

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
<input type="checkbox"/> Tirosint® Capsules	<input type="checkbox"/> 13mcg CAP 3x10 <input type="checkbox"/> 25mcg CAP 3x10 <input type="checkbox"/> 50mcg CAP 3x10 <input type="checkbox"/> 75mcg CAP 3x10 <input type="checkbox"/> 88mcg CAP 3x10 <input type="checkbox"/> 100mcg CAP 3x10 <input type="checkbox"/> 112mcg CAP 3x10 <input type="checkbox"/> 125mcg CAP 3x10 <input type="checkbox"/> 137mcg CAP 3x10 <input type="checkbox"/> 150mcg CAP 3x10 <input type="checkbox"/> 175mcg CAP 3x10 <input type="checkbox"/> 200mcg CAP 3x10	<input type="checkbox"/> Take 1 capsule by mouth every morning 30 to 60 minutes before a meal. <input type="checkbox"/> Other: _____	<input type="checkbox"/> Pack of 90	<input type="checkbox"/> _____
<input type="checkbox"/> Tirosint® Solutions	<input type="checkbox"/> 13mcg AMP 30 <input type="checkbox"/> 25mcg AMP 30 <input type="checkbox"/> 37.5mcg AMP 30 <input type="checkbox"/> 44mcg AMP 30 <input type="checkbox"/> 50mcg AMP 30 <input type="checkbox"/> 62.5mcg AMP 30 <input type="checkbox"/> 75mcg AMP 30 <input type="checkbox"/> 88mcg AMP 30 <input type="checkbox"/> 100mcg AMP 30 <input type="checkbox"/> 112mcg AMP 30 <input type="checkbox"/> 125mcg AMP 30 <input type="checkbox"/> 137mcg AMP 30 <input type="checkbox"/> 150mcg AMP 30 <input type="checkbox"/> 175mcg AMP 30 <input type="checkbox"/> 125mcg AMP 30	<input type="checkbox"/> Drink solution every morning 30 to 60 minutes before a meal. If desired, dilute in water only. <input type="checkbox"/> Other: _____	<input type="checkbox"/> 90 Ampules	<input type="checkbox"/> _____
<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____

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

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