**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. |