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:** _____

□ **Viekira Pak:** Take as directed for _____ weeks

□ **Ribavirin** _____ **mg:** Take _____ in the morning
and _____ in the afternoon for _____ weeks

□ **Peginterferon alfa** _____ **mcg:** Inject once weekly for _____ weeks

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:** _____

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**

(DHMH 120415)