## **Hepatitis C Management Plan**

Patient's Name:	<u>DOB:</u>
Prescriber's Name:	Phone #:
Medication Adherence: Take or use have difficulty refilling your medica	e medication as directed. Do not skip a dose. If you ation please call us right away.
Hepatitis C Treatment Regimen:	
□ Drug Name: □ Direction of use:	
Treatment start Date:	Treatment End Date:
<u>Laboratory Testing</u> : Hep C viral loa ensure sustained virologic response (	nds must be obtained 12 weeks after treatment completion to SVR) or cure.
After treatment is finished – Labor	atory Testing:
Date:	
Special instructions:	
	sed with the patient and the patient agrees to abide by a may lead to the discontinuation of therapy.
Prescriber Signature	Date
Patient Signature	Date

(DHMH 05182022) MDAGP-CD-002894-22 June 2022