Date: ___________ Patient Name: ____
DOB: _____________**Address:** ____
City: _____________State: ______ Phone: ____________ Allergies: _________________
☐ **Call When Ready** ☐ **Text Message When Ready** ☐ **Delivery** ☐ **Mail Out**

☐ **Progesterone 10% Vaginal Gel (MucoLox™/VersaBase®)**
Qty: #30 gm, or: other____________
Sig: Use 1 gm vaginally as directed
or: ____

☐ **Progesterone 100 mg Vaginal Suppository**
Qty: #30 gm, or: other____________
Sig: Use 1 suppository vaginally as directed
or: ____

____ **Refills: 1 2 3 4 5 PRN**
Healthcare Provider Signature:
Print Name: ____________________________________ **Agent sending**: ____________________________
NPI: ____ **DEA**: ____________________________________

Clinic Name: ____
Clinic Address: ____________________________________
Clinic Phone/Fax: __________________________________