

Hospital:

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	

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

Laboratory Results (or attach copy of results)					
Test	Date	Result	Test	Date	Result
HCV RNA*			Albumin		
ALT			Platelet count		
AST			HIV		
Bilirubin			HBsAg		

* HCV genotyping is no longer mandatory before HCV treatment with pan-genotypic medications.

Patient MUST be HCV RNA positive.

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Liver Fibrosis Assessment*		
Test	Date	Result
FibroScan®		
Other (e.g. 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 – for people who are treatment-naive with compensated liver disease

I plan to prescribe (*please select one*):

Pan-genotypic Treatment Regimen	Duration
Sofosbuvir + Velpatasvir	12 weeks <input type="checkbox"/>
Glecaprevir + Pibrentasvir	8 weeks <input type="checkbox"/>

See *Australian Recommendations for the Management of Hepatitis C Virus Infection: A Consensus Statement (2022)* (<http://www.gesa.org.au>) for monitoring recommendations.

People with cirrhosis should be referred to a specialist.

Patients who relapse after DAA therapy should be referred to a specialist for retreatment.

Patients should 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: ()**