|  |  |
| --- | --- |
| Alfred Hospital Liver Clinic (Gastroenterology) | Fax: (03) 9076 2194 |
| Alfred Hospital Infectious Diseases | Fax: (03) 9076 6528 |
| Austin Health Liver Clinic | Fax: (03) 9496 2097 |
| Box Hill Hospital Liver and Hepatitis Clinics | Fax: (03) 9895 4852 |
| St Vincent's Hospital Melbourne Liver & Hepatitis Clinic | Fax: (03) 9231 3596 |
| The Royal Melbourne Hospital Liver Clinic | Fax: (03) 9342 7848 |
| Victorian Infectious Diseases Service – Infectious Hepatitis Clinic | Fax: (03) 9342 7277 |
| Western Health Hepatitis Clinic | Fax: (03) 8345 7217 |

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

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

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Hepatitis C History**  Date of hepatitis C (HCV) diagnosis:  Known cirrhosis\*  Yes  No  \*Patients with cirrhosis, or HBV/HIV coinfection with HCV should be referred to a specialist. | | **Intercurrent Conditions**   |  |  |  | | --- | --- | --- | | Diabetes | Yes | No | | Obesity | Yes | No | | Hepatitis B (HBV)\* | Yes | No | | HIV\* | Yes | No | | Alcohol > 4 standard drinks/day (> 40 g/day) | Yes | No | |
| |  |  |  | | --- | --- | --- | | Discussion about contraception  *(Contraception recommended for duration of treatment as safety of DAA treatment during pregnancy not yet established, if Ribavirin is used - two modes of contraception recommended for duration of treatment and 6 months post-treatment).* | Yes | No | |
| **Prior Antiviral Treatment** | | **Current Medications**  *(Prescription, herbal, over the counter, recreational)* |
| Has patient previously received any antiviral treatment? (please add detail below) | YesNo |
| Has prior treatment included oral antiviral therapy? | 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. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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 |  |  | HBsAg |  |  |

|  |  |  |
| --- | --- | --- |
| **Liver Fibrosis Assessment\*\*** | | |
| **Test** | **Date** | **Result** |
| FibroScan |  |  |
| Other (eg. [APRI](https://www.hepatitisc.uw.edu/page/clinical-calculators/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/tick one):*

|  |  |  |  |
| --- | --- | --- | --- |
| **Regimen** | **Duration** | | **Genotypes** |
| Sofosbuvir + Velpatasvir | 12 weeks | | 1, 2, 3, 4, 5, 6 |
| Glecaprevir + Pibrentasvir | 8 weeks  *No cirrhosis* | 12 weeks  *Cirrhosis* | 1, 2, 3, 4, 5, 6 |
| Elbasvir + Grazoprevir | 12 weeks | | 1 or 4 |
| Sofosbuvir + Ledipasvir | 8 weeks  *No cirrhosis, treatment-naive* | 12 weeks | 1 |

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

See *Australian Recommendations for the Management of Hepatitis C Virus Infection: A Consensus Statement (September 2018)* (<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 direct-acting antiviral therapy should be referred to a specialist for retreatment.

**Declaration by General Practitioner/Nurse 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: ( )** | |