Faxed prescriptions will only be accepted from a prescribing practitioner.

Patient Prescription Form

Fax or e-prescribe your Rx to KnippeRx.

knipperx.com **Fax: 833-546-0611** **Ph: 833-912-0764**

If you have questions or concerns, please contact KnippeRx.

1. Patient Information

Patient Name: ______________________

Date of Birth: ______________________ Known Allergies: ______________________ NKDA: ☐

Preferred Phone: ______________ ◯ cell ◯ home ◯ work Email (optional): ______________________

Home Address: ______________________ City: __________ State: __________ Zip: __________

If Different, Ship to ______________________ City: __________ State: __________ Zip: __________

2. Insurance Information *Please fax FRONT and BACK copy of ALL prescription insurance cards.*

Primary Prescription Insurance: ______________________

Name: ______________________ Phone: ______________________

Policy #: ______________________ BIN: ______________________

Group #: ______________________ PCN: ______________________

3. Prescriber Information

Provider Name: ______________________ DEA#: __________ NPI#: __________ Tax ID: __________

Address: ______________________ Phone: __________ Phone: __________ Fax: __________

City: __________ State: __________ Zip: __________ Key Contact: __________ Phone: __________

4. Diagnosis/Clinical Information

Has your patient been diagnosed with hypoactive sexual desire disorder (HSDD)? If yes, please check here, and bill to ICD-10-CM code F52.0: ☐

Is the patient greater than 18 years old ☐ Yes ☐ No

Is the patient premenopausal ☐ Yes ☐ No

Has the patient experienced HSDD for: Less than 6 months ☐

More than 6 months ☐

Does the patient have uncontrolled hypertension or cardiac disease ☐ Yes ☐ No

Current medications: ______________________

Please attach Clinical/Progress Notes ______________________

Vyleesi ordered as the only on-demand FDA approved treatment for HSDD ☐

Is HSDD Diagnosis due to co-existing:

- Medical or Psychiatric Condition ☐ Yes ☐ No
- Problems with relationships ☐ Yes ☐ No
- Other medication or drug substances ☐ Yes ☐ No

Has the patient tried/failed other HSDD meds? ☐ Yes ☐ No

Does the patient have a history of hepatic impairment? ☐ Yes ☐ No

Does the patient have a history of renal impairment? ☐ Yes ☐ No

Is the patient currently being treated for depression? ☐ Yes ☐ No

5. Prescription Information

Dispense Vyleesi as follows:

☐ Vyleesi 1.75 mg/0.3 ml Prefilled Single-dose Autoinjector Quantity #4 Single-dose Autoinjectors NDC 80064-141-04

Directions: Inject subcutaneously as needed at least 45 minutes before anticipated sexual activity. No more than 1 dose per 24 hours. More than 8 doses per month is not recommended.

Refills: PRN ☐ 6 ☐ 12 ☐

Additional Prescribing Info: ______________________

☐ The Specialty Pharmacy is authorized to submit to a Payer a required completed Prior Authorization form on my behalf.

Prescriber Signature: Please sign and date below

______________________ ______________________

Dispense as written Date

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document right away.

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