

HCV Treatment Work-Up Provider Note

Facility: \_\_\_\_\_

Allergies: \_\_\_\_\_

1. Labs within the last 6 months:

CBC Result: \_\_\_\_\_ CMP. Result: \_\_\_\_\_  
Urine Drug Screen Result: \_\_\_\_\_

2. Labs required within the last year:

HCV PCR RNA \_\_\_\_\_ Hepatitis profile to include HBsAg and anti-HBc Result: \_\_\_\_\_  
HBV PCR DNA (CPL4286- if either HBsAg or anti-HBc positive) Result: \_\_\_\_\_  
AFP Result: \_\_\_\_\_ TSH Result: \_\_\_\_\_  
HIV Antibody Result: \_\_\_\_\_ HCV genotype Result: \_\_\_\_\_  
INR is only indicated in those with cirrhosis as part of the CTP score Result: \_\_\_\_\_  
Fibrosure is only indicated in those with discordant APRI and FIB-4 scores Result: \_\_\_\_\_

3. Problems: \_\_\_\_\_

4. Current Medications: \_\_\_\_\_

5. APRI \_\_\_\_\_  Fib-4 \_\_\_\_\_  Metavir \_\_\_\_\_

6. Has the Inmate requested Hepatitis C Treatment:  Yes  No Comment: \_\_\_\_\_

7. Has the Inmate previously been treated for Hepatitis C:  Yes  No  
If "Yes" When (include year) \_\_\_\_\_ Where: \_\_\_\_\_ Treatment Regimen: \_\_\_\_\_ Duration: \_\_\_\_\_

8. Was treatment completed:  Yes  No If "No" state reason: \_\_\_\_\_

9. High Risk Behaviors/Mode of HCV Transmission/Risks of disease progression (select all that apply)

a. Intravenous drug use:  Yes  No If "Yes" (select all that apply)

<input type="checkbox"/> Methamphetamine/cocaine	Date of first use: _____	Date of last use: _____
<input type="checkbox"/> Opiates/heroin	Date of first use: _____	Date of last use: _____
<input type="checkbox"/> Other "State" _____	Date of first use: _____	Date of last use: _____
<input type="checkbox"/> Other "State" _____	Date of first use: _____	Date of last use: _____

b. Intranasal drug use:  Yes  No If "Yes" (select all that apply)

<input type="checkbox"/> Methamphetamine/cocaine	Date of first use: _____	Date of last use: _____
<input type="checkbox"/> Opiates	Date of first use: _____	Date of last use: _____
<input type="checkbox"/> Other "State" _____	Date of first use: _____	Date of last use: _____
<input type="checkbox"/> Other "State" _____	Date of first use: _____	Date of last use: _____

c. Inhalation (smoking) drug use:  Yes  No If "Yes" (select all that apply)

<input type="checkbox"/> Methamphetamine/cocaine	Date of first use: _____	Date of last use: _____
<input type="checkbox"/> Opiates/heroin	Date of first use: _____	Date of last use: _____
<input type="checkbox"/> THC Amount (daily, weekly, monthly)	Date of first use: _____	Date of last use: _____
<input type="checkbox"/> Other "State" _____	Date of first use: _____	Date of last use: _____

d. Alcohol:  Yes  No If "Yes" Amount: \_\_\_\_\_ Date of first use: \_\_\_\_\_ Date of last use: \_\_\_\_\_

e. Prison tattooing: First \_\_\_\_\_ Last \_\_\_\_\_ Prison piercing: First \_\_\_\_\_ Last \_\_\_\_\_

f. High Risk Sexual Activity:  Yes  No If "Yes" (select all that apply)

<input type="checkbox"/> Anal intercourse	First encounter: _____	Last Encounter: _____
<input type="checkbox"/> Traded sex for money	First encounter: _____	Last Encounter: _____
<input type="checkbox"/> > 50 lifetime sexual partners		

g. Illicit drug use excluded with witnessed Urine Drug Screen (in patients suspected of ongoing high risk illicit drug use):  Yes  No  
If "Yes" Explain: \_\_\_\_\_

10. Inmate failed USD:  Yes  No If "Yes" Refer to local 12 step recovery program

11. Pregnancy excluded via urine test for women without a history of hysterectomy within the last 30 days:  Yes  No

Provider Name: \_\_\_\_\_ Date: \_\_\_\_\_

Inmate Name  
(Last, First)

DOC #

**12. Concomitant HBV excluded with negative HBsAg** (Hepatitis B surface Antigen) **and anti-HBc** (Hepatitis B core antibody):  Yes  No

**13. Concomitant HIV excluded within past year:**  Yes  No

**14. HBsAg/anti-HBc positive - HBV PCR DNA (required)?**  Yes  No

**15. Hepatitis C Decompensation History:**

Hepatic Encephalopathy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment: _____
Jaundice (Bilirubin $\geq$ 2 mg/dL):	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment: _____
Ascites:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment: _____
Bleeding/Ruptured Varcies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment: _____

**16. Hepatitis C Extra-Hepatic Manifestations History**

Thrombocytopenia:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment: _____
Cryoglobulinemia:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment: _____
Lymphoma:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment: _____
Autoimmune Thyroiditis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment: _____
Porphyria Cutanea Tarda:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment: _____
Lichen Planus:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment: _____
Luekocytoclastic Vasculitis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment: _____
Renal Disease such as Membroproliferative Glomerulonephritis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment: _____

**17. Physical Examination Consistent with Cirrhosis Findings:**

<b>Physical Examination Consistent with Cirrhosis Findings:</b>		
Caput Medusae:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment: _____
Loss of body/pubic hair:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment: _____
Hepatic encephalopathy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment: _____
Gynecomastia:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment: _____
Ascites:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment: _____
Spider angiomata:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment: _____
Palmar erythema:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment: _____
Jaundice and scleral icterus:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment: _____

**18. Annual Child-Pugh Score (in those with cirrhosis): Based on current lab tests, calculate the following:**

1. Bilirubin < 2 mg / dl = 1 pt.	2 - 3 mg / dl = 2 pts.	> 3 mg / dl = 3 pts.	Score
2. Albumin > 3.5 g / dl = 1 pt.	2.8 - 3.5 g / gl = 2 pts.	< 2.8 g / dl = 3 pts.	<input type="checkbox"/> Mild 5 - 6 points
3. INR < 1.70 + 1 pt.	1.17 - 2.20 = 2 pt.	> 2.20 = 3 pts.	<input type="checkbox"/> Moderate 7 - 9 points
4. Ascites None = 1 pt.	Medically Controlled = 2 pt.	Poor Control = 3 pts.	<input type="checkbox"/> Severe 10 - 15 points
5. Encephalopathy None = 1 pt.	Medically Controlled = 2 pt.	Poor Control = 3 pts.	

**19. HCC Screen Completed:**

- a. **AFP:**  Yes  No Comment: \_\_\_\_\_
- b. **RUQ/splenic US:**  Yes  No Comment: \_\_\_\_\_
- Splenomegaly** Comment: \_\_\_\_\_
  - Hepatomegaly** Comment: \_\_\_\_\_
  - Coarsened** Comment: \_\_\_\_\_
  - Steatosis** Comment: \_\_\_\_\_
  - Cholelithiasis** Comment: \_\_\_\_\_
  - Cirrhosis** Comment: \_\_\_\_\_
  - Ascites** Comment: \_\_\_\_\_

**20. Pt currently on no medications that would interact with DAA therapy, Epclusa.** Potentially Significant Drug Interactions with Epclusa include: Amiodarone, Digoxin, Carbamazepine, phenytoin, phenobarbital, oxcarbazepine, HIV ART (including tenofovir), HMG-CoA Reductase Inhibitors (Statins), St. John's Wort, and Rifampin. Antacids (e.g., aluminum and magnesium hydroxide) must be Separated from EPCLUSA administration by 4 hours, H2-receptor antagonists‡ (e.g., famotidine) may be administered simultaneously with or 12 hours apart from EPCLUSA at a dose that does not exceed doses comparable to famotidine 40 mg twice daily. Coadministration of omeprazole or other proton-pump inhibitors is not recommended.

- Yes:** The patient is currently not prescribed any medications that would interact with Epclusa.
- No:** The patient is prescribed a medication that would interact with Epclusa.

Provider Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Inmate Name**  
(Last, First)

**DOC #**