



Direct Phone: 940-220-5871 opt. 1
 Main Phone: 940-484-4400
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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 _____ / / _____ X _____ / / _____
 DISPENSE AS WRITTEN DATE PRODUCT SUBSTITUTION PERMITTED DATE

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