

Department of Health and Human Services  
**Latent Tuberculosis Infection LTBI  
Medication Case Management Form**  
(Retain this form on Patient chart and use for prescription refills)

**Prescriber Information**

|                            |       |                            |                          |
|----------------------------|-------|----------------------------|--------------------------|
| Last Name                  |       | First                      | Middle                   |
| Street Address or P.O. Box |       | Phone No. (with area code) | Fax No. (with area code) |
| City                       | State | Zip                        |                          |

**Patient Information**

|                                                           |       |                                                                        |                                                       |
|-----------------------------------------------------------|-------|------------------------------------------------------------------------|-------------------------------------------------------|
| Patient's Last Name                                       |       | First                                                                  | Middle                                                |
| Street Address or P.O. Box                                |       | <input type="checkbox"/> Immigrant<br><input type="checkbox"/> Refugee | Contact No. (with area code)                          |
| City                                                      | State | Zip                                                                    | County of Residence                                   |
|                                                           |       | Birthdate                                                              | Age                                                   |
|                                                           |       | Sex                                                                    | <input type="checkbox"/> M <input type="checkbox"/> F |
| Race                                                      |       | Ethnicity                                                              |                                                       |
| <input type="checkbox"/> White                            |       | <input type="checkbox"/> Black or African American                     |                                                       |
| <input type="checkbox"/> American Indian or Alaska Native |       | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander     |                                                       |
| <input type="checkbox"/> Asian                            |       | <input type="checkbox"/> Unknown                                       |                                                       |
| <input type="checkbox"/> Hispanic                         |       | <input type="checkbox"/> Non-Hispanic                                  |                                                       |
| Country of Birth                                          |       | Language spoken at home                                                |                                                       |
| Contact to an active case of TB?                          |       | Insurance / Medicaid                                                   |                                                       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No  |       | <input type="checkbox"/> Yes <input type="checkbox"/> No               |                                                       |

**TB Medicine Prescription and Dispensing Information**

**Prescription #1**

|                                         |                                                           |                            |                            |
|-----------------------------------------|-----------------------------------------------------------|----------------------------|----------------------------|
| INH300mg #90 (3 bottles, 30/bottle)     | Sig: 1po/day                                              | Date: _____                | Signature _____            |
| Pyridoxine 50mg (VitB6) #100 (1 bottle) | Sig: 1po/day                                              | Date: _____                | Signature _____            |
| Medicine pick-up: Date _____            | # of bottles of INH dispensed: <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| Medicine pick-up: Date _____            | # of bottles of INH dispensed: <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |                            |
| Medicine pick-up: Date _____            | # of bottles of INH dispensed: <input type="checkbox"/> 1 |                            |                            |

**Prescription #2**

|                                         |                                                           |                            |                            |
|-----------------------------------------|-----------------------------------------------------------|----------------------------|----------------------------|
| INH300mg #90 (3 bottles, 30/bottle)     | Sig: 1po/day                                              | Date: _____                | Signature _____            |
| Pyridoxine 50mg (VitB6) #100 (1 bottle) | Sig: 1po/day                                              | Date: _____                | Signature _____            |
| Medicine pick-up: Date _____            | # of bottles of INH dispensed: <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| Medicine pick-up: Date _____            | # of bottles of INH dispensed: <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |                            |
| Medicine pick-up: Date _____            | # of bottles of INH dispensed: <input type="checkbox"/> 1 |                            |                            |

**Prescription #3**

|                                         |                                                           |                            |                            |
|-----------------------------------------|-----------------------------------------------------------|----------------------------|----------------------------|
| INH300mg #90 (3 bottles, 30/bottle)     | Sig: 1po/day                                              | Date: _____                | Signature _____            |
| Pyridoxine 50mg (VitB6) #100 (1 bottle) | Sig: 1po/day                                              | Date: _____                | Signature _____            |
| Medicine pick-up: Date _____            | # of bottles of INH dispensed: <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| Medicine pick-up: Date _____            | # of bottles of INH dispensed: <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |                            |
| Medicine pick-up: Date _____            | # of bottles of INH dispensed: <input type="checkbox"/> 1 |                            |                            |

Therapy Ended (Month, Day, Year)

Note: If INH 100 mg or Rifampin is required, please contact the program manager.

**Please send this form to:**

|                                                                                                           |                        |                 |
|-----------------------------------------------------------------------------------------------------------|------------------------|-----------------|
| <b>State of Nebraska, PO Box 95026, Lincoln, NE 68509, Attn: TB Program Manager / Fax: (402) 742-8359</b> |                        |                 |
| Shala Williams                                                                                            | Jessie Lamprecht       | Ebba Mead       |
| TB Program Manager                                                                                        | DHHS Program Manager I | Staff Assistant |
| (402) 471-6441                                                                                            | (402) 471-8701         | (402) 471-0360  |