**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:**

**□ Sovaldi® (sofosbuvir) 400 mg:** Take once daily for \_\_\_\_\_\_\_\_ weeks

**□ Olysio® (simeprevir) 150 mg:** Take once daily for \_\_\_\_\_\_\_\_ weeks

**□ Harvoni®:** Take\_\_\_\_\_\_\_\_ tablet(s) once daily for \_\_\_\_\_\_\_\_ weeks

**□ 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

**□ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_:** Take \_\_\_\_\_\_\_\_\_\_daily for \_\_\_\_\_\_\_\_ weeks

**Treatment Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Treatment End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Laboratory Testing:** Hep C viral loads must be obtained at treatment weeks 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.**

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**Prescriber Signature Date**

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**Patient Signature Date**