Request Sample for PATIENT

**To ensure your patient receives a sample of Slynd®,** either call or fax GoGoMeds® the required prescription below.

**PHONE: 1-888-795-5826 | FAX: 1-877-766-0185**

## Slynd® New Prescription: Direct to Patient Sample

Patient Name: ______________________ Date of Birth (MM/DD/YYYY): ______________

Patient Address: ______________________________________________

Patient City: ______________________ Patient State: ________ Patient Zip: __________

Patient Cell Phone: ______________________ Patient Email Address: ______________

Patient Allergies: ______________________________________________

Patient Other Medications: ______________________________________________

Medication: **Slynd (drospirenone) tablets, 4mg** DAW: ☐ Yes ☐ No

Quantity: **28 tablets** ICD-10: ______________

Directions: **Take as directed on pack.**

Refills: **N/A**

Comments: **Please dispense Slynd Starter Kit with Slynd Sample, Patient Brochure and Savings Card**.

______________________________________________

Prescriber Name: ______________________ Prescriber Phone: ______________

Prescriber Fax: ______________________________________________

Prescriber Address: ______________________________________________

Prescriber City: ______________________ Prescriber State: ______ Prescriber Zip: __________

Prescriber DEA: ______________________ Prescriber NPI: ______________

Prescriber Signature: ______________________________________________

Date: ______________

DEA: FS4987408 | www.GoGoMeds.com

Slynd® (drospirenone) tablets, 4mg

For full Slynd® prescribing information and product package insert, visit SLYND.COM.

EXP-20-0016 R00