



Missouri Department of Health and Senior Services
 Bureau of Communicable Disease and Prevention
**ISONIAZID/RIFAPENTINE (12-DOSE) TUBERCULOSIS MEDICATION
 ELIGIBILITY/AUTHORIZATION**
 EMAIL TO: TBProgram@health.mo.gov; or FAX TO: (573) 526-0234

PATIENT INFORMATION

PATIENT LAST NAME		PATIENT FIRST NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
ADDRESS		CITY	COUNTY		ZIP CODE
DATE OF BIRTH ___/___/___	AGE ___	WEIGHT ___ lbs	RACE ___	BORN IN ___ (COUNTRY)	ARRIVED IN THE US ___/___/___ CLASS: A - B1 - B2
IS PATIENT EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO			TYPE OF WORK:		
IS PATIENT INSURED? * <input type="checkbox"/> YES <input type="checkbox"/> NO			TYPE OF INSURANCE:		

**If patient is insured or covered by another benefit, the State of Missouri will be the payer of last resort*

IS PATIENT PREGNANT OR TRYING TO BECOME PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO (Because safety in pregnancy is unknown, a birth control barrier such as condoms is recommended during this treatment. If you think you might be pregnant or have been trying to become pregnant, a pregnancy test needs to be completed prior to starting treatment).			
HIV STATUS: {positive/negative/refused/not done-reason}	HIV TEST DATE:	HIV MEDS: <input type="checkbox"/> YES <input type="checkbox"/> NO	PI/NNRTI (name):

RISK FACTORS

<input type="checkbox"/> None	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Homeless	<input type="checkbox"/> Radiographic Findings of Healed Pulmonary TB	<input type="checkbox"/> Resident of Congregate Setting
<input type="checkbox"/> Contact to Case	<input type="checkbox"/> Recent Conversion of TST/IGRA	<input type="checkbox"/> Medical Conditions, Specify:		<input type="checkbox"/> Other, Specify:

TESTING INFORMATION

(Attach copy of prescription and if you answer yes to any of the below diagnostic evaluations; please attach a copy of the results)

TST: <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE GIVEN:	RESULT: (if no induration write "0"mm) _____mm	DATE READ:	INTERPRETATION: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
T-SPOT: <input type="checkbox"/> YES <input type="checkbox"/> NO	RESULT: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/Equivocal		DATE:	
INTERFERON GAMMA RELEASE ASSAY: <input type="checkbox"/> QFT-G <input type="checkbox"/> QFT-GIT		RESULT: <input type="checkbox"/> Responsive <input type="checkbox"/> Nonresponsive <input type="checkbox"/> Indeterminate		DATE:
CHEST X-RAY DONE: <input type="checkbox"/> YES <input type="checkbox"/> NO		RESULT:		DATE:

Is patient experiencing TB symptoms? YES NO

POSSIBLE ADVERSE EFFECTS

TIREDFNESS	LOSS OF APPETITE	FEVER OR CHILLS	NAUSEA	BONE OR MUSCLE PAIN
ITCHING	EASY BLEEDING OR BRUISING	STOMACH PAIN	WEIGHT LOSS	PALE SKIN
SORE MUSCLES	RASH	VOMITING	DIARRHEA	YELLOW SKIN OR EYES

PATIENT AUTHORIZATION

I affirm by my signature that the above statements are true to the best of my knowledge. I understand that this information is being used to determine my eligibility to receive the 12-dose tuberculosis medication treatment through the _____ County/City Health Department.

I also give my permission to the _____ County/City Health Department to share needed information with the Department of Health and Senior Services or care provider to obtain this medication.

The possible side effects of this medication have been explained to me. I will stop taking this treatment regimen immediately if any of the above adverse effects develop and notify my physician and health department immediately. I also understand by initiating this therapy it is a commitment that I am going to complete all 12 doses of treatment by Directly Observed Therapy (DOT).

SIGNATURE OF CLIENT OR PARENT/GUARDIAN (IF CLIENT IS A MINOR) I affirm by my signature I have read and understand this agreement	DATE
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LOCAL PUBLIC HEALTH AGENCY AUTHORIZATION

I _____ County/City Health Department, affirm by my signature that I understand that it is a requirement to give this medication by Directly Observed Therapy (DOT) only and that I must monitor the patient for the above possible adverse effects. I understand it is a requirement to send the DOT Sheet (TBC-16) weekly to the TB Control Program.

PERSON ADMINISTERING DOT	RECEIVED TRAINING ON DOT <input type="checkbox"/> YES <input type="checkbox"/> NO	LPHA INSTRUCTOR NAME(for DOT if applicable)
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SIGNATURE OF LPHA REPRESENTATIVE/TITLE	DATE
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SIGNATURE OF DHSS REPRESENTATIVE	DATE	DHSS APPROVAL FOR RIFAPENTINE TREATMENT <input type="checkbox"/> YES <input type="checkbox"/> NO
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REASON FOR DISAPPROVAL: