

PATIENT INFORMATION

PLEASE INCLUDE COPY OF FRONT & BACK OF PHARMACY INSURANCE CARD

NAME: _____ DATE OF BIRTH: _____

PHONE #: _____ CELL PHONE #: _____ EMAIL: _____

ADDRESS: _____ APT/SUITE: _____

CITY _____ STATE: _____ ZIP CODE: _____

CURRENT MEDICATIONS TAKEN: _____

MEDICAL CONDITIONS: _____

ANY KNOWN ALLERGIES: _____

PRESCRIBER INFORMATION

NAME: _____

DEA #: _____ NPI #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE #: _____ FAX #: _____

OFFICE CONTACT: _____ CONTACT PHONE #: _____

PHYSICIAN EMAIL: _____

PRESCRIPTION INFORMATION

Select one:

Tirosint Capsules

Tirosint-SOL Oral Solution

Strength(s) (Check all applicable):

13mcg 25mcg 50mcg 75mcg 88mcg 100mcg

112 mcg 125mcg 137mcg 150mcg 175mcg 200mcg

Directions: _____

Quantity _____ Refills _____

Prescriber Signature: _____ Date: _____

For **e-PRESCRIBING**, please use the following information for processing requests through your system:

Name: Transition Pharmacy

City: Treose

Pharmacy type: Retail

State: PA Zip: 19053



PHARMACY - ORDER FAX FORM
FAX TO: (866) 694-2555
CUSTOMER SERVICE #: (833) 235-7113

NPI #: 1336325265

NCPDP #: 3989603

There is no additional cost to the patient or physician for this service.