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**

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)
  - Siroiimus/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?_____.