Table. Characteristics of the study population (n=214)

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Characteristic	Value
Median age, (range, years)	64 (27-84)
Male sex	127 (59%)
Race	
White	180 (84%)
Black	18 (8%)
Asian	9 (4%)
Native American	1 (0.5%)
Other	6 (3%)
Hematologic neoplasm	
Lymphoid [a]	149 (70%)
Myeloid [b]	65 (30%)
HCT	15 (7%)
Allogeneic	3/15 (20%)
Autologous	12/15 (80%)
Anti-HCV positive	3 (1%)
HCV RNA positive	2/3 (67%)
HCV RNA negative	1/3 (33%)
HCV RNA positive	2 (1%)
Anti-HCV positive	2/2 (100%)
Anti-HCV negative	0/2
Seronegative HCV infection [c]	0
HCV genotype	
1b	2/2 (100%)

Data are median (range) or n (%).

HCT=hematopoietic cell transplant; HCV=hepatitis C virus.

[a] Lymphoid neoplasms included the following categories based on the 2016 World Health Organization classification: mature B-cell neoplasms and Hodgkin lymphoma.

[b] Myeloid neoplasms included the following categories based on the 2016 World Health organization: myeloproliferative neoplasms, myelodysplastic/myeloproliferative neoplasms, myelodysplastic syndromes, acute myeloid leukemia, and related neoplasms, and B-lymphoblastic leukemia/lymphoma.

[c] Seronegative HCV infection: negative anti-HCV test, positive HCV RNA test.

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1053. The Ecological Relationship Between County-Level HCV Case Rates and Office-Based Buprenorphine in Ohio.

Daniel L. Brook, BS[1]; Shibani Chettri, MPH[1]; Angela Hetrick, MPH[1]; Adams L. Sibley, MPH[2]; Christine Schalkoff, MSPH[2]; Kathryn Lancaster, MPH, PhD[1]; Vivian Go, PhD[2]; David Kline, PhD[3]; William Miller, MD, PhD, MPH[1]; [1]The Ohio State University, Columbus, Ohio; [2]University of North Carolina at Chapel Hill, Chapel Hill, North Carolina; [3]The Ohio State Univeristy, Columbus, Ohio

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Background. The United States is experiencing an epidemic of hepatitis C virus (HCV) infections due to injection drug use, especially in rural areas. Counties may be expanding access to buprenorphine, an evidence-based treatment that has been shown to reduce injection drug use, to control the HCV epidemic. We assessed the county-level relationship between HCV rates in 2013-2015 and office-based buprenorphine prescribing in 2018 in Ohio. We also assessed if this relationship varied between rural and urban counties.

Methods. We fit crude and adjusted negative binomial models to assess the relationship between HCV incidence rates in 2013-2015 and office-based buprenorphine prescribing capacity and frequency in Ohio in 2018. We examined effect measure modification of this relationship by rural-urban status using an interaction term.

Results. We found that a 1% higher acute HCV rate was associated with an 18% (95% Confidence Interval [CI]: -3%, 44%) higher office-based buprenorphine prescribing capacity and an 22% (95% CI: -4%, 55%) higher office-based buprenorphine prescribing frequency. We found that a 1% higher total HCV rate was associated with a 239% (95% CI: 179%, 317%) higher office-based buprenorphine prescribing capacity and a 273% (95% CI: 183%, 405%) higher office-based buprenorphine prescribing frequency. We found no evidence of effect measure modification by rural-urban status.

Conclusion. Counties across Ohio may have expanded access to office-based buprenorphine in response to high rates of total HCV. Expansion of office-based buprenorphine may be less associated with acute HCV rates due to the low frequency with which these cases are seen in outpatient settings.

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1054. A Randomized Controlled Trial of Hepatitis B virus (HBV) Revaccination among Men Who Have Sex with Men and Were Born in the Era of Universal Neonatal HBV Immunization

Yi-Chia Huang, n/a[1]; Hsin-Yun Sun, MD[2]; Yu-Chung Chuang, n/a[3]; Sung-Hsi Huang, n/a[4]; Wen-Chun Liu, MS[2]; Yi-Ching Su, MS[2]; Sui-Yuan Chang, PhD[2]; Chien-Ching Hung, PhD[2]; [1]National Taiwan University Hospital Biomedical Park Hospital, Hsinchu County, Hsinchu, Taiwan; [2]National Taiwan University Hospital, Taipei, Taipei, Taiwan; [3]National Taiwan University Hospital and National Taiwan University College of Medicine, Taipei, Taipei, Taiwan; [4]1. Department of Internal Medicine, National Taiwan University Hospital Hsinchu Branch, 2. Department of tropical medicine and parasitology, National Taiwan University College of Medicine, Hsinchu, Hsinchu, Taiwan

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Background. People who have lost anti-HBs antibody decades after neonatal vaccination but are at high risk of acquiring HBV are recommended to undergo HBV revaccination. The optimal revaccination strategy remains unknown, however. We aimed to compare the efficacy of revaccination with standard- (20-μg) vs double-dose (40-μg) of HBV vaccine among men who have sex with men (MSM).

Methods. MSM aged ≥ 20 years who had undergone HBV vaccination at birth and tested negative for HBsAg and anti-HBc with anti-HBs titer < 10 mIU/ml were randomized to receive standard- or double-dose HBV vaccine (1:1 ratio with a block size of 4) at weeks 0, 4, and 24. Plasma HIV RNA < 50 copies/ml for ≥ 6 months was required for HIV-positive MSM. The primary endpoint was the proportion of participants achieving anti-HBs ≥ 10 mIU/ml at week 28. The secondary endpoints were high-titer response (≥ 100 mIU/ml) at weeks 28 and 48, serological response at week 48, and adverse events (AE).

Results. From Sep 2017 to Jun 2020, 161 HIV-positive and 77 HIV-negative MSM were enrolled. The serological response at week 28 was 86.2% for the standard-dose group and 94.9% for the double-dose group (p=0.070). The proportion of high-titer response was higher for the double-dose group than the standard-dose group at 28 weeks (84.6% vs 70.1%, p=0.041). The respective serological response and high-titer response at week 48 were 81.3% and 58.7% for the standard-dose group vs 94.2% and 78.3% for the double-dose group (p=0.023 and p=0.013, respectively). In generalized estimating equations model, double-dose HBV revaccination (aOR, 1.7; 95% CI, 1.1-2.8) and baseline anti-HBs ≥ 2.5 mIU/ml (aOR, 7.5; 95% CI, 4.3-13.5) were associated with high-titer responses. HIV infection was not associated with serological response (aOR, -1.2; 95%CI, -2.47-1.60) and high-titer response (aOR, -1.1; 95%CI, -1.95-1.49). The double-dose group had a higher rate of local AEs (27.2% vs 38.7%, p=0.118). One (0.8%) severe AE occurred in the double-dose group, which resolved without sequelae.

Table 1. Baseline characteristic of participants

	Standard dose (n=119)	Double dose (n=119)	p-value
Baseline characteristics			
Age, mean (SD)	27.4 (3.1)	27.4 (3.3)	0.881
Anti-HBs titer at baseline, <2.5 mIU/ml, n (%)	76 (36.1)	78 (34.5)	0.786
HIV infection, n (%)	80 (67.2)	81 (68.1)	0.890
Syphilis, n (%)	29 (24.4)	47 (39.5)	0.012
HCV, n (%)	5 (4.2)	10 (8.5)	0.194