Before completing this form, please check if this patient:

Has **hepatitis B, HIV, cirrhosis, hepatocellular carcinoma** or **renal disease,** or is **pregnant?**If **yes**, do NOT complete this form. These patients should be referred to a specialist via the Central Referral Service or privately.

Has **chronic hepatitis C**, i.e. **HCV antibody positive** and **HCV RNA positive** on **2 separate occasions >=6 months apart?**If **no**, patient is not eligible for PBS-funded HCV treatment

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

🞏 Infectious disease physician 🞏 Hepatologist 🞏 Gastroenterologist

Note: GPs and other medical practitionersexperienced in the treatment of chronic hepatitis C infection are eligible to independently prescribe hepatitis C treatment under the PBS without consulting a gastroenterologist or hepatologist or infectious diseases physician**.**

|  |  |
| --- | --- |
| GP name | Dr  |
| Practice name |  |
| Practice address |  | Postcode |  |
| Phone | ( ) | Fax | ( )  |
| Mobile phone |  |
| Email address |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date of HCV diagnosis (dd/mm/yyyy):  / /  | **Co-morbidities**

|  |  |  |
| --- | --- | --- |
| Diabetes | ☐ Yes | ☐ No |
| Obesity | ☐ Yes | ☐ No |
| Alcohol > 40 g/day | ☐ Yes | ☐ No |
| Heart Disease | ☐ Yes | ☐ No |

 |
| **Prior Antiviral Treatment** | **Current Medications**(Prescription, herbal, OTC, recreational):

|  |  |  |
| --- | --- | --- |
| Contraception (female patients only) | ☐ Yes | ☐ No |

I have checked for potential drug–drug interactions with current medications† ☐ Yes ☐ No† [www.hep-druginteractions.org](http://www.hep-druginteractions.org/)If possible, print and fax a PDF from this site showing you have checked drug–drug interactions. |
| Has patient previously received any antiviral treatment? | ☐ Yes ☐ No |
| Has prior treatment included oral antiviral therapy? | [ ]  Yes [ ]  No |
| Prior treatment:  |

|  |
| --- |
| **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 (or attach copy of results)** |
| **Test** | **Date** | **Result** |
| **Choose one test from below** |  |
| **APRI**  |  |  |
| Calculate from AST and platelet countAPRI: (AST to Platelet Ratio Index) (AST [IU/L] ÷ AST upper limit of normal [IU/L] × 100) ÷ platelet count (× 109 /L) [www.hepatitisc.uw.edu/page/clinical-calculators/apri](http://www.hepatitisc.uw.edu/page/clinical-calculators/apri) |
| **OR** |  |  |
| **Hepascore** |  |  |
| Not Medicare funded. Available at Pathwest. Patented formula combining bilirubin, GGT, hyaluronate, a-2-macroglobulin, age and sex. |
| **OR** |  |  |
| **FibroScan®** (EchoSens, Paris) |  |  |
| Not Medicare funded.  |

**People with APRI score≥1.0, Hepascore>0.8 or FibroScan® score ≥12.5 kPa should be referred to a specialist.**

|  |
| --- |
| **Liver Ultrasound (or attach copy of results)**To examine for features of portal hypertension (splenomegaly, reversal of portal vein flow) and to exclude hepatocellular carcinoma. |
| **Date** | **Result** |

**Treatment Choice**

I plan to prescribe*:*

|  |  |  |
| --- | --- | --- |
| **Regimen** | **Genotype** | **Duration (weeks)** |
|  |  |  |

Patients should be monitored during treatment according to the current *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](http://www.pbs.gov.au/pbs/home) .

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.* ☐ *I do NOT agree with the decision to treat this person based on the information provided above. Please refer the patient to a specialist via the Central Referral Service or privately* |
| Signature: |  |
| Name: |  |
| Date: |  |
| Comments: |  |
| **Once completed, please return all 3 pages to Dr (GP’s name), fax ( )**  |

*––*