TIROSINT® DIRECT PROGRAM

PRESCRIPTION ORDER FORM

PRESCRIBER INFORMATION:

NAME: ______________________________ NPI: ______________________

ADDRESS: ______________________________CITY: ______________________

STATE: ____________ ZIP: ___________PHONE: ______________ FAX: ______________

PATIENT INFORMATION:

NAME: ______________________ DATE OF BIRTH: ___________ Circle: Male or Female

ADDRESS: ______________________CITY: ___________STATE: ____ZIP: ______

ALLERGIES: ____

PHONE: ______________ PHONE (2): ______________ EMAIL: ______________

FILL PROCESS:

Please confirm the patient's phone number is correct. Highland Specialty Pharmacy will use the phone number provided to contact the patient to set up their order within 24 hours of receipt of the prescription. Please provide new patients with our 601-268-6033 phone number or notify them of our (601) area code to ensure our call is not missed. A member of our staff will verify all information with the patient, collect a form of payment, and will mail the order directly to the patient.

PRESCRIPTION INFORMATION

CIRCLE ONE: TIROSINT CAPSULES TIROSINT SOLUTION

STRENGTH (circle one):

13mcg	25mcg	37.5mcg	44mcg	50mcg
62.5mcg	75mcg	88mcg	100mcg	112mcg
125mcg	137mcg	150mcg	175mcg	200mcg

DIRECTIONS: ____

QTY (circle – MUST BE in multiples of 30): 30 60 90 **OTHER: ______ REFILLS: ______ DAW (CIRCLE):** YES NO
We do not open or split boxes. 30 per box.

PRESCRIBER SIGNATURE: ______________________________ DATE: ______________

To E-PRESCRIBE (Preferred Method)

Name: Highland Specialty Pharmacy
City: Hattiesburg State: Mississippi (MS) Zip: 39402
Pharmacy Type: Retail NPI: 1679833404 NCPDP: 2588842

FAX: 601-268-6690 **PHONE:** 601-268-6033 **TOLL FREE**: 855-894-4441

Hours of Operation: Monday - Friday 9am to 5pm CST