**O208**
**2-hour Oral Session**
**New insights in viral hepatitis**

# The added role of pharmaceutical intervention on Hepatitis C Virus (HCV) treatment in the DAA ERA: a single center observational prospective cohort analysis

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**Background:** In the enthusiastic DAA era for HCV therapy, there are still some uncertainties. Optimizing treatment improves efficacy and may reduce resistance associated variants. Therefore, multidisciplinary strategies including pharmacists play an important role on HCV management, to minimize compliance issues and drug-to-drug interactions (DDI).

**Material/methods:** Prospective analysis of HCV patients (pts) treated with DAA regimens at a portuguese peripheral hospital (12$^{th}$february-15$^{th}$November 2015) that enroled outpatient pharmaceutical consultation, on a monthly basis. After physician prescription, baseline and ontreatment parameters were reassessed: drug-to-drug interactions (DDI); need for therapeutic changes; behavioural awareness, compliance and adverse events reported.

**Results:** We followed 77 HCVpts (1HIV/HCV, on TARV regimen), treated with LDV/SOF(61pts, 12 with RBV),OBV+PTP/r+DSV+RBV (1), SOF/DAC(1),SOF/RBV(4), SOF/RBV/PegIFN(10). Throughout 272 consultations, over 26 active interventions occurred (9,5%) in 29,8% (23pts). Baseline evaluation- Of the 77pts, 87%(67pts) had concomitant drugs that were reassessed. A) changes performed: PPI in 11,7%(9pts; change the hour of administration in 6pts; 2 of which alerted for dose reduction); oral antidiabetic drugs in 7,8% (6pts; change the hour of administration in 3pts) and insulin in 3,9%(3pts); antihistamines in 3,9%(3pts; 1 diphenydramine stoppage due to DDI); vitamines in 6,5%(5pts; 3 stoppages); venotropic drugs in 3,9%(3pts; 2 stoppages); antidiarrheal drugs in 2,6%( 2pts; loperamide stoppage due to DDI); acetylcystein in 1,2%(1pt-stoppage). B) no changes needed: neuropsiquiatric drugs in 23,4% (31 drugs in 18pts; benzodiazepines-16,9%; antidepressants-10,4%; antipsychotics-6,8%; others-3,9%) and methadone in 3,9%(3pts); beta-blockers in 18,2%(14pts) and other antiarrhythmics in 3,9%(3pts); antihypertensive drugs in 19,5%(15pts); diuretics in 15,6%(12pts); NSAID's in 11,7%(9pts); analgesics in 10,4%(8pts); antiagregation therapy in 6,5% (5pts) and other drugs in 16.9% (13pts). Awareness was made to keep off statins in 7pts. Herbal tea consumption was stopped in 6,5%(5pts). During treatment - compliance assessment: 20,8%(16pts) had error in pill counting (10pts forgot to take the DAA once; 3pts once took 2 instead of one DAA; 3pts forgot from 1 to 7 RBV pills). Introduced drugs/behaviours were reported in 16,9%(13pts;1 St John's wort stoppage and 2 PPI time administration adjustment). 7,8%(6pts) phoned 8times to the pharmacists mostly to report adverse events (AE). AE occurred in 66,2%(51pts); 208 were non-severe and 1 severe (1,3%, grade II encephalopathy drug related): most common were fatigue (22%) and headache (12%); 52,7% during 1$^{st}$month. 3pts were admitted to hospital ward, none with drug relation. 2pts stopped treatment (1pt-encephalopathy; 1pt-hospital admission, not drug related).

**Conclusions:** Pharmaceutical organized intervention during DAA treatment at our center, helps optimizing HCV treatment in almost one third of cases, demonstrating the need for and gain with multidisciplinary management. Pharmacists role therefore complements both nurses and physicians care of the HCV patient on DAA treatment.