ALASKA DHSS, DPH, TB PROGRAM
TB/LTBI Prescription and Medication Request
Fax Completed Form to: 907/563-7868

Date Needed at Facility in month/day/year format:____/____/20___. (Overnight shipping requires Epi approval)

Pt Last Name (printed)_____Pt First Name (printed):_____

Weight:_____kg. HR # _____ D.O.B. _____Allergies: _____

☐ New Medication Request ☐Modification of Existing Medication Order

AutoFill: ☐YES or ☐NO ☐Male ☐Female/Pregnant:☐yes ☐no /Breastfeeding:☐yes ☐no

Dispense in: ☐ Bottles or ☐Dose Packs (NOT CHILD PROOF)

Doses given from Stock: _____ ☐ Send English Medication Info Sheet or other: _____

Provider Prescription

Pt Name :_____Address:_____

Drug	Dose	Route	Frequency	Doses Requested to Complete Therapy
☐ INH	_____mg	____	☐7X wk ☐ 5X wk ☐2X wk ☐Wkly ☐ Other:_____	x _____Doses
☐ RIF	_____mg	____	☐7X wk ☐ 5X wk ☐2X wk ☐Wkly ☐ Other:_____	x _____Doses
☐ PZA	_____mg	____	☐7X wk ☐ 5X wk ☐2X wk ☐Wkly ☐ Other:_____	x _____Doses
☐ EMB	_____mg	___	☐7X wk ☐ 5X wk ☐2X wk ☐Wkly ☐ Other:_____	x _____Doses
☐ B-6	_____mg	___	☐Daily ☐Twice Weekly ☐Other:_____	x _____Doses
☐ RPT	_____mg	___	☐Weekly ☐Other:_____	x _____Doses
☐ Moxifloxacin	____mg	___	☐Daily ☐Other:_____	x _____Doses
☐ _____	_____mg	____	_____	x_____Doses

Notation:_____

Provider Signature:_____Date: _____

Provider Printed Name:_____Provider City: _____

Provider Phone: _____Provider Fax: _____

EMB=Ethambutol, INH=Isoniazid, PZA=Pyrazinamide, RIF=Rifampin, RPT=Rifapentine

Mail to: _____ PHN Requesting Med: _____

Address: _____ City: _____Phone: _____

City: _____St ____Zip_____ Date Requested:_____

AK TB Program Reviewed by:_____Date:_____ Overnight Shipping Approved by:_____
Faxed to Drug Room by:_____ Date:____ _____ Processed by:_____ Checked by:_____

Rev 11-28-2012

Table 1: First-line anti-tuberculosis drugs and dosing for adults and children*

Drug	Preparation	Adult/Child	Dosage (maximum) Daily	1 x wkly	2 x wkly	3 x wkly
Isoniazid	Tablets (100, 300 mg); Elixir (50 mg/5 ml); Aqueous IV/IM solution (100 mg/ml)	Adults	5 mg/kg (300 mg)	15 mg/kg (900 mg)	15 mg/kg (900 mg)	15 mg/kg (900 mg)
		Children	10-15 mg/kg (300 mg)	----	20-30 mg/kg (900 mg)	----
Rifampin	Capsule (150, 300 mg); suspend powder for PO; Aqueous IV solution	Adults❶	10 mg/kg (600 mg)	----	10 mg/kg (600 mg)	10 mg/kg (600 mg)
		Children	10-20 mg/kg (600 mg)	----	10-20 mg/kg (600 mg)	----
Rifapentine	Tablet (150 mg)	Adults	----	10 mg/kg (600 mg); continuation phase only	---	---
		Children	Not approved	Not approved	Not approved	Not approved
Pyrazinamide	Tablet (500 mg)	Adults	40-55 kg → 1,000 mg 56-75 kg → 1,500 mg 76-90 kg → 2,000 mg	----	40-55 kg → 2,000 mg 56-75 kg → 3,000 mg 76-90 kg → 4,000 mg	40-55 kg → 1,500 mg 56-75 kg → 2,500 mg 76-90 kg → 3,000 mg
		Children	15-30 mg/kg (2,000 mg)	----	50 mg/kg (2,000 mg)	----
Ethambutol	Tablet (100 and 400 mg)	Adults	40-55 kg → 800 mg 56-75 kg → 1,200 mg 76-90 kg → 1,600 mg	----	40-55 kg → 2000 mg 56-75 kg → 2,800 mg 76-90 kg → 4,000 mg	40-55 kg → 1,200 mg 56-75 kg → 2,000 mg 76-90 kg → 2,400 mg
		Children	15-20 mg/kg (1000 mg)	----	50 mg/kg (2.5 gm)	----
Dosage for a combination regimen of Isoniazid and Rifapentine in 12 once-weekly doses by DOT for treatment of LTBI❷						
Isoniazid	Tablets (100mg, 300mg)	≥12 years of age	----	15mg/kg (900mg) **Rounded up** to nearest 50 or 100mg	----	----
Rifapentine	Tablet (150mg)	≥12 years of age	----	10.0-14.0 kg → 300mg 14.1-25.0 kg → 450mg 25.1-32.0kg → 600mg 32.1-49.9kg → 750mg ≥ 50kg→ 900mg (900mg)	----	----

* Children weighing more than 40 kg (88 lbs) should be dosed as adults

❶ Dose may need to be adjusted when there is concomitant treatment for HIV/AIDS

❷ CDC. (2011). *Recommendations for use of an isoniazid-rifapentine regimen with direct observation to treat latent tuberculosis infection.* MMWR, 60(48). 1650-1653