STATE OF CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

HCV TREATMENT REFERRAL: END OF TREATMENT EVALUATION

CDCR 7413-4 (Rev. 03/14) **Form:** Page 1 of 1

Patient Information (to be completed by referring clinician)

BASELINE INFORMATION:

Age _____ EPRD _____ Date of 1st Positive HCV test: _____

Genotype/date _____

Liver biopsy result stage: _____ Date: _____ ☐ N/A

FIB4: _____ Date: _____ ☐ N/A

History of cirrhosis ☐ no ☐ yes if yes, Child-Pugh/date: _____

Allergies ☐ no ☐ yes if yes, list: _____

Prior to this treatment course, was patient treatment ☐ naïve ☐ experienced;

If experienced: ☐ null responder ☐ partial responder ☐ relapser;

describe:

_____

MOST RECENT TREATMENT COURSE:

(please attach completed HCV treatment flowsheet)

Weeks indicated ___ weeks completed ___

Combination _____

Did patient complete treatment? ☐ yes ☐ no If no, indicate why:

_____

Viral load response

baseline _____ 4 wk _____ 8 wk _____ ☐ N/A

12 wk _____ 24 wk _____ 48 wk _____ ☐ N/A

MOST RECENT TREATMENT COURSE (continued):

Was dose reduction necessary? ☐ no ☐ yes

If yes, list which medication and why:

_____

Were there interruptions in treatment? ☐ no ☐ yes

If yes, describe:

_____

Did patient have any hospitalizations during treatment course?

☐ no ☐ yes If yes, list diagnosis and length of stay:

_____

Were colony stimulating agents (epo, GCSF) required?

☐ no ☐ yes If yes, list which medication and dates. Include Hgb and response if epo used and/or WBC/ANC and response if GCSF used:

_____

Any other complications associated with HCV treatment?

☐ no ☐ yes If yes, please list:

_____

Was CCHCS HCV warmline or outside hepatologist consulted in regard to this patient's HCV treatment course? ☐ no ☐ yes

If yes, specify which consultant and dates:

_____

Referring Clinician Name and Title (Print): _____

Referring Clinician Signature: _____ Date: _____

To be completed by CCHCS HCV Oversight Committee

Date HCV treatment started _____ Weeks of HCV treatment completed _____

Regimen selected ☐ pegylated interferon; ☐ ribavirin; ☐ boceprevir; ☐ simeprevir; ☐ sofosbuvir; ☐ telaprevir

Assessment and Recommendations

1. HCV Successfully treated? ☐ yes ☐ no

   If no, describe: _____

   a. If successful completion of treatment course, primary care provider or HCV treating clinician to obtain viral load 12 weeks post-treatment completion to ensure SVR.

   b. Refer back to primary care for further monitoring, including HCV screening, if appropriate, and education regarding risk reduction strategies.

   c. If treatment is not successful, may refer back for retreatment pending the availability of new agents for the treatment of HCV.

Clinician Name and Title (Print): _____ Date: _____

Clinician Signature: _____

CDCR #:

Last Name:

First Name: MI:

DOB: