**Remote Consultation Criteria**

Patient details / label:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Non-cirrhotic
* DAA treatment naïve
* No significant co-morbidities

|  |  |  |  |
| --- | --- | --- | --- |
| **Details of prescriber receiving referral** | | | |
| Name and position |  | | |
| Clinic details |  | | |
| Phone |  | Fax |  |
| Email |  | | |
|  | | | |
| **Location to send original prescription (nominated pharmacy or liver clinic)** | | | |
| Pharmacy name |  | | |
| Address |  | | |
| Phone |  | Fax |  |
| Email |  | | |
|  | | | |
| **Details of referring practitioner (MO/RN)** | | | |
| Name and position |  | | |
| Clinic details |  | | |
| Phone |  | Fax |  |
| Email |  | | |
|  | | | |
| **Treatment Instructions** | | | |
| * I have recommended a treatment choice and discussed the below points with the patient, **OR** * I have not recommended a treatment choice and await your advice. Once you have recommended a treatment choice, I agree to discuss the below points with patient: * dosage (number of tablets to be taken) * frequency of medication (number of times per day) * to be taken with or without food * treatment duration * 4 weeks only are dispensed at a time and to contact pharmacy prior to next script dispensing so they can order the next 4 weeks’ supply * importance of avoiding treatment interruption * The patient is aware that they may, or may not, receive a phone call on the number listed above from the prescriber, **OR** * The patient is not contactable by phone | | | |
| **Treatment adherence** | | | |
| * no anticipated challenges with adherence * anticipated challenges with adherence and have planned strategies to address these. | | | |
| Comments |  | | |
| Signature |  | Date |  |

\*Patients with HIV, Hepatitis B or who have previously had HCV treatment with DAA’s should be referred to a specialist

Patient details / label:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient** | | | | | | | | | | | | | | |
| Indigenous? |  Yes  No  Unknown | | | | | | | | | | | | | |
| Medicare # |  |  | |  |  | |  |  |  | |  |  | |  |
| Medicare expiry date |  | | | | | | | | | | | | | |
| Health Care Card # |  |  | |  |  | |  |  |  | |  |  | |  |
| Health Care Card expiry |  | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Hepatitis C History**    Duration of infection: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Previous Antiviral Treatment:  Yes\*  No  Name of prior treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Inter-current Conditions**  Diabetes  Yes  No  Obesity  Yes  No  HIV  Yes\*  No  Hepatitis B  Yes\*  No  Alcohol >40g/day  Yes  No  *\*If previously treated or co-infected refer to specialist* | | | | | | **Medications (prescription, herbal, OTC, recreational)**   * I have attached drug-drug interactions report form <https://www.hepdruginteractions.org/> | | | | | | | | |
| **Harm Minimisation**   * I have discussed harm minimisation strategies to reduce transmission risks including: * Not sharing injecting equipment * Ensuring tattooing and body piercing equipment is single use * Not sharing toothbrushes or razors * I discussed with the patient the benefits of encouraging any contacts to come for HCV testing | | | | | | **Contraception discussion (if female)**  Patient is:   * aware not to become pregnant * taking some form of contraception or planned contraception * taking ethinyloestradiol-containing products\*\*   *\*\* ethinyloestradiol containing contraception products are contraindicated with Maviret* | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Laboratory results *within last 6 months* (or attach copy)** | | | | | | | | | | | | | | |
| **Test** | **Date** | | **Result** | | | **Test** | | | | **Date** | | | **Result** | |
| HCV Genotype if avail |  | |  | | | eGFR | | | |  | | |  | |
| HCV RNA |  | |  | | | Haemoglobin | | | |  | | |  | |
| ALT |  | |  | | | Platelet | | | |  | | |  | |
| AST |  | |  | | | HBsAg | | | |  | | |  | |
| Bilirubin |  | |  | | | HBcAb (anti-HBc) | | | |  | | |  | |
| INR |  | |  | | | HBsAb (anti-HBs) | | | |  | | |  | |
| Albumin |  | |  | | | Comments | | | |  | | | | |

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Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Liver Fibrosis Assessment** | | | | | | |
| * I have assessed the patients for fibrosis using one of the below methods | | | | | | |
| **Test** | | | **Date** | | | **Result** |
| * Fibroscan | | |  | | |  |
| * AST to Platelet Ratio Index (APRI) score   <http://www.hepatitisc.uw.edu/page/clinical-calculators/apri> | | |  | | |  |
| *People with Fibroscan of ≥ 12.5 kPa or APRI ≥ 1 may have cirrhosis and should be referred to a specialist.* | | | | | | |
|  | | | | | | |
| **Treatment Choice \*\*\*** | | | | | | |
| * **After discussion with the patient I have a identified a preferred regimen below, OR** * **I do not have a preferred regimen** | | | | | | |
| **Regimen** | | **Duration** | | | | **Dosage** |
| * Sofosbuvir/Velpatasvir (Epclusa) | |  12 weeks | | | | 1 tablet po daily |
| * Glecaprevir/Pibrentasvir (Maviret) | |  8 weeks  *no cirrhosis* | |  12 weeks  *cirrhosis* | | 3 tablets po  once daily with food |
| \*\*\* Both treatment options listed are suitable for the treatment of chronic HCV, all genotypes. Factors to consider include cirrhosis status, prior treatment, potential drug-drug interactions and co-morbidities. See *Australian Recommendations for the management of Hepatitis C Virus Infection: A Consensus Statement (June 2020)* *( (*[*https://www.hepcguidelines.org.au/*](https://www.hepcguidelines.org.au/) *)* for all regimens & monitoring recommendations.   * Patients must be tested for HCV RNA at least 12 weeks after completing treatment to determine outcome. Please notify this prescriber of the 12 weeks-post treatment results. * Patients who relapse after DAA therapy should be referred to a specialist for treatment. | | | | | | |
| **Declaration by Referrer:** *I declare all of the information provided above is true and correct.* | | | | | | |
| Signature |  | | | | | |
| Name |  | | | | Date |  |
|  | | | | | | |
| **Prescriber Comments (if indicated):** | | | | | | |
| * Phone consultation, **OR** * No phone consultation was required | | | | | | |
| **Declaration by Prescriber experienced in HCV Treatment:** *I agree with the decision to treat this person based in the information provided above or see box below for additional comments.* | | | | | | |
| Signature |  | | | | | |
| Name |  | | | | Date |  |