Second Line Drug Program Eligibility Worksheet

Client Name _____ DOB _____ Date_____
District_____ PHN _____Phone _____

TO BE COMPLETED BY DTBNH or TB Nurse Case Manager

Client on DOT and case-managed by LHD? □ yes □ no

Transferred case □ yes □ no From where _____on (date)_____

Treating clinician _____

Alternate regimen due to (check what applies) □ resistance □ intolerance

If due to intolerance, was reintroduction of first line drugs attempted? : □ yes □ no
If not, why?_____

Test	**Date/Result**
Smear	
GeneXpert/NAA/PCR	
Culture	
Susceptibility/resistance	
QFT/PPD	
CXR	
Histology	

Drug prescribed: start date_____ DOT: □ yes □ no If no: Reason _____

Initial and/or revised treatment	**Dosage (mg)**	**Start date**	**Stop date**	**Reason for rifabutin or second-line drug**

Does client have source of drug coverage (DOD, DOC, Veterans Admin., MA, insurance, etc.)? □ yes □ no
Are they able to purchase drugs with a copay and wait for reimbursement? □ yes □ no

Additional information supporting need for rifabutin and/or second line drug

TB Nurse Consultant Signature _____ **Date** _____ **Approved** □ yes □ no
Plan: □ submit copay for 2nd line drug(s) OR □ completely paid from 2nd line fund/no outside drug coverage