

OREGON HEALTH AUTHORITY TB DRUG ORDER FORM

Routine Monthly Date Emergency Drugs Needed _____

DRUG	OHA Cost Per Unit*	STRENGTH & PILLS PER BOTTLE	Order per Bottle QUANTITY NEEDED	QUANTITY SHIPPED	LOT NUMBER (HS USE ONLY)	EXPIRATION DATE (HS USE ONLY)
INH Isoniazid	1.07ea	100mg/100				
INH Isoniazid	1.64ea	300mg/30				
INH Isoniazid	40.57ea	SYRUP 50mg/5ml				
Rifapentine, Priftin	22.74ea	150mg/24 pill blister pack				
Rifapentine, Priftin	30.32ea	150mg/32 pill blister pack				
RIF Rifampin	54.29ea	150mg/100				
RIF Rifampin	29.11ea	300mg/60				
PZA Pyrazinamide	137.37ea	500mg/100				
EMB Ethambutol	8.05ea	100mg/100				
EMB Ethambutol	13.31ea	400mg/100				
Vitamin B6 Pyridoxine	3.44ea	25mg/100				
Vitamin B6 Pyridoxine	3.89ea	50mg/100				
Vitamin D	4.66ea	1000U/100				
Multivitamin Supplement	1.37ea	100 tablets				

SHIP ORDER TO: _____ **COUNTY** _____

Address: _____

City, State, Zip _____

ATTN: _____

Ph: _____ Fax: _____

Comments: _____

Health Services Use Only:

Filled by: _____

Date: _____

Oregon Health Authority/HST/TB

Ph: 971-673-0174

Fx: 971-673-0178

*For your Information only. The state TB program provides these drugs to LHDs without cost. Cost differentials between drugs are given so LHDs can assist the TB program in controlling medication expenditures.



 Oregon
Health
 Authority

Please contact the TB Program if your order is not as noted on this packing list.

OREGON HEALTH AUTHORITY TB DRUG ORDER FORM SPECIAL ORDER DRUGS

The information below **is required** to request special order drugs. We will call you if there are further questions. Otherwise, assume the drug is being shipped. Please do not order more than one bottle or a month supply at a time.

Patient Name: _____

Clinical Indication for Use: _____

Drug Start Date: _____ Anticipated Drug Stop Date: _____

SPECIAL ORDER DRUGS (NOT ALL ARE KEPT IN STOCK--Allow extra time to order from supplier)

DRUG	OHA Cost Per Unit*	STRENGTH & PILLS PER BOTTLE	Order per Unit QUANTITY NEEDED	QUANTITY SHIPPED	Lot Number (HS Use Only)	Expiration Date (HS Use Only)
Amikacin	84.69/10VL	4ml VIALS				
Cycloserine	359.58ea	250mg/30 pill blister pack				
Ethionamide, Trecator	203.94ea	250mg/100				
Levofloxacin, Levaquin	3.58ea	250mg/50				
Levofloxacin, Levaquin	109.30ea	500mg/50				
Moxifloxacin, Avelox	74.45ea	400mg/30				
Para-Aminosalicylate Acid, PAS	190.00ea	4g/30 Packet				
Rifabutin, Mycobutin	201.12ea	150mg/100				
Streptomycin	87.94/10VL	1g VIALS				
Other						

SHIP ORDER TO: _____ **COUNTY**

Address: _____

City, State, Zip _____

ATTN: _____

Ph: _____ Fax: _____

Comments: _____

Health Services Use Only

Approved by: _____

Filled by: _____

Date: _____

Please contact the TB Program if your order is not as noted on this packing list.