Table 2: On treatment % with decline in eGFR and % developing grade 3/4 anemia in persons treated with sofosbuvir/aimprevir and paritaprevir/ritonavir/ombitasvir + dasabuvir regimens

| Baseline eGFR | eGFR stage | SOF/LDV, no RBV | P-value (SOF vs. PRD) |
|--------------|------------|-----------------|-----------------------|
| CKD 1-2 | 3-15.99 | 35.1 | 251.35 | 10.020 | 0.596 |
| CKD 3 | 22.56 | 16.8 | 23.15 | 0.045 |
| CKD 4 | 22.56 | 16.8 | 23.15 | 0.045 |

Disclosures. A. Butt, Merck: Investigator, Grant recipient; A. Puenpatom, Merck: Employee, Salary; J. M. Arduino, Merck: Employee, Salary; R. Kumar, Merck: Employee, Salary.

520. Factors Associated with Appropriate Hepatocellular Carcinoma (HCC) Screening Among Chronic Hepatitis C (HCV) Patients with Cirrhosis at an Urban Safety-net Hospital System
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Background. The proportion of HCV-exposed infants with a claim for HCV testing is low in the KY Medicaid population; testing for other perinatally-acquired infections is even less common. Children with NAS were less likely to be tested. Statewide guidelines for appropriate testing in children with perinatal HCV exposure and NAS are urgently needed.

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522. Fibrosis Progression and Incidence of Cirrhosis and Hepatic Decompensation in Persons Treated with Paritaprevir/Ritonavir/Ombitasvir/Dasabuvir: Results from EICHVIES
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Background. Data are limited regarding the effect of paritaprevir/ritonavir, ombitasvir, dasabuvir regimen (PRD) upon the rate of liver fibrosis progression and incidence of cirrhosis and hepatitis decompensation after treatment for HCV.

Methods. Within EICHVIES (Electronically Retrieved Cohort of HCV Infected Veterans), we identified HCV infected persons treated with PRD and treatment-naïve controls to determine the effect of PRD treatment upon subsequent progression of fibrosis and incident cirrhosis and hepatic decompensation. Controls were propensity-score matched based on demographic and clinical characteristics. We excluded those with HIV coinfection, positive HBsAg, hepatocellular carcinoma at baseline and those with missing HCV RNA or FIB-4 scores. Fibrosis progression and liver cirrhosis were assessed using the FIB-4 score.

Results. The final propensity score matched sample included 1,473 PRD-treated individuals, and an equal number of matched, untreated controls. PRD-treated patients had significantly reduced median FIB-4 scores over time, compared with controls (median absolute change in FIB-4 = -0.7 [IQR -1.51, -0.3] vs. +0.06 [IQR -0.38, 0.49]; P = 0.001). Compared with matched controls, PRD-treated patients had an 86% relative reduction in the risk of incident cirrhosis over 2,241 patient-years of follow-up (adjusted HR 0.14 [95% CI 0.08-0.23]). Treatment with PRD was also associated with delayed time to first hepatic decompensation event (P < 0.001). In sensitivity analysis, the exclusion of patients with baseline cirrhosis did not materially alter the estimates of effect.

Conclusion. Treatment with PRD is associated with a significant reduction in fibrosis progression, a longer time to the development of cirrhosis, and reduced risk of are also at risk for HIV and syphilis as well as neonatal abstinence syndrome (NAS). A substantial portion of HCV-exposed children are insured by Medicaid. The patterns of testing in this population are unknown. We sought to assess HCV-exposed children pattern of testing for HCV and other perinatal infections in children insured by KY Medicaid.

Methods. We identified HCV-exposed infants (ICD-10-CM code Z20.5) insured by KY Medicaid from 10/1/15 to 9/30/16. The primary outcome was HCV testing by PCR (CPT 87520 (HCV, direct probe), 87521 (HCV, amplified probe), 87522 (HCV RNA, Quantitative)) or antibody (CPTs 86803-4). Testing for HIV (CPTs 86701, 86702, 87396, 87395-3, and syphilis (CPT 86592) was also recorded. NAS was defined as presence of ICD-10-CM code P96.1 in any diagnosis field. Descriptive statistics were used.

Results. During the study period, 625 children with 4005 [median 3, Interquartile range (IQR) 1–8] claims were HCV-exposed. The majority of children were white (393, 76%), non-Hispanic (420, 67%) and male (318, 51%). Patterns of testing are shown in the Table.

Table: Medicaid claims for tests performed in children perinatally exposed to HCV

| Test          | Number of Children* (%) | Median Age (months) IQR |
|--------------|--------------------------|-------------------------|
| HCV PCR      | 69 (11)                  | 77                      |
| HCV antibody | 11 (2)                   | 12                      |
| HIV PCR      | 30 (6)                   | 32                      |
| HIV antibody | 8 (1)                    | 9                       |
| Syphilis     | 26 (4)                   | 26                      |

* A child may have been tested for more than one infection during the study period.

Among HCV-exposed, 197 (32%) were diagnosed with NAS; but only 3 (1.5%) of these children were tested for perinatal infections whereas 84 (19.6%) of children with no documented NAS were tested (P < 0.001).
524. Racial/Ethnic and Socioeconomic Disparities in Initiation of Direct-Acting Antiviral Agents for Hepatitis C Virus in an Insured Population

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Background. The high cost of direct-acting antiviral agents (DAAs) for hepatitis C virus (HCV) infection may present a barrier to access, thus contributing to disparities in treatment. However, few real-world data exist on factors associated with DAA uptake.

Methods. We conducted an observational study of Kaiser Permanente Northern California members with HCV infection, defined as a positive HCV RNA test or an antibody test, during the recent DAA era (i.e., October 2014–December 2016). To evaluate factors independently associated with DAA initiation, an adjusted Poisson regression model was used. Age, sex, race/ethnicity, census-based neighborhood deprivation index, HCV genotype, advanced fibrosis (i.e., Fibroscan >9.5 kPa, if available; else FIB-4 >3.25), prior HCV treatment, drug abuse diagnosis, smoking, alcohol use, and drug abuse per week, HIV infection, and hepatitis B virus infection were evaluated. Results. We identified 18,140 HCV-infected individuals, of whom 6,167 (34%) initiated DAA treatment. Treatment was less likely among Black (risk ratio [RR] 0.83, 95% confidence interval [CI]: 0.79–0.88) and Hispanic individuals (RR 0.92, 95% CI: 0.87–0.98) compared with White individuals, and among individuals with greater neighborhood-level economic disadvantage (quartile 3 vs. 1: RR 0.89, 95% CI: 0.85–0.84; quartile 4 vs. 1: RR 0.79, 95% CI: 0.75–0.83). Treatment was also less likely among those with a history of drug abuse (RR 0.87, 95% CI: 0.82–0.91), smoking (RR 0.84, 95% CI: 0.80–0.87), or more alcohol drinks per week (1–7 vs. 0 drinks: RR 0.88, 95% CI: 0.82–0.83; 8–16 vs. 0 drinks: RR 0.72, 0.63–0.82; ≥17 vs. 0 drinks: RR 0.63, 95% CI: 0.49–0.80). There was a higher likelihood of treatment among individuals with advanced fibrosis (RR 1.39, 95% CI: 1.34–1.44), HCV genotype 1 (RR 1.97, 95% CI: 1.87–2.08), no prior HCV treatment (RR 1.44, 95% CI: 1.37–1.52), or HIV infection (RR 1.19, 95% CI: 1.08–1.30).

Conclusion. Although clinical factors appear to drive HCV treatment decisions, racial/ethnic and socioeconomic disparities exist in DAA uptake. Lifestyle factors, such as alcohol use and drug abuse, may also influence patient or provider decision-making regarding DAA initiation. Strategies are needed to ensure equitable access to DAAs, even in insured populations.

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