

Insert Hospital Name Gastroenterology and Liver Services
Remote Consultation Request for Initiation of Hepatitis C Treatment
Hospital Phone: () Hospital Fax: ()

FOR ATTENTION OF: Dr

Date:

Please note this form is not a referral for a patient appointment.

Referring Practitioner			
<i>Note: General practitioners and nurse practitioners are eligible to prescribe hepatitis C treatment under the PBS</i>			
Name			
Suburb		Postcode	
Phone	()	Fax	()
Mobile phone			
Email address			

Patient	
Name	
Date of birth	
Postcode	

<p>Hepatitis C History</p> <p>Date of HCV diagnosis:</p> <p>Known cirrhosis* <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>* Patients with cirrhosis or HBV/HIV coinfection should be referred to a specialist</p>	<p>Intercurrent Conditions</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Obesity <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis B <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>HIV <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Alcohol > 40 g/day <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Discussion re contraception <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Prior Antiviral Treatment</p> <p>Has patient previously received any antiviral treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has prior treatment included oral antiviral therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Prior treatment:</p> <p>I have checked for potential drug–drug interactions with current medications† <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Current Medications (Prescription, herbal, OTC, recreational)</p> <p>† http://www.hep-druginteractions.org If possible, print and fax a PDF from this site showing you have checked drug–drug interactions.</p>

Laboratory Results (or attach copy of results)					
Test	Date	Result	Test	Date	Result
HCV genotype			Creatinine		
HCV RNA level			eGFR		
ALT			Haemoglobin		
AST			Platelet count		
Bilirubin			INR		
Albumin			HBsAg		

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Liver Fibrosis Assessment**		
Test	Date	Result
FibroScan		
Other (eg. APRI)		

APRI: <http://www.hepatitisc.uw.edu/page/clinical-calculators/apri>
 ** People with liver stiffness on FibroScan of ≥ 12.5 kPa or an APRI score ≥ 1.0 may have cirrhosis and should be referred to a specialist.

Treatment Choice

I plan to prescribe (please select one):

Regimen	Duration			Genotypes
Sofosbuvir + Velpatasvir	12 weeks <input type="checkbox"/>			1, 2, 3, 4, 5, 6
Sofosbuvir + Ledipasvir	8 weeks <input type="checkbox"/> <small>No cirrhosis, treatment-naïve, genotype 1</small>	12 weeks <input type="checkbox"/>	24 weeks <input type="checkbox"/>	1
Elbasvir + Grazoprevir	12 weeks <input type="checkbox"/>	16 weeks <input type="checkbox"/>	+ Ribavirin <input type="checkbox"/>	1 or 4
Sofosbuvir + Daclatasvir	12 weeks <input type="checkbox"/>	24 weeks <input type="checkbox"/>	+ Ribavirin <input type="checkbox"/>	3 or 1
Paritaprevir/ritonavir + Ombitasvir + Dasabuvir	12 weeks <input type="checkbox"/>			1b
Paritaprevir/ritonavir + Ombitasvir + Dasabuvir + Ribavirin	12 weeks <input type="checkbox"/>	24 weeks <input type="checkbox"/>		1a

Multiple regimens are available for the treatment of chronic HCV. Factors to consider include HCV genotype, cirrhosis status, prior treatment, viral load, potential drug-drug interactions, comorbidities.

See *Australian Recommendations for the Management of Hepatitis C Virus Infection: A Consensus Statement (August 2017)* (<http://www.gesa.org.au>) for all regimens, and for monitoring recommendations.

Patients must be tested for HCV RNA at least 12 weeks after completing treatment to determine outcome. Please notify the specialist below of the Week 12 post-treatment result.

Declaration by General Practitioner/Nurse Practitioner

I declare all of the information provided above is true and correct.

Signature:	
Name:	
Date:	

Approval by Specialist Experienced in the Treatment of HCV

I agree with the decision to treat this person based on the information provided above.

Signature:	
Name:	
Date:	

Once completed, please return both pages by email: or fax: ()