The HIV/HCV Co-Infection Watch is a publication of the Community Access National Network (CANN). It is a patient-centric informational portal serving three primary groups – Patients, Healthcare Providers, and AIDS Service Organizations.

Learn more: http://www.tiicann.org
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Overview

The HIV/HCV Co-Infection Watch is a project of the Community Access National Network (CANN) designed to research, monitor and report on HIV and Hepatitis C (HCV) co-infection in the United States. The HIV/HCV Co-Infection Watch delivers the information from a “patient-centric” perspective on access to care and treatment.

People living with HIV-infection face a higher risk of long-term liver failure as a result of co-infection with HCV. In fact, HCV-related liver failure has become the leading non-AIDS-related cause of death among people living with HIV-infection in the United States – and as such, treating HCV is of paramount importance.

With well over half of the HCV-infected population falling near, at, or below the Federal Poverty Limit (FPL), patients frequently rely on coverage provided by state- and federally-funded programs – such as the AIDS Drugs Assistance Program (ADAP), Medicaid and Medicare. It is for these patients, and those who still, for whatever reason, lack coverage, that the HIV/HCV Co-Infection Watch advocates.

The research component of the HIV/HCV Co-Infection Watch is designed to gather the following information:

• Formulary information in every state and territory covered by ADAP, as it relates to coverage for HCV drug therapies.
• Formulary information for HCV drug therapies covered by the State Medicaid programs.
• Formulary information for HCV drug therapies covered by the Veterans Affairs system.
• Information about patient assistance programs (PAPs).
• State-by-state harm reduction data for HIV, HCV, and HIV/HCV co-infection, as well as relevant public policy changes.
• Up-to-date information as it relates to HCV treatment under the U.S. Department of Veterans Affairs.
• Statistics related to HIV/HCV co-infection (i.e., Existing Diagnoses, New Diagnoses, and Morbidity Rates).

For the purposes of this report, coverage is divided into three categories:

• No Coverage – no HCV treatments are covered
• Basic Coverage – only older HCV regimens (Ribavirin, Pegylated-Interferon, etc.) are covered; no Direct Acting Antivirals
• Expanded Coverage – Direct Acting Antivirals are covered

The HIV/HCV Co-Infection Watch list-serve sign-up form is available online: [http://tiicann.org/signup_listserv.html](http://tiicann.org/signup_listserv.html)
Findings

The following is a summary of the key findings for January 2020:

- **AIDS Drug Assistance Programs**
  There are 56 State and Territorial AIDS Drug Assistance Programs (ADAPs) in the United States, 47 of which offer some form of coverage for Hepatitis C (HCV) treatment. Of those programs, 44 have expanded their HCV coverage to include the Direct-Acting Antiviral (DAA) regimens that serve as the current Standard of Care (SOC) for Hepatitis C treatment. 3 programs offer only Basic Coverage and 9 programs offer No Coverage. Three (3) territories – American Samoa, Marshall Islands, and Northern Mariana Islands – are not accounted for in this data. A state-by-state Drug Formulary breakdown of coverage is included in Figure 1, with accompanying drug-specific maps in Figures 2 – 12.

- **Medicaid Programs**
  There are 59 State and Territorial Medicaid programs in the United States, and data is represented for all fifty states and the District of Columbia. As of October 01, 2016, all 50 states and the District of Columbia offer Expanded Coverage. A state-by-state PDL breakdown of coverage is included in Figure 13, with accompanying drug-specific maps in Figures 14 – 24.

- **Harm Reduction Programs:**
  Every State and Territory in the United States currently provides funding for low-income people living with substance abuse issues to enter state-funded rehabilitation services (National Center for Biotechnology Information, n.d.). 47 States and Territories currently have Syringe Services Programs (SSPs) in place, regardless of the legality. 50 states and the District of Columbia have expanded access to Naloxone to avert opioid drug overdoses. 50 states and the District of Columbia have Good Samaritan laws or statutes that provide some level of protection for those rendering emergency services during drug overdoses. 38 states make reporting to Prescription Drug Monitoring Programs (PDMPs) mandatory, requiring physicians and/or pharmacists to report prescriptions written or filled to a state agency for monitoring. 40 states have Opioid-Specific Doctor Shopping Laws preventing patients from attempting to receive multiple prescriptions from numerous physicians, and/or from withholding information in order to receive prescriptions. 40 states mandate a Physical Exam Requirement in order for patients to receive a prescription for opioid drugs. 27 states have in place an ID Requirement mandating that people filling opioid prescriptions present a state-issued ID prior to receiving their prescription. 45 states require prescribing physicians to attend mandatory and continuing opioid prescribing education sessions. 44 states have Medicaid doctor/pharmacy Lock-In programs that require patients to receive prescriptions from a single physician and/or fill prescriptions from a single pharmacy. A state-by-state program breakdown is included in Figure 27, with accompanying drug-specific maps in Figures 28 – 36.
AIDS Drug Assistance Programs (ADAPs) & HCV Treatments

Figure 1. – Figure 12.
# AIDS Drug Assistance Programs (ADAPs) & HCV Treatments

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## AIDS Drug Assistance Programs (ADAPs) & HCV Treatments

**Figure 1. (* Indicates “Preferred Drug”) Con’t.**

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### AIDS Drug Assistance Programs (ADAPs) & HCV Treatments

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AIDS Drug Assistance Programs (ADAPs) & HCV Treatments

There are currently 46 AIDS Drug Assistance Programs (ADAPs) that cover some form of HCV drug therapies as part of their approved drug formularies. To learn more about ADAPs or their approved drug formularies, please visit http://adap.directory.

Figure 2.
Basic Coverage Map Key:
- Lime Green: Basic Coverage
- Red: No Coverage
AIDS Drug Assistance Programs (ADAPs) & HCV Treatments
Sovaldi Coverage Map
January 2020

Figure 3.
Sovaldi Coverage Map Key:
Lime Green: Coverage
Red: No Coverage
AIDS Drug Assistance Programs (ADAPs) & HCV Treatments
Harvoni Coverage Map
January 2020

Figure 4.
Harvoni Coverage Map Key:
Lime Green: Coverage
Red: No Coverage
AIDS Drug Assistance Programs (ADAPs) & HCV Treatments

Viekira Pak Coverage Map
January 2020

Figure 5.
Viekira Pak Coverage Map Key:
Lime Green: Coverage
Red: No Coverage
AIDS Drug Assistance Programs (ADAPs) & HCV Treatments

Daklinza Coverage Map
January 2020

Figure 6.
Daklinza Coverage Map Key:
Lime Green: Coverage
Red: No Coverage
AIDS Drug Assistance Programs (ADAPs) & HCV Treatments

Zepatier Coverage Map
January 2020

Figure 7.
Zepatier Coverage Map Key:
Lime Green: Coverage
Red: No Coverage
AIDS Drug Assistance Programs (ADAPs) & HCV Treatments

Epclusa Coverage Map
January 2020

Figure 8.
Epclusa Coverage Map Key:
Lime Green: Coverage
Red: No Coverage
AIDS Drug Assistance Programs (ADAPs) & HCV Treatments

Vosevi Coverage Map
January 2020

Figure 9.
Vosevi Coverage Map Key:
Lime Green: Coverage
Red: No Coverage
AIDS Drug Assistance Programs (ADAPs) & HCV Treatments
Mavyret Coverage Map
January 2020

Figure 10.
Mavyret Coverage Map Key:
Lime Green: Coverage
Red: No Coverage

![Mavyret Coverage Map](image-url)
AIDS Drug Assistance Programs (ADAPs) & HCV Treatments

Harvoni Generic Coverage Map
January 2020

Figure 11.
Harvoni Generic Coverage Map Key:
Lime Green: Coverage
Red: No Coverage
AIDS Drug Assistance Programs (ADAPs) & HCV Treatments

Epclusa *Generic* Coverage Map
January 2020

**Figure 12.**
Epclusa *Generic* Coverage Map Key:
- Lime Green: Coverage
- Red: No Coverage

![Map of AIDS Drug Assistance Programs (ADAPs) & HCV Treatments](image)
AIDS Drug Assistance Programs (ADAPs) & HCV Treatments

Of the 56 respective State and Territorial ADAPs, only 9 (ID, KS, KY, OH, UT, VT, GU, PW, VI) do not offer any coverage for HCV drug therapies. States whose formularies are not available on the state-run website have been checked against the most recent National Alliance of State and Territorial AIDS Directors (NASTAD) formulary database (last updated February 15, 2019). The data presented are current as of January 15, 2020.

January 2020 Updates:
• No Updates

January 2020 Notes:
• States with Open Formularies: IL, IA, MA, MN, NE, NH, NJ, NM, ND, OH, OR, WA, WY
  – N.B. – Although Ohio is listed by NASTAD as having an open formulary, both NASTAD’s ADAP Formulary Database and Ohio’s ADAP website indicates that the state does not offer any treatment for HCV
  – N.B. – Although North Dakota has adopted an open formulary, they provide only co-pay and deductible assistance for HCV medications
  – N.B. – Wyoming’s ADAP Open Formulary document, the following disclaimer related to HCV is made: Hepatitis C treatment medications (i.e. Harvoni, Viekira XR, Sovaldi, Ribavirin, Zepatier, Technivie, Daklinza, Epclusa) must be prior authorized. To be eligible, clients must have applied for prior authorization from their insurance plan and the WY ADAP Hepatitis C Treatment checklist must be completed and signed by the provider and client
• Colorado’s ADAP offers five coverage options – Standard ADAP, HIV Medical Assistance Program (HMAP), Bridging the Gap Colorado (BTGC), HIV Insurance Assistance Program (HIAP), and Supplemental Wrap Around Program (SWAP). ‘Yes’ indications in Figure 1. for Colorado denote that at least one of these programs offers coverage for each respective drug. The Standard ADAP Formulary covers medications only if funds are available to do so
• Louisiana’s ADAP (Louisiana Health Access Program – LA HAP) offers two coverage options – Uninsured (Louisiana Drug Assistance Program – L-DAP) and Insured (Health Insurance Program – HIP). HIP pays for the cost of treatment only if the client’s primary insurance covers the drug under its formulary
Medicaid Programs & HCV Treatments

Figure 13. – Figure 24.
### Medicaid Programs & HCV Treatments

**Figure 13. (*) Indicates “Preferred Drug”**

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## Medicaid Programs & HCV Treatments

**Figure 13. ( * Indicates “Preferred Drug”) Con’t.**

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## Medicaid Programs & HCV Treatments

**Figure 13. (* Indicates “Preferred Drug”) Con’t.**

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**Medicaid Programs & HCV Treatments**

There are currently **51** Medicaid programs that cover some form of HCV-related drug therapies as part of their Preferred Drug Lists. To learn more about Medicaid or their Preferred Drug Lists, please visit [http://medicaiddirectors.org](http://medicaiddirectors.org).

**Figure 14.**

Basic Coverage Map Key:
- Light Blue: Covered
- Yellow: Not Covered
Medicaid Programs & HCV Treatments
Sovaldi Coverage Map
January 2020

Figure 15.
Sovaldi Coverage Map Key:
Light Blue: Covered
Yellow: Not Covered
**Medicaid Programs & HCV Treatments**

Harvoni Coverage Map
January 2020

**Figure 16.**
Harvoni Coverage Map Key:
Light Blue: Covered
Yellow: Not Covered
Medicaid Programs & HCV Treatments

Viekira Pak Coverage Map
January 2020

Figure 17.
Viekira Pak Coverage Map Key:
Light Blue: Covered
Yellow: Not Covered
Medicaid Programs & HCV Treatments

Daklinza Coverage Map
January 2020

Figure 18.
Daklinza Coverage Map Key:
Light Blue: Covered
Yellow: Not Covered
Medicaid Programs & HCV Treatments

Zepatier Coverage Map
January 2020

Figure 19.
Zepatier Coverage Map Key:
Light Blue: Covered
Yellow: Not Covered
Medicaid Programs & HCV Treatments
Epclusa Coverage Map
January 2020

Figure 20.
Epclusa Coverage Map Key:
Light Blue: Covered
Yellow: Not Covered
Medicaid Programs & HCV Treatments

Vosevi Coverage Map
January 2020

Figure 21.
Vosevi Coverage Map Key:
Light Blue: Covered
Yellow: Not Covered
Medicaid Programs & HCV Treatments

Mavyret Coverage Map
January 2020

Figure 22.
Mavyret Coverage Map Key:
Light Blue: Covered
Yellow: Not Covered
Figure 23.
Harvoni Generic Map Key:
- Light Blue: Covered
- Yellow: Not Covered
Medicaid Programs & HCV Treatments

Epclusa Generic Coverage Map
January 2020

Figure 24.
Epclusa Generic Coverage Map Key:
Light Blue: Covered
Yellow: Not Covered
Medicaid Programs & HCV Treatments

All 50 states and the District of Columbia continue to offer some form of HCV coverage. All 50 states and the District of Columbia have expanded their Preferred Drug Lists to include at least one HCV Direct Acting Agent (DAA).

January 2020 Updates:
• No Updates

January 2020 Notes:
• The follow states’ Medicaid programs offer multiple coverage plans for their respective Medicaid clients. An indication of “Y” in Figure 12, for these states indicates that at least one of that state’s Medicaid coverage plans offers coverage for the drug in question. The plan highlighted in bold typeface represents the most comprehensive plan with the most drugs covered in the respective state:
  – Hawaii – (1.) Advantage Plus; (2.) QUEST Integration
  – Kentucky – (1.) Aetna Better Health of Kentucky; (2.) Anthem BlueCross BlueShield; (3.) Humana – CareSource; (4.) Magellan Medicaid; (5.) Passport Health Plan; (6.) WellCare of Kentucky
  – New Jersey – (1.) Aetna; (2.) AmeriGroup NJ; (3.) Horizon NJ Health; (4.) UnitedHealthcare of New Jersey; (5.) WellCare
  – New Mexico – (1.) BlueCross BlueShield of New Mexico; (2.) Presbyterian Centennial Care
  – Ohio – (1.) Buckeye Health Plan – MyCare Ohio; (2.) CareSource Ohio Medicaid; (3.) Molina Healthcare of Ohio; (4.) Paramount Advantage; (5.) UnitedHealthcare Community Plan of Ohio.
• No data is has been made available by the Medicaid programs in the U.S. Territories

* Medicaid coverage excludes patients from most drug manufacturer patient assistance programs (PAPs)
Veterans Affairs & HCV Treatments
Veterans Affairs & HCV Treatments

The Veteran’s Administration (VA) currently offers coverage for all HCV drugs. This is according to the most recent VA National Formulary, dated July 2018 (U.S. Dept. of V.A., 2018a). The VA Treatment Considerations and Choice of Regimen for HCV-Mono-Infected and HIV/HCV Co-Infected Patients (U.S. Dept. of V.A., 2018b) lists the following therapies as preferred treatments:

Abbreviations:
- CTP – Child-Turcotte-Pugh (score used to assess severity of cirrhosis)
- IU/mL – International Units Per Milliliter
- PEG-IFN/IFN – Peginterferon/Interferon
- RAS – Resistance-associated substitutions
- RBV – Ribavirin

Genotype 1:
- Treatment-naïve without or with cirrhosis (CTP A):
  - Zepatier: 1 tablet orally daily for 12 weeks if GT1a without baseline NS5A RAS or GT1b
  - Mavyret: 3 tablets orally daily with food
- If non-cirrhotic: 8 weeks
- If cirrhotic: 12 weeks
  - Harvoni: 1 tablet orally daily
- If HCV-monoinfected, non-cirrhotic, and baseline HCV RNA <6 million IU/mL: 8 weeks
- If cirrhotic, baseline HCV RNA ≥6 million IU/mL or HIV/HCV coinfected: 12 weeks
- Consider adding RBV in cirrhotic patients
  - Epclusa: 1 tablet orally daily for 12 weeks
- Treatment-naïve with decompensated cirrhosis (CTP B or C):
  - Harvoni: 1 tablet orally daily + RBV (600 mg/day and increase by 200 mg/day every 2 weeks only as tolerated) for 12 weeks
  - Epclusa: 1 tablet orally daily + RBVd for 12 weeks; start at lower RBV doses as clinically indicated (e.g., baseline Hgb)
Veterans Affairs & HCV Treatments

Genotype 1 (Cont.):

- Treatment-experienced (NS5A- and SOF-naïve [e.g., failed PEG-IFN/RBV ± NS3/4A PI]) without or with cirrhosis (CTP A)
  - Zepatier: 1 tablet orally daily for 12 weeks if GT1b, or if failed only PEG-IFN/RBV and GT1a without baseline NS5A RAS
  - Mavyret: 3 tablets orally daily with food
- If PEG-IFN/RBV-experienced: 8 weeks if non-cirrhotic or 12 weeks if cirrhotic
- If NS3/4A PI + PEG-IFN/RBV-experienced: 12 weeks
  - Harvoni: 1 tablet orally daily for 12 weeks; add RBVd if cirrhotic
  - Epclusa: 1 tablet orally daily for 12 weeks
- Treatment-experienced (NS5A-naïve and SOF-experienced) without or with cirrhosis (CTP A)
  - Mavyret: 3 tablets orally daily with food
- If PEG-IFN/RBV + Sovaldi-experienced: 8 weeks if non-cirrhotic or 12 weeks if cirrhotic
- If Olysio + Sovaldi-experienced: 12 weeks
  - Epclusa: 1 tablet orally daily for 12 weeks if GT1b
- Treatment-experienced (prior NS5A-containing regimen) without or with cirrhosis (CTP A)
  - Mavyret: 3 tablets orally daily with food for 16 weeks if failed only an NS5A inhibitor without NS3/4A PI (e.g., Harvoni)
  - Vosevi: 1 tablet orally daily with food for 12 weeks
- Treatment-experienced with decompensated cirrhosis (CTP B or C)
  - Epclusa: 1 tablet orally daily + RBV; start at lower RBV doses as clinically indicated (e.g., baseline Hgb);
- If NS5A-naïve: 12 weeks
- If NS5A-experienced: 24 weeks; NOT FDA approved for 24 weeks
Veterans Affairs & HCV Treatments

Genotype 2:

- Treatment-naïve or treatment-experienced (PEG-IFN/IFN ± RBV or Sovaldi + RBV ± PEG-IFN) without or with cirrhosis (CTP A)
  - Mavyret: 3 tablets orally daily with food
- If non-cirrhotic: 8 weeks
- If cirrhotic: 12 weeks
  - Epclusa: 1 tablet orally daily for 12 weeks
- Treatment-experienced (NS5A-experienced) without or with cirrhosis (CTP A)
  - Vosevi: 1 tablet orally daily with food for 12 weeks
- Treatment-naïve or treatment-experienced patients with decompensated cirrhosis (CTP B or CTP C)
  - Epclusa: 1 tablet orally daily + RBV; start at lower RBV doses as clinically indicated (e.g., baseline Hgb)
- If NS5A-naïve: 12 weeks
- If NS5A-experienced: 24 weeks

Genotype 3:

- Treatment-naïve without cirrhosis or with cirrhosis (CTP A)
  - Mavyret: 3 tablets orally daily with food for 12 weeks
  - Epclusa: 1 tablet orally daily for 12 weeks
- If CTP A, test for NS5A RAS
- Add RBV if Y93H RAS present
- Treatment-experienced (PEG-IFN ± RBV or Sovaldi + RBV ± PEG-IFN) without or with cirrhosis (CTP A)
  - Mavyret: 3 tablets orally daily with food for 16 weeks
Veterans Affairs & HCV Treatments

Genotype 3 (Cont.):

- Treatment-experienced (NS5A-experienced) without or with cirrhosis (CTP A)
  - Vosevi: 1 tablet orally daily with food for 12 weeks
- If CTP A, consider adding RBV (no supporting data)
- Treatment-naïve or treatment-experienced with decompensated cirrhosis (CTP B or CTP C)
  - Epclusa: 1 tablet orally daily + RBV; start at lower RBV doses as clinically indicated (e.g., baseline Hgb)
- If NS5A-naïve: 12 weeks
- If NS5A-experienced: 24 weeks

Genotype 4:

- Treatment-naïve without or with cirrhosis (CTP A)
  - Zepatier: 1 tablet orally daily for 12 weeks
  - Mavyret: 3 tablets orally daily with food
- If non-cirrhotic: 8 weeks
- If cirrhotic: 12 weeks
  - Harvoni: 1 tablet orally daily for 12 weeks
  - Epclusa: 1 tablet orally daily for 12 weeks
- Treatment-naïve with decompensated cirrhosis (CTP B or C)
  - Harvoni: 1 tablet orally daily + RBV (600 mg/day and increase by 200 mg/day every 2 weeks only as tolerated) for 12 weeks
  - Epclusa: 1 tablet orally daily + RBV for 12 weeks; start at lower RBV doses as clinically indicated (e.g., baseline Hgb)
Veterans Affairs & HCV Treatments

Genotype 4 (Cont.):

- Treatment-experienced (Sovaldi-experienced and NS5A-naïve) without or with cirrhosis (CTP A)
  - Mavyret: 3 tablets orally daily with food for 12 weeks
  - Epclusa: 1 tablet orally daily + RBV for 12 weeks; start at lower RBV doses as clinically indicated (e.g., baseline Hgb)
- Treatment-experienced (NS5A-experienced) without or with cirrhosis (CTP A)
  - Vosevi: 1 tablet orally daily with food for 12 weeks
- Treatment-experienced with decompensated cirrhosis (CTP B or CTP C)
  - Epclusa: 1 tablet orally daily + RBV; start at lower RBV doses as clinically indicated (e.g., baseline Hgb)
    - If NS5A-naïve: 12 weeks
    - If NS5A-experienced: 24 weeks; NOT FDA approved for 24 weeks
Patient Assistance Programs (PAPs)
Patient Assistance Programs (PAPs)

The drug manufacturers and various national nonprofit organizations offer a variation of patient assistance programs (PAPs) to assist patients in accessing treatments. They include:

**Support Path (Gilead Sciences):**

- **Financial Assistance**
  - Provides Co-Pay Coupons for Sovaldi, Harvoni, Harvoni (Generic), Epclusa, Epclusa (Generic), and Vosevi
  - Co-Pay Coupons cover out-of-pocket costs up to 25% of the catalog price of a 12-week regimen (3 bottles/packages) of Sovaldi, Harvoni, Harvoni (Generic), Epclusa, Epclusa (Generic), or Vosevi
  - Excludes patients enrolled in Medicare Part D or Medicaid
- **Insurance Support**
  - Researches and verifies patient’s benefits, and gives information they need about coverage options and policies
  - Explain Prior Authorization process and works with HCV Specialist’s office so they can submit PA forms to a patient’s insurance company
  - May be able to provide assistance with appeals process
- **Website:** [http://www.mysupportpath.com/](http://www.mysupportpath.com/)

**AbbVie Mavyret Co-Pay Savings Card:**

- **Financial Assistance**
  - Patient may be eligible to pay as little as $5
  - Excludes patients enrolled in Medicare Part D, Medicare Advantage, Medigap, Medicaid, TRICARE, Department of Defense, or Veterans Affairs programs
- **Website:** [https://www.mavyret.com/copay-savings-card](https://www.mavyret.com/copay-savings-card)
Patient Assistance Programs (PAPs)

NeedyMeds:
• NeedyMeds Drug Discount Card
  – Designed to lower cost of prescription medications by up to 80% at participating pharmacies
  – NeedyMeds DOES NOT keep a list of prescription medications covered
  – No eligibility requirements
  – Patients CANNOT be enrolled in any insurance
  – CANNOT be used in combination with government healthcare programs, but CAN be used IN PLACE of program
  – CANNOT be combined with other offers
• Website: http://ow.ly/fEJo309cJ7Z

The Assistance Fund:
• Status: Closed
• Website: https://tafcares.org/patients/covered-diseases/

Patient Advocate Foundation Co-Pay Relief:
• Status: Closed
• Maximum award of $15,000
• Eligibility Requirements:
  – Patient must be insured, and insurance must cover prescribed medication
  – Confirmed HCV diagnosis
  – Reside and receive treatment in the U.S.
  – Income falls below 400% of FPL with consideration of the Cost of Living Index (COLI) and the number in the household
• Website: https://www.copays.org/diseases/hepatitis-c
Patient Assistance Programs (PAPs)

Patient Access Network (PAN) Foundation:
- Status: Closed
- Co-Pay Assistance with a maximum award of $7,200
  - Patients may apply for a second grant during their eligibility period subject to availability of funding
- Eligibility Requirements:
  - Must be being treated for HCV
  - Have insurance that covers HCV prescribed medication
  - Income falls below 500% of FPL
  - Residing and receiving treatment in the U.S. (citizenship NOT required)

HealthWell Foundation:
- Status: Open
- Co-Pay Assistance with a maximum award of $30,000
- Minimum Co-Pay Reimbursement Amount: None
- Minimum Premium Reimbursement Amount: None
- Eligibility Requirements:
  - Must be being treated for HCV
  - Have insurance that covers HCV prescribed medication
  - Income falls below 500% of FPL
  - Receiving treatment in the U.S.
- Website: [https://www.healthwellfoundation.org/fund/hepatitis-c/](https://www.healthwellfoundation.org/fund/hepatitis-c/)
Harm Reduction Programs

Figure 25. – Figure 34.
Harm Reduction Programs

The HIV/HCV Co-Infection Watch monitors the following Harm Reduction programs nationally:

• **Syringe Exchange:**
  Syringe Services Programs (SSPs) exist to provide injection drug users (or those whose prescriptions require injection) with clean syringes and/or in exchange for used ones. (N.b. – states listed as "Y" indicate only that a Syringe Services Program (SSP) exists within the state, regardless of the legality of SSPs under state law).

• **Expanded Naloxone:**
  Naloxone is a drug used to counteract the effects of opioid overdoses. Expanded Access refers to one of more of the following conditions: Naloxone purchase without a prescription; availability to schools, hospitals, and emergency response units for use in the event of an overdose.

• **Good Samaritan Laws:**
  Good Samaritan Laws are laws that are designed to protect emergency services personnel, public or private employees, and/or citizens from being held legally liable for any negative healthcare outcomes as a result of providing "reasonable measures" of emergent care.

• **Mandatory PDMP Reporting:**
  Prescription Drug Monitoring Programs (PDMPs) are programs established by state and/or federal law that requires prescribing physicians and the fulfilling pharmacies to report to a state agency one or more of the following data points: Patient Names; Specific Drug(s) Prescribed; Prescription Dosage; Date; Time; Form of State-Issued ID.

• **Doctor Shopping Laws:**
  Doctor Shopping Laws are those laws designed to prevent patients from seeking one or more of the same prescription from multiple doctors through the use of subterfuge, falsifying identity, or any other deceptive means. Some states also include provisions that prohibit patients from seeking a new prescription if another physician has denied a similar prescription within a certain period of time.

• **Physical Exam Required:**
  Physical Exam Requirements are those that mandate that the prescribing physician perform a physical examination on a patient before providing a prescription for a controlled substance to determine if the prescription is medically necessary.
Harm Reduction Programs

- **ID Required for Purchase of Opioid Prescription:**
  Federal law requires anyone purchase a controlled substance to provide a state-issued identification ("I.D.") in order to fill the prescription. Mandatory ID requirements go further and require that this information be recorded and stored in an effort to prevent the same patient from obtaining multiple or repeated prescriptions in a given period of time.

- **Prescriber Education Required/Recommended:**
  States that require/do not require that prescribing physicians undergo special training related to safer prescribing and utilization practices.

- **Medicaid Lock-In Program:**
  Lock-In Programs are laws requiring that patients either receive prescriptions from only one physician and/or fill prescriptions from only one pharmacy.
### Harm Reduction Programs

**Figure 27.**

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## Harm Reduction Programs

**Figure 27.**

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<th>Samaritan</th>
<th>PDMP</th>
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## Harm Reduction Programs

**Figure 27.**

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Figure 28.
Syringe Exchange Map Key:
Purple: Syringe Exchange(s)
Red: No Syringe Exchange(s)
Harm Reduction Programs
Expanded Naloxone Coverage Map
January 2020

Figure 29.
Expanded Naloxone Map Key:
Purple: Expanded Naloxone
Red: Restricted Naloxone
Harm Reduction Programs
Good Samaritan Laws Coverage Map
January 2020

Figure 30.
Good Samaritan Laws Map Key:
Purple: Good Samaritan Laws
Red: No Good Samaritan Laws

[Map showing states colored purple and red with map key explaining purple indicates Good Samaritan Laws and red indicates No Good Samaritan Laws.]
Harm Reduction Programs
Prescription Drug Monitoring Programs (PDMPs) Coverage Map
January 2020

Figure 31.
PDMPs Map Key:
Purple: Mandatory PDMPs
Red: No Mandatory PDMPs

[Map of the United States showing PDMP coverage with states shaded in purple for mandatory PDMPs and red for no mandatory PDMPs.]

Created with mapchart.net ©
Harm Reduction Programs
Doctor Shopping Laws Coverage Map
January 2020

Figure 32.
Doctor Shopping Laws Map Key:
Purple: Doctor Shopping Laws
Red: No Doctor Shopping Laws
Harm Reduction Programs
Physical Exam Required Coverage Map
January 2020

Figure 33.
Physical Exam Required Map Key:
Purple: Physical Exam Required
Red: No Physical Exam Required
Harm Reduction Programs
I.D. Required Coverage Map
January 2020

Figure 34.
I.D. Requirement Map Key:
Purple: I.D. Required
Red: No I.D. Required
Harm Reduction Programs
Prescriber Education Required Coverage Map
January 2020

Figure 35.
Prescriber Ed Required Map Key:
Purple: Prescriber Ed Required
Red: No Prescriber Ed Required
Harm Reduction Programs
Lock-In Program Coverage Map
January 2020

Figure 36.
Lock-In Program Map Key:
Purple: Lock-In Program
Red: No Lock-In Program
Harm Reduction Programs

Harm Reduction, as it relates to opioid abuse and HCV, are measures designed to serve as preventive or monitoring efforts in combating opioid prescription drug and heroin abuse, and as an effect, helping to prevent the spread of HCV and HIV. The Co-Infection Watch covers the following measures: Syringe Exchange, Expanded Naloxone Access, Good Samaritan Laws, Mandatory PDMP Reporting, Doctor Shopping Laws, Physical Exam Requirements, ID Requirements for Purchase, Required or Recommended Prescriber Education, and Lock-In Programs.

January 2020 Updates:
• Legislation has been introduced in the West Virginia legislature to outlaw Syringe Services Programs (SSPs) in the state

January 2020 Notes:
• The following state has pending legislation that would legalize state-sponsored Syringe Exchanges – FL, IA, MO, ND
• The following states have pending legislation requiring Mandatory PDMP reporting – MO
• The following state has pending legislation implementing Doctor Shopping Laws – (None)
• The following state has pending legislation requiring a Physical Examination before Opioid Prescribing – MA
• The following state has pending legislation requiring Prescriber Education – MN
Regional Trends

Regional Districts 1 – 3
Regional Trends Con’t.
District 01 - New England (CT, ME, MA, NH, RI, VT)

HIV – New Diagnoses (2018 Preliminary National Rate – 11.4):
• This district has a low burden of HIV, with all six states in District 01 having rates of new HIV diagnoses well below the national rate of 11.4 (per 100,000)
• Massachusetts has the highest rate of new HIV diagnoses in District 01 with a rate of 9.5 and is ranked 20th in the nation for new HIV diagnoses
• Only two states – Massachusetts and New Hampshire – saw an increase in new HIV diagnoses from 2017 to 2018 (MA – 8.7 to 9.5; NH – 2.5 to 2.7).

HBV (2017 National Rate – 1.1):
• This district has a relatively low burden of HBV, with only one state in District 01 having a rate of new HBV diagnoses above the 2017 national rate of 1.1 (per 100,000)
• Maine has the highest rate of new HBV diagnoses in District 01 and the 2nd-highest rate in the nation with a rate of 5.8. This represents two consecutive years of increases in new HBV diagnoses since 2015 (0.7 in 2015 à 4.0 in 2016 à 5.8 in 2017). The increase in new diagnoses is likely the result of both increased Hepatitis testing efforts, and Injection Drug Use (IDU)
• Both CT and MA have seen two consecutive years of slight increases in new HBV diagnoses since 2015. VT has seen two consecutive years of decreases in new HBV diagnoses. NH has seen no change for two years
• Rhode Island does not track HBV

HCV – New Diagnoses (2017 National Rate – 1.0):
• This district has a high burden of HCV, with three states in District 01 – Massachusetts, Maine, and Vermont – having rates of new HCV diagnoses above the national rate of 1.0
• Massachusetts has the highest rate of new diagnoses in District 01 with a rate of 4.8 and is ranked 2nd in the nation behind West Virginia. Maine has the 2nd-highest rate in District 01 and is ranked 9th in the nation with a rate of 1.6 and Vermont has the 3rd-highest rate in District 01 and is ranked 11th (tied with NJ and OH)
• The high rates of new diagnoses in District 01 is likely the result of both increased Hepatitis testing, and Injection Drug Use (IDU)
• Neither NH, nor RI track HCV
Regional Trends Con’t.

District 01 - New England (CT, ME, MA, NH, RI, VT)

Total Drug Overdose Deaths (2017 National Rate – 21.7):
• This district has an extremely high burden of drug overdose deaths, with all six states in District 01 having rates of overall drug overdose deaths significantly higher than the national rate of 21.7
• New Hampshire has the highest rate in District 01 with a rate of 37.0 and is ranked 6th in the nation for overall drug overdose death rates. Maine (34.4), Massachusetts (31.8), Rhode Island (31.0), and Connecticut (31.0) have the next highest rates in District 01 and are ranked 8th, 9th, 10th, and 11th in the nation, respectively
• Vermont has the lowest rate in District 01 with a rate of 23.2 and is ranked 21st in the nation

Total Opioid-Related Overdose Deaths (2017 National Rate – 14.5):
• This district has an extremely high burden of opioid-related overdose deaths, with all six states in District 01 having rates of opioid-related overdose deaths significantly higher than the national rate of 14.5, and all six are ranked within the top twelve in the nation for opioid-related overdose death rates
• New Hampshire has the highest rate in District 01 with a rate of 34.0 and is ranked 4th in the nation for opioid-related overdose death rates. Opioid-related overdose deaths accounted for 90.8% of all drug overdose deaths in New Hampshire
• Maine (29.9), Massachusetts (28.2), Connecticut (27.7), and Rhode Island (26.9) have the next highest rates in District 01 and are ranked 6th, 7th, 9th, and 10th in the nation, respectively
• Vermont has the lowest rate in District 01 with a rate of 20.0 and is ranked 12st in the nation after Michigan
Regional Trends Con’t.
District 02 – Mid-Atlantic (NJ, NY, PA)

HIV – New Diagnoses (2018 Preliminary National Rate – 11.4):
• This district has a moderate burden of HIV, with two states in District 02 having rates of new HIV diagnoses above the national rate of 11.4 (New York – 12.6; New Jersey – 11.8)
• New York is ranked 10th in the nation for new HIV diagnoses, with New Jersey ranked 12th
• All three states in this district have seen two successive years of decreasing HIV diagnoses since 2016 (NJ – 13.0 to 12.7 to 11.8; NY – 14.3 to 13.9 to 12.6; PA – 8.9 to 8.5 to 7.8)

HBV – New Diagnoses (2017 National Rate – 1.1):
• This district has a low burden of HBV, with all three states in District 02 having rates of new HBV diagnoses well below the 2017 national rate of 1.1
• New Jersey has the highest rate of new HBV diagnoses in District 02 with a rate of 0.6 – 17th in the nation (tied with CO, MA, MI, OR, UT, and WA) – and has seen two consecutive years of decreases in new HBV diagnoses since 2015
• Both NY and PA have seen relatively stable rates of new HBV diagnoses since 2015

HCV – New Diagnoses (2017 National Rate – 1.0):
• This district has a high burden of HCV, with all three states in District 02 having rates of new HCV diagnoses above the national rate of 1.0
• Pennsylvania has the highest rate in District 01 with a rate of 1.7 and is ranked 8th in the nation (tied with Florida). New Jersey has the 2nd-highest rate in District 02 with a rate of 1.4 and is ranked 11th in the nation (tied with OH and VT) and New York has the lowest rate in District 02 with a rate of 0.9 and is ranked 16th in the nation
• The high rate of new diagnoses in PA is likely the result of both increased Hepatitis testing, and Injection Drug Use (IDU)
Regional Trends Con’t.
District 02 – Mid-Atlantic (NJ, NY, PA)

Total Drug Overdose Deaths (2017 National Rate – 21.7):
• This district has a high burden of drug overdose deaths, with all but New York in District 02 having rates of overall drug overdose deaths above the national rate of 21.7
• Pennsylvania has the highest rate in District 02 with a rate of 44.3 and is ranked 3rd in the nation for overall drug overdose death rates. New Jersey has the 2nd-highest rate in District 02 with a rate of 30.0 and is ranked 12th in the nation
• New York has the lowest rate in District 02 with a rate of 19.4, below the national rate of 21.7, and is ranked 29th in the nation

Total Opioid-Related Overdose Deaths (2017 National Rate – 14.5):
• This district has a variable burden of opioid-related overdose deaths, with only New York meeting the criteria for data inclusion established in a report released in the CDC's Morbidity and Mortality Weekly Report (MMWR), with a rate of 16.1 (Scholl, Seth, Kariisa, Wilson, & Baldwin, 2019), ranking 19th in the nation for opioid-related overdose deaths
• Neither New Jersey, nor Pennsylvania were included in Scholl, et al's MMWR report. As such, opioid-specific overdose death reporting is not reliable
Regional Trends Con’t.
District 03 – East-North Central (IL, IN, MI, OH, WI)

HIV – New Diagnoses (2018 Preliminary National Rate – 11.4):
- This district has a low burden of HIV, with all five states in District 03 having rates of new HIV diagnoses below the national rate of 11.4
- Illinois has the highest rate of new HIV diagnoses in District 03 with a rate of 10.7 and is ranked 17th in the nation for new HIV diagnoses
- All five states in this district saw either no statistically significant changes, or decreases in new HIV diagnoses from 2017 to 2018 (Illinois – No Change; Indiana – 7.8 to 7.7; Michigan – 7.8 to 7.2; Ohio – No Change; Wisconsin – 4.5 to 3.6)

HBV – New Diagnoses (2017 National Rate – 1.1):
- This district has a relatively high burden of HBV, with two states – Indiana and Ohio – in District 03 having rates of new HBV diagnoses above the 2017 national rate of 1.1
- After two consecutive years of increases in new HBV diagnoses, Indiana has the highest rate of new HBV diagnoses in District 03 with a rate of 2.5 and is ranked 6th in the nation for new diagnoses
- After two consecutive years of decreases in new HBV diagnoses, Ohio has the 2nd-highest rate of new diagnoses in District 03 with a rate of 2.4 and is ranked 7th in the nation
- IL, MI, and WI all have rates of new HBV diagnoses well below the national rate of 1.1

HCV – New Diagnoses (2017 National Rate – 1.0):
- This district has a high burden of HCV, with all states but Illinois in District 03 having rates of new HCV diagnoses above the national rate of 1.0
- Indiana has the highest rate in District 03 with a rate of 2.9 and is ranked 3rd in the nation. Wisconsin has the 2nd-highest rate in District 03 with a rate of 1.6 and is ranked 9th in the nation and Michigan has the 3rd-highest rate with a rate of 1.5 and is ranked 10th in the nation
- Illinois has the lowest rate in District 03 with a rate of 0.3 and has the 7th-lowest rate in the nation
- Indiana's high rate of HCV is likely the result of both increased Hepatitis testing, and Injection Drug Use (IDU)
Regional Trends Con’t.

District 03 – East-North Central (IL, IN, MI, OH, WI)

Total Drug Overdose Deaths (2017 National Rate – 21.7):
• This district has a high burden of drug overdose deaths, with all but two states in District 03 – Illinois and Wisconsin – having overall drug overdose death rates above the national rate of 21.7
• Ohio has the highest rate in District 03 with a rate of 46.3 and is ranked 2nd in the nation for overall drug overdose death rates
• Indiana and Michigan also have rates above the national rate with rates of 29.4 and 27.8 and are ranked 13th and 14th in the nation, respectively
• Illinois and Wisconsin have rates just below the national rate with rates of 21.6 and 21.2 and are ranked 24th and 25th in the nation, respectively

Total Opioid-Related Overdose Deaths (2017 National Rate – 14.5):
• This district has an extremely high burden of opioid-related overdose deaths with every state in District 03, except for Indiana, being included in Scholl, et al, with rates above the national rate of 14.5
• Ohio has the highest rate of opioid-related overdose deaths in District 03 with a rate of 39.2 and is ranked 2nd in the nation for opioid-related overdose death rates. Opioid-related overdose deaths accounted for 84.0% of all drug overdose deaths in Ohio
• Michigan, Illinois, and Wisconsin all have rates of opioid-related overdose deaths above the national rate with rates of 21.2, 17.2, and 16.9 and ranked 11th, 15th, and 16th, respectively
• Indiana was not included in Scholl, et al’s MMWR report. As such, opioid-specific overdose death reporting is not reliable
Latest News
Latest News

• **HepVu Launches New Data Visualizing Hepatitis C's Impact on Americans of Different Ages, Sexes, and Races**

HepVu today launched new interactive maps illustrating the prevalence of Hepatitis C in the United States between 2013 and 2016, stratified at the state-level by age, sex, and race. Published in Hepatology Communications, the data demonstrate that of the estimated 2.3 million people living with Hepatitis C infection in the U.S. during this time, the epidemic continued to disproportionately impact males, the Baby Boomer population (those born between 1945 and 1969), Black Americans, and, increasingly, young persons in states highly affected by the opioid epidemic – a result of injection drug use.

"The data highlight health disparities among certain populations and areas of the country and underscore the continuing need for consistent, well-grounded data that can help public health decision-makers develop tailored strategies to address Hepatitis C," said Patrick Sullivan, PhD, DVM, Professor of Epidemiology at Emory University's Rollins School of Public Health and Principal Scientist for HepVu. "Knowing there is a cure for Hepatitis C, it is even more critical to use data to identify areas where we should strengthen surveillance, screening, and treatment to stop this epidemic." (HepVu, 2020)

• **Mandated hep C treatment for SC inmates gets initial consent**

A federal judge granted preliminary approval Tuesday of a proposed settlement mandating testing and treatment for hepatitis C of all inmates in South Carolina correction facilities.

Plaintiffs Russell Geissler, Bernard Bagley and Willie James Jackson filed a lawsuit in 2017 against the Department of Corrections over a lack of treatment for hepatitis C. A proposed class-action settlement was submitted after the lawsuit was filed.

"This is a major step toward eliminating a point source for hepatitis C," class counsel Reuben Guttman, with the law firm Guttmann, Buschner & Brooks, said in a press release. (Associated Press, 2020)

• **Wiener Introduces bill requiring master plan to end HIV, HCV, STDs**

State Sen. Scott Weiner (D-San Francisco) announced new legislation on Wednesday, Jan. 15 that would require state agencies to create a master plan to drive down infection rates in HIV, HPV and other STDs across California.

The comprehensive proposal, SB 859, would aim to bring new infections down dramatically across all STDs, specifically within the LGBTQ, African American and Latinx community who are affected disproportionately, largely due to a lack of access to proper health care and education. The legislation argues this is unacceptable, particularly in recent years when the wide distribution of drugs like PrEP have made the end of HIV a possible reality. (Collins, 2020)
Latest News Con’t.

• ‘Major milestone’: Governor’s budget targets hepatitis C epidemic in prisons
Nearly half of the people in New Mexico's state prisons are infected with hepatitis C, and for years, the Corrections Department has only purchased enough medicine to treat a fraction of them. But that may be about to change.
The executive budget proposal Gov. Michelle Lujan Grisham released Jan. 6 recommends $30 million in new funding for the Corrections Department for treatment of hepatitis C, with the expectation of curing most inmates by the end of 2024. This parallels an expansion of treatment taking place in other prison systems across the country and would eliminate a focal point of New Mexico’s epidemic.
It appears the money will pass muster with state lawmakers. Last week, the Legislative Finance Committee recommended a slightly smaller appropriation of $25 million.
Observing that both budget proposals acknowledged the issue, state Sen. John Arthur Smith said it was likely additional funds would be appropriated. "When I say very likely, at this stage, I'm willing to say 100%," he said. (Alcorn, 2020)

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• Mental and Cognitive Impairment in Hepatitis C Virus
Although the care of patients with hepatitis C virus (HCV) infection has radically improved since the US Food and Drug Administration approved the first direct-acting antiviral medication for HCV treatment in 2013, the burden associated with the disease remains high, and the opioid epidemic has led to a surge in new cases. Chronic HCV infection is estimated to affect 3.5 million people in the United States and 71 million people worldwide. In this population, health outcomes and quality of life are greatly affected by a range of common comorbidities, including various types of psychological and cognitive disorders.
Studies have shown that approximately one-third of patients with chronic HCV infection experience depression and anxiety, whereas other findings indicate that neuropsychiatric dysfunction occurs in up to 50% of patients. Symptoms of fatigue and "brain fog" are also commonly reported by individuals with chronic HCV infection. "Neurocognitive impairment, one of the most common extrahepatic manifestations of HCV, can lead to subtle changes in processing speed, memory, attention, fatigue, and cognitive performance," according to a review published January 9, 2019, in Frontiers in Psychology. (Rodriquez, 2020)
Contact

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Marcus J. Hopkins is a West Virginia native currently living in his familial hometown of Morgantown, WV. In 2005, Marcus was diagnosed HIV-positive.

After thirty years of involvement in the performing arts (vocal and instrumental music, color guard, and Drum Corps International), he currently spends most of his time dedicated to bringing attention, clarity, and comprehensive education to the world of Patient-Centric HIV and Hepatitis C research and reporting.

Marcus presently serves as the Project Director for the HIV/HCV Co-Infection Watch, which is a publication of the Community Access National Network (CANN). He also blogs for CANN’s “Hepatitis Education, Advocacy & Leadership” (HEAL) coalition.

Marcus also serves as the West Virginia Policy Coordinator for the Community Education Group. He is also a Guest Blog Contributor for the ADAP Advocacy Association.

In his spare time, he’s a video game-addicted, cat-loving insomniac who leaves audiobooks playing in the background at all times.
Disclaimer

Any opinions expressed in this report are the opinions of the Community Access Network, and are in no way to be considered the official position of any other party, including any directors, employees, funders or providers of either ADAP- or Medicaid-related services.

The purpose of these presentations is to provide a clearer picture of the state of the HCV treatment landscape for those patients co-infected with HIV/HCV. While the programs that offer limited or no treatment are color coded, these colors do not represent any judgments made about any of the programs, their directors, their employees, or their providers.

Additionally, any conclusions, observations, or recommendations made related to the design, layout, content, or maintenance of these state-run websites are the opinion of the HIV/HCV Co-Infection Watch, and are not intended to serve as a reflection of the programs, their directors, their employees, or their providers.
Methodology

The HIV/HCV Co-Infection research is conducted using the following resources:

• State- and privately-run websites (publicly available information, only).
• Prior research and reporting conducted by for-profit and non-profit organizations (publicly available information).
• Contact lists from state- and privately-run sources (publicly available information, only).
• Responses to a quarterly formulary survey.

Research gathering is conducted from a “patient perspective,” meaning that the project manager performs all tasks from the view of the patient. When conducting research, the researcher is tasked with considering the following questions:

• Is the information readily available?
• Is the information easy to access, clearly laid out, and easy to understand?
• Does the information answer basic questions about coverage options?
• Is the information up-to-date, recent, and accurate?
• Is the website user-friendly?
• Is there current and correct contact information available?

Using the information gathered during the research phase, data is documented, compiled and presented in a way that is clear and easy to understand. Maps are provided to indicate which states’ and territories’ programs offer HCV treatment coverage, and spreadsheets are provided, as well. “Coverage” is broken down into seven categories - Basic Coverage, Sovaldi, Olysio, Harvoni, Viekira Pak, Daklinza, Technivie, Epclusa, Viekira XR, Vosevi, and Mavyret. This will be expanded as newer treatment options become available.

States and territories where no information could be found, whether because it was not readily available or because those entities failed to respond to requests for information by the researcher, are indicated on the maps by being “greyed” out (as opposed to filled in with color); those programs are indicated in the spreadsheets by being left blank, or with the symbol “?”.

Regional Trends tracks coverage data, HCV-related statistics, and harm reduction strategies in specific U.S. Census regions. This section uses data gathered from various government, public, and private resources, including data represented elsewhere in the Report.
References


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