**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:**

**□ 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 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Special instructions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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**