

LYSODREN® Prescription Form

Tel: 844-LYSODREN (844-597-6373)

Fax: 855-674-6767



To ePrescribe select Direct Success Pharmacy or search by Zip 07727

LYSODREN® (mitotane) tablets, for oral use

Patient Information

PATIENT FIRST NAME PATIENT LAST NAME DATE OF BIRTH (MM/DD/YYYY)

ADDRESS CITY STATE ZIP

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BEST PHONE # TO REACH PATIENT PATIENT GUARDIAN NAME (IF UNDER 18)

PERMISSION TO CONTACT PATIENT VIA TEXT, EMAIL AND BY PHONE

INSURANCE INFO:

RXBIN # PCN # ID # RX GROUP # POLICY HOLDER

Prescription Information

Direct Success Pharmacy fax printers are secure and in compliance with the HIPAA Privacy Standards.


LYSODREN® _____ QTY Tablets
(500 mg / 100 Tablets / Per Bottle)

DIRECTIONS OF USE:

_____ REFILLS

ADDITIONAL PRESCRIPTIONS:

PRESCRIBER SIGNATURE: _____ DATE: _____

 INITIALS REQUIRED - DO NOT SUBSTITUTE: _____
AND IF YOUR STATE LAW REQUIRES ADDITIONAL LANGUAGE TO SIGNIFY NO
GENERIC SUBSTITUTION, ADD SUCH LANGUAGE BELOW:

HCP Information

HCP FIRST NAME

HCP LAST NAME

OFFICE ADDRESS

CITY STATE ZIP

NPI # / LIC #

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FAX #

()
PHONE #

Medical Information

DRUG ALLERGIES: OTHER MEDICATIONS:

PLEASE CONFIRM YOU HAVE INCLUDED:

- Patient's Full Name
- Patient's Birth Date
- Date Prescription Written
- Your NPI or State License Number
- Your Signature (SIGNATURE STAMPS ARE NOT ACCEPTED)

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