

Fax Rx to: _____

Patient Information

Patient Name: _____ DOB: _____

Address: _____

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

Preferred Phone #: _____ Email: _____

Patient's preferred pharmacy & location: _____

	PRODUCT	INSULIN USAGE, PACK SIZE, QUANTITY	DOSING/RX SIG INSTRUCTIONS	REFILLS
Prescription Information	CeQur Simplicity™ 2U 4-Day NDC/NRC: 73108-0000-08 30 Day Supply	<input type="checkbox"/> ≤ 200 Units In 4 Days, 1 Box = 8 Patches <input type="checkbox"/> > 200 Units In 4 Days, 2 Boxes* = 16 Patches <i>*Provide clinical rationale if more than 1 box is needed</i>	<input type="checkbox"/> Change every 3 to 4 days as directed for 30 days <input type="checkbox"/> 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	<input type="checkbox"/> ≤ 200 Units In 4 Days, 3 Boxes = 24 Patches <input type="checkbox"/> > 200 Units In 4 Days, 6 Boxes* = 48 Patches <i>*Provide clinical rationale if more than 3 boxes are needed</i>	<input type="checkbox"/> Change every 3 to 4 days as directed for 90 days <input type="checkbox"/> Change every 2 to 3 days as directed for 90 days	3
	Complete Instructions (if over 200 units)	Daily Bolus Insulin Requirements: _____ units		

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.)

Prescriber Signature: _____ Dispense as written Date: _____