exem® foam
(air polymer-type A) intrauterine foam

RX FAX FORM ScriptsRX

FAX TO (877) 991-1798

For assistance in completing this form, call **ScriptsRx** at:
(800) 266-4907

Date Prescription Issued __/__/____ Date of HyFoSy Procedure __/__/____ (If known)

Section 1. Patient Information

Patient name _____ DOB __/__/____
First name MI Last name

Address _____ City _____ State _____ Zip Code _____

Mobile phone (___)___-____ Alternate phone (___)___-____

Section 2. Prescriber and Shipping Information

Prescription is to be shipped only to the Prescriber's site/facility shipping address below (as applicable by state law).

Prescribing physician name _____ NPI # _____

Site/Facility name _____ Shipping contact name _____

Shipping address _____ City _____ State _____ Zip code _____

Physician contact information: Phone (___)___-____ Fax (___)___-____ Email address _____

Section 3. Prescription Information

Drug name: ExEm® Foam((air polymer-type A) intrauterine foam)
NDC: 7325431001
Drug strength: 1 unit; When prepared by physician as directed ExEm® Foam will contain between 10,000 to 127,000 bubbles per mL.

Dosage Form/Strength:
Intrauterine Foam, single-dose kit containing:
- one syringe with 5 mL clear Gel [polymer type A (hydroxyethyl cellulose), glycerin and purified water]
- one syringe with 5 mL Sterile Purified Water
- one Combifix® Adaptor (coupling device)

Quantity Prescribed: 1 kit

Directions for use: To only be used by licensed physician during in-office procedure.

SIGN _____ _____
Physician Signature Date

My signature certifies that the person named on this form is my patient; the information provided on this Enrollment Form, to the best of my knowledge, is complete and accurate; that this prescription of ExEm® Foam is medically necessary and that I have prescribed ExEm® Foam to the patient named on this Enrollment Form for an FDA-approved indication. I understand that my patient's information provided to the pharmacy is for use of ExEm® Foam solely to verify my patient's insurance coverage; to assess, if applicable, my patient's eligibility for patient assistance and other support programs; and to otherwise administer ExEm® Foam for the patient. I certify that I have obtained my patient's consent, as applicable, to share this information for treatment and payment purposes. I consent to ExEm® Foam contacting me by fax, mail, or email to provide additional information about ExEm® Foam.