

Hepatitis C Management Plan

Patient's Name: _____

DOB: _____

Prescriber's Name: _____

Phone #: _____

Medication Adherence: Take or use medication as directed. Do not skip a dose. If you have difficulty refilling your medication please call us right away.

Hepatitis C Treatment Regimen:

Drug Name: _____

Take one tablet/capsule daily for _____ **weeks**

Drug Name: _____

Take one tablet/capsule daily for _____ **weeks**

Drug Name: _____

Direction of use: _____

Treatment start Date: _____ **Treatment End Date:** _____

Laboratory Testing: Hep C viral loads must be obtained at treatment weeks 2, 4, 12 and 24.

Week 4: _____ **Date:** _____

Week 12: _____ **Date:** _____

Week 24 (if indicated): _____ **Date:** _____

After treatment is finished – Laboratory Testing:

Date: _____

Special instructions:

The treatment plan has been discussed with the patient and the patient agrees to abide by it. Not following the treatment plan may lead to discontinuation of therapy.

Prescriber Signature **Date**

Patient Signature **Date**