**Remote Consultation Criteria**

Patient details / label:

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

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

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

Non-cirrhotic / compensated cirrhotic

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 had documented DAA treatment failure for this current HCV infection should be referred to a specialist

Patient details / label:

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

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

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient** | | | | | | | | | | | | | | | | | | | | | | | | |
| First Nations person? | Yes  No  Unknown | | | | | | | | | | | | | | | | | | | | | | | |
| Medicare # |  |  | | |  | |  | | |  | |  | |  | | |  | |  | |  | | |  |
| Medicare expiry date |  | | | | | | | | | | | | | | | | | | | | | | | |
| Health Care Card # |  | |  | | |  | |  | | |  | |  | |  | | |  | |  | | |  | |
| Health Care Card expiry |  | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| **Hepatitis C History**  Duration of infection: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Documented DAA failure for current infection:  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 | | | | | | | | | **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  using some form of contraception or planned   contraception  taking ethinyloestradiol-containing products \*\*  *\*\* MAVIRET may be co-administered with products containing ≤ 20 μg ethinyloestradiol but is contraindicated with products containing > 20 μg ethinyloestradiol.* | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| **Laboratory results *ideally* *within last 6 months at discretion of prescriber* (or attach copy)** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Test** | **Date** | | | **Result** | | | | | **Test** | | | | | | | **Date** | | | | | | **Result** | | |
| **HCV RNA** |  | | |  | | | | | ALT | | | | | | |  | | | | | |  | | |
| **HBsAg** |  | | |  | | | | | AST | | | | | | |  | | | | | |  | | |
| **HIV Ab** |  | | |  | | | | | Platelet | | | | | | |  | | | | | |  | | |
| HBcAb |  | | |  | | | | | Albumin | | | | | | |  | | | | | |  | | |
| HBsAb (anti-HBs) |  | | |  | | | | | INR | | | | | | |  | | | | | |  | | |
| HCV Genotype if avail |  | | |  | | | | | eGFR | | | | | | |  | | | | | |  | | |
|  |  | | |  | | | | | Bilirubin | | | | | | |  | | | | | |  | | |
| *While all tests should be done where feasible, the tests in* ***bold*** *are non-negotiable (along with determining cirrhosis status). The minimum requirements for treatment initiation are at the discretion of the prescriber.* | | | | | | | | | | | | | | | | | | | | | | | | |

Patient setting / referral source:

GP  Community Corrections

D&A  D&A Rehab  Mental Health

Homelessness Services

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient details / label:

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

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

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Referring Nurse Setting:**  Liver Clinic  Other: | | | | | |
|  | | | | | |
| **Liver Fibrosis Assessment** | | | **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 (2022)* ([*https://www.hepcguidelines.org.au/wp-content/uploads/2022/11/hepatitis-C-virus-infection-a-consensus-statement-2022.pdf*](https://www.hepcguidelines.org.au/wp-content/uploads/2022/11/hepatitis-C-virus-infection-a-consensus-statement-2022.pdf)*)* for all regimens & monitoring recommendations.  \*\*\*\*A treatment duration of 12 weeks may be considered for patients with compensated cirrhosis at the discretion of the prescriber.   * Test patient for HCV RNA 12 weeks after completing treatment to determine outcome (a minimum of 4 weeks is adequate if concern about loss to follow-up). Please notify this prescriber of the results. * Patients who relapse after DAA therapy should be referred to a specialist for treatment. | | | | | |
| **Referrer Declaration:** *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 | | | | | |
| **Prescriber Declaration:** *I agree with the decision to treat this person based in the information provided.* | | | | | |
| Signature |  | | | | |
| Name |  | | | Date |  |

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