COMPOUNDED PROGESTERONE

Prescriber:		Patient:	DOB:
Address:		Phone:	Sex:
		Address:	
City:	State: Zip:		
Phone:	Fax:	City:	State: Zip:
DEA:	NPI:	Email:	
Allergies:			

MICRONIZED PROGESTERONE **IR**

STRENGTH	QUANTITY
☐ 50 MG CAPSULE	☐ 30
☐ 75 MG CAPSULE	☐ 60
☐ 125 MG CAPSULE	☐ 90
☐ 225 MG CAPSULE	
OTHER: _____	OTHER: _____

MICRONIZED PROGESTERONE **MC**

STRENGTH	QUANTITY
☐ 125 MG CAPSULE	☐ 30
☐ 225 MG CAPSULE	☐ 60
☐ 300 MG CAPSULE	☐ 90
☐ 400 MG CAPSULE	
OTHER: _____	OTHER: _____

REFILLS

QUANTITY	
0 ◯	1 ◯
2 ◯	3 ◯
4 ◯	5 ◯
6 ◯	7 ◯
8 ◯	9 ◯
10 ◯	11 ◯

TAKE (1) CAPSULE BY MOUTH:	☐ QHS	☐ BID	☐ QAM	OTHER: _____

SUBLINGUAL TABLETS | MICRONIZED PROGESTERONE

STRENGTH	QUANTITY	DISSOLVE (1) TABLET UNDER THE TONGUE			
☐ 25 MG ☐ 75 MG ☐ 50 MG ☐ 100 MG	☐ 30 ☐ 90 ☐ 60 ☐ 180	☐ QHS	☐ BID	☐ QAM	OTHER SIG: _____

Comments:

PRESCRIBER:

Signature: _____ Date: ☐☐☐