Michigan Opioid Collaborative

MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

Site: ________________ **Provider:** ______________________

HCV Treatment Review Number: _________ **Date of request:** _________________

Age:			
Sex:	If female of child bearing age, pregnancy test done? YES NO Date: Result:		
Brief clinical history, in particular any history of hepatic decompensation (ascites, variceal bleeding, hepatic encephalopathy) or hepatocellular carcinoma. Please include date of HCV diagnosis if known.			
Medical comorbidities			
Current medications (including health supplements taken regularly)			
Current illicit drug use	YES NO		
Current alcohol use	YES NO	Quantity:	
HCV RNA IU/mL		Date:	Result:
HCV genotype		Date:	Result:
HAV IgG Total		Date:	Result:
HBsAg		Date:	Result:
Anti-HBc		Date:	Result:
Anti-HBs		Date:	Result:
Other lab (CBC, Cr, liver panel)		Date:	Result:
Platelets ($10^3/\mu L$)		Date:	Result:
AST (U/L)		Date:	Result:
ALT (U/L)		Date:	Result:
Total bilirubin (mg/dL)		Date:	Result:
Albumin (G/DL)		Date:	Result:
GFR (ml/min/1.73m2)		Date:	Result:
FIB-4 calculation		Date:	Result:
Other Fibrosis measurement (Fibrosure, fibroscan, other)		Date:	Result:
Liver imaging (US, CT, MRI)		Date:	Result:
HCV cirrhosis	YES NO	**If YES,** based on ___________ **Any decompensation:** YES NO	
HCV treatment history			
Naïve	YES		
Experienced	YES	If **YES, date** when last course of treatment completed**, names of drugs** used in last course of treatment:	
Treatment recommendation			
DAA regimen and duration			
Questions			
Phone Consultation (if applicable)	YES NO	**Date:**	
Signed by:		**Date:**	

TURNAROUND TIME: As far as timing, due to the fact that Hepatitis C treatment is rarely urgent, we would ask that we receive the requested signed form, and/or phone consultation when necessary, within 5-14 working days of submission.