

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 (LHD)	LHD Fax Number
----------------------------------	--------------------------------------	-----------------------

*NAME –Patient (Last, First, Middle Initial)		*Date of Birth (mm/dd/yyyy)	
*Address (Street or Rural Route)		*Telephone Number	
*City	*Zip Code	*LHD/Clinic to Send Meds	Other contact, as needed
*Sex	*Race	*Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	*Weight

Patient Insurance Information

Patient has no insurance: WI TB Dispensary covers entire cost.

Patient has insurance (include photocopy of insurance card): WI TB Dispensary to cover co-pay or deductible.
Prescription insurance provider and number: _____

*NAME – Clinician (Print clearly)	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) (Generic only)	<input type="checkbox"/> 300 mg <input type="checkbox"/> ____ mg <input type="checkbox"/> ____ mg/kg <i>See page 3 for dosing.</i>	<input type="checkbox"/> Daily <input type="checkbox"/> Other ____	<input type="checkbox"/> 6 mo <input type="checkbox"/> 9 mo <input type="checkbox"/> Other ____
Rifampin (Generic only)	<input type="checkbox"/> 600 mg <input type="checkbox"/> ____ mg <input type="checkbox"/> ____ mg/kg <i>See page 3 for dosing.</i>	<input type="checkbox"/> Daily <input type="checkbox"/> Other ____	<input type="checkbox"/> 6 mo <input type="checkbox"/> 9 mo <input type="checkbox"/> Other ____
Ethambutol (Generic only)	<input type="checkbox"/> 800 mg <input type="checkbox"/> 1200 mg <input type="checkbox"/> 1600 mg <input type="checkbox"/> ____ mg <input type="checkbox"/> ____ mg/kg <i>See page 3 for dosing.</i>	<input type="checkbox"/> Daily <input type="checkbox"/> Other ____	<input type="checkbox"/> 2 mo <input type="checkbox"/> 6 mo <input type="checkbox"/> Other ____
Pyrazinamide	<input type="checkbox"/> 1000 mg <input type="checkbox"/> 1500 mg <input type="checkbox"/> 2000 mg <input type="checkbox"/> ____ mg <input type="checkbox"/> ____ mg/kg <i>See page 3 for dosing.</i>	<input type="checkbox"/> Daily <input type="checkbox"/> Other ____	<input type="checkbox"/> 2 mo <input type="checkbox"/> 6 mo <input type="checkbox"/> Other ____
<input type="checkbox"/> Vitamin B6 (pyridoxine)	____ mg <i>See page 3 for dosing.</i>	<input type="checkbox"/> Daily <input type="checkbox"/> Other ____	<input type="checkbox"/> 9 mo <input type="checkbox"/> Other ____
<input type="checkbox"/> Other: _____			

MONITORING ORDERS

1. Directly Observed therapy (DOT) is the standard of care for patients being treated for TB disease in Wisconsin.
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: _____

WEDSS Disease Incident Number	Ship medication to:
Pharmacy: <input type="checkbox"/> TB Dispensary Pharmacy <input type="checkbox"/> Other, List	

Patient Name: _____

Patient Reporter DI: _____

PATIENT INFORMATION (*Required)

A. *Tests:

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

2. Quantiferon™ (QFT) blood assay: Date Drawn: _____ Results: Positive Negative Indeterminate

OFT Numeric results: Nil _____ IU/mL TB1 Nil _____ IU/mL TB2 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

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 Cavitory

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
Alkaline Phosphatase	Date	Result
Other:	Date	Result

References

American Thoracic Society; Centers for Disease Control and Prevention; Council of the Infectious Disease Society of America (2016). Treatment of Drug-Susceptible Tuberculosis. Clinical Infectious Diseases. 63(7):e147-e195. Red Book. American Academy of Pediatrics. 31st Edition. 2018.

Submit completed form to: Local Health Department



Tuberculosis (TB) Disease Treatment

Wisconsin Department of Health Services
Division of Public Health, Tuberculosis Program

Once a person is diagnosed with TB disease, treatment and/or isolation are required. We recommend that all treatment and case management be performed in collaboration with the local health department. Assistance with cost for medications and care is available from the Wisconsin TB Dispensary through the local health department.

Principles for the treatment of TB disease

1. Coordination between public (legal health authority) and the private sector is required by State Law.¹
2. Case management including directly observed therapy (DOT) through the local health department (LHD) is the standard of care in Wisconsin.²
3. A four-drug regimen of isoniazid (INH or H), rifampin (RIF or R), pyrazinamide (PZA or Z) and ethambutol (EMB or E) is the preferred initial regimen for TB disease where the organism is drug susceptible.³
4. Treatment consists of two phases; an intensive phase of two months of HRZE followed by a continuation phase of four months of HR.⁴
5. EMB can be discontinued as soon as drug susceptibilities demonstrate that the isolate is susceptible to both INH and RIF.⁵
6. Pyridoxine (vitamin B-6) can be given to all persons at risk of peripheral neuropathy cause by INH.⁶
7. The preferred frequency is once daily.⁷
8. Adult dosing begins at age 15 or weight of > 40kgs (88 lbs.)⁸
9. Drug-resistance and or prolonged sputum culture-conversion are treated differently than the standard TB recommendation in this document. Please consult with the Wisconsin TB Program for assistance.⁹

Table 1. Preferred Treatment Regimens in Wisconsin⁹

Intensive Phase			Continuation Phase			
Regimen	Drugs	Interval and Dose (Minimum Duration)	Drugs	Interval and Dose (Minimum Duration)	Range of Total Doses	Comments
1	INH RIF PZA EMB	7 d/wk for 56 doses (8wks), or 7 d/wk for 14 doses for (2wk) then 5 d/wk for (6wks)	INH RIF	7 d/wk or 126 doses (18wks) 5 d/wk for 90 doses (18wks)	134-182	This is the preferred regimen for patients with newly diagnosed pulmonary tuberculosis.
2	INH RIF PZA EMB	7 d/wk for 56 doses (8wks), or 7 d/wk for 14 doses for (2wk) then 5 d/wk for (6wks)	INH RIF	3 times weekly for 54 doses (18wks)	98-110	Preferred alternative regimen in situations where more frequent DOT is difficult to achieve.

1 Wisconsin Admin Code DHS ch. 145.06 and Wisconsin Statutes ch.252.07(5)

2 Wisconsin Admin Code DHS ch. 145.10

3 Nahid, P., et al. (2016) Official American Thoracic Society/Centers for Disease Control and Prevention/Infectious Disease Society of America Clinical Practice Guidelines: Treatment of Drug Susceptible Tuberculosis in Clinical Infectious Diseases 63(7).

4 Nahid, P., et al. (2016) p.4

5 Nahid, P., et al. (2016) p.4

6 Pregnant or nursing women, breast-fed infants, persons infected with human immunodeficiency virus [HIV], diabetes, alcoholism, malnutrition, or chronic renal failure and those of advanced age

7 Nahid, P., et al. (2016) p. 4

8 Nahid, P., et al. (2016) p. 6

9 Based on Nahid, P., et al. (2016), Table 2, p. 4.

Table 2. Drug Dosing Charts¹⁰

Drug	Preparation	Population	Daily	Thrice-Weekly
Isoniazid	Tablets (100mg, 300mg) Liquid 100mg/ML	Adults	5mg/kg (max 300mg)	15mg/kg (max 900mg)
		Children	10-15mg/kg (max 300mg)	20-30mg/kg (max 900mg)
Rifampin	Capsule (150mg, 300mg)	Adults	10mg/kg (max 600mg)	10mg/kg (max 600mg)
		Children	15-20mg/kg (max 600mg)	15-20mg/kg (max 600mg)
Rifabutin	Capsule 150mg	Adults	5mg/kg (max 300mg)	Not recommended
		Children	Unknown estimated same as for adults	Not recommended
Pyrazinamide	Tablet 500mg	Adults	See below	See below
		Children	35 (30-40) mg/kg (2g max)	50 mg/kg (2g max)
Ethambutol	Tablet 100mg, 400mg)	Adults	See below	See below
		Children	20 (15-25) mg/kg (1g max)	50 mg/kg (2.5g max)

Pyrazinamide Dosing¹⁰, Using Whole Tablets, for Adults Weight 40-90kg^a

Regimen	Weight, kg ^{b, c}		
	40-55	56-75	76-90
Daily (mg/kg)	1000mg (18.2-25.0)	1500mg (20.0-26.8)	2,000mg (22.2-26.3)
Thrice weekly (mg/kg)	1,500mg (27.3-37.5)	2,500mg (33.3-44.6)	3,000mg (33.3-39.5)
Twice weekly (mg/kg)	2,000mg (36.4-50.0)	3,000mg (44.0-53.6)	4,000mg (44.4-52.6)

a With normal renal function.

b Based on estimated lean body weight. Optimal doses for obese patients are not established.

c Numbers in parentheses are the calculated mg/kg doses for patients at the highest and lowest body weights.

Ethambutol Dosing¹⁰, Using Whole Tablets, for Adults Weight 40-90kg^a

Regimen	Weight, kg ^{b, c}		
	40-55	56-75	76-90
Daily (mg/kg)	800 mg (14.5-20.0)	1200mg (16.0-21.4)	1,600mg (17.8-21.1)
Thrice weekly (mg/kg)	1,200mg (21.8-30.0)	2,000mg (26.7-35.7)	2,400mg (26.7-31.6)
Twice weekly (mg/kg)	2,000mg (36.4-50.0)	2,800mg (37.3-50.0)	4,000mg (44.4-52.6)

a With normal renal function.

b Based on estimated lean body weight. Optimal doses for obese patients are not established.

c Numbers in parentheses are the calculated mg/kg doses for patients at the highest and lowest body weights.