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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF COMMUNITY AND PUBLIC HEALTH

LATENT TUBERCULOSIS INFECTION (LTBI) MEDICATION AUTHORIZATION

☐ New Prescription ☐ Refill - Contact the pharmacy when medications need to be refilled

CLIENT INFORMATION

CLIENT LAST NAME	CLIENT FIRST NAME	DATE OF BIRTH	SEX
			☐ MALE ☐ FEMALE

3 HP is contraindicated for the following:

☐ Patient under 2 years of age
☐ Patient is on Antiretoviral therapy with known drug - drug interactions
☐ Patient is pregnant

LTBI PATIENT ELIGIBILITY

☐ Close contact (high or medium risk) to a current active TB case
☐ Child is less than 5 years of age
☐ *Increased risk for progression to TB disease

Source case investigation initiated ☐ Yes ☐ No

**See Core Curriculum on Tuberculosis: What the Clinician Should Know*, Table 2.6, Chapter 2, Page 32.
https://www.cdc.gov/tb/education/corecurr/pdf/corecurr_all.pdf

LTBI MEDICATIONS WILL NOT BE APPROVED UNTIL THREE CONSECUTIVE NEGATIVE SPUTUM CULTURES ARE OBTAINED.
TB Disease must be ruled out before starting treatment for LTBI.
Is patient having signs and symptoms of active TB? ☐ **Yes** ☐ **No**

REQUESTED MEDICATION

CLIENT WEIGHT	IS THIS A RESTART?	IF YES, WHAT WERE THE PREVIOUS MEDS TAKEN	HOW LONG WERE MEDS TAKEN
(Lbs)	☐ Yes ☐ No		

If treatment regimen is prescribed to be taken intermittently, it MUST be administered by DOT

TOTAL DURATION OF THERAPY _______________ MONTHS

COMPLETE FOR 3 HP REGIMEN REQUESTS ONLY

INH _________ mg Rifapentine _________ mg

☐ **1 x week x 12 weeks**

INH _________ mg	☐ Daily	☐ 2 x week	☐ 3 x week
Rifampin _________ mg	☐ Daily	☐ 2 x week	☐ 3 x week
Pyridoxine (Vitamin B6) _________ mg	☐ Daily	☐ 2 x week	☐ 3 x week

DRUG ALLERGIES:	ADDITIONAL MEDICATIONS BEING TAKEN:

A Tuberculin Testing Record form (TBC-4), AND a copy of the chest x-ray or CT report, AND the prescriptions for the medications must be submitted with this form for medication approval.

LPHA AUTHORIZATION

I ____, affirm by my signature, that I understand that 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 possible adverse effects.

LOCAL PUBLIC HEALTH AGENCY (LPHA)	LPHA ADDRESS	LPHA PHONE NUMBER

SIGNATURE OF LPHA REPRESENTATIVE/TITLE	DATE

PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE (REQUIRED)	DATE

DHSS APPROVAL FOR LTBI TREATMENT	SIGNATURE OF DHSS REPRESENTATIVE	DATE
☐ Yes ☐ No		

FAX FORM TO: (573) 884-3504

OR MAIL TO: MU PHARMACY
1020 HITT ST, ROOM 1001
COLUMBIA, MO 65212

PHONE: (573) 882-8300

REASON FOR DISAPPROVAL