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:

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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.

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Prescriber Signature **Date**

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Patient Signature **Date**

SAMPLE