

Request for Medication to Treat Latent TB Infection (LTBI)



Tuberculosis (TB) Prevention and Control Program
 P.O. Box 64975
 St. Paul, MN 55164-0975
 Phone: (651) 201-5414 Fax: (651) 201-5500

Today's Date: / /

1. Patient: PLEASE PRINT CLEARLY Name (last, first, MI) _____ Street address _____ City _____ State _____ Zip _____ County _____ Phone _____	2. Birth date: ____ / ____ / ____ 3. Sex: <input type="checkbox"/> male <input type="checkbox"/> female 4. Country of origin: <input type="checkbox"/> United States <input type="checkbox"/> other: _____
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5. Indication for TB screening: <input type="checkbox"/> foreign-born from high-prevalence area <input type="checkbox"/> chest x-ray indicating stable, inactive TB <input type="checkbox"/> recent contact to known infectious/active TB <input type="checkbox"/> medical condition (e.g., HIV-infected, organ transplant, substance abuse, immunosuppression, diabetes) <input type="checkbox"/> correctional facility inmate <input type="checkbox"/> nursing home resident <input type="checkbox"/> homeless <input type="checkbox"/> drug treatment facility resident <input type="checkbox"/> migrant worker <input type="checkbox"/> employee screening: <input type="checkbox"/> correctional facility <input type="checkbox"/> nursing home <input type="checkbox"/> home health care <input type="checkbox"/> other health care <input type="checkbox"/> drug treatment facility <input type="checkbox"/> homeless shelter <input type="checkbox"/> other: _____ <input type="checkbox"/> other: _____	7. Mantoux test date: ____ / ____ / ____ Result: <input type="checkbox"/> positive* (____ mm#) <input type="checkbox"/> negative and/or QuantIFERON test date: ____ / ____ / ____ Result: <input type="checkbox"/> positive <input type="checkbox"/> negative <input type="checkbox"/> indeterminate <small>* Interpretation depends on the person's risk factors for TB. # Measure crosswise axis of forearm, record mm induration.</small>
8. Chest X-ray date: ____ / ____ / ____ CXR should be done \leq 6 months before treatment is started (\leq 3 months for high risk [i.e., young child, new converter, immunocompromised, prior abnormal CXR, other risk factors]). Result: <input type="checkbox"/> normal (negative for active TB) <input type="checkbox"/> abnormal but not consistent with active TB <input type="checkbox"/> other (please include copy of report)	
9. Has clinician ruled out active TB disease? <input type="checkbox"/> Yes (i.e. CXR negative for active TB and no TB-related symptoms or physical findings. To prevent the development of drug-resistant TB, LTBI treatment should not be started until active TB disease has been ruled out. Report suspected active TB disease to MDH at 651-201-5414 or 1-877-676-5414.)	

6. Health care provider: Name (first, last, degree, i.e. MD, DO, NP, PA) (_____) _____ Phone (_____) _____ Fax _____ Clinic _____ Street address _____ City _____ State _____ Zip _____	10. Additional questions: a. Does the patient have any drug allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes - please specify: _____ _____ b. Does the patient have a chronic medical condition? <input type="checkbox"/> No <input type="checkbox"/> Yes - please specify: _____ _____ c. Is the patient currently taking any other prescription or non-prescription drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes - please specify: _____ _____
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11. Medication(s) requested:

Patient's weight: _____ lbs/kg (required for children or if dose is <300 mg/day)

Drug	Dosage	Frequency	Length of Regimen (mos.)	Start Date: (e.g. start date if currently being treated for LTBI)
Isoniazid (INH)				
Vitamin B6 (pyridoxine): National guidelines do <u>not recommend routine use</u> of vitamin B6 with INH to prevent peripheral neuropathy. MDH will supply vitamin B6 only when clinically indicated. See right. <input type="checkbox"/> 25 mg. daily <input type="checkbox"/> 50 mg. daily			Indication for requesting Vitamin B6: <input type="checkbox"/> diabetes <input type="checkbox"/> malnutrition <input type="checkbox"/> renal failure <input type="checkbox"/> HIV infection <input type="checkbox"/> alcoholism <input type="checkbox"/> seizure disorder <input type="checkbox"/> pregnancy/breastfeeding <input type="checkbox"/> infant who is >50% breastfed and taking INH; recommended Vitamin B6 dose: 6.25 mg daily	
Other:			Rationale for using a regimen other than INH:	

 I have included the required copy of the prescription(s) stated above. I request that the medication bottle be labeled in Spanish.**12. Send medications to:** (must be a health care provider licensed to administer medications):

Name: _____

 Same as provider (#6) Clinic/Agency: _____

Address: _____

Phone: (_____) _____

- You will receive the first monthly shipment of medications within 5 working days of request. Incomplete forms or missing prescriptions will delay processing.
- Complete and return the start date verification sheet received with your 1st shipment of medicine. This will ensure subsequent monthly shipments until treatment is complete.
- National LTBI treatment guidelines (<http://www.cdc.gov/mmwr/PDF/rr/rr4906.pdf>) recommend monthly monitoring by a health care provider throughout treatment to evaluate for adverse effects to medication, signs/symptoms of active TB, and patient adherence. A suggested LTBI monitoring flow sheet is available at www.health.state.mn.us/tb.
- Please notify MDH ASAP if treatment has been interrupted, stopped, or the patient is lost to follow-up.
- It is the facility's responsibility to destroy medication not administered to the patient in a manner consistent with Chptr 7045 of the MN Pollution Control Agency (MPCA) guidelines.

13. Form completed by: Name: _____ Same as provider (#6) Agency: _____ Same as "send to" (#12) Phone: (_____) _____ (please provide direct line if possible)**Notes:** _____