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:** _____

□ **Direction of use:** _____

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

Laboratory Testing: Hep C viral loads must be obtained 12 weeks after treatment completion to ensure sustained virologic response (SVR) or cure.

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 the discontinuation of therapy.

_____

Prescriber Signature **Date**

_____

Patient Signature **Date**

(DHMH 05182022)