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

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

**Note: GPs are eligible to prescribe hepatitis C treatment under the PBS, provided they are experienced in the treatment of chronic HCV infection or they prescribe in consultation with a gastroenterologist, hepatologist or infectious disease physician experienced in the treatment of chronic HCV infection.**

|  |  |  |  |
| --- | --- | --- | --- |
| GP name |  | | |
| GP suburb |  | GP postcode |  |
| GP phone | ( ) | GP fax | ( ) |
| GP mobile phone |  | | |
| GP email address |  | | |

|  |  |
| --- | --- |
| Patient name |  |
| Patient date of birth |  |
| Patient residential 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** | | **Current Medications**  (Prescription, herbal, OTC, recreational) |
| Has patient previously received any antiviral treatment? | Yes  No |
| Has prior treatment included Boceprevir/Telaprevir/Simeprevir? | Yes  No |
| 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. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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 |  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **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** | | | | **Genotype** |
| Sofosbuvir plus Ledipasvir | 8 weeks | 12 weeks | | 24 weeks | 1 |
| Sofosbuvir plus Daclatasvir | 12 weeks | 24 weeks | | plus Ribavirin | 3 or 1 |
| Glecaprevir and Pibrentasvir | 8 weeks (naïve, Non cirrhotic) | | | | 1-6 |
| Sofosbuvir and Velpatasvir | 12 weeks | | | | 1-6 |
| Elbasvir plus Grazoprevir | 12 weeks | | 16 weeks plus Ribavirin | | 1 or 4 |

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

See *Australian Recommendations for the Management of Hepatitis C Virus Infection: A Consensus Statement (January 2017)* (<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.

**Declaration by General 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: (** **)** | |