

**Screening Risk Assessment
Tool Ivermectin**

Patient Name _____

Date _____ Phone number _____

Date of Birth _____

Patient's Weight _____ Dose Dispensed _____

Quantity requested _____

Are you or could you be pregnant or breastfeeding

- Yes, if yes then you cannot obtain ivermectin through this agreement
 No

Are you prescribed or using any of the following medications

- Yes, if yes then you cannot obtain ivermectin through this agreement
 No

- Coumadin/warfarin (blood thinner)
- Sirolimus/Rapamune (anti-rejection organ transplant meds, immunosuppressant)
- Tacrolimus/Advagraf XL/Envarsus XR (anti-rejection organ transplant meds, immunosuppressant)
- Erdafitinib/Balversa (cancer drug for bladder/urinary cancer)
- Lasmiditan/Reyvow (migraine med)
- Tepotinib/Tepmetko (small cell lung cancer med)
- Erythromycin ethylsuccinate, lactobionate, or stearate (antibiotic)
- Itraconazole (anti-fungal med)
- Ketoconazole (anti-fungal med)
- Rifampin/Rifadin (anti-Tuberculosis med)
- Verapamil (blood pressure/ heart rhythm med)

The State of Tennessee Board of Pharmacy requires the following statement as of 2023 "Off-label use of drugs is not prohibited by state or federal law. The FDA has not authorized or approved ivermectin for the treatment or prevention of COVID-19 in people or animals. Ivermectin has not gone through the new drug application process with the FDA for COVID -19."

The State of Tennessee Board of Pharmacy requires the following knowledge of patient comorbidities as of 2023

Primary Care Doctor/Provider

Patient's

I, _____ (print name)

agree to voluntarily obtain ivermectin from this pharmacy under the collaborative pharmacy agreement established by the State of Tennessee TCA § 63-10-908 and attest that the above personal information is accurate.

Signature _____ Date _____

Medication Allergies

