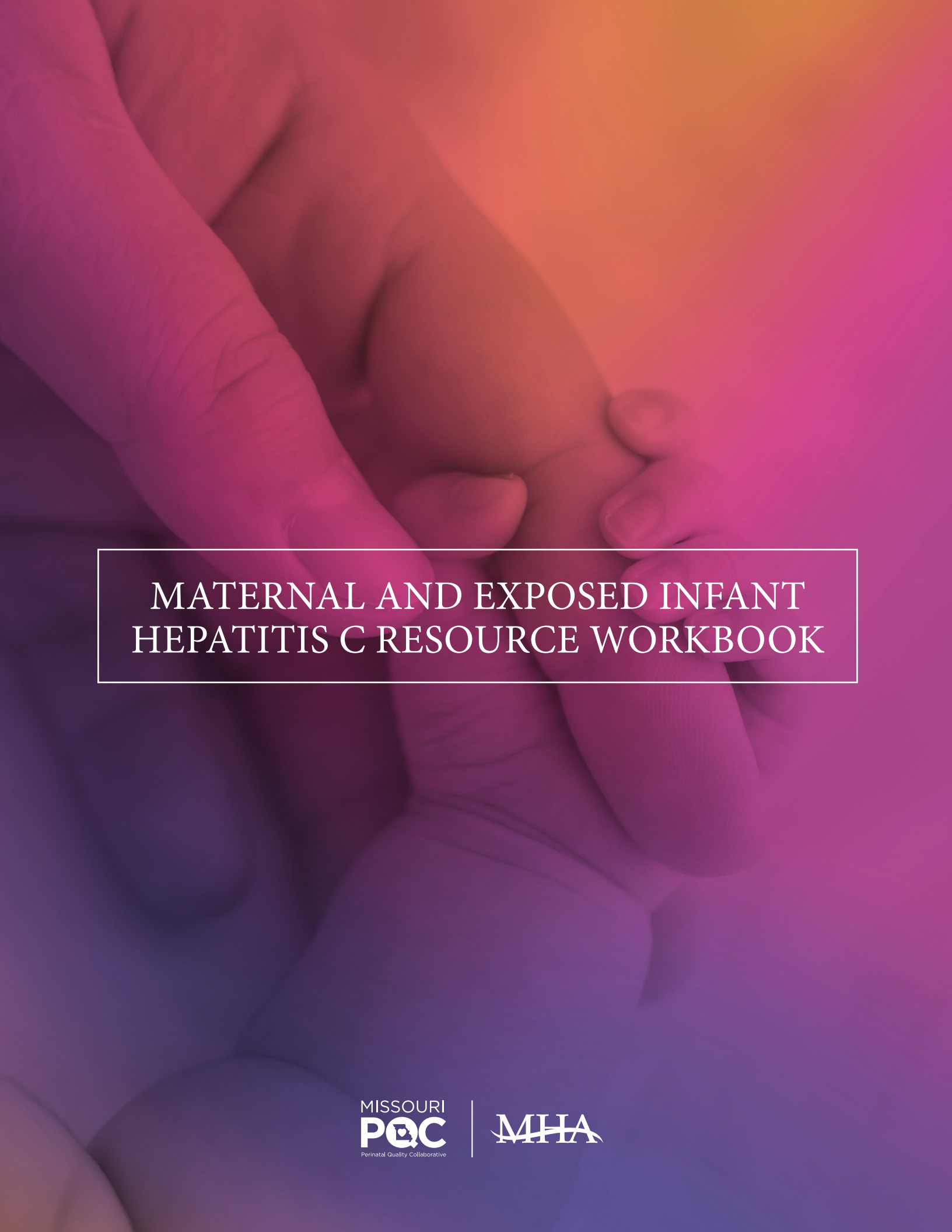




MATERNAL AND EXPOSED INFANT HEPATITIS C RESOURCE WORKBOOK





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The Evidence

Hepatitis C virus infection has increased dramatically over the past decade among reproductive-aged individuals in the United States, largely driven by injection drug use and opioid use disorder. From 1998 to 2018, national maternal HCV prevalence increased 16-fold, reaching 5.3 cases per 1,000 pregnancies.² Additionally, in 2015, more than 20% of women with opioid use disorder at delivery also had HCV. While HCV has predominantly increased among reproductive-aged individuals due to substance use, not all people diagnosed with HCV have histories of substance use and may have acquired HCV through other means like sexual intercourse, tattoos or sharing of razors and other personal items. Women most affected were those on Medicaid, those with lower educational attainment and those living in rural counties.³

Maternal HCV (detectable HCV RNA) has known adverse obstetric risks and is associated with intrahepatic cholestasis of pregnancy, preterm birth, gestational diabetes and progressive liver fibrosis.⁴ Patients with intrahepatic cholestasis of pregnancy are at increased risk of pre-eclampsia, preterm birth and stillbirth.⁵ Furthermore, 6% to 12% of women with active HCV transmit the virus to their infants during pregnancy or delivery.⁶ Without treatment, both mothers and infected children face long-term risks of cirrhosis and hepatocellular carcinoma. Unfortunately, infants are rarely screened for HCV. Nationally, only half of exposed infants are tested, and only one-third of eligible children are treated by 3 years of age.⁷ To improve maternal and child health, we need effective strategies to identify HCV infection early in pregnancy and effectively engage patients in HCV care and treatment.

With the advent of highly effective oral and well-tolerated direct-acting antivirals (DAAs) for HCV, the Centers for Disease Control and Prevention recommended universal HCV screening in 2020.⁸ In 2021, the American College of Obstetrics and Gynecology issued a practice guideline advising routine HCV screening early in each pregnancy and linkage to care.⁹ Recommendations for treatment during pregnancy currently diverge — ACOG and the Society for Maternal-Fetal Medicine do not recommend treatment during pregnancy due to a lack of safety data.¹⁰ Guidelines from the Infectious Diseases Society of America and the American Association for the Study of Liver Diseases endorse individual treatment during pregnancy following a conversation about risks and benefits and shared decision-making.¹¹ While studies remain limited, emerging data are encouraging with clinical trials

on sofosbuvir-based regimens demonstrating safety and efficacy, and a retrospective cohort treated with glecaprevir/pibrentasvir reporting no safety concerns.¹²

Although an eight-week course of the DAA glecaprevir/pibrentasvir (GLE/PIB) or a 12-week course of the DAA sofosbuvir/velpatasvir (SOF/VEL) cures more than 95% of infections, postpartum treatment rates remain below those of other populations. For example, among patients with OUD and HCV, only 6% of Medicaid-insured patients nationally received DAAs within six months of delivery.¹³ Of nationwide insurance claims, women with recent pregnancy, HCV and OUD were significantly less likely to receive DAAs

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by one year than nonpregnant individuals.¹⁴ Unfortunately, the lack of postpartum treatment not only puts the individual at risk for long-term liver-related morbidity and mortality, but also puts future pregnancies at risk for HCV-related complications, with many women reidentified during subsequent pregnancies with no interval treatment.¹⁵

In response, in 2024 the Treatment in Pregnancy for Hepatitis C (TiP-HepC) Community of Practice published best practices for HCV linkage to care in pregnant and postpartum women.¹⁶ The Community of Practice issues four best practices: 1) colocation of services — integrating HCV treatment into routine peripartum care and addiction medicine, 2) treatment by nonspecialist providers — training antenatal and postpartum providers to prescribe HCV treatment, 3) active engagement and patient navigators, and 4) reducing time to treatment. Immediate postpartum treatment at the time of hospital birth discharge or coordinating treatment before delivery may decrease barriers to postpartum linkage to care. Antepartum treatment during the second or third trimester also may be a strategy to reduce loss-to-care and potentially mitigate HCV-related obstetric complications, including perinatal transmission.

As of 2023, the CDC recommends early exposed infant screening for HCV with an HCV nucleic acid test (or HCV RNA) at 2 to 6 months of age. Infants with detectable virus should be referred for care.¹⁷



Lactation Considerations

For patients who are breastfeeding, recent studies of the two front-line agents (SOF/VEL and GLE/PIB) demonstrate that $<0.1\%$ of the medication transfers into breastmilk, well below the relative infant dose cutoff of 10% deemed to be “safe.”¹⁸ In a retrospective study of women treated with DAAs immediately postpartum, no reported adverse events occurred among breastfed infants.¹⁹ While ACOG currently recommends waiting until after completion of lactation due to lack of safety data, these recommendations have not been updated since 2023, before publication of these studies. Given the emerging safety data and significant risk of loss-to-follow-up with deferral until after lactation, immediate postpartum treatment can be considered for patients who plan to breastfeed.

Missouri's Call to Action

In 2016, the CDC identified the jurisdictions where more than half of new HIV diagnoses occurred. Thirteen of the most at-risk jurisdictions for outbreaks of blood-borne viruses, including HIV and HCV, particularly among people who use drugs, were located in Missouri. Most of the Missouri counties were rural, with many in the southeast region, and had limited access to care. A subsequent Missouri vulnerability assessment for opioid overdose and blood-borne infections identified 23 counties at the highest risk for increases in HCV infections — all located across the southern region.²⁰

In 2021, MO HealthNet (Missouri Medicaid), as part of its hepatitis C elimination plan, [Project Hep Cure](#), entered into a subscription partnership to provide GLE/PIB to Medicaid enrollees at no cost, with no prior authorization and with the ability to dispense the full eight-week course upfront.²¹ As of 2023, Missouri continues to have chronic HCV cases above the national rate (55.6 vs. 36.2 per 100,000 population). About 40% of cases are among women. Case rates across all regions have decreased since 2019, though from 2022 through 2023 cases remain stable in the southeast and southwest Missouri regions. In 2023, St. Louis and the southwest regions had the highest number of new reported cases of HCV, with the southwest having a case rate of 67.4 per 100,000, twice that of St. Louis (34.5 per 100,000), and the northwest had the highest new case rate (85.8 per 100,000) but the lowest absolute number of new cases. The southeast and southwest had the highest number of newly reported HCV case rates among females at 55.7 and 57.2 cases per 100,000 population, respectively.²²

While numbers have improved since 2019, Missouri continues to have a higher HCV case rate per population than the national average. Pregnancy and postpartum periods can be an ideal time to link people with HCV to care, as MO HealthNet provides continuous health care coverage for pregnant individuals through 12-months postpartum and covers the full course of HCV treatment at no cost and with no prior authorization upfront.²³ There is a gap in patient ability to access providers able and willing to prescribe the medication, and obstetric care may be a patient's only regular engagement with the health care system. However, referral to specialist treatment alone is not the only option to engage patients in HCV treatment.

At Barnes-Jewish Hospital in St. Louis, providing patients with DAAs directly at labor and delivery admission was associated with 4.7 times higher adjusted odds of treatment completion (95% CI 1.57-14.00) compared with standard postpartum referral.²⁴ More than half of those referred for outpatient HCV care did not attend the consultation appointment. Prescribing and bringing HCV medication to the bedside, however, resulted in 67% of patients completing treatment compared to only 34% of those who were referred for outpatient treatment. Among exposed infants, only 29% had evidence of screening and 10% of those screened experienced perinatal transmission.²⁵ Prenatal care visits and hospital admissions are opportunities for delivering curative HCV treatment, especially for Medicaid patients, who may face fewer logistical barriers to accessing care in these settings, thereby helping prevent perinatal HCV transmission.

HCV treatment is now safe, effective and in most cases can follow published treatment algorithms that can be performed by nonspecialist providers. Non-HCV specialists (e.g., primary care, OB-GYN) can prescribe HCV medications — this includes the postpartum period. These algorithms require only a limited pretreatment workup (typically obtained as part of usual prenatal care), with no monitoring needed during treatment, and cure labs for HCV RNA at four weeks after completion of treatment.²⁶ Even if patients do not obtain cure labs, we know that if patients complete a full course of treatment, more than 95% of people are cured. The key is medication access.²⁷



Recommendations and Interventions

Provider Education and Preparation

- ☐ Collaborate with a clinical pharmacist champion to identify a local or hospital-based pharmacy that can stock HCV medications. The pharmacist also can help determine the appropriate specialty pharmacy required by the patient's insurance when the patient is not covered by Missouri Medicaid.

Screening Recommendations

- ☐ Screen for hepatitis C with HCV Ab with reflex to HCV RNA PCR test early in each pregnancy.
 - ☐ If HCV RNA is indeterminate or invalid, repeat the test.
 - ☐ If HCV RNA is positive, the patient has active HCV infection.
 - ☐ If HCV RNA is not detected but the HCV Ab is positive, the patient does not have HCV at this time. They either spontaneously cleared the virus or were successfully treated. They are no longer infected.
 - ☐ If HCV Ab is negative but the patient has unexplained elevated liver enzymes, consider acute HCV and check an HCV RNA.
 - ☐ If the patient has HCV, screen for substance use disorder and treat following the recommendations included in the [SUD workbook](#).

Treatment Recommendations

Decompensated cirrhosis: refer patient to GI/hepatology for management

All other patients:

Prenatal visit:

- ☐ Ensure CBC, CMP, HIV p24 Ag 1/2Ab and HBV sAg are completed in addition to ACOG-recommended hepatitis B virus surface antibody and total core antibody. Repeat HIV testing should be performed in the third trimester, preferably before 36 weeks gestation.
- ☐ Discuss with your patient the options for timing of HCV treatment — either during pregnancy or during the immediate postpartum period.

Benefits of HCV treatment in pregnancy include a possible decreased risk of vertical transmission and HCV-related pregnancy complications including cholestasis of pregnancy. Risks of HCV treatment in pregnancy include limited clinical trial data with most trials still ongoing. If you have a pregnant patient interested in HCV treatment, please consult the Specialist Referral for Treatment During Pregnancy resource section on p. 12.

- ☐ Follow simplified treatment pathway algorithm (<https://www.hcvguidelines.org/guidance/simplified-hcv-treatment-for-treatment-naive-adults-without-cirrhosis/>). Patients with commercial insurance also may need an HCV genotype and FibroTest-ActiTest or FibroSure test for prior-authorization purposes.
- ☐ Check for medication interactions (<https://www.hep-druginteractions.org/checker>).
- ☐ If the patient has MO Medicaid, the preferred antiviral is glecaprevir/pibrentasvir (Mavyret®)
- ☐ Discuss with pharmacist champion if the patient is not insured by MO Medicaid in order to identify which DAA (glecaprevir/pibrentasvir or sofosbuvir/velpatasvir) is preferred by their insurance formulary.
- ☐ Prescribe DAA in the third trimester to help facilitate immediate postpartum treatment.
- ☐ If the patient has MO Medicaid, the prescriber can fill the full eight weeks (56 days) of DAA at once to be dispensed.

- ☐ Obtain cure labs (HCV RNA) four weeks after completing treatment — these can be obtained through postpartum visits or through the patient's primary care provider (<https://www.hcvguidelines.org/wp-content/uploads/2025/09/HCV-Test-and-Treat-Final-011725.pdf>).
- ☐ Counsel patient and recommend exposed infant screening with HCV RNA at 2 to 6 months of age.

For hospital-based obstetric providers in labor and delivery: if your patient with HCV does not already have a plan in place to begin treatment shortly after delivery, consider the following steps:

- ☐ Ensure CBC, CMP, HIV Ag/Ab and HBV sAg are completed within the last six months.
- ☐ Follow simplified treatment pathway algorithm (<https://www.hcvguidelines.org/guidance/simplified-hcv-treatment-for-treatment-naive-adults-without-cirrhosis/>).
- ☐ Check for medication interactions (<https://www.hep-druginteractions.org/checker>).
- ☐ If the patient has MO Medicaid, the preferred antiviral is glecaprevir/pibrentasvir (Mavyret®).
- ☐ Discuss with pharmacist champion if the patient is not insured by MO Medicaid in order to identify which DAA (glecaprevir/pibrentasvir or sofosbuvir/velpatasvir) is preferred by their insurance formulary.
- ☐ Recommend primary care provider or primary obstetric provider obtain cure labs (HCV RNA) four weeks after completing treatment (in 12 weeks).
- ☐ Counsel patient and recommend exposed infant screening with HCV RNA at 2 to 6 months of age.

Postpartum obstetric visit — if patient has not already been prescribed HCV treatment:

- ☐ Ensure CBC, CMP, HIV Ag/Ab and HBV sAg are completed within the last six months.
- ☐ Follow simplified treatment pathway algorithm, check medication interactions and prescribe medication.
- ☐ Prescribe DAA.
- ☐ If the patient has MO Medicaid, the preferred antiviral is glecaprevir/pibrentasvir (Mavyret®).
- ☐ Discuss with pharmacist champion if the patient is not insured by MO Medicaid in order to identify which DAA (glecaprevir/pibrentasvir or sofosbuvir/velpatasvir) is preferred by their insurance formulary.
- ☐ Obtain cure labs (HCV RNA) four weeks after completing treatment — these can be obtained through postpartum visits or through the patient's PCP.
- ☐ Counsel patient and recommend exposed infant screening with HCV RNA at 2 to 6 months of age.

Patient Education

All patients should know the following information about hepatitis C:

- Most people with hepatitis C do not have any symptoms and may not know they are infected. When symptoms do occur, it may mean the person has advanced liver disease from hepatitis C.
- Hepatitis C is a “blood-borne virus” and spreads from person-to-person through contact with infected blood. This can occur through sharing drug use equipment, razors, unregulated tattoo equipment and less frequently through sexual contact. It does not spread through casual contact like sharing food, hugging or kissing.
- Hepatitis C is not spread through breastmilk. If you have cracked or bleeding nipples and are breastfeeding, there may be a very low chance of transmission. To be on the safe side, we encourage using the other breast and pumping and dumping until the nipple heals.
- It is particularly important that people get screened for hepatitis C during pregnancy. Hepatitis C may require more frequent monitoring during pregnancy and carries an 8% (or about 1 in 10) risk of the baby getting infected during late pregnancy or delivery. All exposed infants should get screened by a blood test between 2 and 6 months of age. Many children go on to clear the virus by 3 years of age but those who do not should be treated.
- Everyone should be screened for hepatitis C, including sexual partners. The good news is that hepatitis C is curable. Treatment not only prevents ongoing liver damage, liver cancer and liver-related death, but also helps prevent transmission to others. Hepatitis C can be treated with an eight- to 12 week-course of pills that has minimal to no side effects and cures more than 95% of people who take the course.

Resources

Education and Training

Show-Me ECHO: [HIV & Hepatitis C](#)

University of Washington Hepatitis C Online: [HCV Course Modules](#)

Treatment Algorithms

HCV Guidelines: [Simplified Treatment Algorithm](#)

HCV Guidelines: [Test-and-Treat Algorithm \(only have HIV, HCV testing available\)](#)

Specialist Referral for Treatment During Pregnancy

If a patient is interested in HCV treatment during pregnancy, refer to the Washington University School of Medicine Infectious Diseases team for consultation (telemedicine options available). Referrals can be made by sending a secure email to gallegos@wustl.edu.

Tools

University of Washington Hepatitis C Online: [Fibrosis-4 \(FIB-4\) Calculator](#)

University of Liverpool: [Drug Interaction Checker](#)

Patient Education

MO HealthNet: [Public Information on Hepatitis C](#)

CDC: [Hepatitis C Fact Sheet](#)

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