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) & LAST CLINICAL CHART NOTE

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	INSULIN USAGE, PACK SIZE, QUANTITY	DOSING/RX SIG INSTRUCTIONS	REFILLS
CeQur Simplicity™ 2U 4-Day NDC/NRC: 73108-0000-08 30 Day Supply	☐ ≤ 200 Units In 4 Days, 1 Box = 8 Patches ☐ > 200 Units In 4 Days, 2 Boxes* = 16 Patches **Provide clinical rationale if more than 1 box is needed*	☐ Change every 3 to 4 days as directed for 30 days ☐ Change every 2 to 3 days as directed for 30 days	11
CeQur Simplicity™ 2U 4-Day NDC/NRC: 73108-0000-08 90 Day Supply	☐ ≤ 200 Units In 4 Days, 3 Boxes = 24 Patches ☐ > 200 Units In 4 Days, 6 Boxes* = 48 Patches **Provide clinical rationale if more than 3 boxes are needed*	☐ Change every 3 to 4 days as directed for 90 days ☐ Change every 2 to 3 days as directed for 90 days	3
CeQur Simplicity™ Inserter NDC/NRC: 73108-0001-00	☐ 1 Inserter, IFU and Literature	Use as directed following consult from your pharmacist and/or healthcare provider	N/A
Complete Instructions (if over 200 units)	Daily Bolus Insulin Requirements: _____ units		

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:** _____