

Indiana State Department of Health Penicillin Program Criteria

Purpose: Infection is the major cause of death in children with sickle cell disease. The treatment guidelines set by the National Institutes of Health for children born with sickle cell disease include Prophylactic Penicillin, started no later than age 2 months and continued through age 5 years, to help prevent such infections. **The purpose of the ISDH Penicillin Program is to ensure that all children with sickle cell disease under the age of 5 have access to prophylactic penicillin, despite their families' financial or insurance coverage status.**

Criteria: Children with sickle cell disease living in Indiana are eligible to receive prophylactic penicillin through this program if the following criteria are met:

- 1. The child has no state or private health insurance coverage.**
- 2. The child has a diagnosis of sickle cell disease by confirmed lab results.**
- 3. The family is willing to apply for health coverage through one of the state health insurance programs (e.g., Medicaid or Children's Special Health Care Services Program, also called CSHCS)**

Applications: The attached request form must be completed by the referring physician.

Review: All requests are reviewed by the program coordinator. If the child qualifies for the ISDH Penicillin Program, the program coordinator will contact the physician to confirm approval. The request is then submitted to the Indiana Hemophilia and Thrombosis Center (IHTC) pharmacy. A 3-month supply will be shipped to the referring physician by FedEx in two business days. All children without health insurance will be referred to the Children's Special Health Care Services Program and/or Medicaid.

**Indiana State Department of Health
Sickle SAFE Program
Penicillin Program**

Date of Request: ___/___/___

Order Status: Initial Request Reorder

Name of Patient: _____

Date of Birth: ___/___/___

Address: _____

Telephone Number: _____

Race/Ethnic Group (*check one*): Black/African American White American Indian
 Asian Hispanic: _____ Other: _____
 Hawaiian Unknown

Date of Diagnosis of Sickle Cell Disease (Attach Lab Report on Initial Request): _____

Child's current dose of Penicillin or Erythromycin: _____

Name of Physician: _____ Pediatrician Family Practice

Address: _____

Telephone number: _____

Name of Hematologist: _____

Please Note: Penicillin is the 1st choice and Erythromycin should only be used in the case of Penicillin allergy.

Check one	PENICILLIN V POTASSIUM	Check one	ERYTHROMYCIN
<input type="checkbox"/>	125 mg/5 ml Powder for oral solution in 100 ml bottles	<input type="checkbox"/>	Erythromycin ethyl succinate ESS 200 mg/5ml Granules for oral suspension in 100 ml bottles
<input type="checkbox"/>	250 mg/5ml Powder for oral solution in 100 ml bottles	<input type="checkbox"/>	Erythromycin ethyl succinate ESS chewable tablets 200 mg tablets
<input type="checkbox"/>	250 mg Tablets in bottles of 100	<input type="checkbox"/>	

All orders are dispensed as a 3 months' supply.

Recommended doses:

Newborn to 3 years: 125 mg Penicillin twice daily OR 100 mg Erythromycin twice daily

3 years and older: 250 mg Penicillin twice daily OR 200mg Erythromycin twice daily

Please mail or fax all orders to:

**Sickle SAFE Program/ISDH Penicillin Program
Indiana Hemophilia and Thrombosis Center, Inc.
8402 Harcourt Road, Suite 500
Indianapolis, Indiana 46260
317-871-0000 / 1-877-256-8837, Ext. 366 Office
317- 871-0010 Fax**