Latent Tuberculosis Infection (LTBI) 3HP

MEDICATION PRESCRIPTION

Patient information:

Patient Name (last, first): _____ DOB (DD/MM/YYYY): _____

Address: _____

Weight (lbs. or kg): _____ Phone number: _____

Treatment regimen:

Maximum Dose

☐ Isoniazid 300mg

Qty.: 12

Sig. Take 3 tabs (900 mg) once weekly

Refills: 2

AND

☐ Rifapentine 150mg

Qty.: 24

Sig. Take 6 tabs (900 mg) once weekly

Refills: 2

Alternative Dose

☐ Isoniazid mg

Qty.:

Sig: Take caps (mg) once weekly

Refills:

AND

☐ Rifapentine 150 mg

Qty.:

Sig: Take tabs (mg) once weekly

Refills:

Date of order: _____

Language preference on label (select/circle): ☐ English ☐ Spanish

Comments:

Clinic information:

NPI (national provider identification number): _____

Provider's name (print): _____

Provider's signature: _____

Clinic name: _____

Address: _____

_____

Phone number: _____ Fax number: _____

DEPARTMENT OF HEALTH

Minnesota Department of Health
Tuberculosis Prevention and Control
651-201-5414 | 1-877-676-5414
Fax: 651-201-5500