Faxed prescriptions will only be accepted from a prescribing practitioner. Prescribers are reminded patients may choose any pharmacy of their choice.

Bicillin and Ceftriaxone Referral Form

3233 Corporate Ct.
Ellicott City, MD 21043

LIFELINE SPECIALTY PHARMACY

Send your Rx to: **Fax Number: 410-203-1515** **Phone Number: 410-203-1010** **Toll Free Number: 1-833-4-LIFELINE** **NPI: 1568975464**

If you have questions or concerns, please contact us.

Date Medication Needed:_____ **Ship To:** ☐ Patient's Home ☐ Prescriber's Office

1: Patient Information

Patient Name:_____ **Birthdate:**_____ **Sex:** ☐ Male ☐ Female **Height:**_____ **Weight:**_____ ☐ lbs. ☐ kg.

Soc. Sec. #:_____ **Preferred Phone:**_____ **Known Allergies:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Alternate Caregiver Name:_____ **Preferred Phone:**_____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information

Provider Name:_____ **DEA#:**_____ **NPI#:**_____ **Tax ID#:**_____

Address:_____ **Phone:**_____ **Fax:**_____

City, State, Zip:_____ **Key Contact:**_____ **Phone:**_____

3: Diagnosis/Clinical Information

Bicillin:

☐ Acute glomerulonephritis ☐ Respiratory tract infections ☐ Rheumatic fever and chorea ☐ Rheumatic heart disease ☐ Syphilis ☐ Streptococcal (group A) chronic carriage

Ceftriaxone:

☐ Acute otitis media ☐ Bacteremia associated with intra-vascular line ☐ Bacterial endocarditis ☐ Bacterial meningitis ☐ Brucella infection of the central nervous system

☐ Chancroid ☐ Epididymitis ☐ Gonorrhea ☐ Infection of bone - Infectious disorder of joint ☐ Infection of skin and/or subcutaneous tissue ☐ Infectious disease of abdomen

☐ Infective endocarditis ☐ Infective proctitis ☐ Lower respiratory tract infection ☐ Lyme disease ☐ Neurosyphilis ☐ Pelvic inflammatory disease (PID) ☐ Postoperative infection

☐ Sexually transmitted infectious disease ☐ Sepsis ☐ Urinary tract infectious disease (UTI) ☐ Other

Patient Support and Injection Training Authorization

I authorize Lifeline Specialty Pharmacy to enroll the patient in the pharmaceutical manufacturer support program that pertains to the prescribed therapy. The purpose of this enrollment is to assist the patient in receiving services, like injection training and administration of the therapy by a nurse. The patient also authorizes the pharmacy to transmit any pertinent information that the manufacturer needs to effectively provide the medications and services that are available with the therapy, as well as, to use unidentifiable data to conduct market research. The manufacturer may contact me with information for research and educational purposes. The patient can revoke this authorization without any effect to the patient's ability to acquire the therapy. If the patient chooses to revoke this authorization, he/she may do so by writing a letter to Lifeline Specialty Pharmacy at 3233 Corporate Court, Ellicott City, MD, 21043 .

4: Prescription Information

Medication	Dose/strength	Sig	Qty.	Refills
☐ Bicillin	☐ LA PFS 600MU 1ML PED ☐ LA PFS 1200MU 2ML ☐ LA PFS 2400MU 4ML ☐ C-R 900/300 PED PFS 2ML ☐ C-R PFS 2ML ADULT ☐ C-R PFS PED 2ML	☐ Inject____ million units intramuscularly every ____ weeks ☐ Inject _____million units intramuscularly as a single dose ☐ Other:		
☐ Ceftriaxone	☐ 100 MG ☐ 250 MG ☐ 500 MG ☐ 1 GM ☐ 2 GM	☐ Inject _____ ☐ milligrams ☐ grams intravenously (IV) every _____ hours for _____days ☐ Inject _____ ☐ milligrams/☐ grams intramuscularly (IM) every _____ hours for _____days ☐ Other: ☐ 10 CC Syringe ☐ Small Sharp Container ☐ 0.9% Sodium Cholride 250 ml ☐ 18 Gage Needles ☐ Alcohol Swabs		

Office Contact Name: _____ **Phone Number:** _____

CoverMyMeds Email: _____

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: Date:

Prescriber Signature: Prescriber, please sign and date below

Dispense as written Date Substitution Permissable Date

# of Prescriptions:___