**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

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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 |  |  | HIV Ab |  |  |

Patient details / label:

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

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 | 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/> )* 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 |  |

|  |  |  |
| --- | --- | --- |
| **Please tick who will capture the NSW Health KPI assessment data** | [ ]  **Nurse Referrer** | [ ]  **Prescriber** |