

Request for Latent TB Infection (LTBI) Medications

Today's date: _____

Patient name: _____

Address: _____

Date of birth: _____

City: _____ State: _____ Zip: _____

County: _____ Phone: _____

Sex at birth:

Country of origin: United States Other, specify: _____

Male

Female

Drug allergies: No Yes, specify: _____

Chronic medical condition: No Yes, specify: _____

Current prescription/non-prescription drugs: No Yes, specify or attach sheet: _____

Tuberculin skin test date: _____ and/or IGRA (TB blood) test date: _____

Result: positive* mm#

negative

* Interpretation depends on the person's risk factors for TB
Measure crosswise axis of forearm, record mm induration

Result: positive

negative

indeterminate or borderline

Chest X-ray date: _____

Result: normal (negative for active TB)

abnormal but not consistent with active TB

other (please include copy of report)

The standard of care requires CXRs to be ≤ 6 months before treatment start and ≤ 3 months for high risk patients (i.e., young child, new converter, immunocompromised, prior abnormal CXR, or other risk factors).

To prevent drug-resistant TB, LTBI treatment must not be started until active TB disease is ruled out. Report presumed or confirmed active TB disease to MDH at 651-201-5414 or 1-877-676-5414.

Has clinician ruled out active TB?

Yes. CXR is negative for active TB with no related symptoms and no physical findings of active TB disease.

Indication for TB screening:

from high-prevalence country

correctional facility inmate

homelessness

CXR indicating stable, inactive TB

nursing home resident

migrant worker

recent contact to known infectious active TB

drug treatment facility resident

employee screening

medical condition (e.g., HIV, organ transplant, diabetes, substance abuse, immunosuppression)

other, specify: _____

Prescription Coverage Information: Medications are at NO COST to the patient. To maximize available funding, MDH will bill insurance and pay co-pays. Notify MDH of any changes in coverage. Attach a readable photocopy (both sides) OR transcribe 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 cannot be insured due to their residency status.

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Medication request: Send all related prescription(s) with this form.

Weight: _____ lb. kg. Required for patients dosed < maximum per CDC guidelines.

Spanish label on medication bottle.

Medications:	Dose / mg	Frequency	Duration (months)	Start date*
Isoniazid (INH)				
Vitamin B6: CDC treatment guidelines state Vitamin B6 is clinically indicated while taking INH to prevent peripheral neuropathy in some patients.				
Condition: <input type="checkbox"/> diabetes <input type="checkbox"/> malnutrition <input type="checkbox"/> seizure disorder <input type="checkbox"/> renal failure				
<input type="checkbox"/> alcoholism <input type="checkbox"/> pregnancy <input type="checkbox"/> breastfeeding <input type="checkbox"/> HIV				
<input type="checkbox"/> infants > 50% breastfed, dose approx. 1mg / kg (6.25, 12.5, or 25mg)				
Dose: <input type="checkbox"/> 25 mg. daily <input type="checkbox"/> 50 mg. daily				
Rifampin (RIF)				

*Regimen start date if currently receiving treatment with medication from alternative source.

Provider name: _____ Office phone: _____

Facility/clinic name: _____ Office fax: _____

Facility/clinic address: _____

City: _____ State: _____ Zip: _____

Ship medications to: Must be a health care provider licensed to administer medications. Same as provider Other, please specify:

Ship to contact: _____

Facility/clinic name: _____ Phone: _____

Facility/clinic address: _____

City: _____ State: _____ Zip: _____

Form completed by: Provider Ship to contact Other, please specify:

Form completed by: _____

Facility/clinic name: _____ Phone: _____

Instructions and reminders:

- Medication will ship within 7 working days.
- Complete & return the start date verification form included in the initial shipment. Your second bottle will ship 3 weeks from start date and 4 weeks thereafter. Additional bottles cannot be shipped without start date information.
- Unused medication cannot be returned to MDH or the pharmacy. If treatment is discontinued for any reason or patient is lost to follow-up, please contact MDH ASAP to stop shipments.
- LTBI treatment guidelines (<http://www.cdc.gov/mmwr/PDF/rr/rr4906.pdf>) indicate monthly monitoring by a health care provider throughout treatment, to evaluate patient for adverse drug effects, signs/symptoms of active TB and patient adherence.
- LTBI monitoring flow sheet is a tool located on the MDH website at: <http://www.health.state.mn.us/divs/idepc/diseases/tb/meds/index.html>
- Review the form for completeness. Missing information will delay your request.
- Attach and send a signed prescription(s) so your request may be processed timely.
- **Fax completed forms and all attachments to: 651-201-5500**



Minnesota Department of Health
Tuberculosis Prevention and Control
Phone: 651-201-5414 | Fax: 651-201-5500