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

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 RNA			eGFR		
ALT			Platelet count		
AST			INR		
Bilirubin			HIV		
Albumin			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 (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):*			
Pan-genotypic treatment 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

Multiple regimens are available for the treatment of chronic HCV. Factors to consider include pill burden, cirrhosis status, drug–drug interactions and comorbidities.

See *Australian Recommendations for the Management of Hepatitis C Virus Infection: A Consensus Statement* (June 2020) (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 DAA 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:	
Please return both completed pages by email: **or fax: ( )**	