DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44126 (Rev. 08/08)

STATE OF WISCONSIN
s. 252.10 (7), Wis. Stats.
(608) 266-9692
FAX: (608) 266-0049

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

Medication	Dosage and Frequency	Prescribed Duration of Therapy
Isoniazid (INH)		
Rifampin (RIF)		
Pyrazinamide (PZA)		
Ethambutol (EMB)		
Streptomycin (SM)		
Other (please specify)		

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