CeQur Simplicity™
MEALTIME INSULIN SIMPLIFIED™

Knipper | KnippeRx | Eagle Pharmacy

Rx Fax: 833-434-1460

Patient Information

Patient Name: ______________________________ DOB: ______________

Address: ____

City: ______________________ State: _____ Zip: _______ Mobile Phone: ______________

Alt Phone: ______________ Email Address: ______________________________

Gender: ☐ Male ☐ Female Preferred Language: ☐ English ☐ Spanish ☐ Other *(please specify)*: __________

Allergies: ☐ No Known______________ Health Conditions: ☐ No Known______________

Other Medications: ☐ No Known______________________________

PATIENT CONSENT (Patient, please initial)

By initialing in the space provided, the patient consents to have a CeQur representative or/and KnippeRx Inc. contact them to provide customer service and support.

I authorize KnippeRx Inc. to use and disclose my health information related to my prescription and medical diagnosis to CeQur for the purposes of providing me with training services related to my therapy - such as educational materials, survey inquiries, offers or information about CeQur products and services that could be of interest to me. I understand that KnippeRx Inc. may be provided compensation for these activities. This authorization applies to the following information: my name, contact information, date of birth, diagnosis, prescription history and any other CeQur-related information KnippeRx Inc. has about me. I understand that I am not required to consent to this authorization and that my healthcare providers including KnippeRx Inc. will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I agree to this authorization. However, I understand that if I do not agree to this authorization, I may not be able to participate in certain CeQur services. I understand that this authorization will expire when the CeQur program ends unless I cancel it sooner. I may cancel my authorization by calling 1-855-647-7379. KnippeRx Inc. will not use or disclose my information after receiving my cancellation, but cancellation will not affect any use or disclosure made before my request was processed. I understand that unless otherwise restricted by state law, my health information released under this authorization is subject to re-disclosure by those who receive my information and will no longer be protected by the federal privacy rules, known as HIPAA.

__________ Initials

PLEASE ATTACH PATIENT DEMOGRAPHICS (INCLUDING INSURANCE) & LAST CLINICAL CHART NOTE WITH EACH PRESCRIPTION FORM
PLEASE ATTACH COPIES OF FRONT AND BACK OF PATIENT'S PRESCRIPTION INSURANCE CARDS IF AVAILABLE

Clinical Information

- ☐ Currently Using Basal/Bolus Therapy
- ☐ Using Basal, Advancing to Basal/Bolus Therapy
- ☐ Currently Using Insulin Pen(s)
- ☐ Currently Using Insulin Syringes and Vials

Diagnosis: ______________________________

Daily Bolus Insulin Requirements: ____________units

- ☐ 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	QUANTITY	DIRECTIONS	REFILLS
CeQur Simplicity™ 2U 4-Day NDC/NRC: 73108-0000-08	**30 Day Supply** ☐ 2-Unit Patch, 8-Pack, **# of Boxes = 1** (Patient requires 180 units of rapid-acting insulin or less in 4 days) ☐ 2-Unit Patch, 8-Pack, **# of Boxes = 2** (Patient requires > than 180 units of rapid-acting insulin in 4 days)	Apply Patch as directed Dose as directed 1 squeeze = 2 Units	**11**
CeQur Simplicity™ 2U 4-Day NDC/NRC: 73108-0000-08	**90 Day Supply** ☐ 2-Unit Patch, 8-Pack, **# of Boxes = 3** (Patient requires 180 units of rapid-acting insulin or less in 4 days) ☐ 2-Unit Patch, 8-Pack, **# of Boxes = 6** (Patient requires > than 180 units of rapid-acting insulin in 4 days)	Apply Patch as directed Dose as directed 1 squeeze = 2 Units	**3**
CeQur Simplicity™ Inserter NDC/NRC: 73108-0001-00	**Inserter Kit** ☐ 1 Inserter, IFU and literature	Use as directed following consult from your pharmacist and/or healthcare provider.	**N/A**

Additional Instructions

- Daily Bolus Insulin Use (units) ____ x ____ days + Extra 20 Units = ____ Total Fill Units Per Patch
- Patch holds a min of 100 units & a max of 200 units. The extra 20 units are used to prime the Patch.
- Patient will need a Rx for a vial of rapid-acting insulin – labeled for use with Humalog® U-100 or Novolog® U-100. Patch may be worn for up to **4 days**. Change Patch after ____ days.

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 in order to expedite the process, please provide chart notes and most recent labs.

Provider Signature: ______________________________ **Dispense as written** **Date:** _____/_____/_____