**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**

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| Diabetes | [ ]  Yes | [ ]  No |
| Obesity | [ ]  Yes | [ ]  No |
| Hepatitis B | [ ]  Yes | [ ]  No |
| HIV  | [ ]  Yes | [ ]  No |
| Alcohol > 40 g/day | [ ]  Yes | [ ]  No |

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| Discussion re contraception | [ ]  Yes | [ ]  No |

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| **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****rachel.wundke@sa.gov.au****or fax: (08) 8204 3035** |