Alabama Medicaid Pharmacy
Patient Consent Form
Hepatitis C Agents

PATIENT INFORMATION

Patient Name_____ Patient Medicaid #_____

Patient DOB_____ Patient phone # with area code_____

This document is to help you understand the drugs prescribed to you used to treat hepatitis C. Your doctor should talk to you about some very important things before you begin the medicine. You should understand the following:

- I must take all of these medicines as my doctor tells me for the number of weeks prescribed.
- I understand that Medicaid will pay for only one course of medicine. If I do not take my medicine as prescribed, I will not be approved for another course of therapy.
- If I do not strictly follow the instructions for my medicine, the drug(s) may not work.
- I understand that bloodwork is required even after I finish the medicine. I agree to follow up with my doctor after I finish my medicine.
- If I am on more than one medicine for hepatitis C, I will take them all as directed. If I stop one of my medicines, then the other will not work.
- The following applies to BOTH **males and females** taking hepatitis C medicines**: Males and females** taking these medicines must use 2 forms of birth control to prevent severe birth defects or baby deaths.
  - I understand this medicine may hurt an unborn child for up to 6 months after I stop the medicine.
  - I understand that a baby may have serious birth defects or die if exposed to these medicines during pregnancy.
  - **I understand that I must use TWO types of birth control EACH TIME I have sex to avoid me or my partner getting pregnant.**
  - **I also understand that I must use 2 forms of birth control for up to 6 months after I finish taking the medicine.**
- If I have questions about my medicine, I will contact my doctor's office for more information.

I understand that my doctor or doctor's representative has explained to me about the hepatitis C drug medicine I am prescribed. I also understand how I am supposed to take the medicine and possible side effects. I have read and understand the above information. I agree to all terms. If I fail on at least one item listed above Medicaid may not pay for my hepatitis C medicine.

Patient Printed Name	Patient Signature	Date

Prescriber Printed Name/NPI	Prescriber Signature	Date

Note: Signed forms should be submitted with each request for hepatitis C medications.