Mirena®
(levonorgestrel-releasing intrauterine system) 20 µg/day

Prescription Form

(866) 647-3646
Fax completed form to:
(888) 281-8199

Physician Information

Prescriber's Name: _____

Contact Name: _____

Name of Practice/Clinic/Institution: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

E-mail _____ State Medical License #: _____

NPI#: _____ DEA#: _____ UPIN#: _____

Prescription Information for Mirena®

Rx Mirena® (levonorgestrel-releasing intrauterine system)

❑ Dispense 1 Mirena® SIG: To be inserted by physician as directed Refills: 0

Physician's Signature X _____ Date _____

Patient Information

Patient Name: _____

SS#: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Preferred Phone: ❑ home ❑ work Okay to leave a message at home: ❑ Yes ❑ No At work: ❑ Yes ❑ No

E-mail: _____

Allergies: _____

Credit Card Information:

Credit Card: ❑ VISA ❑ MasterCard ❑ American Express ❑ Discover

Please select payment option: ❑ One payment in full ❑ Four payment installment plan ❑ Twelve payment installment plan

Card Number: _____ Exp: _____

Signature of Cardholder: _____

Patient Consent

- I acknowledge that items purchased are non-returnable.
- I acknowledge that a photocopy or facsimile of this form is as valid as the original.
- I authorize TheraCom to bill my credit card in full at the time of purchase or in four or twelve payments according to the credit card payment plan.
- I authorize my physician to provide my name and the information on this form to TheraCom, Inc. in order to facilitate the securing of Mirena®. I hereby authorize TheraCom, Inc., its personnel and/or its agents to contact my doctor on my behalf for the release of medical and prescription information which is to be used in the dispensing of my Mirena®. I direct that this authorization be treated as permanent authorization for release of my information unless I otherwise notify TheraCom in writing.

Patient's Signature X _____ Date _____