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. 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:** (Do not include erythema)
IGRA (Blood) Test Date:		**Results:** ☐ Positive ☐ Negative ☐ Other
Chest X-ray/CT Scan Date: Submit Radiology report with this form. CXR/CT Scan must be dated within three months of medication request.		**Results:** ☐ Normal ☐ Abnormal
Inactive TB Diagnosis: ☐ Yes ☐ No	**Pulmonary TB disease ruled out?** ☐ Yes ☐ No	**Extrapulmonary TB disease ruled out?** ☐ 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 515-564-4208.