



**1 Patient Information**

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

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: Male Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs. kg.

Allergies: \_\_\_\_\_ Patient Primary Language: English Spanish Other: \_\_\_\_\_ Hearing Impaired

Patient Phone: \_\_\_\_\_ Patient Email: \_\_\_\_\_ Caregiver Name: \_\_\_\_\_

Patient Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_



**2 Diagnosis/Clinical Information**

Please FAX Clinical Notes, Labs, & Tests with the prescription to expedite Prior Authorization.

Diagnosis/ICD-10: \_\_\_\_\_ Diagnosis Date: \_\_\_\_\_ Other: \_\_\_\_\_

**Rationale for Therapy:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Prior Medications Used:	Drug Name:	Length of Treatment:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



**3 Prescription Information**

Please be sure to choose both induction and maintenance dose where applicable.

Medication	Dose/Strength	Direction	Qty.	Refills
TIROSINT® CAPSULES	TIROSINT 13mcg CAP 3x10	TIROSINT 112mcg CAP 3x10	Pack of 90	_____
	TIROSINT 25mcg CAP 3x10	TIROSINT 125mcg CAP 3x10		
	TIROSINT 50mcg CAP 3x10	TIROSINT 137mcg CAP 3x10		
	TIROSINT 75mcg CAP 3x10	TIROSINT 150mcg CAP 3x10		
	TIROSINT 88mcg CAP 3x10	TIROSINT 175mcg CAP 3x10		
	TIROSINT 100mcg CAP 3x10	TIROSINT 200mcg CAP 3x10		
		Take 1 capsule by mouth every morning 30 to 60 minutes before a meal. Other: _____		

TIROSINT® SOLUTIONS	TIROSINT-SOL 13mcg AMP 30	TIROSINT-SOL 112mcg AMP 30	90 Ampules	_____
	TIROSINT-SOL 25mcg AMP 30	TIROSINT-SOL 125mcg AMP 30		
	TIROSINT-SOL 50mcg AMP 30	TIROSINT-SOL 137mcg AMP 30		
	TIROSINT-SOL 75mcg AMP 30	TIROSINT-SOL 150mcg AMP 30		
	TIROSINT-SOL 88mcg AMP 30	TIROSINT-SOL 175mcg AMP 30		
	TIROSINT-SOL 100mcg AMP 30	TIROSINT-SOL 200mcg AMP 30		
		Drink solution every morning 30 to 60 minutes before a meal. If desired, dilute in water only. Other: _____		

_____	_____	_____	_____	_____
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**4 Provider/Prescriber Information**

Clinic Name: \_\_\_\_\_ Provider Name: \_\_\_\_\_

Provider Phone: \_\_\_\_\_ Provider Fax: \_\_\_\_\_ DEA#: \_\_\_\_\_ NPI#: \_\_\_\_\_

Provider Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Prescriber Signature:** Prescriber, please sign and date below (NO stamps please):

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Dispense as Written (Write "DAW")

I authorize Sterling Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance Prior Authorization process, nursing services, and patient assistance programs. IMPORTANT NOTICE: This fax is intended to be delivered 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.