MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

MONTHLY TB MEDICATION REQUEST

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☐ NEW ☐ REFILL

FOR NEW ORDERS CALL (573) 882-8300 OR FAX (573) 884-3504

LOCAL PUBLIC HEALTH AGENCY (LPHA)	DATE

LPHA ADDRESS (STREET, CITY, ZIP CODE)

CLIENT INFORMATION

NAME	DATE OF BIRTH	WEIGHT (LBS)

PRESCRIPTION INSURANCE INFORMATION (ATTACH COPY OF CARD AT BOTTOM OF PAGE IF AVAILABLE)

INSURANCE PLAN (ie: MEDICAID, BLUE CHOICE, PCS, UNITED HEALTHCARE)		CLIENT'S RELATIONSHIP TO CARDHOLDER (ie: SELF, SPOUSE, DEPENDENT)
CARDHOLDER ID #	GROUP #	CLIENT'S ID # (IF DIFFERENT THAN CARDHOLDER)

PHYSICIAN INFORMATION

NAME	TELEPHONE #

ADDRESS (STREET, CITY, STATE, ZIP CODE)

ADDITIONAL MEDICATIONS BEING TAKEN	DRUG ALLERGIES

TOTAL DURATION OF THERAPY _____ MONTHS

MEDICATION ORDER (ATTACH COPIES OF PRESCRIPTION IF AVAILABLE)

ITEM	RX NUMBER	ITEM	RX NUMBER

POSSIBLE ADVERSE EFFECTS

☐ Tiredness	☐ Loss of Appetite	☐ Fever or Chills	☐ Pale Eyes
☐ Itching	☐ Easy Bleeding or Bruising	☐ Stomach Pain	☐ Yellow Skin or Eyes
☐ Bone or Sore Muscles	☐ Rash	☐ Nausea or Vomiting	☐ Vision Changes
		☐ Nervousness	☐ Trouble Breathing

PERSON COMPLETING FORM

NAME	TELEPHONE #

I _____ , affirm by my signature, that I understand it is a requirement of me while dispensing this medication to the above patient, that I must evaluate the patient at least once a month for the possible adverse effects listed above.

PLEASE PLACE COPY OF INSURANCE CARD HERE

FAX FORM TO: (573) 884-3504

OR MAIL TO: MU PHARMACY
1020 HITT STREET
COLUMBIA, MO 65212

PHONE: (573) 882-8300