

vyleesi[®]
(bremelanotide injection)

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: _____ 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

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.