Hepatitis C Enhanced 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, 6, 12 and 24. (Additional 8 &10 week viral loads per provider discretion.)

Week 2:_____ **Date:** _____

Week 4: _____**Date:** _____

Week 6: _____**Date:** _____

Week 12: _____**Date:** _____

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

After the 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. The patient is aware that if this plan is not followed, it may result in cessation of Medicaid payment for current and future hepatitis C treatments.

_____

Prescriber Signature **Date**

_____

Patient Signature **Date**