



Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Phone: \_\_\_\_\_ Allergies: \_\_\_\_\_

Call When Ready     Text Message When Ready     Delivery     Mail Out

**Clobetasol Propionate 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: \_\_\_\_\_

