CeQur Simplicity™
MEALTIME INSULIN SIMPLIFIED™

**NEW PATIENT 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: _____

***PLEASE ATTACH PATIENT DEMOGRAPHICS (INCLUDING INSURANCE)***

## Clinical Information

☐ Currently Using Basal/Bolus Therapy
☐ Using Basal, Advancing to Basal/Bolus Therapy

Diagnosis: _____

☐ Patient is missing multiple doses of meal-time insulin weekly - due to the delivery method their insulin is given.
☐ Patient has an elevated A1C > 8.0%

## 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

**PRIOR AUTHORIZATION IF REQUIRED**

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.

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

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