IOWA | Health and Human Services
Public Health

# INACTIVE TUBERCULOSIS MEDICATION REQUEST FORM

Report all Suspected/Confirmed cases of "Active" TB Disease by phone to 515-281-0433.

## Patient Demographics

| | | |
|---|---|---|
| **Name:** (Last, First) | **Date of Birth:** (MM/DD/YYYY) | **Weight:** |
| **Address:** | **City:** | **Zip Code:** |
| **County of Residence:** | **Sex:** ☐ Male ☐ Female | **Pregnant:** ☐ Yes ☐ No |
| **Phone**: | **Medication Allergies:** | |
| **Interpreter Required:** ☐ Yes ☐ No | **Specify Language:** | |

## Preferred Regimens CDC/NTCA

Check the box of the preferred regimen or provide a RX based upon patient weight.

☐ **Rifampin 600 mg daily/120 total doses**

**Adults**: 10 mg/kg (max 600 mg) **Children**: 15 - 20 mg/kg (max 600 mg)

☐ **Isoniazid (INH) 900 mg and Rifapentine (RPT) 900 mg once weekly/12 total doses**

Restricted Use: Due to cost of this regimen, use is restricted to patients with compromised immune system, patients discovered during contact investigations and newly arriving refugees. Directly Observed Therapy (DOT) is strongly recommended.

**Adults and Children ≥ 12 years**:
**INH**: 15 mg/kg rounded to nearest 50 or 100 mg (max 900 mg)
**RPT**: 10.0 - 14.0 kg 300 mg
14.1 - 25.0 kg 450 mg
25.1 - 32.0 kg 600 mg
32.1 - 49.9 kg 750 mg
≥ 50.0 kg 900 mg maximum

**Children 2 - 11 years**:
**INH**: 25 mg/kg (max 900 mg).
**RPT**: Same as Adult and Children ≥ 12 years dosing

☐ **Isoniazid (INH) 300 mg daily and Rifampin (RIF) 600 mg daily X 90 doses**

**Adults**:
**INH**: 5 mg/kg (max 300 mg),
**RIF**: 10 mg/kg (max 600 mg)

**Children:**
**INH**: 10 - 20 mg/kg (max 300 mg),
**RIF**: 15 - 20 mg/kg (max 600 mg)

☐ **Pyridoxine (vitamin B6)** 25 mg per day for 3 months for regimens including INH. Available for medical conditions when neuropathy is common

► **Clinician Signature:**

## Prescribing Clinician Contact Information

| | | | |
|---|---|---|---|
| **Clinician's Name:** | **Clinic Name:** | | |
| **Street Address:** | **City:** | **State:** | **Zip Code:** |
| **Phone Number:** | **Fax Number:** | | |

**Send Medications To:**
☐ County Public Health Agency ☐ Clinician's Office ☐ Other (Specify):

| Diagnostics | | |
|---|---|---|
| **Tuberculin Skin Test Date:** | | **Results in mm:**<br>(Do not include erythema) |
| **IGRA (Blood) Test Date:** | | **Results:** ☐ Positive ☐ Negative ☐ Other |
| **Chest X-ray/CT Scan Date:**<br>Submit Radiology report with this form. CXR/CT Scan must be dated within three months of medication request. | | **Results:** ☐ Normal ☐ Abnormal |
| **Inactive TB Diagnosis:**<br>☐ Yes ☐ No | **Pulmonary TB disease ruled out?**<br>☐ Yes ☐ No | **Extrapulmonary TB disease ruled out?**<br>☐ Yes ☐ No |

**Checklist:**

- ☐ Patient is aware of inactive TB diagnosis, treatment plan, and where to pick up medication.
- ☐ Radiology report of Chest X-ray/CT Scan (must be dated within 3 months of medication order).
- ☐ Clinician signature (if this form is not signed by the clinician, a separate prescription is required
- ☐ Send this form and Chest X-ray/CT Scan report to TBControl@HHS.iowa.gov or fax to 515-281-4570