**Hep B Hub WA**

**Chronic Hepatitis B Treatment – GP/NP Prescription Request**

**Once completed, email to** **HepBHubWA@health.wa.gov.au**

**FOR ATTENTION OF: Hep B Hub WA DATE:**

***This form should be used by primary/community health care providers to obtain a Hepatitis B antiviral prescription from the Hep B Hub WA for their patient if they are not an s100 prescriber, or an s100 prescriber is not available to them. Requests can be either to initiate or to continue current treatment and both paper and e-scripts are available.***

***Clinical advice can be obtained by emailing*** ***HepBHubWA@health.wa.gov.au*** ***(this form is not required unless you require an s100 Hepatitis B treatment prescription for your patient).***

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| **GP/NP name and practice** |  |
| **GP/NP address and post code** |  |
| **GP/NP mobile phone** |  | **GP/NP fax** |  |
| **GP/NP email address** |  |
| **GP/NP AHPRA Number** |  |

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| **Patient name** |  |
| **Patient address and postcode** |  |
| **Patient phone and email address** |  |
| **Patient date of birth** |  | **UMRN if known** |  |

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| **Hepatitis B History:**Date of HBV diagnosis: Known cirrhosis\* ☐ Yes ☐ No\* Patients with cirrhosis, HCV/HIV coinfection or who are pregnant should be referred to a specialist. Discuss this with the Hep B Hub WA first.On HCC surveillance? ☐ Yes ☐ NoOther information:(Medicare eligibility, country of birth etc) | **Intercurrent Conditions:**

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| Diabetes | ☐ Yes | ☐ No |
| Obesity | ☐ Yes | ☐ No |
| Hepatitis C | ☐ Yes | ☐ No |
| HIV  | ☐ Yes | ☐ No |
| Alcohol > 40 g/dayHepatitis DOsteopenia/Osteoporosis | ☐ Yes☐ Yes☐ Yes | ☐ No☐ No☐ No |

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| **Potential for pregnancy now or in the future (planned or unplanned)?** | ☐ Yes | ☐ No |

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| **Antiviral Treatment:** | **Current Medications:**(Prescription, herbal, OTC, recreational) |
| Is the patient currently on HBV treatment? **Drug:** | ☐ Yes ☐ No |
| If no, has patient previously received any HBV treatment and when? **Drug and Date:** | ☐ Yes ☐ No |
| Is the patient currently taking HIV PrEP or is there ongoing HIV risk? | ☐ Yes ☐ No |
| **Allergies:** |

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| **Enter or Attach Lab Results (within 3 months) (TDF = Tenofovir Disoproxil Fumarate)** |
| **Test** | **Date** | **Result** | **Test** | **Date** | **Result** |
| **HBsAg** |  |  | **Creatinine** |  |  |
| **HBV DNA level** |  |  | **eGFR** |  |  |
| **ALT** |  |  | **Haemoglobin** |  |  |
| **AST** |  |  | **Platelet count** |  |  |
| **HBeAg** |  |  | **INR** |  |  |
| **Serum PO4 (TDF)** |  |  | **Urine ACR + PCR (TDF)** |  |  |
| **Urine PO4 (TDF)** |  |  | **AFP** |  |  |

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| **Liver Fibrosis Assessment\*\*** |
| **Test** | **Date** | **Result** |
| **FibroScan,** **Hepascore or APRI** |  |  |
| **Abdominal ultrasound** |  |  |
| **Fibroscan is available at tertiary hospitals, or we can bring a scanner to your practice on request. Ask the Hep B Hub WA for more information; Please be aware - Hepascore testing will incur a fee.**APRI calculator: <http://www.hepatitisc.uw.edu/page/clinical-calculators/apri>\*\* People with liver stiffness on FibroScan of ≥ 12.5 kPa, Hepascore > 0.8 or an APRI score ≥ 1.0 may have cirrhosis and should be reviewed by a specialist. Discuss with the Hep B Hub WA first. \*\* |

**Prescription (choose one):**

E-Script via SMS direct to patient (confirm phone number)  ☐

E-Script via email to patient/GP/pharmacy (confirm email address) ☐

Paper script to patient/GP/pharmacy (confirm address) ☐

**Referrer declaration:**

*I declare all the information provided above is true and correct. Follow up in the first year of treatment is 3-monthly, and 6-monthly thereafter as guided by the Hep B Hub WA.*

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| **Referring GP/NP signature:** |  |
| **Referring GP/NP name and practice:** |  |
| **Date:** |  |

**HEP B HUB WA USE ONLY:**

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| --- | --- | --- |
| **Treatment prescribed** | **Script type** | **Follow up plan and clinical notes** |
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| **Hep B Hub WA NP Signature:** |  |
| **Hep B Hub WA NP Name:** |  |
| **Date:** |  |