

Patient Name				DOB		_ Sex M ,	/ F
Cell Phone	Delivery	y Address					
⊘ Prescriptions							—
Medication	Strength	QTY	Directions		Form (cap, tab, e	tc.) Refi	lls
Addyi® (flibanserin)	100mg				Tablet		
DAW	ICD-10			'			
Past Tried/Failed Meds [REQUIRED]: Person Sending Fax First Name Provider Signature Provider Information Provider's Name DEA				Las	st Name		
Office Address							
State & ZIP Nick addyi com/ni for Full Pres		O	ffice Phone		Fax		

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