

PLEASE PRINT AND COMPLETE BOTH SIDES

To request medication through the Unithroid Direct Program, review and complete steps 1 – 3 and enclose your payment and prescription. A prescription may not be required if your Rx label indicates refills are remaining.

STEP 1 : PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **MI:** _____

Patients Social Security Number: - - **Date of Birth:** ___/___/___

Shipping
Address: Home MD's office Other _____ **Sex:** M F

Street (no PO boxes) City State Zip

STEP 2 : PRESCRIPTION INFORMATION

New - enclose new prescription from your physician if no refills are remaining on your prescription or your dose has changed.

Refill - the prescription label on your box of Unithroid lists the number of refills remaining. Please look at the label to ensure the number of refills is greater than zero and write the Rx number and product name below. If no refills are available please ask your doctor for a new prescription.

Rx number: _____ Product Name: _____

Allergies: To provide you with proper healthcare service, it is important that information concerning drug allergies, if any, be provided to us. If you are unsure of what your drug allergies may be, please consult your physician. You must complete this area to avoid delays in receiving your order.

Comments : IMPORTANT: Please list any illnesses, diagnoses (i.e., heart disease, high blood pressure, etc.) or medications (please include over the counter medication) you are currently taking. If you need more space, please use a separate sheet of paper. Our pharmacist need this information to provide you with the best care possible, including screening for drug to drug interactions, drug to condition interaction, etc.

STEP 3 : PAYMENT INFORMATION

MAKE CHECKS OR MONEY ORDERS PAYABLE TO UNITHROID DIRECT.
PLEASE REVIEW PAYMENT OPTIONS BELOW.

- A 12 week supply of Unithroid costs \$30 per strength (2 strengths = \$60)
- Payment must be received prior to order being shipped
- There are 4 ways to pay the \$30 fee: 1) Money Order 2) Cashier's check 3) Credit Card or 4) personal check
- A \$15 fee will be added to balance for non-sufficient funds

I choose to pay the \$30 for each strength using :

- Money Order (please make money order payable to Unithroid Direct, and mail in attached envelope)
- Cashier's Check (please make check payable to Unithroid Direct, and mail in attached envelope)
- Personal Check (please make check payable to Unithroid Direct, and mail in attached envelope)
- Credit Card (if paying by credit card please complete the information below and sign)

Number: ---

Exp Date: /

Type: Visa MasterCard Discover

Name on Card: _____ Signature of Cardholder: _____

By signing, I authorize Rx Direct Clearing House, Inc.TM and its affiliates to charge this credit card for payment.

Before Mailing

- Ensure sections 1-3 are filled out completely and accurately
- Include payment
- Include prescription or ensure there are refills remaining on your current prescription.

After the above steps are completed, please enclose all three pieces of information in the envelope and mail to:

Rx Direct Clearing House, Inc.TM
6 Gloria Lane
Fairfield, NJ 07004

If you have any question please call Rx Direct Clearing House, Inc.TM at 1-800-662-0479 to speak with a representative.