ANTITUBERCULOSIS THERAPY PROGRAM
MEDICATION REFILL REQUEST

Requests for additional medication must be submitted 3-4 weeks before the client needs a refill. Completion of this form is required. Failure to complete all information requested on this form may delay receipt of medication.

Client Name & Address

Physician Name, Address, & Telephone (Include area code)

Client’s Date of Birth (mm/dd/yyyy)

Local Health Department Name

Date Medication First Ordered (mm/dd/yyyy)

Change in Medicaid Status?

Yes
No
If yes, check one of the following

☐ Patient no longer on Medicaid
☐ Patient now on Medicaid: MA number*:

*If patient is now on Medicaid, inclusion of Medicaid number is essential for request processing.

COMPLETE ITEMS BELOW

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage and Frequency</th>
<th>Prescribed Duration of Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isoniazid (INH)</td>
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<tr>
<td>Rifampin (RIF)</td>
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<tr>
<td>Pyrazinamide (PZA)</td>
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<tr>
<td>Ethambutol (EMB)</td>
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<tr>
<td>Streptomycin (SM)</td>
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<tr>
<td>Other (please specify)</td>
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</tr>
</tbody>
</table>

SIGNATURE - Person Completing Request

Date Completed

Print Name

Telephone Number (Include area code)

Return to: Wisconsin Division of Public Health
TB Program, Room 318
P.O. Box 2659
Madison WI 53701-2659