State of Alaska, Department of Health

ALASKA TUBERCULOSIS PROGRAM
TUBERCULOSIS PRESCRIPTION / MEDICATION REQUEST FORM

Projected Start Date: ___________

Date needed at Facility: ___________ or next deliver cycle **Expedited Shipping requires EPI approval, approved by: ________

Patient Last Name: __________________________ Patient First Name: ____________________ DOB: ______________

Weight: ____________ kg HR# ____________ Male Female and Pregnant or Breastfeeding

No Known Allergies Allergies - List: ____

Medication Taking (including OTC's): ____

*Please attach list of medication if exceeding the space above

New Medication Request Modification of Existing Medication Order Info Sheet-English or Other: __________

Doses given from STOCK: __________ Dispense: Bottles or Unit Dose Packs (not child proof)

Provider Prescription

Drug Order	Dose	Route	Frequency				Doses Requested for Therapy
Isoniazid (INH)	_______mg	________	7X wk	5X wk	3X wk	Wkly	______ #doses ____ mos or ____wks
Rifampin (RIF)	_______mg	________	7X wk	5X wk	3X wk		______ #doses ____ mos or ____wks
Pyrazinamide (PZA)	_______mg	________	7X wk	5X wk	3X wk		______ #doses ____ mos or ____ wks
Ethambutol (EMB)	_______mg	________	7X wk	5X wk	3X wk		______ #doses ____ mos or ____ wks
B-6 Pyridoxine	_______mg	________	7X wk	5X wk	3X wk	Wkly	______ #doses ____ mos or ____ wks
Rifapentine (RPT)	_______mg	________	7X wk			Wkly	______ #doses ____ mos or ____ wks
Moxifloxacin (MXF)	_______mg	________	7X wk	5X wk	3X wk		______ #doses ____ mos or ____ wks
_______________	_______mg	________	7X wk	5X wk	3X wk		______ #doses ____ mos or ____ wks

Notation/special Request: ____

Provider Signature: ____ Date: _____________ ____

Provider Printed Name: ______________________________ NPI: ________________ Provider City: _________________

Provider Phone Number: ______________________________________ Provider Fax Number: ____________________

Are these medications to treat Active Disease Latent TB Infection (LTBI) Window Prophylaxis

For Alaska TB Program Use

Mail to: ____ PHN Requesting Meds/Point of Contact: ______________________

Address: ____ Phone Number: __________________ Date of Request: __________

City: ____________________ St: _____ Zip: ________________

FAX COMPLETED FORM TO 907-563-7868 (INCOMPLETE FORMS MAY DELAY PROCESSING)

AK TB Program Review by: Date: Faxed to Drug Room by: Date:

Form in compliance with 12 AAC 52.460 Prescription Drug Order Information

***This form also: "Provides Health Care Under Contractual Arrangements" as defined by HRSA with the prescribing provider and the 340B Covered Entity. Providers agree to use standard and approved regimens as referenced on the links on the second page to treat individuals for suspected or confirmed tuberculosis/LTBI. In special situations and after consultation with the Alaska TB program, other regimens may be approved if clinically indicated.**

State of Alaska, Department of Health

Medication, Dosing, and Monitoring Guidelines

Treatment for TB Disesae

Latent Tuberculosis Infection Treatment Regimen

Pediatric Dosing Guidelines for Tuberculosis

Monitoring for patients on 4-month Rifapentine-Moxifloxacin TB treatment regimen

Updated 7/25/2023