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

□ **Ketotifen 0.4% Vaginal Gel (MucoLox™/VersaBase®)**
Qty: #30 gm, or: other_____________
Sig: Use 1 gm vaginally as directed
or: ____

□ **Tranilast 1%/Betamethasone 0.05% 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: ______________________________________