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 *Note: General practitioners and nurse practitioners are eligible to prescribe hepatitis C treatment under the PBS*			
Name			
Suburb		Postcode	
Phone	( )	Fax	( )
Mobile phone			
Email address			

Patient	
Name	
Date of birth	
Postcode	

Hepatitis C History

Date of HCV diagnosis:

Known cirrhosis* ☐ Yes ☐ No

* Patients with cirrhosis or HBV/HIV coinfection should be referred to a specialist

Intercurrent Conditions

Diabetes	☐ Yes	☐ No
Obesity	☐ Yes	☐ No
Hepatitis B	☐ Yes	☐ No
HIV	☐ Yes	☐ No
Alcohol > 40 g/day	☐ Yes	☐ No

Discussion re contraception ☐ Yes ☐ No

Prior Antiviral Treatment

Has patient previously received any antiviral treatment? ☐ Yes ☐ No

Has prior treatment included oral antiviral therapy? ☐ Yes ☐ No

Prior treatment:

I have checked for potential drug–drug interactions with current medications† ☐ Yes ☐ No

Current Medications
(Prescription, herbal, OTC, recreational)

† 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 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 ☐		1, 2, 3, 4, 5, 6
Glecaprevir + Pibrentasvir	8 weeks ☐ *No cirrhosis*	12 weeks ☐ *Cirrhosis*	1, 2, 3, 4, 5, 6
Elbasvir + Grazoprevir	12 weeks ☐		1 or 4
Sofosbuvir + Ledipasvir	8 weeks ☐ *No cirrhosis, treatment-naive*	12 weeks ☐	1

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

See *Australian Recommendations for the Management of Hepatitis C Virus Infection: A Consensus Statement (September 2018)* (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.

Patients who relapse after direct-acting antiviral therapy should be referred to a specialist for retreatment.

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: ( )**	