Hello,

The Abolitionist Law Center’s Hepatitis C Project was developed to assist incarcerated people throughout the state of Pennsylvania obtain Hepatitis C treatment. The Hepatitis C Project developed out of our work in Mumia Abu Jamal v. Kerestes. Since the project’s inception, we have corresponded with many throughout the state prisons that are living with Hepatitis C.

ALC does not have the individual capacity to represent every prisoner with Hepatitis C. In an effort to reach as many people as possible, we have created this pro se litigation packet. This packet can be used by any incarcerated patient with Hepatitis C to draft pro se litigation in an effort to obtain Hepatitis C treatment. The components of this packet include:

1. Hepatitis C factsheet
2. The American Association for the Study of Liver Diseases Guide on When and in Whom to Initiate HCV Therapy
3. List of common medical terms associated with Hepatitis C
4. List of medical tests associated with Hepatitis C
5. List of questions to ask your medical provider regarding your Hepatitis C
6. The PA DOC Hepatitis C treatment protocol
7. Instructions on how to file a grievance
8. Draft grievance
9. Jailhouse lawyer’s manual (written by Mumia Abu Jamal)
10. Legal brief instructions
11. Draft legal brief
12. Draft complaint

Please use this packet to assist in securing treatment. There is now a safe and effective cure for Hepatitis C, and there is no reason why so many should go without access to this cure. We hope this pro se litigation packet will help you get the Hepatitis C treatment that you are entitled to.

In Solidarity,

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Hepatitis C: the virus, the treatment, and the Pennsylvania DOC

What is Hepatitis C?

- A liver infection that is caused by the blood borne Hepatitis C virus (HCV)
- Most people are infected with HCV through injection drug use
- Can be an acute infection but for 75-85% of those infected, virus will become chronic
- Can result in long-term health problems such as cirrhosis, fibrosis, liver cancer, and death
- Currently there is no vaccine to prevent the spread of HCV
- An estimated 3.2 million people in the U.S suffer from chronic HCV
- Chronic HCV is the leading cause of liver transplantation in the U.S.
- The CDC estimates that 19,659 deaths in 2014 were contributed to or had an underlying cause of HCV
- A recent CDC study published in Clinical Infectious Disease, shows that annual hepatitis C-related mortality in 2013 surpassed the total combined number of deaths from 60 other infectious disease reported to the CDC, including HIV, and tuberculosis.
- HCV is spread through exposure to infected blood

Hepatitis C Treatment Information:

- Until several years ago, Interferon and Ribavirin were the only FDA approved drugs for HCV treatment
- Both of these drugs had 24-48 week treatment periods, adverse side effects, and only a 50% cure rate
- Newly developed direct acting anti-viral medications are only taken for 8-12 weeks, have a 95%+ cure rate, and far fewer side effects
- Several of these new medications are Harvoni, Sovaldi, Epclusa, and Viekira Pak
- While effective, these new medications are expensive, costing between $800-$1000 per pill
- Many private insurance companies and state Medicaid programs have refused to cover the cost of HCV treatment except in the most dire of medical circumstances
- But in states like Massachusetts, New York, and Florida, Medicaid coverage has been expanded to cover HCV treatment

Prison Healthcare and HCV:

- There are currently 6,000+ people in the PA Department of Corrections that are HCV positive and more than 99% are not receiving medical treatment
- Under former protocol, the DOC would delay or deny treatment to those not suffering from advanced disease progression
- Others were denied treatment because they were released prior to completion of the yearlong treatment
- In response to a study on new HCV treatments, the PA DOC suspended its former protocol as obsolete
• The PA DOC failed to authorize treatment with the new medications for almost two years.

• From December 2013 to November 2015, the PA DOC had no treatment protocol for their 6,000+ HCV positive inmates

• Salvatore Chimenti et al v. Pennsylvania Department of Corrections et al, 15-cv-333 (E.D. Pa) is a class action suit that has been filed in Federal Court, alleging that the DOC and its private contractor have refused to provide the new HepC drug to DOC inmates.

Goal of the Hepatitis C Project:

• The Hepatitis C Project developed out of our work in Abu-Jamal v. Kerestes
• The project will organize and train pro bono attorneys to litigate prison medical care claims for prisoners suffering from untreated HCV in the PA DOC
• Our goals are to compel the DOC to aggressively treat HCV, and to draw increased public attention to the HCV epidemic in prison
• By matching prisoners who have the strongest claims with legal counsel, we will greatly increase the pressure on the DOC to change its protocol, while obtaining life-saving treatment for many prisoners much faster, whose immediate need for treatment cannot wait for the resolution of a class action lawsuit.

References

**Common Medical Terms Associated with Hepatitis C**

**Hepatitis C**
- Inflammation of the liver due to the Hepatitis C virus

**HCV**
- Hepatitis C virus

**Genotype**
- Refers to the genetic make-up of the virus
- There are 6 distinct HCV genotypes identified
- Genotype 1 is the most common genotype seen in the United States
- Based on your genotype, the length of treatment, as well as the combination of medication will be determined

**Acute or Chronic HCV Infection**
- An acute infection lasts approximately 6 months and the body clears the virus
- A chronic infection cannot be cured with medical treatment

**Fibrosis**
- The first stage of liver scarring
- Fibrosis can range from very mild to extremely severe
  - F0 - no fibrosis
  - F1 - mild fibrosis
  - F2 - moderate fibrosis
  - F3 - severe fibrosis
  - F4 - cirrhosis

**Cirrhosis**
- The final stage of fibrosis
- Chronic liver damage
  - This stage leads to liver failure and the potential need for a liver transplant
  - As referred to as End Stage Liver Disease

**Sustained Virologic Response (SVR)**
- The body’s clearance of the HCV infection for at least 12 weeks after treatment has concluded
- Generally means patient has been cured

**Alanine Aminotransferase (ALT)**
- A liver enzyme
- High ALT levels can be a sign of liver damage

**Ascites**
- Fluid buildup in the abdomen
- Can be an indicator of liver failure, cirrhosis, or liver cancer

**Aspartate Transaminase (AST)**
- A liver enzyme
- High AST levels can be a sign of liver damage

**Hepatic Encephalopathy**
- Brain disorder that caused by liver damage
- When the liver is so damaged that it cannot remove toxins from the bloodstream and this causes “brain fog”
- Describes a range of cognitive dysfunction that includes mild confusion to personality changes to – in advanced disease stages – a coma.
Hepatocellular Carcinoma
- Liver cancer

HIV
- Human immunodeficiency virus
- The virus that causes AIDS
- People that are co-infected with HIV and HCV are strongly encouraged to be treated for their HCV
- According to the Center for Disease Control and Prevention, HCV related liver damage progresses more rapidly in people living with HIV

Interferon
- Naturally occurring substance that interferes with the ability for viruses to reproduce themselves
- Interferon therapy has been used to treat HCV

Jaundice
- Yellowning of the skin and whites of the eyes
- Is a sign that the liver is not functioning properly

Liver Biopsy
- Medical procedure that removes small portion of the liver to determine if there is any liver damage

Liver Failure
- Inability for the liver to function properly

Liver function tests
- Medical tests to determine the liver’s health and detect liver damage

Necroinflammation
- Tissue inflammation and death

Viral Load
- The amount of hepatitis c virus in the blood

Platelet Count
- Platelets are cells that help the blood clot
- Low platelet levels can indicate cirrhosis

Direct Acting Antivirals (DAA)
- The most recent medications prescribed for the treatment of Hepatitis C
- They work by targeting specific nonstructural proteins of the virus which disrupts viral replication and infection
- Current DAA’s on the market include:
  - Harvoni, Sovaldi, Viekira Pak, Epclusa, Technivie, Daklinza, Zepatier

Esophageal Varices
- Abnormal, enlarged veins in the tube that connects the throat and stomach
- Is found mostly in people with advanced liver diseases
- If varices rupture, there is a risk of bleeding to death internally

Anemia
- Condition where you have less than normal number of red blood cells

Extrahepatic Manifestations
- Conditions that can result from or be further aggravated by a chronic HCV infection
- Specific conditions include
  - Type 2 diabetes
  - Depression
Renal insufficiency
- Cardiovascular diseases
- Thyroid disease (hyperthyroidism and hypothyroidism)

Cutaneous Manifestations
- Skin conditions that can result from a chronic HCV infection
- Specific types of these conditions are
  - Eczema, psoriasis
Medical Tests for HepC

Hepatitis C Virus Test
- A blood test that looks for antibodies against HCV virus. This test determines if you have been exposed to HCV.

Genetic Material (RNA) Test
- A blood test that determines if you are currently infected with the virus.

Genotype Test
- A blood test that determines which genotype of the Hepatitis C virus you have. Knowing your specific genotype is important in terms of which medication will be used for treatment.

Liver Function Test
- A series of blood tests to determine if you have liver damage from the Hepatitis C infection.
  - Alanine aminotransferase (ALT of SGPT)
    - The ALT enzyme is found primarily in the liver. The body uses ALT to break down food into energy. Normally, ALT levels are low. If there is liver damage, it will release more ALT into the bloodstream and the levels will rise.
      - Normal levels of ALT are 7-56 units of the enzyme per liter of blood
  - Aspartate aminotransferase (AST or SGOT)
    - The AST enzyme is an enzyme that the liver makes. Normally, AST levels are low. If there is liver damage, it will increase AST levels in the bloodstream.
      - Normal levels of AST are 10-40 units of the enzyme per liter of blood

Liver Biopsy
- A medical procedure where a doctor inserts a needle into the liver, removes a small portion of it, and tests it to determine whether the Hepatitis C virus has caused liver scarring or damage (also known as fibrosis).

Liver Ultrasound, MRI, CT Scan
- Are all imaging tests to determine if you have liver cancer as a result of your Hepatitis C.

Platelet Count
- Platelets are particles in your bloodstream that help with blood clotting. A low platelet count, a condition called thrombocytopenia, is a dangerous condition where the body is unable to stop bleeding. Advanced Hepatitis C progression can lead to low platelet count.
  - A normal range for a platelet count is 140,000-450,000 platelets per microliter of blood, and they are typically referenced by on the first three numbers, for instance a platelet count of 140 refers to an actual count of 140,000. People that have Hepatitis C often fall below the normal platelet count

METAVIR scale
- An algorithm that is used to determine if you have fibrosis and if so what level of fibrosis you have
- This scale grades the level of fibrosis on a 5-point scale from 0-4, 0 indicates no fibrosis and 4 indicates cirrhosis (which is advanced fibrosis)
- This scale also grades the level of liver inflammation on a 4-point scale from A0 to A3. A0 indicates no inflammation and A3 indicates severe inflammation
- Your METAVIR score is used to interpret the results of liver biopsy, which is the best method to determine if you have fibrosis.

Aspartate aminotransferase-to-platelet ratio index (APRI score)
- Calculation of AST score and platelet count
- An algorithm used to predict the advancement of cirrhosis
  - Considered a less invasive alternative to a liver biopsy
  - Lower APRI scores, however, are known to be highly inaccurate, missing many instances of cirrhosis. Individuals with lower APRI scores may actually have advanced fibrosis or cirrhosis. That is why it is important for a range of information to be considered when assessing the degree of disease progression and the possible extent of liver damage caused by hepatitis C.
  - Information on APRI Scores/Ranges and their meanings
    - APRI score = ratio x 100 = 1.09
    - Interpretation <0.5 no fibrosis; >1.5 cirrhosis; 0.5-1.5 fibrosis grades 1-4

Sheer Wave Elastography
- A noninvasive method of detecting liver fibrosis
- It measures liver stiffness
  - There is a correlation between liver stiffness and liver inflammation (necroinflammatory activity) and liver scarring (fibrosis)
  - Fibrosis increases hardness of tissue
  - Liver stiffness levels in healthy subjects is around 1.5kPa for women and 1.6kPa for men
    - Liver stiffness levels in people with mild fibrosis likely is 2.5-7kPa
    - Liver stiffness levels for people with likely cirrhosis is >12.5kPa

HALT C Score
- A score the DOC uses to measure the percentage of probability (0-100%) that a patient already has cirrhosis

Child Pugh Score
- Is a classification system used to assess the presence of chronic liver disease and cirrhosis
- This system considers scores for bilirubin, albumin, INR, ascites, and encephalopathy
  - Bilirubin
    - A substance released when red blood cells are destroyed and pass on to the liver
    - High bilirubin levels mean the liver is not functioning properly
    - Prolonged periods of high bilirubin levels usually indicates severe liver disease or potentially cirrhosis
  - Albumin
    - A protein made by the liver that prevents fluid from leaking out of the blood vessels
    - Low albumin levels in people with HCV can be a sign of cirrhosis
  - INR (International Normalized Ratio)
    - A blood-clotting test
    - A normal INR is 1.0 and each 0.1 increase means the blood is thinner and less likely to clot
    - For people with serious liver disease or cirrhosis, blood may not clot normally
      - This is indicated by a high INR
- Ascites
  - Condition that is accumulation of fluid in the abdominal cavity
  - Is common in people with cirrhosis and typically develops once the liver has begun to fail
  - Indicates advanced liver disease
  - People with ascites should be referred for consideration of a liver transplant
- Encephalopathy
  - A condition that involves the loss of brain function when the liver is so damaged that it cannot remove toxins from the blood and causes “brain fog”

MELD Score (Model for End-Stage Liver Disease)
- A score used to measure the mortality risk for people with end stage liver disease
- Is score is often used to prioritize people for liver transplants
  - Is currently used more frequently than the Child Pugh score
Questions to ask Medical Provider Re: Hepatitis C

To better advocate for yourself as a patient you need diagnostic information on your hepatitis C infection – its progression, symptoms, and how it affects or may affect other aspects of your health. Below are questions you should ask medical staff when you see them and through informal Requests to Staff.

1. I have been identified as having chronic Hepatitis C, does that mean that I will automatically be monitored in the Hepatitis C Chronic Care Clinic?
2. What is my genotype (1, 2, 3, 4, 5, 6)?
3. What is my viral load?
4. What is my platelet count?
5. What is my APRI score?
6. What is my HALT C score?
7. I am requesting to view my medical records. When will this be scheduled?
8. I currently have (insert your existing symptoms) are any of these symptoms related to my Hepatitis C?
9. Do I have fibrosis, if yes what stage (F0, F1, F2, F3, F4)?
10. Do I have cirrhosis, if yes, is it compensated or decompensated)?
11. Do I have liver cancer?
12. According to my medical records, have I had any of the following tests, and what were the results of these tests if they have been conducted?
   a. Genotype test
   b. Liver function test
   c. Ultrasound
   d. CT scan
13. If the answer to #12 is yes, I would like to discuss the results of my testing and what it means regarding the progression of my Hepatitis C.
Section 20 – Hepatitis C Protocol

Section 20 – Hepatitis C Protocol

A. Introduction

1. This Hepatitis C Protocol for the Pennsylvania Department of Corrections (PA DOC) provides clinical guidelines for the diagnosis, management, and treatment of inmate patients with chronic Hepatitis C Virus (HCV). HCV is a slowly progressive disease, usually requiring more than 20-40 years to progress to cirrhosis; however, the natural history of HCV is variable and not all patients with chronic HCV will develop cirrhosis during their lifetime. Before a patient develops cirrhosis, the short-term risk of a liver-related complication is low. Once a patient progresses to compensated cirrhosis, there is a higher risk of developing decompensated cirrhosis and or hepatocellular carcinoma (HCC).

2. The goal of Hepatitis C anti-viral treatment is to achieve a sustained virological response (SVR), defined as undetectable HCV virus in the blood, 12 or more weeks after completing anti-viral treatment. Achieving an SVR among patients with compensated cirrhosis reduces the risk of developing decompensated cirrhosis and HCC. Thus, patients with cirrhosis are more likely to have a morbidity and mortality benefit from an SVR and require more urgent need for DAA (Direct Acting Antivirals) treatment (for content reference, please see Subsection J.1. below).

B. Screening

1. All new intakes will be screened at their home institutions utilizing the Hepatitis C Antibody test. Anyone may refuse testing by signing a DC-462, Release from Responsibility for Medical Treatment Form.

2. The Infection Control Nurse (ICN) will review positive antibody results with all inmates, whether it be at intake or later during incarceration. The Medical Director/designee will order a confirmatory Hepatitis C Ribonucleic Acid (RNA) Quantitative Polymerase Chain Reaction (PCR) test (viral load). Recommended immunizations, counseling, and literature will be provided during that encounter.

3. The ICN shall advise each patient regarding the DOC's Hepatitis C Protocol relating to the documentation of tattoos, positive drug screens, and non-adherence with medical regimens and have the inmate sign a Hepatitis C Anti-Viral Treatment Protocol Acknowledgement Form (Attachment 20-A). If the inmate refuses to sign the form, the ICN shall follow the instructions noted on the form. The Site ICN shall also sign the form.

4. Inmate patients with documented (+) Hepatitis C Antibody test should not be retested, but entered into tracking.

5. Inmate patients who have a documented undetectable Hepatitis C Quantitative PCR may become re-infected while out on parole. If they return to the PA DOC, the Medical Director/designee shall order a repeat viral load on intake.
C. Tracking

For all patients with a positive HCV antibody test, the ICN will maintain a current Hepatitis C Tracking Spreadsheet (Attachment 20-B) in Excel format. This spreadsheet will be forwarded to the Bureau of Health Care Services (BHCS) Infection Control Coordinator (ICC) on a monthly basis.

D. Diagnosing Cirrhosis (for content reference, please see Subsection J.2. below)

1. Assessing for cirrhosis is important for prioritizing inmates for treatment of HCV and in determining the need for additional health care interventions. Cirrhosis may be diagnosed in several ways:

   a. Symptoms and signs that support the diagnosis of cirrhosis may include: Low albumin or platelets, elevated bilirubin or International Normalized Ratio (INR), ascites, esophageal varices, and hepatic encephalopathy. However, isolated lab abnormalities may require additional diagnostic evaluation to determine the etiology.

   b. The AST (Aspartate Aminotransferase) to Platelet Ratio Index (APRI) score is the DOC-preferred initial method for non-invasive assessment of hepatic fibrosis and cirrhosis:

      (1) An APRI score $\geq 2.0$ may be used to predict the presence of cirrhosis. At this cutoff, the APRI score has a sensitivity of 48%, but a specificity of 94%, for predicting cirrhosis. Inmates with an APRI score $\geq 2.0$ should have an abdominal ultrasound performed to identify other findings consistent with cirrhosis (see abdominal imaging studies below in this list). Lower APRI scores have different sensitivities and specificities for cirrhosis. For example, an APRI score $\geq 1$ has a sensitivity of 77% and a specificity of 75% for predicting cirrhosis.

      (2) An APRI score is not necessary for diagnosing cirrhosis if cirrhosis has been diagnosed by other means.

      (3) The APRI may also be used to predict the presence of significant fibrosis (stages 2 to 4, out of 4). Using a cutoff of $\geq 1.5$, the sensitivity is 37%, and specificity is 95% for significant fibrosis.

      (4) A single APRI score should not be used in isolation. There are multiple medications and conditions that can result in a transient elevation of AST.

      (5) The APRI score may be invalidated in cases of splenectomy.

2. Liver biopsy is no longer required unless otherwise clinically indicated. However, the presence of cirrhosis on a prior liver biopsy may be used to meet the DOC criteria for HCV treatment.
3. Abdominal imaging studies such as ultrasound or computerized tomography (CT) scan may identify findings consistent with or suggestive of the following: cirrhosis (nodular contour of the liver), portal hypertension (ascites, splenomegaly, varices), or hepatocellular carcinoma (HCC).

E. Assessing Hepatic Compensation (for content reference, please see Subsection J.2. below)

1. Assessing hepatic compensation is important for determining the most appropriate HCV treatment regimen to be used. The recommended HCV treatment regimen may differ depending on whether the cirrhosis is compensated or decompensated.

2. The CTP (Child-Turcotte-Pugh) score is a useful tool to help determine the severity of cirrhosis and is used by the American Association for the Study of Liver Diseases (AASLD) to distinguish between compensated and decompensated liver disease in patients with known or suspected cirrhosis.

   a. CTP calculator available in the Resource Section of the electronic health record.

   b. The CTP score includes five parameters (albumin, bilirubin, INR, ascites, and hepatic encephalopathy), each of which is given a score of 1, 2, or 3. The sum of the five scores is the CTP score, which is classified as shown in the table below:

<table>
<thead>
<tr>
<th>CTP SCORE</th>
<th>CTP CLASS</th>
<th>HEPATIC COMPENSATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>5–6</td>
<td>Class A</td>
<td>Compensated cirrhosis</td>
</tr>
<tr>
<td>7–9</td>
<td>Class B</td>
<td></td>
</tr>
<tr>
<td>≥ 10</td>
<td>Class C</td>
<td>Decompensated cirrhosis</td>
</tr>
</tbody>
</table>

   c. A CTP score of 5 or 6 is considered to be compensated cirrhosis, while a score of 7 or greater is considered decompensated.

   (1) Warfarin anticoagulation will invalidate CTP calculations if the INR is 1.7 or higher.

   (2) It is recommended that cases of decompensated cirrhosis be managed in consultation with a clinician experienced in the treatment of this condition because the dosages of DAA medications are not well-established with significant hepatic impairment.

F. Additional Interventions for Inmates with Cirrhosis: (for content reference, please see Subsection J.2. below)

1. Pneumococcal vaccine: Offer to all HCV-infected inmates with cirrhosis who are 19 through 64 years of age.
2. HCC screening: Liver ultrasound is recommended every six months for patients with both cirrhosis and chronic HCV infection.

3. Esophageal varices screening: Screening for esophageal and gastric varices with esophagogastroduodenoscopy (EGD) is recommended for patients diagnosed with cirrhosis.

4. Other healthcare interventions recommended for patients with cirrhosis may include:
   b. Antibiotic prophylaxis if risk factors are present for spontaneous bacterial peritonitis.
   c. Optimized diuretic therapy for ascites.
   d. Lactulose and rifaximin therapy for encephalopathy.

5. In general, Non-Steroidal Anti-Inflammatory Drugs (NSAID) should be avoided in advanced liver disease/cirrhosis, and metformin should be avoided in decompensated cirrhosis. The detailed management of cirrhosis is beyond the scope of these guidelines. Other resources should be consulted for more specific recommendations related to this condition.

G. Chronic Care Clinic

1. All patients who have chronic Hepatitis C (confirmed by a detectable viral load) will be entered into the Liver Disease Chronic Care Clinic. The ICN will confer with the Site Medical Director to determine if the patient’s diagnosis is:
   a. F0-F2 (no fibrosis, mild fibrosis, or moderate fibrosis). All cases not documented F3 or F4.
   b. F3 (advanced fibrosis). Documented by liver biopsy or elastography.

2. Patients who are antibody positive only (confirmed by an undetectable viral load) do not have chronic Hepatitis C and will be followed in Chronic Care Clinic at the discretion of the Site Medical Director, if the patient exhibits signs or symptoms of liver disease. Patients who have been treated with medication will continue to be followed in Chronic Care Clinic, whether or not they achieved a SVR.

3. At a minimum, the following will be documented in a Progress Note during the Chronic Care Clinic encounter:
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a. Subjective:
   (1) symptoms of cirrhosis or liver failure;
   (2) history of ascites, encephalopathy, or esophageal varices (bleeding or not);
   (3) estimated date of contracting the disease; and
   (4) any recent admissions to the Infirmary, emergency room (ER), or hospital.

b. Objective:
   (1) vital signs, weight, and Body Mass Index (BMI);
   (2) examination of the sclera for jaundice;
   (3) examination of the abdomen, including both ascites and the size and character of either hepatomegaly or splenomegaly;
   (4) examination of the skin for changes suggestive of cirrhosis (jaundice, spider angiomata/telangiectasia, palmar erythema, and caput medusae);
   (5) examination of the neurological system for the presence of asterixis ("liver flap");
   (6) fibrosis stage, if known, and method used to determine the fibrosis stage (e.g. liver biopsy or elastography);
   (7) calculation of the APRI, using the calculator located in the Resource Section of the electronic health record;
   (8) calculation of the Model of End Stage Liver Disease (MELD) score and the CTP score for patients with cirrhosis, using the calculator located in the Resource Section of the electronic health record;
   (9) review of any results of the EGD, elastography, or abdominal ultrasound; and
   (10) examination of pertinent laboratory results.

c. Assessment:
   (1) F0-F2 (no fibrosis, mild fibrosis, or moderate fibrosis);
   (2) F3 (advanced fibrosis); or
   (3) F4 (cirrhosis).
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d. Plan of Treatment:

(1) schedule the follow-up Clinic appointment according to the assessment:

(a) F0-F2 (six months);

(b) F3 (three months); or

(c) F4 (one month).

(2) diagnostics ordered will include the following:

(a) initial Chronic Care Clinic for all patients: Comprehensive Metabolic Profile (CMP), Complete Blood Count (CBC), Chronic Hepatitis Panel, and Prothrombin Time (PT)/INR;

(b) yearly labs for all patients: CMP, CBC, and PT/INR.

(c) every six month labs for patients with cirrhosis (F4): CMP, CBC, PT/INR and abdominal ultrasound to evaluate for HCC;

(d) every six month labs for patients without cirrhosis (F0-F3): Liver Function Tests (LFTs) and CBC; and

(e) monthly visits for patients with cirrhosis (F4): No labs required.

4. If the APRI > 1.5 or the Platelet Count is < 100,000/mcL, notify the ICN.

H. Evaluation for Treatment with Anti-Viral Medication

1. The PA DOC will utilize the Federal Bureau of Prisons (FBOP) Priority Criteria as listed in the ‘Evaluation and Management of Chronic Hepatitis C Virus (HCV) Infection Clinical Practice Guidelines, April 2016.’ (please refer to Subsection J.2. below)

2. Determining whether PA DOC priority criteria for treatment are met is an important part of the initial evaluation and ongoing management of inmates with chronic HCV infection. Although all patients with chronic HCV infection may benefit from treatment, certain cases are at higher risk for complications or disease progression and require more urgent consideration for treatment.

3. The PA DOC will use Shear Wave Elastography to determine fibrosis scoring for patients without a diagnosis of cirrhosis who have an APRI > 1.5, a platelet count < 100,000/mcL, or select patients as clinically indicated.

4. The DOC has established priority criteria to ensure that those with the greatest need are identified and treated first (for content reference, please see Subsection J.2. below).
The DOC Chief of Clinical Services will provide periodic guidance on specific strategies for implementing these priority levels:

a. Priority Level 1 – Highest Priority for Treatment

1. Cirrhosis

   (a) This includes cases of known cirrhosis or clinical findings consistent with cirrhosis.

   (b) Cases of decompensated cirrhosis with a CTP score of ≥ 7 should receive the highest priority for treatment.

   (c) Patients with an isolated APRI score ≥ 2 with no other clinical findings of cirrhosis are included in Priority Level 2.

2. Liver Transplant Candidates or Recipients

   Other types of transplant candidates or recipients may be appropriate to prioritize for treatment and will be considered individually on a case-by-case basis.

3. Hepatocellular Carcinoma (HCC)

   (a) At least one third of all cases of HCC occur in association with HCV infection, with most cases occurring in those with advanced fibrosis or cirrhosis.

   (b) Current guidelines do not address the role of HCV treatment in the management of HCC.

   (c) HCV treatment in HCC cases will be determined individually and require consultation with an appropriate specialist.

4. Comorbid Medical Conditions Associated with HCV, including:

   (a) Cryoglobulinemia with renal disease or vasculitis; and/or

   (b) certain types of lymphomas or hematologic malignancies.

5. Chronic Kidney Disease with glomerular filtration rate (GFR) < 30 mL/min per 1.73 m², including dialysis patients.

6. Immunosuppressant Medication for a Comorbid Medical Condition

   Some immunosuppressant medications (e.g., certain chemotherapy agents and tumor necrosis factor inhibitors) may be needed to treat a comorbid
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medical condition, but are not recommended for use when infection is
present. However, data are insufficient and current guidelines are inconsistent
regarding treatment of HCV infection in this setting. Such cases will be
considered for HCV treatment on an individual basis.

(7) Continuity of Care for those already started on treatment, including inmates who
are newly incarcerated in the DOC.

b. Priority Level 2 – High Priority for Treatment

(1) APRI score \( \geq 2 \).

(2) Advanced fibrosis on liver biopsy (e.g., Metavir Stage 3 bridging fibrosis).

(3) Hepatitis B Virus (HBV) coinfection.

(4) Human Immunodeficiency Virus (HIV) coinfection.

(5) Comorbid liver diseases (e.g., autoimmune hepatitis, hemochromatosis,
steatohepatitis, etc.).

(6) Chronic kidney disease (CKD) with GFR 30–59 mL/min per 1.73 m\(^2\) (calculated
at least twice at one month intervals).

c. Priority Level 3 – Intermediate Priority for Treatment

(1) Stage 2 fibrosis on liver biopsy.

(2) APRI score 1.5 to < 2.

(3) Diabetes mellitus.

(4) Porphyria cutanea tarda.

d. Priority Level 4 – Routine Priority for Treatment

(1) Stage 0 to stage 1 fibrosis on liver biopsy.

(2) All other cases of HCV infection meeting the eligibility criteria for treatment, as
noted below under Subsection H.4.f. below, “Other Criteria for Treatment.”

e. Exceptions to the above criteria for Priority Levels 1–4 will be made on an individual
basis and will be determined primarily by a compelling or urgent need for treatment,
such as evidence for rapid progression of fibrosis, or deteriorating health status from
other comorbidities.

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f. Other Criteria for Treatment

In addition to meeting the above criteria for Priority Levels 1–4, inmates being considered for treatment of HCV infection should:

(1) have no contraindications to, or significant drug interactions with, any component of the treatment regimen;

(2) not be pregnant, especially for any regimen that would require ribavirin or interferon;

(3) have sufficient time remaining on their sentence in the DOC to complete a course of treatment;

(4) have a life expectancy > 18 months; and

(5) demonstrate a willingness and an ability to adhere to a structured treatment regimen and to abstain from high-risk activities while incarcerated.

5. The first level of screening patients for treatment with anti-viral medications will occur at the patient’s home site. Patients with either:

a. APRI>1.5, or

b. Platelet Count < 100,000 will have an initial review of their medical chart only.

The review will be conducted utilizing the Hepatitis C Treatment Referral Form (Attachment 20-C) and will be conducted by the Correctional Health Care Administrator (CHCA), ICN, and Site Medical Director, who will look for the presence of any exclusionary indications listed below.

6. Exclusionary indications include the following:

a. medical exclusions:

(1) an unstable medical condition, to include, but not limited to, cardiopulmonary, cancer, and diabetes. The Site Medical Director will provide clinical information to the Hepatitis C Treatment Committee, which will evaluate and make a determination; and

(2) an undetectable Hepatitis C Quantitative PCR (viral load).

b. administrative exclusions – documented by the CHCA:

(1) current incarceration less than 12 months, unless already taking anti-viral medications;
13.2.1, Access to Health Care Procedures Manual
Section 20 – Hepatitis C Protocol

(2) expected release from custody within six months;

(3) documented new tattoos during the previous 12 months of incarceration, resulting in a misconduct;

(4) documented positive drug screens during the previous 12 months of incarceration, resulting in a misconduct; and

(5) documented pattern of non-adherence with medical regimens during the previous two months of incarceration.

7. If the CHCA determines that there are no exclusionary indications to anti-viral treatment, the Hepatitis C Treatment Referral Form shall be forwarded to the BHCS ICC for further evaluation, possible recommendations for further testing, and initial determination.

I. Hepatitis C Treatment Committee

1. The PA DOC has determined that there is no single method of prioritizing patients for treatment with anti-viral medications. Therefore, the patient’s clinical status will be reviewed by a Hepatitis C Treatment Committee, consisting of the PA DOC BHCS Chief of Clinical Services, the Statewide Medical Director for the medical vendor, and the BHCS ICC. Others may be invited to participate on an ad hoc basis.

2. The Committee will utilize the pertinent information available to determine if continued progression through the evaluation process is indicated. The review may include, but will not be limited to, laboratory test trending (INR, AST, albumin, platelet count, bilirubin, etc.), Fibrosure, previous shear wave elastography, liver biopsy, previous treatment results, APRI score, MELD score, and the CTP score. The Committee will also review the stability of any chronic medical and mental health conditions. If the patient is considered a candidate for treatment with anti-viral medication, shear wave elastography will be approved to document the stage of fibrosis/cirrhosis.

3. If the patient meets any of the criteria designated Priority Level 1 – Highest Priority for Treatment, as outlined in Subsection H.4.a. above, proceed with the following:

   a. full ultrasound screening for HCC every six months;

   b. EGD for esophageal varices surveillance;

   c. refer to Supervisory Physician for final review and the ordering of DAA medications unless there are contraindications; and

   d. follow in Chronic Care Clinic every month.

4. For those patients approved for elastography, the results will be forwarded to the Committee for review.
13.2.1, Access to Health Care Procedures Manual
Section 20 – Hepatitis C Protocol

a. Fibrosis Stage 0-2
   (1) Repeat Elastography in two years.
   (2) Follow in Chronic Care Clinic every six months.

b. Fibrosis Stage 3
   (1) Refer to the Supervising Physician for final review and the ordering of DAA medications unless there are contraindications.
   (2) Follow in Chronic Care Clinic every three months.

c. Fibrosis Stage 4
   (1) Full ultrasound screening for HCC every six months.
   (2) EGD for esophageal varices surveillance.
   (3) Refer to the Supervising Physician for final review and the ordering of DAA medications unless there are contraindications.
   (4) Follow in Chronic Care Clinic every month.

4. The Committee will render its decision and forward the determination, along with follow-up recommendations for those not meeting current priority criteria for greatest need of treatment with anti-viral medications, to the ICN and Site Medical Director, who will then discuss the results with the patient and document the encounter in the DC-472, Progress Notes.

5. If the Committee recommends treatment with anti-viral medication, the Site Medical Director will refer the patient to a supervising physician who will direct the anti-viral treatment. The referral will be made utilizing a Hepatitis C Treatment Referral Form, to include the following updated laboratory results:

   a. genotype, if not already documented;
   b. viral load (within one year);
   c. HIV (within one year);
   d. CMP (within one month);
   e. CBC (within one month);
   f. abdominal sonogram for patients with cirrhosis (within six months);
g. as stated in the current contract with the medical vendor, the Supervising Physician must be licensed in Pennsylvania and experienced in the treatment of Hepatitis C utilizing the most current medications. The patient will remain at his/her home institution and treatment will be ordered by the Site Medical Director, under the direction of the Supervising Physician. The Supervising Physician may utilize a Physician Assistant-Certified (PA-C) or a Certified Registered Nurse Practitioner (CRNP), who would be dedicated to the statewide Hepatitis C Program. The Supervising Physician would train and mentor the PA-C or CRNP, and would retain overall treatment responsibility; and

h. the treatment of HCV with anti-viral medications is rapidly evolving. New medications are being approved by the Federal Drug Administration (FDA) frequently. The regimens currently approved by PA DOC will be included in the Diamond Pharmacy Services Formulary for this contract. The Formulary will include all necessary prescribing information and will be updated quarterly via the PA DOC Pharmacy and Therapeutics Committee.

J. References


Grievance Instructions

1. These instructions are for individuals in custody of the PA DOC who have chronic hepatitis C.

2. If you have chronic hepatitis C and wish to pursue legal action seeking treatment you must first complete the grievance process. Failure to complete with the grievance process and follow all its rules will result in any lawsuit you bring being thrown out of court.

3. First, obtain the grievance form at your institution. File a grievance using the enclosed model grievance as a basis. Add additional facts specific to your symptoms and situation.

4. Be sure to identify all those DOC and Correct Care Solutions officials named in the model grievance as well as the medical director at your institution.

5. Include the date and indicate you are filing a grievance about not being provided treatment at this current time.

6. Request treatment and monetary damages. Emphasize there is no medical justification for refusing to provide treatment with direct-acting antiviral medications.

Appeals

7. Upon rejection of your grievance, file a prompt appeal as soon as you can.

8. Follow instructions as provided in the DC-ADM 804.

9. Make the same arguments as in the initial grievance: you request immediate treatment with the direct-acting antiviral medications that are the standard of care in the community for patients with chronic hepatitis C such as yourself.

10. Identify the individuals and entities the grievance is filed against again.

11. Request immediate treatment and monetary damages again.

12. When the facility manager rejects your grievance, repeat the appeal process to Central Office. Same arguments, same officials/entities, same request for relief.

13. You must exhaust the appeals process all the way to Central Office.

14. In the event DOC officials refuse to consider the grievance on the merits and instruct you to file another one, you should both a) appeal that rejection and request merits review on appeal, and b) file a new grievance.
Model Grievance

I am filing this grievance because the continued refusal of DOC to treat my hepatitis C is causing me ongoing health problems, including [INSERT SYMPTOMS HERE].

I am submitting this grievance against the DOC, Secretary Wetzel, Correct Care Solutions, BHCS Director Joseph Silva, Dr. Paul Noel, Dr. Jay Cowan, the DOC’s hepatitis C committee, Superintendent ________________, CHCA ____________, and Dr. __________, any and all individuals or entities responsible for refusing to provide me with direct-acting antiviral medications to cure my hepatitis C.

The hepatitis C from which I suffer is causing on-going and irreversible damage to my liver. I have liver scarring [indicate if fibrosis or cirrhosis if you know] and the above-named symptoms, and been placed at a much greater risk of developing liver disease, hepatocellular carcinoma, as well as an increased risk of death

Dr. ________________ at this institution knows I am in need of treatment. Dr. Noel and Dr. Cowan know that the standard of care for individuals with chronic hepatitis C like myself is immediate treatment with direct-acting antiviral medications.

I am not being treated today, MONTH___, 2018, nor was I treated at all any other previous time, despite it being known by all medical staff that I am in need of treatment. Every day I am not treated I have been in need of treatment and been refused such in violation of my rights under the Eighth Amendment and state medical malpractice law.

As recently recognized by a federal court in Abu-Jamal v. Wetzel, I have an Eighth Amendment right to treatment for my hepatitis C in accord with the standard of care in the community.

There is no medical reason for denying me treatment, as the medications for treating hepatitis C are fast-acting, safe, and effective. The DOC, including all individuals named in this grievance, have denied and delayed treatment without any medical justification up to the present moment. I am requesting treatment with direct-acting antiviral drugs. I am also requesting monetary compensation for the extreme delay and continued denial of necessary treatment for my hepatitis C.

DATE: December ____, 2018

_________________________________
The Hep C Jailhouse Lawyer’s Manual

By Mumia Abu-Jamal, with the assistance of the Abolitionist Law Center in Pittsburgh, PA

This manual is designed to walk any person, infected with Hepatitis C through the obstacle courses erected by medical staff and prison officials who seek to deny or delay hepatitis C treatment which leads to a cure from the infection.

This manual will be simple, clear, and to the point. If you can read, it will provide a step by step process that leads to a cure of Hep C or puts you in the best position to litigate your case successfully.

But let’s not get ahead of ourselves! First you should write to your institution’s medical department to request testing to determine if you have hepatitis c. This response from your institution’s health care provider(s) should answer your request in a relatively short period of time.

If you do not receive an answer, you may wish to formally submit a Sick Call Slip, even if it costs several dollars to do so (Isn’t your life or health worth $5 or $10)? Upon meeting your care giver please be clear on what you want, a hepatitis c blood test.

Initially, this blood test will determine if you are, or are not, hepatitis c positive. Some medical staff provide viral loads, but don’t be fooled, for such a measure has little impact on hep C cases. The viral load only means that the infection is present in one’s system.

You may wish to find out what your “F Scale” level is. F Scales are: F0-F1-F2-F3-F4. F0 represents the lowest level, while F4 represents the highest level, ranging from no fibrosis to cirrhosis of the liver. Cirrhosis of the liver can lead to liver cancer and death.

If the medical staff consents to treat you and treats you with direct acting antiviral medications (like Harvoni, Sovaldi, or Epclusa) your hepatitis problems should be over (although it should be noted that some people have side effects, although these drugs are a vast improvement over the former hep C treatments.) In any event if you do get treated, your hep C problems should be over after some 12 weeks of treatment with the DAAV meds. So good for you!

If, however, they return any response which denies (or unreasonably delays) treatment, or states that you are not sick enough to be treated, it is a violation of the principles set forth in Estelle v. Gamble {429 U.S. 97 (1976)} and Abu-Jamal v. Wetzel {2017 WL 34700 (M.D., Pa. Jan. 3, 2017)}, where the Court, applying Estelle, found that the state defendants, by denying curative treatment for hep C, were “deliberately indifferent” to the prisoners’ “serious medical needs.”

Hepatitis C if left untreated can lead to suffering from what are called “extra hepatic” (liver related) symptoms and maladies. Therefore, an active hepatitis C infection is a serious medical need that requires curative treatment by DAAV meds (direct-acting anti-virals) to avoid further destabilization and liver dysfunction.

Question: “What do I do when I get a denial back?”

Don’t panic. Don’t shrug. Don’t stop
According to the Prison Litigation Reform Act {(PLRA) Tit. 42 U.S.C. 1997e(a)}, a prisoner seeking to sue in federal court must exhaust all administrative remedies available. If you fail to go through this process, your civil rights complaint, and possible your Motion for a Preliminary Injunction, will be dismissed.

So, what do you do?

Once you receive your request slip or statement by the healthcare professional (Dr., RN, NP, etc.) denying treatment, write your grievance stating when you learned you were hepatitis C positive, the date you were refused treatment, and the reasons given to you for such denial (such as not sick enough.)

Next, appeal, appeal, appeal—to the final level of the DOC or prison system in your state. Once you get that final denial, you can then go to court. (If you have any questions about your institution’s grievance process/procedure, read your handbook).

Remember, when you file your suit, be sure to name every person who denied treatment, DOC staff, and medical staff alike. If you notice any symptoms that may be the result of your hep C infection (for example, increased urination, headaches, or fevers), list or recite them in your grievance.

Don’t be shy about asking questions about your health to infirmary/healthcare staff. When you are told anything, it’s a good idea to keep clear notes—and date them. Given the havoc of prison life, keep your notes together, as in a notebook or brown envelope so you can retrieve them for when you are preparing your civil suit, or grievance appeals.

To be absolutely clear, and to ensure that all necessary steps are taken, we are preparing checklists for you. Make a Xerox copy or simply rewrite in this handbook. Make doubly sure that you have checked the necessary boxes to ensure your best chance of preparing, writing, and filing your suit for the state’s violation of your 8th Amendment (cruel and unusual punishments) and medical claims.

**MY HEP-C CHECKLIST**

1. Filing of Sick Call Request:       Date:  
2. Date of Sick Call up to Medical:  Date:  
3. Request for Hep C Blood Test:    Date:  
4. Date blood taken:                Date:  
5. Date blood test returned:        Date:  
6. Date blood test refused:         Dr./Nurse name:  
7. Date blood test noted positive for Hep C:  Dr./Nurse name:  
8. File another Sick Call Slip requesting DAAV meds for Hep C Date:  
9. Note by date and name of denial of DAAV meds Date:  Dr./Nurse name:  
10. Note Hep C viral load Date: Names:  Viral Load #:  
11. Note reason given for denial of DAA treatment: Date
12. Name of person giving reasons for denial:

NOTE: AT THIS POINT YOU MAY FILE YOUR GRIEVANCE WITH THE INSTITUTION. YOU HAVE 15 DAYS TO FILE A GRIEVANCE (UNDER PENNSYLVANIA’S RULES), BUT KNOWING HOW TIME (AND ATTENTION) FLIES, WE SUGGEST YOU CHECK YOUR NOTES AND CHECKLIST—AND FILE AS QUICKLY AS POSSIBLE.

2ND NOTE: REQUEST IMMEDIATE TREATMENT FOR YOUR HEP C INFECTION, AND STATE THAT MED STAFF (NAMES!) INFORMED YOU WHY THEY DENIED TREATMENT. UNDER GRIEVANCE RULES, YOU MAY REQUEST ANY RELIEF THAT A COURT MAY GRANT, SUCH AS PRELIMINARY JUDGEMENT, IMMEDIATE TREATMENT AND UNSPECIFIED MONEY DAMAGES FOR PAIN, SUFFERING AND DENIAL OF TREATMENT.

Later in this manual, we will provide sample pleadings for pro se jailhouse lawyers (like you) prepared by staff attorneys at Abolitionist Law Center. Read them carefully as a guide for your pleadings. Don’t just Xerox and copy. Change stuff to fit your situation, and thus make it your own, ok?

Keep your checklist handy so that you can put in your own facts, names, dates, and events that happened in your own case. The checklist will prove invaluable to you in writing your actual Complaint and also preparing your Motion for Preliminary Injunction (or Temporary restraining order), for example.

If you are in a cell sick, suffering from the symptoms of Hepatitis C, don’t panic. Don’t freak out. Get your ink pen and get to work, ok?

Remember, denial of treatment for your Hep C infection, for any reason, is a violation of your Eight Amendment, constitutional rights, under Estelle v. Gamble, where the US Supreme Court ruled that states cannot show “deliberate indifference” to a prisoner’s “serious medical needs.”

Anything that can kill you is “serious.” But you must prepare the ground. You must take the first steps to forcing the DOC to treat your “serious medical need.”

If you sit back and wait—you sit back and die.

It’s important for you to know that the private company (known as the medical contractor), that operates in your prison is engaged more in a business than in medicine. To make money—to save money—they will deny you treatment that you need, and watch you die in a prison cell.

It ain’t personal. It’s just business. It is therefore your duty to fight for your life and your health.

Thanks to Bret Grote, Esq., Robert Boyle, Esq., and Dr. Joseph Harris, MD (our expert witness), who prevailed in Abu-Jamal v. Wetzel et al., there is hope.

Prisoners across the country have used Abu-Jamal to win rulings allowing them to go farther in their single and class action pleadings and claims against state governments and medical care
provider companies. Prisoners from Kansas to Missouri have prevailed in their civil actions. (See Postawko v. Missouri Dept. of Corrections, 2017 WL 1968317 (W.D., May 11, 2017); Paige v. Martell et al., 2017 WL 3149300 (D. KS, July 25, 2017), for example).

An aside…

Some of you who will read this Manual are Jailhouse Lawyers, and therefore, this isn’t your first rodeo. You’ve filed a suit or two, and you know the ropes.

But because hepatitis C is such a commonly occurring viral infection, many of you have never filed a civil suit before, and the prospect of going back to court—even for a civil case (instead of a criminal case)—is downright intimidating.

To you, we offer these last words before you leap into the legal abyss.

Have no fear, for thousands of people have filed suits before you. In fact, I’d bet that, percentage-wise, given the extraordinary number of prisoners in America (‘mass incarceration’ right?) the average prisoner is more litigious than the average ‘free’ person.

Fear not. Read these words, scan the exhibits and sample pleadings included in these pages, and imagine putting your name on the captions (or headings naming the lawsuit). Remember that old saying about the lottery: “You gotta play to win!”

The laws that made these suits possible were written into law by a Congress sitting after the US Civil Way. Why did they do this? Because state courts were notorious and blatant in denying the so-called ‘freedmen’ to prevail in their courts. Think about it.

When you think from an historical perspective, that means these laws were literally written for many of your ancestors! But no matter who you are, you are able to use these laws to make the State begin to do the right thing: to treat your Hepatitis C infection—with cures!

If you have trusted friends or family in the free world, especially those with access to a computer, please have them go to nlg.org. This is the website for the National Lawyers Guild, which publishes something called the Jailhouse Lawyers Handbook. Your friends or loved ones can download that Handbook from the website for free and send you a copy. It’ll show you a step by step of how to litigate in America’s federal courts.

But these papers will get you into court and in the perfect position to whip the state and the state’s contractors (medical health corporations) in your battle to get treated. With this brief Manual and the attached exhibits, you can get in court—and win!

Good luck to you all!

M. Abu-Jamal @ Mahanoy Joint.
The next few pages include documents prepared by our friends at the Abolitionist Law Center in Pittsburgh, PA. These lawyers and legal researchers have developed both information packets and sample documents to give you a guide from which to prepare and develop your Complaints, both against the prison and in Court. Read them carefully, and where indicated, put in your name, and the names of the Defendants (those who you are suing). Take your time so that you get the information right, and in good form for the court.

Remember: You Can Do This.

We are also providing scientific health materials, so that you can understand the damages and side effects from hepatitis C infections.
How to Use the Sample Legal Brief

The sample legal brief included in this packet is intended to provide a template for incarcerated pro se litigants seeking a court order that prison officials provide direct-acting antiviral medications to treat and cure their hepatitis C.

The **BOLD** language in the sample brief indicates places where you should insert the relevant factual or other information for your individual case.

The brief is merely the legal argument section pertaining to an Eighth Amendment claim under the federal Constitution. Please keep in mind that litigation can involve different motions with their own legal standard, such as a motion to dismiss, a motion for preliminary injunction, or a motion for summary judgment. When briefing the Eighth Amendment issue be careful to apply the necessary standard for each motion – which will require reviewing the cases cited in the sample brief, doing one’s own research, and consulting with those who are knowledgeable in these matters.

If you are filing for a preliminary injunction the primary issues you have to prevail upon are whether 1) you have a reasonable likelihood of success on the merits, and 2) if failure to grant the preliminary injunction will result in irreparable injury. The *Abu-Jamal* case is on point for how to argue this.

The central arguments being advanced in any case where an incarcerated patient is not receiving hepatitis C treatment is that a chronic hepatitis C infection constitutes an existing medical injury in need of treatment; failure to treat exposes the patient to an increased risk of more serious medical injury, up to and including death; and that delays or denials in treatment are in contravention of the applicable medical standard, and thus lack medical justification and constitute deliberate indifference on the part of defendants.

Also keep in mind that the cases discussed in this brief that deal with the new hepatitis C treatments are in different procedural postures, meaning that the cases are ongoing. That means that new opinions can issue from the courts in these cases, as well as others. As the law develops on this issue use your judgment to adapt usage of the case law so that it is up to date and most effectively used in advocating for treatment.

While the Abolitionist Law Center will do our best to be of assistance to pro se litigants, due to the large number of mail and requests for assistance we receive we cannot always respond or respond in a timely manner. We hope this brief provides the necessary legal roadmap to help you all in your just fight for your health and your rights.
PLAINTIFF’S MEMORANDUM IN SUPPORT OF MOTION FOR A PRELIMINARY INJUNCTION

I. STATEMENT OF FACTS

The plaintiff, NAME, a prisoner at SCI ________________, suffers from chronic hepatitis C. Additionally, s/he suffers from [List other illnesses and medical conditions that are either caused by hepatitis C or made worse by hepatitis C]. Although his/her diseases are progressing and his/her health is deteriorating, the defendants have refused to provide direct acting ant-viral drugs, such as Harvoni or Sovaldi, that have a 90-95% chance of curing her/his hepatitis C. Plaintiff is seeking a preliminary injunction requiring the defendants to provide these medications to her/him in order to cease ongoing and serious harm to her/his health and to abate the excessive, worsening risk that progressing, untreated, chronic hepatitis C poses to his future health.

Plaintiff has been in DOC custody since _____________ and was diagnosed with chronic hepatitis C [Insert exact or approximate date].

Plaintiff’s medical records show that s/he also suffers from [list other medical conditions]. These co-morbidities represent additional, compelling medical reasons to commence DAA treatment of his hepatitis C immediately, as each condition can be exacerbated by untreated, chronic hepatitis C, and, concomitantly, the prognosis for each co-morbidity will improve upon Plaintiff being cured of his hepatitis C.

Hepatitis C is a major public health issue “[i]n the United States and worldwide.” Abu-Jamal v. Wetzel, 2017 WL 34700, *2 (M.D. Pa. 2017). Those who, like Plaintiff, have chronic hepatitis C have a 20-50% chance of deteriorating to cirrhosis, or severe scarring throughout the
entirety of the liver architecture.\textsuperscript{1} That condition can cause liver failure and other life-threatening complications such as portal hypertension. \textit{Id.} Of those who develop cirrhosis, 2-7\% \textit{per year} will develop liver cancer, which represents an actual progression rate of between 11-19\%.\textsuperscript{2} In the United States, hepatitis C caused more deaths each year than all other infectious diseases combined.\textsuperscript{3}

In 2014, drugs known as Direct-Acting Anti-Viral medications have been available for treatment of hepatitis C. On average, these drugs have a 90-95\% chance of cure. \textit{Abu-Jamal}, 2017 WL 34700 at *3. Risk of disease progression to conditions such as cirrhosis, liver cancer or even severe fibrosis would be reduced to zero. \textit{Id.} In addition, early treatment (i.e. treatment before advanced fibrosis) affords numerous other health benefits. AASLD guidelines, p. 2-3, describing benefits of early treatment. The AASLD, to which the CDC looks to set the standard of care, recommends that all chronic hepatitis C patients regardless of disease stage or risk of progression be treated. \textit{Abu-Jamal}, 2017 WL 34700 at *15. In May 2018, the AASLD updated its treatment guidelines to include specific standards for prisons, stating that “Chronically infected individuals should receive antiviral therapy according to AASLD/IDSA guidance while incarcerated.”\textsuperscript{4}

\textbf{II. LEGAL ARGUMENT}

\textbf{A. Plaintiff Has a Reasonable Likelihood of Success on the Merits In Showing Deliberate Indifference To A Serious Medical Need}

Prison officials “have an obligation to provide medical care for those whom it is punishing by incarceration.” \textit{Estelle v. Gamble}, 429 U.S. 97, 103 (1976). To prevail on an Eighth Amendment

\begin{itemize}
\item \textsuperscript{1} Cutaneous Manifestations of Hepatitis C, Schwartz, et al., accessed at: \url{https://emedicine.medscape.com/article/1134161-overview#a2}.
\item \textsuperscript{2} \textit{Id.}
\end{itemize}
medical care claim a plaintiff “must show (i) a serious medical need, and (ii) acts or omissions by prison officials that indicate a deliberate indifference to that need.” Natale v. Camden County Correctional Facility, 318 F.3d 575, 582 (3d Cir. 2003). “Hepatitis C constitutes the type of ‘serious medical need’ which triggers Eighth Amendment scrutiny in a corrections context.” Barndt v. Pennsylvania Dept. of Corrections, 2011 WL 4830181 *9 (M.D. Pa. 2011); see also Abu-Jamal v. Wetzel, 2017 WL 34700 (M.D. Pa. 2017). Plaintiff has been diagnosed with chronic hepatitis C, and therefore indisputably meets the first prong of showing a serious medical need.

Deliberate indifference to a serious medical need “requires proof that the official ‘knows of and disregards an excessive risk to inmate health or safety.’” Natale, 318 F.3d at 582 (quoting Farmer v. Brennan, 511 U.S. 825, 837 (1994)). The defendants herein have deviated from the standard of care by refusing to provide an available, safe, and effective cure for Plaintiff’s hepatitis C. Defendants are acting with deliberate indifference to Plaintiff’s serious medical need for hepatitis C treatment, exposing her/him to an excessive risk to her/his health, by: 1) refusing to treat her/his serious medical need; 2) knowingly providing less efficacious care that consists of mere monitoring and no treatment; and 3) deviating from the applicable medical standard of care without medical justification. Refusing treatment, providing less efficacious care, and making medical decisions for non-medical reasons, each establish deliberate indifference under controlling precedent of the U.S. Supreme Court and Third Circuit Court of Appeals.

1. The Defendants’ Refusal to Treat Plaintiff’s hepatitis C Deviates From The Standard of Care, Exposes Her/Him to Serious Harm and Excessive Risk to Her/His Future Health, and Constitutes Deliberate Indifference

The court in Abu-Jamal unequivocally stated that the standard of care for hepatitis C treatment, established by the CDC and AASLD, “is to administer DAA medications such as Harvoni, Sovaldi, and Viekira Pak . . . regardless of the disease’s stage.” Abu-Jamal, 2017 WL 34700 at *15. The court went on to find that the DOC’s protocol for treatment of hepatitis C,
which is still in effect, was not constitutionally adequate because “it refuses, without medical justification, to provide treatment for certain inmates with hepatitis C and also imposes an unreasonable condition—having vast fibrosis or cirrhosis—on treatment.” *Id.* at *16. The AASLD has recently reinforced this standard by promulgating a prison-specific standard stating that “Chronically infected individuals should receive antiviral therapy according to AASLD/IDSA guidance while incarcerated.”

The defendants acknowledge that Plaintiff has chronic hepatitis C. [CITE Medical Records] and has, at a minimum, progressed to stage ____ fibrosis. [Insert description of degree of fibrosis/cirrhosis and other symptoms applicable to plaintiff]. Without treatment the disease will continue to progress, exposing Plaintiff to an increasing risk of developing liver cancer and other complications of the disease. The defendants know that if Plaintiff’s hepatitis C were treated it would terminate the infection, end the ongoing inflammation and scarring of her/his liver, and prevent further progression of the disease to decompensated cirrhosis, liver cancer, and death. As acknowledged in *Abu-Jamal v. Wetzel*, Defendant Noel admitted that there was no medical reason for denying the plaintiff’s treatment in that case with direct-acting anti-viral medications. He testified: “I can think of no medical contraindications at this time [for withholding treatment]”. 2017 WL 34700 at *8. His sentiment was echoed by Dr. Cowan, who testified that if he had a private patient with good insurance or sufficient resources, he too would recommend treatment with the anti-viral medications. *Id.* As Plaintiff also has an active hepatitis C infection, a fibrosis score of F__, faces the same risks from disease progression that Abu-Jamal faced, and should be treated under the applicable medical standard of care, Defendants failure to provide treatment in her/his case similarly constitutes deliberate indifference to Plaintiff’s serious

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medical need for hepatitis C treatment in violation of the Eighth Amendment.

“Outright refusal of any treatment for a degenerative condition that tends to cause acute infection and pain if left untreated and [] imposition of a seriously unreasonable condition on such treatment, both constitute deliberate indifference on the part of prison officials.” Id. (quoting Harrison v. Barkely, 218 F.3d 132, 138 (2d Cir. 2000)); See also Farmer, 511 U.S. at 837 (knowledge of and disregard of an excessive risk to inmate health and safety constitutes deliberate indifference); Estelle, 429 U.S. at 104; Durmer v. O’Carroll, 991 F.2d 64, 68 (3d Cir. 1993); Monmouth County Correctional Inst. Inmates v. Lanzaro, 834 F.2d 326, 346–47 (3d Cir. 1987); Rouse v. Plantier, 182 F.3d 192, 197 (3d Cir. 1999). Likewise, deviation from the accepted standard of care for treating an illness without medical justification also constitutes deliberate indifference. Roe v. Elyea, 631 F.3d 843, 862–63 (7th Cir. 2011); De’lonta v. Johnson, 708 F.3d 520, 525–26 (4th Cir. 2013) (failure to provide care consistent with prevailing standard states a claim under the Eighth Amendment); Smith v. Jenkins, 919 F.2d 90, 93 (8th Cir. 1990) (treatment that deviates from professional standards may amount to deliberate indifference). Plaintiff suffers from a serious, chronic disease that causes her/him physical distress and that, if left untreated, could result in substantially more pain, liver failure, liver cancer, and death. Moreover, there is no medical justification for denying treatment. Accordingly, the failure to appropriately treat his hepatitis C constitutes deliberate indifference.

A growing number of federal courts have recognized and enforced the applicable standard of care based on the availability of DAA drugs to treat hepatitis C. A federal court in Florida granted a preliminary injunction in favor of a class of plaintiffs who “all suffer from chronic HCV” and who were “faced with substantial risks of serious harm” due to the Florida Department of Corrections’ failure to provide treatment with direct-acting antiviral medications. Hoffer v. Jones, 290 F.Supp.3d 1292, 1299 (N.D. Fla. 2017). These risks included “bleeding from any site
in the body, accumulation of fluid in the legs or abdomen, life-threatening infections, significant pain or discomfort, organ failure, liver cancer, and death.” *Id.* Finding the defendants had acted with deliberate indifference by refusing to treat those with chronic hepatitis C, the Court emphasized the medical importance of prompt treatment:

> If these inmates are not treated, they will undoubtedly suffer irreparable injury. Although DAAs can cure a person of HCV, they do not necessarily reduce the level of fibrosis a person has already suffered. Consequently, it is important to treat patients with HCV as soon as possible so that they can be cured of the virus before their liver becomes significantly diseased.

*Id* at 1304. A similar result should follow in the case present before this Court.

Relying heavily on the reasoning in *Abu-Jamal*, a court in the Western District of Missouri likewise found that prisoners with chronic hepatitis C alleged facts sufficient to overcome a motion to dismiss where the Missouri Department of Corrections’ refusal to treat the vast majority of incarcerated patients with chronic hepatitis C and imposed “an unreasonable condition on qualification for treatment.” *Postawko v. Missouri Dep’t of Corrections*, 2017 WL 1968317, *8* (W.D. Mis. 2017). The Court recognized that plaintiffs’ allegations regarding prison officials’ “‘wait and see’ policy of relying solely on APRI scores and delaying DAA treatment until the disease has progressed to a far more serious level contravenes the applicable medical standard of care without any medical justification.” *Id.* at *7* (citing *Abu-Jamal v. Wetzel*, 2017 WL 34700, at *15, and *Monmouth Cty. Corr. Ins. Inmates v. Lanzarao*, 834 F.2d 326, 347 (3d Cir. 1987) (“Deliberate indifference is also evidenced where prison officials erect arbitrary and burdensome procedures that result in interminable delays and outright denials of medical care to suffering inmates.”)).

A federal court in the Eastern District of Pennsylvania has also recognized that a class action lawsuit raising the same allegations regarding the DOC’s hepatitis C protocol as the case *sub judice* has stated a claim that this protocol fails to meet constitutional standards:
We conclude, accordingly, that the Amended Complaint sufficiently alleges that the DOC’s use of its Hepatitis C Protocol to ration medical treatment with DAADs based solely on cost, even though there is no other recommended medical treatment for Chronic Hepatitis C, disregards an excessive risk to the health of the infected inmates and thus constitutes deliberate indifference to a serious medical need. As the United States Court of Appeals for the Third Circuit has explained, “while ‘administrative convenience and cost may be, in appropriate circumstances, permissible factors for correctional systems to consider in making treatment decisions, the Constitution is violated when they are considered to the exclusion of reasonable medical judgment about inmate health.’” Allah v. Thomas, 679 F App’x 216, 220 (3d Cir. 2017) (quoting Roe v. Elyea, 631 F.3d 843, 863 (7th Cir. 2011)) (concluding that complaint alleging that DOC denied plaintiff treatment with DAADs for his Hepatitis C infection based solely on cost, causing him to suffer medical complications, “plausibly alleged an Eighth Amendment violation”). Consequently, we deny the DOC Defendants' Motion to Dismiss Count I of the Amended Complaint as to this argument.


As recognized in Abu-Jamal and Chimenti and federal courts analyzing comparable hepatitis C policies, the DOC’s protocol falls below constitutional standards. Only patients with cirrhosis are even considered for treatment, and even then it is not clear that they will be treated or within what time frame, as the protocol is silent on those matters. CITE DOC protocol. Patients like Plaintiff are simply seen by a medical professional periodically to answer questions and have blood drawn, but no treatment is provided. Id. The protocol sets forth no plans for treating those, such as Plaintiff. Id. The DOC does nothing to prevent further deterioration of an inmate’s liver or progression to liver cancer. Id. That the DOC’s protocol requires deterioration to cirrhosis before treatment, greatly increasing the risk of liver failure, liver cancer, and other serious health complications outside of the liver, places cases such as Plaintiff’s squarely in the realm of those “worst cases” that “may actually produce physical torture or a lingering death[.].” Estelle, 429 U.S. at 103. Adherence to a policy for non-medical reasons such as administrative convenience or cost is not a constitutionally valid basis for denying care. Natale, 318 F.3d at 582–83; Roe, 631 F.3d at 862–63; Colwell v. Bannister, 763 F.3d 1060, 1068–69 (9th Cir. 2014). Cf. BE v. Teeter, 2016 WL
3033500 (W.D. Wash. 2016) (granting preliminary injunction requiring the State to provide hepatitis C anti-viral drugs to Medicaid recipients since such treatment is medically necessary).

2. Because Chronic Hepatitis C Is The Cause Of Damage To The Plaintiff’s Liver And The Cause Of Other Severe Symptoms, Refusal To Treat And Cure The Disease Constitutes Deliberate Indifference

Medical evidence regarding the Plaintiff’s condition demonstrate the following material points. First, Plaintiff has chronic hepatitis C. Second, the disease has caused fibrosis, or scarring, to Plaintiff’s liver. Third, 20-50% of all chronic hepatitis C patients progress to cirrhosis, or severe scarring of the liver. Fourth, cirrhosis has many life-threatening complications, including portal hypertension, liver failure, and, in nearly 20% of cases, progression to hepatocellular carcinoma, i.e. liver cancer. Id. [Insert additional information about Plaintiff’s hepatitis C infection and symptoms and other health problems]. This evidence plainly demonstrates that Mr. Eaddy is seriously ill, and, if not treated, will be “exposed [] to . . . an unreasonable risk of serious damage to his future health.” Helling v. McKinney, 509 U.S. 25, 35 (1993).

- Insert paragraphs as appropriate discussing additional health symptoms or conditions caused or made worse by hepatitis C.

This is not a case involving a mere dispute between medical professionals. First, there is only one recognized way to treat hepatitis C – that is, with the direct-acting antiviral medications that have the 90-95% cure rate. Second, under the Eighth Amendment, the intentional provision of inferior or less efficacious treatment for non-medical reasons constitutes deliberate indifference. Durmer, 991 F.2d at 69; White, 897 F.2d at 109–11; West v. Keve, 571 F.2d 158 162 (3d Cir. 1978); Parkell v. Markell, 622 Fed. App’x 136, 141 (3d Cir. 2015).

B. Plaintiff Has Suffered And Continues To Suffer Irreparable Harm And Absent An Injunction His Health Will Continue To Deteriorate

By the simple fact that he has chronic hepatitis C, Plaintiff has a 20-50% chance of developing
cirrhosis. CITE. Even at a fibrosis stage of 2, plaintiff would. This evidence demonstrates that failure to treat Plaintiff will “expose[] him to . . . an unreasonable risk of serious damage to his future health.” Helling, 509 U.S. at 35.

C. Treating Plaintiff’s Hepatitis C Will Not Harm Defendants And Will Further The Public Interest

“There is the highest public interest in due observance of all constitutional guarantees.” United States v. Raines, 362 U.S. 17, 27 (1960). In addition, “the public has a strong public interest in the provision of constitutionally adequate health care to prisoners.” Flynn v. Doyle, 630 F.Supp.2d 987, 993 (E.D. Wisc. 2009).

An injunction will not impose substantial burdens on the DOC. The only “adverse” consequence would be that the DOC will have to pay for DAA medications for Plaintiff.

CONCLUSION

For the foregoing reasons, this Court should grant plaintiff’s motion for preliminary injunctive relief and order DOC defendants to treat his hepatitis C with the direct-acting antiviral medications.

Respectfully submitted,

X__________________________
IN THE UNITED STATES DISTRICT COURT FOR THE _______________ DISTRICT OF PENNSYLVANIA

INSERT NAME

Plaintiff,

v.

Dr. Paul Noel, Pennsylvania DOC Bureau of Health Care Services, Chief of Clinical Services,

Insert Treating Physician at your Facility

Defendants.

Case No.

JURY TRIAL DEMANDED

ELECTRONICALLY FILED

COMPLAINT

JURISDICTION

1. This is an action for injunctive and monetary relief for violations of the Eighth and Fourteenth Amendments of the United States Constitution pursuant to 42 U.S.C. § 1983.

2. This Court has jurisdiction pursuant to 28 U.S.C. SS 1331, 1343(a)(3) and (4).

3. This Court is the appropriate venue pursuant to 28 U.S.C. § 1391 (b)(2) because the events and omissions giving rise to the claims occurred in the (insert Eastern, Middle, or Western) District of Pennsylvania.

PARTIES

4. Insert your name is insert age-year-old male/female currently incarcerated in the custody of the Pennsylvania Department of Corrections (DOC) at the State Correctional Institution (SCI) at insert institution. Mr./Ms. Insert your name is suffering from chronic hepatitis C, insert Hepatitis C symptoms. This disease has caused and is causing severe health
problems. He/she has requested that he/she be provided with anti-viral medication that would cure his/her disease, but the defendants have denied that treatment.

5. Defendant Paul Noel, M.D. is the Chief of Clinical Services for the DOC's Bureau of Health Care Services (BHCS). In that capacity, he oversees the delivery of health care services to prisoners within the DOC. In addition, Dr. Noel sits on the Hepatitis C Treatment Committee that is responsible for implementing the DOC's hepatitis C protocol and makes decisions concerning which prisoners will receive hepatitis C treatment. He is sued in his official capacity for injunctive relief and his individual capacity for damages. At all times relevant hereto defendant Noel acted under color of state law.

6. Defendant **insert doctor’s name** is the Treating Physician at SCI **insert institution**. S/he is the physician assigned to SCI **insert institution** who is responsible for plaintiff **insert your name** health care. S/he is sued in his official capacity for injunctive relief and his individual capacity for money damages. At all times relevant hereto the defendant acted under color of state law.

**STATEMENT OF FACTS**

7. This action seeks an injunction against defendants in their official capacities to immediately provide plaintiff, **insert your name**, with the Federal Drug Administration (FDA) approved hepatitis C direct-acting antiviral medications, as well as damages claims against the same defendants in their individual capacities.

**Hepatitis C**
8. Hepatitis C (HCV) is a virus that infects cells of the liver. Approximately 75-85 percent of individuals infected with the HCV will develop chronic hepatitis C, causing progressive inflammation of the liver.6

9. Inflammation caused by the virus can lead to scarring, known as fibrosis, and extreme scarring, known as cirrhosis, both of which affect liver functioning.

10. One of the ways liver inflammation is measured is on the Metavir scale. On that scale FO means no fibrosis and F4 means cirrhosis

11. Chronic hepatitis C patients with any liver scarring, i.e. greater that FO are at a greater risk of rapid disease progression.

12. At least twenty percent of chronic hepatitis C patients, and perhaps as high as fifty percent, will develop cirrhosis.7

13. Approximately 11-19% of those who develop cirrhosis will go on to develop liver cancer.8

14. In the United States, hepatitis C causes more deaths than all other infectious diseases combined.9

15. Chronic hepatitis C often causes complications outside of the liver, including anemia and diabetes.

16. Between 20-40% of chronic hepatitis C patients have cutaneous (skin) manifestations of the disease. Among them are the relatively rare conditions of lichen planus and necrolytic

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6 Center for Disease Control and Prevention, Hepatitis C FAQ for Health Professionals, accessed at: https://www.cdc.gov/hepatitis/hcv/hcvfaq.htm.
8 Id.
acral erythema (NAE), and more common ones such as psoriasis, eczema and pruritus (persistent itching).

17. In or about 2013, new anti-viral drugs became available. These drugs have a 90-95% cure rate and few, if any, side effects. These drugs, two of which are Harvoni and Sovaldi, have become the standard of care in the medical community.

18. Because of the numerous benefit of early treatment, the American Association for the Study of Liver Diseases (AASLD), recommends that everyone with chronic hepatitis C be treated with those anti-viral drugs irrespective of disease stage on the Metavir scale or prognosis for progression.

19. The Center for Disease Control (CDC) has issued its own guidelines that state that the guidelines issued by the AASLD are the standard of care for the treatment of hepatitis C.

20. In May 2018, the AASLD updated its treatment guidelines to include specific standards for prisons, stating that “Chronically infected individuals should receive antiviral therapy according to AASLD/IDSA guidance while incarcerated.”

**Hepatitis C and the Policy of The Pennsylvania DOC**

21. The Pennsylvania Department of Corrections (DOC), through its Bureau of Health Care Services is charged with delivery of necessary medical care to prisoners under the jurisdiction of the DOC.

22. There are at least 5,400 prisoners under the jurisdiction of the DOC who have active, i.e. chronic, hepatitis C.

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23. In 2013, when the current anti-viral drugs became available, the DOC, through its Bureau of Health Care Services and under the direction of defendant Noel, ceased treating all prisoners in the custody of the DOC who have active, i.e. chronic, hepatitis C.

24. This policy continued under the direction of defendant Noel throughout 2014 and most of 2015.

25. In late 2015, defendant Noel formulated and adopted a medical protocol concerning who would be treated and not treated with hepatitis C anti-viral drugs.

26. The hepatitis C protocol was added as Appendix 16-B to the Access to Health Care Procedures Manual of the Department of Corrections and is part of the DOC Policy Statement 13.1.1 entitled "Management and Administration of Health Care". The Policy Statement was personally authorized by defendant Wetzel.

27. Under that policy, only prisoners with decompensated cirrhosis with esophageal varices are authorized to receive the anti-viral drugs.

28. When the disease has advanced to decompensated cirrhosis with esophageal varices, a person has already suffered irreversible damage to their health and are at a grave risk of death.

29. In addition, long before the disease has progressed to that stage, individuals suffering from it have suffered irreversible damage to their liver, decreased liver function, and are at a significantly higher risk of developing liver cancer. Many also suffer severe extra hepatic manifestations of the disease that adversely affect quality of life.

30. On August 31, 2016, the Honorable Judge Robert Mariani of the federal court for the Middle District of Pennsylvania held that the DOC’s hepatitis C protocol constituted deliberate indifference to the serious medical needs of incarcerated patients with hepatitis C because it “fails to provide treatment for hepatitis C through the administration of DAA
medications such as Harvoni, Sovaldi, and Viekira Pak until an inmate has progressed to the stage of advanced compensated cirrhosis or early decompensated cirrhosis manifested by esophageal varices. As such, the interim Hepatitis C Treatment Protocol presents a conscious disregard of a known risk of advanced cirrhosis and death by esophageal hemorrhage.” Abu-Jamal v. Wetzel, 2016 WL 4574646, *9 (M.D.Pa. 2016).

31. As discussed infra, insert your name was known to have insert your symptoms on date of onset of symptoms, while in DOC custody.

32. Despite insert your name medical records indicating that he/she suffered from insert your symptoms, he/she was and remains denied hepatitis C treatment.

33. The protocol delegates determinations as to who will be treated to the Hepatitis C Treatment Committee.

34. Defendant Noel as BHCS Chief of Clinical Services and member of the Hepatitis C Treatment Committee is the principal decision-maker as to who will or will not receive treatment for their hepatitis C.

35. This policy was adopted and implemented by defendant Noel even though he knew that denying treatment to prisoners who did not fall under the protocol had no medical justification, causes harm to those patient’s health and places them at risk of death.

36. Defendant Noel adopted and implemented this protocol knowing that the standard of care in the community, as articulated by the AASLD and CDC is to treat all who have chronic hepatitis C.

37. After Judge Mariani’s decision of August 31, 2016, in which he found the DOC’s hepatitis C protocol unconstitutional under the Eighth Amendment but denied relief on procedural grounds, the DOC revised its protocol.
38. The current protocol has been adopted as Section 20 of the DOC’s 13.2.1 Access to Health Care Procedures Manual.

39. The policy still denies treatment until a patient has developed cirrhosis.

40. Insert your name has insert your symptoms, he/she has continued to be denied treatment under this revised protocol.


42. This protocol remains in effect and is administered and enforced by defendant Noel and Defendant insert treating physician’s name as the doctor at SCI insert institution.

The Plaintiff’s Medical Care

43. Insert your name history in the DOC, extending back more than insert how many years incarcerated, includes documentation of his/her chronic hepatitis C infection.

44. Insert your name entered DOC custody on insert date of incarceration, and since insert date of diagnosis, he/she has been noted as having chronic Hepatitis C.

45. A physical examination on insert the date of your physical examination found that insert your name had hepatitis C and insert your symptoms.

46. DOC records from insert timeframe for medical records you have reviewed, indicate that insert your name suffers from insert your Hepatitis C symptoms.

47. DOC records from insert date, stated “insert your Hepatitis C symptoms as quoted directly from DOC medical records”

48. Insert your name diagnostic findings have been repeatedly noted throughout his/her medical records up to the present.
49. When the DOC issued its first hepatitis C protocol to permit treatment with the new direct-acting antiviral medications for hepatitis C, the only patients specifically authorized for treatment were those with cirrhosis and esophageal varices.

50. The reasoning for non-treatment was never explained to him/her or documented in his/her medical records.

51. The DOC has not enacted policies and protocols requiring that individuals with chronic hepatitis C, such as insert your name, automatically receive medically necessary treatment.

52. Defendants Noel and insert treating physician are continuing to withhold treatment to insert your name, exposing him/her to medical injury and risk of further harm, up to and including death.

53. The policy is enforced on the facility level by insert treating physician, Treating Physician at SCI insert physician.

54. Plaintiff is being denied medically necessary treatment, to wit, the anti-viral medication, due to this policy and the actions of the defendants in formulating, implementing, and enforcing it.

55. Defendants Noel and insert treating physician know through correspondence from plaintiff, requests made by the plaintiff, and plaintiffs own DOC medical records, that their refusal to provide plaintiff with the anti-viral medication has caused plaintiff suffering, irreversible damage to his/her health, and places him/her at risk of developing liver cancer, end stage liver disease, and eventual death.

56. The antiviral medications are necessary to save Plaintiff’s life.

57. Defendants are knowingly playing with insert your name health and life and putting him/her at risk of dying from complications of Hepatitis C.
58. In fact, according to official DOC death records obtained via a Right-to-Know request multiple prisoners died in DOC custody in 2015 and 2016 from complications of hepatitis C.

59. These deaths occurred at a time when the DOC was providing no treatment for hepatitis C to anybody, or else denying it to such an extent that people were left to die from a curable illness.

60. Plaintiff has no adequate remedy at law.

61. If insert your name does not obtain an immediate injunction ordering treatment with the direct-acting antiviral medications he/she is at increasing risk of disease progression each day.

CAUSES OF ACTION

Count I — Deprivation of Eighth Amendment Right to Medical Care for Hepatitis C

(Against defendants Noel and insert treating physician in their official capacities for injunctive relief and their individual capacities for monetary relief.)

62. Plaintiff re-alleges paragraphs 1-61 as if fully stated herein.

63. Defendants Noel and insert treating physician at SCI insert institution violated and, if injunctive relief is not issued, will continue to violate plaintiff’s Eighth Amendment right to be free from cruel and unusual punishment through their deliberate indifference to his/her chronic hepatitis C. These defendants have failed and are failing to treat his/her chronic hepatitis C, causing plaintiff serious injuries, pain, suffering, and risk of death. Plaintiff’s injuries and damages were a direct and proximate result of the acts and omissions of defendants in the following ways:
a. In failing to adopt, maintain or follow policies or practices with regard to diagnosing, assessing, treating or providing for the medical care of incarcerated people in DOC custody;

a. systematically, regularly and continuously delaying the proper treatment of Plaintiff’s condition;

b. in failing to properly follow up with Plaintiff in light of his repeated medical requests, symptoms and complaints;

c. in failing to give significance to the findings and/or diagnoses involved in Plaintiff’s care and treatment;

**PRAYER FOR RELIEF**

WHEREFORE, Plaintiffs request that the Court grant the following relief:

A. Grant a preliminary and permanent injunction ordering the defendants to administer to

   *insert your name* direct-acting anti-viral drugs, such as Harvoni or Sovaldi as treatment for his/her hepatitis C;

B. Enjoin defendants from requiring an endoscopy or any other further testing prior to

   initiating life-saving direct-acting antiviral medications;

C. Award compensatory and punitive damages;

Respectfully submitted,

*Insert your name and contact information*