Community Pharmacy

Direct Phone: 940-220-5871 opt. 1
Main Phone: 940-484-4400
Secure Fax: 940-898-1986

Methergine® Prescription Form
(methylergonovine maleate tablet)

1. PATIENT INFORMATION

Patient Name _____

Address _____

Apt. _____

City, State, ZIP _____

Home Phone _____ Alternate Phone _____

DOB _____ Gender: _____

Language Preference: ◯ English ◯ Spanish ◯ Other _____

2. PRESCRIBER INFORMATION

Prescriber's Name _____

DEA _____

NPI _____

Address _____

City, State, ZIP _____

Phone _____ Fax _____

Contact Person _____ Phone _____

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Prescription Card: Name of Insurer _____ ID # _____ BIN _____ PCN _____ Group _____

Primary Insurance: Subscriber _____ ID # _____ Name of Insurer _____ Phone _____

Secondary Insurance: Subscriber _____ ID # _____ Name of Insurer _____ Phone _____

4. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
Methergine®	0.2mg methylergonovine maleate tablet			

5. PRESCRIBER SIGNATURE - *stamped signatures are **NOT** permitted*

x _____ / / DISPENSE AS WRITTEN DATE

x _____ / / PRODUCT SUBSTITUTION PERMITTED DATE

v 1.0 02/18