REQUEST FOR ACTIVE TB MEDICATIONS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DISEASE CONTROL AND FORENSIC PATHOLOGY
SFN 61293 (6-2023)

Demographics:

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

Testing Information:

Tuberculin Skin Test (TST): ☐ Positive ☐ Negative ☐ Not Performed ☐ Documented Prior Positive	Date Test Performed:	Induration in mm:
IGRA: ☐ Positive ☐ Negative ☐ Not Performed ☐ Documented Prior Positive	Date Test Performed:	Test Value:

Chest X-ray: Date Performed: ☐ Normal ☐ Abnormal Evidence of Cavity? ☐ Yes ☐ No Evidence of Miliary TB? ☐ Yes ☐ No	CT Scan: Date Performed: ☐ Normal ☐ Abnormal Evidence of Cavity? ☐ Yes ☐ No Evidence of Miliary TB? ☐ Yes ☐ No

Type of TB: ☐ Pulmonary ☐ Extrapulmonary If yes, Site of Disease: _____	AFB Smear Results: ☐ AFB Not Seen ☐ 2+ ☐ Few/Rare ☐ 3+ ☐ 1+ ☐ 4+
HIV Test: ☐ Positive ☐ Negative ☐ Not Performed ☐ Refused	Date Test Performed:
Previous Diagnosis of TB Disease (not LTBI) ☐ No ☐ Yes If Yes, in what year: _____	

Symptoms:

☐ Cough lasting three or more weeks, Onset Date: _____ ☐ Chest Pain ☐ Hemoptysis
☐ Fever/Chills ☐ Night Sweats ☐ Unintentional Weight Loss ☐ Fatigue ☐ Loss of Appetite

Primary Reason for Testing

☐ TB Symptoms ☐ Abnormal CXR ☐ Contact Investigation ☐ Immigrant/Refugee Exam ☐ Incidental Laboratory Finding

Risk Factors for Disease

☐ From a High-Prevalence Country ☐ Refugee ☐ Immigrant ☐ Correctional Facility Inmate ☐ Foreign-Born Student ☐ Employee Screening ☐ Nursing Home Resident ☐ Homelessness ☐ Recent Contact to a Known Infectious Active TB Case	☐ HIV ☐ Organ Transplant ☐ Diabetes Mellitus ☐ Immunosuppression ☐ Rheumatoid Arthritis ☐ Other, Please Specify:

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
Isoniazid			
Vitamin B6 (Pyridoxine)**			
Rifampin			
Ethambutol			
Pyrazinamide			
Moxifloxacin			
Other, Specify:			
Weight: ☐ lb. ☐ kg	Weight required for patients that are being dosed at less than the maximum per CDC guidelines.		

*The CDC treatment guidelines state Vitamin B6 is clinically indicated while taking INH to prevent peripheral neuropathy in some patients. ☐ Diabetes ☐ Malnutrition ☐ Seizure Disorder ☐ Renal Failure ☐ Pregnancy ☐ Breastfeeding ☐ Alcoholism ☐ HIV

Provider Information:

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

Prescription Coverage Information: (Medications will be billed to the patients insurance if available; however, NDHHS will over the remaining out-of-pocket costs. Patients utilizing this program will not have a financial responsibility for medications.)

☐ 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: ☐ Self ☐ Spouse ☐ Dependent		
To maximize available funding, NDHHS will bill insurance and pay co-pays. Please notify NDHHS of any changes in coverage. **Attach a readable photocopy (both sides) of insurance card or fill in insurance information above.**		

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

☐ Local Public Health Unit (preferred) ☐ Same as Provider
Local Public Health Unit:

Instructions: (Information Required to Process Request for Active TB Medications)

- Completed *Request for Active TB 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 - 25th Street S.
Fargo, ND 58103
Telephone Number: 701.241.1360

Ward County: Fax No. 701.852.5043
First District Health Unit
TB Program
801 - 11th 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 4th 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

North Dakota Health and Human Services
Disease Control and Forensic Pathology
600 East Boulevard Ave., Dept 325
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 Active TB Medications* form for completeness. Missing information will delay your request.

For any questions and to make a case report, call the North Dakota Department of Health and Human Services, TB Prevention and Control, at 701.328.2377.