MEDLY PHARMACY

Tirosint®-SOL (levothyroxine sodium) oral solution

Tirosint® (levothyroxine sodium) capsules

5 Science Park, Ste 1 New Haven, CT 06511
T: 833-497-7370 F: 203-497-7371 Medly Mail NPI: 1740771021

Please detach before submitting to a pharmacy.

PATIENT INFORMATION: Complete or include demographic sheet

Full Name:	DOB:	SSN:
Sex: ☐ Male ☐ Female Preferred Pronouns:	Primary Language:	
Address:		
City:	State:	Zip:
Phone #:	Alternate Phone #:	
Allergies (Required): ☐ NKDA	Height:	Weight:
Product Shipping Options: ☐ Patient's Home ☐ Prescriber's Office ☐ Alternative Address:		

PRESCRIBER INFORMATION

Practice Name:	Office Contact:	
Prescriber Name:	NPI:	DEA:
Practice Address:		
City:	State:	Zip:
Phone #:	Fax #:	

CLINICAL INFORMATION

Diagnosis:	**IDC-10:**	
Comments:	Weight:	DEA:
Prior Medications:	Patient type: ☐ Naive ☐ Experienced	
Duration and Reason for D/C:		
Insurance Carrier:	Rx Bin:	PCN:
ID:	Group:	

PRESCRIPTION INFORMATION

MEDICATION	DOSE		DIRECTIONS	QUANTITY	REFILLS
☐ Tirosint® Capsules	☐ 13mcg CAP 3x10 ☐ 25mcg CAP 3x10 ☐ 50mcg CAP 3x10 ☐ 75mcg CAP 3x10 ☐ 88mcg CAP 3x10 ☐ 100mcg CAP 3x10	☐ 112mcg CAP 3x10 ☐ 125mcg CAP 3x10 ☐ 137mcg CAP 3x10 ☐ 150mcg CAP 3x10 ☐ 175mcg CAP 3x10 ☐ 200mcg CAP 3x10	☐ Take 1 capsule by mouth every morning 30 to 60 minutes before a meal. ☐ Other: _____	☐ Pack of 90	☐ _____
☐ Tirosint® Solutions	☐ 13mcg AMP 30 ☐ 25mcg AMP 30 ☐ 37.5mcg AMP 30 ☐ 44mcg AMP 30 ☐ 50mcg AMP 30 ☐ 62.5mcg AMP 30 ☐ 75mcg AMP 30 ☐ 88mcg AMP 30	☐ 100mcg AMP 30 ☐ 112mcg AMP 30 ☐ 125mcg AMP 30 ☐ 137mcg AMP 30 ☐ 150mcg AMP 30 ☐ 175mcg AMP 30 ☐ 125mcg AMP 30	☐ Drink solution every morning 30 to 60 minutes before a meal. If desired, dilute in water only. ☐ Other: _____	☐ 90 Ampules	☐ _____
☐ _____	☐ _____	☐ _____	☐ _____	☐ _____	☐ _____

PRESCRIBER SIGNATURE: Please sign and date below

Prescriber Authorization: By signing below, I hereby authorize the Pharmacy to submit this info to the patient's insurance company/payor for the prescribed medication, including providing a copy of this completed form for any prior authorization request when allowed by the insurance company.

☐ Product substitution permitted

☐ Dispense as written

Prescriber Signature

Date