

Latent Tuberculosis Infection (LTBI) 3HP

MEDICATION PRESCRIPTION

Patient information:

Patient Name (last, first): _____

Date of birth (DD/MM/YYYY): _____

Weight (lbs. or kg): _____

Treatment regimen:

Maximum Dose

Isoniazid 300mg

Qty.: 12

Sig. Take 3 tabs (900 mg) once weekly

Refills: 2

AND

Rifapentine 150mg

Qty.: 24

Sig. Take 6 tabs (900 mg) once weekly

Refills: 2

Alternative Dose

Isoniazid _____ mg

Qty.:

Sig: Take _____ caps (_____ mg) once weekly

Refills:

AND

Rifapentine 150 mg

Qty.:

Sig: Take _____ tabs (_____ mg) once weekly

Refills:

Date of order: _____

Language preference on label (English is default): _____

Comments:

Clinic information:

NPI (national provider identification number): _____

Provider's name (print): _____

Provider's signature: _____

Clinic name: _____

Address: _____

Phone number: _____

Fax number: _____



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