Screening Risk Assessment Tool
Ivermectin

Patient Name_____ Address _____

Date_____ Phone number_____

Date of Birth_____

Patient's Weight_____ Dose Dispensed_____

Quantity requested_____

Medication Allergies

_____

_____

_____

_____

_____

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)

Patient's Primary Care Doctor/Provider_____

- ☐ 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_____