STATE OF CALIFORNIA — DEPARTMENT OF CORRECTIONS AND REHABILITATION

HCV TREATMENT AUTHORIZATION: INITIAL

CDCR 7413-2 (REV. 03/14) — **Form:** Page 1 of 1

Patient Information (to be completed by referring clinician)

Date of 1st Positive HCV test: _____ Genotype/date: _____ HCV quant viral load/date: _____ Liver biopsy result stage: ____ date: _____ ☐ N/A FIB4 score: ____ date: _____ ☐ N/A History of cirrhosis? ☐ no ☐ yes Child-Pugh score/date: _____ HIV antibody test result/date: _____	Is patient treatment experienced? ☐ no ☐ yes *If no, proceed to next section.* Year of treatment: ____ Location: _____ Regimen used: _____ Weeks of treatment: ____ Was dose reduction necessary? ☐ no ☐ yes If yes, describe:	Was SVR achieved? ☐ no ☐ yes ☐ unknown Was patient ☐ null responder ☐ partial responder ☐ relapser ☐ unknown Allergies: ☐ no ☐ yes *If yes, list:* _____ Weight (kg): _____

Patient Information (may attach a completed CCHCS primary care HCV intake/screening form instead)

Exclusion Criteria *(* for pegylated interferon candidates only)*	
Release date does not allow for completion of HCV treatment (see HCV Care Guide for details)	☐ no; EPRD: ☐ yes
Allergy to ribavirin	☐ no ☐ yes
Hgb <11 gm/dl	☐ no ☐ yes; last Hgb/date:
WBC <1500 cells/µl*	☐ no ☐ yes; last WBC/date:
Plt <75,000 cells/µl*	☐ no ☐ yes; last Plt/date:
Autoimmune disease	☐ no ☐ yes
HX of decompensated cirrhosis: variceal hemorrhage, ascites, hepatic encephalopathy, spontaneous bacterial peritonitis, hepatopulmonary disease, hepatorenal disease or a Child-Pugh score of = 7 (Child-Pugh score of ≥ 6 if HIV/HCV co-infected)	☐ no ☐ yes Child-Pugh score/date:
Poorly controlled lung disease, heart disease, cancer, cerebrovascular disease	☐ no ☐ yes
Diabetes (HgbA1c>8.5)	☐ no ☐ yes; last Hgb A1C/date:
Thyroid disease (uncontrolled)	☐ no ☐ yes; last TSH/date:
HIV (CD4 <200 cells/mm^3) or active opportunistic infection (OI)	☐ no ☐ yes; last CD4/date: current OI ☐ no ☐ yes (specify):
Inability to give informed consent	☐ no ☐ yes
Inability to cooperate with treatment	☐ no ☐ yes
Kidney, lung or heart transplant recipient	☐ no ☐ yes
Ongoing illicit drug/alcohol use	☐ no ☐ yes
Pregnancy or inability to practice contraception	☐ no ☐ yes
For potential pegylated interferon treatment candidates only: Over the past 2 weeks, patient-inmate felt down, depressed, or hopeless. Over the past 2 weeks, patient-inmate felt little interest or pleasure in doing things. The patient-inmate is in EOP level of care or on psychoactive medications prescribed by Mental Health. **(If yes to any of the above statements, refer to Mental Health (MH) for clearance prior to starting HCV treatment and submit MH response with Treatment Authorization Form.)***	☐ no ☐ yes ☐ no ☐ yes ☐ no ☐ yes

Referring Clinician Name: _____ Title: _____

Submit to HCV Oversight Committee for review by scanning and emailing with liver biopsy report to CPHCSHCVQuestions@cdcr.ca.gov.

To be completed by CCHCS HCV Oversight Committee - *Please allow up to 10 working days to receive response*

Date referral reviewed: _____ ☐ treatment naïve ☐ relapser ☐ partial responder ☐ null responder Cirrhosis? ☐ no ☐ yes

1. HCV treatment recommended: ☐ no ☐ yes If no, reason: _____

   If yes, HCV treating clinician to complete consent for treatment with patient. Treatment recommendations:

   - ☐ pegylated interferon 180 mcg SubQ weekly; anticipated length of treatment: _____ weeks
   - ☐ ribavirin: total daily dose: ☐ 800 mg ☐ 1000 mg ☐ 1200 mg ☐ other: _____ ; anticipated length of treatment: _____ weeks
   - ☐ simeprevir 150 mg: 1 capsule daily for 12 weeks (anticipated)
     - ☐ Medication profile reviewed for potential drug-drug interactions
   - ☐ sofosbuvir 400 mg: 1 tablet daily for _____ weeks (anticipated)
     - ☐ Medication profile reviewed for potential drug-drug interactions

   Additional recommendations: _____

2. Monitoring tests to be ordered and followed by HCV treating clinician onsite per protocol listed in CCHCS HCV Care Guide.
3. Follow up with HCV provider onsite as per protocol listed in CCHCS HCV Care Guide.
4. CCHCS HCV Oversight Committee and CCHCS HCV Warmline are available during treatment for consultation if requested by onsite HCV clinician by emailing CPHCSHCVQuestions@cdcr.ca.gov.
5. Onsite HCV clinician will notify CCHCS Oversight Committee of end of treatment by submitting form CDCR 7413-4, End of Treatment Evaluation to CPHCSHCVQuestions@cdcr.ca.gov.

_____
HCV Oversight Clinician Name and Title (Print):

Date: _____

_____
HCV Oversight Clinician Signature

CDCR #:

Last Name:

First Name: MI:

DOB: