment referrals, 76 patients were denied or ineligible, two
n = 49, Gilead: Grant Investigator and Scientific Advisor,
work flow. Clinic referrals continue to grow, additional staff may further support organizational
are maintained, even in the large proportion of cirrhotic patients in our cohort. As
established clinic protocol and support of a multi-disciplinary team, high SVR rates
92.5% (210/227).

Most patients received ledipasvir/sofosbuvir (70%). Overall SVR rate was 93.5%
Week 4, end of treatment, and 12 weeks thereafter were collected.
HCV treatment burdens.
We present a clinic protocol with collaborative drug therapy management to alleviate
staffing to meet demands of screening efforts may prevent access to treatment. Recent
adverse events. Prior authorizations, complex treatment criteria, and inadequate clinic
HCV treatment due to high-sustained virologic response (SVR) rates and minimal
initiation, a plateau was reached.
Conclusion. Establishing a co-located HCV clinic within an HIV clinic has been
successful in facilitating pre-treatment evaluation with overall SVR achieved in 48% of
co-infected patients which compares favorably to published national HCV treatment
cascades in mono-infected patients. Additional patient and provider barriers to
complete clinic-wide HCV elimination are being analyzed. New approaches for promoting
eing engagement in care are needed.

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2235. A Collaborative Drug Therapy Management Model for the Treatment of Hepatitis C Virus (HCV) in an Urban Clinic
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Background. Direct-acting antivirals (DAAs) have changed the paradigm of
HCV treatment due to high-sustained virologic response (SVR) rates and minimal adverse events. Prior authorizations, complex treatment criteria, and inadequate clinic
staffing to meet demands of screening efforts may prevent access to treatment. Recent
literature suggests that pharmacist involvement in HCV treatment can optimize care. We present a clinic protocol with collaborative drug therapy management to alleviate
HCV treatment burdens.

Methods. A retrospective review of patients referred and evaluated for HCV
treatment between February 2014 and April 2018 at the Ruth M. Rothstein CORE
Center. Exclusion was no SVR12 data. Demographic data along with HCV RNA at
Week 4, end of treatment, and 12 weeks thereafter were collected.

Results. Of 682 treatment referrals, 76 patients were denied or ineligible, two
referred to study, and six not treated (lost to care, incarceration, or death). Of the
598 patients treated, complete data were available for 430. Of the remaining 168
patients, 72% have upcoming appts, 26% lost to follow-up, and 2% died. Mean age
was 57.6 years (range 22-82), 70.5% male, 67% black, 17.2% Hispanic, 12.8% White.
HCV genotype 1 were (47.2%) HCV/HIV co-infected. Majority were treatment naïve
(86.3%) and cirrhotic (42.1%) with a median Fibro Scan of 13 (range 3.4-75). Most
patients received ledipasvir/sofosbuvir (70%). Overall SVR rate was 93.5%
(402/430); HCV co-infected patients 94.6% (192/203) and mono-infected patients
92.5% (210/227).

Conclusion. A collaborative approach in HCV treatment allows us to overcome
adherence barriers such as health literacy, medication acquisition issues, and drug
interactions, as well as increase clinic productivity. A retrospective study may not
capture all pharmacist interventions that prevent lapses in therapy such as frequent
pharmacy calls and insurance resolution. However, this study shows that with an
established clinic protocol and support of a multi-disciplinary team, high SVR rates
are maintained, even in the large proportion of cirrhotic patients in our cohort. As clinic
referrals continue to grow, additional staff may further support organizational
work flow.

2236. Direct-Acting Antivirals: Efficacy in a Real-World, Urban, Undeserved, HIV-HCV Co-Infected Population
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Background. Clinical trials demonstrated high sustained virologic response
(SVR) rates for HIV-HCV co-infected patients treated for HCV with direct-acting
antivirals (DAAs). SVR data for real-world cohorts are increasingly available, yet lim-
ited in underserved populations. Individual and systematic barriers can limit treat-
ment success in underserved patient populations.

Methods. Investigators performed a retrospective cohort study of HIV-HCV
co-infected adult patients treated with DAAs in a hepatology clinic and an infectious
disease clinic network within an urban, academic medical center from February 2, 2014 to March 13, 2018. Patients were treated by multidisciplinary teams including
clinical pharmacists. DAA selection was based on the American Association for the
Study of Liver Disease and Infectious Diseases Society of America HCV Guidance
and the patient's insurance formulary at the time of treatment. For DAA-experienced
patients, results from the most recent DAA course were included. The primary out-
come was SVR at 12 weeks after HCV treatment completion. Descriptive statistics were
utilized to analyze data.

Results. Seventy-one patients started HCV treatment. SVR data were available
for 62 patients. Of those, the majority were Black (68%), genotype 1a (76%), cir-
rhotic (50%), HIV treatment-naïve (66%), on HIV antiretrovirals (97%), and insured
through Medicare or Medicaid (66%). Mean age was 59 (±8) years. Ledipasvir/sofo-
sbuvir (LDV/SOF) was the most commonly used DAA regimen (65%). Overall SVR
rate for all regimens was 94% (58/62 patients). SVR by DAA regimen was 75% for
LDV/SOF + ribavirin (3/4), 93% for LDV/SOF (37/40), and 100% for simeprevir +
SOF (6/6), SOF/velpatasvir (6/6), elbasvir/grazoprevir (4/4), and SOF + ribavirin (2/2).
The four treatment failures were cirrhotic patients with genotype 1a or 1b; three were
treatment-naïve and one was DAA-experienced.

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Consulting fee; Proteus: Grant Investigator, Grant recipient.
2237. Validity of Self-Reported HCV Status Among Justice-Involved Persons Living with HIV

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Background. The prevalence of hepatitis C virus (HCV) and human immunodeficiency virus (HIV)-1 co-infection among justice-involved persons is high and HCV health literacy is low. The validity of self-reported HCV status in this population has important implications for HCV testing and education programs inside correctional facilities and in the community after release, yet its assessment is limited.

Methods. HIV-positive justice-involved persons from the District of Columbia were enrolled into a study evaluating a health intervention for improved HCV treatment adherence and linkage to community-based HCV care. Participants completed a comprehensive medical intake and were randomized to receive either three-standard-doses HBV vaccination in HIV-infected adults with isolated anti-HBc antibody.

Results. Of 110 participants, 103 were available for HCV testing and were included in analyses. Twenty participants (19%) self-reported being HCV+(+6 of which 11 (55%) were HCV Ab(+) while all were HCV RNA(+) in total. Nine participants reported being HCV Ab(-) and HCV RNA(+) and one was HCV Ab(+) and HCV RNA(+) among the eight participants not reporting HCV infection. Thirty-six participants (33%) self-reported having a sigmoidoscopy or colonoscopy and among three participants in whom adenoma was detected, one had a sigmoidoscopy and two had a colonoscopy. Overall, self-report and lab results had a moderate agreement (Cohen’s Kappa = 0.60) and lab-confirmed prevalence of RNA(+) was 13%.

Conclusion. The validity of self-reported HCV status among justice-involved persons living with HIV was moderate. Only one-half of persons who reported HCV infection were confirmed to be HCV infected. In addition, two women (2.4%) who did not report HCV infection were found to be infected. These findings support the need for expanded HCV testing, counseling and education among justice-involved persons, with focused attention on justice-involved women who may be at particularly high risk for undiagnosed HCV.

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2238. Immunogenicity and safety of four- vs. three-standard doses HBV vaccina- tion in HIV-infected persons with isolated anti-HBc antibody

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Background. HIV-infected patients have decreased serological response to HBV vaccination with faster decline of protective antibody (Ab) titer. In those with isolated anti-HBc Ab, the role of vaccination remains controversial. We, therefore, conducted this study to assess the immunogenicity and safety of four-standard and standard doses HBV vaccination in HIV-infected adults with isolated anti-HBc antibody.

Methods. An open-label randomized controlled trial with 1:1 allocation was conducted among HIV-infected patients attending the Infectious Diseases clinic of the Maharaj Nakorn Chiang Mai Hospital, Faculty of Medicine Chiang Mai University, Chiang Mai, Thailand between July and September 2017. Eligibility participants must have reached the age of ≥18 years old, taking CART, CD4 ≥200 cells/mm³, HCV VL < 20 copies/mL, and positive isolated anti-HBc Ab. The participants were randomized to receive either three-standard-doses (20 μg at Month 0, 1, 6) or 3-standard-doses (20 μg at Month 0, 1, 2, 6) IM HBV vaccination and were evaluated for anamnestic response at Week 4 after vaccination. The anamnestic response occurred in 25.9% vs. 33.3% in three doses vs. four doses arm respectively (P = 0.551). After vaccination, the response rates at Week 28 were 85.2% in three doses arm vs. 88.9% in four doses arm (P = 0.1000); were 44.4% vs. 63.9% being high level responders, respectively (P = 0.172). GMT of anti-HBs Ab at Week 28 in three doses arm and four doses arm were 63.8 and 209.8 mIU/mL, respectively, P = 0.030. No adverse events were reported. A younger age (<45 years old) and higher nadir CD4 count (≥200 cells/mm³) were independent predictive factors of anamnestic response with the odd ratio (OR) of 17.4 (95% CI 3.0–102.0) and 21.6 (95% CI 2.7–170.4) respectively. No predictive factors of responders at Week 28 were found.

Conclusion. In Thai HIV-infected patients with isolated anti-HBc Ab, anamnestic response occurred respectively with both regimens, but the majority was still unprotected. Hence, a single dose vaccination is insufficient. The usual three-standard-doses vaccination was highly effective with high response rate.

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2239. Colorectal Cancer Screening Rates and Outcomes in HIV-Infected and HIV- Uninfected Individuals

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Background. As people with HIV live longer, age-appropriate colorectal cancer (CRC) screening will be an increasingly important component of care. However, it remains unclear whether CRC screening guidelines for the general population, which recommend screening of average-risk persons starting at age 50, are appropriate for people with HIV particularly those with advanced HIV disease.

Methods. We compared CRC screening rates and outcomes among HIV-infected and demographically-matched HIV-uninfected subjects in a large integrated health-care system. Using electronic health records, we identified subjects aged 50–75 years old with CRC screening. We evaluated time to first CRC screen (FIT, sigmoidoscopy or colonoscopy) using Kaplan–Meier estimates, and compared adenoma and CRC prevalence following first sigmoidoscopy or colonoscopy, by HIV status. Adjusted prevalence ratios (PR) accounted for age, sex, race, smoking status, body mass index, and diagnosis of type 2 diabetes or inflammatory bowel disease.

Among HIV-infected subjects, we also evaluated whether CD4 count (<200, 200–499, ≥500) was associated with screening outcome.

Results. Among 3,177 HIV-infected and 29,219 HIV-uninfected CRC screen- ing eligible subjects, HIV-infected persons were more likely to be screened within 5 years of health plan enrollment or turning 50 (85.6% vs. 79.1%; P < 0.001). Among those with a sigmoidoscopy or colonoscopy, adenoma was detected in 161 (19.6%) HIV-infected and 1,498 (22.6%) HIV-uninfected subjects (P = 0.048) and CRC was detected in 70 (0.5%) HIV-infected and 543 (0.7%) HIV-uninfected subjects (P = 0.13).

We found suggestion of a lower prevalence of adenoma and CRC among HIV-infected subjects, which only reached statistical significance in unadjusted models (unadjusted PR: 0.86, 95% CI: 0.75–1.00, P = 0.049; adjusted PR: 0.89, 95% CI: 0.77–1.03, P = 0.134). Lower CD4 count did not increase likelihood of a positive CRC screening result.

Conclusion. In a setting with overall high screening uptake, we found similar adenoma and CRC prevalence in individuals with and without HIV. Our findings sug- gest that current CRC screening guidelines for the general population are also suitable for the HIV population.

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2240. Characteristics of Lung Cancer Treatment in Recent ART-era HIV+ Patients Takaaki Kobayashi, MD*; Kimberly Stone, MPH; Keith Sigel, MD, PhD;* Internal Medicine, Mount Sinai Beth Israel, New York, New York, 2Medicine, Ichan School of Medicine at Mount Sinai, New York, New York, 3Department of Medicine, Division of Infectious Disease, Ichan School of Medicine at Mount Sinai, New York, New York

Session: 240. HIV: Malignancy
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Background. Human immunodeficiency virus (HIV) infection is independently associated with lung cancer risk. Due to the aging of the U.S. HIV+ cohort, a high prev- alence of smoking and lower rates of HIV-related mortality, lung cancer is now a major source of mortality in this group. Little is known about the tolerability of lung cancer treatment in HIV+ persons in the recent antiretroviral therapy (ART) era.

Methods. We identified all patients and controls of four and more years of age with an incident of lung cancer between 2005 to 2016 with no prior CRC screening. We evaluated time to first CRC screen (FIT, sigmoidoscopy or colonoscopy) using Kaplan–Meier estimates, and compared CRC screening rates and outcomes among HIV-infected patients, which only reached statistical significance in unadjusted models (unadjusted PR: 0.86, 95% CI: 0.75–1.00, P = 0.049; adjusted PR: 0.89, 95% CI: 0.77–1.03, P = 0.134). Lower CD4 count did not increase likelihood of a positive CRC screening result.

Conclusion. In a setting with overall high screening uptake, we found similar adenoma and CRC prevalence in individuals with and without HIV. Our findings sug- gest that current CRC screening guidelines for the general population are also suitable for the HIV population.

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