



Rx Direct Clearing House, Inc.™
6 Gloria Lane, Fairfield, NJ 07004
Phone: 866-502-4911 Fax: 866-502-4912

PLEASE COMPLETE ENTIRE FORM

www.unithroiddirect.com

Section 1 - Patient Information

Patient's Name: _____ Phone: _____

Street Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Last Four Digits of Social Security #: _____

Allergies: Yes No

If Yes, please list: _____

Other Medications: _____

Medical Condition: _____

Section 2 - Physician Information:

Physician's Name: _____

Street Address: _____

City: _____ State: _____

Zip: _____

State License Number
OR DEA NUMBER: _____

Phone: _____

Section 3 - Method of Payment:

I Choose to pay \$30 for each strength by (choose one):

Money Order (please make money order payable to Unithroid Direct; then mail this form and money order to above address)

Cashier's Check (please make check payable to Unithroid Direct; then mail this form and check to above address)

Personal Check (please make check payable to Unithroid Direct; then mail this form and check to above address)

Credit Card (if paying by credit card, please complete information below; sign and have your physician fax to this number: 1-866-502-4912, or mail this form to above address.)

Type: VISA MASTERCARD DISCOVER

Number: _____ - _____ - _____ - _____

Exp. Date: __/__/__

Name on card: _____

Signature of cardholder (required) _____

By signing, I authorize the Pharmacy Benefit Management Company, and its affiliate to charge this credit card for payment.

IMPORTANT - PLEASE REVIEW PAYMENT INFORMATION BELOW:

- A 12 week supply of Unithroid Direct costs \$30 per strength (2 strengths = \$60) including shipping and handling
- \$15 will be CHARGED for non-sufficient funds

Payment must be received prior to prescription being shipped

Section 4 - Prescription Options:
Use this section as your prescription OR attach regular prescription here:

Prescription Options for Unithroid Direct™:
Unithroid Direct- 1 tablet daily

Please mark if patient will take: one strength or multiple strengths

25 mcg 50 mcg 75 mcg 88 mcg 100 mcg

112 mcg 125 mcg 150 mcg 175 mcg 200 mcg

300 mcg

12 Week Supply - 84 Tablets Refills: 0 1 2 3 prn

Physician's Signature: _____

Required: _____ Dispense as Written

May Substitute