**Consent for Hepatitis C Treatment**

I am requesting treatment of my Hepatitis C with **interferon alfa** based therapy.

* I am aware that **interferon alfa** based treatment requires giving myself injections at least once a week. (In some cases someone else can be taught to give the injections to me.)
* I am willing to take each dose of my medication as directed, to give myself the best chance of clearing the virus.
* I understand that **interferon alfa** has many known side effects, some of them can be serious and rarely may even result in death.
* Although a great deal is known about treating viral hepatitis with **interferon alfa**, ribavirin and protease inhibitors, unknown risks may still exist.
* I am aware that many side effects can be reduced by carefully following my providers instructions.

Some of the known side effects of **interferon alfa** include

|  |  |
| --- | --- |
| **Common Adverse Effects** | **Rare Adverse Effects** |
| * Flu like symptoms
* Joint/Muscle aches
* Hair loss/Thinning
* Rash/Skin reaction
* Headache
* Fatigue
* Diarrhea
* Anemia
* Depression/Anxiety/Mood swings (suicide has occurred)
* Fever/Chills
* Nausea/Vomiting
* Thyroid abnormalities: (may require life long medications)
* Low platelets
* Decreased appetite
* Low white blood cells
 | * Hearing loss/Ringing in ears
* Diabetes
* Eye problems (blindness has occurred)
* Autoimmune disease (including psoriasis)
* Seizures
* Heart attack/Heart problems
* Kidney failure
* Worsening liver disease (including liver failure)
* Substance abuse relapse
* Stroke
* Lung disease
 |

**Ribivirin** is an oral medication used in combination with **interferon alfa**, to improve viral clearance.

* Ribavirin should not be used alone for the treatment of viral hepatitis.
* In most cases this medication will be taken twice a day with food.

Some of the known side effects of ribavirin include

|  |  |
| --- | --- |
| Rash/ItchingHemolytic anemiaDifficulty sleeping | * Cough/Shortness of breath

Poor appetite Birth defects |

**Telaprevir** is an oral medication used in combination with intereferon and ribavirin, to improve viral clearance.

* **Telaprevir** must not be used alone for the treatment of viral hepatitis
* Resistance can develop on **telaprevir**, especially if it is not taken as prescribed or if it is taken by itself
* **Telaprevir** must be take every 8 hours with food.

Some of the known side effects of **telaprevir** include

|  |  |
| --- | --- |
| AnemiaNauseaDiarrhea Anal discomfort | * Shortness of breath

VomitingHeadaches Rash/Itching |
|
|

 *I have read and understand the above information Patient initials:*

I am aware that both **interferon alfa** and **ribavirin** can cause birth defects and miscarriage.

* I understand that pregnancy must be avoided in myself and my sexual partners during treatment and for 6 months after completion.
* I agree to use effective birth control methods if I am capable of becoming pregnant or causing pregnancy.
* I am aware that I must not use alcohol during treatment and I may be screened for alcohol or drug use during treatment.
* Details of my condition and treatment may be fully discussed with

Name Relationship: Phone:

Name Relationship: Phone:

Name Relationship: Phone:

I am aware that telaprevir has many interactions with other medications, including statins (for cholesterol), rifampin (for infections), anti-seizure medications, birth control pills, ergots (for headaches), St. John’s wort (for depression), certain heart medications, as well as several others.

* I understand that I will let any medical or dental provider know that I am on this medicine prior to starting any new medication
* I agree to let the clinic know about any new medication prior to starting it, to make sure there are not bad combinations.

Typical treatment schedule

* I understand that regular clinic visits and blood draws are required to monitor for safety and effectiveness of therapy.
* A typical schedule will look like this but more frequent visits and blood draws may be required.

Initial 24 weeks of treatment

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Prior to start | 2 weeks | 4 weeks | 2 months | 3 months | 4 months | 6 months |
| Clinic Visit | X | X | X | X | X | X |
| Blood Draw | X | X | X | X | X | X |

If you require 48 weeks of treatment

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | 7 months | 8 months | 9 months | 10 months | 11 months | 12 months |
| Clinic Visit | X | X | X | X | X | X |
| Blood Draw | X | X | X | X | X | X |

Contact Numbers

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Question** | **Hours** | **Contact** | **Phone Number** |
| Appointments | 8-5 M-F | Office staff | 208-282-4700 |
| Nursing | 8-1 M-F | Rebekah Elquist | 208-282-4700 |
| Medication Refill | **(Call when you have 2 weeks of medication left)** | Your Pharmacy (ask them to contact us for refills) |  |
| Patient Support | 24 hours a day 365 days a year | Pegasys user | 1-877-734-2797 |
| 24 hours a day 365 days a year | Peg-Intron users | 1-888-437-2608 |
|  | Telaprevir users | 1-855-837-8394 |

**I have read and understand the above information.** Failure to comply may effect my chances of clearing the virus and/or result in discontinuation of treatment.

Print Name:

Signature:

Date: / /