



Facility: COM HKH MQE MVH RNS RYD

# REMOTE HEPATOLOGY CONSULT: HCV TREATMENT

FAMILY NAME		MRN	
GIVEN NAME		MALE	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

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>				
Date of HCV Diagnosis:			Non-pregnant (female patients)	Yes No
Known Cirrhosis*?	Yes No		Discussion re contraception for both male & female patients?	Yes No
<b>Prior Antiviral Treatment</b>			<b>Current Medications</b> ‡	
Has patient previously received any antiviral treatment?	Yes No		(Oral, topical and inhaled: incl. all prescriptions, herbal, over the counter & illicit drugs). If insufficient space attach a summary page of medications.	
Has prior treatment included Boceprevir/Telaprevir/Simeprevir?	Yes No			
I have checked for potential drug-drug interactions with current medications.‡	Yes No			
<b>Intercurrent Conditions</b>				
Diabetes	Yes No			
Obesity	Yes No			
Hepatitis B	Yes No			
HIV	Yes No			
Alcohol > 40 g/day	Yes No			

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

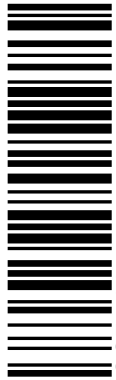
### Laboratory Results (or attached copy of results)

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 \*\* 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.



COR5147

Holes punched as per AS2828.1:2019 BINDING MARGIN - NO WRITING

CATALOGUE NUMBER NS11743-E JUL22/V6

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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

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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	
	1	No cirrhosis	12 weeks	
Sofosbuvir plus Daclatasvir	1	No cirrhosis treatment – naive	12 weeks	
	1	No cirrhosis treatment – experienced	12 weeks or 24 weeks	
Sofosbuvir plus Daclatasvir	3	No cirrhosis	12 weeks	
Sofosbuvir plus Ribavirin	2	No cirrhosis	12 weeks	
Paritaprevir/Ritonavir plus Ombitasvir plus Dasabuvir	1b	No cirrhosis	12 weeks	
Paritaprevir/Ritonavir plus Ombitasvir plus Dasabuvir Ribavirin	1a	No cirrhosis	12 weeks	
Grazoprevir-Elbasvir	1 or 4	Naive – no cirrhosis	12 weeks	
	1b	Treatment experienced – no cirrhosis	12 weeks	
Grazoprevir-Elbasvir Ribavirin	1a or 4	Treatment experienced – no cirrhosis	16 weeks	
Sofosbuvir-Velpatasvir	1, 2, 3, 4, 5 or 6	Treatment naive – no cirrhosis	12 weeks	
		Treatment experienced – no cirrhosis	12 weeks	

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](mailto: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: \_\_\_ / \_\_\_ / \_\_\_\_

Notes punched as per AS2828.1:2019  
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