Request for Active Tuberculosis Medications (Presumed/Confirmed)

Patient name: _____

Weight: _____ ☐ lb. ☐ kg. Date of birth: ____/____/_____

Prescription Coverage Information:

Medications are at NO COST to the patient. To maximize available funding, the Minnesota Department of Health (MDH) will bill insurance and pay co-pays. Notify MDH of any changes in coverage. Attach a readable photocopy (both sides) OR transcribe prescription coverage information.

RX coverage carrier: _____ Carrier's phone# on card: _____

Policy/ID/Member #: _____ RX group#: _____ RX bin#: _____

Card holder name: _____ ☐ Self ☐ Dependant ☐ Spouse

☐ Patient does not have prescription coverage and will receive assistance in acquiring it.

☐ Patient will not be insured.

Regimen / Medications:

	Dose / mg	Frequency	Route	Dispense	Refills
Isoniazid (INH)			po	30 days	
Rifampin (RIF)			po	30 days	
Pyrazinamide (PZA)			po	30 days	
Ethambutol (EMB)			po	30 days	
Pyridoxine (Vit B6)			po	30 days	

Therapy: ☐ Directly Observed Therapy (DOT) (standard of care per CDC)

Drug allergies: ☐ No ☐ Yes, specify: _____

Chronic medical condition: ☐ No ☐ Yes, specify: _____

Comments:

NOTE: Patients must be reported to MDH (Communicable Disease Rule, Chapter 4605) in order for this form to be processed. Report presumed or confirmed TB patients to 651-201-5414.

Today's date: ____/____/_____ Facility/clinic name: _____

Provider name: _____ Facility/clinic address: _____

Provider signature: _____ City: _____ State: _____ Zip: _____

DEPARTMENT OF HEALTH

Minnesota Department of Health
Tuberculosis Prevention and Control Phone:
651-201-5414 | Fax: 1-800-296-0993
www.health.state.mn.us/tb

Phone: _____

Fax: _____