CEDAR VALLEY
Digestive Health Center

Consent for Hepatitis C Medication Management - Epclusa

You have been diagnosed as having Hepatitis C. This chronic viral infection causes liver cells to die at an accelerated rate and can cause liver cirrhosis, liver failure and death. Without medical therapy, the body does not seem to be able to eliminate this infection on its own. Your healthcare provider has determined that medication may be the appropriate treatment for you.

The medication(s) selected below will be used as part of your treatment.

□ **Epclusa (400mg sofosbuvir/100 mg velpatasvir)**
Epclusa is a prescription medicine used to treat adults with chronic Hepatitis C for genotype 1 through 6 infection. This medication is a daily tablet that can be taken with or without food. The most common side effects of this medication include headache and tiredness. Epclusa may cause a slower heart rate if it is taken with Amiodarone or similar medications.

There is no guarantee that your hepatitis will respond to therapy. This is dependent on many different factors, including: genotype, previous use of Interferon/Ribavirin and whether you take your medications exactly as prescribed. Self-adjustment of medications is not allowed. You must notify our office if you are experiencing side effects.

You do not have to accept any therapy for your condition. If you choose to be treated for this condition, you or your healthcare provider may elect to stop therapy at any time. Treatment may be discontinued if you do not follow instructions, you become pregnant or your healthcare provider feels that it is in the best interest of your health and welfare to stop therapy.

By signing the consent form, you acknowledge that you have read the consent form and/or the meaning of the information has been explained to you. By signing, you acknowledge that you have been given an opportunity to ask questions about Hepatitis C, its management, side effects associated with treatment and agree to the required laboratory monitoring and office visits while receiving therapy.

_____ _____

Patient/Patient Authorized Representative Signature Date

_____

Patient Name (Printed)

_____ _____

Witness Signature Date

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