



FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. DD / MM / YYYY	M.O.	
ADDRESS		
		PH
M/C	FIN	
LOCATION / WARD		ADM DD / MM / YYYY
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Facility: COM HKH MAN MQE MV RNS RYD

# REMOTE HEPATOLOGY CONSULT: HCV TREATMENT

Note: This form is not a referral for a patient appointment

## For the Attention of the Hepatologist

Date:

Note: Patients must be treated by a medical practitioner experienced in the treatment of chronic hepatitis C infection; or in consultation with a gastroenterologist, hepatologist or infectious disease physician experienced in the treatment of chronic Hepatitis C infection.

Patient First Name ..... Patient Surname .....

Date of Birth: ..... Gender:  M  F

Address ..... Postcode .....

<b>Hepatitis C History</b>	Non-pregnant (female patients) <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of HCV Diagnosis:	Discussion re contraception for both male & female patients? <input type="checkbox"/> Yes <input type="checkbox"/> No
Known Cirrhosis*? <input type="checkbox"/> Yes <input type="checkbox"/> No	

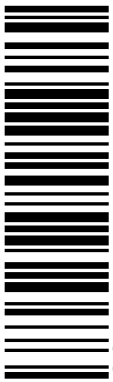
<b>Prior Antiviral Treatment</b>	<b>Current Medications†</b> (Oral, topical and inhaled: incl. all prescriptions, herbal, over the counter & recreational drugs). If insufficient space attach a summary page of medications.
Has patient previously received any antiviral treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has prior treatment included Boceprevir/Telaprevir/Simeprevir? <input type="checkbox"/> Yes <input type="checkbox"/> No	
I have checked for potential drug-drug interactions with current medications.‡ <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Intercurrent Conditions</b>	
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	

\* Patients with cirrhosis, hepatic decompensation or HBV/HIV co-infection should be referred to a specialist.  
 † [www.hep-druginteractions.org](http://www.hep-druginteractions.org) Print and attach a PDF from this site, showing you have checked drug-drug interactions.

Laboratory Results (or attached copy of results)					
Test	Date	Result	Test	Date	Result
HCV genotype			Creatinine		
HCV RNA level			eGFR		
ALT			Haemoglobin		
AST			Platelet Count		
Bilirubin			INR		
Albumin			Weight (kg)		

Liver Fibrosis Assessment**		
Test	Date	Result
FibroScan or		
Other (e.g. APRI)		

**APRI, AST to platelet ratio index: [www.hepatitisc.uw.edu/page/clinical-calculators/apri](http://www.hepatitisc.uw.edu/page/clinical-calculators/apri)**  
 \*\* People with liver stiffness on Fibroscan of  $\geq 12.5$  kPa or an APRI score  $\geq 1.0$  may have cirrhosis and should be referred to a specialist.



COR5147

Holes punched as per A52828-2012  
 BINDING MARGIN - NO WRITING

MAR17/2

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## REMOTE HEPATOLOGY CONSULT: HCV TREATMENT

### Treatment Choice (Select one prescribing choice)

Regimen	Genotype	Status	Duration	Select
Sofosbuvir plus Ledipasvir	1	Treatment naive – no cirrhosis HCV RNA < 6 x 10 <sup>6</sup> IU/mL	8 weeks	<input type="checkbox"/>
	1	No cirrhosis	12 weeks	<input type="checkbox"/>
Sofosbuvir plus Daclatasvir	1	No cirrhosis treatment – naive	12 weeks	<input type="checkbox"/>
	1	No cirrhosis treatment – experienced	12 weeks or 24 weeks	<input type="checkbox"/> <input type="checkbox"/>
Sofosbuvir plus Daclatasvir	3	No cirrhosis	12 weeks	<input type="checkbox"/>
Sofosbuvir plus Ribavirin	2	No cirrhosis	12 weeks	<input type="checkbox"/>
Paritaprevir/Ritonavir plus Ombitasvir plus Dasabuvir	1b	No cirrhosis	12 weeks	<input type="checkbox"/>
Paritaprevir/Ritonavir plus Ombitasvir plus Dasabuvir <input type="checkbox"/> Ribavirin	1a	No cirrhosis	12 weeks	<input type="checkbox"/>
Grazoprevir-Elbasvir	1 or 4	Naive – no cirrhosis	12 weeks	<input type="checkbox"/>
	1b	Treatment experienced – no cirrhosis	12 weeks	<input type="checkbox"/>
Grazoprevir-Elbasvir <input type="checkbox"/> Ribavirin	1a or 4	Treatment experienced – no cirrhosis	16 weeks	<input type="checkbox"/>
Sofosbuvir-Velpatasvir	1, 2, 3, 4, 5 or 6	Treatment naive – no cirrhosis	12 weeks	<input type="checkbox"/>
		Treatment experienced – no cirrhosis	12 weeks	<input type="checkbox"/>

Patients should be monitored during treatment according to the *Australian Recommendations for the Management of Hepatitis C Virus Infection: A Consensus Statement* ([www.gesa.org.au](http://www.gesa.org.au)). Information is also available at: [www.pbs.gov.au/info/healthpro/explanatory-notes/general-statement-hep-c](http://www.pbs.gov.au/info/healthpro/explanatory-notes/general-statement-hep-c)

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/Medical Officer

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

GP/MO Name .....

Address ..... Postcode .....

Phone ..... Fax .....

Mobile Phone .....

Email .....

Signature ..... Date: .....

Once completed please return both pages and the drug interactions and other attachments by email:  
**NSLHD-RNS-HepatologyService@health.nsw.gov.au**

### Approval by Specialist Experienced in the Treatment of HCV (Office Use Only)

- I agree with your decision to treat this person based on the information provided above  
 This patient would be more suited to HCV treatment under specialist supervision. Please forward a formal referral for this patient and an appointment will be scheduled.

Name ..... Signature .....

Designation ..... Date: .....