

Patient Demographics

PHIN
Last Name
First Name
Date of Birth
Address
Postal Code

**Manitoba Pandemic Influenza Antiviral Stockpile
Prescription Tracking Form**

This form must be completed by pharmacists (or designate) each time antivirals from the Manitoba Pandemic Stockpile are provided to patients.

Usage of the Manitoba pandemic antiviral stockpile is only for treatment of people ill enough to require hospitalization with severe respiratory infections and presenting within 48 hours of symptom onset; if beyond 48 hours ID consult is recommended.

Treatment of patients with significant influenza-like symptoms (ILI) including i) those with severe ILI and ii) those with co-morbidities and any degree of ILI, presenting within 48 hours of onset of ILI and not ill enough to require hospitalization are asked to get their prescriptions filled at community pharmacies. If beyond 48 hours, ID consult is recommended.

Date Antiviral Prescribed _____

Antiviral Treatment Dosing Specifics		
Adults and Children ≥13 years		<input type="checkbox"/> Oseltamivir (Tamiflu®) 75 mg po twice daily x 5 days
Children age 1 to <13 years (by weight)	≤15 kg	<input type="checkbox"/> Oseltamivir (Tamiflu®) 30 mg po twice daily x 5 days
	> 15 to 23 kg	<input type="checkbox"/> Oseltamivir (Tamiflu®) 45 mg po twice daily x 5 days
	> 23 to 40 kg	<input type="checkbox"/> Oseltamivir (Tamiflu®) 60 mg po twice daily x 5 days
	> 40 kg	<input type="checkbox"/> Oseltamivir (Tamiflu®) 75 mg po twice daily x 5 days
Adults and Children ≥ 7 years		<input type="checkbox"/> Zanamivir (Relenza®) 2 inhalations twice daily x 5 days
➤ Children < 1 year old ➤ People with renal impairment (Creatinine clearance <30ml/min)		See Clinical Care Guidelines located at: http://www.gov.mb.ca/asset_library/en/flu/interim_guidance_clinicians_ambulatory.pdf
Use this space if Rx differs from standard dosing from above.		Explanation: _____

Prescribing Physician Information		
Surname		Facility Name: Address Phone #
First Name		
License #		

Completed by Pharmacist or Designate		
Surname		Dispensing Facility Name Address Phone #
First Name		
Address		
Designation	<input type="checkbox"/> Pharmacist <input type="checkbox"/> RN <input type="checkbox"/> Other, <i>specify</i>	
Signature		Entered into DPIN <input type="checkbox"/> Yes <input type="checkbox"/> No
Date		

Once form is completed fax to (204) 948-2040 for inventory management and manual DPIN entry if needed.