**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** | | Month/Year: | | Result: |
| **HCV genotype** | | Month/Year: | | Result: |
| **HAV IgG Total** | | Month/Year: | | Result: |
| **HBsAg** | | Month/Year: | | Result: |
| **Anti-HBc** | | Month/Year: | | Result: |
| **Anti-HBs** | | Month/Year: | | Result: |
| **HIV** | | Month/Year: | | Result: |
| **Other lab** (CBC, Cr, liver panel) | | Month/Year: | | Result: |
| **Platelets (103/μL)** | | Month/Year: | | Result: |
| **AST (U/L)** | | Month/Year: | | Result: |
| **ALT (U/L)** | | Month/Year: | | Result: |
| **Total bilirubin (mg/dL)** | | Month/Year: | | Result: |
| **Albumin (G/DL)** | | Month/Year: | | Result: |
| **GFR (ml/min/1.73m2)** | | Month/Year: | | Result: |
| **FIB-4 calculation** | | Month/Year: | | Result: |
| **Other Fibrosis measurement** (Fibrosure, fibroscan, other) | | Month/Year: | | Result: |
| **Liver imaging** (US, CT, MRI) | | Month/Year: | | 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. | | | | |