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: ☐ 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 but Not Consistent with Active TB ☐ Abnormal Consistent with Active TB **If Yes, Has Active TB Been Ruled Out?** ☐ Yes ☐ No		**To prevent drug-resistant TB, LTBI treatment must not be started until active TB disease is ruled out.**
HIV Test: ☐ Positive ☐ Negative ☐ Not Performed ☐ 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):

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

For more information, visit 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: ☐ lb. ☐ kg	Weight required for patients that are being dosed at less than the maximum per CDC guidelines		

*Although efficacious, treatment regimen of daily Isoniazid has higher toxicity risk as compared to short-course rifamycin-based treatment regimens.

**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 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: ☐ Self ☐ Spouse ☐ Dependent		
To maximize available funding, NDDoH will bill insurance and pay co-pays. Please notify NDDoH 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 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 - 25th Street S.
Fargo, ND 58103
Telephone Number: 701.241.1360

Ward County: Fax No. 701.852.2103
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
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.