From the Maryland Department of Health and Mental Hygiene

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**: _____

□ **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, 12 and 24.

Week 4: _____ **Date:** _____

Week 12: _____ **Date:** _____

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

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 discontinuation of therapy.

_____

Prescriber Signature **Date**

_____

Patient Signature **Date**