# STD DRUG ORDER FORM (REV 09/2019)

**Clinic:** _____
(PLEASE PRINT LEGIBLY)

**Address:** _____

**Town:** _____ **Zip:** _____

**Primary Contact:** _____
(PLEASE PRINT LEGIBLY)

**Phone: (_____)** _____

**Email:** _____

**Date:** _____

**SUBMIT ORDER AND RETURN ALL EXPIRED MEDS TO:**

State of Connecticut
Department of Public Health
410 Capitol Ave., MS #11STD
P. O. Box 340308
Hartford, CT 06134-0308
(860) 509-7920 Phone
(860) 509-7275 Fax
**DPH.TB-STDDRUGS@CT.GOV**

| DRUG | DRUGS ON HAND | | AMOUNT REQUESTED | AMOUNT APPROVED | (STD CP USE ONLY) *Please do not write in this column.* LOT #/EXP DATE NDC NUMBER |
|---|---|---|---|---|---|
| | Amount | Expiration Date | | | |
| **Azithromycin** 500 mg<br>30 tablets/bottle | Pills | | **Btls** | **Btls** | |
| **Bicillin** 1.2 ml syringe<br>10 syringes/box (can request individual syringes) | Syr | | **Syr** | **Syr** | |
| **Bicillin** 2.4 ml syringe<br>10 syringes/box (can request individual syringes) | Syr | | **Syr** | **Syr** | |
| **Cefixime** 400 mg<br>10 capsules/box | Pills | | **Btls** | **Btls** | |
| **Ceftriaxone** 250 mg<br>10 vials/box | Vials | | **Vials** | **Vials** | |
| **Clotrimazole** 1% cream<br>5 applicators/box | Box | | **Box** | **Box** | |
| **Doxycycline** 100 mg<br>50 tablets/bottle | Pills | | **Btls** | **Btls** | |
| **Erythromycin** 250 mg<br>100 tablets/bottle | Pills | | **Btls** | **Btls** | |
| **Fluconazole** 150 mg<br>12 pills/box (can request individual pills) | Pills | | **Pills** | **Pills** | |
| **Gentamicin** 80 mg per 2 ml vial | Vials | | **Vials** | **Vials** | |
| **Imiquimod (Aldara) cream *5%***<br>24 packets/box | Pkts | | **Box** | **Box** | |
| **Lidocaine (Xylocaine) 1%** 2 ml (20 mg/2 ml) vial | Vials | | **Vials** | **Vials** | |
| **Metronidazole** 500 mg<br>100 tablets/bottle | Pills | | **Btls** | **Btls** | |
| **Metronidazole Vaginal Gel, 0.75%**<br>5 applicators/box | Box | | **Box** | **Box** | |
| **Moxifloxacin** 400 mg<br>30 tablets/bottle | Btls | | **Btls** | **Btls** | |
| **RID Shampoo** 2 oz bottle | Btls | | **Btls** | **Btls** | |
| **Valacyclovir** 1g<br>30 caplets/bottle | Pills | | **Btls** | **Btls** | |

***STD CP Use Only*** **STD Approval:** _____ **Date:** _____
**Filled By:** _____ **Date:** _____

***Medications are mailed on Wednesdays each week.** ***Please return all expired drugs to CT Dept. of Public Health at the address above.***