Thyroid Disorders
Prescription Referral Form
NPI: 1225548480 • Ph: 888.618.4126 • F: 866.588.0371

Note: Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

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: ______

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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 25mcg CAP 3x10 TIROSINT 50mcg CAP 3x10 TIROSINT 75mcg CAP 3x10 TIROSINT 88mcg CAP 3x10 TIROSINT 100mcg CAP 3x10	TIROSINT 112mcg CAP 3x10 TIROSINT 125mcg CAP 3x10 TIROSINT 137mcg CAP 3x10 TIROSINT 150mcg CAP 3x10 TIROSINT 175mcg CAP 3x10 TIROSINT 200mcg CAP 3x10	Take 1 capsule by mouth every morning 30 to 60 minutes before a meal. Other: ______	Pack of 90 ______	______
TIROSINT® SOLUTIONS	TIROSINT-SOL 13mcg AMP 30 TIROSINT-SOL 25mcg AMP 30 TIROSINT-SOL 37.5mcg AMP 30 TIROSINT-SOL 44mcg AMP 30 TIROSINT-SOL 50mcg AMP 30 TIROSINT-SOL 62.5mcg AMP 30 TIROSINT-SOL 75mcg AMP 30 TIROSINT-SOL 88mcg AMP 30	TIROSINT-SOL 100mcg AMP 30 TIROSINT-SOL 112mcg AMP 30 TIROSINT-SOL 125mcg AMP 30 TIROSINT-SOL 137mcg AMP 30 TIROSINT-SOL 150mcg AMP 30 TIROSINT-SOL 175mcg 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: ______	90 Ampules ______	______
______	______		______	______	______

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.