Tirosint® (levothyroxine sodium) capsules Sample Request Form

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Practitioner First Name*	Practitioner Last Name*	Professional Designation*
		☐ MD ☐ DO ☐ PA ☐ NP

Street Address*	Suite No.	City*	State*	Zip*

State License Number*	Office Phone Number*	Office Fax Number*

Office Contact Name	Office Email Address	NPI Number

Product Number	Product Description	Qty (Copay card included)
71858-0005-1	Tirosint® (levothyroxine sodium) capsules 13 mcg 10 capsules	
71858-0010-1	Tirosint® (levothyroxine sodium) capsules 25 mcg 10 capsules	
71858-0015-1	Tirosint® (levothyroxine sodium) capsules 50 mcg 10 capsules	
71858-0020-1	Tirosint® (levothyroxine sodium) capsules 75 mcg 10 capsules	
71858-0025-1	Tirosint® (levothyroxine sodium) capsules 88 mcg 10 capsules	
71858-0030-1	Tirosint® (levothyroxine sodium) capsules 100 mcg 10 capsules	
71858-0035-1	Tirosint® (levothyroxine sodium) capsules 112 mcg 10 capsules	
71858-0040-1	Tirosint® (levothyroxine sodium) capsules 125 mcg 10 capsules	
71858-0045-1	Tirosint® (levothyroxine sodium) capsules 137 mcg 10 capsules	
71858-0050-1	Tirosint® (levothyroxine sodium) capsules 150 mcg 10 capsules	
71858-0055-1	Tirosint® (levothyroxine sodium) capsules 175 mcg 10 capsules	
71858-0060-1	Tirosint® (levothyroxine sodium) capsules 200 mcg 10 capsules	

PLEASE SIGN AND DATE TO RECEIVE SAMPLES

I certify that I am a licensed practitioner eligible to receive samples. I am requesting the following prescription samples from [name] for the medical requirements of my patients and acknowledge these samples cannot be sold, traded, bartered, or returned for credit.

X_____DATE_____

Practitioner's Original Signature (please sign your name here)

Instructions: To receive the sample product you must be a licensed practitioner with a valid state license number who can legally prescribe in your state. Follow these instructions to place your request for samples.

Please note that requested drug samples cannot be shipped to you if any information is missing from this form. A unique document ID# must be submitted with each request. **DO NOT DUPLICATE THIS FORM**

1. Confirm that your full name, professional designation, office shipping address, state license number, and telephone number are printed correctly on this form.
2. Sign your name and provide the date of request where indicated below. A Practitioner's signature is required – NO signature stamps.
3. Return the completed form to: 1-973-644-2379 (cover sheet not necessary)

For questions regarding the status of your order, please call the "IBSA Direct-to-Physician Support Line" at 1-877-446-9809.

Manufactured by: Institut Biochimique SA, 6903 Lugano, Switzerland
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