Tirosint® (levothyroxine sodium) capsules

Tirosint®-SOL (levothyroxine sodium) oral solution

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.

Prescription Referral Form NPI:_____ Phone: _____ Fax: _____

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:

❑ E03.9 Hypothyroidism
❑ E06.3 Autoimmune Thyroiditis
❑ O21.1 Hyperemesis Gravidarum with Metabolic Disturbances
❑ Other: _____

Rationale for Therapy:

❑ Patient has allergies, intolerances, or sensitivities to (check all that apply):
- ❑ Acacia ❑ Gluten ❑ Other: _____
- ❑ Corn ❑ Lactose
- ❑ Dyes ❑ Sucrose

❑ Patient has difficulty swallowing
❑ Patient is using a feeding tube
❑ Pediatric use
❑ Precise dose needed that is not able to be achieved with alternatives
❑ Patient is currently stabilized on the requested medication, and changing the medication could cause adverse reaction or loss of effectiveness. Start date of Tirosint: _____

Prior Failed Treatments: Must be completed for all patients.

Treatment Type	Drug Name	Dates of Use
❑ Armour Thyroid		
❑ NP Thyroid		
❑ Unithroid		
❑ Synthroid		
❑ Levoxyl		
❑ Levothyroxine		
❑ Cytomel		
❑ Liothyronine		
❑ Other: _____		

Treatment Naïve: ❑ Yes ❑ No

❑ Provider has determined that the alternative treatment options would not be as effective as the prescribed medication, may cause adverse reaction or intolerability issues, and therefore the requested medication is medically necessary.

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 37.5mcg CAP 3x10 ❑ TIROSINT 44mcg CAP 3x10 ❑ TIROSINT 50mcg CAP 3x10 ❑ TIROSINT 62.5mcg 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 this pharmacy and its representatives to act as an agent to initiate and execute the insurance Prior Authorization process, nursing services, and patient assistance programs.