CeQur Simplicity™
MEALTIME INSULIN SIMPLIFIED™

NEW PATIENT RX INSTRUCTIONS
Fax Rx to 833-434-1460

Knipper® KnippeRx® Eagle PHARMACY

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

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