CeQur Simplicity™
MEALTIME INSULIN SIMPLIFIED™

REFILL RX INSTRUCTIONS

Rx Fax to:

Patient Information

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____ Gender: ☐ Male ☐ Female

Preferred Phone #: _____ Email: _____

Patient's Preferred Pharmacy & Location: _____

Prescription Information

PRODUCT	PACK SIZE, QUANTITY	DOSING/RX INSTRUCTIONS	REFILLS
CeQur Simplicity 2U Extended Wear 2.4ml Patch NDC/NRC: 73108-0000-13	☐ 1 Box = 5 patches for 30 days	Use up to 40 units of rapid acting insulin per day	**11**
	☐ 2 Boxes = 10 patches for 30 days	Use up to 80 units of rapid acting insulin per day	
	☐ 3 Boxes = 15 patches for 90 days	Use up to 40 units of rapid acting insulin per day	**3**
	☐ 6 Boxes = 30 patches for 90 days	Use up to 80 units of rapid acting insulin per day	
CeQur Simplicity 1U Extended Wear 2.4ml Patch NDC/NRC: 73108-0000-11	☐ 1 Box = 4 patches for 28 days	Use up to 34 units of rapid acting insulin per day	**11**
	☐ 3 Boxes = 12 patches for 84 days	Use up to 34 units of rapid acting insulin per day	**3**
CeQur Simplicity Extended Wear Inserter Kit NDC/NRC: 73108-0000-14	☐ 1 Inserter Kit	Use to apply CeQur Simplicity Patch	**N/A**

Prescriber Information

Prescriber Name: _____ NPI: _____

Address: _____

City: _____ State: _____ Zip: _____ Tel: _____ Fax: _____

PRESCRIBER SIGNATURE (No stamps. Signature and date must be completed in prescriber's handwriting.)

I authorize the receiving Pharmacy and its representatives to act as an agent to initiate and execute prior authorization for the above patient to expedite the process, please provide chart notes and most recent labs.

Prescriber Signature: _____ **Dispense as Written** **Date:** _____

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