

Bicillin and Ceftriaxone Referral Form

3233 Corporate Ct.
Ellicott City, MD 21043



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	Inject _____ million units intramuscularly every _____ weeks		
	LA PFS 1200MU 2ML	Inject _____million units intramuscularly as a single dose		
	LA PFS 2400MU 4ML	Other:		
	C-R 900/300 PED PFS 2ML			
	C-R PFS 2ML ADULT			
Ceftriaxone	100 MG	Inject _____ milligrams/ grams intravenously (IV) every _____ hours for _____ days		
	250 MG	Inject _____ milligrams/ grams intramuscularly (IM) every _____ hours for _____ days		
	500 MG	Other:		
	1 GM	10 CC Syringe Small Sharp Container 0.9% Sodium Chloride 250 ml		
	2 GM	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 Permissible Date

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

of Prescriptions: _____