**FOR ATTENTION OF: Dr**  **Date:**

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

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| **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 |  | | |

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| **Patient** | |
| Name |  |
| Date of birth |  |
| Postcode |  |

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| **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** | | **Current Medications**  (Prescription, herbal, OTC, recreational) |
| Has patient previously received any antiviral treatment? | Yes  No |
| Prior treatment: | |
| I have checked for potential  drug–drug interactions with current medications† | Yes  No |
| † <http://www.hep-druginteractions.org>  If possible, print and fax a PDF from this site showing you have checked drug–drug interactions. | | |

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| **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 APRI/Ultrasound |  |  |
| 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. | | |

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| **Treatment Choice: HCV RNA + required, Genotype no longer essential** | | | |
| I plan to prescribe *(please select one):* | | | |
| **Pan-genotypic treatment regimen** | **Duration** | | **Eligibility** |
| Sofosbuvir + Velpatasvir (EPCLUSA) 400/100mg (1 tablet once daily) | 12 weeks | | Non-Cirrhotic & Compensated Cirrhosis (Child-Pugh A) |
| Glecaprevir + Pibrentasvir (MAVIRET) 100/400mg (3 tablets once daily) | 8 weeks |  | Non-Cirrhotic & Compensated Cirrhosis (Child-Pugh A) |
| 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 (May 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. | | | |

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| **Declaration by General Practitioner/Nurse Practitioner**  *I declare all of the information provided above is true and correct.* | |
| Signature: |  |
| Name: |  |
| Date: |  |

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| **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:** [**rosalie.altus@sa.gov.au**](mailto:rosalie.altus@sa.gov.au)[**rachel.wundke@sa.gov.au**](mailto:rachel.wundke@sa.gov.au)  **or fax: (08) 8204 3035** | |