Date: _____ Patient Name: _____
DOB: _____**Address:** _____
City: _____State: _____ Phone: _____ Allergies: _____
☐ Call When Ready ☐ Text Message When Ready ☐ Delivery ☐ Mail Out

☐ Acyclovir 5%/Lidocaine HCl 5%/Deoxy-D-Glucose 2% Vaginal Gel (MucoLox™) *(circle one)* Qty: #30gm, #90 gm, #240gm, or: other_____ Sig: AAA 1-2 times daily 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: _____