Woodland Hills Compounding Pharmacy

THYROID ORDER FORM

Phone: (855) 876-3060 | Fax: (866)893-9320

PATIENT INFORMATION

PATIENT NAME (PRINT) _____ DOB _____

ALLERGIES _____ DIAGNOSIS CODE _____

PATIENT ADDRESS _____

CITY STATE ZIP _____

HOME PHONE _____ CELL PHONE _____

INSURANCE INFORMATION

INSURANCE NAME _____ MEMBER ID _____

BIN _____ GROUP # _____ PCN # _____ HELP DESK PHONE# _____

T3/T4 Immediate Release Capsules

PRODUCT	QTY	REFILLS
☐ 5mcg/20mcg	☐ #30 ☐ #60	
☐ 5mcg/112mcg	☐ #30 ☐ #60	
☐ 10mcg/6mcg	☐ #30 ☐ #60	
☐ 10mcg/40mcg	☐ #30 ☐ #60	
☐ 10mcg/112mcg	☐ #30 ☐ #60	
☐ 12.5mcg/50mcg	☐ #30 ☐ #60	
☐ 12.5mcg/60mcg	☐ #30 ☐ #60	
☐ 12.5mcg/88mcg	☐ #30 ☐ #60	
☐ 15mcg/15mcg	☐ #30 ☐ #60	
☐ 15mcg/88mcg	☐ #30 ☐ #60	
☐ 20mcg/25mcg	☐ #30 ☐ #60	
☐ 20mcg/60mcg	☐ #30 ☐ #60	

Liothyronine (T3) SR Capsules

PRODUCT	QTY	REFILLS
☐ 2.5mcg SR	☐ #30 ☐ #60	
☐ 5mcg SR	☐ #30 ☐ #60	
☐ 7.5mcg SR	☐ #30 ☐ #60	
☐ 10mcg SR	☐ #30 ☐ #60	
☐ 12.5mcg SR	☐ #30 ☐ #60	
☐ 15mcg SR	☐ #30 ☐ #60	
☐ 20mcg SR	☐ #30 ☐ #60	
☐ 30mcg SR	☐ #30 ☐ #60	
☐ 40mcg SR	☐ #30 ☐ #60	
☐ 50mcg SR	☐ #30 ☐ #60	
☐ 60mcg SR	☐ #30 ☐ #60	

T3/T4 Sustained Release Capsules:

PRODUCT	QTY	REFILLS
☐ 12.5mcg/13mcg SR	☐ #30 ☐ #60	
☐ 15mcg/60mcg SR	☐ #30 ☐ #60	
☐ 25mcg/100mcg SR	☐ #30 ☐ #60	

Desiccated Thyroid (Porcine) Capsules

PRODUCT	QTY	REFILLS
☐ 15mg	☐ #30 ☐ #60	
☐ 30mg	☐ #30 ☐ #60	
☐ 60mg	☐ #30 ☐ #60	
☐ 90mg	☐ #30 ☐ #60	
☐ 120mg	☐ #30 ☐ #60	
☐ 150mg	☐ #30 ☐ #60	
☐ 180mg	☐ #30 ☐ #60	

All Thyroid Formulation Directions: Take 1 capsule by mouth every morning

Other Compounds:

_____ _____ _____

Directions:

_____

Physician Verification

I have reviewed my patient's medical record and determined the medication(s) / supplies ordered are medically necessary. I verify I have examined and diagnosed the patient as indicated above. I will comply with state and federal documentation requirements by retaining a copy of this prescription in the patient's medical record. The prescription is to be dispensed as written unless otherwise instructed by me.

Signature: _____ Date: _____

Physician: _____ NPI #: _____

Address: _____ City: _____ ST: ____ Zip: _____

Phone: _____ Fax: _____

FAX FORM TO: (866) 893-9320

IMPORTANT: Please fax insurance card. Your patient will be called promptly.

Revision Date: 09/06/2016