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: _____

□ Metformin 10% Vaginal Gel (MucoLox™/VersaBase®)
Qty: #30 gm, or: other_____
Sig: Use 1 gm 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: _____