ViiV who didn’t common reason. Out of the patients that had DXA scans, 19 (39%) were found to have test ordered by another provider. Of the 89 patients referred for DXA, only 49 (47%) were selected randomly. Data regarding referral for DXA (dual X-ray absorptiometry) scan, its results, and their insurance provider was collected. The plan was to analyze how the prevalence of abnormal BMD, from 47-93%. Interestingly, the prevalence of low BMD in our cohort was close to the national average in non-HIV patients.

Disclosures. All Authors: No reported disclosures

830. Central Nervous System Involvement in Disseminated Mycobacterium avium Complex Infection in Patients with Newly Diagnosed HIV
Antonio Camiño, MD, MSc; Andrea Llamas-López, MD,
Mercedes Aranza-Audelo, M.D.; David H. Martinez-Oliva, M.D.; Estefanía Sierra-Iracheta, MD; Patricia Rodriguez-Zulueta, MD; Centro Médico ABC, Mexico City, Distrito Federal, Mexico; Hospital General Dr. Manuel Gea González, Mexico City, Distrito Federal, Mexico

Session: P-46. HIV: Complications and Co-infections

Background. With HIV therapy, the life expectancy of persons with HIV (PWH) has improved and complications associated with long-standing HIV and antiretroviral drugs have become more apparent. Low bone mineral density (BMD) (defined by T score < -1) and osteoporosis (defined by T-score < -2.5) are common in PWH. In a meta-analysis of 884 HIV-infected patients, 67% had reduced BMD, of whom 15% had osteoporosis which is 3 times greater than HIV uninfected controls. EDAs guidelines recommend routine screening for osteoporosis in PWH aged ≥ 50 years, yet the rate of screening for osteoporosis in these patients remains low (7.4%-17%). This QI project aimed to estimate the frequency of and identify the barriers to screening for osteoporosis in PWH aged ≥ 50 years.

Methods. We conducted a retrospective case series in the outpatient infectious diseases clinic in the hospital "Dr. Manuel Gea González" in Mexico City. We reviewed all records from October 2020 to May 2021 and identified all culture proven MAC infections.

Results. We found 7 cases of MAC, with disseminated infection (positive bone marrow cultures) with 3 out of those 7 meeting our definition for CNS-MAC (positive cerebrospinal fluid culture). All cases of CNS-MAC infection occurred in patients with < 50 CD4/mm^3 and recent HIV diagnosis (1-4 months) that were referred to our institution with consumptive syndrome and fevers. All patients were receiving antiretroviral treatment (ART) with RIC/FTC/TAF and initiated ART in less than 1 month since HIV diagnosis. Opportunistic infections were ruled-out at the moment of CNS-MAC diagnosis (cerebrospinal meningitis, cytomegalovirus retinitis, tuberculosis and histoplasmosis). All patients exhibited non-specific neurologic symptoms at arrival (headache and bradipsquia) mixed with more severe symptoms (one case of ataxia, one case of vertigo, one case of III nerve palsy). All patients were treated with Clarithromycin/Levofloxacin/Ethambutol. Two patients achieved symptom remission and 1 patient was lost to follow-up. Of important note, all CSF analysis and CNS imaging studies carried-out were normal. No MAC bacilli were identified with direct Ziel-Neelsen staining of CSF.

Conclusion. We found a high proportion of CNS-MAC in patients with disseminated MAC infection (42.8%) during the study period. All patients presented CNS symptoms and normal CSF characteristics. In our setting, patients with suspected disseminated MAC infection CD4 counts < 50 cells/mm^3 might represent a specific population that could benefit from routine targeted diagnostic test at presentation in order to establish CNS involvement.

Disclosures. All Authors: No reported disclosures

831. Hepatitis C Virus Micro-elimination Within a Human Immunodeficiency Virus Clinic: Challenges in the Home Stretch
Jakin Hana, PharmD1; Jin S. Suh, MD1; Humanto Jimenez, PharmD3; Mount Sinai hospital, New York, New York; 1St. Joseph's University Medical Center, Ridgewood, New Jersey; 3St. Joseph’s University Medical Center, Paterson, New Jersey

Session: P-46. HIV: Complications and Co-infections

Background. Hepatitis c virus (HCV) eradication among persons with HIV (PWH) is alluring since DAAs efficacy is high regardless of HIV status and PWH in care are usually screened for HCV. Despite the potential, barriers to care have prevented many from achieving sustained virologic response (SVR). We performed a pharmacist-led campaign to reduce the proportion of PWH with active HCV and describe the barriers to care.

Disclosures. Jason J. Schafer, PharmD, MPH, Gilead (Advisor or Review Panel member, Research Grant or Support)
Grant/Research Support
HIV/HCV co-infection was present in 10 (1%) of 1045 participants, participants with HIV-1 RNA < 50 c/mL receiving CAB + RPV LA (Employee, Shareholder).

Models analyzed each outcome as a function of BMI, controlling for age, sex, race, and weight (NW; 18.5-< 25), overweight (OW; 25-< 30) and obese (OB; ≥ 30). Multivariable models analyzed each outcome as a function of BMI, controlling for age, sex, race, and weight (NW; 18.5-< 25), overweight (OW; 25-< 30) and obese (OB; ≥ 30).

Conclusion. Pharmacists can impact the burden of HCV among PWH receiving care. The HCV care cascade remains tied to the HIV continuum of care, with disengagement from care remaining an important rate-limiting step impeding micro-elimination.

Disclosures. Jennifer Ken-Opurum, PhD, Kantar Health (Employee) Girish Prajapati, M.B.B.S., MPH, Merck & Co., Inc. (Employee, Shareholder) Joana E. Matos, PhD, Kantar Health (Employee) Princy N. Kumar, MD, AMGEN (Other Financial or Material Support, Honoraria) Eli Lilly (Grants/Research Support) Gilead (Grants/Research Support, Shareholder, Other Financial or Material Support, Honoraria) GSK (Grants/Research Support, Shareholder, Other Financial or Material Support, Honoraria) Merck & Co., Inc. (Employee, Shareholder, Other Financial or Material Support, Honoraria)

Table 1. Comorbidity Burden and Quality of Life in People Living with HIV by BMI Categories

| BMI Category | Normal Weight (n=223) | Overweight (n=199) | Obese (n=148) |
|--------------|-----------------------|-------------------|--------------|
| Cognitive Component Summary scores (MCS and PCS) | | | |
| Cognitive Component Summary scores (MCS and PCS) | | | |
| EQ-VAS score, mean (SD) | 69.3 (24.1) | 69.4 (26.6) | 65.3 (23.99) |
| SF-36 | 43.4 (12.2) | 46.1 (12.9) | 44.3 (12.5) |

Disclosures. Jennifer Ken-Opurum, PhD, Kantar Health (Employee) Girish Prajapati, M.B.B.S., MPH, Merck & Co., Inc. (Employee, Shareholder) Joana E. Matos, PhD, Kantar Health (Employee) Princy N. Kumar, MD, AMGEN (Other Financial or Material Support, Honoraria) Eli Lilly (Grants/Research Support) Gilead (Grants/Research Support, Shareholder, Other Financial or Material Support, Honoraria) GSK (Grants/Research Support, Shareholder, Other Financial or Material Support, Honoraria) Merck & Co., Inc. (Employee, Shareholder, Other Financial or Material Support, Honoraria)

833. Efficacy and Safety of Long-Acting Cabotegravir + Rilpivirine in Participants with HIV/HCV Co-infection: ATLAS-2M 48-Week Results

Ronald D'Amico, DO, MSc; Paul Benn, MB CHB FRCP; Shanker Thakiarajah, MB CHB; Susan L. Ford, PharmD; Eileen Birmingham, MD, MPH; Ojesh R. Upadhayay, MPhil, MRA; Louise Gar dassi, PhD; Rodica Van Solingen-Rutjes, MD; Kati Vandermeulen, MSc; William Speeren, PharmD; ViV Healthcare, Research Triangle Park, NC; GlafoxSmithKline, London, England, United Kingdom; Janssen Research and Development, Raritan, New Jersey; Janssen Research & Development, LLC, Beers, Antwerp, Belgium; Janssen R&D, Beers, Antwerp, Belgium

Session P-46. HIV: Complications and Co-infections

Background. The phase IIIb ATLAS-2M study demonstrated non-inferiority of long-acting (LA) cabotegravir (CAB) + rilpivirine (RPV) dosed every 4 weeks (QW) compared with every 4 weeks (Q4W) for maintenance of virologic suppression. Hepatitis C virus (HCV) co-infection occurs in ~6% of people with HIV due to shared modes of transmission. We report efficacy and safety of CAB + RPV LA in participants with HIV/HCV co-infection in ATLAS-2M.

Methods. Participants with HIV-1 RNA < 50 c/mL receiving CAB + RPV LA Q4W (transitioned from ATLAS [NCT02951052]) or oral comparator ART were randomized 1:1 to receive CAB + RPV LA Q4W or QW. Baseline HCV RNA was assessed by polymerase chain reaction. Participants with symptomatic chronic HCV infection requiring treatment within 12 months or liver enzymes not meeting entry criteria were excluded. Week 48 assessments included proportion with HIV-1 RNA ≥50 and < 50 c/mL (Snapshot algorithm), general and hepatic safety, and pharmacokinetics.

Results. HIV/HCV co-infection was present in 10% (1045 participants, 60% of whom were female at birth. At Week 48, 9/10 (90%) and 972/1035 (94%) participants with HIV/HCV co-infection and HIV mono-infection, respectively, had HIV-1 RNA < 50 c/mL (adjusted difference: 4.1; 95% CI, −14.5 to 2.2). No participants with HIV/HCV co-infection had HIV-1 RNA ≥ 50 c/mL (vs 14/1035 [1%] with HIV mono-infection) or confirmed virologic failure through Week 48 (vs 10 [1%] with HIV mono-infection); 1/10 (10%) discontinued for reasons other than adverse events (AEs). Excluding injection site reactions (ISRs), AEs and serious AEs were reported in 4 (40%) and 0 participants with HIV/HCV co-infection, respectively; the only AE reported in >1 participant was injection site pain (n=5; 50%). In participants with HIV/HCV co-infection, all ISRs were grade 1/2; none led to withdrawal. No hepatic or hematology abnormalities were reported in participants with HIV/HCV co-infection through Week 48; rates were low in those with HIV mono-infection (Table). Plasma CAB and RPV concentrations were similar between groups.

Session P-46. HIV: Complications and Co-infections

Background. The phase IIIb ATLAS-2M study demonstrated non-inferiority of long-acting (LA) cabotegravir (CAB) + rilpivirine (RPV) dosed every 8 weeks (QW) compared with every 4 weeks (Q4W) for maintenance of virologic suppression. Hepatitis C virus (HCV) co-infection occurs in ~6% of people with HIV due to shared modes of transmission. We report efficacy and safety of CAB + RPV LA in participants with HIV/HCV co-infection in ATLAS-2M.

Methods. Participants with HIV-1 RNA < 50 c/mL receiving CAB + RPV LA Q4W (transitioned from ATLAS [NCT02951052]) or oral comparator ART were randomized 1:1 to receive CAB + RPV LA Q4W or QW. Baseline HCV RNA was assessed by polymerase chain reaction. Participants with symptomatic chronic HCV infection requiring treatment within 12 months or liver enzymes not meeting entry criteria were excluded. Week 48 assessments included proportion with HIV-1 RNA ≥50 and < 50 c/mL (Snapshot algorithm), general and hepatic safety, and pharmacokinetics.

Results. HIV/HCV co-infection was present in 10% (1045 participants, 60% of whom were female at birth. At Week 48, 9/10 (90%) and 972/1035 (94%) participants with HIV/HCV co-infection and HIV mono-infection, respectively, had HIV-1 RNA < 50 c/mL (adjusted difference: 4.1; 95% CI, −14.5 to 2.2). No participants with HIV/HCV co-infection had HIV-1 RNA ≥ 50 c/mL (vs 14/1035 [1%] with HIV mono-infection) or confirmed virologic failure through Week 48 (vs 10 [1%] with HIV mono-infection); 1/10 (10%) discontinued for reasons other than adverse events (AEs). Excluding injection site reactions (ISRs), AEs and serious AEs were reported in 4 (40%) and 0 participants with HIV/HCV co-infection, respectively; the only AE reported in >1 participant was injection site pain (n=5; 50%). In participants with HIV/HCV co-infection, all ISRs were grade 1/2; none led to withdrawal. No hepatic or hematology abnormalities were reported in participants with HIV/HCV co-infection through Week 48; rates were low in those with HIV mono-infection (Table). Plasma CAB and RPV concentrations were similar between groups.