Faxed prescriptions will only be accepted from a prescribing practitioner.

vyleesi® (bremelanotide injection)

Patient Prescription Form

Fax or e-prescribe your Rx to KnippeRx.

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: _____ Known Allergies: _____ NKDA: ☐

Date of Birth: _____ Email (optional): _____

Ship to Address: _____ Preferred Phone: _____ ◯ cell ◯ home

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#: _____

Address: _____ Tax ID: _____

City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: _____

Phone: _____ Fax: _____ Uses Cover My Meds: ☐ Yes ☐ No

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

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 _____

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

If yes, list meds: _____

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 ☐ #8 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: _____

Prescriber Signature: Please sign and date below

_____ _____

Dispense as written Date