

## REQUEST FOR LATENT TB INFECTION (LTBI) MEDICATIONS

NORTH DAKOTA DEPARTMENT OF HEALTH  
DIVISION OF SEXUALLY TRANSMITTED & BLOODBORNE DISEASES  
SFN 61294 (8-2017)

### Demographics:

First Name:		Last Name:		Date of Birth:	
Street Address:		City:	State:	ZIP Code:	Telephone Number:
Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Refused				Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Refused	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender M to F <input type="checkbox"/> Transgender F to M <input type="checkbox"/> Other _____		Pregnancy Status: <input type="checkbox"/> Pregnant <input type="checkbox"/> Not Pregnant <input type="checkbox"/> N/A		Country of Birth:	
Drug Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Specify:			
Current Prescriptions/Non-Prescription Drugs: <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Specify:			

### Testing Information:

Tuberculin Skin Test (TST): <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Performed <input type="checkbox"/> Documented Prior Positive		Date Test Performed:	Induration in mm:
IGRA: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Performed <input type="checkbox"/> Documented Prior Positive		Date Test Performed:	Test Value:
Chest X-ray:                      Date Performed: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal but Not Consistent with Active TB <input type="checkbox"/> Abnormal Consistent with Active TB <b>If Yes, Has Active TB Been Ruled Out?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>To prevent drug-resistant TB, LTBI treatment must not be started until active TB disease is ruled out.</b>	
HIV Test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Performed <input type="checkbox"/> Refused			Date Test Performed:
The standard of care requires CXR's to be performed within 6 months of treatment initiation and within 3 months for high risk patients such as young children, a contact to an Active TB case, new converter, immunocompromised, prior abnormal CXR or other risk factors.			

### Indication for TB Screening (please check all that apply):

<input type="checkbox"/> From a High-Prevalence Country <input type="checkbox"/> Refugee <input type="checkbox"/> Immigrant <input type="checkbox"/> Correctional Facility Inmate <input type="checkbox"/> Foreign-Born Student <input type="checkbox"/> Employee Screening <input type="checkbox"/> Nursing Home Resident <input type="checkbox"/> Homelessness <input type="checkbox"/> Recent Contact to a Known Infectious Active TB Case	<input type="checkbox"/> HIV <input type="checkbox"/> Organ Transplant <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Immunosuppression <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Other, Please Specify:
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For more information, visit [health.nd.gov/tb](http://health.nd.gov/tb)

or call 701.328.2378 or 800.472.2180.

**Medication Request:** (e-Scribe Prescription(s) to Center for Family Medicine Pharmacy- Bismarck, ND)  
Pharmacy also listed as: Bismarck CFM Pharmacy

Medication	Dose/mg	Frequency	Duration
Rifampin (RIF)			
Isoniazid (INH)*			
Vitamin B6 (Pyridoxine)**			
Isoniazid (INH)* and Rifampin (RIF)			
Weight: <input type="checkbox"/> lb. <input type="checkbox"/> kg	Weight required for patients that are being dosed at less than the maximum per CDC guidelines		
<p>*Although efficacious, treatment regimen of daily Isoniazid has higher toxicity risk as compared to short-course rifamycin-based treatment regimens.</p> <p>**The CDC treatment guidelines state Vitamin B6 is clinically indicated while taking INH to prevent peripheral neuropathy in some patients. <input type="checkbox"/> Diabetes <input type="checkbox"/> Malnutrition <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Renal Failure <input type="checkbox"/> Pregnancy <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Alcoholism <input type="checkbox"/> HIV</p>			

**Provider Information:**

Provider Name:	Office Telephone Number:	
Facility/Clinic Name:	Office Fax Number:	
Facility/Clinic Address:		
City:	State:	ZIP Code:

**Prescription Coverage Information:** (Medications Are Provided at **NO COST** to the Patient)

Patient Does Not Have Prescription Coverage

Rx Coverage Carrier:	Carrier's Telephone Number on Card:	
Policy/ID/Member Number:	Rx Group Number:	Rx Bin Number:
Card Holder Name:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	
To maximize available funding, NDDoH will bill insurance and pay co-pays. Please notify NDDoH of any changes in coverage. <b>Attach a readable photocopy (both sides) of insurance card or fill in insurance information above.</b>		

**Ship Medications to:** (Must Be a Healthcare Provider Licensed to Administer Medications)

<input type="checkbox"/> Local Public Health Unit (preferred) <input type="checkbox"/> Same as Provider
Local Public Health Unit:

**Instructions:** (Information Required to Process Request for LTBI Medications)

- Completed *Request for LTBI Medications* (front and back)
- Copy of chest X-ray report, QuantiFERON test report and office visit notes
- Copy of insurance card (front and back) or complete insurance information in Page 2
- Send e-Script to Center for Family Medicine Pharmacy- Bismarck. If unable to e-scribe, please fax a copy of the **signed** prescription/s to the Local Public Health Offices listed below.

**Fax Forms to Local Public Health Offices at:**

**Cass County: Fax No. 701.298.6929**

Fargo Cass Public Health Dept.  
TB Program  
1240 - 25<sup>th</sup> Street S.  
Fargo, ND 58103  
Telephone Number: 701.241.1360

**Ward County: Fax No. 701.852.2103**

First District Health Unit  
TB Program  
801 - 11<sup>th</sup> Ave. S.W.  
P.O. Box 1268  
Minot, ND 58701  
Telephone Number: 701.852.1376

**Grand Forks County: Fax No. 701.787.8145**

Grand Forks Public Health Dept.  
TB Program  
151 South 4<sup>th</sup> Street  
Suite N301  
Grand Forks, ND 58201  
Telephone Number: 701.787.8100

**Burleigh County: Fax No. 701.221.6883**

Bismarck-Burleigh Public Health Dept.  
TB Program  
500 East Front Avenue  
P.O. Box 5503  
Bismarck, ND 58504  
Telephone Number: 701.355.1540

**For All Other Counties: Fax No. 701.328.2499**

N.D. Department of Health  
Division of Disease Control  
600 East Boulevard Ave., Dept 301  
Bismarck, ND 58505  
Telephone Number: 701.328.2378

**Reminders:**

- All medications will be shipped to the local public health unit indicated on the form unless prior arrangements are made. Medications will ship within 7 days.
- Local public health will monitor the patient for adverse drug effects, signs/symptoms of active TB and adherence. **LPH may also request additional information for care coordination purposes.**
- Review the *Request for LTBI Medications* form for completeness. Missing information will delay your request.

To request medications for active TB, complete the *Request for Active TB Medications* form and fax the form to the local public health unit where the patient is living. Call the North Dakota Department of Health, TB Prevention and Control, at 701.328.2377 to report the case.