COMPOUNDED PROGESTERONE

Prescriber:		Patient:	D.O.B.:
Address:		Mobile Phone:	Home Phone:
City:	State: Zip:	Address:	
Phone:	Fax:	City:	State: Zip:
DEA:	NPI:	Allergies:	

CAPSULES | MICRONIZED PROGESTERONE **IR**

Choose Strength:	Choose Qty:	SIG: Take one capsule by mouth:			Refills:
☐ **125 mg**	☐ 30	QHS ☐	BID ☐	QAM ☐	1 ◯ 2 ◯ 3 ◯ 4 ◯
☐ **225 mg**	☐ 60	Other:			5 ◯ 6 ◯ 7 ◯ 8 ◯
	☐ 90				9 ◯ 10 ◯ 11 ◯ 12 ◯

CAPSULES | MICRONIZED PROGESTERONE **MC**

Choose Strength:	Choose Qty:	SIG: Take one capsule by mouth:	Refills:
☐ **125 mg**	☐ 30	☐ QHS	1 ◯ 2 ◯ 3 ◯ 4 ◯
☐ **225 mg**	☐ 60	☐ BID	5 ◯ 6 ◯ 7 ◯ 8 ◯
☐ **300 mg**	☐ 90	☐ QAM	9 ◯ 10 ◯ 11 ◯ 12 ◯
☐ **400 mg**		Other:	

SUBLINGUAL TABS | MICRONIZED PROGESTERONE

Choose Strength:	Choose Qty:	SIG: Dissolveone (1) tablet under tongue:	Refills:
☐ **25 mg**	☐ 30	☐ QHS	1 ◯ 2 ◯ 3 ◯ 4 ◯
☐ **50 mg**	☐ 60	☐ BID	5 ◯ 6 ◯ 7 ◯ 8 ◯
☐ **75 mg**	☐ 90	☐ QAM	9 ◯ 10 ◯ 11 ◯ 12 ◯
☐ **100 mg**		Other:	

Custom Formula:

PRESCRIBER: Signature: _____ Date: ☐☐☐

Fax to the Pharmacy at 888-560-6691 or 940-382-2694.