

Ivermectin Screening Risk Assessment Tool

Patient Name: _____ **Address:** _____

Date: _____ **City, State and Zip:** _____

Date of Birth: _____ **Phone number:** _____

Patients Weight: _____ **Dose Dispensed** (pharmacist will calculate based on weight): _____

Quantity Requested: _____.

Are you or could you be pregnant or breastfeeding? (circle Yes or No)

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

Do you have any ongoing health conditions/comorbidities that may affect your care or participation?

- If Yes, please describe: _____
- No

Are you prescribed or using any of the following medications? (circle Yes or No)

- 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/Revow (migraine medication)
 - Tepotinib/Tepmetko (small cell lung cancer med)
 - Erythromycin ethylsuccinate, lactobionate, or stearate (antibiotic)
 - Itraconazole (antifungal med)
 - Ketoconazole (antifungal med)
 - Rifampin/Rifadin (antiTuberculosis med)
 - Verapamil (blood pressure/heart rhythm med)

Patients Primary Care Doctor/Provider . _____

• I, _____ (print your name) agree to voluntarily obtain Ivermectin from this pharmacy under the collaborative pharmacy agreement established by Tennessee TCA 63-10-908 and attest that the above personnel information is accurate.

Signature: _____ **Date:** _____.

How did you hear about us? _____.

*"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.