



Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Phone: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 Call When Ready     Text Message When Ready     Delivery     Mail Out

**Diazepam 10 mg/Gm Vaginal Gel (MucoLox™/VersaBase®)**

Qty: #45gm or: \_\_\_\_\_  
 Sig: Insert 1 gm vaginally once daily at bedtime as directed.  
 Or: \_\_\_\_\_

**Ketamine HCl 0.5%/Diazepam 1%/Baclofen 2% Vaginal Gel (MucoLox™/VersaBase®)**

Qty: #45gm or: \_\_\_\_\_  
 Sig: Insert 1 gm vaginally once daily at bedtime as directed.  
 Or: \_\_\_\_\_

**Diazepam 5 mg Vaginal Suppository**

Qty: #30 or: \_\_\_\_\_  
 Sig: Insert 1 suppository vaginally once daily at bedtime as directed.  
 Or: \_\_\_\_\_

**Ibuprofen 600 mg Vaginal Suppository**

Qty: #30 or: \_\_\_\_\_  
 Sig: Insert 1 suppository vaginally once daily at bedtime as directed.  
 Or: \_\_\_\_\_

**EXTERNAL USE ONLY**

**Ibuprofen 20% Topical Lipoderm®**

Qty: #30gm or: \_\_\_\_\_  
 Sig: AAA externally as directed.  
 Or: \_\_\_\_\_

**Ketoprofen 10% Topical Lipoderm®**

Qty: #30gm or: \_\_\_\_\_  
 Sig: AAA externally as directed.  
 Or: \_\_\_\_\_

**Ketoprofen 10%/Cyclobenzaprine HCl 2% Topical Lipoderm®**

Qty: #30gm or: \_\_\_\_\_  
 Sig: AAA externally 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: \_\_\_\_\_

