

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**