



**Clark County Public Health
Bicillin Request**

STD Program
PO Box 9825
Vancouver, WA 98666-8825
Phone: (360) 397-8082
Confidential fax: (360) 397-8080

Instructions for requesting Bicillin for treating a confirmed syphilis case:

- 1) **Call CCPH to make request:**
 - a. Cheryl Mixer: (360) 397-8443 or
 - b. Provider STD Reporting Line: (360) 397-8082
- 2) **Confirm case is syphilis:**
 - a. Fax confirmatory test and positive RPR to CCPH at (360) 397-8080 (confidential fax).
- 3) **Bicillin delivery:**
 - a. CCPH will deliver to your clinic.
 - b. The below form must be completed by your clinic and signed by a clinic representative. The intended patient information must also be included.
 - c. Bicillin received by clinic is to be used only on the intended patient.
 - d. CCPH can supply, but will not administer the Bicillin.

Important notes:

- 1) There are no age or gender restrictions for a confirmed syphilis case to have Bicillin supplied by CCPH.
- 2) Unused Bicillin can be returned. Cheryl Mixer/or other STD staff should be called to arrange returns (see contact information above).
- 3) Since Bicillin is provided free of charge by CCPH, clinics may not charge for it. However, clinics may charge for administering the injection.
- 4) Providers requesting Bicillin are responsible for following the **2015 STD Treatment Guidelines:**
<http://www.cdc.gov/std/tg2015/>

PROVIDER RECEIPT OF ANTIBIOTICS		
<input type="checkbox"/> Medication delivery <input type="checkbox"/> Medication pick-up	Bicillin L-A <i>(penicillin G benzathine injectable suspension)</i> # of dose(s): _____ 2.4 MU/syringe	LOT #: _____ Exp. Date: _____
Intended Patient Information:		
Name of patient to receive meds.: _____		DOB: ____/____/____ <small>(mm / dd / yyyy)</small>
Clinic Representative:		
Print Name: _____		Date: ____/____/____ <small>(mm / dd / yyyy)</small>
Signature: _____		
CCPH Representative:		
Print Name: _____		Date: ____/____/____ <small>(mm / dd / yyyy)</small>
Signature: _____		