DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44000 (Rev. 05/2016)

STATE OF WISCONSIN
s. 252.10 (7), Wis. Stats.
Public Health Madison & Dane Co.
Phone: (608) 266-4821
FAX: (608) 266-4858

TUBERCULOSIS DISEASE
INITIAL REQUEST FOR MEDICATION

Fields marked with an (*) asterisk are required. Please complete patient information on reverse side.
Submit completed form to the Local Health Department.

Submit completed form to: **Local Health Department** **Fax Number**

*NAME –Patient (Last, First, Middle Initial)	*Date of Birth (mm/dd/yyyy)
*Address (Street or Rural Route)	*Telephone Number
*City *Zip Code *County	Other contact, as needed

*Sex	*Race	*Ethnicity ☐ Hispanic ☐ Non-Hispanic	*Weight	*Prescription Insurance Provider & Insurance No.

*NAME – Clinician	NAME - Hospital/Clinic/Facility
*Address (Street, City, State, Zip code)	*Telephone Number

*MEDICATION ORDERS (Check mg/kg for patients with variable weight)

Medication	Dose	Frequency	Duration of Therapy
Isoniazid (INH)	☐ 300 mg ☐ _____ mg ☐ _____ mg/kg	☐ Daily ☐ Other _____	☐ 6 mo ☐ 9 mo ☐ Other _____
	10-15 mg/kg infants + children; 5 mg/kg up to 100 lb/45.5 kg adults; 300 mg maximum daily all others		
Rifampin	☐ 600 mg ☐ _____ mg ☐ _____ mg/kg	☐ Daily ☐ Other _____	☐ 6 mo ☐ 9 mo ☐ Other _____
	10-20 mg/kg infants + children; 10 mg/kg up to 100 lb/45.5 kg adults; 600 mg maximum daily all others		
Ethambutol	☐ 800 mg ☐ 1200 mg ☐ 1600 mg ☐ _____ mg ☐ _____ mg/kg	☐ Daily ☐ Other _____	☐ 2 mo ☐ 6 mo ☐ Other _____
	20 mg/kg infants + children; 40-55 kg, 800 mg; 56 – 75 kg, 1200 mg; 76 – 90 kg, 1600 mg; long term EMB=15mg/kg		
Pyrazinamide	☐ 1000 mg ☐ 1500 mg ☐ 2000 mg ☐ _____ mg ☐ _____ mg/kg	☐ Daily ☐ Other _____	☐ 2 mo ☐ 6 mo ☐ Other _____
	30-40 mg/kg infants + children; 40 – 55 kg, 1000 mg; 56 – 75 kg, 1500 mg; 76 – 90 kg, 2000 mg; long-term PZA=25mg/kg		
☐ **Vitamin B6** (pyridoxine) *10 – 50 mg/day when on INH*		☐ Daily ☐ Other _____	☐ 9 mo ☐ Other _____
☐ **Multivitamin**		☐ Daily ☐ Other _____	☐ 9 mo ☐ Other _____
	To include Vitamin D ≥ 400 IU (10 mcg) for infants 0 – 12 months, 600 IU (15 mcg) for children and adults; for the duration of the prescription.		
☐ **Other:**			
☐ **Other:**			

Standard of care: All medications are given together under directly observed therapy (DOT). Medications are administered seven (7) days per week for at least the first two weeks of therapy. Then medications may be administered five (5) days per week by DOT, with the remaining two doses self-administered over the weekend. Medications for those expected to gain weight during therapy are written as mg/kg; the nurse will weigh the person weekly and drug dosage will be adjusted to maintain the mg/kg dose as closely as can be measured. Adjustments to dose, frequency, and duration of therapy are common and depend upon the individual patient's disease and response to therapy.

MONITORING ORDERS

1. Beginning with the third week of therapy, collect one sputum sample weekly and send to WSLH for smear and culture.
2. Assess the patient at least weekly for side effects and medication toxicity. Hold medications and call clinician if present.

SIGNATURE

*__SIGNATURE__ – Clinician: _____ * Date Prescription Ordered: _____

For Division of Public Health Use Only

Patient Reporter DI. _____ Send to:

WI Case No. _____ Date _____

Add label here

Patient Name: **Patient Reporter DI:**

PATIENT INFORMATION (*Required)

A. *Tests:

1. T-Spot™ blood assay: Date Drawn: _____ **Results:** ☐Positive ☐Negative ☐Indeterminate ☐Invalid
2. Quantiferon™ blood assay: Date Drawn: _____ **Results:** ☐Positive ☐Negative ☐Indeterminate

Numeric/spot results: Nil _____ IU/mL TB Nil _____ IU/mL Mitogen _____ IU/mL

3. Tuberculin Skin Test: Date Applied: _____ Date Read: _____ Results **(induration only)** _____ mm

4.

Specimen (Sputum or BAL)	Sample Date	Results		
		Smear	PCR	Culture
Other:				

5. Sputum/other culture: Specimen source: _____ Date positive culture reported _____

B. *Is patient symptomatic? (check all that apply) ☐ **No**

☐ Fever ☐ Night sweats ☐ Cough > 3 weeks ☐ Sputum ☐Blood in sputum ☐ Weight loss

☐ Other _____

C. *Reason for referral for treatment: (check all that apply)

☐ Suspect TB **disease** ☐ Confirmed TB **disease**
☐ Contact to a current or past case of TB: Name of case, if known _____

D. *Chest X-Ray or CT: (Include copy of chest x-ray and/or CT report with this request)

Date _____ **Results:** ☐ Normal ☐ Abnormal ☐ Cavitary

E. *Prior treatment for tuberculosis infection or disease?

☐ **NO** ☐ **YES** Please explain: _____

F. Risk factors for adverse reactions or non-adherence?

Specify _____

G. *Risk factors for drug-resistance or poor response to medication? (check all that apply)

☐ Born outside US, or parents born outside US Country of birth: _____ Year arrived in US: _____ ☐ NA

☐ Liver impairment (hepatitis, alcohol use, drug use, other _____)

☐ Diabetes: ☐ Insulin-dependent ☐ Oral hypoglycemic ☐ Poorly-controlled

☐ Immunosuppressed? Explain: _____

☐ Population risk factor (travel outside US, jail or prison in other state/country)

H. *Baseline blood tests

HIV	Date	Result
ALT/AST	Date	Result
CBC w/platelets	Date	Result
T. BIL	Date	Result
S. Creatinine	Date	Result
Uric Acid	Date	Result
Other:	Date	Result

References

Treatment of tuberculosis. *MMWR Recommendations and Reports*. 52:RR-11. June 20, 2003.
Red Book. American Academy of Pediatrics. 29th Edition. 2012.

Submit completed form to: Local Health Department

Clear / Reset Form

Wisconsin Tuberculosis (TB) Program
Guidance for use of Dispensary and Medication Funding

The Wisconsin Tuberculosis (TB) Program manages and facilitates the various activities and interventions necessary to assure identification and proper treatment of all individuals with TB to eliminate its subsequent spread to others. The TB Program provides medication and educational services to prevent and control infection and disease caused by *Mycobacterium tuberculosis*. Persons with latent TB infection (LTBI), suspected of, or with confirmed TB disease, or household contacts of infectious TB patients may receive anti-TB medication through their local health department. In an effort to provide care for the most vulnerable portions of our population we ask that you keep the following points in mind when using the TB dispensary.

Who should be tested and/or treated?

The main risk factors of TB infection and disease in Wisconsin are:

- Knows or knew someone with active TB disease
- Foreign born; especially from high-risk countries where the TB incidence is over 20/100,000
    - ie.,Laos/Thailand/Philippines/Malaysia/Burma/Bhutan/India/China/Africa/Mexico/ Myanmar/former USSR.

Eligibility Criteria for using the TB Medication Program and TB Dispensary Program

The TB Program has a limited budget to reimburse local health departments for medical management of TB cases, suspects, and those with LTBI. The TB Program prioritizes the use of funds for those with the following criteria:

- Confirmed diagnosis of TB disease
- TB suspects
- Known contacts to active TB case
- Foreign born from high-risk countries
- Risk factors for progression of infection to active TB case (ie., HIV positive or going to receive TNF-α antagonist)

The dispensary does not reimburse for testing of employees, students, or initial hires that do not have any of the above risk factors. The TB Dispensary limits the reimbursement for low-risk individuals with no known risk factors. Use of the TB Dispensary funds for low-risk individuals or fully insured persons diminishes the ability to provide services for high risk individuals.

We ask for your cooperation in limiting the use of the TB program funds to cases of tuberculosis, suspects, contacts, and LTBI patients with a high risk of progression to active disease.

Updates on the Initial Request for Medication (IRM) Forms

There are two forms. One for TB INFECTION (F-00905) and the other is for TB DISEASE (F-44000).

Please make sure you use the correct form for the appropriate diagnosis. A physician may request medication from the state by completing the appropriate form and submitting it to the patient's local health department.

In addition to requiring more detailed testing information significant changes include:

1. **Requirement for the patient's insurance provider and number. MA # if public insurance.**
2. **Elimination of multi-vitamin and Vitamin B6 on the TB Infection form, i.e., for LTBI's**

All fields with an asterisk (*) are required. The following information is **required** in order to process a medication order:

- patient demographic information specifically including weight, gender, race, ethnicity, and date of birth
- patient's medication ID number i.e., insurance or MA number
- quantifiable test result numbers – dates and induration of TST, the 3 test results Nil, TB Nil and Mitogen Nil for the QFT-G blood assay
- the actual patient risk i.e., reason for referral or treatment
- radiographic results (within 6-months of the order)
- provider information with signature and date.

Note

- Vitamin B-6 is recommended ONLY for those with risk of peripheral neuropathy (diabetics, malnourished, alcoholics, pregnant or breast-feeding women, etc.). For the 12-week regimen, isoniazid plus rifapentine, vitamin B-6 is only given once-per week and NOT daily.
- Multi-vitamins are not needed unless a patient is malnourished and is reserved for active TB cases. They are not generally needed for LTBI. Consequently the Initial Request for Medication form for TB INFECTION (F-00905) has been updated to remove these items. The IRM will require a physician to specifically order vitamin B-6 or multi-vitamins based on the risk of peripheral neuropathy or malnutrition.