HEPCROADSHOW
NORTHERN BC: HEPATITIS C OUTREACH ROADSHOW
APRIL 24-MAY 10

Three HepCBC volunteers – two nurses and an HCV+ person – are on the road, bringing our stories and pamphlets to remote communities, seeking to discover new friends and hoping to share ideas to help address the severe inequity of HCV treatment and care between BC’s urban and rural areas. We are making 3-hour presentations including a great new 1-hour movie about hepatitis C: DEAL WITH IT, in 20 communities in the Williams Lake to Bella Coola corridor, and in the Prince George toKitamaat Village corridor. We are Fran Falconer, long-time hepatology nurse/nurse educator from Nanaimo, HepCBC president and retired nurse Rosemary Plummer, plus retired teacher recently cured of hepatitis C, Cheryl Reitz. Below is the itinerary of our exciting journey. For details, consult our online Calendar (right side of every webpage of www.hepcbc.ca).

Apr. 24: Yunesit’in/Stone Youth Centre 1:30 – 4:30 pm

(Continued on page 2)

WORLD HEPATITIS DAY

AN OPPORTUNITY TO EDUCATE AND TO FIGHT STIGMA

On July 28th every year, people living with and fighting hepatitis B and C throughout the world join hands to let others know of their struggles and how others can help them try to eradicate these two terrible diseases from the face of the earth. It is also a wonderful opportunity to show the diversity of our faces and stories; nothing dissolves stigma faster than when a real person we can relate to replaces a negative stereotype in our minds, right?

(Continued on page 3)

“FIRE IN THE BLOOD”
(fireintheblood.com/trailer)

A film by Dylan Mohan Gray, Fire in the Blood is narrated by William Hurt. One of our volunteers, went to see it and sent in the following review:

Last Saturday Doctors Without Borders had a showing of the documentary film festival movie, “Fire in the Blood”, which reveals the power of the pharmaceutical companies in controlling not only drugs, but lives. It left me feeling both powerless and powerful at the same time: powerless, seeing so many lives lost when drugs are available, but powerful enough to see that a small group of people believing in a cause can make a difference.

The film takes you back to the start of the AIDS epidemic: discovery, break-through of drugs to treat the disease, and the monopoly arising from the patent granted to pharmaceutical company. As a result, the price of the drug is far beyond what is reasonable in terms of production cost. In the film, the cost of medication in South Africa and Uganda is not affordable for the average person, and as a result people were dying when drugs were available simply because they were poor, thus putting a price on lives. If you are rich, you can get treated. The patent is not international, but Pfizer had an agreement with these countries to have the exclusive right for the distribution of AIDS drugs. The generic versions of these drugs were available in other countries, such as Thailand and India. In the end, India supplied the AIDS drug cocktail at a cost of $1 per day, compared to $10,000 per year.

After the film, there was a presentation by Mr. James Love, Director of KEI, Knowledge Ecology International, who was actively involved in the process and was featured in the film. He informed us that, although “the people” won the war on AIDS drugs with the pharmaceutical

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HepCBC - Send to our NEW address:

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Victoria, BC V8T 5G7

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☐ “I want to volunteer. Please contact me.”
☐ “I want to join a support group. Please call.”

(Note: The hepc.bull is mailed with no reference to hepatitis on the envelope.)

You may also subscribe or donate on line via PayPal at

www.hepcbc.ca/orderform.htm

Download the hepc.bull free at

http://hepcbc.ca/hepc-bull-monthly-newsletter/

SUBMISSIONS: The deadline for any contributions to the hepc.bull is the 15th of each month. Please contact the editors at jking2005@shaw.ca, (250) 595-3892. The editors reserve the right to edit and cut articles in the interest of space.

ADVERTISING: The deadline for placing advertisements in the hepc.bull is the 12th of each month. Rates are as follows:

Newsletter Ads: Maximum 4 per issue, if space allows. $20 for business card size ad, per issue. Payments will be refunded if the ad is not published.

HEPC.Clinic AT PERCUCO

The Hepatology Clinic at PerCuro provides HCV education and long-term support to patients and their families undergoing HCV treatment in the Greater Victoria/Southern Vancouver Island region, according to their individual needs. Specialized nurses help procure financial coverage for treatment, ensure lab tests are scheduled, teach self-administration of injectable medication, help manage side effects, facilitate a monthly support group, and liaise with family doctors and specialists regarding the patient’s treatment and any other issues of concern.

This type of professional support is imperative now that standard of care therapy often involves three medications.

PerCuro also offers access to cutting edge clinical trials for both naïve and treatment-experienced patients.

There is no cost involved.

Nursing Support improves outcomes.

Contact 250-382-6270

THANKS!!

HepCBC thanks the following institutions and individuals for their generosity: The late John Crooks, Allison Crowe, Billie Wood and Adrian, Community Living Victoria, Victoria Positive Living Centre, Provincial Employees Community Services Fund, the Victoria Foundation, Dr. C. D. Mazoff, Judith Fry, and the newsletter team: Beverly Atlas, Diana Ludgate, Alp, Cheryl, Anamaria, S.J., L.P.

Please patronize these businesses that have helped us: Top Shelf Bookkeeping, Merck Canada, Roche Canada, Vertex, Gilead, Janssen, Bristol-Myers Squibb, Boehringer-Ingelheim, AbbVie, Rx&D, VanCity, Shoppers Drug Mart, Market on Yates, Country Grocer, Safeway and Thrifty Foods.

TIP OF THE MONTH:

HOPEFULLY YOU ARE CONSIDERING TREATMENT, IF YOU STILL HAVE HEP C.

Please check out the EASL Highlights (page 4). They are organized by genotype (ALL, GT1, GT2-3, GT4), and the hardest groups to treat are at the top of each of those sections.

Page 2
This year HepCBC once again is working with other groups to organize and publicize World Hepatitis Day events throughout the province. Let us know what you are planning to do in your community before July 1st, and your event will get advertised in BC’s three major newspapers. Last year 11 communities were on the ad. Of course, we’re hoping to include more this year! The best events are educational, friendly, colourful, meaningful, musical, and tasty!

VANCOUVER WHD 2014 will be the largest yet, held at the outside Georgia St. entrance to the Vancouver Art Gallery. Tents, tables, speakers, music in (we hope!) the sun. The Planning Committee this year includes representatives from First Nations Health Authority, BC Centre for Disease Control, HepCBC, SUCCESS (the major hepatitis B group in BC), and the Purpose Society.

We hope you will consider hosting a unique and wonderful event in your community, and let HepCBC know about it, so we can add it to the list in the World Hepatitis Day ads. For ideas, go to http://whdcanada.org/ and worldhepatitisalliance.org/en/about-whd-2014.html

## COMPARING TRIAL RESULTS

It is very difficult to compare clinical trial results and choose a treatment based on the information from studies such as those presented at even the top medical conferences such as EASL. Why?

- The studies don’t usually compare the various drugs to drugs produced by other pharmaceutical companies (head-to-head studies).
- The trials producing the best results might be published and those with poorer results might not. (This has not been found in Hep C trials, thanks to clinical trials registries like ClinicalTrials.gov.)
- The studies may use different duration of treatment and types of patients, different combinations of drugs and doses, differences regarding baseline viral load, presence of viral mutations, genotype, IL28b allele, state of the liver, age, gender, previous treatment, exercise, body mass index, use of alcohol and other substances.
- Most trials publicly report the people who dropped out. Some don’t.
- Some trials use few people, while others use many.
- You should also take into account the side effects and how serious they were. (This issue of the bulletin does not mention side effects or other details, but you can find them in links.)

Source: [www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001526](http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001526)

Info about clinical trials: [www.clinicaltrials.gov](http://www.clinicaltrials.gov)

## WILL WE STILL NEED IFN?

Interferon (IFN) has been used for the treatment of Hep C for more than 20 years. Poor SVR (sustained viral response) rates back then were low, but improved when ribavirin (RBV) was added, and improved more when the IFN was pegylated. Those improvements allowed over 50% of patients to attain SVR. Unfortunately, that treatment (pegIFN/RBV) took up to 1 year of injections weekly, and had many side effects. The pharmaceutical companies continued to search for something more effective and with fewer side effects, no injections and shorter treatment times. As a result, we now have several effective oral direct acting antivirals (DAAs), which include some that are effective without pegIFN/RBV. These are not widely available yet. PegIFN/RBV may eventually be needed only to reduce treatment time or number of DAAs used, in patients with difficult-to-treat genotypes, or who fail to achieve SVR.


## WHAT IS A Q80K?

We have heard about the IL28b gene, part of our own immune system that we were born with, and we know that, if we could choose, we would want the kind of the gene that has the CC allele (a variant—a type of DNA coding, occupying a certain part of a chromosome), which can mean the virus might respond to IFN treatment more easily or even go away spontaneously, perhaps even before we are diagnosed. If you have the CT allele, you may or may not respond to treatment. But if you have inherited the TT allele, then it is very difficult for you to respond to conventional Hep C treatment with IFN. Luckily, the new DAAs don’t care about what kind of IL28b gene we have. (Just think: A few years ago, they couldn’t even find the virus, and now they’re studying its genes!!)

But, some researchers have discovered yet another stumbling block: Q80K.

Q80K is a polymorphism—a variation in the virus’s NS3/4A protease enzyme that occurs naturally in up to 48% of patients with genotype 1a (GT1a). The GT1b virus rarely has this mutation.

Trials suggest that, even though simeprevir (formerly TMC45235, now Olysio in the US and Galexos in Canada) cures 80% of treatment-naïve patients, those with the Q80K mutation should consider a different therapy, and not waste their money or time. (“Notably, no Q80K-related reductions in efficacy were observed during the pivotal trials of the currently approved NS3/4A protease inhibitors, telaprevir and boceprevir.”)


### DISCOVERY OF IFNL3

Researchers in Seattle have discovered that DNA changes on the IFNL3 (interferon lambda 3) gene on chromosome 19 are linked to spontaneous clearance of Hep C, or better treatment responses, and may be a good target for new pharmaceutical products. Until recently, they couldn’t figure out the mechanism.

When they noticed that Asians responded better than Africans, they started collecting data, hoping to find genes associated with SVRs.

They believe that two genetic variations on the IFNL3 gene found near an area that produces IL28b help fight HCV. Those with the T (which stands for thymidine) variant are (Continued on page 6)
**GENOTYPES I**

**HALLMARK-DUAL STUDY DIFFICULT-TO-TREAT GT 1**

Bristol-Myers Squibb presented the results of their multinational HALLMARK-Dual study Phase III with all-oral daclatasvir (DCV) and asunaprevir (ASV). The results include data for difficult-to-treat GT1b cirrhotic and non-cirrhotic, treatment-naïve, non-responder, and pegIFN/RBV ineligible/intolerant patients. A 24-week regimen achieved overall SVR12 as follows:

- 90% in treatment-naïve
- 82% in NRs to previous pegIFN/RBV
- 82% in pegIFN/RBV ineligible/intolerant patients, including cirrhotic and non-cirrhotic patients (84% and 85%).

The treatment was very well tolerated, even among those with advanced liver disease (anemia/neutropenia 91% SVR; depression 80% SVR; compensated advanced fibrosis/cirrhosis with thrombocytopenia 73%).

**SAPPHIRE-I and SAPPHIRE-II**

AbbVIE announced Phase III results:

- 96% SVR12 was achieved in both SAPPHIRE-I (treatment-naïve) and SAPPHIRE-II (treatment-experienced with pegIFN/RBV) in adult non-cirrhotic GT 1a/b patients.

- 95-100% in the SAPPHIRE-II study in all patients.

- 96.2% in SAPPHIRE-I (95.3% of GT1a, 98% of GT1b)

- 96.3% in SAPPHIRE-II Phase III with 12 weeks of ABT-450/rl/ABT-267/ABT-333/ RBV (96% of GT1a, 96.7% of GT1b)

49.2% of patients were prior null-responders, 29% were prior relapers, and 21.9% were prior partial-responders.

The SAPPHIRE-II trial consisted of 12 weeks of treatment with AbbVie's regimen: ABT-450/rl + ABT-267 (Ombitasvir) + ABT-333 (Dasabuvir) + RBV, in non-cirrhotic, GT1a/b patients who previously failed treatment with pegIFN/RBV.

Of 394 patients, 297 were randomized to the AbbVie regimen for RBV with 12 weeks, and 97 patients were randomized to a placebo for the first 12 weeks. Those randomized to placebo for the first 12 weeks later received treatment with the AbbVie regimen plus RBV.
**SVR HONOUR ROLL**

Have you responded to treatment and remained undetectable for a minimum of 12 weeks after finishing treatment? Celebrate and give others hope. Please take a minute to send us your info and we’ll add your name (or initials). Congratulations to our friends:

1. **GJ** - SVR Dec 1998 - IFN/RBV 52 wks - Dr Anderson / Natalie Rock, Vancouver, BC.
2. **Amberose** - 2000 (GT 2A/2C) - Schering IFN/RBV 24 wks
4. **Kirk Leavesley** - (GT1) - 2004 - Roche
5. **Darlene Morrow** - (GT1 relaper) - Mar 2004 - Hyperthermia/Induction + pegIFN/RBV.
6. **Beverly Atlas** - (GT1a) - 2005/2006 - Albuferon/RBV 44 wks
8. **Gloria Adams** - (GT1b relaper) - Fall 2009 IFN/RBV/Telaprevir 48 wks - Drs Erb & Yoshida, Vancouver, BC.
9. **Don Crocock** - (GT1 Stage II) - Dec 2010 IFN/RBV - 48 weeks
10. **Daryl Luster** - (GT1a) - Feb 2011 - IFN/RBV/Ro5024048 48 wks
12. **Cheryl Reitz** - (GT1b partial responder) SVR2 Mar 2013 - Asunaprevir/Daclatasvir 24 wks - Dr. Ghosquierre, Victoria, BC.
13. **Anita Thompson** - (GT1a treated 3 times) Cirrhosis - April 2013 - Pegasys/Boceprevir 48 wks. Dr. M. Silverman, Whitby, ON.
15. **Joan King** - (GT1b treated 5 times) June 2013 - Asunaprevir/Daclatasvir 24 wks Dr. Ramji, Vancouver, BC
17. **Andrew P.** - (GT 1a treatment veteran - multiple previous attempts including Incevik over 10+ years.) Jan 2014. GS-7977/GS-5885 (Sofosbuvir/Ledipasvir) + RBV 24 wks
18. **Diane Stoney** - Transfused 3/21/79 (GT1a treatment naïve) 2/4/2014 - 12 wks placebo, then 12 wks on ABT-450/r+ABT-267+ABT-333+RBV. Dr. Tam, Vancouver, BC
19. **“C”** - (GT 1a treatment naïve) Mar 2014 MK5172/MK8742 12 weeks Dr. Ramji, Vancouver, BC. [NEW]
20. **Jack Swartz** - (Treated 3 times) Apr 2014 IFN/RBV/Victrellis, Dr. S. Wong, WHSC. [NEW]

We know there are many more of you. Please send your name and info to Joan at info@hepbc.ca

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**SVOSBUVIR (Sovaldi or SOV) and Ledipasvir**

GT1 prior null responders with fibrosis stage 0-2, took Janssen’s simprevir (TMC435 aka SMV) plus Gilead’s sofosbuvir (GS-7977 aka SOV) with/without RBV. This regimen resulted in high SVR regardless of the length of therapy, or whether or not RBV was added, and in spite of GT1 subtype α or b, IL28b genotype or Q80K polymorphism. RVR did not predict SVR.

Results with 24 weeks treatment:
- 79% with SMV/SOF/RBV (17% of non-SVRs not due to virologic failure (non-VF)
- 93% with SMV/SOF (7% non-VF)

Results with 12 weeks treatment:
- 96% with SMV/SOF/RBV (4% non-VF)
- 93% with SMV/SOF (7% non-VF)

OPTIMIST-1 and -2 Phase III trials are ongoing.

Sofosbuvir/Simprevir is now approved for treatment in the US and Canada, with or without RBV, in GT1 prior non-responders.

**STUDY M12-999 TRANSPLANT PATIENTS**

AbbVie presented interim results of the ongoing Phase II M12-999 Study of ABT-450/r-ABT-267/ABT-333 + RBV for 24 weeks in non-cirrhotic liver transplant patients with GT1 recurrent infection. 97% achieved SVR4 and 96.2% achieved SVR12. Only 1 patient withdrew because of side effects. There was no loss of the transplanted liver or signs of rejection.

**PEARL-III STUDY**

Results from AbbVie’s PEARL-III were presented, showing that 12 weeks of ABT-450/r-ABT-267/ABT-333 + RBV produced SVR in over 99% of 419 GT1b treatment-naïve, non-cirrhotic subjects, in both arms (with or without RBV), which included patients with characteristics generally found as males, blacks, and those with the non-CC alleles of the IL28b gene. There was only one failure in the RBV arm during treatment, and none documented in either arm during the 12 weeks post-treatment.

**C-WORTHY STUDY**

This Merck all-oral trial with MK-5172/MK-8742 was taken by GT1 treatment-naïve patients without cirrhosis, once daily with or without RBV for 12 weeks, and produced an SVR of 94-98%.

**ION-3 TRIAL: SOFOSBUVIR/LEDIPASVIR**

Previously, high rates of SVR were seen among those treated who received 12 weeks of Gilead’s sofosbuvir with the NSSA inhibitor ledipasvir. This phase III study treated 647 treatment-naïve GT1 non-cirrhotic patients for 8 weeks with the above regimen. They were randomized to 3 arms. The SVR12 rates were as follows:

(Continued on page 6)
**GENOTYPES 2&3**

**PENODPHARM: THE RIBAVIRIN SOLUTION**

Montreal-based Pendopharm has received a priority review designation from Health Canada for the first stand-alone ribavirin (RBV) tablet, already part of the current standard of care for treating hepatitis C. Stand-alone RBV is required for some new IFN-free treatment regimens to be effective. However, it is currently only approved by Health Canada when co-packaged with pegIFN, so Gildead’s Sovaldi (sofosbuvir), recently approved by Health Canada, is used in combination with RBV alone for HCV patients with GT 2 and 3. Sovaldi is the first new all-oral treatment regimen that eliminates IFN entirely. Pendopharm’s RBV will be part of the solution to bring the newest IFN-free HCV treatment regimens to patients with GT 2 and 3, who make up approximately 30% of HCV cases in Canada.

“Interferon has been the main stumbling block to treatment in the past. New regimens without interferon are a huge advance, giving us higher cure rates and shortened treatment duration with a lot fewer side effects,” said Jordan Feld, MD, MPH, Staff Hepatologist, Toronto Western Hospital, Division of Gastroenterology.


**SOVALDI AND NRs**

In another presentation, Phase III studies FISSION, FUSION and POSITRON, treated GT2 or 3 NR patients with 12 or 16 weeks of Sovaldi (SOV)/RBV (36% of the patients had cirrhosis). Patients were retreated either with a 12-week regimen of SOV/RBV/peg-IFN, or a 24-week, IFN-free regimen of SOV/RBV. The choice of regimen was determined by study investigators.

Among patients with available SVR12 data, 63% of those on the 24-week all-oral regimen and 92% of those on the 12-week regimen of SOV/RBV/peg-IFN achieved SVR12.

The results support re-treatment with the above regimens in GT2 or GT3 patients who failed earlier treatment with Sovaldi.

Additional information about the study can be found at www.clinicaltrials.gov.

Source: http://investors.gilead.com/Phoenix.zhtml?c=69964&p=irclnews&nyo=0

**GENOTYPE 4**

RESTORE STUDY FOR GT4

Genotype 4, found mostly in Egypt, the Middle East, and Central Africa, is spreading all over the world, infecting 10-24%. Results from Janssen’s RESTORE, a phase III, multicentre study, treated 107 GT4 patients. Results showed that simeprevir (Galexos) (NS3/4A protease inhibitor) for 12 weeks combined with pegIFN/RBV, followed by 12 or 36 weeks of pegIFN/RBV (without simeprevir) was effective in GT4 patients. SVR12 was achieved by 65.4% of patients (82.9% of treatment-naive, 86.4% of prior relapsers, 60% of previous partial-responder and 40% of previous null-responder patients.) IL28B CT and TT patients achieved SVR12 rates of 65.6% and 59.5%, respectively. Of patients with stage 4 liver scarring (F4), 46.7% achieved SVR12.

Patients were chosen by their response to receive 24 weeks of treatment. Those chosen were 88.6% of the treatment-naive and 90.9% of the prior-relaper patients. 93.5% and 95.0% of them, respectively, achieved SVR12. Simeprevir is also effective against HCV GT 1, 2, 4, 5 and 6. It is approved for GT1 patients in Japan, Canada, the US and Russia, including patients with compensated cirrhosis, combined with pegIFN/RBV.

In a second study involving treatment-naive and treatment-experienced GT4 patients of Egyptian ancestry, sofosbuvir/RBV was simple, effective, well-tolerated. With 12 weeks of treatment, SVR12 rates were 79% in treatment-naive patients and 59% in treatment-experienced patients. Treatment for 24 weeks resulted in better SVR12 rates: 100% and 87%.

Source: www.reuters.com/article/2014/04/12/janssen-idUSnBw125021a+100+BSW20140412

**NEUTRINO TRIAL**

A previous small trial enrolled GT4 patients, both treatment-naive and experienced, born in Egypt or of Egyptian ancestry. They were treated for 12 weeks with sofosbuvir/RBV. SVR12 rates for treatment-naive patients were 79% and for treatment-experienced patients, 59%. When treatment was extended to 24 weeks, the results went up to 100% and 87%, respectively. Based on these results, the Phase III NEUTRINO trial used sofosbuvir + pegIFN/RBV for 12 weeks, resulting in an SVR12 of 96%.

Source: http://hepatitisnewdrugs.blogspot.ca/2014/04/easl-simeprevir-and-sofosbuvir-based.html

**SUMMER ANNOUNCEMENTS**

JULY IS VACATION MONTH THIS YEAR FOR THE BULL. We will do a July/August issue.

ALSO: IF YOU ARE SUSPENDING MEETINGS FOR THE SUMMER, let us know, please, at info@hepbc.ca

PLEASE TELL US WHAT YOU ARE DOING FOR WORLD HEPATITIS DAY

See more: http://hepatitisresearchandnew-updates.blogspot.ca/2014/03/new-genetic-targets-identified-for-hepv.html?showanchor

(CLINICAL TRIALS—Continued from page 3)

unfortunate, while those with the G (which stands for guanosine) variant are luckier. They found that HCV can encourage liver cells to produce 2 microRNAs (silencers that stop “messengers” from sending info to form a protein from a gene like IFN lambda-3.) Those 2 microRNAs are usually “sleeping” until HCV wakes them up and puts them to work. Usually they are used for skeletons and hearts, but the HCV hijacks them, thus becoming invisible to the immune system, except when the patient carries the “G” variant. But with this discovery, scientists can use the microRNAs as targets, so they can restore the patient’s immune system.

Source: genetics 0513blog 380766

For more: http://hepatitisresearchandnew-updates.blogspot.ca/2014/03/new-genetic-targets-identified-for-hep.html?showanchor
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The PegAssist Reimbursement Assistance Program provides reimbursement coordination assistance for patients who have been prescribed Pegasys or Pegasys RBV. The program will assist in securing funding for patients to ensure that they can start, stay on, and complete their treatment successfully. PegAssist Reimbursement Specialists are available (Monday to Friday, 10 AM - 6 PM EST) by calling: 1-877-PEGASYS or 1-877-734-2797. Patients can also obtain a program enrollment form from their nurse/physician to gain access to the program.

The program provides financial aid to qualified patients, alleviating financial barriers which may prevent patients from starting treatment, i.e., deductibles and/or copayments. In partnership with CALEA Pharmacy, the program can conveniently deliver the medication directly to patients’ homes or to the clinics.

Vertex’s Incivek Care Patient Assistance Program supports patients with the reimbursement process for Incivek (telaprevir) treatment (Incivek, pegIFN, ribavirin). It will give you an efficient assessment of your options and eligibility. You may qualify to receive co-payment and other financial assistance to supplement your private and provincial drug program coverage. The program also provides dispensing and home delivery options, and expert treatment advice. Call the Support Line at 1-877-574-4298. (Select option 2 for English, then 2 for Incivek Care.)
**ONTARIO**

Barrie Hepatitis Support
Contact Jeanie for info/appointment
ejenivilleneuve@hotmail.com

Hamiltion Hepatitis C Support Group
1st Thurs. monthly, 6-7 PM, Hamilton Urban Core Community Health Centre, 71 Rebecca St. Hamilton. Contact Maciej Kowalski, Health Promoter 905-522-3233
mkowalski@hchc.ca

Hep C Team, AIDS Committee of North Bay & Area. Education, outreach, treatment, individual & group support, harm reduction, needle exchange.
269 Main St. W, Suite 201, North Bay. Contact 705-497-3560, 1-800-387-3701 or hepccommcoord@gmail.com, www.northbayhchc.com

Hepatitis C Network of Windsor & Essex County
Last Thurs. of the month, 7 PM, Teen Health Centre-Street Health Program Office, 711 Pelissier St., Suite 4, Windsor. Contact Andrea Monkman 519-967-0490 or hepchenetwork@gmail.com.

Kingston Hep C Info
HIV/AIDS Regional Support. Contact 613-545-3698, 1-800-565-2209 haro@kingston.net
www.khrs.ca

Kitchener Area Support Group
3rd Wed. monthly, 7:30 PM, Ray of Hope Community Room, 659 King St. East (Enter off King St) Kitchener. Contact Bob 519-886-5706, Mavis 519-743-1922 or waterlooregionhepbc@gmail.com

London Hepatitis C Support
186 King St. London. For those infected as well as affected by Hep C. Contact 519-434-1601, 1-866-920-1601, www.hivaidscanadian.ca

Niagara Region Hepatitis C Care
Port Colborne and St. Catharines Clinics. Education, counseling, individual/group support, treatment, outreach, harm reduction. Contact 905-378-4674 ext 32554 HCC@niagararegion.on.ca www.niagararegion.on.ca/services/hepatitis-c-care

Oshawa Community Health Hepatitis C Team
Drop-in, lunch provided each Thurs. 12-1 PM, 79 Milliken St. www.ochc.ca Contact 1-855-808-6242

Owen Sound Info, support. Contact Debby Minnei
unlimited-liv@publichealthgreybruce.on.ca

Peel Region (Brampton, Mississauga, Caledon) 905-799-7700 healthline-peelregion.ca

Toronto CLF 1st Mon. monthly Oct.—June, 7:30 PM, North York Civic Centre, 5100 Yonge Street. Contact Billie 416-491-3353, ext. 4932.
www.torontolive.ca

Thunder Bay Hep C support. Contact Sarah Tycholiz 807-345-1516 (or for 807 area only 1-800-488-5840)

Unified Networkers of Drug Users Nationally
unido@sympatico.ca

York Region Hepatitis C Education Group
3rd Wed. monthly, 7:30 PM, York Region Health Services, 4261 Hwy 7 East, B6-9, Unionville. Contact 905-940-1333, 1-800-361-5633 info@hepworkyr.org www.hepworkyr.org

QUEBEC:

Quebec City Region
Contact Renee Dauro 418-836-2307 reneedaurio@hotmail.com

CAHAP support group meetings 3rd Thurs. monthly 6-8PM, 5055 Rivard St., Montreal) Contact 514-521-0444 or 1-866-522-0444

ATLANTIC PROVINCES

Hepatitis Outreach Society of NS. Info and support line for the entire province. Call 1-800-521-0572, 902-420-1767.

Online Peer Support: info@heps.ca
www.heps.ca

PRAIRIE PROVINCES:

Manitoba Hepatitis C phone and email support and outreach. Info Line: 1-204-779-6464 or contact Kirk at info@mmbhep.com. Direct line: 1-204-389-5814

Medicine Hat, AB Hep C Support Group 1st & 3rd Wed. monthly, 6:30 PM, HIV/AIDS Network of S.E. AB 1-800-587-2550. Allowance Ave. Contact 403-527-7099 bettyw2@iwethernet.ca

To list Canadian groups here, please send details to info@hepca.ca by the 15th of the month. It’s free!